

**PSYCHOLOGICAL AND SOCIO-CULTURAL EFFECTS OF FORCED AND
COERCED STERILISATION ON WOMEN LIVING WITH HIV (WLHIV) IN
NAMIBIA: IMPLICATIONS FOR INTERVENTION**

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ABSTRACT

The forced and coerced sterilisation of women living with HIV (WLHIV) is one of the serious forms of fundamental human rights violations, which has occurred, the world over. In Namibia, cases of forced and coerced sterilisation were first reported in 2007 to 2008. With the support of civil society organisations; these cases have gone through litigation. The litigation of Namibia's forced and coerced sterilisation cases has been successful and considered a best practice, with the courts ordering financial compensation for the victims. Yet, aspects of the well-being of the victims have not been fully addressed. This research aimed to explore and obtain an in-depth understanding of the psychological and socio-cultural effects of forced and coerced sterilisation on WLHIV in Namibia, in order to ascertain the implications for further intervention. A qualitative approach was applied, using semi-structured interview schedules to acquire comprehensive information on the experiences of seven research participants residing in the Khomas region of Namibia. Content analysis was carried out, and results indicated negative psychological and socio-cultural effects on the lives of research participants following forced sterilisation. The themes that emerged from the findings include psychological symptoms that are usually associated with anxiety and depression. Symptoms of depression comprised: withdrawal, overthinking or ruminating, feelings of helplessness, feelings of hopelessness, feelings of worthlessness, feelings of sadness, anger, sleep disturbance, change in weight, loss of interest, self-blame and shame. Symptoms of anxiety included fear and uneasiness, sleep disturbance, persistent anxious and stressful feelings. Additionally, the themes of negative health effects and poor state health care services, gender-based violence, discrimination, victimisation and unemployment emerged. It was noted that cultural principles and values regarding reproduction, marriage and decision-making also contribute to negative socio-cultural and psychological effects. While victims have received emotional, legal and material support from support groups and from civil society, coping has been difficult, with some psychological and socio-cultural challenges still significantly affecting the women's lives. It is recommended that in addition to the legal assistance, stakeholders should also target responses at aspects of the well-being of the victims, principally, the psychological and physical well-being of the victims.

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LIST OF ABBREVIATIONS

ICW	International Community for Women Living with HIV
LAC	Legal Assistance Centre
NWHN	Namibia Women's Health Network
PLHIV	People Living with HIV
WHO	World Health Organization
WLHIV	Women Living with HIV

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DEDICATION

To my Creator, with Whom all things are possible

“And Jesus looking upon them said, with men it is impossible, but not with God: for
with God all things are possible.”

Mark 10:27

DECLARATION

I, Kudzai Bakare, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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Name of student

Signature

Date

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Sterilisation is a form of family planning, but unlike other family planning methods such as the pill or the injection, it is a permanent form of family planning. Forced sterilisation occurs when a medical procedure eliminating a woman's ability to bear children is performed without her informed consent, referring to instances where the woman is unaware of the fact that she will be sterilised and only learns of the sterilisation after the surgery (Nair, 2010). Coerced sterilisation is defined as the use of coercion in obtaining the required informed consent for the sterilisation procedure. It encompasses "emotionally coerced sterilisation, in which a patient is pressured into consenting to sterilisation in a way that diminishes his or her autonomy in making the decision" (Nair, 2010, p. 223). Coerced sterilisation happens when misinformation, intimidation tactics, financial incentives, access to health services or employment are used to compel individuals to agree to the procedure (Open Society Foundation, 2011). For women, sterilisation can be carried out through one of two surgical procedures: hysterectomy, where the uterus is removed, or tubal ligation, where the fallopian tubes are restricted (i.e. cutting or tying the fallopian tubes) so that a woman's egg does not reach her uterus) (Nair, 2010).

The forced and coerced sterilisation of women living with HIV (WLHIV) is a global phenomenon (World Health Organization [WHO], 2014). It is a violation of

fundamental human rights that happens to vulnerable groups, such as women living with HIV, disabled women, indigenous women, poor women, inmates and transsexual men. The reasons for the sterilisations are diverse but are mainly rooted in discrimination and paternalism (Namibia Women's Health Network [NWHN], 2015). Cases of forced and coerced sterilisation have been documented by the International Community of Women Living with HIV (ICW) (n.d) and others in – Bangladesh, Brazil, Botswana, Cambodia, Chile, China, Democratic Republic of Congo, Dominican Republic, El Salvador, Fiji, Honduras, India, Indonesia, Kenya, Malawi, Mexico, Mozambique, Namibia, Nepal, Nicaragua, Pakistan, Philippines, South Africa, Sri Lanka, Swaziland, Tanzania, Thailand, Uganda, Ukraine, Venezuela, Viet Nam and Zambia. The widespread nature of this practice necessitates a strong and coordinated response at the national, regional and global levels, but most of all it calls for the psychological and social support for the victims (NWHN, 2015).

The reasons for forced and coerced sterilisation, vary from country to country and context to context. In Namibia, the first cases of forced or coerced sterilisation were discovered in 2007-2008, and the women were sterilised in state hospitals, apparently because of their HIV statuses (Mwale, 2015). The Supreme Court of Namibia in its 2014 final ruling found that the women were indeed sterilised without their informed consent and ordered the Government to compensate the women financially (Chutel, 2014). Although this was a resounding victory for the human rights activists who have been leading the Stop Forced Sterilisation Campaign in Namibia, it has recently been recognized that the psychological and social well-being of the victims of this gross and traumatic human rights violation was not adequately addressed over the years (NWHN,

2015). The major focus in assisting the victims of forced sterilisation by service providers (civil society organizations) has been trying to understand the legal frameworks, policies and laws related to this issue, so as to advocate for justice and to ensure that this practice is stopped (Strode, Mthembu & Essack, 2012). While success was achieved in the legal battle in Namibia, the psychological, social and cultural impact of the sterilisations on women has not been investigated and addressed accordingly.

The mental well-being of the women who were victims of forced and coerced sterilisation cannot be ignored, considering their low socio-economic status and the stigma and discrimination that comes with being HIV positive. According to a consultative discussion with local, regional and international stakeholders in civil society and some of the women who were victims of forced sterilisation in Namibia, it was concluded that the women need more support, not only to engage in the legal process and advocacy, but also to receive psychosocial support and professional counselling (NWHN, 2015). This reveals the fact that the psychological well-being of the women who were victims of forced sterilisation needs urgent attention to enable them to live normal lives again as well as to obtain closure regarding the fact that they will not be able to have children again. It is against this background that this study sought to explore the psychological and socio-cultural effects of forced and coerced sterilisation and to find out what the implications are for intervention.

1.2 Statement of the problem

The sterilisation of WLHIV in Namibia and across the world has been regarded as one of the worst forms of violence against women and a gross human rights violation (WHO,

2014). Along with the human rights violation that forced sterilisation infringes upon individuals, comes some health risks, psychological repercussions, social repercussions as well as financial implications. According to the Matsumoto (2009), a traumatic event is any event that inflicts physical damage on the body or severe shock on the mind or both. From the definition above, forced sterilisation may be considered a traumatic or stressful event because of both its negative effects on the body and the possible psychological shock experienced by the victims. With this in mind, it is construed that, with forced sterilisation, mental well-being should be highly prioritized since there could be a risk of developing mental health problems. Therefore, how the women cope and attach meaning to the fact that they were sterilised becomes important in determining their well-being. The major focus in assisting the victims of forced sterilisation in Namibia has been providing litigation services to facilitate compensation of the victims (Nair, 2010). It has been recently recognized that more focus should be directed towards the psychological and social well-being of the victims (NWHN, 2015).

It is unfortunate that the psychosocial impact of forced sterilisation has not been adequately acknowledged, and this study contributes towards filling this gap. Over and above the physical effects (that often go beyond the lack of ability to reproduce, with women reporting severe pain, excessive bleeding etc.), the psychological and socio-cultural effects need to be explored as these are often linked to the complex issue of gender-based violence that the country is currently facing (NWHN, 2015). This study aimed to explore and obtain an in-depth understanding of the psychological and socio-cultural implications of forced and coerced sterilisation on Women Living with HIV in Namibia, through analysing patterns, trends, similarities and differences within seven

cases. The ultimate purpose is to inform psychological and social intervention strategies that could be developed to further support the women to fully reclaim their lives.

1.3 Research objectives

The overall aim of this research was to explore and obtain an in-depth understanding of the psychological and socio-cultural effects of forced and coerced sterilisation on WLHIV in Namibia, in order to ascertain the implications for further intervention. This study had the following research objectives:

- 1.3.1 To explore the negative psychological symptoms resulting from forced and coerced sterilisation.
- 1.3.2 To describe the socio-cultural effects of forced and coerced sterilisation
- 1.3.3 To investigate the meanings that individuals attach to the circumstance of being forced and coerced into sterilisation and how these influence coping.
- 1.3.4 To find out if there is need for psychological, social and other forms of interventions for the women who were victims of forced or coerced sterilisation.

1.4 Significance of the study

This research is significant because to date, no scientific studies specifically focusing on the psychological and socio-cultural effects of forced and coerced sterilisation on WLHIV have been conducted in Namibia. The few studies that have been done on the forced and coerced sterilisation of HIV positive women in other parts of the world have focused on establishing reasons why this atrocity takes place, exploring the prevalence of the problem, analysing the legal frameworks and policies related to sterilisation and

describing the reasons why service provision for WLHIV is poor (Oliveira et al., 2007; Strode et al., 2012). Hence, this study is the first of its kind. Additionally, only a few scientific studies (Strode et al., 2012; Oliveira et.al 2007; Kendall & Albert 2015) have been done on the forced and coerced sterilisation of HIV positive women in other parts of the world. Hence this study fills the knowledge gap on this matter.

The outcomes of this study are an important reference point to other countries that are also in the process of advocating for the rights of the women who were forcibly sterilised, so that they may be able to include the aspect of psychological and social well-being in their endeavours. The litigation of the forced sterilisation cases in Namibia has been considered a best practice in Africa (Chutel, 2014), and this is also evidenced by the article written by Gatsi, Kehler and Crone (2010, p.1), titled, “Make it Everybody’s Business...Lessons Learned from Addressing the Coerced Sterilisation of Women Living with HIV in Namibia: A Best Practice Model”. This research thus, continues to put Namibia on the map when it comes to excellence in human rights work.

Since this study also focused on the implications for intervention, it is beneficial to the target population because the results will inform the development of future interventions, such as supportive therapy by service providers (civil society). It addresses a specific need requested by NWHN and its stakeholders in a 2015 consultative meeting, in which interventions comprising of mental health and wellbeing were reckoned to be essential and lacking (NWHN, 2015). In addition to the litigation support that the women have currently received from civil society organizations, this is

most important because it is a process that may lead to the women getting holistic reparation.

This study also helps communicate the importance of mental-health or psychological well-being to policy makers, professionals, academics and the general public in Namibia considering the dire need for psychological interventions to the general population and the shortage of mental-health personnel in the country.

1.5 Delimitation of the study

The study was limited to only seven research participants. Therefore, due to the limited number of participants, no further analysis and comparisons were done of how the impact of forced or coerced sterilisation affected the women differently in terms of differences in age groups, in terms of number of children the women have, marital or relationship status etc. The data obtained was however sufficient to address the research objectives. The present study only looks specifically at WLHIV and not all groups of vulnerable women that may be sterilised.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In order to understand the psychological and socio-cultural effects of forced and coerced sterilisation of WLHIV, we must draw from previous research. This study uses the concepts of stress, coping and meaning making to establish how these are applicable to the experience of being forced and coerced into sterilisation. In this section, the history and causes of forced sterilisation are examined. Additionally, relevant research that has been carried out and the theoretical concepts of meaning making and coping are outlined and synthesized accordingly in order to clarify concepts and propose relationships among the concepts, as well as to provide a context for interpreting the study findings.

Sterilisation is a widely used form of contraception in the world (WHO, 2014), which should only be provided with full, free and informed consent. Among other contraceptive methods, it is an important option for individuals and couples to control fertility. When performed according to appropriate clinical standards with informed consent, sterilisation methods such as vasectomy and tubal ligation are safe and effective means of permanently controlling fertility (WHO, 2014). However, in some countries, people belonging to certain population groups, including WLHIV continue to be sterilised without informed consent (WHO, 2014). According to Cussins (2013, p.1), “sterilisation laws that enforce sterilisation may be in the past, but the practice and ideology lives on”.

There is a history of forced and coerced sterilisation around the world. In the United states of America, North Carolina, 7,600 people were sterilised between 1929 and 1974 for a range of reasons, including findings by authorities that they were lazy, promiscuous, or poor (Cussins, 2013). In the other parts of the world, forced sterilisations have occurred in huge masses. For example, in Nazi Germany 400,000 men and women were forcibly sterilised. In Sweden 63,000 people, mostly women, were sterilised. Over 800,000 men and women in Japan as well as 11,000 women from Finland were also sterilised without consent (Cussins, 2013).

2.2 The Namibia forced sterilisation cases: An overview

The first mention of forced sterilisation of women living with HIV (WLHIV) in southern Africa was in an article in a feminist journal, *Agenda* in 1998. Although the issue went largely un-noticed, this act of disclosure ensured that the sterilisation of WLHIV was at least in the public domain, notwithstanding that it took years for the issue to ignite (Patel, 2008). Forced sterilisation was raised in Namibia in 2008 in an International Community for Women Living with HIV (ICW) Young Women's Dialogue, during a discussion on sexual and reproductive rights, when a young woman in the group mentioned that with all the issues surrounding pregnancy and HIV she was “grateful” that the health care facility had insisted that she be sterilised. Three other women in the group had similar experiences and it became clear that this was an issue to be addressed urgently as an extreme violation of women’s rights (Gatsi-Mallet, 2008).

Further investigation by the ICW Namibia chapter demonstrated that the incidence of forced sterilisation was not isolated and that more women had been sterilised. Namibia Women's Health Network (NWHN) a local Non-Governmental Organization (NGO) together with ICW conducted a research on this issue and realized that the forced sterilisation was part of a broader range of discriminations faced by HIV positive women in reproductive health services and particularly against women living with HIV who are pregnant or desire children (Gatsi-Mallet, 2008). Forty out of the two hundred and thirty women living with HIV (sixteen per cent) interviewed indicated they were subjected to forced or coerced sterilisation. Fifteen of the forty cases were further explored and submitted to the Deputy Minister of Health and Social Services (Gatsi-Mallet, 2008). The documented forced and coerced sterilisations occurred at Katutura State Hospital, Central State Hospital, and Oshakati State Hospital. The alleged stated reason for the sterilisations given by the Ministry of Health and Social Services was that the practice was government policy (Gatsi-Mallet, 2008).

