

Contraceptive use among women in Namibia. A case study of Khorixas, Kunene South

Martina Gockel-Frank

Abstract

This article deals with patterns of contraceptive use in Namibia. Historical data as well as data from recent ethnological fieldwork in Khorixas, Kunene South, are presented. Though the majority of women have practised contraception it is not applied systematically. Mothers who already find themselves in difficult economic situations have further children even though modern contraceptives are available for free in Namibia. This article tries to identify what women know about contraception, why and when they choose to control their fertility and how sex education is dealt with in general. Different aspects such as gender roles and relations, social norms defining the value of children and influences from colonial times will be presented to show the effect they have on the use of contraception and thus reproductive decisions.

“I was on the farm when the injection expired that’s why I’m pregnant again.”
(Woman, 43, three children)

“My husband doesn’t like condoms.” (Mother of three children, 35)

“Whites talk about it but not us.” (Mother of two children, 23)

“We were not supposed to do anything but get as many children as our heavenly father gave to us. As it is said in the Bible.” (Mother of four children, 68)

“I don’t like contraception.” (Woman, 23, no children)

“I experienced physical problems, that’s why I stopped the injections.”
(Mother of three children, 34)

“Do you want to open a factory, the doctor asked me, thirteen children, that is too much, I have to stop you. The doctor said so. So he did the operation.” (Mother of 13 children, 68)

Introduction

My first interviews with mothers and nurses in Khorixas left me a little puzzled.¹ While the first group told me about their difficult economic situation and how every new child meant a further financial burden for them, the latter group explained that different contraceptives were available for free in Namibia. From the viewpoint of a white European woman this option seemed to give every woman the choice of having only the number of children she really wanted and could take care of. With every further interview and discussion it became more and more obvious that there were many different

¹ I wish to thank Dr Julia Pauli, Dr Gertrud Boden, Dr Andrew Newsham and the anonymous reviewers of JNS for their critical reading of former versions of this article and for their helpful comments.

aspects which had an influence on the use of modern contraceptives and that decisions, perceptions and knowledge concerning this topic had been shaped by history.² Apartheid and the colonial situation in general not only affected the public sphere but also the most intimate decisions. Obviously this influence did not simply vanish with independence. As nurses told me in 2006, a variety of modern contraceptives was available including two different injections (Depo Provera and Nur Esterate could be injected giving protection for three months), the pill, condoms and the loop. Nevertheless women chose in most cases the Depo Provera injection even though they suffered severely from side effects. The study of the historical development of family planning policies in Namibia illustrated how other contraceptives were systematically withheld from the coloured and black population, who were forced into taking Depo Provera. Besides the historical influence aspects like gender relations, the economic situation and social norms affected the decision whether to use contraception at all.

In the broader context of my research topic on the reproductive decision-making of women in urban Namibia the handling of contraception can definitely not be neglected as the great majority of women interviewed had already used a modern contraceptive method at some point in their reproductive life. The previously mentioned fact that contraceptives are available for free in Namibia raises a number of questions:

- Why do women have children who according to them aggravate their already difficult economic situation?
- Why do women continue to use contraceptives which their body does not tolerate while alternatives are available?
- When and why do women use contraception at all and when and why do they stop using it?

In order to find answers to these questions data on the educational background of the interviewees have been collected:

- What do women know about contraception, where do they get information on contraceptive methods and how do they deal with them?

The findings are based on 12-months of field research in Khorixas, Kunene South, from May 2005 until June 2006.³ The research was focused on my ethno-demographic dissertation topic about “Reproductive decision-making of women in urban Namibia

² According to the *Namibia Demographic and Health Survey 2000* (NDHS) the expression ‘modern contraceptive methods’ includes female and male sterilisation, the pill, IUD, injections, male condom, female condom, diaphragm/foam/jelly and emergency contraception. With traditional or natural methods rhythm (periodic abstinence) and withdrawal are meant (Ministry of Health and Social Services, *Namibia Demographic and Health Survey 2000*, Windhoek, MOHSS, 2003: 57).

³ My work was part of an interdisciplinary research project called ACACIA (Arid Climate Adaptation and Cultural Innovation in Africa) which was based at the University of Cologne, Germany and funded by the DFG (German Research Foundation). ACACIA worked in close collaboration with UNAM, Windhoek and was terminated on December, 31st 2007. For first results see Martina Gockel-Frank, “The gift from God: Reproductive decisions and conflicts of women in modern Namibia”, in: Suzanne LaFont and Diane Hubbard, (eds.), *Unravelling Taboos: Gender and Sexuality in Namibia*, Windhoek, Meinert, 2007: 182-196.

under the threat of HIV/AIDS". The study was focused on women and used a combination of qualitative and quantitative methods. After identifying different aspects supposed to have an influence on fertility patterns by studying relevant literature and conducting informal interviews, the results of qualitative interviews were combined with those of a questionnaire.

After a short introduction to the research site, this article presents the historical development of family planning programmes and compares it with the results found in Khorixas.⁴ The following paragraphs summarize official figures concerning contraceptive use in Namibia and the research results from Khorixas. In the final paragraph the latter will be discussed and analyzed.

The research site: Khorixas

Khorixas is a small town about 130 km west of Outjo on the road to the tourist attractions of the Petrified Forest and Twyfelfontein. The town is divided into three parts: the so-called 'town' north of the main road where all the commercial places such as the gas station, supermarket, bank, post office, repair station and some smaller shops as well as the bigger houses are situated. All of the white families (in the years 2005/2006 there were six in total) lived in this part of Khorixas. South of the main road is the bed of the Unib river and behind it the location where the main part of the population lived. Houses in this location are made of brick and differ in size from one to more than four rooms. Electricity and water connections are provided for the people who stay there. Behind the location and a small hill is the third part of Khorixas called Donkerhoek. As the name already reveals there was no electricity at this time and water had to be collected at two public points. Here people from all over Namibia build their houses with whatever they have and find. Nobody knows how many people reside in this part of the town. That is one of the reasons why the population figure is usually given with the vague estimation of 5.000 – 6.000.⁵

Khorixas used to be the administrative capital of Damaraland. That is why most of the people in this town are Damara and the town is one of the few which is still run by the UDF.⁶ Nevertheless the research was not designed to present data on the Damara ethnic group but on women in a typical Namibian town. Because of its urban

⁴ The composition of the households chosen by random sample for a quantitative survey reveals a trend which seems to be typical for small towns in Namibia as personal communication with colleagues showed. Thus in many cases the grandparents did not stay in town permanently but lived on their surrounding farms where they took care of the preschool children and the family's livestock. For this reason only 11 women whose reproductive years were already over or close to being over in 1990, the year of Namibia's independence, took part in the questionnaire survey. Qualitative interviews were conducted with an additional eight women who were already in their 40s in 1990.

⁵ Personal communication, Town Council Khorixas, March 2006.

⁶ UDF is the abbreviation for United Democratic Front. This party is traditionally the Damara party meaning that it is mainly Damara who vote for it and who are members of the party. Current head of the party is Justus Garoëb who is at the same time Chief of the Damara.

infrastructure Khorixas is of special importance for its rural surroundings like the community of Fransfontein, which is only about 35 km away and also for the different communal farms. In 1999 Khorixas lost its status of administrative capital. Since then Opuwo has become the capital of the Kunene region.⁷

There are two main reasons why Khorixas was chosen as research site for an ethno-demographic study on fertility patterns in the presence of HIV/AIDS. First of all research in and about small towns is still very rare in ethnological research dealing with urban centres even though more and more people in Southern Africa move to those places in search of work. Secondly the leaders of the project I researched, Drs Julia Pauli and Michael Schnegg, carried out a long term study in the Fransfontein community focusing on, among other topics, social relations. During their fieldwork it became obvious that various relations with the next urban centre, Khorixas, were of great importance for the majority of the inhabitants of the Fransfontein area. Relatives, schools for their children, shops and the state hospital were frequently visited sites. From a second research project in Khorixas itself we expected comparable data on the ties and the differences between an urban centre and its rural surroundings. This will be treated in more detail in my forthcoming dissertation.

Health care

The state hospital in the Khorixas location was inaugurated on the 6th April 1976 with 37 employees. In 2005 there were three doctors, 54 nurses (24 of them were also skilled midwives), one health inspector, 24 cleaners, four ambulance drivers (two vehicles) and seven workers for the kitchen, the garden and the laboratory.⁸ None of the doctors was from Namibia but originated instead from Nigeria, Cuba and Rwanda. Patients who could not be adequately treated in Khorixas were taken to Otjiwarongo by ambulance once a week. Besides the state hospital there was a private doctor's surgery in the commercial centre run twice a week by white doctors from Otjiwarongo. The majority of the population said that they could not afford treatment there.

