CHAPTER FOUR
Results and Discussion

4.1 Introduction

In this chapter, I present the descriptive, bivariate and multivariate analyses of the effect of selected independent variables on contraceptive use in Namibia. The independent variables were selected on the basis of empirical findings and theoretical explanations. Information obtained from responses to the questionnaire provides data on socio-economic, cultural and demographic characteristics of users of a variety of contraceptive methods. Moreover, the NDHS data provide information for constructing contextual community factors (for example, the proportion of women reached by information campaigns through mass media such as radio) that are also included in the analysis. Background characteristics were selected for inclusion in the analysis based on their significance in the previous studies of contraceptive behaviour or on their hypothesized association with contraceptive choice. They can be grouped broadly into contextual factors (region, place of residence); demographic factors (age, number of living children, marital status); socio-economic factors (religion, education, employment status) and behavioural factors (exposure to SHR messages on radio, TV).

The analysis excludes infecund and pregnant or sterilized women. Current use includes use of any contraceptive method: this can either be a modern, traditional or folk method. Non-users on the other hand, refer to women who are not using any methods to delay or prevent pregnancy.

This chapter is divided into four main parts: analyses of the determinants of contraceptive use, analyses of the determinants of contraceptive method choice, factors associated with condom use among young women in Namibia

as well as focus group discussion results. The discussion for each sub-section is also included after the presentation of the data. The significant aspects of the findings will be addressed in the final chapter.

4.2 Contraceptive use

Current use of a contraceptive method is the aspect of contraceptive practice that is of greatest interest both to demographers (as a proximate determinant of fertility) and to family planning policymakers (as a measure of the coverage of their programs). However, several other aspects of contraceptive practice are of interest: ever use of a method, knowledge of contraceptive methods, and knowledge of sources of contraception and fertility preferences. Family planning researchers often use these variables as indicators of constraints on use in a population (Curtis & Neitzel, 1996). Ever use of contraception can signal the degree to which contraception is accepted or tried. Low levels of knowledge of contraception may indicate that the population is unaware of fertility-limiting options. Low levels of knowledge of sources of contraception may suggest that access to family planning is limited and programme extension is warranted.

Knowledge of contraceptive methods is one important aspect of the changing social context of fertility and reproduction. Although many young women know about contraception, they do not necessarily use it. Bledsoe and Cohen (1993) suggest that young women who are most knowledgeable about contraceptives are those living in urban areas or those living in households with a radio or television or those who have more education. Information on young women's knowledge of contraception was collected in two ways. Respondents were first asked to mention any "ways or methods" of contraception that they might have heard about (spontaneously). Interviewers then described methods not mentioned spontaneously to see if the

respondents recognized the method. Knowledge of a family planning method was, therefore, defined as “having heard of a method”. The data suggest that the overall level of knowledge among young women was very high (98 per cent). Almost all young women have heard of at least one contraceptive method and all young women who knew a method knew a modern method. Less than half of all young women have heard of a traditional method. This was because the existing family planning programmes only promote modern methods as effective methods other than the traditional methods. Nurses responsible for family planning services also do not recommend use of traditional methods to young women because of fear that the methods might fail, thus resulting in unwanted pregnancies. Traditional methods were viewed as not reliable. Table 4.1 presents the percentage of young women by knowledge of contraceptive methods.

Table 4.1: Percentage of young women’s knowledge of contraceptive methods, Namibia, 2000

Contraceptive method	per cent
Modern method	
Pill	85.6
Injections	90.0
Male condom	94.1
IUD	40.4
Female sterilization	49.8
Male sterilisation	27.3
Female condom	65.2
Vaginal cream	19.6
Emergency contraception	17.8
Traditional methods	
Withdrawal	30.1
Periodic abstinence	29.2
Others	5.1
N	**2576**

Source: NDHS 2000

The most commonly recognized method among all young women was the male condom (94 per cent), followed by injectables (90 per cent), and the pill (86 per cent). Knowledge of the female condom among young women was also quite high (65 per cent), while 50 per cent of young women had heard of female sterilization and 40 per cent had heard of the IUDs. These results reflect the fact that many programmes targeting young people on sexual and reproductive health matters promote the use of the condom more readily than other methods. This is due to the fact that the programmes are more concerned with young people contracting STIs, including HIV, than preventing pregnancies.

There are currently programmes targeting young people on sexual and reproductive health on national radio and television that invite young people to express their views among themselves on current sexual behaviour. Sometimes there are meetings for young people where they are shown how male and female condoms are used. Thus, condoms are widely known. The Ministry of Women and Child welfare under a programme supported by UNFPA has been highly involved in the promotion of both male and female condoms by sending them to almost all regions. Community meetings have also been held in which women have been advised on how they are used. It is thus not surprising that high proportions of sexually active young women have heard of both male and female condoms.

Injectables are also known because they are the most available methods at almost every clinic. Injectables have been popular methods in Namibia since the introduction of family planning in the late 1970s. During the colonial era, injectables were the only methods offered to the majority black population. Although the pills were also available, the education level of women at that time was very low and it was difficult for them to accurately follow the pill instructions. Pills were thus not popular. The least widely known methods are

emergency contraception (18 per cent), vaginal contraceptives (20 per cent) and male sterilization (27 per cent). Less than one third of all young women have heard of periodic abstinence and the same proportion have heard of withdrawal. This indicates that knowledge of modern methods of contraception is more predominant than any other method among young women.

Knowledge of contraceptive methods among young women is high in all health directorates in Namibia. In the South and Central health directorates knowledge of contraceptives is as high as 98 per cent. The least known methods (IUD, vaginal cream, emergency contraception) appeared to be mostly known by young women in urbanized regions: Khomas, Erongo and Karas regions (results not shown here). These methods are less likely to be available in rural hospitals and hence young women in rural dominated regions are less likely to know them. The IUD in particular requires a professional nurse or doctor to insert it and in some cases clinics in rural areas do not have experienced nurses to insert IUDs or there are no adequate facilities to offer such services. In addition, vaginal cream and emergency contraception are mostly available in pharmacies, which are only easily accessible in urban areas.

The pill, injections and male condoms are known by young women in almost all regions. Furthermore, knowledge of modern methods of contraception is more predominant than knowledge of any other method among young women in all regions. Knowledge of other contraceptive methods, which included herbs, etc., was high among young women in the Kavango region (Ministry of Health and Social Services, 2001[b]). This region is more rural and access to health facilities is not easy, in terms of location and transport. Young women are forced to walk or travel long distances to health facilities. It is, thus,

assumed that young women in this region have limited knowledge of modern contraceptive methods.

All young women interviewed in the 2000 NDHS, who said they had heard of a contraceptive method, were asked if they had ever used that method. The level of current use of contraceptive methods is one of the indicators most frequently used to assess the success of family planning programmes. Current use in this context was defined as the proportion of young women 15 –24 years who reported that they were using a family planning method at the time of interview. The table below shows the percentage of sexually active young women who reported that they were using contraceptive methods at the time of interview. According to the 2000 Namibia Demographic and Health survey, 53 per cent of sexually active young women were using contraceptives (Table 4.2).

Table 4.2: Percentage of sexually active young women (15-24 years) who reported using contraceptives by type of method, Namibia 2000

Contraceptive method	prevalence
All methods	**53**
Modern methods	**52**
Pill	7
Injection	28
Male condom	17
Other modern methods	0.7
All traditional methods	**0.8**
Calendar /periodic abstinence	0.1
Withdrawal	0.1
Other traditional (herbs etc)	0.6
N	**1776**

Source: NDHS 2000

The table above shows a relatively high prevalence of modern contraceptive methods (52 per cent). Injection had the highest prevalence (28 per cent) followed by the male condom (17 per cent) and then the pill (7 per cent) and other methods (0.7 per cent). Only less than one per cent of sexually active young women were using traditional methods. Overall, the prevalence of use of contraceptive methods among sexually active young women in Namibia is still below the regional prevalence level of 60 per cent.

4.3 Factors associated with contraceptive use

Descriptive analyses

Characteristics associated with the use of contraceptives are shown in table 4.3 below, which displays the sample distributions.

Current age

Several researchers (Bertrand et al., 1993; Agyei & Miggade, 1995; Bertrand et al., 2001; Burgard, 2004) report that a woman's age is one of the factors associated with contraceptive use. The age categories used are 15-19 and 20-24 years. One could anticipate that contraceptive use is highest among the youngest (adolescents) because they are most likely to want to delay childbearing. In contrast, Table 4.3 shows that a large proportion (61%) of sexually active young women was young adults (aged 20-24 years). Marital status can also influence young women's use of contraceptives. Among sexually active young women who were sampled during the Demographic and Health Survey, only 25 per cent suggested that they were married or were living as married with their partners. Thus, 75 per cent 'not in union' would include those without partners/boyfriends as well. In Namibia, age at first marriage has increased and there are few women who get married before age 20. The majority of young women in Namibia get married from age 25.

Table 4.3: Sample distribution of sexually active young women by background characteristics associated with contraceptive use, Namibia 2000.

Characteristic	per cent	N
Age group		
15-19	39	695
20-24	61	1081
Place of residence		
Urban	43	761
Rural	57	1015
Discuss FP with partner		
No	90	1604
Yes	10	170
Discuss FP with mother		
No	92	1637
Yes	8	137
Regions		
Northwest	28	505
Northeast	17	305
Central	27	472
South	28	494
Time to nearest health facility		
Less than an hour	77	1373
1 hour or more	16	291
Education level		
None	8	144
Primary	26	469
Secondary+	66	1163
Marital status		
Not in union	75	1329
In union	25	447
Number of living children		
None	46	824
At least 1	54	952
Total	**100**	**1776**

Source: NDHS 2000

Number of living children

The number of living children is a measure of women's previous experience of childbearing and an indicator of demands already placed on household resources. Women with at least two or more living children are likely to be more interested in limiting childbirth than are childless women, or those with only one living child, whereas those with no living child may be trying to delay the start of childbearing. The majority of women in the sample reported having at least one living child (54 per cent). This could be an indication of high premarital childbearing.