The ways in which women were either forced or coerced into sterilisation included; consent obtained under duress; consent was invalid, as the women were not informed of the contents of the documents they signed; medical personnel failed to provide full and accurate information regarding the sterilisation process (Nair, 2010). Language barriers were also reported as a factor as well as lack of knowledge about sexual and reproductive health rights and sterilisation in particular. In 2009, a campaign was launched in Namibia to fight against the forced sterilisation of WLHIV and this campaign included a legal campaign, which sued the Government of Namibia for damages with the Legal Assistance Centre (LAC) as the litigating partner (Gatsi-Mallet,

2008). The final Supreme Court was made on 3 November 2014. The Supreme Court's decision in *Government of the Republic of Namibia v LM and Others*, affirmed the High Court's July 2012 order finding that the government had subjected women to coercive sterilisation (NWHN, 2015). The High Court found in favour of the women and held that the practice of coerced sterilisation violated the women's legal rights. It was a resounding victory as Namibia set the pace and showed other countries in the region and the world over that justice on human rights issues can be obtained no matter how long it takes. A best practice on advocacy and pursuing litigation for human rights violation was set in the Namibian context to be followed the world over.

However, although the win was a relief and pleasing for the women who were sterilised, forced sterilisation is an extreme form of violence against women, which not only violates a woman's right to control her body and to make reproductive decisions but most importantly affects the woman's mental wellbeing or psycho-social wellbeing. Over and above the physical effects, the psychological effects may include stress, depression, loss of self-esteem and self-worth, fear and anxiety. Women report many adverse socio-cultural effects including limited marriage prospects, stigmatization, prejudice, and social isolation (NWHN, 2015). Many women are silent about their sterilisation fearing the many negative social and cultural consequences. It is only now that the human rights activists are aware that although the legal campaign was successful, the women continue to suffer both psychologically and socially due to the inhumane treatment, they received and they never received any psychological support.

2.3 Previous studies on forced and coerced sterilisations of Women Living with HIV in Africa

While there is documentation of cases of forced sterilisation in other African countries such as South Africa, Botswana, Zambia, Zimbabwe, Kenya and Swaziland (ICW, n.d), the scientific research studies available are very limited. This study fills the knowledge or information gap on forced and coerced sterilisation in Africa. A research conducted in South Africa on forced and coerced sterilisation by Strode et al. (2012), found issues of lack informed consent, the availability and yet ineffectiveness of legal frameworks and policies in protecting individuals from being forcibly sterilised, stigma and discrimination as well as the negative attitudes of health professionals. These issues are like those that have been highlighted in Namibia. However, the research did not include issues of the mental well-being of the women post-sterilisation. Strode et al. (2012), highlight the need for further research, thus the current study aimed to build on such previous research initiatives with a focus on the psychological and socio-cultural effects of forced or coerced sterilisation, as well as how aspects of coping and meaning are linked to the experiences of the victims.

Essack and Strode (2012), examined the socio-cultural, physical and emotional/psychological impacts of coerced and forced sterilisations on HIV-positive women in South Africa. It was highlighted that forced and coerced sterilisation affects victims mentally and physically, and impacts on their relationships with their partners, families and the wider community. In countries that are more ingrained in the traditional patriarchal system, female sterilisations can inspire abusive behaviour from husbands who may become angry and aggressive if the decision to be sterilised was made without

consulting him. Essack and Strode (2012), note that in such cultures, where the value of a woman is placed on her ability to bear children, the socio-cultural effects of sterilisation may be intense. If a woman marries again after sterilisation, her new husband might be displeased with her inability to bear him children, causing tumult in the marriage. Hence the issue of gender-based violence is likely to be present when forced and coerced sterilisation occurs. This finding is relevant to this study, which aimed at finding out if this is the same for women who were sterilised in Namibia. Building on this, this study delved into an analysis of the types of emotional and psychological challenges experienced by the women and looked into the possible intervention programs that can be developed thereof.

As mentioned before, the only scientific investigations on forced and coerced sterilisation in Africa were done in South Africa and this study adds on to this literature. The next section delves into aspects of forced and coerced sterilisation and mental wellbeing.

2.4 Forced and coerced sterilisation and mental well-being

Currently no studies have focused specifically on the psychological impact of forced and coerced sterilisations of WLHIV. However, a wealth of information on the subject can be drawn from studies done on voluntary sterilisations and loss of fertility in other populations. While it can be difficult to measure or determine the psychological effects of sterilisation due to extraneous variables such as poverty and other life stressors, a relationship or correlation between psychological problems and sterilisation may still be

established. There are several trends surrounding the psychological health of those who have been subjected to forced sterilisation.

In a qualitative report of the experiences of WLHIV who were sterilised in South Africa some aspects of the effects of forced sterilisation on mental wellbeing were highlighted. Although the study did not focus on mental well-being specifically, it was found that “most respondents reported on-going and significant emotional distress because they can no longer bear children, with a few women even reporting clinical depression and the use of anti-depressants” (Mthembu, Essack & Strode, 2011, p. 25). In the same study, symptoms of “feelings of trauma, isolation, helplessness and stress” were also reported (Mthembu et al., 2011, p. 25). Lin et al. (1996) in their study on sterilisation of both men and women in China also found symptoms of depression and anxiety, indicating that the risk for depression was 2.34 times greater after tubal ligation, and 3.97 times greater after vasectomy.

In a study by Leppert, Legro and Kjerulff (2007), in the United States of America, in which research participants were women who had voluntarily decided to be sterilised due to medical reasons, the study assessed the implications of loss of fertility on women’s mental health. Of the respondents, about ten per cent desired to have more children and there were differences in psychological distress between respondents who desired children and those who did not. Those who desired to have children had higher levels of depression, anxiety, anger, and confusion, which persisted for two years, and were more than twice as likely to have seen a mental health professional for anxiety or depression before surgery. Conclusions were that loss of fertility should be discussed

unequivocally with women to minimize chances of psychological distress, for psychological distress was found to be present in a significant number of individuals who voluntarily chose to be sterilised. If psychological distress and mental health concerns are present for women who actively and knowingly choose to undergo sterilisation, one can only imagine how much more the risk is for psychological distress for women who are forcibly sterilised. If an individual goes into the procedure after being coerced or with a lack of understanding of the procedure and its consequences, he or she is more likely to suffer negative psychological consequences afterwards.

Oliveira et al. (2007) had similar findings when they investigated sterilisation of HIV positive women in Brazil, a developing country just like Namibia. Results revealed that ninety-six per cent of the women in the study who were diagnosed to be HIV positive and had voluntarily consented to sterilisations indicated that the reason for their choice was that they did not want to have any more children. The recommendation from this study was that non-coercive counselling should be provided so that HIV-positive women can make informed decisions on their reproductive options, indicating that the women need psychological support prior the operation. So, it becomes worse for those that are forcibly sterilised and only find out only after the procedure has been done, meaning that the psychological implications may be adverse.

Correspondingly, Winston (1977) investigated why 103 women in Britain asked for reversal of sterilisations. He concluded that it is unwise to sterilize women who are under thirty years immediately after pregnancy or if their marriage was in jeopardy because often they may regret and desire to have more children. In a case in Chile,

reported by the Centre for Reproductive Rights (2012), a young woman aged twenty-one who was forcibly sterilised was reported to continuously suffer physical and psychological harm from this human rights violation. This shows that negative psychological effects may occur and they can persist after the sterilisations, thus they need to be addressed.

Kendall and Albert (2015) investigated the experiences of coercion to sterilize and forced sterilisation among WLHIV in Latin America. Results indicated that HIV-related stigma and discrimination by healthcare providers was found to be a primary driver of coercive and forced sterilisation and that WLHIV are most vulnerable to forced sterilisation when they seek maternal health services. Twenty-three per cent of the participating WLHIV received pressure to sterilize after they were diagnosed to be HIV positive. Unlike the WLHIV whose statuses were unknown during their pregnancy, those who knew their status were six times more likely to experience forced and coerced sterilisation. Among other things, Kendall and Albert (2015) recommend health worker training on HIV and reproductive rights and improving counselling on HIV and sexual and reproductive health for WLHIV. This to some extent communicates that the mental well-being of WLHIV is important, especially when they are confronted with life changing decisions like sterilisation. This further justifies why it is a high priority to focus attention on the psychological functioning of the women who have undergone forced sterilisation.

In an article by Holt (2005) on cases of forced and coerced sterilisation in which Roma women were sterilised because of their affiliation to a minority ethnic gypsy group,

women became outcasts in their community because being unable to have more children is abhorred in a society where a woman's fertility is much valued. Likewise, there are socio-cultural expectations of womanhood and motherhood in African contexts that greatly influence the extent to which women are able to cope with the effects of sterilisation within their communities. Feelings of isolation, worthlessness, helplessness and lack of belonging may be present in such situations.

In summary, the studies show that due mental health effects may include psychological symptoms of anxiety, depression, isolation, stress, psychological distress, feelings of worthlessness and helplessness. The present study sought to investigate the presence of any psychological effects on the WLHIV who were forced and coerced into sterilisation in Namibia. Although there is limited literature on forced and coerced sterilisation of WLHIV, the studies presented above reveal that it is a life changing experience, which may have negative psychological and socio-cultural effects. This research relevantly explored these effects.

2.5 Conceptualization of the study/ Theoretical framework

This study draws on theoretical concepts of stress and coping (Lazarus, 1993), and how these relate to psychological well-being and healthy socio-cultural functioning. According to Plattner and Meiring (2006), having HIV can be very stressful and the addition of being subjected to forced and coerced sterilisation is most likely to heighten the distress. How one manages to cope with such difficult life experiences becomes important.

Lazarus (1993, p. 237) in his theory of stress and coping defines coping as the “on-going cognitive and behavioural efforts to manage psychological stress”. This theory distinguishes between problem-focused coping and emotion-focused coping. With problem focused coping, focus is on altering the disturbed person-environment relationship by acting on the environment or oneself. Emotion-focused coping emphasizes “changing either the way the stressful relationship with the environment is attended to (as in vigilance or avoidance) or the relational meaning of what is happening, which mitigates the stress even though the actual conditions of the relationship have not changed” (Lazarus, 1993, p. 238). Altering the relational meaning is extensively used for regulating stress and emotion (Lazarus, 1993). For this reason, the theoretical concept of meaning making was also important to consider in this research.

Park and Folkman (1997) describe meaning making as a psychological process that explicates the manner in which people make sense of stressful and potentially harmful events. For example, a cognitive reappraisal of a stressful event may be made which eliminates the threat, and this change of meaning is a healthy and effective approach to coping. On the other hand, meaning in which the individual blames himself or herself for the occurrence of a stressful circumstance is unhealthy and may lead to failure to cope. Plattner and Meiring (2006) advance that the question ‘why did this happen to me’ is usually asked when individuals are faced with life changing, traumatic and stressful events, thus they try to comprehend the events by creating meanings. To effectively gather the meanings women attach to being sterilised, this study utilized a narrative approach which explores participants’ biographies and their social and cultural stories,

interpreting these by fully understanding people's life experiences and how they handle them (Biggerstaff, 2012).

In summary, this chapter has illustrated that there is limited research on the forced and coerced sterilisation of WLHIV. However, the few studies that have been conducted on this subject matter show that individuals who are subjected to this human rights violation often suffer adverse consequences. Previous findings have outlined social, cultural, functional, medical as well as possible psychological effects. The available literature on stress, coping and meaning-making also elucidates how stressful or traumatic situations events affect well-being, especially emotional and mental well-being. The literature review provides not only a justification for the study, but it also contributes to the methodologies used as well as to the discussion of results, conclusions and recommendations.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The aim of this chapter is to outline the research methods used in this study to give a clear picture of how the research was conducted. A qualitative methodological approach was used for the present study. This chapter highlights and discusses the research design, research instruments, research procedure, data analysis, and research ethics.

3.2 Research approach and research design

This study utilized a qualitative research approach to gather in-depth information to describe the psychological and socio-cultural effects of forced and coerced sterilisation. Qualitative methods are useful and appropriate when there is need to explore people's feelings or request participants to reflect on their experiences (Biggerstaff, 2012). While it is difficult to generalize findings from qualitative research, this approach to research is suitable for the present study whose purpose is to understand topics deeply and in detail. It allows for in-depth analysis of issues and addresses research purposes where little is known, and the aim is to make sense of complex situations and multi-contextual data, such as in this research (Richard & Morse, 2007). In this study, the aim was to learn from participants about an issue, how they experienced it and how they interpreted (and still interpret) what they experienced; hence the choice of a qualitative approach, which allows for a complete discovery of individuals' perceptions and the complexity of their understanding (Richard & Morse, 2007).

The case study research design was used in this study. Case studies can be defined as empirical inquiries that investigate phenomena within real-life contexts, providing in-depth and multi-sided information that often sheds light on issues pertaining to human thinking and behaviour (Yin, 2017). In particular, a multiple case study design was utilised, whereby multiple cases (seven) of forced and coerced sterilisation in Namibia were studied. This enabled the researcher to analyse the data within each situation and across different situations, tapping into differences and similarities (Gustafsson, 2017). This research design was selected because it allows an investigation to retain the holistic and meaningful characteristics of real-life events. This was significantly relevant for this study because it sought to fully understand and explore how the participants experienced forced and coerced sterilisation by delving into all areas of each participant's life. This research design provided detailed and rich qualitative information. It permitted investigation of otherwise impractical or unethical situations and also provided insight for further research (McLeod, 2008).

3.3 Population

The target population for this study was the 40 women who were victims of forced sterilisation in Namibia, whose cases were documented since 2007-2008. The population data was obtained from Namibia Women's Health Network (NWHN), the NGO that has been spear-heading advocacy initiatives pertaining to the forced and coerced sterilisation cases in Namibia.

3.4 Sample

Convenience sampling was used to select a sample of seven WLHIV who were victims of forced and coerced sterilisation in Namibia. Convenience sampling is whereby subjects are selected because of their convenient accessibility, availability and proximity to the researcher (Kothari, 2004). According to Dworkin (2012), a sample size of seven is appropriate for qualitative studies that seek to obtain in-depth information. Participants were selected according to their availability and as well as their proximity to the researcher. Therefore, only participants residing in the Khomas region of Namibia were selected to be part of the research. With the assistance of NWHN, available research participants from the target population were identified. A sample of seven participants provided sufficient data for qualitative analysis (Terre Blanche, Durrheim & Painter, 2006).

3.5 Research instruments

The researcher made use of semi-structured interview schedules (see APPENDIX D), which were developed by the researcher using literature on forced and coerced sterilisation. These were used to obtain detailed information about the psychological effects, socio-cultural functioning, physical well-being and other issues of adjustment after the sterilisation. Socio-demographic variables collected in this research are age, marital status, number of children, sterilisation date, and type of sterilisation performed, level of education, employment status and occupation.