The opinions about the hospital differed. While some of the inhabitants were very content others complained about long waiting hours, a lack of medication (often patients had to wait for their prescribed drugs until the next delivery a couple of days later), drunken ambulance drivers, ignorant nurses and a lack of local language skills on the part of the doctors. Actually none of the doctors knew any Afrikaans or Khoeh-khoegowab (Nama-Damara) and the doctor from Cuba also struggled with English. The first diagnosis was usually made by the nurses who transferred the patient to the doctor in cases of doubt. Contrary to many inhabitants who preferred to see an Afrikaans-speaking doctor in Outjo (about 130 km away from Khorixas) the PMO (principal

⁷ Philippe Talavera, *Challenging the Namibian Perception of Sexuality: A Case Study of the Ovahimba and Ovaherero Culture-Sexual Models in Kunene North in an HIV/AIDS Context*, Windhoek, Gamsberg Macmillan, 2002: 48.

⁸ Personal communication with the matron, Sister Day, 17th October 2005.

medical officer) did not feel the lack of local language skills to be a problem between him and his patients as there was always a nurse who could assist with translating.⁹ In cases of emergency it is quite difficult to reach the hospital, for example from Donkerhoek which is about a 30-minute-walk away. In such cases neighbours or someone who owns a vehicle is asked for help. Usually such favours have to be paid for. Acting from the assumption that health care in Namibia is provided on three different levels, the Khorixas hospital belongs to the second level meaning that doctors are available and inpatient treatment is possible.¹⁰

There are still numerous so-called 'traditional healers' in Khorixas.¹¹ Among my interviewees were five women who knew how to produce treatments according to orally transmitted recipes, how to massage and who worked as midwives. Two of these women explained that even the hospital asked them to come in in difficult cases such as a breech presentation birth. They stated that the population consulted them when the doctors were unable to help and when infants felt sick. Today about 2.500 traditional healers are united in the Namibia Eagle Traditional Healers Association (NETHA).¹² Surprisingly none of the interviewed women ever mentioned traditional healers in relation with contraception.¹³

Family policy and contraceptive use before independence

At the same time that cars in Windhoek carry stickers urging whites to "Sleep with a South-Wester [sic]! We need more of them", loudspeaker vans are touring the townships of Katutura and Khomasdal, urging black women to limit their families and radio programmes in African languages are relatively crude propaganda encouraging birth control. Depo-Provera

⁹ Personal communication with the PMO, 28th April 2006.

¹⁰ Matthias Rompel, "It will really knock on to everybody's door ..." *Die sozialen Folgen der AIDS-Epidemie in Namibia. Eine Untersuchung in Katutura und Ovamboland*, Gießen, Universität, Diss., 2003: 56 f. Health posts which are visited by nurses regularly as well as clinics, buildings where nursing staff offers ambulant treatment, belong to level one while well-equipped and most specialized hospitals like those in Rundu, Oshakati and Windhoek are regarded as level three health care institutions.

¹¹ For further information on the situation of healers in the past and present see Rompel, *Folgen*: 56.

¹² Ibid. and www.namibweb.com/aids.htm (accessed August 2009).

¹³ Traditional methods of contraception were also hardly ever mentioned. If the knowledge of traditional contraceptives was higher in former generations and got lost in the course of time or because of the separation of families during colonial times or because the interviewed women did not want to report about alternative methods in front of me, a white woman, whom they related to western medicine, cannot be definitely assessed. It might be that the women feared being considered ignorant or behind the time if mentioning them, cf. Julia Pauli, *Das geplante Kind. Demographischer, wirtschaftlicher und sozialer Wandel in einer Mexikanischen Gemeinde*, Münster et al., LIT, 2000: 231; for communication about contraception in general see Lucile F. Newman, "Context variables in fertility regulation", in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 179-191 (186).

injections and contraceptive pills are being handed out free from a government that gives away very little else to black communities.¹⁴

During the interview period of the fieldwork in Khorixas in 2006 women around 60 years of age nearly unanimously agreed that there were no contraceptives available during their fertile years. Thus they had no chance to influence their fertility except by abstinence or by sterilisation. Furthermore, none of the sterilised women among them received the operation of her own volition but because of (white) doctors who recommended or performed it without even informing the woman or asking her consent. Jenny Lindsay, the author of one of the very rare studies on the policy of fertility control in Namibia before 1990, concluded her undercover research by stating that “population control policies, wherever they are implemented, are an aspect of class/race/gender relations. State control of population is nearly always directed at some groups, not all and particularly at the poor.”¹⁵

The study of the scarce material on the topic supports the assumption that it was either too explosive or regarded as not important enough for intensive research. The few existing sources suggest that the former rulers of Namibia – then called South West Africa – wanted to limit reproduction of the black and coloured population in order to be able to control them more easily and to preserve resources assumed to be limited.

Lindsay explains how Neo-Malthusianism advocating population control in order not to overstrain resources became popular again at the beginning of the 1970s in South Africa and Namibia. At the same time unemployment rates and the marginalisation of the black population increased. The change towards capital-intensive industries and agriculture together with the incipient economic recession fuelled the fear of social uproar and the discussions about overpopulation and the reproduction of manpower. By applying a policy of population reduction South Africa and correspondingly Namibia followed an international policy trend of controlling so called Third World populations.¹⁶

Control or reduction was only meant for the black population, whose increase was perceived as the ‘swart gevaar’ (black threat). For South Africa an enormous increase of the black population until the year 2000 was predicted, which would overstretch land and other resources as South African demographers feared. The white middle class in the region adopted the European and American practices to limit family size in order to follow “more modern lifestyles”.¹⁷ Lindsay refers to discussions in the South African Journal of Medicine held between 1960 and 1988 when showing that the medical fraternity also followed neo-Malthusian thinking by believing that poverty was due to uncontrolled population growth. Furthermore she reveals that an argument like overpopulation could not be convincing in a country like Namibia with a total population of

¹⁴ Jenny Lindsay, “Population control policies in Namibia”, *Leeds Southern African Studies*, 1989, 3: 1-48 (17).

¹⁵ *Ibid.*: 1.

¹⁶ *Ibid.*: 2 f.

¹⁷ *Ibid.*

1.5 million and a relatively low growth rate of 2.5%, a high infant- and child mortality as well as high mortality rates because of TB, pneumonia etc.¹⁸

In the case of Namibia the attitude of the white medical personnel was most important. Though many black South African nurses came to work in Namibian hospitals – Lindsay explicitly mentioned Katutura Hospital in Windhoek – when South Africa took over the power in the country and extended its Apartheid policy on the Namibian terrain, the majority of the physicians were white South Africans. Many of them were of the opinion that over-population was like a chronic epidemic which could be healed by rational control of the fertility rate. The execution of the National Family Planning Programme began in 1974 with the financial support of among others the Upjohn Company which produced contraceptives like the Depo Provera injection. National family planning programmes were implemented in hospitals and clinics and offered hormonal injections, the pill and diaphragms for free. All over South Africa and Namibia vehicles toured around companies, farms and schools offering free contraceptives. In rural areas farmers or mainly their wives invited these mobile teams for regular visits.¹⁹ Women interviewed in 2006 supported these findings. “It was in 1974 that I first heard of modern contraceptives. It was a white lady, my boss, who told me about it” (Elisabetta, 63)²⁰ or “According to our white boss we had to go for injections once we were 20” (Tilda, 47, six children).

Family planning programmes promoting contraception were focused on the coloured and black population. White rulers wanted to reduce the reproduction of these groups whereas the reproduction of the white population was promoted as the quotation at the beginning of this paragraph vividly reveals. Posters, brochures, films and slide shows as well as radio programmes in the different local languages, newspaper articles and full-page advertisements supported this family policy.²¹

Lindsay states that one of the main tasks of the only clinic for 37.000 inhabitants in Katutura, Windhoek, was to inject the female population with the contraceptive Depo Provera. The effect was that many women hid or pretended to be out when they saw a nurse.²² In 1985 a nurse admitted that Depo Provera was injected in a dose of 450 ml. The same nurse continued that very young women only received Nur Esterate in a lower dose of 200 ml.²³ But she frankly explained that it was often not possible to estimate the girls' age and that contraceptives were injected without parents' consent. In cases of

¹⁸ Ibid.: 4.

¹⁹ Ibid.: 11-13.

²⁰ In order to protect the interviewed women and preserve their anonymity all names have been changed. The given ages are those of the year 2006.

²¹ Lindsay, “Population”: 13.

²² Ibid.: 17.

²³ According to the product information sheet from May 2006 a dose of 150 ml Depo Provera every three months (13 weeks) is recommended.

parents protesting no further injections were given.²⁴ Cleaver and Wallace also mention that Namibian women tried to resist the forced taking of contraceptives but often without success: “women’s resistance to contraception, notably to Depo Provera, which has been administered to black Namibian women without their consent or knowledge and even in some circumstances during rape and torture.”²⁵

Sterilisations were often carried out during a Cesarean section as well as during the insertion of IUDs (intrauterine devices). An interview partner, Erna (68) explained:

I got all my children at home with women from my family or the neighbourhood assisting. And the last one, I wanted to get it at home as well but it took hours and I thought, I better go to the hospital and ask the doctor what it is. The doctor asked why I wanted so many children. He thought 13 are too many and asked if I wanted to open a factory. So he sterilised me right after the birth though I told him, you cannot do it, my husband will be afraid.²⁶ And I wanted to talk to my husband but the doctor did it [the operation, the author] at once. I would have liked to have more kids. Maybe 15, as long as our heavenly father is giving.

