
Contraceptive choice and Use of methods among young women in Namibia

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Abstract

This paper examines social, demographic and behavioural factors that influence contraceptive use and method choice among young Namibian women. It also explores ways to improve the accessibility of health facilities and family planning services for young women. The logistic regression method has been applied to examine the determinants of contraceptive use and method choice. The study reveals that whilst there is provision, the accessibility and convenience of existing reproductive health services for young women is poor and levels of contraceptive use are still low. There is a lack of support from parents and health care providers especially in rural areas. Health facilities are also ranked by young women as user-unfriendly as most of them, as public spaces, lack confidentiality and privacy. These negative experiences of young women impact on their utilization of reproductive and health services and their use of contraceptives. The findings thus suggest that government strategies, which aim to increase the use of contraceptives amongst young women in Namibia, ought to enhance and improve parent-child communication and make a range of choices available.

Young women (aged 15-24 years) are increasingly exposed to reproductive health risks such as sexually transmitted infections (STIs), unintended pregnancy and childbirth (Mfono, 1998; Creel & Perry, 2003). The exposure to these risks has attracted considerable research attention in different societies, in efforts both to understand its extent, causes and to address it as a problem. In Africa, studies (Muhwava, 1998; Burgard, 2004) have demonstrated that a large proportion of young women are exposed to the risk of conception, receive poor or no sex and contraceptive education, and experience a high incidence of adolescent childbirth.

Although reports indicate a decline in teenage pregnancy, most of the premarital births still occur among young women aged 15-24 years, the majority of whom are neither economically nor emotionally ready to deal with parental responsibilities (Creel & Perry, 2003). Thus, improving young women's reproductive health is key to improving the situation of women as

well as the world's future generations. Young women often lack basic reproductive health information. They need information on the consequences of unprotected sexual intercourse and they also need to be well informed on developmental body changes. In addition to the above-mentioned information, young women need skills in negotiating sexual relationships, and knowledge about affordable confidential reproductive health services. Many do not feel comfortable discussing sexual issues with parents or other key adults with whom they can talk about their reproductive health concerns (Meekers & Ahmed, 1997; Whitaker et al. 1999). Likewise, parents, health care workers, and educators frequently are unwilling or unable to provide complete, accurate, age-appropriate reproductive health information to young people. This is often due to their discomfort in discussing the subject or the false belief that providing the information will encourage increased sexual activity (Karim et al. 2003). Because of this, most young women enter into sexual relationships with very little knowledge on the consequences, either shared by their peers or from the media; and also contributed to a low prevalence of using protective measures i.e. contraceptives.

Substantial evidence is also found in existing literature that broadening the choice of contraceptive methods increases overall contraceptive prevalence (Magadi & Curtis, 2003; Chen & Guilkey, 2003). The provision of a wide range of contraceptive methods increases the opportunity for individuals to obtain a method that suits their needs. Ross et al. (2001) confirm that prevalence of contraceptive use is highest in countries where access to a wide range of methods is uniformly high. However, studies of contraceptive use and contraceptive methods choice among young women in countries in sub-Saharan Africa are few, probably because of the generally low contraceptive prevalence in the region. Researchers have primarily focused on contraceptive use and method choice among married women, leaving the vulnerable unmarried young women unattended. A growing need, though, exists for an examination of contraceptive use and methods choice patterns among young women. In addition, improving contraceptive access and use is vital to overcome the challenge of unintended pregnancy among unmarried young women.

Furthermore, several research studies (Bertrand et al., 2001; Magadi & Curtis, 2003; Rani & Lule, 2004) have looked at the individual and community influence on contraceptive use of young women but there is a dearth of knowledge in research on household influence, especially that of immediate family members on the use of contraceptives among young women. Although programmes that equip young women with sexual and reproductive health information exist in Namibia, parents and other family elders are left behind because there are very few programmes targeting them

with regard to how they should communicate with their children on sexual issues.