The interview questions were translated into Oshiwambo, since all the members of the target population are primarily Oshiwambo speaking (NWHN, 2015). Language

differences and translation in research may have challenges and meaning may be lost during translation or interpretations. In order to enhance the quality of translation; two independent individuals were hired to do the translation. The first translator translated the interview guide and consent form from English to Oshiwambo and a second translator was asked to review the translated documents for consistency in meaning. A pilot study was done to inform the editing and finalization of the research instrument, for content validity purposes.

3.6 Procedure

The procedure followed in the processes of this research was in such a way that a step-by step or systematic manner was followed.

Step one: Ethical clearance to conduct the study was obtained from the University of Namibia. Thereafter, the first step was to translate the interview guide and consent form from English to Oshiwambo. A second independent bi-lingual consultant was engaged to check and verify the translated documents for consistency in meaning.

Step two: When these documents were ready, the second step was to recruit and train the research assistants for data collection. The researcher recruited and trained three research assistants who are Oshiwambo speaking to conduct the individual interviews since the researcher and research participants do not have the same native language. The training was imperative to also ensure that challenges that usually come with language differences and translation are addressed. One of the expected outcomes of the training was that all the research assistants would have the same understanding of the meaning

denoted by the questions in the interview guide, in order to ensure issues of validity and reliability. This meant that, the responses obtained from the interviews were directly linked or would speak to the research objectives. The three research assistants have a background in Psychology and this was done deliberately to ensure that information on the psychological well-being of the participants was adequately captured. The researcher conducted one-day training with the research assistants, which covered the research processes, the interview guide content and how to conduct the interviews. The training included role plays in which the assistants were able to practise how they would conduct the interviews.

Step three: The third step was to conduct a pilot study with one representative of the target population, to further inform research procedure, the editing and finalization of the interview schedule. According to Baker (1994), a pilot study should constitute at least ten to twenty per cent of the sample size. Hence, one participant was appropriate. The feedback derived from the pilot study further informed the research process.

Step four: After the pilot study the fourth step was to conduct a two-hour information briefing session with the research assistants to relay the important points that came from the pilot study, points that they needed to pay attention to.

Step five: The fifth step was recruitment of participants by selecting a sample of seven participants from the target population of forty individuals. For recruitment of research participants, the researcher used convenient sampling and worked together with Namibia Women's Health Network (NWHN) and the International Community of Women Living with HIV (ICW), the organizations that have been assisting the women who were victims of forced sterilisation. The research participants were briefed telephonically

about the research and its aims and objectives. Only those interested were invited to the NWHN office where the researcher further explained in detail all aspects of the study before she obtained consent from them.

Step six: After consent was obtained, the participants were asked to select a pseudonym (for confidentiality) which was then used when the participants were introduced to the research assistants. With informed consent from the participants, the interviews were audiotape recorded and transcribed. The interviews were sixty to eighty minutes long. After transcription, the transcripts were translated into English for analysis.

Step seven: After the data was collected, the next step was data analysis. The researcher sought for the qualitative data analysis software Atlas ti 7 from the University of Namibia's computer centre. The data were analysed and the report of the research study compiled.

3.7 Research ethics

Research ethics refers to the application of moral rules and professional codes of conduct to the collection, analysis, reporting and publication of research data (Gordon, 1998). This research took into consideration ethical issues of confidentiality, anonymity, privacy, informed consent, deception, debriefing, mental and physical stress and discomfort, recognition of participants' rights to withdraw, and problems with involuntary participation and intervention (Coolican, 2009).

The goal of considering ethical issues in this research was to ensure that the research participants are protected throughout the research process, considering the vulnerability of the target population. To ensure confidentiality, anonymity and privacy, the research

assistants and translators signed confidentiality clauses. The use of third parties in research is often crammed with ethical issues, so the researcher ensured that each research assistant signed a confidentiality form in which they stated that they would be sworn to non-disclosure under whatever circumstances. The data collected were stored, reported and distributed in such a way that no identities of participants were used (pseudonyms and participant codes used instead).

The researcher ensured that full informed consent was obtained from each participant (see APPENDIX B for consent form). The nature of the research and how the results are going to be published and used was clearly articulated to participants before they signed consent forms and they were also informed that participation was strictly on a voluntary basis and in no way compulsory. Additionally, the researcher informed the participants of their right to withdraw from the study any time if they felt the need to. To ensure that the participants fully understood what the research was about and that there were no language barriers, the consent forms (which had full information about the research) were translated into Oshiwambo, the native language of the participants. No names were used or written down; instead, a pseudonym and a coding system were used to identify participants. The identities of the research participants were (and will be) kept anonymous throughout the research process; during data collection, the data analysis, reporting and publication processes

The target population is vulnerable because of the stigma and discrimination associated with being HIV positive and being sterilised. Additionally, the nature of the research was such that the possibility exists for research participants to re-experience the distress

they suffered when they were forcibly sterilised. Therefore, the goal of the researcher was to minimize psychological harm during the research through ensuring that counselling and debriefing were readily available when need be during the research process. The researcher utilized research assistants with a psychology background (i.e. Masters of Arts in Clinical Psychology students and Bachelor of Psychology students), and they were better positioned to detect and mitigate psychological distress. To some extent, discomfort was also minimized by the fact that the interviews were conducted in a setting that the participants were familiar with and felt safe in (Namibia Women's Health Network offices). Assuring the research participants of anonymity, confidentiality and privacy also helped minimize discomfort and encouraged openness when responding to interview questions.

Considering the fact that the research topic may be uncomfortable or stressful for participants (Bahn & Weatherill, 2013), it was imperative to employ some strategies to mitigate this. One of the strategies used being the incorporation of the narrative style in the interview guide, an approach whereby a case is presented to the participants and most questions are then related to the case rather than directly to the participants. This was done to keep some distance (psychological distance) between the research participants and the issue being researched, to minimize tension and harm. This also allowed the participants to be more open and free in sharing their thoughts and stories (Alty & Rodham, 1998).

There was also need to consider and protect the research participants from legal implications that may arise from the outcomes of this study (that is, possible use of

research outcomes legally to counter the Supreme Court ruling, which was in favour of the women). The researcher sought for legal advice from lawyers who have been handling the forced sterilisation cases, to find out if there are possibilities of infringing on the legal rights of the participants by conducting this research. During the discussions with the lawyer, the researcher was informed that, in the Namibian context, a Supreme Court ruling could not be appealed against. Hence, in that regard, the participants' legal rights were protected. The researcher ensured that all ethical considerations were well thought-out and implemented before, during and after the research process.

3.8 Data analysis

Content analysis was used to interpret meaning and derive themes. This interpretive analysis method was used to provide a thorough description of the psychological and socio-cultural effects obtained from the data. The following steps derived from Terre Blanche et al. (2006) were taken:

Step 1 Familiarization and immersion: Data from this section was studied thoroughly through a repetitive process.

Step 2 Including themes: Themes were extracted in relation to research objectives.

Step 3 Coding: The data was demarcated analytically.

Step 4 Elaboration: Themes were explored more closely, and sub issues identified.

Step 5 Interpretation and checking: A written account of the findings was produced and checked which is reported in the results section of this document.

The qualitative computer software analysis, Atlas ti 7 obtained from the University of Namibia, was used to assist with analysis, specifically during the coding process.

3.9 Procedural rigour

The present study's validity was determined using the concept of trustworthiness, which was assessed using the criteria of credibility, dependability and confirmability, (Golafshani, 2003). "While the terms reliability and validity are essential criterion for quality in quantitative paradigms, in qualitative paradigms the terms credibility, confirmability and dependability are essential criteria for quality" (Golafshani, 2003 p. 601). Credibility refers to the degree of correspondence that exists between the findings of a study and reality. Dependability establishes the research findings as consistent and repeatable. Confirmability refers to issues of bias and how it can be verified that participants shape the findings, more so, than they are shaped by researcher (Golafshani, 2003). To establish credibility, dependability and confirmability, the present study utilized analyst evaluation whereby another analyst (supervisor of this research) was used to review the research findings as well as the research protocol and research instruments. This was helpful in illuminating blind spots throughout the research processes, including the analysis process. Additionally, a well-established research method, a censoriously developed research instrument and a verified research procedure (through a pilot study) also helped with credibility, dependability and confirmability. The researcher also utilized peer examination, in which the research process was discussed with uninvolved peers with the intention of keeping the research process honest and enabling an analysis that was more deeper and reflexive (Golafshani, 2003). Please see chapter six for a further reflection on the aspect of bias.

In summary, this chapter outlined the research methodology that was used in this study. The rational for selecting the qualitative approach was laid out, highlighting the

importance of using qualitative methods in obtaining in-depth and detailed information when researching people's experiences, perceptions, interpretations and understanding of both their personal and social contexts. Ethical issues were considered judiciously throughout the research process, especially considering the vulnerability of the target population. Finally, issues of credibility, dependability and confirmability in the research processes were deliberated.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the research findings following the analysis of the data obtained. The aim of this study was to explore and obtain an in-depth understanding of the psychological and socio-cultural implications of forced and coerced sterilisation on Women Living with HIV in Namibia. In addition, the purpose was to ascertain what the implications for interventions could be. This was done through analysing patterns, trends, similarities and differences within seven cases. The results are hereby presented with reference to the following four research objectives that informed this study:

- a) To explore the negative psychological symptoms resulting from forced and coerced sterilisation;
- b) To describe the socio-cultural effects of forced and coerced sterilisation;
- c) To investigate the meanings that individuals attach to the circumstance of being forced and coerced into sterilisation and how these influence coping;
- d) To find out if there is need for psychological, social and other forms of interventions for the women who were victims of forced or coerced sterilisation.

During in-depth interviews, research participants described in detail their experiences with forced and coerced sterilisation. They also gave recommendations that can be used in interventions or as interventions going forth. The research findings that this chapter reports are based on analysis of one data source, that is, semi-structured interviews.

To present the research results, an outline and analysis of demographic data is given at the beginning. After that, brief biographical summaries of participants are recorded. Thereafter, themes and subthemes that emerged from the data are considered separately, highlighting and expounding them in relation to the experiences of the research participants.

4.2 Demographic data

Table 1 below has detailed information on the characteristics of research sample (n=7).

Table 1: Research participants' demographics

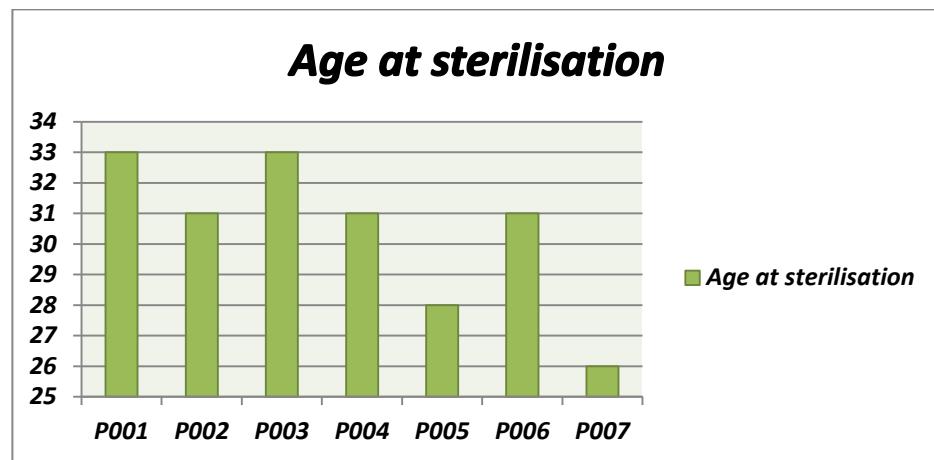
Participant Code	Age	Highest Education level obtained	Employment	Marital status	Sterilisation date	No// of Biological Children
P001	43	Grade 10	Unemployed	Previously married-Separated	2007	4
P002	44	Grade 10	Volunteer	In a relationship- 6 years	2004	4
P003	43	Grade 12	Employed-Night supervisor in catering	In a relationship -2 years	2007	3
P004	41	Grade 12	Unemployed	Married- 5 years	2007	3
P005	39	Grade 9	Employed-Security guard	Single	2006	2
P006	41	Grade 9	Employed-cleaner	Married- less than 12 months	2007	2
P007	38	Grade 6	Unemployed	Divorced	2005	3

All research participants were Oshiwambo speaking. They all resided in the informal settlements, suggesting that they are from a low socio-economic status. The participants' occupations also indicate low socio-economic status or poverty. Three of the participants

were employed, one as a security guard, one as a night supervisor in catering and the other as a cleaner. Those that were unemployed indicated that they sometimes sold in the market, volunteered or did casual housekeeping jobs. Only two out of the seven research participants were married, three have never been married, one was divorced due to forced sterilisation and one was previously married but separated, also because of the sterilisation. Two of the participants were in intimate relationships of two and six years respectively. Table 1 also shows that all the women have biological children, ranging between two to four children each. The research participants' ages ranged between 38 years and 44 years (average age = 41.3).

At the time of the research, it had been ten to thirteen years since the sterilisations occurred. Participants were sterilised when they were in their late twenties to early thirties, a critical period for child bearing for women (see Figure 1).

Figure 1



4.3 Biographical summaries of the participants

Participant one

Participant one is aged 43, is separated from her husband and is not in a relationship. She was separated from her husband in 2013 after he found out that she was sterilised, and he was not informed about it. She has four children, all female. She is unemployed but does casual jobs such as housekeeping. She was sterilised without informed consent in 2007 (when she was 33 years) at childbirth, during which a caesarean section was done. After giving birth, she experienced many health problems that the nurses and doctors could not explain or treat adequately. She only found out that she was sterilised in 2013 (10 years later) because of the stop forced sterilisation campaign that was conducted by Namibia Women's Health Network.

Participant two

Participant two is aged 44. She has never been married before and she has been in an intimate relationship for six years. She has four female children, and works as a volunteer community worker for a local NGO. She was sterilised without informed consent 13 years ago in 2004 (when she was 31 years), at childbirth, during which a caesarean section was done. She found out that she was sterilised 6 weeks after giving birth when she went to seek for family planning, only to be told that she was sterilised, and she does not need it because she was sterilised. She mentioned that she believes she was sterilised because of her HIV status.

Participant three

Participant three is 43 years old. She works as a guard. She has never been married before and she has been in an intimate relationship for two years now. She has three biological children and takes care of eleven children from her siblings. She was sterilised without informed consent 10 years ago in 2007 (when she was 33 years) at childbirth, during which a caesarean section was done. She found out that she was sterilised 6 weeks after giving birth when she went to the hospital for postpartum examination. She mentioned that she believes she was sterilised because of her HIV status.