Erna’s statement illustrates that in some cases sterilisations might have been recommendable from a medical standpoint but that the responsible doctors respected neither the patients’ sentiments nor their decisions. Furthermore there was no detailed health education, a necessity if the medical wellbeing of a patient was the main aim. Lindsay interviewed women who went to see their doctor because of severe pain in the abdomen and only got to know there and then that they had received the loop.²⁷

When studying the results from the quantitative survey in Khorixas it becomes obvious that women in the older birth cohorts are far more often sterilised than younger women. Among the women born between 1929 and 1951 50% have been sterilised, often in their early to mid-thirties, whereas the number of sterilised women decreases to less than 11% in the group of women born after 1952. The clear decline in sterilisations becomes particularly obvious after independence. After 1990 women who wanted to use a contraceptive had the chance to choose it themselves. The fact that none of the interviewed women born after 1961 was sterilised shows that sterilisation was not a preferred option. The trend towards fewer sterilisations complies with the national findings: while the Demographic and Health Survey 1992 concluded that 26% of the Namibian women were sterilised, this dropped to only 4% in 2000 according to the National Demographic and Health Survey 2000.²⁸

²⁴ Lindsay, “Population”: 17.

²⁵ Tessa Cleaver and Marion Wallace, *Namibia: Women in War*, London, Zed Books, 1990: 5.

²⁶ While the reader might expect the expression ‘angry’ here, the informant used ‘afraid’. Probably the action was frightening herself but as the relationship between the couple was explained as quite open the consequences for his wife’s physical and mental condition might have been scary for the husband as well.

²⁷ Cleaver and Wallace, *Namibia*: 18.

²⁸ Ministry of Health and Social Services, *Namibia Demographic and Health Survey 1992*, Windhoek, MOHSS, 1993: 8; Ministry of Health and Social Services, *Namibia Demographic and Health Survey 2000*, Windhoek, MOHSS, 2003: 62.

In a society which attributes great value to fertility, a sterilisation can have disastrous consequences like in the following example: A woman who was unwillingly sterilised after her fifth child (all were from different fathers) was continually betrayed by her subsequent husband and mistreated by her in-laws because she could not bear him a child. Another woman described the fate of a woman who suffered for many years because of her infertility. When she finally went for an operation she regarded as a small one she woke up recognizing that her whole uterus had been removed.²⁹ A nurse from Katutura hospital told Lindsay about a young girl who underwent an operation because of an assumed cyst. During the operation the physician noticed that she was pregnant. The fetus was removed without ever informing the girl.³⁰ Though there have obviously been doctors who were interested in their female patients' wellbeing they had no chance to treat them especially in smaller clinics in the countryside from where they had to transfer the women to Windhoek in case of any complication where they were treated without information or operated on as mentioned above.³¹ While reproductive fertility received medical attention, infertility, a problem from which many women suffered, was hardly noticed. Only couples who could prove a civil marriage were treated whereas women who already had children got no treatment at all though further children remain very important until today for example with a (new) husband.³² It was a general custom to inject women with Depo Provera right after giving birth without further information and even though the brochure of Upjohn in England explained: "If the puerperal woman will be breast-feeding, the initial injection should be delayed until 6 weeks post-partum, when the infant's enzyme is more developed."³³ A Namibian physician told Lindsay: "Depo-Provera injections are simply being banged into black and coloured women' without discussion, explanation or even permission."³⁴

Black and coloured women were deprived of the contraceptive pill by being told they would forget to take it. The prejudice that they would forget or not take it regularly was internalised by the women themselves. Nurses and female interview partners still believed it themselves when asked about it in 2006. Although they had never tried it, many of them said the pill was not meant for them as they would forget to take it regularly. The hormonal injection was and still is preferred for another advantage already told to Lindsay in 1983 by a former nurse: "Injections also have the advantage

²⁹ Lindsay, "Population": 19.

³⁰ Ibid.: 21.

³¹ Ibid.: 20. Even in 2006 this was still true. For more complicated operations or treatments patients from Khorixas had to be transferred to Otjiwarongo or Windhoek.

³² Ibid.: 21.

³³ Ibid.: 23.

³⁴ Ibid.: 22. In 2006 it was still common practice in Khorixas to inject women in childbed with Depo Provera. The women were informed about this injection and when asked about this procedure a thirty-year-old-woman stated that this was best for the woman as many would not return to Khorixas regularly once they returned to their farms (interview from March, 28th 2006).

that men don't know about them, for there are a lot of men opposed to any kind of contraception."³⁵

Even though Depo Provera was abandoned in North America as early as 1978 by the United States Food and Drug Administration (FDA) because of studies suggesting that it increases the risk of breast cancer, might cause birth defects in children whose mothers used the injection while already being pregnant and reduces breast milk, the contraceptive was and still is injected in Namibia. Further side effects were repeatedly mentioned during fieldwork in Khorixas, including amenorrhea (absence of menstruation), dysmenorrhoea (painful menstruation), menorrhagia (heavy and continuous bleeding), increase in weight, general indisposition, depression and loss of libido.³⁶ A decrease in fertility after taking the injection for some years was also observed. Furthermore, Lindsay reports on women who looked for treatment against TB. The treatment was only given after the patients agreed to take the contraceptive injection first. This procedure was explained by telling them that the medication against TB could be dangerous for pregnant women.³⁷ This reason does not explain why the affected women could not choose the contraceptive themselves. According to Nashilongo Elago, the general secretary of the former women's organization Namibian Women's Voice, female farm workers risked losing their job when refusing to take the injection and towards the end of the 1980s cases increased where black women had to prove regular use of contraception by a so-called 'family planning card' in order to get work as a housemaid or in a company.³⁸ Women who were suffering from mental problems were also administered the injection while they were treated in hospital and often agreed to take a new one after three months in order to not be hospitalized again.³⁹

During the liberation fight in the late 1980s contraception was in many cases closely linked with violence from fellow countrymen as a quotation from Cleaver and Wallace illustrates. The authors interviewed a woman who informed them about the following event:

In the North, I saw and heard about daily repressions. For instance, a fifteen-year-old girl, Olivia Haitembu and her friend Helenda Naitenge, sixteen years, were raped at Eunda by a group of Koevoet soldiers when they were returning from school in February this year [1988]. When they tried to resist their captors, they were thoroughly beaten up. Having [repeatedly] raped the children ... the soldiers injected [them] with ... Depo Provera. Later when the two girls were released, their buttocks swelled and they were taken to Oshandi hospital by their parents. They were discharged after two days.⁴⁰

³⁵ Ibid.: 29.

³⁶ Ibid.: 30.

³⁷ Ibid.: 41.

³⁸ Heike Kleffner, "Depo Provera: Verhütung mit der Spritze", *informationsdienst südliches afrika*, 1989, 4: 30-31 (31).

³⁹ Lindsay, "Population": 41.

⁴⁰ Cleaver and Wallace, *Namibia*: 1.

In the 1980s Depo Provera was still in use in Germany but only for 'second class women' like mentally handicapped women, women who lived on social aid, foreigners, women receiving psychiatric treatment and those who were not thought reliable enough to take other contraceptives regularly. At the same time the contraceptive was forbidden in Great Britain.⁴¹ In Zimbabwe Depo Provera was taken from the market with independence in 1980 but was re-launched later because of the public demand.⁴² Apart from the above mentioned side-effects the drug is a matter of controversial debate in the western world. The contraceptive was regarded as being explicitly dangerous for young women as it probably inhibits the growth of the bones. This accusation is not denied by the producer in the product information sheet for 2006.⁴³ In general the practices around family policy and the use of contraception in Namibia are accurately summarized by a statement of a nurse from Katutura which is still up-to-date as the following discussion of the topic in Khorixas will show: "Women are not accustomed to asking questions or contradicting whites and peasant women are not likely to contradict professional women such as nurses."⁴⁴

The study of the age-specific fertility rates (ASFR) of the women interviewed in Khorixas reveal a cut-off point around the time of independence.⁴⁵ While a continuous decline is evident in the ASFR from the mid 1970s until the end of the 1980s in all age groups a rise can be observed for the years after independence in nearly all age groups.⁴⁶

Table 1: Decline of the age specific fertility rates, Khorixas 1976-1986

Age group	Years		Decrease %
	1976	1986	1976-1986
women aged 10-19	0,0923	0,0704	24%
women aged 20-29	0,2938	0,1692	42%
women aged 30-39	0,1625	0,1188	27%
women aged 40-49		0,025	

⁴¹ Kleffner, "Depo Provera": 30.

