

CHAPTER TWO

Theoretical Framework and Literature Review

2.1 Introduction

This chapter presents a review of the literature on the utilisation of health facilities and use of contraceptives among young women worldwide. Special attention is paid to contraceptive use and health facilities utilisation in Africa and, in particular, sub-Saharan Africa. Utilisation of health facilities is one of the important aspects because in Namibia most sexual and reproductive health services, including contraceptives, are offered by the Ministry of Health and Social Services through its health centres. To access contraceptives young women have to be able to utilise health facilities where such services are offered. Hence, if utilisation of health facilities by young women is limited then it can be assumed that contraceptive use for young women is also limited. The evolution and importance of contraceptive use as well as other reproductive health services in sub-Saharan Africa are the central issues addressed in this chapter. A conceptual and theoretical framework is introduced: it comprises an adaptation of the Davis and Blake (1956) model, the Health Belief model and Easterlin's supply and demand theory. Socio-economic, demographic and behavioural factors that influence contraceptive use among young women are also reviewed.

2.2 Theoretical and conceptual framework of the determinants of contraceptive use

When the modern family planning movement began in the early 20th century, its primary purpose was to liberate women from social and health consequences of unwanted pregnancies. When organized family planning

programmes reached developing countries in the early 1950s, these programmes were viewed as the means to alleviate the pressure of rapid population growth on economic development. In the last few decades, the purpose of family planning has broadened to encompass both these objectives and the objective of improving women's health and welfare. Previous research (Castro & Juarez, 1994) has examined how women's roles and status influence their use of contraception and their fertility. However, although young women are seen as beneficiaries of family planning, too little attention has been paid to assessing their behaviour in relation to family planning.

The theoretical framework presented in this chapter is based on research and literature concerned with young women and family planning. The framework is an integration of the intermediate determinants' framework proposed by Davis and Blake (1956) and the fertility decision-making model presented by Bulatao and Lee (1983). The Davis-Blake model starts from the premise that reproduction involves three necessary steps: intercourse, conception and completion of gestation. The fertility decision-making theory is based on the notion that as society modernises, changes occur including rational decision-making and changes on the structure of the family.

The integration of the two approaches leads from the assumption that decisions have a direct input in altering the intermediate variables. While it might not be possible to include all the variables and pathways in any one model, it provides a useful starting point and guide in selecting the variables which have a direct influence on contraceptive use. In the framework, the proportion of current contraceptive users in a population is a product of new users (adoption), continuing users (continuation) and those who have resumed use (resumption). These can be used to distinguish pre-adoption

and post adoption stages of contraceptive use. These stages are themselves influenced by socio-economic, cultural and macro factors.

Decision-making consists of three elements: knowledge, motivation and assessment of fertility regulation. The initial step involves being aware of the alternatives of influencing ones' costs of reproductive behaviour. However, knowledge alone would not be sufficient to influence fertility regulation although it is a precondition. Knowledge about contraceptives should be accompanied by perceptions about access and availability of methods in order for proper considerations to be given whether to use or not. In order for women to adopt contraception, they should have a perception of the availability and accessibility of the means of fertility regulation, so that they can translate these perceptions into action according to Davis & Blake model (1956).

The second stage of the decision-making process involves motivation. Within a population, motivation is influenced by socio-economic, cultural and family life cycle patterns. The concept of motivation has been used widely in the economic models of fertility in which motivation is thus defined as the balance between supply and demand (Davis & Blake, 1956). The last stage in the decision-making process is assessment, which is the weighting of the positives and negatives of adopting contraception.

A key purpose of the framework is to highlight how parental involvement acts as an intervening factor in influencing young women to use family planning services. Young women's contraceptive behaviour is multidimensional and has been studied extensively with or without a theoretical basis (Bender & Kosunen, 2005). Attitudes and beliefs about contraceptive use are considered to be of great importance regarding contraceptive intention and behaviour. If young women trust their ability to have control, if they believe that pregnancy

at a young age is a serious matter and that it is beneficial to use contraception and have parental support, they are considered more likely to obtain sexual and reproductive health services, including contraceptives, effectively. However, if young women do not believe in the above-mentioned items and think there are several barriers to obtaining sexual and reproductive health services, then they are considered less likely to use contraceptives.

Several theoretical models on health behaviour such as the Health Belief Model and the Health Promotion Model, have been developed (Becker, 1974). These models have been applied and tested with regard to the use of contraception. Several studies (Boohene et al., 1991; Bongaarts & Johansson, 2000) have shown a significant relationship between attitude and contraceptive intention and behaviour. Considering the value of the attitude/belief behaviour relationship and its relevance to preventive strategies like sexual and reproductive health services, it is considered of importance to explore some beliefs of young women in Namibia regarding contraception by adapting some ideas from the Health Belief Model and Easterlin's supply and demand theory (Easterlin, 1975) of fertility regulation.

According to the Health Belief Model, individual perceptions such as perceived seriousness of pregnancy, perceived benefits and perceived barriers are more likely to affect the preventive actions such as using contraception which can prevent a specified condition such as unplanned pregnancy. In addition, perceived barriers such as difficult access to sexual and reproductive health services (SRH) and providers' negative attitudes can prevent use of services. In contrast, the perceived benefit of communicating with parents may result in more effective use of contraception. This model promotes an ability to weigh benefits and make changes when confronting a health risk. An example of a scenario for this model would be: a young

woman having unprotected intercourse who must first perceive that sexual activity involves consequences such as an unintended pregnancy (susceptibility); then, that the consequence could be negative, such as having a child and dropping out of school to support her child (severity); and finally, that the prescribed interventions such as using contraception and finishing school before becoming a parent are useful (benefits) and outweigh potential negative side effects, such as weight gain from contraceptive use or potential loss of social status by delaying parenthood (Brindis & Davis, 1998).

The Health Belief Model provides a framework for understanding the potential influence on an individual's decision to make use of available health services. Although the model provides a framework for understanding factors operating at the individual level to influence the decision to use reproductive health services, it does not examine factors operating beyond the individual level, nor does it include the role of community and health system characteristics in shaping this decision. Thus, previous studies on the use of sexual and reproductive health services focus largely on the barriers and facilitators involved in the decision to seek care, that is, the modifying factors taken into account in the Health Belief Model (Stephenson & Tsui, 2002; Glover et al., 2003). These studies highlighted a range of potential modifying factors in a woman's propensity to seek health care that are broadly categorized as demographic, socio-economic, cultural and health experiences characteristics. Demographic factors that have been shown to increase the likelihood of health service use are low parity (Magadi et al., 2000; Stephenson & Tsui, 2002); young maternal age (Bhatia & Cleland, 1995); women's employment status and educational level.

Socio-economic factors, however, have been shown to be of greater importance than demographic factors in influencing the use of health services (Obermeyer & Potter, 1991). Although demographic factors may shape a

woman's desire to make use of services (for example, younger women may have more modern attitudes towards health care), the socio-economic status of an individual and her household determines her economic ability to do so. In terms of socio-economic factors, the determinants of reproductive health-service use have been found to be most consistent with a woman's educational attainment (Magadi et al., 2000). Higher levels of educational attainment result in greater use of sexual and reproductive health services. Apparently, increased educational attainment influences service use in several ways, including an increased woman's decision making power and awareness of health services, changing marriage patterns and creating shifts in household dynamics (Obermeyer, 1993).

Cost has been shown to be a barrier in service use (Bloom et al., 1999; Griffiths & Stephenson, 2001) and it also influences the choice of source from which care is sought. In a study of the use of antenatal care in India, Griffiths and Stephenson (2001) show that although women perceive private services to offer greater quality care, the cost of such services often makes them unaffordable. Socio-economic indicators such as urban residence (Addai, 1998), household living conditions (Bloom et al., 1999; Magadi et al., 2000) and employment status have also proven to be strong predictors of a woman's likelihood of using reproductive health services.

Both demographic and socio-economic determinants of the use of reproductive health services are mediated by cultural influences on health care seeking behaviour that shape the way an individual perceives her own health and available health services (Stephenson & Tsui, 2002). Community beliefs and norms relating to health care seeking behaviour are reflected in individuals' decisions which are based, to some extent, on how the community views their actions (Rutenberg & Watkins, 1997). Community beliefs concerning childbearing preferences and sexual and reproductive

health behaviour are a strong influence on individual attitudes towards family planning and fertility preferences (Greenwell, 1996). In addition, Goodburn and her colleagues (1995) note that in many cultures, the use of reproductive health services is an alien concept, because services are perceived as existing solely for curative purposes. This belief was also highlighted by Griffiths and Stephenson (2001) who found that women in India would only avail themselves for antenatal care if they experienced problems during their pregnancies. Thus although demographic and socio-economic factors are key determinants of health service use, the individual's cultural environment and behaviour influences the extent to which these factors can lead to service use.

A woman's previous exposure to health care services has been shown to be a strong predictor of her propensity to make use of available reproductive health services (DeGraff et al., 1997; Bloom et al., 1999). Bloom et al. (1999) found that contact with health care professionals during pregnancy leads to an increased likelihood of postpartum contraceptive use. A woman's positive previous experience with health care professionals can instil confidence in and familiarity with care services, so that she may be more likely to use reproductive health services on future occasions.

Interest has grown in examining community influences on individual health outcomes so as to place and characterise health care seeking behaviour of the community, including levels of economic development and the community's health care infrastructure (DeGraff et al., 1997; Manda & Makandi, 1998; Magadi et al., 2000; and Stephenson & Tsui, 2002). A community has the potential to influence the health of an individual in several ways. Community attitudes and practices relating to health influence individual health care decision strongly (Greenwell, 1996; Rutenberg & Watkins, 1997). Clearly, the level of a community's economic development