In response to the 1994 ICPD Programme of Action, the Namibian government introduced the reproductive health and family planning programme with the overall objective of promoting, protecting and improving the health of family members, especially women and children. The objectives of the programme was to reduce maternal and infant deaths, increase contraceptive use among women of reproductive age to enable reproductive women to space births and avoid unwanted pregnancies as well as promote and improve access to reproductive health services at all levels of health care delivery. The objectives of these programmes have not been fully achieved. Teenage pregnancy, unwanted premarital childbirths as well as prevalence of new HIV infections among young women have been on the increase in Namibia despite efforts on the part of the Ministry of Health and Social Services emphasizing on the provision of adolescent and youth friendly health including contraceptive services. Multi-purpose youth resource centres were established in all 13 regions of the country with the purpose of serving as resource base for young people and to provide youth friendly services to address the needs of the youth. How accessible and convenient these centres are has been the subject of many questions over the past few years. Do they meet the needs of young women, and if not, why not? Do these facilities readily offer contraceptives to young women and do young women have choices when selecting contraceptives? These are some of the questions that frame the larger research problem.

This paper is, therefore, of importance as it probes availability, accessibility and convenience of sexual and reproductive health services and informs policy makers on the gaps in the policies that affect young women's reproductive health and contraceptive needs. The paper addresses gaps in understanding the dynamics of contraceptive use among 15-24 year old young women by:

- Identifying the demographic and behavioural determinants of contraceptive use and method choice among young women in Namibia.
- Describing the key perceptions young women have about the availability, accessibility and convenience of sexual and reproductive health services.

It should be emphasised that whilst these gaps are not novel, they require examination in the Namibian case. Little information is available to guide policymakers' decisions or help programme managers design interventions to address sexual and reproductive health needs of young women in Namibia since no other study to date has addressed and found substantive answers to the basic research questions raised about the situation of young women in

Namibia. Given the increasing vulnerability of young women to the risks of unintended pregnancy, it is of program and policy relevance to better understand the barriers to effective contraceptive use among sexually active young women in order to help them lead healthy sexual and reproductive lives.

METHODS

Sources of data

This paper presents both quantitative and qualitative research methods. The Namibian Demographic and Health Survey (NDHS) conducted between September and December 2000 and focus group discussions conducted with young women aged 15-24 in June/July 2004 are the major sources of data used in this study. The NDHS provided secondary data for this study and primary data was generated from the focus groups discussions and are used to complement the quantitative results and provide more in-depth information, which cannot be provided by the DHS. The NDHS is the latest national dataset with information on contraceptive use and June 2004 was the convenient time to conduct focus groups discussions for this study. There was a period of 4 years between the survey and the interviews. This could hold consequences for the conclusion. However, although attitudes change with time the change is usually slow and minimal. A total of 6755 women aged between 15 and 49 years were successfully interviewed. Of these, 2748 women were aged 15-24. Because this research study focuses on the determinants of current contraceptive use and current method choice among young women, the sample was limited to young women (15-24 years old) who were exposed to the risk of conception at the time of the survey that is, those who were not pregnant at the time of the survey. This reduced the sample to 2576 young women, which included 1776 sexually active young women. Table 3.1 on the next page shows the age distribution of these young women.

Table 3.1: Age distribution of young women (15-24 years)

Age group	all young women		sexually active	
	N	%	N	%
15-19	1380	54	695	39
20-24	1196	46	1081	61
Total	2576	100	1776	100

In the focus groups, categories of young women whose views would be important to an understanding of health service utilisation, contraceptive use and contraceptive method choice were identified. The following categories were chosen: married or never married young women (15-24 years); with or without children; current users, dropouts or those who have never used contraceptives; those who are in school or out of school; living in urban or

rural areas. Six focus group discussions were conducted. Each group consisted of 8 to 10 participants. Those in school were interviewed separately from the out of school young women and the groups were homogeneous as to age. The researcher followed an interview guide that ensured that the same subject matter was discussed in each group. However, apart from this guide, the discussions were left relatively unstructured and time was reserved for the exploration of particularly interesting areas that arose spontaneously. All discussions were audio recorded. But, besides the audio recording, the researcher took notes on the discussion as it proceeded. Table 2 below shows the age distribution of young women who participated in the group discussions.

Table 2: Age distribution of young women selected for the Focus Group Discussions

Age group	number of participants	percent
15-16	8	15
17-18	14	26
19-20	9	17
21-22	12	23
23-24	10	19
Total	53	100

Methods of quantitative analysis

The prevalence of a specific contraceptive method is determined by two related processes, namely: the decision to practise contraception and the choice of method. Therefore, these processes are modelled here in two stages. In the first stage the determinants of the decision to use contraception are examined. This analysis is based on data gathered from all young women who were ever sexually active (a total of 1776) in the NDHS. Contraceptives are mainly used for the purpose of limiting, preventing, delaying or spacing births (MOHSS, 1995). Thus it is sufficient to consider young women who are sexually active (ever had sexual relationships). The response variable is contraceptive use which has two outcomes: using and not using contraceptives. The determinants are therefore modelled using a binary logistic regression. It was chosen as the most suitable method because of its ability to detect changes in measurements that are brought about by addition of new variables to the equation. In logistic regression, the dependent and independent variables do not need to have a linear relationship and data for variables do not need to be normally distributed. The results of the logistic regression models are converted to odds ratios, which represent the effect of

one unit change in the explanatory variable on the indicator of contraceptive use. Odds ratios larger than one indicate a greater likelihood of contraceptive use than for the reference category; odds ratios smaller than one indicate a smaller likelihood compared with the reference category.