Educational level

Socio-economic characteristics are also key determinants of the use of contraceptives. Education may affect contraceptive use in multiple ways: it may expose women to modern ideas about contraception and family size limitation, and it may enhance their ability to exercise control over their sexual relationships and childbearing preferences. Women with more schooling may be more comfortable interacting with medical personnel and may have better access to sources of modern contraceptive methods than women who have little or no education. In addition, better-educated women may be more likely than others to earn incomes or to live in households having higher incomes, and thus may have greater economic resources or health insurance that could improve their access to the type of contraception that they prefer. In the sample, there were few young women who reported that they have never been to school (8 per cent) and about two-thirds reported having at least secondary education (66 per cent).

Place of residence

Community conditions may influence the availability of contraceptives and the perceptions of potential users. Current area of residence was one of the measures which was included in the analysis regarding community influence.

Women living in rural areas were likely to have poorer access to information about contraception or available family planning services. The sample included 57 per cent young women from rural areas and 43 per cent young women from urban areas.

Parental influence

Parental involvement in their children's sexual and reproductive health was a community factor, which has an influence on young women's use of contraceptives. Young women who discuss family planning issues with their mothers were more likely to be discouraged by their mothers from using contraceptives, because in most societies parents believed that contraceptives may promote promiscuity among their daughters. In the sample there were few young women who discussed family planning with their mothers (8 per cent). However, the data does not show a significant difference in discussing family planning with mother for young women who live in rural or urban areas. Among those who discuss family planning with their mothers, 50 per cent live in urban areas and 50 per cent live in rural areas.

Health directorates

In addition, the sample includes a fair distribution of sexually active young women from each health directorate. It is expected that contraceptive use would be high among sexually active young women who live in urbanised and industrialized health directorates than in the least urbanised. Central and South are the most industrialized health directorates. It is important to consider health directorate as a variable for the analysis to assess which health directorate lags behind others on sexual and reproductive health services for young women and to advise programme implementers accordingly.

Bivariate and multivariate analyses

This section presents the bivariate and multivariate analyses of socio-economic and demographic factors, which have an influence on contraceptive use. The bivariate analysis was done through cross tabulations and the multivariate analysis was carried out using logistic regression. Since it has been indicated in several studies that in various countries of the sub-Saharan region, contraceptive use prevalence had increased, it was important to examine factors that influence contraceptive use. This will help policy makers to establish proper strategies for raising contraceptive prevalence, especially among young people. Although the family planning policy in Namibia clearly stipulates the fact that all women of childbearing age are free to seek and use family planning services/methods, in practice young women, especially those 'not in union', have limited access to such services. This has contributed to a problem of high premarital births, most of which are unwanted.

According to the United Nations (2003) report, contraceptive use varies according to income, education, ethnicity, proximity to clinics and the strengths of family planning programmes. It is argued that the wealthiest women are four times more likely to use contraception than the poorest, according to the UNFPA report (2004). In some countries, such as Mali, the rate is 12 times higher. Several factors affect demand for contraception. Social, cultural and gender related obstacles can prevent a woman from realising her childbearing preferences. Women who cannot read or have limited education may know little about their own bodies and much less about family planning. Misconceptions and myths about pregnancy and contraceptive methods also abound. Men tend to want more children and to want them earlier than women do, and in many cases have greater decision-making power to determine family size. Furthermore, social norms

surrounding fertility and virility, and the overall low status of women, keep many women from seeking family planning.

Table 4.4 on the next page summarises the bivariate and multivariate results for use of contraceptives and the associations of use with socio-demographic and behavioural characteristics among sexually active young women in Namibia. Many of the independent variables have statistically significant effects on contraceptive use in the bivariate analyses, but these effects are often not significant in the multivariate models. In addition, some determinants of contraceptive use are in agreement with what other researchers found in their earlier studies while others contradict their findings. Several interactions between variables were carried and only significant variables and interactions are presented for interpretation. Variables that are not significant as well as interactions, which are not significant, are not presented. The results show that there is a significant association between contraceptive use and the education level of a woman, place of residence, access to media, communication with mother and communication with partner. Overall, the prevalence of contraceptive use among sexually active young women in Namibia stands at 53%. Although in a sense higher, there is still more than a quarter of sexually active young women who are not using contraceptives. The differences between users and non-users are then explained in relation to characteristics identified above.

Table 4.4: Percentage distribution of sexually active young women using contraceptive methods and their estimated odds ratios of the likelihood of contraceptive use, by selected background characteristics. Namibia 2000.

Characteristic	%	odds ratio
Educational level		
Never been to school (r)	35	1.000
Primary education	45	1.450
Secondary or higher	58	2.092**
Listen to radio at least once a week		
No (r)	42	1.000
Yes	54	1.312*
Read newspaper at least once a week		
No (r)	45	1.000
Yes	58	1.397**
Time to nearest health facility		
Less than an hour (r)	54	n/a
1 hour or more	42	n/a
Health directorate		
Northwest (r)	44	1.000
Northeast	52	1.370
Central	64	1.714
South	50	0.711*
Discuss FP with partner		
No (r)	51	1.000
Yes	62	1.520*
Discuss FP with mother		
No (r)	51	n/a
Yes	65	n/a
Place of residence		
Urban (r)	58	1.000
Rural	48	0.623**
Interactions		
Not discuss FP with mother & urban (r)	n/a	1.000
Discuss FP with mother & rural	n/a	1.694*
Northwest & Urban (r)	n/a	1.000
Northeast and rural	n/a	1.365
Central & rural	n/a	1.261
South & rural	n/a	2.900**

NDHS 2000: *p<0.05; ** p<0.01, based on Wald's chi-square test for the significance of the regression coefficient.

r=reference category; n/a = not significant, -2 log likelihood = 751.645**

Educational level

Women's education occupies a unique place in demographic discourse and policy because a large amount of empirical research has revealed that educated women delay marriage, use contraceptives, reduce fertility and produce other beneficial reproductive and child health outcomes (Benefo, 2006). He further states that elite educated women play a major role of exposing other women to new ideas about fertility control. They develop a heightened awareness of the opportunity costs of childbearing, learn about western contraception and become empowered to adopt them. They therefore, act as sources of information, social support and social pressure that diffuse their lifestyles and ideas to other women.

The results show that contraceptive use is higher among young women with some level of education. Among those who have never been to school, only 35% reported that they use contraceptives and 65% of the uneducated do not use contraceptives. The logistic regression results show that young women with at least secondary education were more likely to use contraceptives than those who have never been to school (odds ratio = 2.092). The literature on fertility studies (Kasarda et al., 1986; Robey et al., 1992) also reports that the higher the education level of a woman the more likely she is to practise contraception. Other studies (Bertrand et al., 1993; Castro and Juarez, 1994) document the relationship of female education to the decline in fertility. According to the above studies, education influences women's reproduction by increasing knowledge of fertility, increasing socio-economic status, and changing attitudes about fertility control. Education also affects the distribution of authority within households, whereby women increase their authority with their partners and affect fertility and use of contraceptives. Caldwell et al. (1992) see education as a vehicle through which people learn more Western views about the family, which lead to a more child-centred parenting approach, and to different definitions of acceptable child care. This also leads

to a demand for fewer children, and consequently the use of contraceptives to prevent or to space childbirth.

In Namibia, like in many African societies, educated women in a community initiate social and ideational changes that undermine traditional patriarchal power and reduce men's interest in having large numbers of children, whom they cannot afford to take care of. Educated women are also competitive in the labour market and can make them interested in practising safe sex and use contraceptives. However, although education is good on its own, because of the benefits attached, some earlier researchers (Kiragu et al., 1995; Glei, 1999) argue that the lengthening process of formal schooling and the concomitant postponement of marriage can be expected to lead to an increase in problems associated with premarital sexual activity among young women.

Educated young women are also likely to be employed and earning income; thus the relationship between women's status, employment and childbearing are complex. Some statistical studies (Kasarda et al., 1986; Castro & Juarez, 1994; Bongaarts et al., 1994, DeGraaf et al., 1997; UNFPA, 2005) found lower fertility associated with more female participation in the labour force, while others found the opposite. Such inconsistency is not surprising, given the variety of jobs and occupations, demographic and household characteristics, cultural forces, and socio-economic circumstances around the world. While statistical research into women's labour force participation and women's use of contraception had not produced clear findings, the conceptual links are clear. With effective contraception, women are better able to work when they need to without the interruption of unplanned childbearing. Whenever unplanned pregnancy limits the types of work available to women, effective contraceptive use may help provide women with broader opportunities to obtain the economic security of a job. When a

woman cannot be sure of avoiding pregnancy, her occupational choices often are limited. More detailed studies (Gbolahan & McCarthy, 1990; Shapiro & Oleko, 1997) offer a clear view of how contraceptive use and employment are linked. For example, in Nigeria researchers found that young unmarried women out of school were using contraception in order to work longer before marriage (Gbolahan & McCarthy, 1990), because they were aware that after getting married they would have the responsibility of bearing children and looking after them. Such a situation would require some to even leave their jobs and take care of the family.

Access to media

Media access is also found to influence young women to use contraceptive methods. Young women who report that they listen to radio or read newspapers at least once a week use contraceptives more than those who do not have access to such media. For example, among young women who state that they listen to radio at least once a week, 54% (odds ratio = 1.312) report that they use contraceptives. Similarly, for those who read newspapers or magazines the odds of using contraceptives is 1.397. Reading newspapers is related to educational level and also to employment. Young women with some level of education are able to read and understand the content of the newspaper or magazine. If there is information provided on sexual and reproductive health in the newspaper they have the advantage of gaining additional knowledge. In most cases, as mentioned earlier, those with some level of education are also employed, hence the relationship. Several studies (Namibia Broadcasting Corporation, 2001; Keller & Brown, 2002) show that exposure to family planning messages through radio and print media are strongly associated with contraceptive use. Safe sex media campaigns are associated with increased teen condom use with casual partners and reduction in the number of teenagers reporting sexual activity.