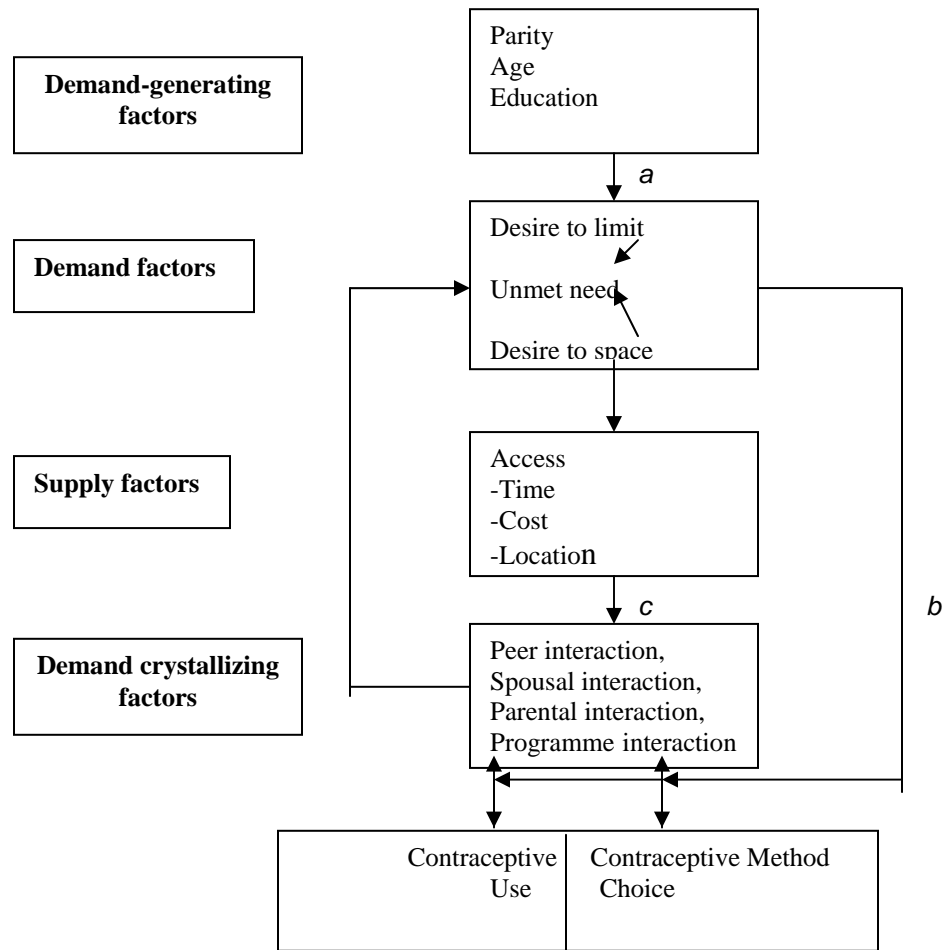
can influence health directly through the association between poverty, deprivation and poor health (Kriegar et al., 1993) and indirectly through access to health care services and social support systems (Diex-Roux, 1998). Economic development is positively related to health outcomes as a result of its relationship to increased female decision making power, through the increased likelihood of female labour force participation and through positive attitudes towards the use of health care services (Grady et al., 1993). Characteristics of a community's health service infrastructure influence individual behaviour through access to services. Many studies (Brindis & Davis, 1998; Hague & Faizunnisa, 2003; Hock-Long et al., 2003; Belmonte et al., 2000) have demonstrated a relationship between measures of access to services (for example, travelling distances to services) and individual health care seeking behaviours (Jahn et al., 1998). There is however dearth knowledge on the dimension of household influences on the use of sexual and reproductive health services. This is crucial especially for young women who are still in the care of parents.

The framework presented on the next page is based on structural models of fertility in which contraceptive use is an endogenous determinant of fertility. These models take into account demand and supply side factors that affect contraceptive use and ultimately fertility. The simple form of these models suggests that exogenous individual background factors affect a woman's fertility preferences. These factors include the woman's age, education, parity, spousal interaction, familial support, as well as family planning programme variables. Together with the direct effects of household and programme variables, parental support affects contraceptive practices.

The outcomes that are modelled here are contraceptive use and contraceptive method choice. The focus of this study is on the behavioural effect of young women on contraceptive use and contraceptive method

choice. The main concern is about the specific pathway by which individual and behavioural variables affect the outcomes.

Figure 3: Conceptual framework for the determinants of contraceptive use and contraceptive method choice



Source: Adapted from Davis & Blake (1956)

The schematic presentation in figure 3 examines the relative roles of individual and social support factors as determinants of use of contraceptive and choice of methods. Determinants are divided into four general classes: (i) demand-generating factors such as education, age and other personal characteristics; (ii) demand components which are composed of desire to limit

births and desire to space future births (iii) supply factors and (iv) demand crystallising components which are composed of factors that facilitate the implementation of the outcome such as spousal support, social (peer) support and parental support.

In this specification, individual agency is generated by individual socio-economic characteristics indicated by the pathways *a* and *b* representing the extent to which demand fosters adoption of contraceptive methods in the absence of facilitating factors. Pathway *c* represents the role of crystallizing factors in fostering the implementation of demand. In this framework, programme activities play a role in contraceptive method adoption that is similar to the roles of social, familiar and spousal support. The psychological, logistical and social constraints to contraceptive adoption are offset by programme activities that enhance service accessibility, improve the climate of information exchange and legitimize contraceptive behaviour.

2.3 Background information on contraception

Any deliberate practice undertaken to reduce the risk of conception is considered as contraception (Mturi, 1996). Hennink (1997) similarly defines contraceptive use as “the deliberate employment of a technique or device to prevent conception”. Contraceptive use has been described as the most important proximate determinant of fertility (Bongaarts et al., 1994). The proximate determinants of fertility are the biological and behavioural factors through which social, economic and environmental variables affect fertility. These were first described by Davis and Blake in 1956 who provided 11 determinants categorized into those which affected exposure to sexual intercourse; the chance of successful conception; and finally successful gestation. Demographers study the use of contraceptives because of its relationship with fertility and birth spacing. It is well known that contraceptive

use has a significant impact on reducing a woman's fertility level (Ntozi & Ahimbisibwe, 2001; Mturi & Hinde, 2001). Use of contraception is also one of the indicators most frequently used to assess the success of family planning programmes (Rutenburg et al., 1991; Curtis & Neitzel, 1996). When modern contraceptives, such as the oral contraceptives and the intrauterine device (IUD), became available more than 35 years ago, excitement prevailed about their potential to prevent unintended pregnancies, while concerns were also raised about their long-term safety.

Later, Bongaarts et al. (1994) argues that four intermediate variables are key to the determinations of fertility; namely age at marriage, duration of lactation amenorrhoea, use of contraception and the incidence of induced abortion. The idea of Bongaarts' framework is that couples who wish to control their childbearing will do so by using one of these strategies and that the choice of approach and propensity to control childbearing will depend on socio-economic and cultural factors. Actual use of contraception among women may be considered a function of interest or motivation in delaying, spacing or limiting childbearing within a population and the accessibility of contraceptive services to that population. Effective access may in turn be defined in terms of: awareness or knowledge of source of family planning information and other services; proximity to one or more sources of those services; and the extent to which other constraints that limit utilisation of those services exist. Such constraints may include the cost of contraception, social barriers, and the quality of service available (Curtis & Neitzel, 1996). The spread of contraceptive use within a society can be viewed as a diffusion process (Curtis & Neitzel, 1996). The first stage is to become aware of and have informed knowledge about contraceptive methods. In populations with family planning policies designed to increase contraceptive use, measuring the level of awareness of contraception also provides a useful measure of success of

information, education and communication activities and may help to identify programme areas that need to be strengthened.

Mturi & Hinde (2001) reported that differences in levels of contraceptive use explain about 92 per cent of the variation in fertility and argued that this implies that where contraceptive use is widespread, fertility is expected to decline and birth spacing is equally widespread. Thus, contraceptive use is important not only for its effect on fertility but also because it has health implications for both mother and child. The consequences of teenage fertility are well documented and raise fundamental concerns about the health and social development of young mothers and their children. Pregnancy and childbearing during young ages are generally associated with higher rates of maternal mortality and greater risks for abortion, delivery complications and low birth weight infants. Pregnancy related complications are among the main causes of death for 15–19 year old women worldwide (McDevitt et al., 1996).

The Population Reference Bureau (PRB) (2004) reported that teenage women are less likely than women over age 20 to use contraceptive methods. Reasons given for this include lack of information, misinformation and fear of side effects, along with geographic, social, cultural and economic barriers to access and use of contraceptives. In addition, most of these women are not sexually active and thus they do not need contraceptives. Furthermore, in most African countries, young women aged over 20 years are married and use contraceptives mainly to space births and those who are not married use contraceptives to delay first births. Although family planning services are designed to serve all women of reproductive ages, there are studies (Belmonte et al., 2000) which report that unmarried young women find service providers hostile or unhelpful, especially where strong cultural or religious beliefs condemn sexual activity among unmarried women (Belmonte et al., 2000). Young women may also be unwilling to disclose their sexual activities

to adult health service providers. In addition, the sporadic and unplanned nature of adolescent sexuality can be an obstacle to consistent contraceptive use (PRB, 2004).

The quality of family planning services has a strong impact on contraceptive use (Koc, 2000). Choice is the first and fundamental element in providing quality family planning. Making family planning available at various types of outlets also promotes choice. Until the 1990s the emphasis was on the quantity of services provided rather than the quality (DeGraaf, 1991). DeGraaf (1991) argues that evidence from field programmes demonstrates that the quality of services provided can have an important impact on contraceptive use.

Quality in family planning programmes means extending the choice of contraceptive methods, providing adequate information, increasing the technical competence of providers, improving interpersonal relations between providers and clients, and incorporating adequate client support and follow-up. Much of the failure to use existing services is attributable to lack of quality. A study in Indonesia found that 12 months after receiving contraceptive services, 85 per cent of women who had not received their first choice of method had stopped using contraception (Fathonah, 1996). In addition, a Bangladesh study found that lack of counselling about usual side effects and their significance was the main reason why women discontinued using injectables (DeGraaf, 1991).

According to Shane (1996) between 12 per cent and 42 per cent of married young women in less developed countries who say they would prefer to space or limit births are not using contraceptives. This is an indication of unmet needs for contraceptives among young women. There is a need for them to use contraceptives but there are barriers which prevent them. Some

of the barriers include disapproval from partners or in-laws, access to health facilities and so on. Shane (1996) further suggests that if sexually active unmarried young women were taken into account, the unmet needs figure would certainly be higher. Shane (1996) also reports that married young women worldwide can benefit from contraceptive use by delaying first births until their bodies are physically mature enough to carry a healthy pregnancy to term, and by delaying subsequent births. However, this might not be the case in most African countries where a married woman is normally expected to bear at least one child immediately after marriage. In the African context, married couples are under immense pressure from in-laws and family members if they fail to bear a child immediately after marriage, because childless marriage is regarded as a shame in the family (Nengomasha et al., 2004).

However, UNICEF (2004) and Griffiths et al., (2001) report a strong relationship between a mother's pattern of birth and the survival chances of her children. Infants and young children have a high risk of death if they are born to very young mothers or if they are born shortly after another birth or if their mothers already have many children. This is, thus, not taken into account among many African societies, where people believe that if you are married then you are grown up and ready to bear children no matter how young you are (Nengomasha et al., 2004).

The transformation in contraceptive practice reflects the growing desire of couples and individuals to have smaller families and to choose when to have children. It also reflects great increases since the 1960s in the availability of effective modern contraceptives in developing countries and of associated family planning information and services. The introduction of modern methods has also brought about a transformation in contraceptive practice in the more developed regions, although changes concern primarily the choice of specific

birth control methods rather than the overall level of contraceptive use (United Nations, 1988; Koc, 2000; Ketende et al., 2003).