Participant four

Participant four is 41 years old. She is not employed but does casual housekeeping jobs. She has been married for five years and has three biological children. She was sterilised without informed consent 10 years ago in 2007 (when she was 31 years) at childbirth, during which a caesarean section was done. She found out that she was sterilised in 2010 after checking her health passport because of the stop forced sterilisation campaign that was conducted by NWHN.

Participant five

Participant five is 39 years old and she works as a security guard. She is single and she has two children. She was sterilised without her consent in 2006 (11 years ago), when she was 29 years old, during childbirth. She found out she was sterilised a day after giving birth while she was still in hospital and the doctor told her that they sterilised her because she is HIV positive.

Participant six

Participant six is 41 years old and works as a cleaner. She is recently married (not more than a year) and she has two biological children. She does not have any children with her spouse. However, she is taking care of her husband's child and a relative's child.

Participant six was sterilised in 2007, 10years ago when she was 31 years old. She was coerced into sterilisation with the doctors telling her “we were told by our boss that we must sterilize all women who are positive, so if you don't want then we can't help you to deliver your baby... I decided to sign as I was afraid that something might happen to my baby”. Therefore, there was use of threat to get her to consent to the sterilisation.

Participant seven

Participant seven is 38 years old. She is divorced and has three children. She was coercively sterilised in 2005 (when she was 26 years old) at childbirth during which a caesarean section was done. She explained that, “the doctor said you are going to be sterilised, I said no, he said you are even HIV positive, if you don't want then see what you will do. I was in pain I couldn't even talk, because I refused to be sterilised they waited until I became tired, because I was in pain for so long I decided to sign.”

4.4 Themes

To give meaning to the rich qualitative data that were collected, themes were derived. Five primary themes were identified and each of these themes consists of several subthemes (see Table 2). The themes were; psychological symptoms, negative health effects of forced and coerced sterilisation, sterilisation and culture, negative social

effects of forced and coerced sterilisation and support and coping with sterilisation. The themes were selected based on the prominence with which they recurred throughout the data. These themes are elaborated and discussed according to the subjective and contextual experience of each research participant. The unique personal experiences, beliefs and perceptions of the participants have been carefully captured and illustrated with the use of direct quotes from the participants. The data pertaining to each theme and subtheme are summarized and interpreted. The interpretations made characterize the researcher's subjective endeavour to provide a true and accurate understanding as to the meaning of the participants' experiences.

Table 2: Themes

Index	Themes	Subthemes	Example Quote
4.4.1	Psychological symptoms	a) Anxiety and stress b) Isolation/withdrawal c) Fear d) Overthinking/ Ruminating e) Feelings of helplessness f) Feelings of hopelessness g) Feelings of worthlessness h) Feelings of sadness i) Feelings of anger j) Change in sleep pattern k) Change in weight l) Loss of interest m) Self-blame/ Blame n) Shame	<i>"It causes me to have headaches because I am always thinking too much about all those things...this will not leave one's mind; more especially when you are thinking that, you will not have the number of children that you wanted anymore... mind is always occupied by this problem." (Participant three)</i> <i>"Yes, I blame myself because I ask myself why I came in this world to face this kind of things." (Participant five)</i>
4.4.2	Negative health effects of forced and coerced sterilisation	a) Physical symptoms /Health effects b) Poor health care service provision	<i>"When I got sterilised that was in 2007 December, but since that year 2007, until now, I am just having severe pain almost every month. It is back pain, heavily bleeding and that is where I started being concerned... the bleeding is too much, it takes about 2 weeks... you cannot even be able to walk, not at all. When you go to the hospital you don't get any help, they will just tell you that is just how you will be" (Participant one)</i>
4.4.3	Sterilisation and culture	a) Cultural expectations of marriage and	<i>"In our culture there is no sterilisation. People are against it, they are not happy with</i>

		reproduction b) Cultural principles in decision on making	<p><i>it. For us we are 12, so I wanted to have many children as much as I can now I cannot. In my culture people will go for many children they don't know sterilisation".</i> (Participant seven)</p> <p><i>"...then, my husband said how could she get herself sterilised without letting me know. That is when the conflict started...Yes, he was saying that, "how can you get yourself sterilised without informing me?,,, you are married you cannot be sterilised without letting your husband know."</i> (Participant one)</p>
4.4.4	Negative social effects of forced and coerced sterilisation	a) Effects on interpersonal relationships and Gender-based violence b) Discrimination c) Victimisation d) Effects on Occupational functioning	<p><i>"This feeling (stress) does not end, it is always in my mind. There are things that make sterilisation even more difficult to live with, such as revealing it to someone who wants to marry you. In my life so far, I have been left by three men who wanted to marry me, but just because I can't have children they left".</i> (Participant three)</p>
4.4.5	Support and coping with sterilisation	a) Support received after sterilisation b) Meanings attached to forced and coerced sterilisation and coping	<p><i>"Yes, You know sometimes it really bothers you, for example if you come across someone with a baby, it just comes into your mind that I wish I can able to have a baby again and be like her, although now I am growing old, those years I think like that.."</i> (Participant two)</p> <p><i>"The only help I got, is from the support groups that I have been attending, as well as from the organization that is called Namibia Women's Health Network, it has given us a lot of help."</i> (Participant two)</p>

4.4.1 Theme one - Psychological symptoms

In order to explore the indications of negative psychological symptoms that may be associated with forced and coerced sterilisation, the semi-structured interview guide had a specific section on sterilisation and mental health problems which intended to tap into aspects related to this research objective. This objective was also addressed throughout the interview because as the women narrated their experiences they also reflected on their feelings, emotions and thoughts. The aim was not to make psychological assessment for diagnosis, but rather to explore possible psychological symptoms that women who were forced or coerced into sterilisation may experience. It is important to note that the questions asked in this study were mainly related to some psychological

symptoms associated with mood disorders, anxiety disorders and trauma and stressor related disorders. This study did not exhaust all possible psychological symptoms. However, as the participants shared their experiences they highlighted some symptoms that were not asked in the questions (for example anger, shame, helplessness, hopelessness and worthlessness). This indicates that the interviews brought out more. Analysis of the participants' data brought about the following symptoms under the theme psychological effects of sterilisation.

Table 3: Psychological symptoms

Psychological Symptom	Number of participants who mentioned symptom	Examples
a) Anxiety and stress	7	<i>"In my culture, children are very important because if you cannot have children, you are not counted as valuable in the community. Some women have one child; therefore, they face hurtful words such as, you only have one kid, what if she dies. This kind of statement can be very stressing." (Participant three)</i>
b) Isolation or withdrawal	6	<i>"Physically you might be present together with people but mentally you are totally not there." (Participant three)</i>
c) Fear and anxiety	7	<i>"I don't trust them anymore. That is why even the paper they gave my daughter at hospital, maybe they just want to look for way to sterilize her. I'm afraid of them." (Participant seven)</i>
d) Overthinking/ Ruminating	5	<i>"It causes me to have headaches because I am always thinking too much about all those things...this will not leave one's mind; more especially when you are thinking that, you will not have the number of children that you wanted anymore... mind is always occupied by this problem." (Participant three)</i>
e) Feelings of helplessness	7	<i>"If for example you ask them, to give you your file saying that I need my hospital file, maybe there is someone out there who might be able to help me, so I might need to take it there to see what kind of medicines I will be able to get, to help me feel much better. The file is not there". (Participant one)</i>
f) Feelings of hopelessness	7	<i>"I thought it is over, I do not know what to do anymore." (Participant five)</i>

g) Feelings of worthlessness	5	<p><i>"You will feel that you are no longer useful...I was thinking that I am no longer a real woman." (Participant four)</i></p> <p><i>"...to me it's like I am not important..." (Participant five)</i></p>
h) Feelings of sadness	7	<p><i>"Yes, if it just comes to your mind you will start crying. I know I am a big person but if you just happen to think of your life before and your life now you will just start crying. Or if you see others being active and you will also want to do the same but you just can't, because most of the times I feel so weak and without any strength and that is what makes me cry." (Participant two)</i></p>
i) Feelings of anger	1	<p><i>"I do not know why they did this to me; they were supposed to let it in God hands, who give them that permission? They caused problems in our lives, we are bleeding every time, and some of us we are divorced, because man cannot stay with barren woman. They must know that whatever they did to us was very wrong; they were supposed to let us know. They cannot decide what is right for us. Who told them those women who are HIV positive deserve to be sterilised? Because for me I told them that I wanted help I do not want to be sterilised, but they did not listen to me, they forced me." (Participant seven)</i></p>
j) Change in sleep pattern	6	<p><i>"...before I used to sleep well because you do not have a lot things to think about, but after I got sterilised. even though that day you are not in pain you are still thinking what to do while you are not sick, because you already know that after a few days I will start getting sick again. Even if you try to sleep, you won't really sleep peacefully because you are just thinking of the pain." (Participant one)</i></p>
k) Change in weight	5	<p><i>"Being sterilised, it brings changes in body weight, that day my weight was at 68Kg, now my weight is 30 Kg. It real changed me." (Participant five)</i></p>
l) Loss of interest	3	<p><i>"I remember during those years 2007 and 2008, I liked singing very much, singing songs with youths, but those two years I did not sing, I was just in the house, thinking that it is over." (Participant five)</i></p>
m) Self-blame/ Blame	7	<p><i>"Yes, I blame myself because I ask myself why I came in this world to face this kind of things." (Participant five)</i></p>
n) Shame	3	<p><i>"...and I was kind of feeling ashamed because, I was thinking that I am no longer a real woman." (Participant four)</i></p>

Psychological symptom 1- Anxiety and stress

Anxiety is “a distinct internalized emotion as it arises internally from a perceived threat” (Roy, 2010, p.1) and according to Furnham (2008, p. 31), “stress is different things to different people”. The present study considered anxiety and stress in relation to both the presence of a stressor and in relation to how individuals emotionally respond to the stressor. So, the subjective definitions and perceptions of individuals about how they feel are considered. This also includes aspects of demand and control, whereby the physical and psychological demands or challenges exerted on an individual by a stressor are weighed against the control they have to meet the demands or solve the challenges. Thus, “high demand and low control situations are the worst” and often lead to anxiety and stress (Furnham, 2008, p. 28). The way individuals appraise a stressful situation is very important, hence the subjectivity of the descriptions and experiences of stress.

The participants expressed the stress and anxiety using terms such as, “it was very stressful”, “I was very worried”, “ I am always feeling bad”, “ it worries me a lot”, ‘my heart would beat very fast”, “ it troubles me”, “I feel uneasy”, “I am concerned about my health all the time”, “I was disturbed by the news”, “it’s always on my mind”, and “it does not give me peace in my mind”. According to the results, the participants expressed that the stress resulting from the forced sterilisation, was (and in some cases still is) caused by the infertility (as they all wished to have more children), the negative severe health effects, the negative socio-cultural effects and the resulting financial difficulties. These are discussed in detail as themes and subthemes in sections 4.3.2, 4.3.3, and 4.3.4.

Psychological symptom 2- Fear

According to Roy (2010, p.1), fear can be defined as “an externalized emotion or feeling which may or may not be accompanied by bodily reactions and fear could be conscious or unconscious”. From the analysis of the data, all participants reported experiencing fear because of forced and coerced sterilisation. They described the fear using words such as “afraid”, “terrified”, “scared” and “shocked”. The causes of the fear however vary, and these include; fears linked to the negative physical health and mental health effects that resulted from forced sterilisation, fear of disclosing sterilisation to intimate partners, family and community, fear of rejection by intimate partners, fear of future loneliness, fear of discrimination, fear of victimisation and fear of contact health centres and health professionals.

Psychological symptom 3- Withdrawal or isolation

According to Jones-Smith (2016, p. 245), “interpersonal isolation pertains to the chasm that exists between yourself and other people”. The forced and coerced sterilisation experience resulted in six of the participants being isolated or estranged by her spouses, intimate partners and family. Participant six did not report of being isolated by family or community because of the sterilisation because she has not told anyone, except her spouse. Additionally, two participants (participants five and seven) reported of feelings of wanting to withdraw. It is interesting to note that in order to avoid being discriminated at macro level, participants one and six, did not disclose to the community. Isolation was also a way of avoiding the verbal and emotional abuse that came with being sterilised both in family and community settings. It was also a way of trying to avoid the stress that comes with seeing other women pregnant or with their babies. One participant (participant three) experienced some isolation where she would

mentally isolate herself from others. She never isolated herself physically and said, “Physically you might be present together with people but mentally you are totally not there”.

This symptom has since resolved for five participants and they highlighted that the support they received from NWHN, support groups and church helped with this symptom. However, for participant five this symptom persists. She experienced an extreme case of isolation. Her family ostracized her for being sterilised. She said,

My family decided to chase me out of their house. The problem is still there, my family they are not even visiting me, there is no one who check if I am fine or not, to me is like I am not important, even I tried to call them, they will not pick up,

Psychological Symptom 4- Loss of interest

Loss of interest is a common symptom for trauma and stressor related disorders and well as mood disorders. Loss of interest in daily activities is a symptom that three research participants experienced (four and five). This includes loss of interest in occupational activities (participants one), loss of interest in sexual intimacy and intercourse (participants four), loss of interest in hobbies (participant five). Loss of interest is a symptom that goes hand in hand with themes of stress and isolation mentioned above. The participants mentioned that the emotional support from NWHN and support groups helped them.

Psychological symptom 5- Change in weight

Change in weight (decrease or increase) is a psychological symptom that is usually associated with stress, anxiety, mood disorders and trauma and stressor related disorders.

Five research participants noted that they experienced a decrease in weight after being sterilised. The weight loss was due to negative health effects of the sterilisation, (“if you become too full your stomach will start paining as if there is a wound inside”- participant one) as well as due to loss of appetite because of the stress and depressed mood. For participant five, the decrease in weight was severe. From sixty-eight kilograms, she became thirty kilograms. Four participants still perceive change in weight as a challenge that they still face.

Psychological symptom 6- Change in sleep pattern

Six out of the seven research participants reported change in sleep succeeding forced sterilisation. The sleep problems described are characterized by failure to or difficulty falling asleep. This change in sleep pattern was mainly attributed to, the pain from the negative health effects they experienced and still experience, thinking about the pain, the stress and constantly thinking about the forced sterilisation. Participant five explained that her sleep problems were such that she could not sleep for three consecutive days, and she would have nightmares. The nightmares have since gone but she still experiences sleep problems and this affects her occupational functioning. Five of the participants (participant one, two, three, five and seven) reported that up to today they still experience sleeping problems. Two of the participants sought for assistance with this symptom at hospital but no effective treatment was provided. Two participants indicated that their faith has helped them minimize the effects of this symptom. For example, while participant three still has this problem to date, she indicated that she has developed some coping strategies that she uses sometimes, such as listening to gospel music to help her avoid the overthinking and to fall asleep. Participant four indicated

through her prayers, this problem ended. This is an indication of post-traumatic growth and the participants' resilience in to coping with this symptom.