The relevance of a particular independent variable as a predictor of contraceptive use can be determined by comparing the magnitude of the regression coefficient with that of its standard error. Evidence of the usefulness of the independent variable becomes apparent if the coefficient is much larger than its standard error. The overall form of the model was determined by the square of the multiple correlation coefficients between the dependent and independent variable (R^2), measuring the percentage of variation explained by the variables. The models assumed no relationships between the independent variables. The models were fitted to the data using backward stepwise procedure, where the full model was fitted but at every step, terms already in the model were checked to see if they were still significant. To test whether a variable is significant the t-value was produced for each variable coefficient. The value was used to test whether any levels of categorical variables could be combined or whether any term of categorical variables should be removed from the model. The 5% significance level was used as a basis for deciding if a particular variable should be retained in the model. In all cases a reference category was chosen. The models were interpreted in terms of the odds ratios. The odds ratios are generally obtained by taking the exponential of the parameter estimate (e^β) and used to compare odds between two groups.

The logit model is of the form

$$\text{logit}(p) = \log\left(\frac{p}{1-p}\right) = \beta_0 + \beta_1 x_1 + \dots + \beta_k x_k$$

The odds of using contraceptive methods can equivalently be determined in terms of probability of current use, p , as

$$p = \frac{\exp(\beta_0 + \beta_1 x_1 + \dots + \beta_k x_k)}{1 + \exp(\beta_0 + \beta_1 x_1 + \dots + \beta_k x_k)} = \frac{1}{1 + e^z}$$

where $z = \beta_0 + \beta_1 x_1 + \dots + \beta_k x_k$

In the second stage, determinants of the choice of methods among sexually active young women who are using contraceptives are examined. The interest here is on examining which method is preferred by young women, why it is preferred and what the characteristics of young women are who are using a specific contraceptive method. The response variable is method choice among the commonly used methods in Namibia (the injection, male condom, pill and other methods). The determinants are modelled through the multinomial

logistic regression using injection as a reference category. The multinomial logistic model is of the form:

$$\log\left(\frac{p_j}{p_J}\right) = \sum b_{jk} x_k$$

and this can be interpreted as the logarithm of the ratio of the odds of an individual belonging to category j for j = 1, 2,, j-1, to the odds of being in the reference category J. In applying the multinomial logistic model to contraceptive method choice, it is necessary to examine, carefully, some assumptions of the model. The assumption of mutual exclusiveness and exhaustiveness of the choices does not pose a serious problem. For women who may use more than one method concurrently, a choice has to be made about which method should be chosen as the one used. All analyses were performed using SPSS.

Methods of qualitative analysis

Audiotapes were transcribed and those focus group discussions that had been conducted in Oshiwambo were translated into English. Field notes were used to enhance and substantiate data from the transcripts. Audio tapes of each focus group discussion were reviewed several times in order to get an adequate impression of the discussion climate and to make a verbatim transcription in which hesitations, silences, enthusiasm and other psychological indicators are noted. Findings, together with pertinent quotations, were then organised according to the theme discussed, so that differences of thoughts, beliefs and emotions of groups representing diverse characteristics would become evident. New themes and unique responses from the focus group discussions and these were also included in the analysis. Furthermore, verbatim quotes, which were common in the focus groups, were considered for analysis.

RESULTS

Sample characteristics

The sample included 1776 sexually active respondents aged 15-24. The majority were aged between 20 and 24 and lived in rural areas. Most respondents had enrolled for or obtained secondary or higher education and most (75%) were still single at the time of the survey. Nevertheless, the majority of young women report having at least one child. Only 8% of young women reported that they discuss family planning issues with their mothers and only 10% discuss family planning with their partners.