Substantial evidence is found in existing literature that broadening the choice of contraceptive methods increases overall contraceptive prevalence (Magadi & Curtis, 2003). The provision of a wide range of contraceptive methods increases the opportunity for individual couples to obtain a method that suits their needs. A study (Ross et al., 2001) of contraceptive method choice in developing countries confirmed that prevalence is highest in countries where access to a wide range of methods is uniformly high. Contraceptive choice is also a central element of quality of care in the provision of family planning services and an important dimension of women's reproductive rights (Bruce, 1990; Diaz et al., 1999). To increase prevalence of use, family planning programmes should offer a variety of safe, effective, acceptable and affordable contraceptive methods to help women to prevent unwanted pregnancies and sexually transmitted diseases (STDs) and to help them achieve their childbearing goals. The report of the International Conference on Population and Development issued the following directive:

Recognize that appropriate methods for couples and individuals vary according to their age, parity, family size-preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice (UNFPA, 1996).

Although most countries have made much progress in addressing the reproductive health of young women in particular, there are still some countries in sub-Saharan Africa which offer a limited choice of contraceptive methods and couples cannot easily choose the method that best suits their reproductive needs (Ross et al., 2001). Substantial evidence also indicates that restrictive choice of contraceptive methods has constrained the

opportunity of individual couples to obtain a method that suits their needs, resulting in lower levels of contraceptive prevalence. Method mix is a key determinant of the fertility impact of contraceptive practice; the use of more effective methods even by a smaller proportion of eligible couples can produce a greater decline in fertility than can the use of less effective methods by a larger proportion of couples (Magadi & Curtis, 2003).

Until the 1960s, rhythm and barrier contraceptives were the only methods of birth control widely available to couples desiring to plan the number and spacing of their children. In the late 1960s, oral contraceptives were introduced and new efficacious intrauterine devices (IUDs) became widely available so that the choice of effective methods of contraception increased substantially. Later, in the 1970s, female and male sterilization techniques became much more widely accepted and used (Parnell, 1989). Couples were then able to choose from several different temporary and permanent methods of contraception and to switch from one to another. World-wide, family planning programmes expanded and the prevalence of contraceptive use increased. As these methods of contraception became more widely used, anecdotal reports of adverse health effects associated with their use began to appear. Not surprisingly, the first generation of contraceptive technologies brought unanticipated risks and benefits. Since that time, these methods have been reformulated and redesigned to increase their safety and effectiveness. Indeed, contraceptive drugs and devices have been, and continue to be, subjected to extensive worldwide research to expand our knowledge of their safety (Shane, 1996; Miller et al., 1998; PRB, 2004). This research has documented many unanticipated benefits of methods, such as protection against certain cancers.

Since the United Nations World Population Conference in 1974, government policies have shifted in the direction of increased support for services

providing modern, effective contraceptive methods. Repeatedly at the international level, and at the International Conference on Population and Development held in Cairo in 1994, and the Fourth World Conference on Women held in Beijing in 1995, governments have affirmed the right of couples and individuals to choose the number and timing of children and to have access to the information and means to do so (United Nations, 1998). Many governments support family planning as part of basic reproductive health services. The United Nations report (2004) stated that 75 per cent of countries support the provision of contraceptives directly through government facilities, while 17 per cent of governments provide indirect support through non-governmental organizations such as family planning associations and the private sectors. Namibia is one of the countries that provides direct support for family planning services through government operated facilities such as hospitals, clinics, health posts and health centres.

2.4 Contraceptive use in developed and developing countries

The United Nations report (2004) claims that men and women in developing nations are marrying later, having fewer children and having them later in life. As a result of these trends, average fertility in poor countries has fallen below three children for each woman. The United Nations report (2004) shows that investment in reproductive health programmes including family planning has helped reduce fertility in developing countries from six children per woman in 1960 to around three in 2000. Further declines in fertility are contingent on the ability of couples worldwide to realize their desire for smaller families. UNFPA (2003), on the other hand, reports that growth rates and fertility are falling much more slowly in the poorest countries than elsewhere. The 49 least developed countries are expected to grow from 668 million people today to 1.7 billion by 2050 (United Nations, 2004) and their share of the world's adolescent population will increase from 14 to 25.6 per cent.

Young women's fertility is also reported to be high in developing countries (Mturi & Hinde, 2001). UNFPA (2003), on the other hand, highlights that young women from poor societies are more likely to not complete schooling and hence they are deprived of the education on reproductive health and sexuality that is provided at higher grade levels and do not know how to find health information. UNFPA (2003) also reports that poorer young women are likely to marry earlier, which contributes to them bearing more children, thus contributing to high fertility levels among young women. However, UNFPA highlights that differences in young women's fertility are driven by many factors, including life opportunities, service access, providers' attitudes, socio-cultural expectations, gender inequalities, education aspirations and economic levels.

The belated fertility transition in sub-Saharan Africa is now definitely underway not only in Southern Africa but also more widely (Caldwell & Caldwell, 2003). By the standards of the rest of the world, fertility in Africa as whole is still high. However, Southern Africa has a remarkably low fertility rate (total fertility rate (TFR) = 2.9) as shown in Table 2.1, compared to the other regions of Africa (World Population Data Sheet, 2006). In addition, for the period 2000-2005, fertility at the world level stood at 2.65 children per woman.

The percentage of all births to young women under age 20 is also high in most of the sub-Saharan African countries as compared to the developed countries and demographers project that this number might increase over the next few decades. This is primarily due to an increase in the number of young people in the region. Dickson (2003) argues that fertility has been declining over the past two decades in most countries of Africa and teenage birth rates show some decline too. However, the fertility gap between the rich and the poor has widened. Poor rural women and men lack access to modern birth control methods and to condoms that will prevent sexually transmitted

infection (STIs) and AIDS, and in most countries of the region, there is still a high percentage of sexually active young women with unmet needs for contraception.

Table 2.1: The total fertility rates and births by region of the world

Region	Total fertility rate (TFR) 15-49
World	2.7
Developed countries	1.6
Africa	5.1
Eastern Africa	5.5
Middle Africa	6.3
Northern Africa	2.0
Southern Africa*	2.9
Botswana	3.1
Lesotho	3.5
Namibia	3.9
South Africa	2.8
Swaziland	3.7
Zimbabwe	3.8
Western Africa	5.8

Source: World Population Data sheet, 2006

In Namibia, there are currently 190 496 young women aged between 15 and 24. These young women account for 10.4 per cent of the total population. According to the Namibian Demographic and Health survey (2000), about 15 per cent of teenage women in Namibia are already mothers and another 3 per cent are pregnant with their first child. Evidence has also shown that about 7 percent of teenage women in Namibia give birth in one year (Population Reference Bureau, 2005)

Tracking trends in fertility and birth rates help support effective social planning and adequate age-appropriate resources to accommodate changes in population composition. Sustained high fertility rates create large populations of young dependents, creating demand for support for young children, for an adequate number of schools, and for affordable childcare. For example,

during the Baby Boom period (1946-1964), the unanticipated period of high fertility rates caught communities unprepared and without the school facilities needed to accommodate the rapidly increasing number of school age children (World Fertility Report, 2003).

On the other hand, sustained low fertility rates lead to a rapidly aging population and in the long run may place a burden on the economy and the social security system because the pool of younger workers responsible for supporting the dependent elderly population is smaller while the dependent elderly population is comparatively larger.

One of the most consistent findings of analyses in developing countries is a strong correlation between the level of women's education and fertility regulation. Schooling of women is often viewed as an indicator of socio-economic development and the variable is also negatively associated with infant mortality, thus reducing the overall demand for children (Addai, 1998). Education thus improves reproductive health, because, educated women are more likely to seek adequate prenatal care, skilled attendance during childbirth and use of contraception. They also tend to initiate sexual activity, marry and begin childbearing later than uneducated women.

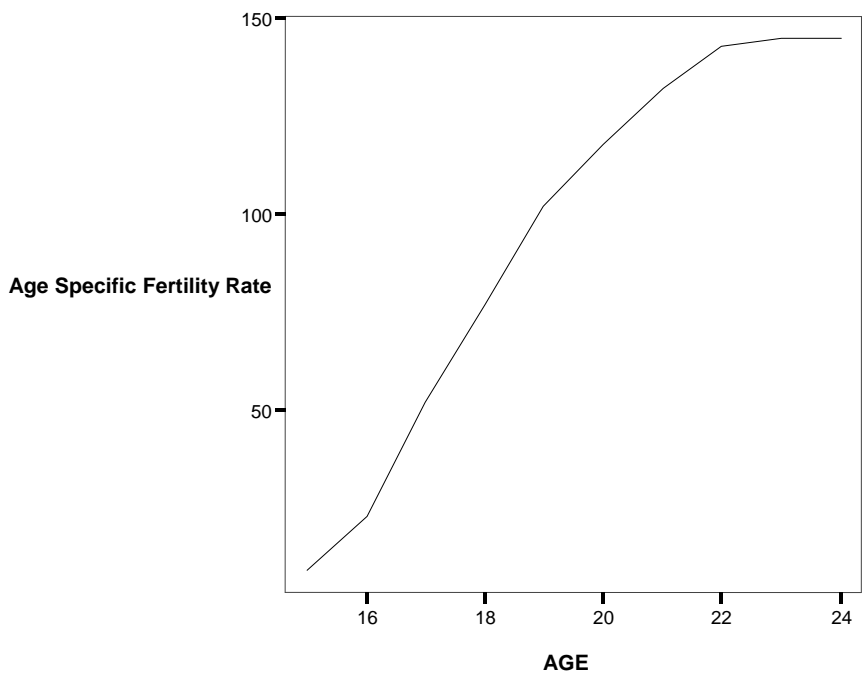
Early pregnancy and childbirth limit a young woman's educational opportunities, compromise her ability to support herself and her family and limit her self-determination and quality of life. Among young women, while higher levels of education are associated with a lower probability of giving birth, the direction of causality is less clear. Some young women may delay childbearing in order to complete their formal education while teenage mothers may be forced to leave school early upon having a child. The situation in most African countries is that marriage is now delayed, and the proportions of never married women are increasing (UNFPA, 2004). This

behaviour seems to be related to increasing levels of education, urbanization and economic opportunity.

In addition, fertility levels are expected to be lower in urban areas than in rural areas. This differential pattern in reproductive behaviours can often be attributed to the influences of cultural differences. On the other hand, access to contraceptive services might have contributed to this differential. Although a large number of family planning clinics and services exist throughout the country, young women are often not welcome at these services. As mentioned earlier in this study, the difficulties young women encounter in accessing contraceptive services have been documented in several studies (Wood et al., 1998; Dickson, 2003). Staff attitudes can be judgmental or even hostile, and the professional norms of confidentiality and empathy are often neglected when providers deal with young women. Health facilities can also have opening times that prevent easy access for youth.

An indicator of the level of fertility namely, age-specific fertility rate (ASFR) for young women aged 15-24 years is used in this analysis. Figure 4 below provides information on ASFR for Namibian young women. Although evidence suggests that fertility is falling in Namibia (TFR of 4.1 in 2000, 3.9 in 2006 compared to 6.2 in 1992), age-specific fertility rates for adolescents and youth are still relatively high by world standards. As expected, the ASFR rises rapidly with age. For example, the number of births to young women aged 24 per 1000 young women aged 24 is 145 compared to only 9 for young women aged 15.