⁴² Lindsay, "Population": 41.

⁴³ Pharmacie & Upjohn Company, "Depo Provera contraceptive injection medroxyprogesterone acetate injectable suspension", USP, Division of Pfizer Inc, NY, NY 10017, 2006: 5.

⁴⁴ Lindsay, "Population": 23.

⁴⁵ The ASFR illustrate the average number of births by women of a specific age group and can be calculated by dividing births in year to women aged x by women aged x at mid-year (cf. Colin Newall, *Methods and Models in Demography*, Chichester et al., Wiley & Sons, 1994: 39).

⁴⁶ As none of the women taken into account for this calculation had already been 40 years old in 1976, data for the age group 40-49 are missing.

Table 2: Rise of the age specific fertility rates, Khorixas after 1986

Age group	Years			Increase %
	1986	1996	2006	
women aged 10-19	0,0704	0,0372	0	
women aged 20-29	0,1692	0,2	0,1882	10%
women aged 30-39	0,1188	0,1347	0,2185	46%
women aged 40-49	0,025	0,025	0,0521	52%

The 2001 Population and Housing Census also comments on the rise in fertility after independence. Obviously it was observed at the national level as well and regarded as a result of the fact that “most couples would like to make up for what was lost during the war”.⁴⁷ Comparing the figures for the most relevant components influencing fertility, age at first birth, age at last birth and birth interval, meaning the space between two births, it becomes obvious that the first is of no great relevance for the discussed context.⁴⁸

Table 3: Age at first birth and average length of birth intervals⁴⁹

Birth cohort	Number of women	Women with at least 1 birth	Ø Age at first birth	Women with at least 1 birth interval	Ø Length of interval
1937-1946	8	8	19,8 (4,3)	7	2,4 (1,5)
1947-1956	16	16	21,5 (5,0)	16	4,1 (1,9)
1957-1966	26	26	19,2 (3,3)	24	5,0 (2,6)
1967-1976	27	26	19,5 (2,4)	24	4,3 (2,1)
1977-1986	35	30	20,1 (2,3)	12	1,3 (2,0)
1987-1996	18	/	/	/	/
total / Ø	130	106	20,0 (0,1)	83	3,4 (1,5)

Concordant with the findings of the NDHS 2000 the age at first birth has hardly changed over the years.⁵⁰ The variation according to the average length of birth intervals on the other hand shows that there is a trend to prolong these intervals. This trend starts with the second birth cohort, women who were in their twenties during the mid 1970s leading to the assumption that they have been the first who could control their fertility by using modern contraceptives. The third component, age at last birth, can only be calculated for those women who have already finished their reproductive life.

⁴⁷ Central Bureau of Statistics, *2001 Population and Housing Census*, Windhoek, National Planning Commission, 2003: 62.

⁴⁸ Cf. Pauli, *Kind*: 213.

⁴⁹ The respective standard deviance is given in brackets.

⁵⁰ Ministry of Health and Social Services, *Namibia Demographic and Health Survey 2000*, Windhoek, MOHSS, 2003; 53.

Table 4: Age at last birth, Khorixas

Birth cohort	Number of women	Ø Age at last birth
1929-1941	4	39,3 (7,8)
1942-1951	8	31,6 (7,2)
1952-1961	28	34,4 (6,7)
total / Ø	40	35,1 (3,9)

In the first cohort one of the interviewed women obviously suffered from secondary infertility (infertility occurring after a birth) as she delivered her first and only child at the age of 28. She never used any method of contraception and wanted more children. At 43 (2.6) years, the average age at last birth is considerably higher for the other women. Whereas 50% of the first two births cohorts had been sterilised it was only 10% in the youngest cohort (see above). Thus the component 'age at last birth' has also been influenced by the use of contraception. The following section will treat current patterns of contraceptive use in Namibia and particularly Khorixas in order to find more detailed answers to the questions raised in the introduction.

Current contraceptive use in Namibia

"Information on knowledge of family planning methods provides a measure of the level of awareness of contraception in the population and indicates the success of information and education programmes."⁵¹

According to the results of the Namibia Demographic and Health Survey 2000 (NDHS)⁵² 97% of the interviewed women asked to mention how a couple can prevent a pregnancy listed at least one contraceptive method spontaneously.⁵³ Strikingly all methods mentioned were modern ones. Condoms were named by 93%, the hormonal injection by 92% and the pill by 89%.⁵⁴ No more than a third of the women mentioned periodic abstinence or withdrawal. According to the MOHSS report the level of knowledge of contraceptive methods and devices is slightly higher for men than for women. Among the male interviewees 99% mentioned at least one method spontaneously. Again the

⁵¹ Ibid.: 57.

⁵² When no further details are given the following facts on knowledge about, the attitude towards and the use of contraceptive methods are taken from the *Namibia Demographic and Health Survey 2000*: 57-79. This survey is based on interviews with more than 6.500 women and 3.000 men in 260 areas including all 13 regions of Namibia during a 3-month period (October until December 2000).

⁵³ The fact that the answer was given spontaneously is regarded as being important because it can be assumed that something mentioned that way is of some importance in the interviewee's life and he/she has at least read or heard about the phenomenon before.

⁵⁴ Whenever 'condoms' are mentioned in this essay without further explanation, the expression refers to the male condom. In Namibia the expression 'injection' describes a hormonal injection whose contraceptive effect lasts for three months. Women often talked about "going for the injection" or "going for the shot" when talking about renewing their contraceptive protection. In 2006 the injection with Depo Provera was still the most popular.

majority mentioned the condom (99%), the injection (98%) and the pill (83%). The female condom (femidom) was mentioned by 66% of the women but 74% of the men. Among women in their reproductive years between the age of 15 and 49, 63% had already practised contraception, mostly using a modern method (61%). The most popular device was the injection (39%) followed by condoms (28%) and the pill (24%). The number of women who had ever practised a form of contraception was highest among those in their late twenties (77.1%) and decreased amongst older age groups. In the age group of women between 45 and 49 it was still 57.7%.

During the interview period in 2000, 38% of all interviewed women practised contraception with 37% using a modern method. Again the injection turned out to be the most popular method used by 17%. 9% used condoms and 6% the pill. 4% of the women were sterilized. Married women were far less likely to use condoms but were more often sterilised. The use of contraceptive methods was highest in the age group of the 20-to-30-year-olds. For women above 40 years sterilisation was the most commonly used method. The evaluation of the data collected for the Namibia Demographic and Health Survey revealed that women who lived in an urban surrounding more often used a form of contraception and a high correlation between education and the use of contraceptives could be observed. The ratio of women who practised contraception during the period of the survey rose from about one third among those without education to two thirds among those who finished secondary school. In all cases the injection was the preferred method. The use of contraceptives increased generally with a rising number of children.⁵⁵

In general an explicit trend towards an earlier use of contraceptive methods during the reproductive phase could be observed. Among women aged 45 to 49 there are fewer women who ever practised contraception and among those of them who did it the majority only started after having given birth to two children. By contrast, among women between 20 and 24 years of age who ever used contraception the majority started using it before they had their first child. Data referring to the knowledge about the female cycle showed that women hardly know about it. Only 12% knew that the fertile period lies just in the middle between two menstruations. The report mentions 33 years as the average age for sterilisation. Concerning the acquisition of contraceptive devices the public sector was mostly mentioned as the source. For 83% of the respondents the national health centres like clinics and state hospitals were the places to go.

With regard to the level of information the study concluded that education and information on contraceptive methods should be improved as for example only 38% of those women who use a contraceptive device during the period of the survey got information on possible side effects at first use. This means that only one in three women got information about what to do when experiencing side effects. 40% of the interviewed women confirmed that they got further information on other available

⁵⁵ Starting with 42% of those without children to 62% of those with three children but decreasing again to 30% among mothers with four or more children.

contraceptive methods. According to the MOHSS report two thirds of the married women and men answered that they had talked about family planning with their partner in the year prior to the interview.

Contraceptive use in Khorixas

The following data are based on the answers of 138 women aged between 15 and 85.⁵⁶ The answers were collected in a quantitative survey conducted in 80 households chosen by random sample from February until May 2006. For this survey a questionnaire was distributed to and filled in together with all female members (total number of women interviewed: n = 138). These results were enriched by the outcome of group discussions, in-depth-interviews, biographic interviews, group discussions with four to ten women of different age groups, interviews with experts including doctors, nurses, teachers, priests and numerous informal discussions with other women and experts as well as participant observation during the 12-month fieldwork. If my interview partners were able and willing to answer in English or Afrikaans I could conduct the interviews myself but as many interview partners preferred to talk about these sensitive and intimate topics in their mother tongue (Khoekhoegowab, Otjiherero or Oshiwambo) I depended on my research assistant, a 32-year-old Otjiherero speaking woman who was fluent in Khoekhoegowab, Oshiwambo, English and Afrikaans. In order to get at least a glimpse into the male sphere of reproductive decision-making, 31 structured interviews with men between 16 and 57 were recorded by my husband and a male assistant.⁵⁷ Whenever figures appear in percent they present the questionnaire results.