Psychological symptom 7- Over thinking/ruminating

From the data provided by participants one, two, three, four and seven, the symptom of ruminating or overthinking was found. Ruminating refers to thinking deeply about something or being fixated and continuously dwelling on something. All seven participants exhibited this symptom in relation to forced and coerced sterilisation. The overthinking and ruminating tendencies were mainly linked to the negative medical, social and cultural effects of forced sterilisation. The blame received from family and community, the mistreatment and victimisation at hospital, shuttered dreams of having more children, shuttered dreams of marriage and the conflict in intimate relationship that started because of sterilisation all consist of the aspects that participants ruminate over.

Psychological symptom 8- Feelings of sadness

Sadness is a psychological symptom that is mainly related to mood disorders. All the seven research participants expressed that they experienced feelings of sadness and these were extreme when they first found out that they were sterilised. The feelings of sadness were usually, but not exclusively, characterised by excessive crying. The subsequent negative medical and socio-cultural consequences also presented as sources of sadness. For instance, for participant one, the feelings of sadness expressed were related to the fact that she was sterilised against her will, she was never going to be able to have children again, she subsequently lost her marriage, the constant pain and the lack of adequate treatment from hospitals. The participants expressed that the sadness has mostly subsided but it often comes back when triggers are present to remind them of the

forced sterilisation. Thus, the feelings of sadness are still present at varying intensity and frequency for the participants.

Psychological symptom 9 – Feelings of helplessness

All research participants expressed feelings of helplessness resulting from the fact that their ability to have children was taken away from them and it is something that they may not regain. The feelings of helplessness were also linked to the negative health effects and poor health care service provision at the hospital. Participant one for example shared that she expressed her desire for a hysterectomy at the hospital as a way of trying to get rid of the pain that she is feeling, but again a barrier was there as she was told to go and ask for a police declaration. Participant two indicated that, while she wishes to seek for assistance from private doctors, she does not have the financial means to do so, considering the fact that she is of low socio-economic status: highlighting the sense of helplessness. Very important to note are the ultimate feelings of helplessness expressed by participant three when she said, “I only want to add that, the government must give us what they have promised us in court one year ago. The government must also register our beneficiary for this program just in case something happen to any of these women because as we speak two of our fellow women has passed on already while waiting on this promise”. The research participant fears that she may die without receiving her compensation, yet she is helpless and has no control over the situation.

Psychological symptom 10– Self-blame/blame

All research participants reported to have experienced blame from others because of the forced sterilisation. However, five of the participants (participants three, four, five, six and seven) reported that they also blame themselves and regret that they were forcibly sterilised. When regret and self-blame are present, this in-turn influences the way an

individual copes with a stressful event in a negative way. The participants blame themselves for something that was out of their control and subconsciously they may have not yet fully acknowledged that the human rights violation was not her fault. This self-blame is likely to have a negative impact on ability to cope with this situation. Research participant five also experienced and continues to experience self-blame in an intense manner and this came out when she said, “Yes, I blame myself because I ask myself why I came in this world to face this kind of things”. In the above statement, participant five exhibits struggles with issues of existentialism as a consequent of the negative effects of forced sterilisation. For this participant, the effects on her mental wellbeing may be adverse and she may require psychological intervention. Participant seven also indicated that she regrets ever falling pregnant in the first place and this signals negative coping processes as the participant struggles to find the meaning of why she was forcibly sterilised. She may benefit from psychological counselling.

Psychological symptom 11 – Feelings of hopelessness

While a sense of hopelessness emerged slightly in the other six research participants' experiences especially in terms of the loss of fertility and poor health care services, for participant five, this theme came out distinctively. She said, “I thought it is over, I do not know what to do anymore”. This theme is closely related to the issues of existentialism that the client is struggling with as well as with the themes of stress, isolation, helplessness and blame mentioned above. The fact that she is unable to seek for assistance from private doctors also presents as a source of the feelings of hopelessness.

Psychological symptom 12- Feelings of worthlessness

Participants two, three, four, five and seven shared that they experience feelings of worthlessness due to being sterilised. This is due to the cultural values and principles

that attach a woman's worth and respect on her ability to bear children. The participants perceive themselves as worthless because of their inability to bear children. These feelings of worthlessness are strongly linked to themes of helplessness, hopelessness, stress, overthinking and fear. This significantly illustrates how forced sterilisation may be linked to negative mental health effects.

Psychological symptom 13- Feelings of anger

Anger is a psychological symptom that emerged specifically from participant seven's data. She showed anger as an emotion when she shared her experience. She expressed her anger, frustration towards the people who sterilised her and is still angry towards what happened to her, she has many unanswered question. This anger shows that she is still trying to make sense and find meaning of what happened to her. She therefore may have not fully coped with the situation.

Psychological symptom 14 - Shame

Three participants (participants two, four and six) showed symptoms of shame. Participant two first told her mother what had happened to her and she was sworn to silence, never to share the information with anyone because of the shame associated with a woman not being able to bear children. Due to this shame, she waited about three years before she could share the information with anyone. This theme also reflects the cultural aspects related to forced sterilisation. These feelings of shame may emanate from or may cause the feelings of worthlessness mentioned above as well as from socio-cultural expectations of motherhood. Due to the negativity associated with sterilisation and fear of discrimination, the research participant six was ashamed to inform her family and community about the sterilisation.

Fourteen psychological symptoms associated with depression and anxiety emerged in this study. This indicates that the women have experienced and continue to experience symptoms indicating psychological distress linked to forced or coerced sterilisation and its negative consequences. The information provided above does not represent diagnoses of psychological disorders, but it is rather an exploration and description of the psychological symptoms that may be associated with the forced and coerced sterilisation experience.

4.4.2 Theme two: Negative health effects of forced and coerced sterilisation

A dominant theme, that came out most strongly from the collected data is that of the negative health effects of forced and coerced sterilisation. The closely related subthemes of physical symptoms and poor health services that emerged are outlined below.

a) Subtheme one - Physical symptoms /Health effects

All seven research participants elaborately explained and emphasized that a major consequence of forced and coerced sterilisation has been the severe health problems that they have suffered and continue to suffer. All the participants complained about heavy menstrual bleeding, severe abdominal pain, severe back pain, weakness and problems with lower limbs. These physical symptoms are said to have started soon after the sterilisation operations and persist to this day. For example, participant one explained this saying,

When I was sterilised that was in 2007 December, but since that year 2007, until now, I am just having severe pain almost every month. It is back pain, heavily bleeding and that is where I started being concerned...

the bleeding is too much, it takes about 2 weeks you cannot even be able to walk, not at all. When you go to the hospital you do not get any help, they will just tell you that is just how you will be. (Participant one)

Participant five explained that she started having negative health effects after she was sterilised (and these still present and are severe), in particular, “heavy bleeding” whereby she “would fill three buckets a day” and “used and still uses pampers”. The negative health effects also meant financial strain and this was a cause for stress. According to her, she has been constantly hospitalized because of the heavy bleeding. The severities of the physical symptoms or health problems have been a cause of stress, helplessness, hopelessness and fear for the research participants. Participant one expressed that she would rather have a reversal, not because she was another child, but because she would like to get rid of the pain that she constantly has.

Most research participants indicated that due to their health problems, they have financial difficulties because they are constantly ill and they need to purchase a lot of pampers and sanitary pads for the heavy bleeding. In addition to the financial implications, the participants noted that the negative health effects have affected their day to day and occupational functioning. For participant five negative health effects have affected her work and income because she is hospitalized almost after every two weeks. All the participants indicated that doing heavy and strenuous jobs has become impossible because of the pain, thus they are now mostly unable do the casual jobs that gave them income to provide for their children. The pain serves as a trigger for negative emotions for all participants; hence, it contributes to most of the psychological symptoms mentioned above as well as to negative coping.

c) Subtheme two - Poor health care service provision

The above mentioned severe physical symptoms require the women to constantly seek for health services. Since all of them are of low socio-economic status, they cannot afford private health care hence they rely solely on state hospitals. All seven participants indicated that they have received poor health care services, specifying that they are not examined and treated properly, and no information is given to them regarding the status of their health. Participant five mentioned that, “once they look at my health passport they tell me that nothing can be done, and I should just go home and accept my situation”. In addition, she also wishes to seek for help from private doctors but financial difficulties have been a barrier.

Participant one elaborated the aspect of poor health service provision saying,

Yes, they never told me anything that why I am in so much pain, even in my health passport I could not really read what is written there, because I do not know the word. I just go to the hospital, today I am given Ibuprofen, tomorrow Panadol, sometimes they will tell you your blood is low, we will give you tablets that are usually taken by pregnant women even though you are not pregnant. One day I even found myself being injected with the family planning injection, apparently, I should just take that injection so that my blood level can go back to normal. They continued injecting me but they know exactly what is going on. After the injection then that is where the problem started, when I am trying to walk, I could not able to walk; my legs could not able to move.

The above shows that the poor health service provision described by participants is rooted in discrimination and victimisation. Most participants reported that because of the stop forced sterilisation campaign in which the government was sued, and the Ministry of Health and Social Services was implicated, the health care professionals mistreat, victimize and insult the women who were sterilised when they go and seek for assistance with the health problems. According to participant two, “when you go there in the consulting rooms, the nurses will say those are the people that have been marching against us in the streets saying that they want their wombs back, therefore you won’t be treated as you were supposed to anymore”. Two participants have resorted to changing health passports in order to avoid discrimination and victimisation. Participant seven mentioned that the stress she suffers is because she has not received much help when she goes to state hospitals to be treated; rather she stated that she is mostly “insulted” and told that there is nothing that can be done to help her.

The poor health care services described go beyond inadequate and ineffective treatment. Participant one shared that

The only problem is if you start paining, and when you go to the hospital, they will answer you bad. If for example you ask them, to give you your file saying that I need my hospital file, maybe there is someone out there who might be able to help me, so I might need to take it there to see what kind of medicines I will be able to get, to help me feel much better. The file is not there.

Participant one also shared that she expressed her desire for a hysterectomy at the hospital as a way of trying to get rid of the pain that she is feeling, but again a barrier

was there as she was told to go and ask for a police declaration. For her a sense of helplessness is there because of mistreatment at the hospital and this leads to the frustration she expressed when she refers to health services.

Because of the negative health effects of forced sterilisation, all participants have sought for health care services in state health care facilities. However, the service they have received has been poor and filled with discrimination, victimisation, mistreatment and inadequate remedies. The negative health effects together with the poor health care service provision have precipitated perpetuated and maintained the psychological symptoms that the participants face; they have subsequently contributed to negative and ineffective coping.

4.4.3 Theme three: Sterilisation and culture

The findings of this study reflected how cultural beliefs and expectations strongly influence the effects of sterilisation on the women. Cultural beliefs, principles and values shape individuals' and society's perceptions, behaviours and expectations. Thus, when pertinent issues that challenge the cultural or contextual status quo arise, resistance ensues because cultural equilibrium is threatened, and the system reacts in a way that tries to revert the situation or to protect the engraved beliefs. In a bid to do so, individuals, situations or ideas that are found at the opposing side of cultural values and principles may be rejected or shunned. Subthemes regarding cultural expectations that emerged included, cultural expectations of marriage and reproduction and cultural principles in decision making,

a) Subtheme one - Cultural expectations of marriage and reproduction

All seven research participants noted that in the Namibian culture there are specific and important expectations regarding reproduction and marriage. Firstly, they sighted that their culture ascribes that having children is very important for women. Additionally, the value, worth and respect for women is mainly attached to their ability to have children. For example, participant three stated that, “In Oshiwambo culture, children are very important, that a man who is getting married is always expecting to have children with his wife. The thought that I will never have children again hurts”. Participant two was sworn to silence by her mother because in society or in the community not having children is shameful. She said, “Because once you got sterilised people don’t look at you as a person anymore”, a reality which may then lead to feelings of worthlessness

Participant one also elaborated the importance of a woman’s ability to have children when she mentioned that she is grateful that when she was sterilised she had her four children. She went on to describe the case of one of the women who were forcibly sterilised, saying

Yes, that one is faced with lot of challenges because, almost every time people are saying bad things to her, and it looks like it has also affected her mental health. I remember I saw her this year, but you can just see that her mental health is not right at all, maybe because of the bad things that people say to her, and all the insults that she has received from the family, because when all that happened she just got married, now the husband’s family is insulting her, that she is of no use to them, she should just go back to her family, what else is she doing there if she does not have a child?

All seven participants explained that in their culture, getting married is important for women and every woman wishes to get married. They believed that the outcome of every marriage should be children and when men marry, they immediately expect their wives to get pregnant and have children. Two participants (participants one and seven) lost their marriages because of forced sterilisation, their spouses did not understand and blamed them, and for participant six her husband still expects and puts pressure on her to have children, even though she was sterilised. Participant four mentioned that what is important in a marriage is the children and when a woman is unable to bear children for her husband, she faces emotional abuse especially from her in-laws. Participant four expressed herself as follows, “In my culture people don’t understand it all, because for married people like me, your parent in-law will be expecting you to have more children”. Participant six elaborated that having one or two children only is unacceptable, and for a woman society will continue pressuring her to have children.

Participant seven explained that in their culture, marriage is synonymous to having children and in her culture, having many children is important. Therefore, we find that although all the research participants had biological children when they were sterilised, most of them were still rejected or abandoned by their spouses, who expected more children. According to participant seven, to her family being sterilised is worse than being HIV positive. This signifies how having children is important.

For participants two, three and five who have never been married and still hope to get married, the socio-cultural effects of sterilisation have been such that marriage now seems impossible because they are unable to have children anymore. Participant three

mentioned that she has already lost three intimate partners who were potential spouses after revealing to them that she was sterilised cannot bear children.

The seven participants indicated that the backlash resulting from being unable to have children is very challenging, with women experiencing verbal, emotional and sometimes physical abuse that stems from cultural expectations. In some cases, for instance in the case of participant five, one may be ostracized and estranged by family. Socio-cultural effects of forced and coerced sterilisation include hostile responses from community, family, friends and intimate partners. They reported that just the circumstance of not being able to have children alone results in a lot of verbal abuse. Participant three explained as follows, “They might say very hurtful words. If you did not inform your partner about your condition he might not understand why you are not falling pregnant, and this can lead into him ill-treating you mentally”. Thus, this socio-cultural backlash also brings about gender-based violence and this in turn affects mental wellbeing.

b) Subtheme two - Cultural principles in decision on making

The results show that all participants indicated that in the Namibian culture, women are not supposed to make major decisions without informing their spouses or partners and in some cases families and elders. Participant one stated that because sterilisation is a major decision and she was sterilised without her knowledge and without the knowledge of her husband, this resulted in the loss of her marriage. Both her mother and husband blamed her saying, “if you are married you cannot be sterilised without letting your husband know”. Therefore, it is clear that in the patriarchal system, forced sterilisation leads to conflicts in intimate and other interpersonal relationships mainly because of

cultural principles and practices that engender aspects such as decision-making. Forced sterilisation defies these cultural values of decision-making. According to the participants, this was the cause of why; two participants ended up losing her marriage, one participant did not disclose to her family, six of the participants did not disclose to the community, one participant was ostracized by family and all the seven participants have been blamed for apparently making such as huge decision to get sterilised without consulting partners and families. Yet this is not a decision that the women made, but was rather something that they were forced and coerced into; and yet they were left with the consequences.