Figure 4: Age specific fertility rates (ASFR) per 1000 young women in Namibia



Source: NDHS 2000

The world has experienced a contraceptive revolution over the past 25 years. Contraceptive prevalence has risen from less than 10 per cent around the world in the early 1960s to an estimated 55 per cent in the late 1980s and early 1990s (Bertrand et al., 1993) and to 67 per cent in 2004 (Population Reference Bureau, 2004). The prevalence levels are higher in developed than in developing world. But, it is noted that more than half of women of reproductive age in developing countries are currently using some form of contraception. Hennink, (1997), Dang (1995), DeGraff (1991) and Bertrand et al., (2001) show that this contraceptive revolution has been brought about through improvements in medical technology which have led to the development and availability of a whole range of safe and reliable methods of contraception as well as the social and economic changes which have led to

women having more control over their fertility and a greater sharing of the responsibility of contraception between the genders.

In comparison to the above, the United Nations report (2004) claims that 62 per cent of married or in-union women of reproductive age are using contraception. In the more developed regions, 70 per cent of married women use a method of contraception, while in the less developed regions 60 per cent do. In Africa, only 25 per cent of married women are reported using contraception, whereas in Asia and Latin America, the prevalence of contraceptive use is fairly high – 66 per cent and 69 per cent respectively. Most contraceptive users worldwide rely on modern methods. The most commonly used modern methods are IUDs for older women and oral pills for younger women. Modern methods are considered more effective at preventing pregnancy and require access to family planning services. The United Nations (2004) reports that short acting and reversible methods are more popular in the developed countries, whereas longer-acting and highly effective clinical methods are used more frequently in the developing countries. In the developed countries, contraceptive users rely mostly on oral pills (17 per cent of married women) and condoms (15 per cent). In contrast, female sterilization and IUDs, used by 22 per cent and 16 per cent, respectively, of married women, dominated in the developing countries. Traditional methods are also reported to be more popular in the developed countries than in the developing countries. The most used traditional methods include rhythm (periodic abstinence) and withdrawal. Despite the increase in contraceptive use prevalence in developing countries, high levels of unmet needs for family planning remain. In sub-Saharan Africa, an average of 24 per cent of married women need family planning (because they want no more children or want to delay their next pregnancy) but, for various reasons such as not knowing where to get a method or fear of side effects, are not using any method of contraception.

Since the late 1960s and early 1970s, epidemiological studies have evaluated the health effects associated with the use of different contraceptive methods more rigorously (Parnell, 1989). Most of these studies have been conducted in developed countries. In the process, researchers have recognized that different contraceptive methods have important beneficial health effects, in addition to the desired effect of preventing pregnancy. For example, oral contraceptives can protect a woman against pelvic inflammatory disease, ovarian and endometrial cancers, and benign breast disease (Shane, 1996). Condoms, when used correctly and consistently, can prevent infection from sexually transmitted diseases, including HIV/AIDS. Although much research is still needed, especially targeted to the developing world, a large body of information is now available to assess the health effects of the various contraceptive methods. Reproductive health programmes have been established in many countries (Zambia, South Africa, Namibia, Zimbabwe) with rising contraceptive use among couples indicating greater access to family planning (United Nations, 2004). The level of contraceptive use by couples in union is estimated at nearly 70 per cent in the more developed regions and 60 per cent in the less developed regions (United Nations, 2004). However, many births are still unwanted or mistimed and modern family planning methods remain unavailable to large numbers of couples.

In most of the developed world, the majority of young women become sexually active during their teenage years (McDevitt et al., 1996). For instance, young women in the United States are more likely to have sexual intercourse before age 15 and have shorter and more sporadic sexual relationships than young women in other developed countries. Young women in the United States have the highest rates of pregnancy, childbearing and abortion as compared to other developed countries. There is low use of contraceptives which have a high effective rate like the pill and other long-

acting reversible hormonal methods. Other factors in cross-country differences in young women's contraceptive use include negative societal attitudes towards teenage sexual relationships, restricted access to and high costs of reproductive health services, ambivalence towards contraceptive methods and lack of motivation to delay motherhood or to avoid unintended pregnancy.

Despite the United States, there has been a drop in unwanted pregnancy rates in the developed world. Some of the reasons for the decline in pregnancy rates include increased motivation in the youth to achieve higher levels of education, employment training and goals in addition to motherhood and family formation, provision of comprehensive sexuality education, leading to young women's greater knowledge about contraception, more effective contraceptive use and improved ability to negotiate contraceptive practice, and greater social support for services related to both pregnancy and disease prevention among young women (Manlove et al., 2003).

Young people constitute a large proportion of the society in many developing countries, including Namibia. While there has been increasing recognition of the importance of young people's health in policy, developing intervention strategies that are effective and feasible for implementation on a large scale represents a difficult challenge. This is particularly the case for programmes addressing the sexual and reproductive health needs of young people with the aim of preventing HIV/AIDS infections and unwanted pregnancies. There are few appropriate mechanisms in place for young people to be educated about self-protection from adverse reproductive health outcomes. In addition, young people do not make much use of existing services for contraception and STD care. Thus, they are at risk of early unsafe sex which, combined with low contraceptive use, may lead to unwanted pregnancies with often

poor obstetric outcomes and high rates of often unsafe abortions (Matasha et al., 1998).

Using the 1992 NDHS data, Chimere-Dan (1997) reports that teenage mothers are concentrated in the northern part of Namibia which is more rural, and among people with low levels of education. Chimere-Dan (1997) further argues that the high number of cases of teenage pregnancies indicates that young women have unmet sexual and reproductive health needs which require immediate attention. The pregnancy rate of girls could be an indication that young girls are involved or forced into sexual relations with older men who have greater experience and exposure to sex. Mukonda (1998) reports that there are some girls in the Caprivi region (Northeast) who believe that the easy way to make money for themselves is by “selling their bodies” to teachers, policemen and male nurses.

Other studies (Hailonga, 1993; Voeten, 1994; Mufune, 2003; Witte et al., 2003) indicate that many young women get involved in sexual relationships because men, especially older men give them gifts, money and other social or economic favours. However, there are also those young women who want to experiment with sexual intercourse, yet have little knowledge on how to avoid pregnancy. There are also those who fall pregnant deliberately in order to keep their relationships.

As young people make the transition to adulthood they are faced with many challenges such as understanding changes in their bodies, forming relationships and re-developing communication skills (Namibia Broadcasting Corporation, 2001). During this transition period, young women have increased desires for experimentation and imitation of adult behaviour, including sexuality in its various cultural manifestations. Unfortunately, in Namibia, sexual experimentation often occurs before young people have

acquired knowledge of sexual and reproductive health (SRH), important life skills to guide behaviour or have had experience with reproductive health care services. Risks associated with early sexual activity include unwanted pregnancies, STIs including HIV/AIDS. In addition, Mchombu (1998) notes that communication between adults and youth on sexual matters - including STDs and HIV - is restricted or is often simply non-existent. Although, in some cases grandparents, aunts or uncles play some role in sexual and reproductive health education; there is still a vacuum in the sex education arena.

Looking beyond, reproductive health interventions targeted at young people are relatively new phenomenon in sub-Saharan Africa with the first programme having been established in the late 1970s. Most of these programmes are educational and are delivered via youth centres, peers, the media and schools (Erulkar et al., 2004). Few of these programmes provide sexual and reproductive health services perhaps because of discomfort with addressing the needs of unmarried, sexually active young people. Despite considerable evidence to the contrary, many policy makers fear that discussing family life or sex education will encourage young people to experiment with sex and may increase risky sexual behaviour.

Namibia has relatively good health care facilities, especially in urban areas. The fact is, however, that these services do not specifically cater for young people's sexual and reproductive health care needs and problems. This lack of facilities for young people's SRH is partly due to the fact that in the past, young people had been assumed to be in good health because being young has always been synonymous with having good health. However, during the past two decades, the HIV/AIDS pandemic has drastically altered the health profile of young people in Namibia. There is a need to know and understand young people's sexual and reproductive perceptions, attitudes and practices

as well as gender influences, thereby improving the provision of SRH services. There is also a need to identify the cultural and social contexts within which sexual relationships involving young people occur if viable SRH programmes are to be designed and implemented. In Namibia, most women describe their role as one characterised by hard work – in the field and at home. They see themselves as subordinate to their husbands and primarily responsible for bearing children, caring for them and managing households, while men are seen as the ones who possess wealth – often in the form of cattle (Mufune et al., 1999). Men are believed to make significant contributions to their communities, have many children, and look after their families, all of which can lead to serious communication problems between women and men.

2.5 Patterns of contraceptive use in Africa

In Africa, a large proportion of teenagers and even young adolescents are having children. Among sexually active adolescents there has been a very low level of contraceptive use despite widespread knowledge (Sapire, 1988; Speizer et al., 2001). This, in part, may reflect both a lack of interest in the use of contraception among those who wish to bear children as well as socio-cultural barriers that attach a stigma to the use of contraception by young women, and thus prevent them from having access to contraceptive methods. Speizer et al. (2001) report that only a small minority of adolescent women could identify their fertile period. The lack of understanding of the fertile period is a reflection of general deficit in basic knowledge about human reproduction. Such knowledge is particularly relevant to sexually active young people many of whom may have no access to contraceptives, and for whom the use of the rhythm method may be one of their alternatives.

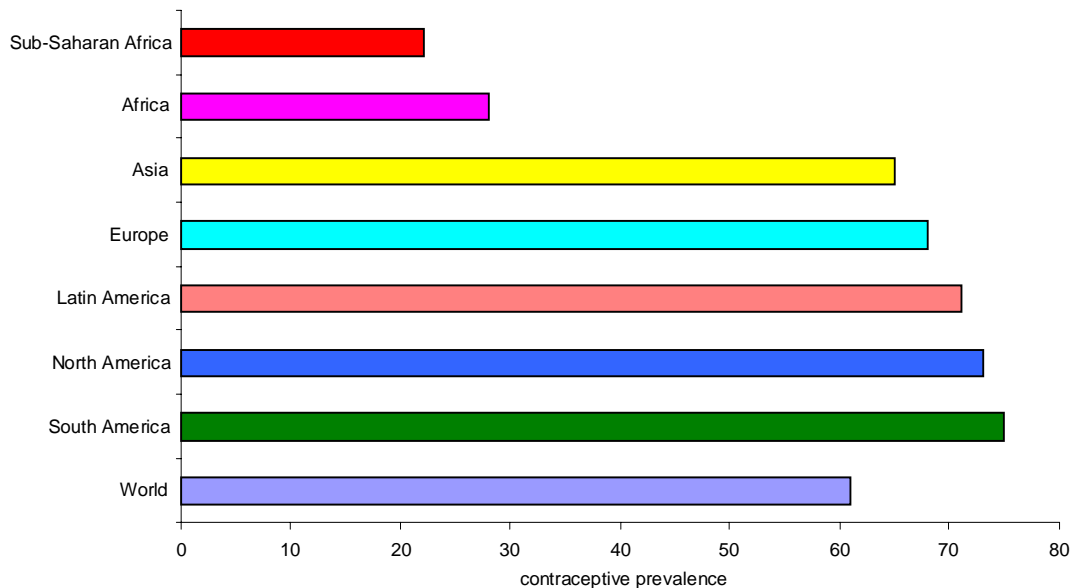
In addition, today's adolescents attain puberty earlier and marry later. They are more likely to engage in premarital sex than members of their parents' generation were (UNFPA, 1999; UNFPA, 2003). Adolescents who have premarital sex often fail to use contraceptives thus exposing themselves to the risk of unintended pregnancy and of sexually transmitted infections, including HIV. Globally, more than 15 million adolescents younger than 20 give birth each year, contributing roughly 10% of the total annual number of births (World Population Data Sheet, 2004). Moreover, about one-half of all HIV infected individuals are younger than 25 and the majority of these young people are women (Speizer et al., 2001). In many developing countries, data indicate that up to 60 per cent of all new HIV infections are among 15-to 24-year olds (World Population Data Sheet, 2004).