Table 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	

Contraceptive use

Overall, the prevalence of contraceptive use among sexually active young women in Namibia stands at 52%. This prevalence is still below the Southern African region prevalence level of 60 per cent. 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 explained in relation to characteristics presented in table 4. 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. This is significantly supported with the logistic regression results which 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). This result supports evidence from literature that 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 this affects use of contraceptives.

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.

Young women in the rural areas are less likely to use contraceptives than those in urban areas (odds ratio = 0.623). The 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. Furthermore, the 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 had perceptions 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 perception.* The study results 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. In addition, the results also show a significant relationship between contraceptive use and discussing family planning with partner. Among those who use contraceptives, 62 per cent report that they discuss family planning with their partners. Whitaker et al. (1999) report that communicating with a 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 lead to safer sexual behaviours.

The results also show significant regional differentials in use of contraceptives. Regional differential is however interpreted in term of the significant interaction with place of residence (rural-urban). It is evident from the results that the odds of using contraceptives for young women who live in the rural areas in the South health directorate is 2.9 times the odds of young women using contraceptives who live in the urban areas of the Northwest health directorate. This is an indication of a low prevalence in contraceptive use among young women in the Northwest health directorate.

Table 4: Percentage distribution of sexually active young women using contraceptive methods and their estimated odds ratios of the likelihood of contraceptive use, by 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, $-2 \log \text{likelihood} = 751.645^{**}$

Contraceptive Method choice

Young women decide on their choice of methods depending on the availability and convenience of the method. The results show a relatively high prevalence of modern contraceptive methods. Injection had the highest prevalence, followed by the male condom and then the pill. The results indicate that most sexually active users aged 15-19 years have a high prevalence of condom use than those aged 20-24 years. Those who discuss family planning with their friends also showed a high percentage of making the choice of condom. Condom use was also higher among young women with no living child, 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, injection was the most preferred choice and the male condom was unpopular. 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.

Although the injection is the most preferred method, there are differentials in method choice with respect to health directorates. 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 prefers 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.

Table 4: Predicted probabilities for young women's choice of contraceptive methods, by selected variables, Namibia 2000

<u>Variables</u>	<u>Other methods</u>	<u>Pills</u>	<u>Condom</u>	<u>Injection</u>
Age(in years)				
15 -19	0.0095	0.132	0.304	0.554
20 –24	0.0077	0.142	0.216	0.634
Discuss family planning with friends	0.0142	0.138	0.232	0.616
No	0.0022	0.141	0.288	0.569
Yes				
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	0.0116	0.133	0.188	0.667
Number of living children	0.0059	0.097	0.507	0.394
None	0.0094	0.158	0.110	0.723
At least one				
Marital status				
Not in union	0.0077	0.120	0.241	0.631
In union	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	0.0069	0.157	0.243	0.594
Time to nearest health facility				
Less than 1 hour	0.0089	0.125	0.260	0.606
1 hour or more	0.0063	0.211	0.200	0.582

Focus Groups discussion

The DHS by its nature does not collect in-depth information on understanding young women's basic perceptions and attitudes towards use of sexual and reproductive health services in order to understand specific problems and fears relating to sexual and reproductive health utilisation, including use and non-use of contraceptives and the method choice. The focus groups discussions were thus conducted to fill gaps, which cannot be addressed through quantitative analysis. The emphasis in the group discussions was on the in-depth investigation of respondents' attitudes and opinions through a guided discussion. In this study, qualitative focus group discussions complement the quantitative data collection. 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.

“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).

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 exemplified 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).

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).

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).

From the above vignettes, it is observable that young women have problems utilising sexual and reproductive health services which could lead to a low prevalence of contraceptive use in Namibia.

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, convenience, 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).

“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).

“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).

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).

“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).

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.

Poor parent–child communication was also raised as a concern and as a barrier to the use of contraceptives among young women. Young women indicated 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 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.

“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)

“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).

“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).

“My mother is a good friend of mine. We talk a lotshe 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).

“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).

Discussion

The major finding that emerged in this study was communication between parents (especially mothers) and their daughters on sexual issues. Considering the strict culture, tradition and religious influence on reproductive health, it was assumed and hypothesised that the involvement of mothers in the reproductive health of their daughters has negative influences on contraceptive use. Mothers were assumed to be more traditional and not in support of their daughters, especially those who were not yet married, using contraceptives. The study, however, demonstrates more positive results towards contraception among young women who communicate with their mothers than was expected. Young women in rural areas who discuss family planning with their mothers were among those who had a higher probability of using contraceptives. The study indicates, however, that only a small proportion of young women discuss family

planning with their mothers, implying potentially significant possibilities which need to be further probed. This result stresses the importance of educating mothers about sexual and reproductive health issues and fostering better relationships between mothers and their daughters, which is likely to lead to stronger dialogue and greater social acceptance for girls to use contraceptives and make good choices of contraception.