4.4.4 Theme four: Negative social effects of forced and coerced sterilisation

a) Sub-theme one- Effects on interpersonal relationships and Gender-based violence

The data collected showed that forced and coerced sterilisation negatively affected the participants' interpersonal relationships. Relationships with spouses, intimate partners and family members were noted to be affected by forced and coerced sterilisation. Participant one also indicated that forced sterilisation affected her relationships with her spouse and mother. With her spouse, after she gave birth (the same time she was sterilised) conflict started because she was consistently bleeding which affected their sex life. When he found out that she was sterilised the conflicts got worse and she ended up losing her marriage. Participant one's relationship with her mother, the first person she told about what happened to her, was also affected because instead of receiving some comfort and support that she was looking for, her mother did not believe that she was sterilised without her knowledge and blamed her for being sterilised.

On the other hand, participant two feared that conflict would arise because she was sterilised so she did not disclose this information to anyone for three years after finding out. When she finally disclosed this to her partner, a lot of conflict arose as he became angry with her because of not informing him and he blamed her for getting sterilised calling her illiterate. She said he never fully accepted that it was not her fault and would often talk about it and even threaten her that “I can even go and look for someone that can be able to give me children”. Participant two emphasized that having children is important especially for healthy intimate relationships and the relationship with families, in laws and the community. Similarly, participant six has faced and continues to face marital because she is unable to bear children for her husband. Yet her husband continues to put pressure on her to “go and get her womb re-opened” and he threatens to go and look for other women who can give birth.

Participant three expressed that she constantly faces conflicts in intimate relationships because of being unable to have children and she has faced a lot of rejection by potential spouses because of this. For participant four who is still married the conflicts arose when she first told her spouse that she was sterilised, for he blamed her, but he later understood that it was done without her consent. However, sterilisation is still a cause of conflict in her relationship because she experiences loss of interest in sexual intimacy and intercourse since she “feels there is no need for her to have sex if she will not conceive”.

Participant five’s experience in intimate relationships has been such that because the menstrual bleeding is non-stop, ever since she was sterilised in 2006; she has not

managed to engage in intimate relationships, hence the negative effects on her social and sexual life. The major conflict she has faced interpersonally has been with her family that ostracized her for being sterilised. She said, “My family decided to chase me out of their house”, and today she still has no relationship with her family members because of forced sterilisation. Likewise, participant seven was blamed not only by her spouse but by her family as well as they criticized her for making the decision without telling them. To her, because of sterilisation, the relationships with her family members were shattered.

An important topic of abuse and violence in intimate relationships because of forced sterilisation emerged. While none of the participants reported to have faced physical violence because of the sterilisation, they perceived it is something that some women who were sterilised experience, and that it may be linked to socio-cultural expectations. All the seven research participants’ highlighted gender-based violence as a challenge emanating from forced and coerced sterilisation. The participants reported that they have faced verbal and emotional abuse from their intimate partners, family and community, which subsequently led to emotional distress or stress. For participant two, in her intimate relationship the abuse was emotional as well as verbal. To add to that she alluded that abuse in intimate relationships is common for women that were sterilised and she said, “I don’t think among all my fellow women that are sterilised are still married, most of them the marriages are broken”. This abuse from intimate partners, families and society is perceived by the participants to be due to the unmet important cultural expectations of having children. For these women it is now something that is impossible.

Participant four also stated that the cultural expectation of women having children with their spouses or boyfriends usually results in gender-based violence for the women who were forcibly sterilised. Participant five concurred with this explaining that,

Mothers who were sterilised are facing bad things in their life, whether gender-based violence and bad words, because some people if you are married, one will tell her husband that I am sterilised, but the husband will take you are nothing and have nothing to do with you, from there he can even go for a week, if she happens to ask him, he will say I was with those who can give birth.

Furthermore, participant six clarified that women who were sterilised, especially those who are married usually face gender-based violence because of the conflict that emerges due to unmet socio-cultural expectations of having children. Thus, the verbal, emotional and sometimes physical abuse that stems from cultural expectations may affect the mental health of those who were sterilised.

According to participant three, forced sterilisation can bring about gender-based violence that may be characterised by verbal emotional and physical abuse, and this in turn affects mental wellbeing. She explained as follows, “*They might say very hurtful words. If you did not inform your partner about your condition he might not understand why you are not falling pregnant, and this can lead into him ill-treating you mentally*”.

Therefore, the findings were that forced and coerced sterilisation negatively affects interpersonal relationships and often results in gender-based violence.

b) Sub-theme two – Discrimination

Discrimination was a theme that came out in all seven participants' data. According to Williams (2017), discrimination refers to unfair or unequal treatment of an individual or group of people based on certain characteristics. The present study reports on discrimination that was experienced and perceived to be due to sterilisation. The women reported that they faced and still face discrimination in health care centres, in family contexts as well as in the community. This discrimination is an addition to the discrimination that they may already face because of their HIV status.

All participants alluded to discrimination when accessing state health care services for treatment of the negative health effects of forced and coerced sterilisation. For instance, participant two expressed that,

If you are not feeling well you just tell them that you have a backache then they will give you the back-pain medicines, but you don't have to mention about the issue of being sterilised because you won't be helped well" and "If you mention anything to the nurse that you are sterilised they will inform others that, that person should not be treated because is one of those that wants to sue the government.

This indicates that the group of women who were forcibly sterilised in Namibia face discrimination because of the having taken steps to obtain justice for the violation that occurred. Due to this discrimination, they have received poor health care services and have not been adequately treated for the medical ailments resulting from the forced sterilisation. Two of the women (participant one and two) mention that because of this discrimination, they have resorted to changing her health passports so that she may be

able to be treated like others patients. However, the negative side of changing health passports is that it contributes to the problem of not receiving comprehensive, relevant and appropriate treatment, since there is no full picture and history of the presenting problems.

Participant three underlined fear of discrimination and fear of victimisation in health care centres because of the stop forced sterilisation campaign. The statement below shows some of the participant's fears.

These whole issues are difficult to bring to light because; people will start looking at you in a different way and start labelling you as those that took the government to court, therefore it sometimes become very difficult for us to share some of our true feeling when it comes to what was done to us

Similarly, participant two expressed fear of discrimination when she said, "It has really brought me fear, when you go there in the consulting rooms, the nurses will say those are the people that have been marching against us in the streets saying that they want their wombs back, therefore you won't be treated as others".

According to the women's reports, discrimination related to forced and coerced sterilisation has been because of the mere fact of not being able to have children or many children. Family members and communities have discriminated the women who were sterilised, and this has sometimes been expressed in the form of verbal and emotional abuse. For example, participant four highlighted that while she has not disclosed up to this day that she was sterilised, her family mocks her for having only two children. Her

non-disclosure is linked to fear of discrimination for there was a time in the past when her family discriminated against her because of her HIV status by not sharing the same utensils with her. Additionally, participant five faced discrimination, which resulted in her being alienated from her family. Thus, due to socio-cultural expectations of reproduction, the women who were forced into sterilisation are prone to face discrimination because of being unable to bear children.

c) Sub-theme three – Victimisation

Victimisation happens when individuals are treated badly because they have complained about discrimination or when they help someone who has been discriminated against (Citizens Advice, 2017). It is a subtheme that is closely related to that of discrimination explained above. The seven research participants reported that they suffered and continue to suffer victimisation and mistreatment particularly at state health care facilities. Due to forced sterilisation's negative health effects, participants are forced to continuously seek for health services at health centres. It is during this process that they have apparently been victimized by health care professionals.

Participant five highlighted that because of the sterilisation, there is backlash from the community through verbal abuse and victimisation from health centres because of the court case. Like participant one, participant two also alluded to the fact that there is victimisation of the women who were sterilised the hospitals when she stated that “if you are not feeling well you just tell them that you have a backache then they will give you the back-pain medicines, but you don’t have to mention about the issue of being

sterilised because you won't be helped well". There is a connection between themes of stress, poor health service provision, victimisation and discrimination.

Worth mentioning is the similarity between participant one and two's explanations that because of the victimisation and discrimination, they have resorted to changing their health passport to avoid victimisation. This victimisation has contributed to fear of contact with health centres for participant two. Yet she had no option but to continue going there because of the health effects as well as her inability to afford private doctors.

d) Sub-theme four – Effects on Occupational functioning

Due to the negative physical and mental effects of forced and coerced sterilisation, occupational functioning has been affected for all participants, including those who are not employed and do casual jobs and sell in the market. For the three participants that are employed, negative health effects have resulted in them spending more time in hospital and thus income at the end of the month is negatively affected. The occupations of the two participants that are employed are such that they work at night and because of the psychological symptoms of sleep problems and thinking a lot, their ability to work has been affected. Participant six is employed and she mentioned that when she went to seek for medical assistance at the state hospital, "they told me that there is nothing they can do as the person who sterilised her did not do it right". She however said she has learnt to avoid doing work that makes her condition worse, but this is difficult since she works as a cleaner. Thus, the sterilisation has affected the participant's occupational functioning.

For the four participants who are unemployed, negative health effects and psychological symptoms have also affected occupational functioning. For example, participant one indicated that due to her health problems, which include heavy bleeding and severe back and leg pain, she is sometimes unable to do the casual jobs that give her income to take care of her children, and when she is unable to work this stresses her. Participant four indicated that when she found out that she was sterilised, she developed sleep problems in which she was unable to fall asleep and this in turn resulted in severe headaches, which made it impossible for her to work. This lasted for two years after she was sterilised, and it affected her occupational functioning as she had headaches most of the time. Therefore, one of the social effects of forced and coerced sterilisation has been that, the subsequent physical and psychological have an effect on the individuals' occupational functioning.

4.4.5 Theme five: Support and coping with sterilisation

When stressful and traumatic events occur, the individuals' ability to cope effectively is partly determined by the nature and amount of support they receive in their social circles. The present study also considered the support that the women who were forced into sterilisation received as well as the meanings they attached to being sterilised and how they managed to cope.

a) Sub-theme one - Support received after sterilisation

All participants indicated that they received most of their support from Namibia Women's Health Network (NWHN) and the Legal Assistance Centre (LAC) when they found out they were sterilised. They mentioned that NWHN provided emotional support

through counselling, material support in the form of sanitary pads or taxi money and practical support by accompanying some of the women to the hospital. According to the women, the counselling obtained from NWHN assisted them by lessening the impact of the emotional problems during difficult times and difficult days. They indicated that through the counselling they were encouraged, supported and given more information about what forced sterilisation. As an example, participant five who was estranged by her family found the counselling to be helpful. She said,

We were helped by NWHN, by Ms Jennifer, since 2006. We shared with her our situation that we are facing in our lives. I could tell someone, that I was sterilised, and after sterilisation I experienced difficulties; there is no communication between me and my family, my life changed.

We find that since all the participants faced blame from family and other social support structures, there was rather very limited or no emotional support for them, thus, the counselling provided by NWHN served as a buffer for some of the negative effects faced by the women. LAC provided and continues to provide legal support for the women. However, the women mentioned that the support rendered by NGOs should continue and that other NGOs should join in to provide support from the victims.

Support groups are also said to have played a major role in supporting the women within their communities as they served as a space in which women that were sterilised strengthened and encouraged each other. For example, participant two received help from her support group leader when she wanted to disclose to her partner that she was sterilised. Participant five was ostracised by her family and support group members constituted her only support and she obtained employment with the help of one of the

support group members. She said, “The only help I got, is from the support groups that I have been attending, as well as from the organization that is called Namibia Women’s Health Network, it has given us a lot of help”

In addition to the support that they received from NGOs and support groups, all participants reflected that faith played a critical role in helping them cope. For example, participant three notes that listening to gospel songs sometimes helps her with her sleeping difficulties. While the participant four’s dream of having children seems to be out of reach, she still believes that through her faith, her belief in God, a miracle is possible and she may one day be able to give birth. This hope influences the participant’s coping in a positive way and she is the only participant that exhibited some positive coping. Although stress is often triggered in her, this hope and faith in God that she is holding on to helps her cope in a positive manner. This is why participant four did not show any psychological symptoms of hopelessness and helplessness. While all the other six, participants expressed that their belief in God has helped them, they still showed hopelessness throughout the interview.

Consistent in all the participants’ accounts was the fact that little or no support, acceptance and understanding was obtained from spouses, intimate partners, family members and community members. Due to socio-cultural beliefs and values, they faced blame, verbal abuse, victimisation, emotional abuse and discrimination instead of support and comfort. Only one participant’s spouse (participant four) stayed after the sterilisation and although he initially blamed her, he later understood that it was not her

fault. Participant two for instance showed need for acceptance, support and understanding when she said,

In addition, men that have their women who became victims of forced sterilisation they need to just accept their women, they just need to understand that it is not their women's fault that they were sterilised, it is the doctors' fault that sterilised the women without informing them. Most women were just sterilised without their knowledge, they were just told to sign the form quickly.

b) Sub-theme two - Meanings attached to forced and coerced sterilisation and coping

When individuals are confronted with stressful or traumatic situations, how they cope and make sense of the situations is important, for this may affect well-being. Since the seven participants had unique experiences in different contexts, the meanings they have attached to being forcibly sterilised that emerged were different and were predominantly negative.

Participant one has mostly associated forced sterilisation with pain, thus for her forced sterilisation means pain. Due to the severe and negative health effects that she has suffered and continues to suffer because of the sterilisation operation, most of the themes that emerge from her interview are linked to the pain that she faces. Her wish to have her womb completely removed stems from her need or desire to get rid of the physical pain that she is feeling. Because to participant one sterilisation means pain, to her it subsequently means that she may never be healthy again, it means that her future is uncertain and that it will be difficult to achieve any of her goals. These meanings are

then reinforced by the experiences she has when she seeks for help at mental health clinics, where she does not receive adequate treatment and support, but is rather discriminated upon and told that she will be like that for the rest of her life because she is HIV positive.

Coping for participant one has been difficult because of the negative meaning (pain) derived from the forced sterilisation and this pain is still present and severe. The pain serves as a trigger of all the negative experiences that she has gone through because of the sterilisation. While coping has been difficult for her, this is made worse by the fact that those closest to the participant, her spouse and mother do not support her. Together with feelings of rejection, this makes coping much more difficult. The ability to fully or adequately cope for participant one may require frequent counselling and quality health care attention. This might help her deal with issues of closure as she continues to ask herself the questions “why” and “what if”.