In addition, the Namibian Broadcasting Corporation has several educative and informative dramas relating to sexual and reproductive health in all Namibian languages, which are of importance to young people. Those who listen to such programmes through the radio can learn from them. There are also other NGOs like UNICEF who develop prototypes for advertisements and these are heard in all radio and television services. For example, UNFPA and UNICEF have funded projects which directly work with young people to promote safer sexual behaviour. Furthermore, the Ministry of Health and Social Services together with other NGOs have developed informative and educational posters on reproductive health, which are displayed in health centres and clinics.

Media campaigns influence the sexual behaviour of young women. The young women who rely on media for information are more likely to use effective contraceptive methods. Some young women report being fearful and being too shy to be seen at health facilities for SRH services by older people and by their friends (FG, 2004). Thus, if information is published on posters, in leaflets or booklets which they can easily obtain and read on their own, it will be to their advantage. The mass media are useful for teaching young adults because the media can use elements of popular culture to articulate a message in young people's own terms.

Place of residence

Young women in the rural areas are less likely to use contraceptives than those in urban areas (odds ratio = 0.623). The bivariate results show that among young women who live in urban areas, 58% report that they use contraceptives while among those who live in rural areas only 48% report that they use contraceptives. This finding is consistent with a number of earlier studies on contraceptive use. Earlier researchers (Parnell, 1989; May et al., 1990) argue that in rural areas, access to and availability of contraception are

limited. Transport costs to health centres is one of the barriers reported in several studies to obtaining contraceptives, along with shortage of nurses, unavailability of some contraceptive methods and lack of motivation from parents and other adult members of the community are also reported. In some studies (Ross et al., 1999, 2002), the cost of contraceptives was reported by several young women in rural areas as inhibiting their ability to get contraception. In the Namibian context, contraceptive methods are freely offered in government hospitals and clinics; young women do not have to pay for them in either rural or urban areas. Therefore, the cost of contraceptives is not a barrier to use. However, there is a shortage of nurses in some clinics, especially in rural areas and this has led to some young women not getting the contraceptives when they require them.

Some contraceptive methods are also not available or not offered at some health centres and young women have to be referred to other hospitals or health centres. This necessitates incurring the cost of transport. In addition, some health centres in rural areas have shortages of doctors and young women who need the service of some contraceptive methods like IUDs have to wait for their appointments which are sometimes months away from the time they need them.

The multivariate results show a significant relationship between living in urban or rural area and communication with mother on family planning issues. Young women in rural areas who discussed family planning with their mothers were more likely to use contraceptives than those in urban areas and do not discuss family planning with their mothers (odds ratio = 1.694). *This is an indication of the importance of parental involvement in the reproductive health of young women.* Parents are viewed as knowledgeable by their children. Children thus tend to believe in whatever they are told by their parents. When parents discuss contraception with their children, they (young women) tend to

view contraceptives as important services and become motivated to use them whenever they need to.

This study hypothesised that young women who discuss family planning with their mothers are less likely to use contraceptives because their mothers are likely to discourage them from using contraceptives. *However, the data fail to support this hypothesis.* The results in Table 4.4 confirmed that among young women who discuss family planning issues with their mother as many as 65% use contraceptives and only 35% of them do not use contraceptives. Thus, discussion with mothers on sexual issues breaks the fear and encourages closeness. Young women who are close and open to their mothers can ask questions relating to sexual issues. They also become free and motivated to seek out additional information from health centres which their mothers could not provide. Most studies on contraceptive use (Agyei & Miggade, 1995; Meekers & Ahmed, 1997; Manlove et al., 2003) have not taken account of parental communication as a determinant because they only considered married women of childbearing ages. An exception in this regard would be the findings of Whitaker et al. (1999) in their comparative analysis of parents and teenagers in New York and Puerto Rico. Thus, the needs of those who are not married and those who are very young are often not taken into account.

The study shows significant regional differentials in use of contraceptives. Among young women who live in the Central health directorate, as many as 65% use contraceptives. In contradiction to the set hypothesis, the Northeast health directorate which is largely rural has a large proportion of young women using contraceptives. It is also surprising to note a lower proportion of young women in the South health directorate, which is largely urban, who use contraceptives. However, the implications can be due to a large population which live in the informal settlement of the area. Furthermore, among young women who live in the Northwest health directorate, only 44% report that they

use contraceptives. There is, however, an urban-rural relationship in contraceptive use with respect to health directorates. Young women who live in the rural areas in the Central, South and Northeast health directorates are more likely to use contraceptives than those who live in the urban areas in the Northwest health directorate (odds ratio = 1.261, 2.9 and 1.365 respectively). There is thus a clear indication that young women who live in the Northwest health directorate have a lower probability of using contraceptives. There are several factors contributing to this difference: firstly, the Northwest health directorate covers a large part which is rural. Although there are adequate health facilities, there is a shortage of nurses at most health facilities. Some health facilities are reported to have only 2 or 3 nursing sisters and most of the time they are not able to attend to all patients and hence those seeking sexual and reproductive health services, like contraceptives, and counselling, are often turned away. The negative attitude of nurses towards young women obtaining contraceptive services has also contributed to the low use of contraceptives among young women in the Northwest region as a whole (Voeten, 1994). Even those young women in urban areas are undermined by prevailing cultural norms and traditions, because some nurses who serve them suggest that young, unmarried, girls are breaking cultural rules by attempting to gain contraception. Abstinence, rather than safe sexual practices, would be regarded as more appropriate. Some nurses ask young women many questions that make them feel embarrassed, thus preventing them from using and obtaining the services they need.

Furthermore, in the Northwest, not all the contraceptive methods are available at clinics or health centres. Most clinics, especially those in rural areas, could run out of stock of some methods. Due to this, young women in the Northwest (urban or rural) would be left with few choices in terms of contraceptives. Agyei and Migadde (1995) also conclude in their study that in rural areas family planning services do not meet the needs of potential clients.

Communication with partner

The results also show that young women who discuss family planning with their partners are more likely to use contraceptives than those who do not discuss family planning with their partners (odds ratio = 1.520). Several studies (Manlove et al., 2003; Magadi & Curtis, 2003; Chen & Guilkey, 2003) document the same relationship. These studies suggest that the type of relationship that young women have with their partners influences their contraceptive use patterns. Young women who have just met their partners and those who consider the relationship non-romantic are less likely than those who are 'going steady' or are in a romantic relationship to use a contraceptive method such as the male condom. In addition, Manlove et al. (2003) also report that young women who are in relationships with older men (partners) are less likely to practice contraception, and a greater age difference between partners is associated with reduced contraceptive use.

Furthermore, Whitaker et al. (1999) report that communicating with a sex partner is an important self-protective health behaviour which can help one to learn about a partners' prior sexual behaviour and level of risk, information that will presumably lead to safer sexual behaviours. Whitaker et al. (1999) also conclude that communication with a sex partner is associated with increased condom use. Therefore, in the light of this, encouraging young women to communicate with their partners about sex and family planning is potentially an effective strategy for preventing STDs, including HIV and teenage pregnancy.

In Namibia, programmes like "Men involvement in sexual and reproductive health" were designed to equip young men on how to negotiate safe sex with their partners (Mufune et al., 1999). This programme provides SRH information through workshops and seminars. Young women may lack the power to negotiate reproductive decisions with their partners and within their

families and to navigate health and legal systems. The wider socio-cultural and economic environments may influence the opportunities and choices that women have in the realm of reproductive health and rights. UNFPA (2005) reports that rights-based reproductive health programmes may encourage shared responsibility for reproductive health by counselling couples. They may mobilize communities into an understanding of the risk of child marriage and too early or poorly spaced births. Rather than simply making condoms available, a rights-based approach will seek to empower women, to sensitize their partners and facilitate mutual cooperation and negotiation on condom use.

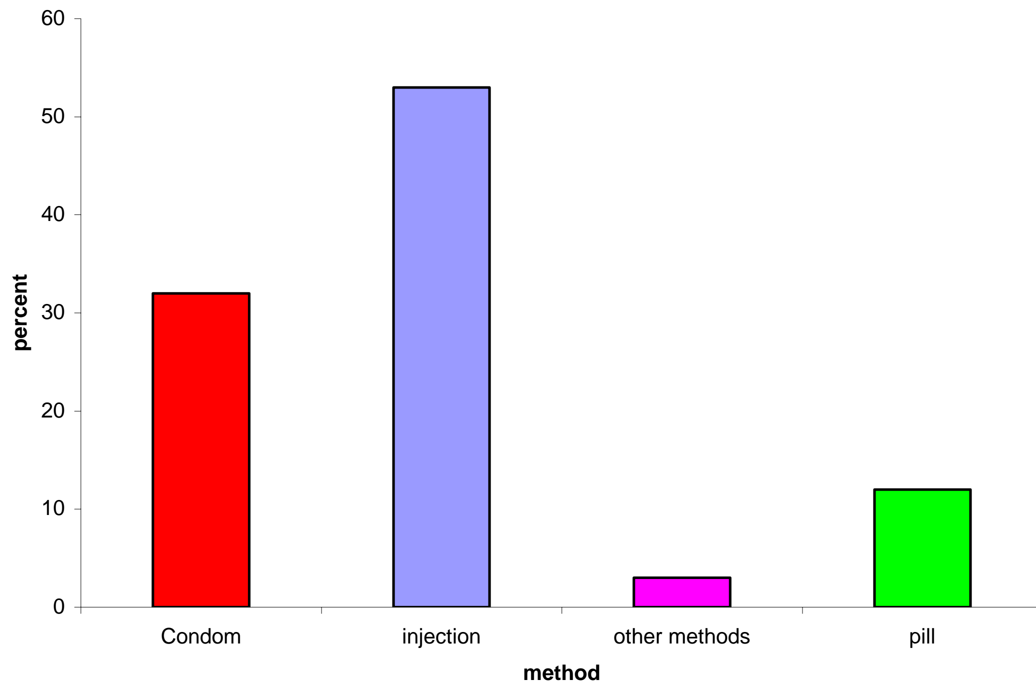
To sum up, knowledge of contraceptive methods is high; however knowledge does not necessarily result in use. Although 98% of young women report that they know a contraceptive method only 53% say that they use contraception. There are several factors that determine contraceptive use among sexually active young women in Namibia. The most significant ones include their educational level, access to media, where they live and communication with their partners and their mothers. There has been a dearth of knowledge on how parents, especially mothers, influence their children on the decision to use contraceptives. However, findings from this study revealed a positive relationship between contraceptive use and parent-child communication of family planning issues, thus rejecting the second hypothesis of our study. Regional differentials are also observed, thus supporting the first hypothesis, but differences are not as expected, as young women in some rural regions tend to report a higher percentage of contraceptive use than those in urban regions. It is, thus, important to examine further whether young women use contraceptives of their choice or not.