What do women know about contraception?

“In those days there was nothing we could do.” (Sofia, 77, 15 children)

“I’ve heard about something but I forgot.” (Roselda, 16, no children)

When asked in the questionnaire which methods – traditional or modern – they knew in order to not get pregnant, 7.25% of the women could not mention any method

⁵⁶ Following demographic habit a woman is regarded as fertile from the age of 15 (see Hartmut Lang, “Ethnodemographie”, in: Thomas Schweizer, Margarete Schweizer and Waltraud Kokot, (eds.), *Handbuch der Ethnologie*, Berlin, Reimer, 1993: 117-144 (124 f). Usually the fertile phase of a woman ends in her late 40ies. Though there might be exceptions, this article follows the habit of the *Namibia Demographic and Health Survey 2000* which defines the fertile phase in a woman’s life as between the age of 15 and 49 (p. 57).

⁵⁷ As I did not want to lose the confidence of my female interview partners and in view of the sensitivity of the research topic I decided that it made more sense to let men do the interviews with male interview partners. Neither my husband nor the local research assistant are social anthropologists but the latter already had experience in conducting interviews as he was assisting my colleagues and project leaders, Drs Julia Pauli and Michael Schnegg during their research in the nearby Fransfontein community. I designed the questionnaire for male interview partners according to the results already received by interviews with women, explained it and my research interest in detail to both my husband and the assistant and we conducted detailed discussions before and after every interview.

spontaneously. Three of them were teenagers, two in their early twenties, three between 44 and 62 years old and two between 77 and 82 years old. Whereas the teenagers like Roselda (see above) admitted that they had heard about something but had forgotten it, the older women agreed in stating that they did not know anything and that there had been nothing to inhibit pregnancy.

As was also the case in the NDHS 2000 condoms, injections and the pill were the best known contraceptives with the injection mentioned by 83.1%, followed by condoms (50%) and the contraceptive pill (37.7%). Both, withdrawal and male sterilisation were only mentioned once. Equally unknown were chemical means like foam or jelly as well as diaphragms. Sterilisation and the loop were both mentioned by 13.4% of the women. Periodic abstinence was mentioned by 5.1%. The observation of the menstrual cycle was never mentioned spontaneously and when asked about it only two women, among them a former nurse, mentioned the correct point of time – right in the middle between two menstruations – for their fertile days. All other informants, a practising nurse included, knew that there is a special period when the occurrence of a pregnancy is more probable but thought this period was reached immediately after the bleeding stopped. Similar results were received in the NDHS 2000 for the whole country and are also common in other parts of the world as a study about Afghanistan shows.⁵⁸ The interviewed women in Khorixas were not familiar with natural methods like controlling the body temperature or observing the secretion.

Though the paragraph on contraceptives in the questionnaire was introduced by a question on the importance of breastfeeding no woman mentioned it explicitly as a method to prevent pregnancy. It was answered that breast milk is healthy for the baby. It was regarded as a cheap food which is always available having the correct temperature. The aspect of being able to nourish an infant in the appropriate manner was obviously much more important than the contraceptive effect. Women over 60 years of age mentioned breastfeeding indirectly as a measure to control reproduction by explaining that breastfeeding was usually done until the baby started walking which was usually after a year. During this time they abstained from sexual contacts as they were warned it would harm the baby and also the mother herself. If possible those women moved in with their own mothers again and stayed with her and the baby until the abstinence taboo was over in order not to be seduced by being too close to the father of the child. Women suffered from the fact that the taboo was not taken as seriously by the fathers but did not talk about their grief. Children with neighbouring women or other female family members procreated during this period were often raised by the own wife or female partner as one of the interviewees explained: "It was often difficult when your husband was with other ladies. You were sad but kept quiet. Later when there were kids you as the wife even raised them." (Christiane, 85, seven children). Many women did not

⁵⁸ Pamela A. Hunte, "Indigenous methods of fertility regulation in Afghanistan", in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 43-75 (53). The fathers of modern medicine like Hippocrates and Soranus, a greek gynaecologist in the second century A.D., shared this opinion (ibid.).

comply with the taboo even in those days as they feared to lose their husband at least for that period.⁵⁹

Sara, 77, with 16 children from one husband, explained: "There was this practice but it caused problems. If you did not want problems in your house you better stay with your husband." Asked whether she was not afraid to cause harm to herself and the newborn by having sex with her husband she answered: "No, this is not true. You can be together with your husband and breastfeed at the same time." It has to be taken into account that during her fertile years Sara stayed on a farm together with her husband and without the extended family exerting social control, thus she had no fear of being blamed for risky behaviour.

Paula, a 66-year-old interviewee mentioned burying the placenta as a method to prevent a further pregnancy. "You have to bury the afterbirth upside down." Discussions with Julia Pauli revealed that this practice was described by women in Fransfontein as well. Paula herself was born on a farm near Fransfontein suggesting this might be a regional phenomenon. A 24-year-old woman talked about drinking a special herbal drink but did not know which ingredients it contained or the time a woman should drink it. Surprisingly neither her mother nor her grandmother mentioned this method. Results from qualitative interviews showed that younger women in particular tried different means to prevent or abort a pregnancy while at school and staying in hostels.⁶⁰ Thus it might be possible that women invented drinks from necessity and which are probably not based on traditional recipes.

Where did women get sexual education and information on contraception?

"The nurses told me after I had my first baby."

(statement heard from many women of different age groups)

"The doctors decided to sterilise me after my fourth baby, because I had a baby every year and my body got weak." (Maria, 63)

The average age when women heard about family planning and methods to exercise it was 19 years. The most important source of information on this topic was the school, which was mentioned by 40.9% of the interviewees, followed by personnel from the health sector (32.8%). Women quite often got information on available contraceptives from doctors or nurses after giving birth for the first time or after their first birth in a medical facility. This fact led to special connotations referring to the topic of contraception. Because of the medical surroundings it is more often connected to the

⁵⁹ Hill finds a similar result for West Africa. Particularly in polygamous households sexual activity is started soon after a birth because of the man's pressure, cf. Allan G. Hill, "Understanding recent fertility trends in the Third World", in: John Landers, (ed.), *Fertility and Resources*, Cambridge, Cambridge University Press, 1990: 146-163 (155).

⁶⁰ In Namibia abortion is illegal. Due to the limited time it was not possible to collect detailed information on this sensitive and intimate topic.

dichotomy healthy – sick than to a free decision process referring to the own configuration of one's life.

Close to 14% of the women got their first information on contraceptive measures from their mothers. Although most of all women did not know about risks like the ineffectiveness of the pill in case of vomiting and/or diarrhoea or they were not informed about side effects of the injection and could often only mention one method, 65% felt they knew enough about family planning methods.

Women received information regarding how they could become pregnant on average at the age of 16, a little bit earlier than the age at which they were told how to prevent it. 23% were sexually educated by their mothers, 17% by other family members mainly the grandmother (11%). In most cases women stayed with their children and their own mother. Accordingly it was she who did this job. Slightly more than 4% of the interviewed women got this first information from their aunt. Both the father's and the mother's sisters were mentioned equally often. As many as 18.5% found out how they could become pregnant only when they were already expecting their first baby. "We were told that babies come with airplanes. I didn't know what was wrong with me when I was pregnant. When they told me that I would have a baby I ran out of the house, looking for a plane to take it back." (Maria, 63, four children)

I got pregnant when I was in grade 11 at 18 years but I did not know anything. I did not know that you could get pregnant through sexual intercourse. I got very angry with my boyfriend when he told me that he had known before. I even tried to beat him. (Ellen, 46, four children)

Nearly all women over 50 years talked about the dark hut (!khae-oms in Khoekhoegowab). This inspiring initiation ritual was barely mentioned by the younger generations. As the following report reveals it gave the young girls a feeling of being a woman although it contributed little to their sexual education.

I was put in that hut and it was decorated and this wood, this nice kind of wood was burnt with the nice smell. And I was put on this red, you know, from the Ovahimba people. And people came to the house and the guys and they were told 'Oh, something is happening to this house.' Meat was there every day, every day. I was there for one week and then I was released from the house and there was dancing and the guys came with their guitars and wanted to dance with me. There was dancing and singing. And there was one man who was also dancing with me and this man was saying 'Oh, I will dance with a lady, with a particular lady who is now a woman'. If you want to go to the toilet while you are in that house they just take you maybe to the bush and then they bring you back and with the last day you wear long clothes and this ---- (trying to find the right word), this for the head (showing her traditional Damara head covering). And maybe the ladies that brought you out and clean your clothes with the blood and they tell you. And with the ones you go to the bush maybe to take some wood and you will also be learn how to get this big kind of wood because when you were small you just go for the small one maybe the light ones but now you go for this big ones maybe. And while you are still in the house you don't eat with your hands because normally we like to eat with hands so you have to eat with spoons. And then afterwards the day you come out you have to wash properly, after the wash you bring the wood. You just have proper wash, enjoying food and so you can now eat with the hands. So they will just tell

you maybe about adulthood but not about boyfriends. They have told to be aware of men because you might fall pregnant. It was very strict and they did not chat to you about all this stuff and because it was for you like I don't know...