Participant two has mostly associated forced sterilisation with her inability to have more children (boys), something that she had planned for as a future goal. She still wishes to have more children, but practically it is impossible. Therefore, for her sterilisation means hampered future personal goals. Because to participant two sterilisation means hindered future goals, if she does not set new personal goals, this may result in negative psychological consequences. Yet, she has expressed that her goal now is to reclaim her health that was affected by the sterilisation. There are barriers that stand in the way of the participant that seem to be out of her control and these are poor health service provision and unavailable finances. To this effect, how participant one copes is

important. The meanings that participant two attached to being forcibly sterilised are most likely to negatively affect the way she copes. This is significantly illuminated by the fact that the participant continues to ask herself why this happened to her and why it still bothers her. Professional counselling may be required in this case. The ability to fully or adequately cope for participant one may also require quality health care attention.

For participant three, forced sterilisation has been associated with loss of marriage. As a result, for her forced sterilisation means very limited marriage prospects. Her future goals were centred on getting married one day and she explained saying, “Yes, my dream was to be married, of which I do not think it is possible anymore”. Sterilisation thus also means important personal goals that will never be fulfilled. In this case coping is difficult because while she is unable to conceive, she is still pursuing marriage. This pursuit is met with a lot of rejection from potential spouses and this triggers the negative emotions linked to forced sterilisation. The participant is then constantly trying to find out why she was forcibly sterilised. This is an indication that she has not fully coped and she is struggling to cope with the fact that she was sterilised. Additionally, coping is probably made much more difficult because of the triggers that are readily available to spark the negative emotions. A present trigger is that she is in a relationship and she has to constantly deal with the issue of not having children. The socio-cultural triggers also negatively contribute to coping. The meaning of forced sterilisation for participant three is filled with regrets and impossibilities and this leads to feeling of helplessness, hopelessness, stress and other psychological symptoms mentioned above. There is clarity in the fact that psychological support is needed for participant three to assist her

with issues coping as well as with the negative psychological symptoms that may be present.

For participant four, forced sterilisation means her inability to have more children. Her plans or goals included having at least six children and with the sterilisation, this is now impossible. Sterilisation is thus interrelated to important personal goals that will never be fulfilled. The meaning that she has attached to being sterilised composes future personal goals that are now out of her reach. While the participant's dream of having children seems to be out of reach, she still believes that through her faith, her belief in God, a miracle is possible and she may one day be able to give birth. This hope influences the participant's coping in a positive way. Although stress is often triggered in her, this hope and faith in God that she is holding on to helps her cope in a positive manner. This is why participant four did not show any psychological symptoms of hopelessness and helplessness. Important to note is the fact that unlike other participants, participant four has a spouse who has understood her situation and accepted her with her condition. This support also positively influences her coping. Triggers and socio-cultural effects often present setbacks, thus some psychological intervention may be required to assist the research participant.

To participant five, sterilisation means loss, loss of her fertility, loss of her health and most importantly loss of her family. Furthermore, it means loss of her boyfriend, loss of an opportunity to engage in intimate relationships and loss of her worth. She has mostly associated forced sterilisation with pain, thus for her forced sterilisation also means pain. Because of the sterilisation operation, we find that most of the themes that emerge from

her interview are linked to the losses she has faced and how they have consequently affected her wellbeing, including her mental wellbeing. Since, she associates sterilisation with loss; subsequently she experiences feelings of helplessness, hopelessness and worthlessness, which lead to intense stress or depressive mood. Issues of existentialism then come to play. Coping for participant five has been very difficult because of the negative meaning (loss) derived from the forced sterilisation and the effects of the loss interfere with coping. When individuals experience traumatic or stressful events and the meanings they attach to those events are such that they begin to question issues of existentialism, coping is negative and psychological intervention may be required. The ability to fully or adequately cope for participant five is highly questionable and she may require psychological counselling.

According to participant six, sterilisation is associated with fear, especially fear of future loneliness. To her she will never be able to have a girl child to help her and be with her in the future when she is unable to take care of herself. Therefore, for participant six, sterilisation means an uncertain future and this brings fear to her. Additionally, sterilisation means that she will never be able to make her husband happy, because she cannot have children. It means that although she is married, she may always have a difficult marriage. She also subsequently fears that her husband will eventually abandon her if she does not get the sterilisation reversed and bear children. The meanings that participant six attaches to sterilisation are filled with impossibilities. She mentioned that she expected support from her loved ones but she could not tell them because of the lack of support she experienced in the past. It is understandable why fear dominates the meanings that the participant attaches to being sterilised. Her family have proved their

lack of support and she fears that no one will support her in the future. Constant triggers from her spouse and her fears may be a source of stress and she may require assistance with.

For participant seven, forced sterilisation has been associated with injustice. She understands that what happened to her was unfair, unjust and cruel. This is why she has many questions as to how and why this injustice could have happened to her. This prompts feeling of anger towards those that sterilised her, with her stating that, “Who told them to do that to people it is very bad and whoever did this to me God will punish them”. She seeks justice and without any redress coping may be very difficult for her as she may be stuck with these feelings of anger and frustration. She finds the sterilisation to be a huge injustice because of the losses that she suffered. She lost her marriage and the respect from her family. She lost her dreams of having many children and she lost her health. With the losses, anger and self-blame, coping may be difficult for participant seven. She continues to search for meaning of how such an unprecedented injustice could happen and this shows that although she was sterilised twelve years ago, she still has not coped. Psychological intervention may be required to assist her.

The information above illustrates that coping has been difficult and negative for research participants and that the psychological and socio-cultural effects of forced sterilisation persist. As an example is Participant Three said, “Yes, you know sometimes it really bothers you, for example if you come across someone with a baby, it just comes into your mind that I wish I can able to have a baby again and be like her, although now I am growing old, I think like that.” This shows that if not addressed the psychological

implications of forced sterilisation may persist and may be long term. Thus, psychological intervention may be appropriate and necessary to deal with negative effects on coping as well as to strengthen and reinforce any already existing positive coping skills.

4.5 Recommendations for intervention

The present study also sought for the suggestions and perceptions of the participants, as to what appropriate interventions would look like. According to Gcabo and Moleko (2012, p. 181), effective social interventions constitute of a needs assessment, whereby the targeted individuals or communities “identify issues about which they are really concerned”. All participants in this study emphasized the need for psychological, social and other forms of intervention because of the negative consequences that they still face because of the sterilisation. Table 4 is a summary of what the participants specified as interventions required for the future.

Table 4: Recommended Interventions

Type of Intervention	Specific Intervention Suggested	Examples
Psychological	i. On-going counselling and emotional support for the women - Psychological help	<i>“Counselling is the number one thing that we need, counselling is really important it helps us to deal with the situation and also to know that there is nothing else that can be done”.</i> (Participant two) <i>“If one sees a counsellor at least three times a month, it can help a lot”. “They need to be visited at least once in a while. A lot of these women are suffering especially those who live in the deep rural areas; therefore any help that can make a person feel human and valuable is important.”</i> (Participant three)
Social	i. Civil society organizations to join forces with NWHN to continue supporting the women. NGOs should continue supporting the	<i>“They just need to realize that, these women are women who were really damaged and they really need to be looked after and talked to”. Civil</i>

	<p>women.</p> <ul style="list-style-type: none"> ii. Financial assistance for the women because a lot of the money is spent on negative health effects of forced sterilisation, leaving the women without money to fulfil other responsibilities such as taking care of their children. iii. The Namibian Government should apologise to the women who were sterilised by providing them with jobs and homes. iv. Awareness raising initiatives so that forced sterilisation does not happen to other women, for example putting informative posters on sterilisation in all health centres 	<p><i>society organisations should continue supporting the women because some of them have no support at all". (Participant four)</i></p>
Medical	<ul style="list-style-type: none"> i. Ministry of Health and Social Services to provide doctors and specialists to fully examine and treat the women as well as to provide full information on their health status ii. Facilitating reversal of the sterilisation for those that can be reversed. iii. Ministry of Health and Social Services should focus on the improvement of health service provision in public health centres in order to deal with issues of mistreatment, discrimination and victimisation. iv. To have an audience with the president to have him assist the women who were sterilised to deal with the health effects by getting qualified doctors. (Participant two) 	<p><i>"The kind of help that we need is just for the doctors, we need doctors that can able to examine us that what is really going on with each of us, they need to examine us one by one probably they can be able to treat us, so that maybe we can regain our health back." (Participant two)</i></p>
Legal	<ul style="list-style-type: none"> i. Government to compensate the women promptly because some are dying without obtaining redress for the violations. The Namibian Government should facilitate quick compensation for the women who were sterilised. 	<p><i>"I only want to add that, the government must give us what they have promised us in court one year ago. The government must also register our beneficiary for this program just in case something happen to any of these women because as we speak two of our fellow women has passed on already while waiting on this promise." (Participant three)</i></p>

From table four, we can see that the recommendations given by participants point to the negative consequences of forced sterilisation which are both internal (psychological effects) and external (socio-cultural).

In summary, this chapter, the results of the interviews showed that there are negative psychological and socio-cultural effects of sterilisation that the women who were sterilised faced and continue to face. While some resilience and coping has been facilitated through emotional and material support from NWHN and support groups, the coping strategies exhibited by the women have been negative and somewhat temporary and ineffective. This is why all the participants still ask themselves “why did this happen to me?” Therefore, the psychological symptoms and socio-cultural effects that came out are reported to still be present for the women. This is why in the recommendations given by the women; they express desperation for continued support to deal with the psychological, health, financial, socio-cultural effects of forced sterilisation.

CHAPTER FIVE

DISCUSSION

As an extension of the previous chapter, this chapter presents a critical analysis of the findings of chapter four, for the purpose of addressing research objectives by linking context and literature. As mentioned earlier, the aim of this study was to explore and obtain an in-depth understanding of the psychological and socio-cultural effects of forced and coerced sterilisation on Women Living with HIV in Namibia as well as to ascertain the implications for intervention. This discussion provides an overview of the main points that speak to the findings and research objectives. The discussion also allows a chance to make recommendations for future practice and further studies.

In examining the interviews with regard to how forced and coerced sterilisation has affected the participants' mental health, common psychological symptoms emerged. While the symptoms were mostly similar in all cases, we find that the precipitating, perpetuating and maintaining factors of these symptoms vary from participant to participant. The women revealed that the psychological symptoms commenced after sterilisation and they report that they did not experience these symptoms before. This may be shown by the reasons given by research participants for the emergence of symptoms, which are linked to effects of forced sterilisation.

Anxiety and stress are psychological constructs that were common in all seven cases. By definition stress is a process whereby an individual perceives and responds to events that

he or she appraises as overwhelming or threatening to his well-being (Lazarus & Folkman, 1984). For there to be stress or anxiety, there has to be a stressor, in the form of stimuli that initiates the stress process. External environmental events that are judged as threatening, negative, demanding or harmful to the individual often act as stimuli. In the results presented in the previous chapter, all participants shared a common threatening external event, forced and coerced sterilisation, a stimulus that sparked the stress process.

The participants perceived this event as harmful and threatening to their health, to their relationships, to their dignity and to their personal goals. In response to these perceptions, the responses included feeling of sadness, worry, distress, anger, frustration and fear, all of which form the broad and general definition of anxiety and stress. The present study is consistent with findings in previous studies, which indicated that sterilisation resulted in negative effects on mental wellbeing. For example, Lin et al. (1996) in a study on voluntary sterilisation in China found depression as a symptom. Similarly, Leppert, Legro, and Kjerulff (2007) found symptoms of depression, anxiety, anger, and confusion, which persisted for two years. The findings of this study show that the symptoms may persist even longer as the mean time since sterilisation was eleven years. Apart from anxiety and stress, this study's results also found that the psychological symptoms that the participants have experienced and are still experiencing are at varying degrees due to forced and coerced sterilisation. These symptoms include feelings of sadness, feelings, of helplessness, feelings of worthlessness, and feelings of hopelessness, self-blame, feelings of anger, sleep disturbance, loss of weight, and loss of interest, shame, fear and isolation. Likewise, Holt (2005) found that symptoms of

feelings of isolation, worthlessness, helplessness and lack of belonging might be present in situations where individuals are ostracized because of sterilisation when he documented cases of forced and coerced sterilisation of Roma women.

While being sterilised without informed consent may have been (and still is) anxiety provoking and stressful in its own right, the consequences of being sterilised add on to the stress and serve as precipitating perpetuating and maintaining factors of stress. For example, participant one experiences adverse negative health effects from the sterilisation. This constant pain serves as both a precipitating factor and maintaining factor of stress. Moreover, due to the negative health effects she must constantly visit the hospital to seek treatment, which means she must constantly deal with the discrimination, mistreatment and victimisation from health care professionals and this exacerbates the stress. As another example, participant three faces repeated rejection by potential spouses because of the sterilisation. However, because she really wants to get married she continues to try dating. The constant rejection serves as a source of anxiety and stress for her as it reminds her of the impossibilities of her goal of getting married one day.