4.4 Determinants of contraceptive method choice

Descriptive analyses

Figure 6 below shows the prevalence of choice of method among sexually active young women who reported using a contraceptive method at the time of the survey. According to the bar chart below, among all sexually active young women who were using contraceptives, the injection was the most frequently chosen method during the survey. The next choice was the male condom and then the pill. Other contraceptive methods were only chosen by very few young women. Although the injection is the most preferred method, there are differentials in method choice with respect to health directorates. Some contraceptive methods are chosen more often in some health directorates than in the other health directorates. For example, as shown in Figure 7, in the Northwest health directorate, condoms are the most widely chosen method (65%). Evidence shows that it is not because they are the most preferred method, but basically because male condoms are readily available in most places in the Northwest.

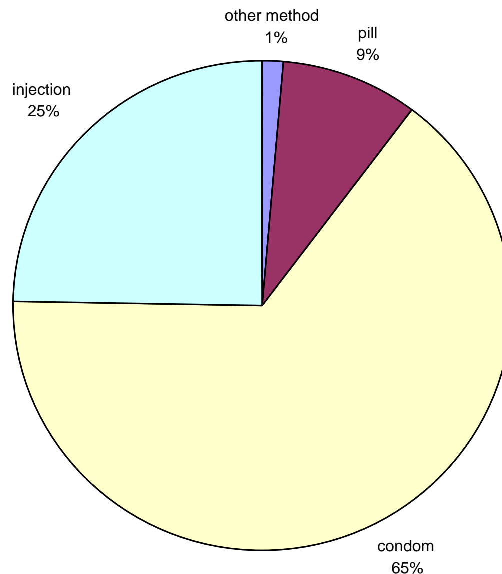
Figure 6: Choice of contraceptive methods among young women in Namibia



Source: NDHS 2000

"condom" refers to male condom . Female condom is included in other methods

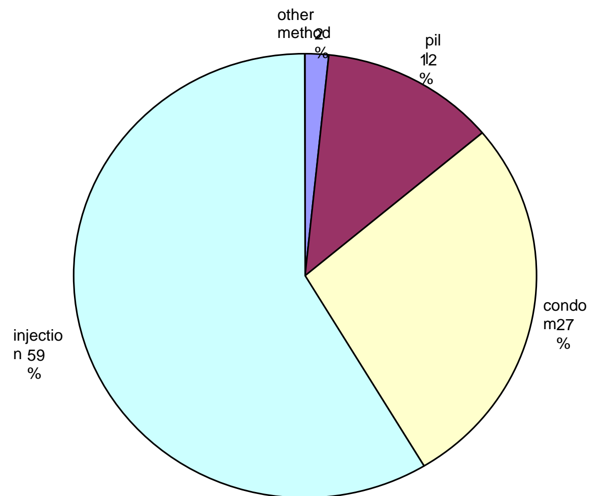
Figure 7: Method Choice for Young Women in the Northwest Directorate



Source: NDHS 2000

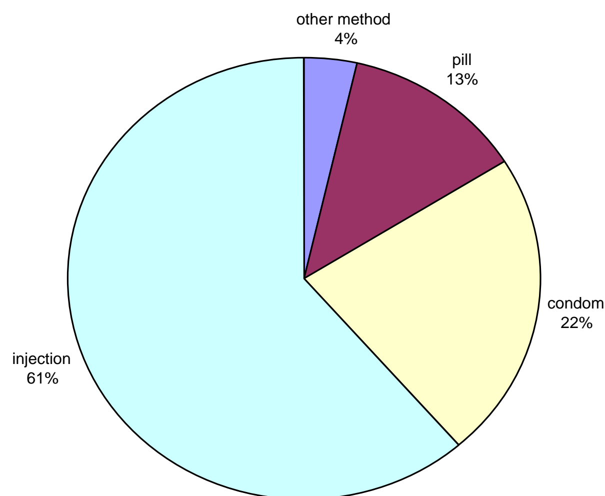
Apart from young women in the Northwest health directorate who use male condoms, sexually active young women in all other health directorates tend to choose injectables. The use of condoms in these health directorates is very low considering the fact that a high level of HIV infection was recorded in the Northeast and Central health directorate as shown in figures 8, 9 and 10. It is worrying to note that use of male condoms is very low in the Northeast directorate despite the fact that most non-governmental organisations have funded projects in reproductive health in that area.

Figure 8: Method Choice for Young Women in the Central Directorate



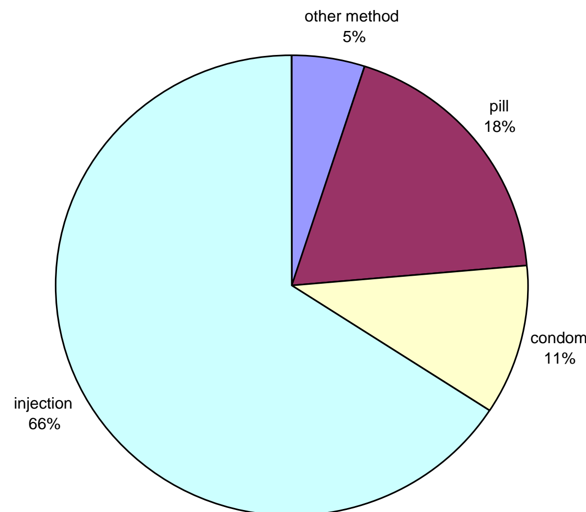
Source: NDHS 2000

Figure 9: Method Choice for Young Women in the South Directorate



Source: NDHS 2000

Figure 10: Method Choice among Young Women in the Northeast Directorate



Source: NDHS 2000

Bivariate and multivariate analyses of method choice

This section presents the bivariate and multivariate analyses results on young women's choice of contraceptives. Young women decide on their choice of methods depending on the availability and convenience of the method. Method choice in this context is defined as the method currently used by a young woman. Multivariate analysis was carried out using the multinomial logistic regression.

The results in Table 4.5 below indicate the percentage distribution of method choice by some selected socio-demographic and behavioural characteristics. The results indicate that most sexually active users aged 15-19 years were

Table 4.5: Per cent distribution of method choice by selected socio-demographic and behavioural characteristics, Namibia 2000.

Variable	Other method	Pill	Condom	injection
Age group*				
15-19 years	2.8	10.1	43.6	43.6
20-24 years	2.6	14.2	25.0	58.1
Discuss family planning with friends**				
No	3.6	12.3	30.6	53.5
Yes	0.4	13.0	36.3	50.4
Currently employed*				
No	2.4	11.2	34.7	51.7
Yes	3.6	17.1	23.9	55.4
Read newspaper at least once a week*				
No	4.4	12.5	25.7	57.4
Yes	1.8	12.7	35.7	49.8
Listen to radio at least once a week*				
No	4.4	10.6	23.0	61.9
Yes	2.5	13.0	33.6	50.9
Number of living children*				
None	1.6	8.8	52.4	37.2
1+	3.6	15.9	14.5	65.9
Marital status*				
Not in union	1.9	9.9	38.5	49.7
In union	5.2	20.6	13.3	60.9
Education level*				
Never been to school	4.0	16.0	14.0	66.0
Primary	5.7	10.0	29.7	54.5
Secondary+	1.6	13.1	34.3	50.9
Time to nearest health centre**				
Less than 1 hour	2.7	11.1	32.8	53.4
1 hour +	2.4	19.5	28.5	49.6
Overall %	**2.7**	**12.6**	**32.2**	**52.5**

Source: NDHS 2000 **$p<0.05$; *$p<0.01$, based on chi-square test for the significance of the relationship/association between variables.

using male condoms and the injection more frequently while those aged 20-24 years were using injectables more than any other method. Those who discuss family planning with their friends also showed a high percentage of making the choice of condom. Among those who report having no living child, most mention male condoms as their choice, while those with at least one living child chose the injection. The results also show a significant relationship between method choice and the marital status of a woman. Among married young women, injections were the most preferred choice and the male condom was chosen by very few married young women. Some relationship

was also observed between method choice and the educational level of young women. Among young women who have never been to school, only 14 per cent chose to use male condoms. Most of these women chose the injection. However, a high percentage of young women with some level of education express a preference for male condoms. It is also observed that the pill and other contraceptive methods like IUDs and vaginal creams were only mentioned by very few young women as their chosen method despite the fact that 20 per cent of married young women chose the pill. The results also show a significant relationship between contraceptive method choice and employment status of a woman. Overall, young women who are employed have a high percent of using contraceptives than those who are not employed. Although they are more likely to choose injection than any other method, only few percent (24%) of them chose condom. One of the reasons attributed to the low percent in condom use could be that most young women who are employed are likely to be aged between 20-24 and likely to be in marital relationships where condom use is generally low.

Results from the multivariate analysis (Table 4.6) indicate that the woman's age, whether she discusses family planning with her friends, her educational level, the health directorate she lives in, the number of children she has, her marital status and the time she took to the nearest health facility were significant determinants of choice of contraceptive methods among young women. Table 4.6 on the next page shows the estimated probabilities of contraceptive method choice. Overall, the results indicate that young women in Namibia prefer to use injections to any other contraceptive method. However, there are exceptions with regard to health directorates and number of living children.