Unprotected premarital sex is especially prevalent in Sub-Saharan Africa. For example, Speizer et al. (2001) report that a study of female senior high school students in Nigeria found that mean age when engaging in sex for the first time was 15 years and that 23% of those who were sexually experienced had already experienced pregnancy. The vast majority of these pregnancies ended in abortion. Another recent analysis conducted in Cameroon demonstrates that by age 18, the majority of adolescents, regardless of their marital status, are sexually experienced and have been exposed to risky sexual practices, including exchanging sex for money, having multiple partners and failing to use condoms (Speizer et al., 2001).

The contraceptive use rate in Africa is comparatively lower than other regions of the developing world (Gbolahan & McCarthy 1990; United Nations, 2004). This is also supported in Figure 5 below. In sub-Saharan Africa, high birth rates have been the norm (Mturi & Hinde, 2001; Ntozi & Ahimbisibwe, 2001). Some factors that have contributed to sustained high fertility are a large

percentage of the population living in rural areas where there are markedly low contraceptive prevalence and low levels of socio-economic development.

Figure 5: Contraceptive Use Levels Among Women of Childbearing Ages by regions of the world



Source: World population data sheet, 2006

Contraception was not heavily used in sub-Saharan Africa prior to 1980s mostly because access was limited (Population Reference Bureau, 1992). On the other hand, the report from the Population Reference Bureau (1992) consistently shows that women in sub-Saharan Africa are much less likely than those in other regions to state that they currently want no more children. This is mainly a function of the large number of children desired. Other factors contributing to the relatively low proportions of women wanting no more children may include high levels of disease – induced sterility, which remains a problem in parts of Africa and relatively high levels of child mortality.

The contraceptive prevalence rate estimated in most African countries was less than 15 per cent by 1990 except in Zimbabwe, Botswana, South Africa

and Kenya where the prevalence was high (Rutenberg et al., 1991; Ngom et al., 2005). In Tanzania, the contraceptive prevalence rate has doubled from 10 per cent in 1991/92 to 20 per cent in 1994 (Mturi, 1996). The main reason given for using contraceptives in many African societies is birth spacing rather than limiting fertility. Recent demographic and health surveys (DHS) conducted in sub-Saharan Africa have shown an increase in contraceptive prevalence rates in various countries (World Population Data Sheet, 2004). The Population Reference Bureau (2004) also indicated that modern methods account for a large proportion of current contraceptive use, especially in the less developed regions where they constitute 90 per cent of contraceptive use. The three most popular methods among married women are female sterilization, IUD and the pill with prevalence levels of 21 per cent, 14 per cent and 7 per cent respectively. However, modern methods typically used by youths include condoms, oral pills and hormonal injections.

Contraceptive use varies substantially by region and country (Bertrand et al., 1993; World Population Data Sheet, 2004). Only 13 per cent of married adolescents aged 15 to 19 use contraception in sub-Saharan Africa compared with 55 per cent in Latin America and the Caribbean (Population Reference Bureau, 2004). The breakdown between use of modern and traditional methods also varies from one country to another. Efforts to meet the need for contraception in less developed countries are hindered by factors such as population growth, contraceptive shortages and inadequate funding (Population Reference Bureau, 2004). Many factors including issues related to demand and supply constrains the use of family planning in poor countries. Regarding demand, couples may not know about contraception. Cultural values may support high fertility and in some cases, a woman's low status relative to her husband's and other family members may limit her ability to use family planning. PRB (2004) report also highlighted that supply side factors are important obstacles in using family planning. Many couples still

lack access to choices regarding contraceptive methods. Providing contraceptives without sufficient information, education and counselling may also not be efficient: couples may have misperceptions about the health effects of contraceptive use or may not know enough about methods.

Meeting the needs of young people is a special concern. Past population growth in less developed countries has meant that the largest ever generation of young adults are entering their reproductive years. Rani & Lule (2004) reported that rapidly growing populations such as in Nigeria, which has 44 per cent of its population under age 15, will need to greatly expand their services to meet the needs of young people coming of age.

Early marriage and childbearing is a common occurrence in Africa. The average age at marriage among women, while slowly rising, is still generally below 20 years in most African countries, and the fertility rate among young women aged 15-24 years is higher than in any other region of the world. As opportunities for education grow for young women, the time between menarche and marriage will also increase, leaving young women exposed to the risk of premarital pregnancy for a longer period. For a school girl, an unplanned pregnancy guarantees that she will drop out of school (Al Azar, 1999). In many countries, schools prohibit pregnant students from continuing their studies while in other countries, social pressure forces them to stop school.

Several explanatory variables for differentials in the reproduction of young women have been identified in the literature and may be broadly classified according to either their socio-economic or cultural nature. Some of these factors have positive effects on fertility levels of young women while others have negative effects. One of the most consistent findings of analyses of fertility behaviour in developing countries is a strong correlation between the

level of women's education and fertility regulation (Castro & Juarez, 1994; Barnett, 1997; Shapiro & Oleko, 1997; Villarreal, 1998; Sarup, 2005). Schooling of women is often viewed as an indicator of socio-economic development and the variable is also negatively correlated with infant mortality, thus reducing overall demand for children.

Among young women higher levels of education are associated with a lower probability of giving birth, but the direction of causality is less clear. Young girls may delay childbearing in order to complete their formal education but teenage mothers may also be forced to leave school early upon having a child. Education has been proven to have the undisputed effect of delaying the age at marriage and first union. With higher levels of education the incidence of adolescent pregnancy decreases (Voeten, 1994). However, part of this reported decrease may be just an effect of attrition, given that pregnancy usually leads to the end of the educational process for the girls. The lower rates of pregnancy and births are due to the fact that educated women are more likely to use contraceptives and are also more likely to resort to abortion (where legalized). Education provides alternative means of creation of status for women as well as a source of self-esteem and self-value. It thus provides the motivation to use contraception, facilitates its putting into practice as well as the motivation to terminate the pregnancy if unwanted (Al Azar, 1999; Magadi et al., 2000).

Women are key agents in determining the quality of life of their families. Children's success in schools and their health and their productivity in later life may depend to a considerable extent on their mother's health, education, welfare and skills (Shapiro & Oleko, 1997). Education is the strongest of all factors enabling women to improve their own lives and those of their children. Education increases family income and reduces poverty by boosting the wages women can earn. Education also has a strong effect on child health.

Educated women have better knowledge of nutrition and sanitation and are in a better position to obtain outside help if needed as concluded in the case of Kenya by Magadi et al. (2001). Educated women tend to marry later, have fewer children and use contraception (Caldwell & Caldwell, 2003). They are more open to change and more aware of social services. These effects combine to reduce women's fertility. Family planning helps to improve women's status and education. Where women marry early or risk teenage pregnancies while still at school they are more likely to have to cut short their education (Hailonga, 1993; Dickson, 2003). Women who are exposed to repeated pregnancies find it harder to get and keep jobs outside the home. When family planning is widely available, women are more able to choose what type of work they do. Educated and working women are presumed to have closer conjugal ties with their husbands or partners compared to non-educated and unemployed women. This is supported by findings from a study conducted in South Africa by Caldwell and Caldwell (2003). The educated women are therefore expected to have similar reproductive attitudes as their husbands or partners according to Barnett (1997). This is in line with the fact that educated young women tend to date educated men. On the other hand, education and employment tend to give greater freedom and power within the household.

Another socio-economic variable that emerges from the literature as an important influence on fertility behaviour is place of residence (Ntozi & Ahimbisibwe, 2001; Mturi & Hinde, 2001). Fertility levels are expected to be lower in urban areas than in rural areas. A study conducted in Zimbabwe by Boohene et al. (1991) support this evidence. On the other hand, differential patterns in reproductive behaviour that are not readily explained by socio-economic variables can often be attributed to the influence of cultural differences.

Mass media are believed to play significant roles in promoting social change with respect to attitudes about fertility and reproductive behaviours (Ministry of information and Broadcasting, 1998; Keller & Brown, 2002). Differences in fertility levels, according to ethnicity and religious affiliation, have also been observed in several studies (Amin et al., 1995; Meekers & Ahmed, 1997). These studies suggest that Catholics experience relatively high fertility rates when compared to other religious groups.

Keller (1997) emphasises that media campaigns are an effective way to inform people about where to obtain contraceptive or other reproductive health care services. Clinic locations, hotline phone numbers and referral networks can be included in media campaigns to direct listeners to where to go for services. Campaigns seem to be more effective if messages appear in different media simultaneously e.g. music, television, radio, movies and posters. For example, a 1992 AIDS prevention campaign by the National Youth Union and CARE International in Vietnam combined leaflets, television, radio, posters, newspaper articles, booths, discussion groups and a parade on World Aids Day (Dang, 1995).

Television, radio, music, magazines and other media have become powerful tools for giving young adults perspectives on the consequences of sexual activity. For example, HIV prevention media campaigns in Uganda have played a major role in encouraging safer sexual behaviour, condom use in risky sexual relationships and later age of sexual debut which has led to a decline in HIV prevalence among young women in Uganda. These pertain to behaviour messages that were emphasized in HIV prevention media campaigns (Keller, 1997). Another Ugandan media campaign that can be mentioned is the following: the AIDS information Centre used radio announcements to attract clients to anonymous and voluntary HIV testing services over several years. When the programme advertised special days for

young adults to receive free testing, young people turned up in large numbers (Keller, 1997).

Keller (1997) reports that research in Nigeria suggests that media campaigns can help influence family planning behaviour. She further notes that a 1993 survey of Nigerian reproductive age women correlated current use of contraception with whether the woman had watched television, music or videos. Women who were exposed to pro-family planning messages seemed to be more likely to use contraception and desire fewer children, even when other variables such as education and urban residence were taken into account.