Author: Like a taboo?

Giselda: Ja and they will just saw you pregnant and they will ask you and it was like they have to find out what, who's the person responsible for that.

Giselda, 81, was full of excitement whilst she talked about her experience in the dark hut. The old woman, who was nearly blind, became very active waving her arms and swinging her body back and forth when describing the dancing.

It was obviously at menarche that young girls were informed about deep changes in their life. It was very rare that they got further details on what these changes might look like. Statements like the recommendation to rather flee from male friends from now on, to stay closer to home and avoid too short clothes were mysterious. Many women were as surprised by their own pregnancy as they were by their first menstruation when they did not know what was happening to them:

I remember that someone shouted at me, that I was bleeding, if I had a wound at my foot. I did not know what happened to me and was very scared. Older people told me to be careful of sex from now on but I didn't even know what that was. (Maria, 63)

I was also afraid in the dark hut and sometimes I was crying. So you don't know that's why you are crying. You thought you are having a big disease something wrong is going on. (Sara, 77)

The interviewed women had their first intimate boyfriend at an average age of 17 years and had their first child in their late teenage years or early twenties. Both figures hardly vary in the different cohorts.

Communication about contraception

"Whites talk about it but not us." (Carola, 34, five children)

The fact that 74.1% of the interviewed women did practice a form of contraception during the course of their reproductive life shows that contraception was of interest to them.⁶¹ The high figure is confirmed on the national level by the findings of the NDHS 2000. Obviously, the need to control births existed, which does not mean that births should have been completely prevented but that women wanted to have an influence on the space between births ('spacing').

When asked whether they made decisions about contraception together with their partner, 63.6% of the interviewees answered in the affirmative. On the national level it was about the same amount, a result which raises doubts since qualitative interviews and observation suggest that only a few couples discussed family planning in detail and

⁶¹ Upton's study about Botswana led to a similar result. The majority of the women already practised contraception, cf. Rebecca L. Upton, "Infertility makes you invisible": Gender, health and the negotiation of fertility in Northern Botswana", *Journal of Southern African Studies*, 2001, 27 (2): 349-362 (361).

that 'common decision' more or less only meant that the fact that something was used was communicated. Further findings concerning the topic of HIV/AIDS showed that a discussion about contraception between partners is at least problematic.

Whereas the majority (67.2%) of the interviewed women stated that they knew other women who used contraception, 18% still remain who did not talk about this topic at all. In general the most important discussion partners for the topic of family planning methods were the own children who should be educated by these talks as well as sisters and friends. A more detailed look at the 'own children as discussion partners' revealed that it was mainly daughters with whom mothers talked about pregnancies. Only 16.7% of the women had already talked with both daughters and sons about it and about 20% never talked about this topic with their children. During group discussions it became obvious that all those conversations usually remained very superficial as the women often left it by saying that they would wish to have more occasions where they could talk openly and in detail about topics like sexuality and contraception.

Actual use of contraception

"I stopped taking anything because the injections let me bleed too much."
(Delia, 23, three children)

"I was on the farm while the injection expired that's how I got pregnant again. But I'm already having enough problems." (Wilma, 35, six children)

„I experienced physical problems because of the pills that's why I stopped it."
(Renzia, 44, three children)

"I am using the loop for a long time now and I am very satisfied with it."
(Phyllis, 47, six children)

„I don't like contraception." (Christa, 23, one child and Ritha, 17, having a partner but no children)

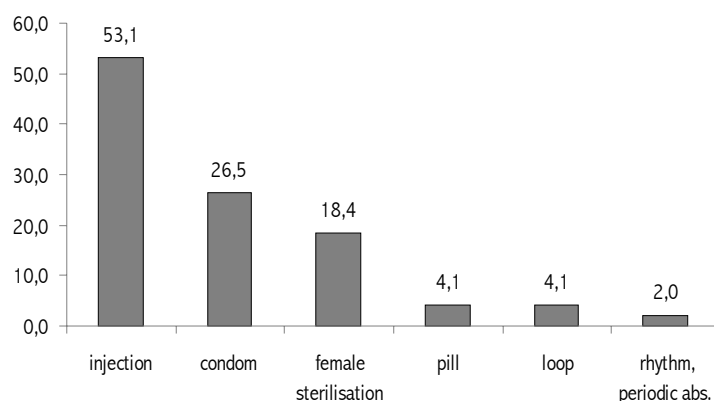
"It is dangerous." (Jane, 18, having a partner but no children)

At the time of the survey 35.8% of the women practised contraception, a result which agrees with the 38% found on the national level. Figure 1 demonstrates which methods the women in Khorixas used.

With 53.1% the hormonal injection was again the most popular method. Condoms were used by 26.5% and 18.4% were sterilised. The contraceptive pill as well as the loop were both used by 4.1% and only 2% relied on periodic abstinence. The result was nearly the same when asking the women who had at some point in their reproductive period used something, except for the pill replacing sterilisation in that case.

Among the 23.9% of women who never used a form of contraception until the time of the survey were teenagers who answered they were still too young and had never had a sexual relationship. Women over 45 years of age mentioned their age and the fact that no methods had existed or that they did not know about any. The generations between these two age groups answered that they did not like contraceptives or that they regard them as dangerous. One woman explained that they could produce problems in the female organs like for example cysts.

Fig. 1: Actual use of contraceptive methods, Khorixas, spring 2006



Source: own survey, answers in percent, multiple answers were possible.

Women who were sterilised often did not mention it when asked if they practised any kind of contraception. Just like the fact that withdrawal or abstinence were not mentioned at all, this suggests women regarded contraception as an action which has to be performed by the woman. She has to do something in order to prevent pregnancy. Though 30 (21.8%) women practised a six-month sexual abstinence after the birth of their last child, 15 women even did so for 12 months and another 15 even longer, only seven women (5.1%) mentioned periodic abstinence as a contraceptive method and only one woman (0.7%) said that she was practising it at the time of the survey. As a reason for prenatal abstinence the interview partners mentioned tradition.

Six (4.35%) women stated that they were currently not using any kind of contraception because their babies were still very small and they were still breastfeeding but none of these women mentioned periodic abstinence. Further reasons for not using any contraceptive method were the fact that the women were staying without a partner or their old age. Physical problems such as high blood pressure, heavy monthly menstruations and a feeling of general indisposition which they thought was caused by the contraception were frequently given reasons for abstaining from any kind of contraceptive.

Mostly women over 55 years repeatedly answered: "We were not supposed to do anything but get as many children as our heavenly father gave to us as it is said in the Bible." (Maria, 63, four children) However, religion or faith did not seem to influence younger women's decision for or against contraception and the choice of the method.⁶²

⁶² For further details on the influence of religion on fertility patterns and HIV/AIDS see Martina Gockel-Frank, "My scriptures help me when I have to make decisions' – Zum Einfluß von Pfingstkirchen auf fertiles Verhalten und den Umgang mit HIV/AIDS in der namibischen Kleinstadt Khorixas", *EthnoScripts*, 2008, 10, 1: 44-64.

With regard to sterilisations the trend to execute it quite early in a woman's reproductive life was supported by the results of qualitative interviews which showed that sterilisations were recommended by (white) doctors or were done directly after a birth without the woman's agreement.⁶³

Maria (63) „I got a baby every year. After the fourth one the doctors said my body would be too weak for another one and sterilised me.”

Author: “Would you have liked to have more children?”

Maria: “Yes, as long as our heavenly father is giving.”

In Maria's case a contraceptive extending the space between births would have been her preferred solution but she was not given a choice.

Some women in their mid-thirties said they would like to go for 'the cut' after their next baby. It was usually their third or fourth child and they felt that that number of children was enough for them and they did not want to think about contraception again. These women were in general well-educated and felt themselves to be in a stable relationship.

The average age for using a contraceptive method for the first time was 21.5. This correlates with the age at first birth and the fact that the majority of the women were informed about contraception by nurses or doctors after giving birth.

Discussion

The research results presented definitely show that the whole topic of contraception was of interest to the women in Khorixas. The great majority could mention at least one and in most cases more than one contraceptive methods and they had already used one or another sometime during their reproductive years. Many of the interviewed women felt they knew enough about this topic but in-depth-interviews and more detailed questions showed that they were barely informed about the different contraceptives available, about possible side effects and risks which could disturb the effectiveness of the chosen method. Some regarded contraception as dangerous, feared its use could result in cysts and worst of all infertility. Usually sex education was received at school or from medical staff after giving birth. The afore mentioned lack of knowledge as well as the reactions to group discussions when many women stated, they would love to have such intensive and detailed discussions on topics having to do with reproduction in the broader sense much more often, reveal that information must have been too superficial and general. Many women stated that they talked to nobody about this topic. As mentioned above this behaviour partly results from historic circumstances when women were forced into passive acceptance and not educated for self-determined decisions.