Young women who live in the Northwest health directorate had a higher probability (0.682) of making the choice of male condom than any other

contraceptive method. The Northwest health directorate is mainly the area that was formerly known as "Ovamboland" where more than fifty per cent of the Namibian population live. It was regarded as one of the most underdeveloped areas in Namibia, with poor health facilities and a high per cent of poor people. It is also the area where culture, tradition and religion play a vital role, in the upbringing of children. In the era of HIV/AIDS, there are many programmes promoting the use of condoms countrywide. Through these programmes, condoms are distributed and obtained freely at health centres, schools and public places like bars, restaurants, hotels and many others. This finding suggests that despite a social context in which women prefer more secretive approaches to managing their fertility e.g. through injections, room exists for the promotion of male condoms. It is unusual for the condom to gain such wider acceptance in a rural-like environment. This is, thus, testimony to the effective programmes that have been put in place.

Male condoms have also become the most easily accessible method of contraception, especially in rural areas, where health facilities are not easily accessible in terms of distance. This has contributed to a high use of condoms rather than any other method among young women in the Northwest. This finding is, however, in contradiction to what other researchers have concluded. Magadi and Curtis (2003) found that condom use is more associated with urban residence than rural residence, implying that the male condom is more likely to be used in urban areas than in rural areas. They further argue that in rural areas women tend to use injection because they get it once in every three months and they do not have to come back several times to look for contraceptives. In addition, young women who have at least one living child report a higher per cent (72.3 per cent) of using the injection while those with no child prefer to use the condom (50.7 per cent).

Table 4.6: Predicted probabilities for young women's choice of contraceptive methods, by background characteristics, Namibia 2000

Variables	Other methods	Pills	Condom	Injection
Age(in years)				
15 -19	0.0095	0.132	0.304*	0.554
20 –24 (r)	0.0077	0.142	0.216	0.634
Discuss family planning with friends				
No	0.0142**	0.138	0.232	0.616
Yes	0.0022	0.141	0.288	0.569
Health Directorate				
Northwest	0.0047	0.089**	0.682*	0.224
Northeast	0.0138	0.186	0.064*	0.736
Central	0.005	0.113	0.197	0.685
South(r)	0.0116	0.133	0.188	0.667
Number of living children				
None	0.0059	0.097	0.507*	0.394
At least one(r)	0.0094	0.158	0.110	0.723
Marital status				
Not in union	0.0077	0.120*	0.241	0.631
In union(r)	0.0105	0.211	0.261	0.517
Education level				
Never been to school	0.0037	0.111	0.237	0.648
Primary	0.0191**	0.099	0.264**	0.618
Secondary or higher(r)	0.0069	0.157	0.243	0.594
Time to nearest health facility				
Lest than 1 hour	0.0089	0.125**	0.260	0.606
1 hour or more(r)	0.0063	0.211	0.200	0.582

Source: NDHS 2000 The reference category is : injection. **p<0.05; * p<0.01, based on Wald's chi-square test for the significance of the regression coefficient. Likelihood ratio test: chi-square = 373.953 significant at p<0.001, (r) = reference category.

4.5 Factors associated with Condom Use

Social marketing and other condom promotion schemes have substantially increased condom availability in Africa, but condom use in many African countries remains below the level needed to alleviate threats to sexual and reproductive health. Condoms offer dual protection against unwanted pregnancy and some STIs and are one of the most effective means of preventing HIV transmission (Prata et al., 2005). Sexually transmitted infections have been shown to facilitate HIV infection and therefore interventions to promote condom use are essential in efforts to slow the spread of HIV. To protect young women against infection, it is important to understand the factors that influence their use of condoms.

Various factors have led to the renewed attention to condom use. The World Health Organization (WHO) encourages those working in the area of STD prevention to make increased condom use an important goal (Adetunji, 2000). Before the arrival and increased prevalence of these reproductive health problems, condoms were promoted mainly as contraceptive devices. Now, they are promoted both as contraceptives and prophylactics.

Meekers and Klein (2002) report that government and nongovernmental organizations in most sub-Saharan African countries have implemented youth-oriented reproductive health programmes to reduce the incidences of HIV, other STIs and mistimed pregnancies. Because condoms are effective for preventing both unplanned pregnancies and STIs (Zellner, 2003), condom distribution and promotion programmes can play an important role in improving young people's reproductive health. To facilitate the design of effective programmes and policies, programme managers and policymakers need to better understand the factors that facilitate or deter condom use among the target population. To date limited information is available

concerning the specific determinants of condom use among Namibian young women.

Scattered studies (Adih and Alexander 1999; Adetunji, 2000; Meeker & Klein 2002) on condom use among young African people indicate that multiple factors may vary across societies. Other studies (Agha, 2002, Gilmour et al., 2000; SIAPAC 1995) report that most people in sub-Saharan Africa know about male condoms. However, it was realised that condom use was entirely socially, culturally and context bound – even when available, usage was not universal and could be inconsistent. It was, therefore, not surprising that demographic and health surveys (DHS) from different African countries reported low condom use.

The results for Namibia showed that only 16.8 per cent of sexually active young women (15-24 years) used condoms during sexual intercourse (MOHSS 2003). This is considered to be low, taking into account the fact that most of these young women are still attending school and only few of them are married. Sexually active young women are more afraid of falling pregnant before they get married than they are of being infected with STDs. This has also contributed to the low use of condoms among them. Despite the generally low levels of condom use, the NDHS (2000) suggests that preference for the condom may be higher than anticipated.

The sample includes 1776 sexually active young women of whom 299 were using male condoms. The main outcome variable was condom use. Young women who reported use of condoms were defined as users and all others were defined as non-users. Factors possibly influencing condom use were selected on the basis of previous findings in the literature. Bivariate analyses provided preliminary information about the associations between explanatory

variables and condom use, and binary logistic regression was used to examine observed associations within a multivariable framework.

The bivariate results show that several respondent variables are significantly associated with condom use. Condom use is associated with the educational level of a woman, the number of children she has, whether she is in a union or not, her access to media, her age, distance to the nearest health facility and the health directorate she is in, as indicated in Table 4.7. It is important to note that the results support the hypothesis that teenage women are more likely to use condom than young adults aged 20-24 years (odds ratio = 0.763). Most of the teenagers are still attending school, and as highlighted in the literature, they do not feel free to visit health centres for sexual and reproductive health because of either long queues, or because they are served by nurses of their mothers' ages, since they do not want to be seen by older women. Condoms are readily available, not only at health centres but also at multipurpose youth centre or shops where they can be picked without consulting a nursing staff. Several studies (Santelli, 1997; Adetunji, 2000; Meekers & Klein, 2002; Manlove et al., 2003) report that condom use was high within new relationships. As a relationship develops then use of condoms decreases. One of the contributing factors to the low use of condom among young women aged 20-24 years was that most of these women might be in steady relationships or some were either married and were using other forms of contraceptives just to delay or space childbirth. Lutalo et al. (2000) similarly reports that a substantial and significant rise in condom use is among adolescents (15-19) years. This concurs with the findings of Prata et al. (2005). Prata and his colleagues report that the prevalence of condom use among married young women in Angola is low, and most of the married ones are aged 20 to 24 years. They further conclude that condom use is equated with lack of trust, a belief which is associated with a reduced likelihood of condom use among young women in Namibia.

Table 4.7: Percentage of sexually active young women using condom, by background characteristics, and odds ratios from logistic regression analysis assessing associations between characteristics and condom use, Namibia 2000.

Characteristic	%	odds ratio
Age group		
15-19(r)	52	1.000
20-24	48	0.763*
Educational level		
Never been to school (r)	2	1.000
Primary education	21	1.579
Secondary or higher	77	2.331*
Number of children		
None (r)	76	1.000
At least one	24	0.221**
Marital status		
Not in union	90	n/a
In union	10	n/a
Listen to radio weekly		
No	9	n/a
Yes	91	n/a
Read newspapers weekly		
No	27	n/a
Yes	73	n/a
Health directorate		
Northwest (r)	48	1.000
Northeast	6	0.114**
Central	28	0.424**
South	18	0.267**
Discuss FP with partner		
No (r)	n/a	1.000
Yes	n/a	2.257*
Interaction		
Not in union & discuss FP with partner (r)	n/a	1.000
In union & discuss FP with partner	n/a	0.406*

Notes: for percentages, significance level refers to findings from chi-square test. r=reference group.

** significant at 0.01 level, * significant at 0.05 level

-2Log likelihood = 743.803 Chi square = 333.808 **

In relation to the above, most of the teenagers are not in union and also most do not have children. Among those who use condoms, 76% do not have children and those with at least one child are less likely to use condoms (odds ratio = 0.221). Similarly, only 10% of young women who are in union use condoms. Furthermore, the multivariate results show a significant association between condom use and communication with partner with respect to their marital status. Young women who are in union and discuss family planning issues with their partners have a lower probability of using condoms (odds ratio = 0.406). This is more likely though, because a relationship which is built on communication, promotes trust among partners. Generally, couples use condoms in risky sexual relationships for fear of contracting STIs. However, if safety is assured through communication and behaviour of partners, condom use ceases.

There is also a regional differential on condom use among young women. Among those who use condoms, the majority (48%) belong to the Northwest health directorate. This implies that most young women in the Northwest regard condoms as most effective and perhaps easy to use because they lack knowledge of other methods. It is, however, surprising to note that use of condoms is lower among young women who reside in more urban regions than those residing in more rural regions. This is due to the fact that young women in urban areas have access to a wider variety of contraceptive methods than those in rural areas. On the other hand, programmes that promote condom use are more concentrated and pay more attention to the rural regions than in urban regions.

In summary, young women make choices of contraceptives. A wide range of contraceptive methods exist, although there are some methods which are more readily available and easier to get than other methods. The most chosen method is the injection. Most young women find the injection as the

most convenient method to use because it does not require someone to remember instructions; it is a long-term method which is normally taken once in 3 or 6 months. It is thus only good for preventing unwanted pregnancy. However, it should be stressed that the emphasis is not only in controlling fertility but mainly to prevent STIs among young women so that they grow up healthy. In addition, male condoms are more chosen by young women in the Northwest than any other contraceptive method. This signifies the impact that the government implemented and NGOs programmes have on the SRH of young women. Despite the regional differentials on condom use, the analysis makes us accept the research hypothesis that teenagers use contraceptives more than young adults.