The government of South Africa during the early 1990s had given health a priority status on the development agenda and integrated family planning programmes with AIDS education, prenatal care and reproductive health care (Haffajee, 1996). The Youth Information Centre, which is part of the Planned Parenthood Association, uses creative strategies to teach adolescents about the effects of teenage pregnancy. The approaches at the Youth Information Centre are used to help young people make realistic choices by providing contraception and health education. Haffajee (1996) reports that the need for adolescents' services is apparent from the survey results that indicate that 1 in 3 South African young women had babies by the time they were 18 years old, but only 33% of these pregnancies were planned and almost 50% were to youth who were enrolled in school. In addition, the study concludes that the major obstacle in successful implementation of programmes targeting the youth remains the involvement of men and changes in the attitudes of men, because even men who are counselled still refuse to use condoms.

The importance of ethnicity has been largely overlooked in relation to adolescent fertility. Ethnicity is of prime importance in defining age at

marriage, acceptability of sexual behaviour, initiation of sexuality, use of contraception and the resolution of pregnancies when they occur. A study of Nepal singled out ethnicity as the most important factor in the determination of the timing of marriage and of the first birth, and is much more important than education, religion, urban/rural and ecological regions (Bledsoe & Cohen, 1993; Bongaarts et al., 1994; Caldwell & Caldwell, 2003).

In Kenya, where adolescent fertility is reported to be among the highest in Africa, sexual custom varies greatly among ethnic groups, with differing values on virginity, consequences of premarital pregnancy, practice of genital mutilation, level of knowledge and use of contraception, among other characteristics (McDevitt et al., 1996; Gage, 1998). A study of ethnic differences between non-Hispanic whites and Mexican American female adolescents concluded that Mexican Americans who had been born in Mexico tended to initiate sexual intercourse later than non-Hispanic whites, but that they had the highest rate of early births because they were the most likely to become pregnant if sexually active and the least likely to terminate pregnancy (Neeru & Leite, 1999).

In Namibia, like many other African countries, women have limited control over their reproductive health. In most cases men have final decisions on family size. There have been a number of cases made for sustained efforts to address the reproductive health of men (Mufune et al., 1999). There have been efforts made to overcome the reluctance of men to use available health facilities in third world countries as well (Babalola, 1999; DeRose et al., 2004).

Dickson et al. (2001) explains that health care facilities can play an important role for adolescents in preventing health problems, in promoting sexual and reproductive health and in shaping positive behaviours. South Africa has a national Adolescent Friendly Clinic Initiative programme which is designed to

improve the quality of adolescents' health services at the primary care level and strengthen the public sectors' ability to respond to adolescent health needs (Ehlers et al., 2000). The key objectives of the programme are to make health services more accessible and acceptable to adolescents, establish national standards and criteria for adolescent health care in clinics throughout the country and build the capacity of health care workers to provide quality services. Despite this, Dickson et al. (2001) report that extensive research has established that South African public health facilities are failing to provide adolescent friendly health services.

Inconvenient hours or location, unfriendly staff and lack of privacy are among reasons many young adults give for not using reproductive health clinics (Ersheng et al., 2003; Hock-Long et al., 2003; Finger, 2000; Erulkar et al., 2004). Finger also reports that a study by the Washington based International Centre for Research on women, based on research with adolescents in Africa, Asia, Latin America and the Caribbean, recommends that reproductive health services for the youth be private, confidential, affordable, accessible and staffed with sensitive providers. Finger (1997) reports that better ways to make services more accessible involve the positive attitude of health care providers and training on sexual and reproductive health services, the logistics of clinic location and service, questions of privacy and confidentiality and other issues that will address the unique needs of young women. Finger (2000) further emphasizes that for programmes on adolescent sexual health to succeed, providers need special training to serve the youth.

Mouli (2003) and Belmonte et al. (2000) maintain that even when young women choose to seek care, there are certain barriers which prevent them from gaining access. In many places health services such as emergency contraception and safe abortions are not available either for young women or for adults. In other places where these health services are available restrictive

laws and policies may prevent them from being provided to some groups such as unmarried young women. Even when laws and policies are not an obstacle judgmental health workers may withhold services from unmarried young women. Mouli (2003) further reports that even where services are available young women may not be able to obtain them for some reasons. For example, they may not know where to go, facilities may be located a long distance away from where they live, study or work; or in places that are difficult to reach, facilities may also not be open at times of the day when they can get away from study/work. On the other hand, Mouli (2003) reports that health services may be delivered in ways that young women perceive to be threatening or of poor quality. For instance, young women may be reluctant to use available services for fear that they may be observed by acquaintances also awaiting services, or may be required to go through long bureaucratic procedures before they get to see a health worker. They may also be obliged to wait for lengthy periods before they see a health worker or obtain the services they need. Of great concern are their fears concerning interaction with health workers. For example, young women may fear that they will be humiliated by health workers who ask awkward questions or subject them to unpleasant and painful procedures, that health workers will demand the consent of parents or guardians or will not respect confidentiality (Masilamani, 2003; Poonkum, 2003).

Ersheng et al., (2003) on the other hand, report that family planning workers from urban areas are more likely to oppose providing reproductive health services. One important reason given by them was that they did not consider youth to be their target population. At a youth information centre set up by the Planned Parenthood Association of South Africa, young women said the most important factors determining their choice of a clinic were the attitudes of staff, location and atmosphere, contraceptive methods available and clinic hours in that order (Finger, 2000). Mensch et al., (1998) report that the

attitudes of providers have discouraged even married young women. They further report that providers in some countries refuse to provide services until the young wives have given birth. Ehlers et al., (2000) recommend that accessibility of contraceptives for young women should be investigated in specific areas and attempts made to enhance such accessibility. Ehlers et al. (2000) further argue that this might necessitate offering these services over weekends or during evenings when schoolgirls could attend without fear of meeting their mothers, aunts or teachers at those clinics.

2.6 Gender and cultural perspectives on contraceptive use

The family obviously has a strong influence on young people's aspirations and values from an early age (Speizer et al., 2001). For example, adolescents who learn about or are strongly aware of their parents' and elders' values regarding premarital sexual activity or contraceptive use are less likely to engage in risky sexual behaviours than their peers who are not exposed to their elders' value system. Family influence comes from parents and from other family members who interact with youth such as aunts, uncles, older siblings and grandparents.

Many parents believe that sex education leads to promiscuity. But the opposite seems to be true. Haffajee (1996), Finger (1997) and Al Azar (1999) have shown that sex education leads to responsible sexual behaviour, higher levels of abstinence, later initiation of sexual relationships, higher use of contraception and fewer sexual partners. These good effects are even greater when parents talk honestly with their children. In general, such talks are unusual in most societies. In the United States, for instance, fewer than one in three girls and one in six boys discuss these concerns with either parent (UNFPA, 1999). UNFPA reports that family life education has been part of the curriculum in many countries, but all too many have forbidden discussion

of contraception or even reproductive physiology. Teachers' discomfort with these subjects, opposition from some traditionalists and religious groups, fear of parents' criticism, and difficulty in setting priorities can all cause problems.

According to the UNFPA report (1999), most parents want to protect and guide their children, but none want to give them a free rein to do whatever they please. UNFPA emphasizes that parents must be realistic about the possibility that their children will engage in sexual activity at a young age, and without their knowledge. The only way to protect them from unwanted pregnancies, diseases and death will be to make available to them the information about sexual and reproductive health and the services they need to take care of themselves.

Finger (1997) maintains that it is crucial to acknowledge the importance of culture and tradition when advocating what young people need. Involving community leaders, parents, teachers and others help to achieve this difficult balance. The UNFPA report (1999) explains that lack of contact with parents and other invested community groups misses an opportunity to gain their support. Finger (1997) however, concludes that several programmes have successfully invested time and resources in involving parents. For example, in Zimbabwe, the National Family Planning Council offered a programme to help parents educate their children about sexuality and reproductive health. In Tanzania, a parents' organization developed a manual designed to help parents communicate with their children (Finger, 1997).

The transition from traditional societies to modern societies that is occurring throughout the world is generating a radically different culture for reproductive and sexual decision-making among today's adolescents. When most of today's older generation were adolescents themselves, social roles and expectations were arguably better defined. Individuals appointed by the

community taught adolescents a set of clear and unambiguous rules that governed sexual conduct. With increased urbanization, however, the role originally played by community appointed teachers must now be assumed in part by an adult family member and by parents in particular. Parents and other family members are often reluctant to talk to young people about reproductive health issues (Briggs, 1998; UNFPA, 1999; Mturi, 2001; Shapumba et al., 2004; Gebhardt et al., 2004). This reluctance may result from parents' lack of reproductive health knowledge or from a concern that adolescents will interpret such communications as affirming the acceptability of premarital sexual activity. Parents may also think that their information is outdated (Adedimeji, 1999). When families do not provide reproductive health information, young women will seek out that information from other sources, including their peers. Nonfamiliar sources of information may provide incomplete or inaccurate messages about sexuality which can increase adolescents' participation in behaviour that exposes them to the risk of unintended pregnancy and STIs, including HIV (UNFPA, 1999). In many developing countries, parents still have a tremendous influence over their children despite eroding traditional values, especially in urban areas. Therefore, meeting the reproductive health needs of young women mostly rests on the shoulders of parents. However, most parents do not discuss sexual matters with their daughters as a result of shyness, ignorance on sexual matters or societal norms that do not encourage open mother-with-daughter discussion on sexual matters. As was pointed out by Briggs (1998), most parents are either not knowledgeable on sexual matters or are embarrassed to discuss them with their daughters.

Lack of information or misinformation about reproductive and sexual health may lead to teenage pregnancy. However, the lack of economic alternatives in the labour market and poverty are other factors that encourage girls to get pregnant and drop out of school prematurely (Al Azar, 1999). They may

believe that the economic benefits of engaging in a sexual relationship with a sugar daddy is more rewarding than any economic opportunities that are available for better educated women. Al Azar (1999) reported that young girls may also use pregnancy to hook a man of their liking or they may think it is important to prove their fertility in order to get a husband. More often than not, premarital pregnancy does not result in marriage. Instead the girl's family name and honour is soiled, their bride price is decreased; their education is ruined and their chances of getting married are lowered. They become socially and economically dependent on their families.

Political, social and economic changes and resulting social problems affect parent-child relationships, views of parental authority and the institutions that serve adolescents. There is great diversity in the circumstances of young people between and within countries. In many settings, child parent relationships have traditionally been just one component of a web of extended family relations. However, according to Dilorio et al., (1999) migration, new values and understandings, poverty, family dispersal and impact of HIV/AIDS have reduced reliance on the extended family, particularly in cities. Many young people live without one or both of their parents and may not be able to rely on their families for support.