Parents' participation in guiding their children's sexual and reproductive behaviour is not stressed sufficiently in both the national reproductive health policy and the family planning policy. Ideally, parents are expected to provide information and advice to their children about sexual and reproductive matters. However, given the social and cultural context in Namibia, parents are often reticent when dealing with sensitive issues with their children. Most parents especially those in rural areas, would not want their daughters to become sexually active, nor would they want them to endure an unwanted pregnancy. These findings suggest that parents, in particular mothers, need to be aware of the importance of reproductive health education if they are to play a vital role in avoiding unwanted pregnancies among young women who become sexually active. Higher levels of contraceptive practice by sexually active young women who wish to avoid pregnancy might decrease the incidence of unwanted births in Namibia. It was apparent from focus group discussions that mothers discuss family planning with their daughters who have advanced in education, especially at tertiary level, than those who are still attending primary or secondary school. There is need for programmes to stipulate clear guidelines on how mothers could communicate effectively with their daughters on sexual and reproductive health issues at all stages of schooling, and at different ages.

As recommendations, policies and programmes should adopt several approaches to address the need for more education on reproductive health. In rural areas, most mothers do not teach their children about contraceptives for fear that this will encourage permissiveness and promiscuity. This tendency leaves young women in an information vacuum. It is already argued by earlier researchers elsewhere that sex education does not increase sexual activity and can in fact lead to postponement of sexual initiation and to preventive behaviour once sexual activity begins (Grunseit & Kippax, 1993). Carefully constructed education programmes that address the needs of young women, gain their trust and work through their many misconceptions and fears, would be more successful than the present silence. Secondly, there is a need for policy makers to initiate on the implementation of Parent Education Programme on young peoples' sexual and reproductive health. The main purpose of the program should be to break down the poor communication between parents and children on sexual issues as well as to help improve

parents' skills for educating and communicating with their children on sexual and reproductive health issues.

References

- Chen S. and Guilkey D.K. (2003). Determinants of contraceptive method choice in rural Tanzania between 1991 and 1999. *Studies in family planning* 34(4): 263-276.
- Creel L. C. and Perry R.J. (2003). Improving the quality of reproductive health care for young people. Population reference bureau, Washington DC.
- Bertrand J.T., Seiber E. and Escudero G. (2001). Contraceptive dynamics in Guatemala:1978–1998. *International Family Planning Perspectives* 27(3):112-118.
- Burgard S. (2004). Factors associated with contraceptive use in late and post-apartheid South Africa. 35(2) 91-104.
- Grunseit A. and Kippax S. (1993). Effects of sex education on young people's sexual behaviour. World health organization, Geneva.
- Karim A. M., Magnani R.J, Morgan T.G. and Bond K.C. (2003). Reproductive health risk and protective factors among unmarried youth in Ghana *International family planning perspectives* 29(1): 14-24.
- Magadi M. A. and Curtis S.L. (2003). Trends and determinants of contraceptive method choice in Kenya. *Studies in family planning* 34(3): 149-159.
- Meekers D. and Ahmed G. (1997). Adolescent sexuality in Southern Africa: cultural norms and contemporary behaviour. PSI Research division, working paper n0.2: Washington, D.C. 28.
- Mfono Z. (1998). Teenage contraceptive needs in urban South Africa: A case study. *International family planning perspectives* 24 (4):180-183.
- Ministry of Health and Social Services (1995). Family planning policy. Republic of Namibia.
- Muhwava W.C. (1998). Patterns of contraceptive use at the edge of fertility transition in Zimbabwe. *African population studies* 18(1):19-34.
- Rani M. and Lule E. (2004). Exploring the socioeconomic dimension of adolescent reproductive health: a multicountry analysis. *International family planning perspectives* 30(3): 110-117.
- Ross J., Hardee K., Mumford E. and Eid S. (2001). Contraceptive method choice in developing countries. *International family planning perspectives* 28(1): 32-40.
- Whitaker D.J., Miller K.S., May D.C. and Levin M.L. (1999). Teenage partners' communication about sexual risk and condom use: The importance of parent-teenage discussions. *Family planning perspectives* 31(3):117-121.