Several issues were explored through qualitative data analysis. Some of the issues explored include barriers to the use of sexual and reproductive health services, why young women make choices of some specific methods, as well issues relating to communication between parents and children on contraceptive use.

4.6 Information from focus groups

This section reports on the qualitative data which was gathered from focus group discussions. Qualitative information was collected according to selected topics of interest. These included: utilisation of sexual and reproductive health services by young women, contraceptive use, and contraceptive method choice, special focus on condom use as well as the focus on parent-child communication on sexual and reproductive issues. Results from focus group discussions were then arranged according to the above themes and linked to the findings from quantitative analysis and then also as compared to findings from related literature. As mentioned earlier in Chapter 3, six focus group discussions were conducted with young women

volunteers aged between 15 and 24 years in selected secondary schools and youth centres, with permission from relevant authorities. They were arranged as follows:

Focus group 1 (FG 1) in school (Oshana region) "O" [5]
Focus group 2 (FG 2) out of school (Oshana region) "O"
Focus group 3 (FG 3) in school (Ohangwena region) "O"
Focus group 4 (FG 4) out of school (Ohangwena region) "O"
Focus group 5 (FG 5) in school (Khomas region)
Focus group 6 (FG 6) out of school (Khomas region)

4.6.1 Health services utilisation

Although young women in the focus group discussions reported that they utilise health facilities for sexual and reproductive health services, those who were married were more comfortable and free to utilise health facilities for such services than those who were not married. This theme was considered because in Namibia most contraceptive services are offered at health facilities. The younger women and particularly those who were not married reported that they mostly utilised health facilities for STI treatments or when they fall pregnant and seek maternity care. However, the married ones utilised health facilities for family planning, counselling and information services. It was also observed from focus group discussions that only few young women were aware of their rights with regard to sexual and reproductive health and reported feeling guilty when seeking these services. Several barriers to utilizing sexual and reproductive health services were highlighted from focus group discussions as follows:

[5] "O" indicates translation from Oshiwambo to English

*"I am scared to meet with elder women from
my village because they will ask me questions" (in school, aged 17, FG 3, 2004).*

*"The fact that you have to queue up with elder women and you will
be the only tiny poor thing among them looking for contraceptives is already discouraging. You know what… if there is a good understanding between us (young girls) and our parents, it won't bother me to queue up with my neighbours or other elders for sexual and reproductive health services……… even if I am on school uniform, but now it is impossible because if they find you there (at the clinics) it is a big story in the village, if you even have an elder sister who fall pregnant (premarital) and is not yet married they (elders in the village) will even start labelling you as "sexholic" " (in school aged 15, FG 1, 2004).*

"Some nurses know my parents and they do not keep secrets, they will just tell my parents that I was at the clinic for contraceptives. Parents (including nurses) talk, especially when they meet at the well to fetch water" (in school, aged 21, FG 3, 2004).
"The nurses at a nearby clinic are of the same age as my mother. I do not feel comfortable discussing my sexual problems with them. It is so embarrassing; they will think that I do not have respect for elders" (out of school, rural, aged 23, FG 4, 2004).

"The society we live in is not supporting young unmarried women to get sexual and reproductive health services. Therefore, if you are really strong enough, you can walk long distances to go to the clinic which is a bit far from where you live, so that you are not seen by people who know you" (rural, aged 23, FG 4, 2004).

After probing on what type of nurses they needed to feel comfortable with discussing sexual issues, most were in agreement that they wanted nurses of their ages (their peers) to serve them. This is exemplied in the following statement:

" If the nurse is of my age and I know that she is not married, no problem I can talk to her freely because I know she also have a boyfriend" (in school aged 24, FG 3, 2004).

Young women also had concerns about being served by a male nurse. This is what one of them said:

"Sometimes when you enter the consulting room, the nurse who is on duty is male. So you are already shy to even say what has brought you to the health centre. If you are suffering from STD you may just tell him that you have come for the pill or injection, because you don't want him to check your private parts" (in school, 16, FG 5, 2004). 'O'

Access to health facilities was another factor that could impede or facilitate health care and utilisation of available facilities for young women. The structural environmental factors like location of the clinic, speed with which care can be obtained, the physical and administrative structure, availability of youth friendly personnel, privacy and, most importantly providers' attitudes have been cited as important factors that facilitate or hinder accessibility to health care. Provider attitudes, beliefs and values, when these are negative, may promote unwillingness in young women to utilise available services. A young woman in one of the focus group discussions in the urban areas said the following:

" I prefer the private clinic than the government owned hospital, because the way the nurses look at you and ask you questions, you will feel that you have committed the worst offence ever, but in the private hospital the nurses cannot really shout you because it is business and they know that you are paying your money" (out of school, 18, FG 6, 2004). 'O'

Others were concerned about the physical appearances of the clinics, as indicated in the following statement:

"Some clinics have labels which are embarrassing like "family planning". Everyone who finds you there will know what you have come for" (in school, 19, FG 5, 2004). 'O'

From the above vignettes, it is observable that young women have problems utilising sexual and reproductive health services in Namibia. Clearly, the interaction between older and younger women represents a problem. The results confirm that younger women do not feel comfortable interacting with older women when seeking sexual health services. Older women, on the other hand, do not seem to understand or know the rights of younger women on sexual health issues. In most cases, older women are reported to label younger ones (15-24 years) bad when they meet them at health facilities seeking sexual and reproductive health services.

Young women were not in favour of some health facilities which were too close to their homes because they ran into family members and neighbours every time they sought services. Other facilities-related barriers include: a lack of privacy; no area set aside where young people can wait to be seen; and décor that is overly clinical, too adult and welcoming only to older women and not to younger women.

Negative attitudes of some nurses are reported by several researchers in other countries as one of the barriers affecting use of health services (Grady et al., 1993; Wood et al., 1998; Ersheng et al., 2004). This seems to be the case in Namibia as well. Young women in the focus groups kept on referring to being attended to by some nurses with bad attitudes who shouted at them and asked them offending questions. In many societies and cultures, adults have difficulty accepting young people's sexual development as a natural and positive part of growth and maturation. Young women are not encouraged to seek care if they encounter providers whose attitudes convey that young women should not be accessing sexual health services. Young women may be deeply embarrassed and refuse to return for services if staff ask personal questions loudly enough to be overheard by others. Young women may also reject future sexual health services if staff in the facility fail to take seriously the young woman's need for services, treat her without respect, or try to dissuade her from engaging in sexual intercourse.

It was also pointed out clearly from discussions that young women, especially those who are still very young and not yet married, did not want to be served by older nurses who were in the same age group as their mothers. They recommended that there should be separate rooms for young women who could be served by their peers. Young women were also too shy to be served by nurses who knew them well, who were from the same community, or who knew their parents. Often young women used sexual and health services clandestinely. They do not in these circumstances want their parents to know that they go for sexual and reproductive health services. For example, they do not want their parents to know that they were treated for STIs or that they are using pills or taking injections.

4.6.2 Use of contraceptives

Results from the focus group discussions indicate that although knowledge about contraceptives was widespread among young women in Namibia, their acceptability and use was not as widespread. This is in line with the 2000 NDHS, which indicates that in Namibia, the percentage of sexually active young women currently using contraceptive methods stood at 53 per cent while knowledge of contraceptives is as high as 97 per cent. Although more young women in the focus groups report current use of contraceptives, they highlight that the process of obtaining them is not as easy as it should be. Preferences for certain methods such as injection and the male condom were also noted. Educational level also played a major role in deciding whether to use or not to use contraceptives. Poor parent–child communication was raised as a concern and as a barrier to the use of contraceptives among young women. Gender inequalities, especially in relation to culture and tradition, were also reported as prohibiting contraceptive use among young women. Examples can be seen in the following statements:

"I decided to use contraceptives because every time I discuss with my friends about contraceptives, everyone talks about them in a positive manner, no one criticizes them. Maybe they also use contraceptives" (in school, aged 19, FG 3, 2004).

"Contraceptives are for people from urban areas. They give us sexually transmitted diseases because they use contraceptives. We (in rural areas) do not even like boyfriends from urban areas because they infect us with the "rubbers" which they like to use. Our boyfriends from rural areas do not use those "rubbers" and we do not get diseases" (out of school, aged 18,FG 4,2004).

Most families encourage virginity among their daughters to avoid the embarrassment of premarital pregnancy. If a premarital conception occurs, the couples may be forced by the two families to marry quickly or else just pay compensation to the woman. Thus most young women try hard not to fall pregnant out of wedlock. This is evidenced in the following statement:

"I use any type of contraceptives …whichever I find accessible at the time just to make sure that I don't become pregnant because my mother is totally against contraceptives and falling pregnant before marriage. If my mother hears that I have sexual intercourse… I will not rest in the house… she will call me hurting names as if I am a useless person. Sometimes she will even tell her friends who come to visit her that I am no longer a "pure" girl just because I have sexual intercourse. If I even become pregnant it is a worst thing you will ever regret. Shouting, chased out of the house, the way you eat, the way you walk, you can mention all the bad things…, you are totally excluded from your family. They don't regard you as a valuable person…they may be planning their things without even being informed… parents need to be educated …" (Out of school, aged 20,FG 4, 2004).