Family planning programmes have mostly concentrated their attention on women. In Africa research on the effectiveness of these programmes indicate limited success in curbing fertility although women consistently prefer to delay, limit or cease childbearing at some point (Lapham & Mauldini, 1985; Ross & Mauldini, 1996). Family planning programmes have been struggling with this unmet need of African women. A major reason for the failure to reduce fertility and to deal with the unmet need has been the fact that programmes have not involved men (Benefo & Pillar, 2005). Men are an increasingly "popular" focus of reproductive health interventions. In the past,

men's participation was sought by family planning programmes to increase the use of condoms. However, later, men's involvement was considered necessary to support women's contraceptive use, when studies in both rural and urban areas showed that husband's approval was the most important determinant of contraceptive use by women. Mufune et al. (1999) reports that, according to research conducted in Kenya, men who have some education on reproductive and sexual health are more likely than those who have not, to support their partners in family planning and contraception. They are also more likely to support their partners in pregnancy and in making better sexual and reproductive health care decisions. Therefore, the role of gender in family planning should not be downplayed. Both men and women together play an important role in fertility decisions, including decisions to use contraceptives and it is thus their responsibility. Ndunyu (1999) reports that family planning programmes have been guilty in ignoring the role of men in family planning in their keenness to improve better contraceptive prevalence rates.

In Africa, research has concentrated on finding out the nature of men's involvement in reproductive decision-making. Some studies (Babalola, 1999; Rono, 1999) reveal that men are instrumental in reproductive decision-making. This is because in most African cultures, upon marriage, a man and his family pay lobola (dowry price) to the family of the bride. An implicit outcome of this transaction is that it shifts reproductive decision-making power to the male side. The gendered nature of marriages favours men whose costs in reproduction are minimal. Ntozi & Ahimbisibwe (2001) state that for men, more children add to prestige; therefore men in this context do not usually favour contraceptives. Ntozi & Ahimbisibwe (2001) further argue that Uganda is predominantly agricultural and children contribute a lot to the subsistence living of their families in form of labour in producing food and cash crops and looking after domestic animals.

There has been evidence that many married women got pregnant even when they took contraceptives, especially the pill, because their husbands objected to them using it. They had to hide the pills in the garden and take them at irregular hours (Kaufman, 1998). There are also many myths circulating regarding the use of contraceptives – for example, that the “loop” (an intra-uterine device) makes a woman cold and unresponsive in bed (Jackson & Harrison, 1999).

Ross and Mauldini (1996) recommend that family planning programmes must offer abortion services along with contraceptive services if the aim of these programmes is to ensure that all children born are wanted children. They argue that contraception, by itself, does not prevent all unwanted births as contraceptive failures do occur. They also report that many adolescents believe that they cannot become pregnant and others fear that their sexual activity will be discovered if they utilise available contraceptive services.

Urbanization is an especially important influence in the least developed countries. Rural areas are changing, small towns are becoming cities and big cities are still expanding. People migrate in response to opportunity, economic deprivation and environmental emergency, reflecting both under-investment in rural development and poor resource management. The urban experiences offer young people opportunity and expose them to sexual risks (Shapumba et al., 2004; Gebhardt et al., 2004; Nengomasha et al, 2004). In every area of their lives, migrant young people remain highly vulnerable and an often hard to reach group. Young people may move with their families or on their own in search of work or education. The experience of rural to urban migrants varies considerably. In many developing countries, domestic work is one of the main sources of income for young women in urban areas (Kaufman, 1998). In Nigeria, young women apprenticing to be tailors are very

vulnerable to sexual abuse because of their subordinate position at work and separation from their families (Akande, 1994).

The process of urbanization and the increasing influences of western cultural precepts on many population groups, but especially the young, are seen to be responsible for the breakdown of traditional customs. In this sense, the increase in premarital sexual activity and the increase in unmarried teenage pregnancy is seen by Villarreal (1998) as a consequence of the introduction of “western” values and ways of conduct, which expand more easily in the urban context and through the media available in this context. Villarreal (1998) reports that urbanization and detribalisation have loosened social practices and in the process sexual behaviour among the youth has become more extended and unmarried teenage pregnancy more frequent. Westernization has had an important influence in the disappearance of certain taboos and certain practices like initiation ceremonies. In the process of urbanization two factors are relevant in the changes in sexual practices and outcomes: education and the changes in traditional systems of social controls. In Latin America, the rural-urban migration flow is reported to provide young women with a physical way to escape the traditional controls on their sexuality, for with the change of location, young women are able to flee the controlling eye of parents, the local priest and the community (Purdy & Ramsey, 1999).

With urbanization, the socialization process has shifted from being entirely the responsibility of the direct or extended family to being partially dominated by social institutions like the school, under the ever-stronger influence of the media. The introduction of western systems of thought – within the power relationship that is generated by a dominant culture – often destroys local taboos, along with the element that legitimizes them within the local belief systems (Kinsman et al., 2000). In the same manner other forms of social

control lose relevance, as the weight of the western values, attractive to the young cannot be countered by local propositions. Early marriages and childbearing continues to be mostly a rural phenomenon. In the urban areas young women have their first child significantly later, although this does not necessarily mean later first pregnancies, for illegal abortion is much more widely practiced among urban adolescents.

According to Mufune et al., (1999), a large number of people are migrating from the Northern to the Southern part of Namibia. Many of them are in search of jobs and education. Migration is associated with the spread of STD and HIV/AIDS. This is due to the fact that the sexual behaviour of young women at home significantly differs from their sexual behaviour away from home. They are outside the controls of family, friends and community. The anonymous sex that they engage in is more likely to involve a new partner, exchange of money or materials and many partners (Kim et al., 2001). A large number of married men also migrate to urban areas in search for jobs and leave their wives and children to work in the fields in the rural areas. The periodic and prolonged absence of men holds implications for women's status and livelihood and for reproductive dynamics.

Kaufman (1998) reports that the absence of men at home is hypothesised to be negatively associated with contraceptive use because of lower coital frequency and a decreased risk of pregnancy. Kaufman (1998) further argues that the absence of men is also likely to increase demand for children because of the future labour and support children represent to women who may find themselves in unstable social and economic relationships with men. Anecdotal evidence suggests that many men working away from their wives are opposed to their wives' use of contraceptives, perceived as a sign of promiscuity and that men departing for contract work prefer to leave their

wives pregnant, also eliminating the need for contraceptives (Kaufman, 1998).

In most of sub-Saharan African countries (e.g. Zambia, Namibia, Malawi, Kenya, South Africa) it is a tradition that women should not have sex before marriage and because of this most teenage women find it difficult to have access to contraceptives to protect themselves from pregnancy and infections (Population Reference Bureau, 1992). They often feel shy if they are seen getting condoms from the nearby clinics. They fear that people will know that they are having sex outside marriage and will not be respected in their communities. On the other hand, most young girls do not want to deny their boyfriends sex because they are afraid that they might lose their boyfriends as well as lose their relationships. Thus most of them decide to have sexual intercourse without protection (Eggleston et al., 1999). Some girls believe that relationships without sex will not turn into true love and hence this has caused most girls to have sex very young (in their first relationships). Furthermore, some girls tend to emphasize prevention of pregnancy in relationships by using the pill, injections or the IUD, but these do not protect them against HIV and other infectious diseases.

There is evidence and cases reported that a high percentage of married women have been infected with HIV/AIDS by their husbands (Ntozi & Ahimbisibwe, 2001). Simply being married is a major risk factor for women who have little control over abstinence or condom use at home or their husband's sexual activity outside. In Zambia, generally, it is reported that women lack complete control over their lives and are taught from early childhood to be obedient and submissive to males. In sexual relations, a woman is expected to please her male partner, even at the expense of her own pleasure and well being. Dominance of male interests and lack of self assertiveness on the part of women put their reproductive health at risk.

Women are taught to never refuse having sex with their husbands regardless of the number of partners he may have or his non-willingness to use a condom, even if he is suspected of having HIV or another STD (Zambian Ministry of Health and Central Board of Health, 1997; Benefo, 2004).

A question that has stimulated considerable research is the degree to which organized family planning programmes are responsible for recent increases in contraceptive prevalence in developing countries. It may be observed that the countries where contraceptive use has grown rapidly (Kenya, South Africa and Zimbabwe) do tend to have relatively strong programmes (Ngom et al., 2005). However, cultural and economic conditions affect the ease with which an effective network of family planning services are provided, and also affect the desire of couples to practice family planning.

Certainly, there are some developing countries where contraceptive prevalence has reached high levels with little or no official support for family planning (United Nations, 1988). In Brazil, for example, although during the 1970s the government adopted a generally permissive stance towards dissemination of contraceptive information and supplies, which improved the ability of non-governmental organizations and commercial sectors to provide services, organized programme activities were limited in scope; the strength of the programme effort has been rated weak (United Nations, 1988). The level of fertility, however, has fallen rapidly, and contraceptive prevalence reached 65 per cent by 1986 (United Nations, 1988). Although strong support for family planning programmes is clearly not always necessary for contraceptive practice to become established in a population, most evidence indicates that organized family planning programmes have had an important role in increasing the level of contraceptive use in developing countries.

Gender imbalances in sexual decision-making influence young women's contraceptive use. Waszak et al., (2000) report that some young women would rather risk pregnancies than ask a partner to use a condom. Gender roles and gender norms are culturally specific and they vary around the world. Almost everywhere men and women differ from each other in power, status and freedom. However, in most societies men have more power than women. Gender roles begin at birth and span a lifetime. At very young ages boys and girls learn from their families and peers how they are expected to act around people of the same sex and of the opposite sex (Bender and Kosunen, 2005). Almost universally, young males experience more sexual freedom than young females.

Gender has a powerful influence on reproductive decision-making and behaviour. In many developing countries, men are the primary decision makers about sexual activity, fertility and contraceptive use (OsayiOsemwenkha, 2004). Men are called “gatekeepers” because of the powerful roles they play in society – as husbands, fathers, uncles, religious leaders, doctors, policy makers and local and national leaders. In their different roles men can control access to health information and services, finances, transportation and other resources. Gender is just one of the many factors that influences couples and affects their reproductive decisions. Educational level, family pressures, social expectations, socio-economic status, exposure to mass media, personal experience, expectations for the future and religion also shape such decisions (Grady et al., 1993).

In some developing countries, husbands dominate reproductive decision-making, whether regarding contraceptive use, family size, birth spacing or extramarital sexual partners. Traditional gender roles can jeopardize the reproductive health of both women and men. Inequities in power often make women vulnerable to men's risky sexual behaviour and irresponsible

decisions. Because of their gender roles, many women around the world have trouble talking about sex or mentioning reproductive health concerns. They may not be able to ask their partners to use condoms or to refuse sex even when they risk getting pregnant or being infected with STD, including HIV/AIDS. Women engage in dangerous sexual practices with men because they are afraid of retaliation, such as being beaten or divorced because their gender roles place them in subordinate positions in society (Grady et al., 1993; Mufune et al., 1999; lipinge et al., 2004).

Kim et al. (2001) on the other hand report that gender roles along with a host of economic factors contribute to risky sexual behaviours. Kim et al. (2001) further report that young women are socialized to be submissive and not to discuss sex with their partners, which leaves them unable to refuse sex or insist on condom use. Women's economic dependence on men also leads young females to exchange sex for the opportunity of marriage or for gifts, sometimes with older "sugar daddies". There are reports in the local newspapers that some of the "sugar daddies" engage in sexual intercourse with school-going young women in exchange for paying school fees and providing transport.