Concerning sexual education at school an interview with the principal of the only high school in Khorixas displayed that the topic of sexuality in general was part of the

⁶³ About forced sterilisations in Bolivia cf. Kirstan Hawkins and Neil Price, “From international policy to local reality: Women's reproductive health strategies in El Alto, Bolivia”, in: Soraya Tremayne, (ed.), *Managing Reproductive Life*, New York, Oxford, Berghahn, 2001: 52-70 (59).

curriculum but the responsible teachers were never controlled so nobody knew “if they broach the issue itself, what they tell and how they do it” (A. Howaseb, interview 05.04.2006). One of the sisters at the Khorixas hospital who was responsible for education on contraception frankly stated that she was not able to talk about these matters with her own teenage daughter. “I left her with a book on these things and asked my sister to one day talk to her” (Interview 19.10.2005). In rare cases it was the own mother doing sex education. Preferably other female family members like the grandmother, a sister or an aunt were responsible for explaining the facts of life.⁶⁴ Throughout the different generations this kind of information was quite vague as was revealed by the explanations given by older women about their experience of the initiation at first menarche in the dark hut and also by the answers from young teenage girls. While the former were informed that from then on their lives would change fundamentally but did not receive more detailed information on what these changes would entail, the latter were often sexually educated by their peers in school hostels and did not dare to ask more detailed questions. This phenomenon is also present in western societies as an article in a German magazine illustrates. Accordingly teenagers are “sexually educated but innocent” meaning that youth are already sexually active but do not know about side-effects and risks of contraceptives and are ignorant about the fertile period within a menstrual cycle.⁶⁵

These facts clarify that topics concerning sexuality remain a taboo and are not openly talked about in the private sphere. Thus the past is repeated in the present: women who themselves did not receive a profound sexual education and experienced these topics as taboo do not properly educate their own children, pupils or patients. Most of the women obviously feared to discuss problems concerning the use of contraception with the medical personnel because they were not used to contradicting these reputable persons. Furthermore there were only male physicians without any knowledge of Afrikaans or any local language in the Khorixas hospital. Thus a possible examination or discussion with them would have meant “crossing cultural boundaries of gender interaction”.⁶⁶ An action requiring discreetness and caution like the acquisition of modern contraceptives becomes a public one by for example a third person being necessary for translation.⁶⁷

⁶⁴ This seems to be a widespread phenomenon as friends and colleagues in Germany with teenage children admitted that they as mothers often felt themselves to be the wrong person to explain these intimate facts to their daughters.

⁶⁵ “aufgeklärt, doch ahnungslos”, Barbara Esser, “Erste Liebe, erster Sex”, *Fokus*, 2007, 4 (Juli/August): 10-22 (15).

⁶⁶ Ibid. Discussions with relatives, friends and colleagues revealed that women in Germany also prefer to be informed and / or examined by a female expert.

⁶⁷ Lucile F. Newman, “An introduction to population anthropology” in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 1-23 (5, 13).

One of the reasons why women in Khorixas who used contraception in accordance with the results of the national survey presented in paragraph three mostly choose the injection was the fact that it was usually recommended by the nurses. Even when experiencing severe side effects women either left contraception completely or continued with the injection. This behaviour suggests that they were either afraid to discuss their problems in a more detailed way with the medical staff or that it was not important enough. Other reasons for preferring the injection were its convenience and the long lasting protection: a single injection gives security for three months. Last but not least its discreetness was regarded as a great advantage. Men were often opposed to contraception as they liked to prove their virility with every new child. In Khorixas a rumour was heard that there existed a competition among two men in their late thirties to determine who would have fathered most children by the age of 40.⁶⁸ The use of condoms was therefore much more problematic. Whereas 58% of the interviewed women knew that condoms protect from an HIV/AIDS infection only 47% mentioned them when asked for contraceptive methods and only around 10% used it in order to prevent a pregnancy. Condoms have only become popular for the wider public through HIV/AIDS campaigns and thus have little significance for the topic of contraception. The fear of partners to be blamed for unfaithfulness when being the one asking for protected sex was widespread. On the other hand they could be an ideal alternative for women experiencing problems with other contraceptives or those who fear to become infertile when using contraceptives for some time.⁶⁹ Additionally the injection was the best known method as it was strongly promoted and often forced on women during the colonial era.

Obviously women had a need to control their fertility as the majority had already tried a method of contraception. Even those women whose reproductive period was mainly after independence followed this trend, which shows that contraceptive use was of interest even without being forced into it. While there were still women of all ages who "let God decide" about their number of children, there were many interviewees who felt three to four children were enough. Women who already had a job, those who hoped to get one and young women with a higher education thought they would proceed more easily with fewer children. The same is true for women who lived in a stable relationship or were married. They preferred to stop at three or four children and relied on contraception. But even these women might leave or forget contraception again when realising that their expectations would not be fulfilled for instance if a professional career failed or a relationship ended. This behaviour explains why sterilisation was only in very few cases regarded as a good option as it meant the definite end of fertility while other kinds of contraceptives only interrupted it.

⁶⁸ Compare Brody's results from Jamaica: Eugene B. Brody, "Everyday knowledge of Jamaican women, in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 161-178 (162).

⁶⁹ Compare Upton's results from Botswana where also many women feared that the use of contraceptives would lead to infertility (Uton, "Infertility": 360).

Whereas some interviewees, who supported the idea of three to four children as an ideal number of children for a woman, could not understand why women still had more children than they wanted, this condition could often be observed. In some cases the women either forgot the extension of the injection or this was simply impossible because of the missing infrastructure. Many women were mobile and migrated to other towns in search of work or for shopping or travelled to the surrounding farms. The fear of forgetting or the missing infrastructure were both also mentioned when asking why women in Khorixas and Namibia as a whole did not rely on the contraceptive pill, which is very popular in western contexts. Many women seemed to have adopted the opinion of the white population and parts of the medical personnel who did not believe that indigenous women could handle the pill reliably. In other cases contraceptives did not agree with the women's bodies or they found no other solution for their (often financially) miserable situation than to have another baby accompanied by the hope of being supported by the father. On the other hand children were also desired. They were simply a part of life and the interviewed persons were felt to depend on them. Children were closely connected with security in old age: "I prefer to have many children so that at least one will make it into a good job and will assist me" (56-year-old mother who regretted having only three children).

Furthermore a cultural norm regarding children as important in a marriage existed. "Without children there is no love in a marriage" (group discussion with 35-45-year-old women, 04.05.2006). Even those women who only married when older and who already had children with former partners hoped for another child with their husband. "I have to follow our tradition!" explained a 31-year-old well-educated mother of two children who actually did not want any more babies but got pregnant less than 10 months after her wedding. 'Tradition' did not indicate a tradition of one specific ethnic group: The statement was made by Damara as well as Herero women. Participant observation revealed that the social pressure on married women to reproduce was high. Statements like "You have to pay your wedding dress" by giving your husband a baby were heard repeatedly. Boserup summarizes this attitude as "One of the roles of the family is to produce offspring".⁷⁰

Even without people being married a child was of great importance in a relationship.⁷¹ Women who already had one or more children with former partners had another baby in a new relationship. Chimere-Dan calls this process an

emerging reproductive regime in the sub-region of Southern Africa, a regime that is characterized by a separation of motherhood from marriage. Although marriages and the traditional family life are under great pressure from various

⁷⁰ Ester Boserup, "Population, growth, innovation and resource exploitation", in: John Landers, (ed.), *Fertility and Resources*, Cambridge, Cambridge University Press, 1990: 118-125 (119).

⁷¹ As marriage was quite rare (less than one third of the interviewed women had been married) the phenomenon of a woman having children with different fathers was very common (compare Pauli's data for Fransfontein: Julia Pauli, "'We all have our own father!' Reproduction, marriage and gender in rural North-West Namibia", in: Suzanne LaFont and Diane Hubbard, (eds.), *Unravelling Taboos: Gender and Sexuality in Namibia*, Windhoek, Meinert, 2007: 197-214).

quarters, African societies still place a high premium on children, and having children remains a principal determinant of the social status of a woman.⁷²

Even though many women had themselves experienced that reality did not comply with their expectations, they linked a child to the hope of getting married or at least to the chance of making demands on the father or his family.⁷³ In reality these were rarely legally claimed. Many women did not know about their rights (result of a workshop on the Maintenance Act by the Legal Assistance Center in Khorixas, 14.02.2006) or regarded the procedure as too troublesome.