The focus group discussions indicated that young women often used contraceptives in secret and hide this information from both their partners and their parents. They also suggested that their parents, in many cases, did not even know that they were sexually active. In addition, young women indicated that they mostly discuss contraceptive use with their friends and that they were mainly influenced by what their peers do. However, it was observed that knowledge and understanding of contraceptive methods among some rural young women was very poor. Some young women who lived in rural areas still believed that contraceptives were not needed to prevent pregnancy. They also believed that contraceptives could transmit STIs. They even went to the extent of reporting that contraceptives, like condoms, were only used by

young men from urban areas because they were infected with STDs. Furthermore, it was noticed that most young women did not really make their preferred choice of method because of the pressure they get from their parents and other adult community members. They just use any type of contraceptive method to mainly prevent falling pregnant. It was, therefore, also observed that some parents hurt young women by calling them rude names, shouting at them and labelling them 'bad girls' once they knew of their sexual behaviour. This was an indication that there were still parents who were not aware or were basically ignorant of the rights of young women with regard to sexual and reproductive health. This, of course, needs careful consideration and attention in future policy formulation.

4.6.3 Contraceptive method choice

Young women were asked about their preferred contraceptive methods and about the reasons for their choice. All were able to talk about a number of modern methods and a few traditional ones. A substantial proportion of women cited the condom as the method they preferred because of its widespread availability, low cost and usefulness in preventing the spread of STIs as well as conception. Below are some statements made by focus group members, which support this view:

"I think that the condom is the best method for young women because it is more discreet and used by the man. When you use the condom you are not only protected from unwanted pregnancy but also from STIs." (urban 24, employed, FG 2, 2004)

"Male condoms are easy to grab and can easily fit in a jeans pocket. Female condom is big and even if you want to grab, it cannot fit in a trousers pocket

unless you have a handbag" *(College student, aged 21, FG 5, 2004).* *'O'*

"The fact that the female condom has to be inserted for sometime before even sexual intercourse puts off the man's feelings. A man has to beg for sex for sometime and a woman has to pretend even if she knows that she is ready for sex" (University student, aged 23, FG 5, 2004). *'O'*

"I use the male condom because it is my boyfriend who carries it and he is the one who should suggest that we have to use it. He is a man and he has to take all sexual decisions. I cannot tell my boyfriend to use condom unless he suggest it" (out of school, aged 19, FG 2, 2004).

Amongst most women interviewed, the overriding reason given for favouring the condom was that, unlike hormonal methods, its use would not lead to long-term sterility. This view persisted among young women regardless of their educational level. Here is one view:

"I don't have any problem with the condom but regarding other methods of contraception, there can be side effects. For example, someone who uses pills to avoid unwanted pregnancy can find themselves left sterile forever". (out of school, 19, FG 4, 2004).

Asked why there was resistance to condom use for some women, the groups indicated that the use of the condom reduces sexual pleasure for both men and women. This apparently seemed to be based more on what the respondents had heard from other people and not from their own experiences. Below are two statements that confirm this view.

"If your boyfriend does not get sexual pleasure from you he will leave you for other girls who won't even have to use condom. They will do it flesh to flesh

and he will like it more than when you do it with condom" (rural, aged 24,FG 4,2004).

"Sometimes when men use the condom they feel that they are not doing their duty as men in terms of sexual satisfaction; they like their women to feel fluid entering their bodies" (rural, aged 19, FG 4,2004).

Young women in the groups were also concerned with stigmatization that goes with the possession and use of condoms. They reiterated that if a person was known to be using condoms, that person was regarded as promiscuous; hence users of condoms were regarded as having loose morals. The following statements support this:

"If you are seen with a condom even by your boyfriend or friends, you are stigmatized. You are seen as a 'cheap bitch' who is looking for men to sleep with" (urban, aged 21, FG 6, 2004). 'O'

"Condoms are good for us, the only problem is that you need to negotiate with your partner. If your partner does not understand it brings fighting around condom use again. Condoms involve participation of the men because he is the one to use it. Sometimes you are in a steady relationship which you don't want to spoil and leave everything to the men to decide". (rural, aged 24, FG 2, 2004).

Religious teachings were also cited by some young women in groups as one of the factors inhibiting condom use. Some religions forbid the use of contraceptives, arguing that such use amounts to promiscuity. Most of the young women interviewed in this study belong to the Catholic and the Evangelical Lutheran churches. In Namibia, both of these churches are against sex before marriage. Although Catholics and the Evangelical

Lutherans have organizations to fight STIs, including HIV/AIDS, their religions are still in support of abstinence for unmarried people and faithfulness to one partner for those in marriages. However, these young women had different understandings. One of them claimed:

"Christianity is not adhered to nowadays when it come to sexual practices, I go to church every Sunday but I still have sexual intercourse with my boyfriend either with or without a condom, although I am told every Sunday that sexual intercourse outside marriage is a sin and use of contraceptives is killing" (urban, aged 24, FG 6, 2004). *'O'*

In addition, there were also young women who supported the use of other methods like the injections or the pill. Those who were out of school, especially, highlighted that the injection was the most convenient method for them for the reason indicated in the following statement:

"When you are on injection, no one would tell that you are using any form of contraceptive, not even your boyfriend. In addition, you do not need to remember anything everyday like taking the pill or carrying the condom. No one can even stigmatize you with sexual activities" (urban, aged 23, FG 2, 2004).

The method most preferred by young women was the male condom. Most young women in the focus groups suggested that they chose the condom for several reasons. Some felt that male condoms were easy to select from display and could be put in one's pocket without any one noticing. Young women did not want to be seen in possession of condoms either by their peers or other adult community members. Some young women did not even want to be seen by their partners carrying condoms because of fear of being stigmatised. Others wanted to choose the condom but they felt reticent and

awkward about asking their partners to use one. This raised questions about male dominance and power in sexual relationships. Young women believe that men have the power to make all the decisions including sexual decisions. Some young women report arguing with their partners when they suggested condom use. This was as a consequence of poor communication between partners on sexual issues, which greatly needed to be addressed so that young people learn how to negotiate safer sex. In addition, there were many young women who depended on their partners for a living. Some depended on their partners for payments of school fees, transport, clothing and so on. This dependency made young women less powerful in the domain of sexual decision-making.

Other preferred contraceptive methods include injectables and the pill. Although these were not really supported by most women, especially those who were still in school, the out of school young women praised the convenience of the injections. They mentioned that they do not want their partners to know that they were taking any preventive measures. In addition, they also did not want the burden of remembering to carry the condom or take the pill everyday. Although they claimed that they faced criticisms from health care providers and other adult members of the community, especially when they queued up together at the clinics for contraceptives, they were not particularly concerned because they only did it once in three or six months.

Young women who were in school were not really in support of the injections. They gave time and clinic location as barriers for them to choose such methods. They were concerned that the clinics are located outside the school yard and they needed permission from the Principal or teachers to go to the clinic. They also argued that clinics usually offered family planning services during weekdays only and on weekends they only attended to emergencies. Young women who were in school felt excluded from obtaining the services.

4.6.4 Parent –child communication on sexual issues

Several varying views were expressed in the group discussions. Here are some examples:

"Discussing sexual issues with my father is totally out. My mother sometimes likes to bring up the topic when we are alone in the kitchen, but when she asks me anything to do with boyfriends or sex, I get very angry because I am embarrassed to talk to her about my sexual experiences" (out of school, aged 22, FG 2, 2004).

"My mother is never comfortable bringing up the discussion on sex with me. She has to first tell you a rumour of neighbours who have their daughter fall pregnant before she drag you into what she wants to tell you" (in school, aged 17, FG 3, 2004)

"My mother is more concerned about what her friends and neighbours will think of her...If my friends and neighbours hear that I talk about sex with my children what will they think about me……, the church is another thing….. I will not even be free to attend church meetings with my friends… I will not be free to contribute something to my church if they know that I encourage my children to use contraceptives…My mother thinks that we have small brains, don't keep ideas to ourselves … she fears that everything we talk with her we go and tell our friends… That is the reason she is so reluctant to tell us anything with regard to sex. Currently, I cannot even tell my mother that I have a boyfriend and sex…… she will take me to church and to the pastor for "ekuthilo"[6] because she will think that I have sinned against the 6th commandment. I do my things in secret". (in school, 17, FG 1, 2004).

[6] "Ekuthilo" means confession

"My mother is scared of Dad .She always say…… what if my husband hear that I talk to children about sexual issues….. if any of them became pregnant, he will think that I am the one who teach them to do things……" (in school, 19, FG 1, 2004).

"Yes…… parents really have to talk to us. If we have good platform and every parent in the community is supportive, we will not even be making mistakes of falling pregnant, we will not even contract STDs because we will be able to use contraceptives which are protective and safe every time. We will be able to have planned sexual intercourse because our boyfriends will be willing to wait until the right time rather than now when we have to involve ourselves in rush and take chances sex". (in school, 20, FG 5, 2004). 'O'

"You will have the freedom to obtain condoms. ……..now we just take chances you always wait until there is time to sneak out of the house for your boyfriend, even if it is not the right time for you to have sex, or even if you are not using contraceptives …….. if you miss it will take quite a while to come again". (out of school, 22, FG 6, 2004). 'O'

Parents ought to be informed that premarital childbearing is not the end of the world for their children but it can be the end of their children's lives. Here are some of the opinions from the focus group discussions:

"I almost lost my life when I found that I missed my two consecutive menstrual period. Having experiences how my elder sister was treated when she fell pregnant….I tried everything I could to abort the pregnancy by myself…. I finally succeeded but also ended up in hospital after fainting. That is how my parents knew……..afterwards they were blaming me for aborting the pregnancy saying that I could just have the baby…..so which side do we take as young people?" (out of school, 18, FG 4, 2004).

"The last time I talked to my mother about sexual issues is when I told her that I noticed blood on my pant. It is good she told me that I will be having that every month…..She warned me not to talk to boys at all……. I should be far from them even in class I should not sit next to boys….. they are dangerous. At first she made me believe that boys are dangerous people but later on ….. I realized that we need each other as human beings. So …..sometimes parents give us wrong information instead of clarifying issues." (in school, 17, FG 3, 2004).

"My mother told me that it is very important that the day I get married and have sexual intercourse with my husband, there should be a lot of blood on those white linens in our bed………. that is when my husband will respect me as a woman… If there is nothing he will know that I have already slept with other men"…… (employed, 24, FG 2, 2004).