2.7 The role and importance of reproductive health programmes

Reproductive health programmes are carried out within a variety of social and economic contexts and their effects coincide with those of other influences on contraceptive use and health service utilisation. Since the 1960s, there has been a substantial increase in the number of countries that have organised efforts to provide reproductive health suppliers and services (Ross et al., 1999). These efforts have involved both public and private channels – more often the former, but with significant and growing emphasis on the latter.

Reproductive health encompasses many elements: safe childbirth and postnatal care, prevention and treatment of STIs, including HIV/AIDS, prevention and treatment of infertility, elimination of harmful practices and violence against women. The Programme of Action thus calls for all countries to provide these services, mainly through the primary health care system.

Each year more young women are reported to have died from complications of pregnancy, childbearing and unsafe abortions (Shane, 1996). Most of these deaths are often reported in developing countries. Reproductive health programmes can prevent many of these deaths by enabling women to bear children during their healthiest times for themselves and their children (Ross et al., 1999). It also allows couples to decide how many children they want and when to have them.

Innovative services for youth have been developed in general settings in many countries. In Zambia, the Lusaka Urban Youth Friendly Health Services project used participatory needs assessments and learning exercise to involve community leaders and parents (Nelson et al., 2000). The project provided education on contraception and prenatal care and this led to the number of young women using clinics doubling with significantly more nonpregnant young girls seeking counselling and contraceptive services. In addition, adolescent reproductive health in Zambia remains a sensitive issue. A 1994 study found that most Zambian adolescents have limited knowledge about reproduction and sexuality and that 20.4 per cent of childbearing, teenage women in urban Zambia were HIV positive (Shannon, 1998). Although providing family planning information and services to adolescents is legal in Zambia, Shannon (1998) reports that youth were routinely scolded by clinic staff who were reluctant to provide services to young, unmarried people.

In 1994, public health workers in Lusaka clinics realized that existing health care services were not reaching the youth (Nelson et al., 2000). Zambian NGOs further found that providing reproductive health information and education to adolescents did not encourage their use of health care services. Even though the youth understood the importance of using health services, they were still fearful of using them. The NGOs and clinics began to collaborate to identify and reduce barriers to young people's access to reproductive health services. The Ministry of Health (MOH) Maternal and Child Health/Family Planning unit launched an adolescent Health Task Force. The Task Force was drafted to develop a National Health Programme for Youth, made up of Youth serving organisations (YSOs) and clinics. The aim was to establish the Youth Friendly Health Services (YFHS) Project. The YFHS was established and peer educators were trained to provide counselling, information, condoms and referrals to their peers. The response from adolescents has been reported to be positive towards the programme (Shannon, 1998).

Successful programmes typically identify a specific target group to be served, often defined by age, school status, marital status and other social factors. Finger (1997) maintains that this helps in analyzing the needs of the target group and in developing appropriate strategies to meet those needs. Finger (1997) also reports that young women should not be treated as a homogenous group. This implies that focusing on specific characteristics is important, especially marital status, school enrolment and geographical location. For example, the reproductive health needs of urban and rural youth are usually different as are the available resources to serve them. In an evaluation of projects focusing on adolescents, UNFPA found that almost none of the projects had defined its target population clearly (Finger, 1997). Programme planners were not always clear about the age range they intended to serve and in some cases; they chose the least costly channel

such as in-school programmes, even though the most needy and underserved are out of school youth.

Finger (1997) thus emphasizes that in designing a programme for a particular group, it is essential to use specific and measurable objectives. Marital status can be important to consider. Both married and unmarried young women have common biological and developmental issues regarding reproductive health. Thus, the need for information about sexuality, contraceptives, pregnancy and other issues are similar for all youth. Whether married or unmarried, young people face health risks from pregnancy and STDs. However, young women who are unmarried often face more obstacles to services and have different contraceptive needs.

In 1998, South Africa received a financial grant from the World Health Organization to establish whether adolescent mothers aged 19 or younger at the birth of their babies utilised contraceptives. The findings reported by Ehlers et al., (2000) indicate that adolescent mothers in Gauteng did not make optimum use of the available reproductive health care services. The report recommends that education about sex, pregnancy and contraceptives should commence at the age of 10 as the majority of the respondents did not have the necessary knowledge to make informed decisions about their futures. Sex education guides young people towards healthy attitudes that develop concern and respect for others (Sapire, 1988). Sapire (1988) claims that research shows that young women exposed to sex education are not more likely to engage in sexual intercourse than are other adolescents, and those who become sexually active are more likely to use a contraceptive method at first intercourse and are slightly less likely to experience premarital pregnancies. The non-use of contraceptives is, thus, related to ignorance, lack of awareness of the consequences of sexual activity and inaccessibility of suitable services.

Many young women who become sexually active do so without accurate information about reproductive health. This lack of information can put them at risk of unplanned pregnancy or sexually transmitted diseases (STDs). Barnett (1997) recommends that sexual health education can be one way in which young people can be helped to prevent these problems and improve their future reproductive health. The most effective sexual health programmes are those that include more than information on reproductive health. These programmes also help young women to enhance communication and negotiation skills, clarify their values and change risk behaviours. According to Barnett (1997), basic information on reproductive health is important for youth just as basic information about other types of health issues is important. Barnett (1997) further reports that sex education programmes might be the only place that young women can learn accurate information about reproductive health. Sex education programmes may offer the only setting in which young people can practice the skills necessary to maintain good reproductive health.

Misinformation and misunderstandings about conception, family planning and STD risks abound among young adults. In Jamaica, research conducted by the University of the West Indies and Family Health International (FHI) Women's Studies Project found that a group of adolescents had little accurate information about reproductive health issues (Eggleston et al., 1999). In India, of 100 girls who came to a hospital seeking abortion, 80 per cent did not know that sexual intercourse could lead to pregnancy or STDs, and 90 per cent did not know about contraception (Griffiths & Stephenson, 2001). A study of Russian adolescents' knowledge of AIDS found that, among 370 high school students surveyed, only 25 per cent of the girls and 35 per cent of the boys knew that condoms should be used just once. Thirty eight per cent of students incorrectly believed that condoms could be washed and used several times (Belmonte et al., 2000). In Chile, where 948 public school

students were surveyed in Santiago's poorer communities, 57 per cent of boys and 59 per cent of girls said condoms could be re-used. Sixty-seven per cent did not know the fertile or infertile periods of a woman's menstrual cycle (Diaz et al., 1999) Lack of information may be one reason that young women's use of family planning methods is generally low. In South America, for example, only 43 per cent of young married women, aged 15 to 19 use contraception, according to the data compiled by the Population Reference Bureau (2004). The FOCUS on Young Adults programme recently analyzed reproductive health programmes in developing countries and found few studies that demonstrate sex education results in behavioural change. Experts say more research is needed, and evaluation measures need to be refined (Reproductive Health Outlook, 2002). However the FOCUS project reports that sex education programmes that include activities to help young people build skills in communication and negotiation are likely to be more successful than programmes that only provide information on reproductive health (Barnett, 1997).

The US based Sexuality Information and Education Council (SIECUS) recently updated its guidelines for sex education programmes (Waszak et al., 2000). Originally published in 1991, the guidelines were designed to help local communities develop their own curricula or evaluate existing programmes. The SIECUS guidelines emphasized that sex education should begin in early elementary school, when children are ages five to eight, and continue through adolescence, ages 15 to 18. SIECUS recommends that parents and other important family members, teachers, administrators, community and religious leaders and students should all be involved. SIECUS has worked in Brazil, Nigeria and Russia to help local government and nongovernmental organizations that work with adolescents develop their own guidelines for sex education programmes. Involving young people in the design and implementation of sex education programmes is an important

element in ensuring that the programme addresses teens' needs. The Youth for Youth Foundation in Romania began with a survey of students at 17 high schools in Bucharest to determine young people's knowledge of reproductive health issues and their health needs. Lack of basic information on reproductive health was found to be one of the main reasons for unplanned pregnancies and abortions among Romanian youth (Waszak et al., 2000).

In Namibia, improvements in sexual and reproductive health service provision took place on both the supply and demand side, after independence. The government and the private sectors worked to increase the availability of contraceptive supplies and services and at the same time initiate information and education campaigns to influence the demand for those services (MOHSS, 2002).

2.8 Conclusion

In this chapter, the theoretical and conceptual framework on the use of contraceptives among young women adapted from the Davis and Blake model, Easterlin model and Health Belief Model was presented. The literature on contraceptive use among young women, particularly in sub-Saharan Africa, was reviewed. Contraceptive use prevalence among young women in sub-Saharan Africa has improved, although still low as compared to other developing regions of the world. Some socio-economic, demographic and behavioural factors that influence contraceptive use were reviewed and adapted to the conceptual framework. Finally the role and importance of reproductive health programmes targeting young women and their success were discussed. The following issues discussed will receive particular attention in the next few chapters: the availability and accessibility of reproductive health services, privacy and confidentiality on reproductive

health services for young women, urbanisation process as well as traditional and cultural issues on reproductive health, including parental involvement.

There is ample evidence to show that reproductive health services are in short supply in many African countries and even where available, young women do not make adequate use of them. A key barrier to access is the perception among young women that reproductive health services are not confidential and that their private information will become known, particularly to their parent. Confidentiality has been identified by most researchers (Ringheim, 2006) as the barrier in utilisation of reproductive health services for young people. Fear that the confidentiality of private information will not be protected by RH service providers prevents many young people from seeking needed services like contraceptives, STIs treatment, maternal care as well as counselling services.

According to international law, young women must enjoy the same human rights as adults. The ICPD Programme of Action recognises that sexual and reproductive health services “must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent” (United Nations, 1994). The Key Actions document resulting from the ICPD plus Five conference in 1999 specifically noted that countries should ensure that programmes and attitudes of health care providers do not restrict the access of young people to appropriate services and information. Many countries, however, have developed national youth policies that specifically endorse the rights of young people to receive confidential RH information and services. Yet, in practice these policies are far from being fully implemented and more young women do not enjoy access to private and confidential RH services. The issue of privacy and confidentiality is also of great importance in Namibia. There are some health care providers who feel that morally, their primary obligation is to inform and involve the parents rather than to protect the confidentiality of the

adolescent clients. Furthermore, cultural and religious beliefs underlie the harsh judgement and ridicule with which some providers treat adolescent clients, a treatment which further alienates adolescents from seeking services.

With urbanization, some cultural and traditional practices lose value. Sexual intercourse outside marriage for young women is no longer a taboo. Traditional story telling for young women with adult members of the community do not exist anymore, because more young women have moved to urban areas for better living conditions i.e. in search of good education, employment opportunities, etc. Thus, urbanisation has also the advantage of promoting the well-being of women. More women are attaining high levels of education and have good employment opportunities.