Furthermore the emotions connected to having a child should not be neglected as Montgomery articulated for the much more difficult context of teenage mothers in Thailand's prostitute milieu: "A child, even an unwanted child, could be a source of moral and financial recompense" and "[a] child also provided a source and focus of love which should not be underestimated, however obvious this point seems".⁷⁴ With these two statements the author tries to explain why even among sexually-educated women contraception was rarely practiced. For the presented urban area in Namibia both declarations are of great importance as well: "Reproduction is therefore a dynamic process, which is not limited to two people reproducing biologically."⁷⁵

Contraceptives like Depo Provera which are regarded more than critically in other parts of the world were continually administered in Khorixas. Topics like sexuality and contraception remained a taboo. Even though there might be public awareness campaigns, particularly since the HIV/AIDS pandemic, these facts of life were not discussed openly in the private sphere. Hawkins and Price quote Schuler et al. with a research result from Bolivia: "Sexuality and reproduction are not openly talked about and it has been suggested that women learn reticence about sexual matters at an early age".⁷⁶

Women who themselves only got a very rudimentary and often mysterious sex education continued in the same way concerning the education of younger generations. Many women did not yet have the self confidence to decide which contraceptive they wanted to use and which one was best for their body. Like in former times they let others – no longer white doctors but local nurses and/or male partners – decide for them. If nurses recommended the injection they took it and continued using it though experiencing physical and mental problems. If partners refused contraception they complied. Even

⁷² Oriji Chimere-Dan, "Non-marital teenage childbearing in Southern Africa: The case of Namibia", *African Population Studies/Etude de la Population Africaine*, Vol. 12, No. 2, 1997.

⁷³ Cf. Upton's study on Tswana in northern Botswana: "... one may need to have a child *in order to get married*. Many respondents argued, 'what man will want to marry you unless you have a child?'" (Upton, "Infertility": 354, italics in the original).

⁷⁴ Heather Montgomery, "Motherhood, fertility and ambivalence among young prostitutes in Thailand", in: Soraya Tremayne, (ed.), *Managing Reproductive Life*, New York, Oxford, Berghahn, 2001: 71-84 (79).

⁷⁵ Soraya Tremayne, "Introduction", in: Soraya Tremayne, (ed.), *Managing Reproductive Life*, New York, Oxford, Berghahn, 2001: 1-24 (1).

⁷⁶ Hawkins and Price, "Policy": 69.

younger women in their 20s or 30s admitted in group discussions that it was the man who took decisions in the private sphere and who decided about using or not using contraception. Thus the previously mentioned advantage of the contraceptive injection becomes obvious: It can be used without the partner's knowledge. Newman calls such methods "methods that will not arouse notice".⁷⁷

As was already expressed in the quotation at the end of paragraph 2 there remained a kind of respect towards experts like the medical staff restraining women from insisting on more detailed information and a more individual treatment. Children continued to be very important although it might be very difficult for a mother to support them especially in a town like Khorixas where they and their children often depended on the help of their parents' little farms in the surrounding areas as they could neither grow anything in town nor keep livestock there. Like in former times children were still regarded as a security for old age; the more children the better the chance that one might find well-paid work to support the mother.

Finally it can be concluded that contraception was being practiced but in many cases only temporarily because of poor information, economic pressure or social norms. The historical development of family planning and the introduction of modern contraception during Apartheid forced women into a passive role and did not leave room for critical thinking. In addition the use of family planning methods was closely related to activity by the woman. This was probably also due to the fact that the great majority of modern (and also traditional) contraceptives were meant for use by the woman thus making it easy for men to regard the whole topic as a female one.⁷⁸

Bibliography

- Boserup, Ester, "Population, growth, innovation and resource exploitation", in: John Landers, (ed.), *Fertility and Resources*, Cambridge, Cambridge University Press, 1990: 118-125.
- Brody, Eugene B., "Everyday knowledge of Jamaican women, in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 161-178.
- Central Bureau of Statistics, *2001 Population and Housing Census*, Windhoek, National Planning Commission, 2003.
- Chimere-Dan, Oriji, "Non-marital teenage childbearing in Southern Africa: The case of Namibia", *African Population Studies/Etude de la Population Africaine*, Vol. 12, No. 2, 1997
www.bioline.org.br/request?ep97016 (accessed September 2009)
- Cleaver, Tessa, and Marion Wallace, *Namibia: Women in War*, London, Zed Books, 1990.

⁷⁷ Lucile F. Newman, "Context variables in fertility regulation", in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 179-191 (184).

⁷⁸ John Cleland, "Fertility decline in developing countries: the roles of economic modernization, culture and Government interventions", in: John Landers, (ed.), *Fertility and Resources*, Cambridge, Cambridge University Press, 1990: 126-145 (137).

- Cleland, John, "Fertility decline in developing countries: the roles of economic modernization, culture and Government interventions", in: John Landers, (ed.), *Fertility and Resources*, Cambridge, Cambridge University Press, 1990: 126-145.
- Esser, Barbara "Erste Liebe, erster Sex", *Fokus*, 2007, 4 (Juli/August): 10-22.
- Gockel-Frank, Martina, "The gift from God: Reproductive decisions and conflicts of women in modern Namibia", in: Suzanne LaFont and Diane Hubbard, (eds.), *Unravelling Taboos: Gender and Sexuality in Namibia*, Windhoek, Meinert, 2007: 182-196.
- Gockel-Frank, Martina, "'My scriptures help me when I have to make decisions' – Zum Einfluß von Pfingstkirchen auf fertiles Verhalten und den Umgang mit HIV/AIDS in der namibischen Kleinstadt Khorixas", *EthnoScripts*, 2008, 10, 1: 44-64.
- Hawkins, Kirstan and Neil Price, "From international policy to local reality: Women's reproductive health strategies in El Alto, Bolivia", in: Soraya Tremayne, (ed.), *Managing Reproductive Life*, New York, Oxford, Berghahn, 2001: 52-70.
- Hill, Allan G., "Understanding recent fertility trends in the Third World", in: John Landers, (ed.), *Fertility and Resources*, Cambridge, Cambridge University Press, 1990: 146-163.
- Hunte, Pamela A. "Indigenous methods of fertility regulation in Afghanistan", in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 43-75.
- Kleffner, Heike, "Depo Provera: Verhütung mit der Spritze", *informationsdienst südliches afrika*, 1989, 4: 30-31.
- Lang, Hartmut, "Ethnodemographie", in: Thomas Schweizer, Margarete Schweizer and Waltraud Kokot, (eds.), *Handbuch der Ethnologie*, Berlin, Reimer, 1993: 117-144.
- Lindsay, Jenny, "Population control policies in Namibia", *Leeds Southern African Studies*, 1989, 3: 1-48.
- Ministry of Health and Social Services, *Namibia Demographic and Health Survey 1992*, Windhoek, MOHSS, 1993.
- Ministry of Health and Social Services, *Namibia Demographic and Health Survey 2000*, Windhoek, MOHSS, 2003.
- Montgomery, Heather, "Motherhood, fertility and ambivalence among young prostitutes in Thailand", in: Soraya Tremayne, (ed.), *Managing Reproductive Life*, New York, Oxford, Berghahn, 2001: 71-84.
- Newall, Colin, *Methods and Models in Demography*, Chichester et al., Wiley & Sons, 1994.
- Newman, Lucile F., "An introduction to population anthropology" in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 1-23.
- Newman, Lucile F., "Context variables in fertility regulation", in: Lucile F. Newman, (ed.), *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, New Brunswick, Rutgers University Press, 1995: 179-191.
- Pauli, Julia, "'We all have our own father!' Reproduction, marriage and gender in rural North-West Namibia", in: Suzanne LaFont and Diane Hubbard, (eds.), *Unravelling Taboos: Gender and Sexuality in Namibia*, Windhoek, Meinert, 2007: 197-214.
- Pauli, Julia, *Das geplante Kind. Demographischer, wirtschaftlicher und sozialer Wandel in einer Mexikanischen Gemeinde*, Münster et al., LIT, 2000.
- Pharmacie & Upjohn Company, "Depo Provera contraceptive injection medroxyprogesterone acetate injectable suspension", USP, Division of Pfizer Inc, NY, NY 10017, 2006.
- Rompel, Matthias, "It will really knock on to everybody's door ... " *Die sozialen Folgen der AIDS-Epidemie in Namibia. Eine Untersuchung in Katutura und Ovamboland*, Gießen, Universität, Diss., 2003.

- Talavera, Philippe, *Challenging the Namibian Perception of Sexuality: A Case Study of the Ovahimba and Ovaherero Culture-Sexual Models in Kunene North in an HIV/AIDS Context*, Windhoek, Gamsberg Macmillan, 2002.
- Tremayne, Soraya, "Introduction", in: Soraya Tremayne, (ed.), *Managing Reproductive Life*, New York, Oxford, Berghahn, 2001: 1-24.
- Upton, Rebecca L., "'Infertility makes you invisible': Gender, health and the negotiation of fertility in Northern Botswana", *Journal of Southern African Studies*, 2001, 27 (2): 349-362.