"When I got married at the age of 18 …… I was fed up with my husband because he was forcing me to have sexual intercourse everyday…..when I talked to my mother she even made things worse by telling me to respect my husband….. I have to have sex with him even if I don't want to…..I have to satisfy him sexually…. I should not refuse my husband sex….. She made me believe that we must be servants of our husbands…. I felt so useless and helpless and I even lost weight because I was not happy in marriage until I finally talked to the pastor about my problems who gave us counselling together with my husband… things improved, however, my mother did not realise that I was being sexually abused all the time. She didn't want me to divorce my husband, because it will embarrass her as well." (rural , 24, FG 4, 2004).

"My mother is a good friend of mine. We talk a lot ….she gives me advice even regarding boyfriends and leaves the option for me to decide…… she

warns me about the danger of falling pregnant when I am still young….about HIV/AIDS…..However, I have a boyfriend in our neighbourhood and we have sexual intercourse….my mother does not know about this… I cannot talk to her about having sexual intercourse because I still do not know how she will react….I rely on sneaking out of the house while she is at work during the day to have sex with my boyfriend…. Sex does not leave a scar on someone…..as you will still look the same after having it…" (in school, 17, urban, FG 5, 2004). 'O'

"Now that I am at the University, my mother is more comfortable discussing contraception with me……she knows I know a lot about contraceptives… she is therefore sort of assured that I cannot fall pregnant because I can use contraceptives….. I think parents want us to use contraceptives but it is just difficult for them to tell us straight that we should use them…". (Urban, 23, FG 5, 2004). 'O'

Most young women who participated in the focus group discussions pointed out clearly that they did not discuss sexual issues with their fathers. It was reported by earlier researchers that in most African cultures fathers talked with their sons and mothers discussed with their daughters. It was thus not surprising that fathers did not talk to their daughters about sexual issues in Namibia. Young women suggested that it was impossible to discuss sexual issues with their fathers. However, it was also noticed that even if mothers wanted to discuss sexual issues with their daughters, their children did not welcome the initiatives; they did not feel free to join in the discussion. Thus, although there is room for such discussion with their mothers there is still a feeling of insecurity. There is uncertainty about what their mothers' reactions would be if they proceeded with the conversations. This is perhaps due to the fact that most young women, especially those in rural areas, were brought up

to fear and respect adults to the extent that they felt too guilty to discuss sexual issues with them.

Despite this, young women maintain that their mothers are not knowledgeable on 'how' and 'what' to address when talking about sexual issues with their children. Some parents simply do not know how to bring up the topic for discussion, whilst others seem to feel that it is not good to discuss sexual issues with their young children in any way. Parents are bound by the culture, tradition and the communities' taboos around them. They are also bound by their religions which are against premarital sex. It was also learnt from the focus group discussions that some mothers did not discuss sexual issues with their children because their husbands were against it.

Some young women blamed their parents for being old fashioned and for not adjusting to modern times where issues of sex are supposed to be discussed more openly. Their parents still related to the fact that in the past even if you were engaged to get married you were never left alone with your future husband for fear that the two of you would lose control and mess things up. Even holding hands was not allowed and that girls only knew about sex the day they got married. Nobody would tell them anything about sex. However, young women were concerned that things have changed and it was time for their parents to engage in dialogue about sexual issues at an early age before serious mistakes are made. Young women were also concerned that their parents still believed that sexual issues were not normally discussed at home because they were regarded as taboo and led to an atmosphere of immorality. They suggested that their parents perpetuated age-old practices about morality that they had learnt, in turn, from the previous generation.

Parents in urban areas were regarded as a bit free in discussing sexually related issues with their children, perhaps because of the media influence.

They often watch television together and in some instances there are those advertisements regarding sex which could come up on the screen and, thus, could trigger discussions. In rural areas the platform of parents to discuss sexual issues with their children was probably poor. Parents generally found it difficult to come up with the appropriate approach because most of them were not well informed.

Although most programmes involve young people, parents were left out. Also, most young women in rural areas reported that their parents still expected many grandchildren from them and, thus, they do not really want their children to "spoil" themselves before they get married, because they (parents) believe it was honourable for them to wed their children who have not had premarital births.

Finally, it was observed from focus groups that young women want their parents to understand their sexual rights so that they may make the right decisions. However, parents do not have adequate information on the sexual matters of young women to share with their children and they also lack skills to educate their children on sexual issues.

4.7 Conclusion

The results presented in this chapter highlight several general reproductive health issues facing young women in Namibia. Premarital sexual activity is common among young women. High levels of awareness of the condom and other contraceptives are not accompanied by widespread contraceptive use. Furthermore, the spread of HIV does not persuade young women to practise protected sex, and a substantial number of young women experience unwanted pregnancies. Attitudes and social norms appear to be important barriers to contraceptive use. Specifically, existing norms seem to inhibit

conversations about contraceptives within relationships and between parents and their children. Therefore, it is difficult for young women to learn what their partners/parents know. In addition, the data support their view that young women seem to have mixed or negative attitudes about buying and carrying condoms.

The traditional focus of family planning has been on the promotion of highly effective methods of preventing pregnancy. However, with the rapid spread of HIV, awareness that such programmes can play an important role in preventing, not only pregnancy, but also, disease has been growing. Although family planning and AIDS awareness programmes in Namibia promote the use of the condom, the study has revealed many obstacles to use. Negative attitudes about condoms are a major barrier. For Namibians like many Africans, condoms suggest unfaithfulness and mistrust. Because of the stigma attached to condom use, personal and emotional concerns often supersede the choice to the use of the condom. The findings are in agreement with what Bankole et al. (2005) report in their studies that despite extensive efforts in promoting condom use, young women still engage in risky sexual behaviours and condom use remains low in sub-Saharan Africa. In their study, they argued that young women's perceptions of condoms tend to be negative because of concerns and experience of condom safety and breakage, the negative effect of condom use on sexual enjoyment, the low quality of condoms (especially condoms that are free), all which coincide with the findings of this study.

A study in South Africa found that condom availability varied greatly according to the type of distributor and could be hindered by short business hours and the attitude of providers (Gilmour et al., 2000). However, in Namibia, these are not the main barriers as condoms are freely available at public places and young women pick them up without direct consultation with health providers.

The major barrier for young women in Namibia is the fact that men control much of the decision-making regarding sexual encounters. There is a strong belief among men that women need their partners' permission to use contraceptives and as a result of this gender differential, women find themselves in situations that increase their risk of STIs, including HIV infections, despite the knowledge they may have about how to protect themselves. Knowledge of condoms is virtually universal among young women in Namibia, but the method is still more commonly associated with disease prevention than with pregnancy prevention. The challenge for reproductive health programmes is to emphasise the dual protective benefits of correct and consistent condom use and, more specifically, the role of this method in preventing pregnancy. Beliefs about condoms are likely to influence use. Other studies (Maharaj, 2006) have found that numerous beliefs about condoms - that they are used only for illicit sex and prostitution, they are difficult to use and that they reduce sexual pleasure - have limited their accessibility and use. The results of this study are, to some extent, encouraging as condoms are reported to be gaining acceptance despite other concerns about them.

Focusing on young women's reproductive health is both a challenge and an opportunity for health care providers. Young women often lack basic reproductive health information, skills in negotiating sexual relationships, and access to affordable confidential reproductive health services. Many do not feel comfortable discussing sexuality with parents or other key adults with whom they can talk about their reproductive health concerns. Likewise, parents, health care workers, and educators frequently are unwilling or unable to provide complete, accurate, age-appropriate reproductive health information to young people (Adedimeji, 1999). This is often due to their discomfort about the subject or the false belief that providing the information will encourage increased sexual activity. Because of this, most young women

enter into sexual relationships with very little knowledge of the consequences either shared by their peers or obtained from the media.

The objectives of the research study were achieved through either quantitative or qualitative analyses. Educational attainment, place of residence, access to media, access to health facilities, discussion with partner, friends or mother on sexual issues, number of living children age and marital status were identified as demographic and behavioural determinants of contraceptive use and contraceptive method choice among young women in Namibia. Different patterns on contraceptive use and contraceptive method choice were also observed. Preference of certain contraceptive methods was evident from the quantitative analysis. Regional differentials were also observed through quantitative analysis, with young women who live in more rural health directorates reporting poor access and utilisation of SRH than those in urban areas, thus accepting the first hypothesis of the research study. According to the Health Belief model, perceived barriers such as difficult access to sexual and reproductive health services and providers' negative attitudes lead to low use of contraceptives. Thus, the experiences of being judged by either health care providers or other elder members of their community (including their mothers), negatively impact on their use of contraceptive methods accurately, which is also in line with the concepts of the Health Belief Model. Age differential on condom use was also reported, with teenagers reporting high prevalence of condom use than young adults. Finally, parent-child communication was found to be an influential factor on young women's use of contraceptives, which led us to reject the second hypothesis and this agrees with the concept of Davis and Blake's (1956) motivation that young women have to be motivated to use contraceptives either by their parents or peers in order to prevent unintended pregnancy and STIs.

There are, however, some contradicting findings from the qualitative analysis. Although young women who live in the Northwest have a high percentage of condom use, there are still those who believe that condoms transmit STIs and, thus, do not use them. In addition, there is need to address misunderstanding in communication between parents and their children on sexual issues. From the focus groups, it is apparent that some parents are willing to talk to their children about sex and reproduction, for example, how to prevent unwanted pregnancy but they lack the skills to approach them. Sometimes, parents fear acting differently from others in their community. Communication between parents and children was better in urban than in rural areas.

In all, the findings from this study concur with earlier research on contraceptive use. One significant factor not paid careful attention to in previous studies, however, is the importance of communication between parents, especially mothers, and their children on sexual and reproductive health issues, which needs to be strengthened in programme implementation. The focus in this thesis is largely on mother-daughter communication; men have not been dealt with comprehensively and it would be useful to focus on both parent communication in future studies, as well as the particular circumstances of young men (15-24 years) and communications with regard to contraceptive/condom use. Since the 1994 Cairo Conference Programme of Action, more attention is being paid to the intersection between men's and women's behaviour and health.