The above examples illustrate a critical element of the definition of stress given above, with regard to meaning making and coping. When individuals are presented with a stressor, how they appraise, judge, make sense of or derive meaning of the event is very important. The meanings and judgments individuals attach to traumatic or stressful events in turn influence their reactions to such events and they also influence how they cope. According to (Lazarus & Folkman, 1984) there are two types of appraisals of

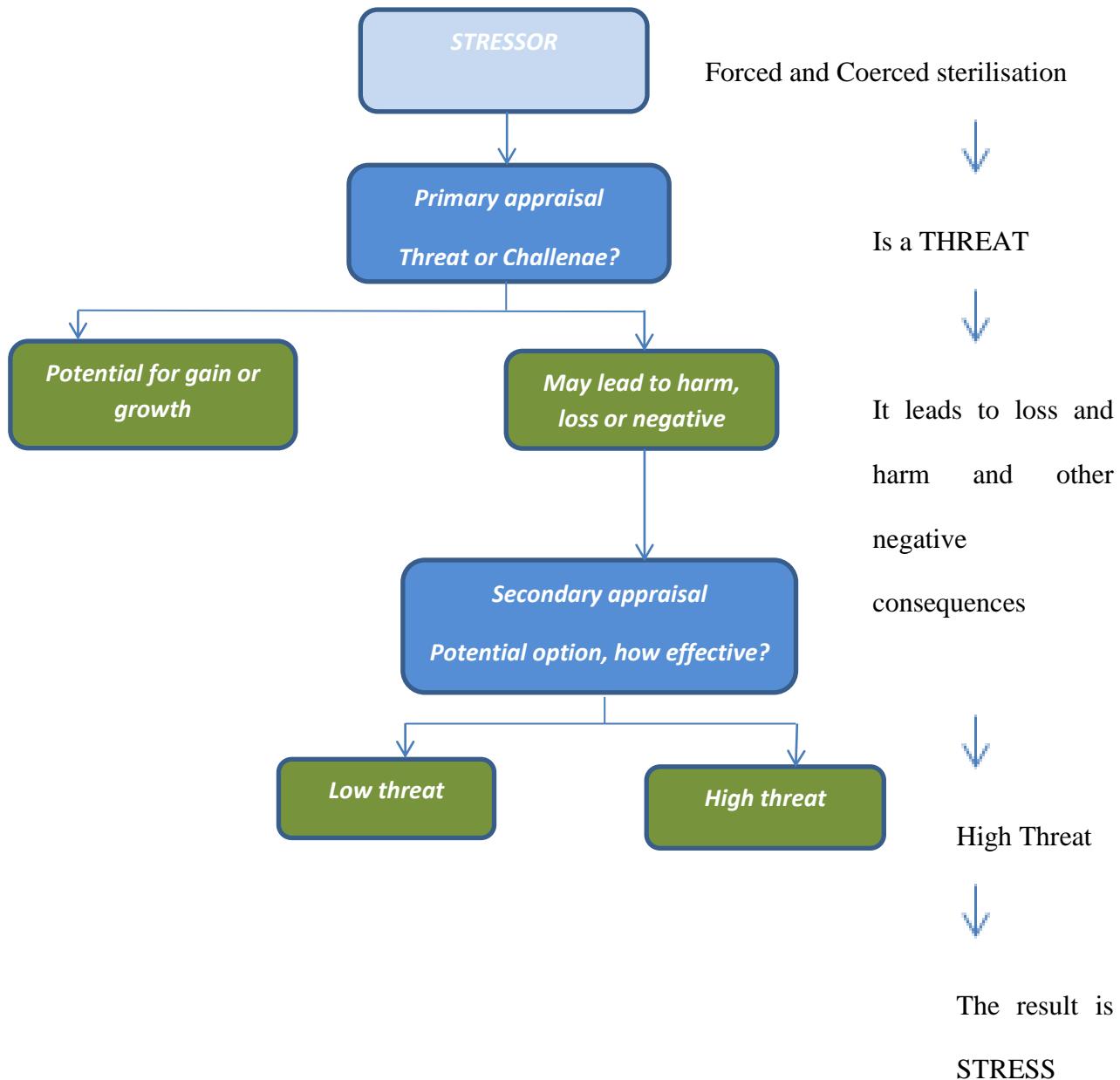
stressors that are important. They talk of a primary appraisal, which comprises judgment about the magnitude of potential harm or threat to well-being that a stressor might entail. They go on to explain that a stressor would likely be appraised as a threat if one forestalls that it could produce harm, loss, or other negative consequence; conversely, a stressor would likely be appraised as a challenge if one believes that it carries the potential for gain or personal growth.

Therefore, to put this in context of the results of the current study, we find that their primary appraisals of being forced into sterilisation are principally based on the negative consequences thereof. We find that they not only anticipated but experienced harm (negative health effects), loss (of fertility, relationships, health, self-worth, family, dignity etc.) as well as negative socio-cultural consequences, and negative financial consequences. Thus, the meanings that they attach to being sterilised are negative; they do not see forced sterilisation as a challenge from which growth can take place. For participant one sterilisation means pain, for participant two it means hindered personal goals of having more children (boys), for participant three it means limited marriage prospects, for participant four it means the impossibility of ever having children again, for participant five it means loss (of fertility, health and family, for participant six it is associated with fear of future loneliness and for participant seven it means injustice. The theoretical concepts of stress, coping and meaning making (Park, Lazarus and Folkman, 1984) provide a model for the participants' explanations of anxiety and stress as major symptoms due to sterilisation.

According to Robertson (2016, p. 189-190), “What doesn’t kill you makes you mentally stronger...What doesn’t kill you gives you one crucial lesson...so long as adversity is not too severe, adversity teaches us that bad things will come to an end eventually”. This is contrary to the findings of the present study for we find that there does not even emerge one positive meaning and a sense of post traumatic growth from the data, yet, as the above quotation and other literature find, you often find that people who face extreme hardship experience some growth, positive meaning or resilience. This contradiction may be due to the fact that, with forced sterilisation, the adversity may have been too severe, and the negative effects have persisted over a very long period. For example, the negative medical effects and socio-cultural effects are still present after over ten years since the sterilisation, and as Robertson (2016) indicated, resilience is possible only if the adversity is not too severe and when there is an expectation that bad things will come to an end. For the women, while they may have experienced some hope, such as from the stop forced sterilisation campaign in which they were assisted to seek justice for the violations, the campaign has lasted for over a decade and still no compensation has been received to date. Additionally, the negative health effects they reported are severe, yet there are significant barriers to access to health. Therefore, while literature rightfully, notes that with adversity comes mental resilience (Robertson, 2016), in exceptional cases where the effects are too severe over a prolonged period, post-traumatic growth may be unlikely. For this reason, this study recommends psychological intervention for the women to facilitate the development of positive meanings or “theories about their emotional problems-and hence about whether they have control over them, which is key to how they eventually cope” (Robertson (2016, p. 221).

Coping in adverse situations is also partly determined by the secondary appraisals that individuals make (Lazarus & Folkman, 1984). Secondary appraisals involve assessing the available options to help with coping. A threat tends to be viewed as less catastrophic if one believes something can be done about it (Lazarus & Folkman, 1984). For the women who participated in this research, their loss of fertility is something that is permanent and for them the perception is nothing can be done about it. Two participants indicated that they still wish that reversals of the sterilisations, however, it has been ten to thirteen years since the sterilisations occurred and no help has been rendered in terms of reversals. The women are also getting older and slowly this possibility seems to be only a wish. In terms of family and relationships, not having children has had negative effects, and since the women cannot have any children, there is no anticipation for regaining lost relationships. Thus, for most of the consequences that the women are facing due to sterilisation, no anticipated solution is in the horizon. The participants have mainly made primary appraisals of the threats posed by forced and coerced sterilisation rather than secondary appraisal. The Figure 2 below illustrates how the women have made meaning of the stressor of being forcibly sterilised and its negative consequences.

Figure 2 The Meaning making process and forced sterilisation: Based on the concepts of stress, coping and meaning making by Lazarus, Park and Folkman (1984)



If a person appraises an event as harmful and believes that the demands imposed by the event exceed the available resources to manage or adapt to it, the person will subjectively experience a state of stress. For instance, the negative primary appraisals or meanings of sterilisation that the women attach to being sterilised, lead to perceptions of

forced sterilisation and its negative consequences as threats, high threats because of limited potential options of mitigating the effects. This then leads to heightened stress and difficulties in coping. In contrast, if one does not appraise the same event as harmful or threatening, she is unlikely to experience stress. According to this definition, environmental events trigger stress reactions by the way they are interpreted and the meanings they are assigned.

It has been illustrated above that the meanings that the women attach to forced sterilisation are mainly negative and they pose high threat with very limited effective options. One of the objectives of this research was to find out how the women have managed to cope with the sterilisation. It was therefore necessary to find out how the women have managed with the psychological stress. This study was conceptualized using the theory of stress and coping by Lazarus (1993), in which problem-focused coping and emotion-focused coping are distinguished. The finding has been that the women have been trying to cope using the problem-focused approach, which involves, altering the disturbed person-environment relationship by acting on the environment or oneself to mitigate stress (Park & Folkman, 1984). However, this approach to a large extent has not been and is not useful for the negative consequences they are facing because the options for changing the stressful situation or solving the problem of not having children have not available and seem almost impossible.

Similarly, we find that the women have no or very limited prospects of changing the negative health effects, the destroyed marriages, the discrimination in community, the discrimination and victimisation in health centres, their broken relationships with

families etcetera. Thus, the ability to fully or positively cope is limited. This however, does not take away from the help and support the women have received from NGOs and support groups to assist them with dealing with the situation. This support has played an important role in minimizing the negative consequences of the sterilisation so that the women move forward and continue with the routine of life. With the interventions carried out thus far by NGOs, a process of empowering the women was started.

Radebe (2012, p. 154) describes empowerment as “a process by which people, organisations or groups that are powerless or marginalised become aware of the power dynamics at work in their life context and develop skills and capacity to gain reasonable control over their lives”. The LAC empowered the women legally while NWHN empowered the women by providing them with information and education on aspects of their rights especially as WLHIV. What remain lacking are the critical psychic elements that will allow the women to take control of the situation and to be able to cope individually and positively with the negative outcomes on a somewhat permanent basis. As Robertson (2016, p. 222), stated that empowering individuals psychologically would involve “helping them understand their own beliefs and so become more confident about being able to shape their own mental abilities, motivation and emotional balance by understanding better what determines these psychological states”. Therefore, the present study recommends professional psychological counselling to facilitate these processes.

What would be more useful to assist the women cope would be to use emotion-focused coping which emphasizes, “changing either the way the stressful relationship with the environment is attended to (as in vigilance or avoidance) or the relational meaning of

what is happening, which mitigates the stress even though the actual conditions of the relationship have not changed” (Lazarus, 1993, p. 238). The research participants and other members of the target population would benefit from professional psychological guidance to use this effective and extensively used method for regulating stress and emotion (Lazarus, 1993).

While it is impossible to use this study to make specific diagnosis of possible psychological disorders, the exploration of the psychological symptoms in this study reveals that there are negative psychological effects due to forced and coerced sterilisation as was indicated in other studies on sterilisation and mental health (Lin et al., 1996; Leppert et al., 2007; Oliveira et.al., 2007; Winston, 1977; Kendall & Albert, 2015; Holt, 2005). In addition to the health effects, financial effects and sociocultural effects, mental health effects continue to be present for victims of forced and coerced sterilisation. Important to note is that the aforesaid psychological symptoms have also affected the participants’ occupational and social functioning. This finding of psychological symptoms points to or implicates professional psychological counselling for the victims as future intervention.

Objective two of this study sought to describe the socio-cultural effects of forced and coerced sterilisation. According to Moleko (2012, p. 164), culture is described as “the attitudes, behaviours and traditions a certain group of people abide by and these characteristics are passed from one generation to the next”. It was found from the accounts given by the participants that principles and values in the Namibian culture places great importance in children. Literature also corroborates this, for example, in a

research done by Gockel-Frank (2007) in Namibia on the reproductive decisions of women, the finding was that fifty per cent of the women stated that the most important task in a woman's life was to have children and to take care of them. Thus for women, their value and worth is weighed against their ability to have many children.

This study showed that sociocultural effects are closely linked to mental health problems. The women feel worthless because of their inability to give birth and because of the realities, they are facing in the community where they are not respected, not "counted", belittled and mocked because of what happened to them. This is similar to what Holt (2005) reported on cases of forced and coerced sterilisation where Roma women were sterilised because of their affiliation to a minority ethnic gypsy group. In the Roma case, women became outcasts in their community because being unable to have more children is abhorred in a society where a woman's fertility is much valued. The present study had similar findings, whereby one participant was ostracized by her family and all participants were blame for apparently allowing the forced sterilisation to occur. The study on forced sterilisation in South Africa by Strode et al. (2012) is also consistent with the findings that children are important for the dignity of women. Therefore, socio-cultural consequences of forced sterilisation are entrenched in cultural traditions, beliefs and expectations of motherhood.

It is essential to place culture as a central feature when trying to understand individual and community behaviour (Moleko, 2012). Individuals do not live in a vacuum, hence when something occurs that is contrary to societal and cultural beliefs and values, the individuals involved often suffer some negative consequences. This is probably why

participant two was sworn to silence by her mother, who told her not to reveal that she was sterilised to anyone. She probably did not want her daughter to face the shame, rejection and discrimination associated with not being able to have children in her community. Not being able to have children is considered shameful. Additionally, participant seven mentioned that to her family being sterilised is worse than having HIV because at least there is treatment for HIV. This reveals that just like discrimination associated with being HIV positive, the women suffer discrimination because they were sterilised and are unable to have children. Strode et al. (2012) in their study on forced and coerced sterilisation of WLHIV in South Africa Also found discrimination in social contexts to be a major theme. The negative socio-cultural consequences end up affecting one's social life and one's mental wellbeing.

The socio-cultural effects of sterilisation reported in this study include broken marriages, limited marriage prospects and fear of losing marriages. Research participants, one and seven lost their marriages because of forced sterilisation. While they had four and three children respectively, this did not cushion them from suffering the socio-cultural effect of losing their marriages. The participants that are not married experience rejection and fear of rejection. Likewise, participants that are married also fear possibility of rejection due to their inability to bear children.

Additionally, a socio-cultural effect of forced sterilisation is Gender-based violence. Due to forced sterilisation, the women reported a lot of conflict ensuing in intimate relationships because of the inability to have children. The unmet socio-cultural expectations of men when it comes to children precipitate emotional and verbal abuse in

intimate relationships because of forced sterilisation. All the participants affirmed that gender-based violence is often experienced by women who were forced and coerced into sterilisation. The denoted poverty in turn highlights the extreme vulnerability of the research participants and probably of most members of the target population.

Results of the research done by Gockel-Frank (2007) with women in Namibia concerning reproduction and decision making is consistent with this deduction because it also reports of gender-based violence that emanates from issues surrounding decisions pertaining to reproduction in intimate relationships. The experience of gender-based violence poses negative effects on the women's mental wellbeing. This is also consistent with the findings of Essack and Strode (2012), that forced and coerced sterilisation affects victims mentally and physically, and impacts on their relationships with their partners, families and the wider community. They also noted that in countries that are more ingrained in the traditional patriarchal system, female sterilisations could inspire abusive behaviour from husbands who may become angry and aggressive if the decision to be sterilised was made without consulting him.

Edwards-Jauch (2016), notes that Namibia is a patriarchal society and gender inequality and gender-based violence is deeply rooted in the country's history and traditional African patriarchy. Similar to the findings herewith, Essack and Strode (2012) noted that in such cultures, where the value of a woman is placed on her ability to bear children, the socio-cultural effects of sterilisation might be intense.

According to the research participants, in the Namibian culture, women are not supposed to make major decisions without informing their spouses, partners or families. Previous research supports this finding, as Gockel-Frank (2007) in her study with women in Namibia, reported that even though the women knew their rights, it was still the man as head of the household who decided important things, indicating that it is a tradition they learnt from their parents. Therefore, a socio-cultural effect of sterilisation is that the women have been estranged by their intimate partners, families and at times communities for allegedly making the decision to be sterilised without informing them. Participant six did not even disclose to her family that she was sterilised because of fear of being discriminated upon. On the other hand, participant five was ostracized by her family because she allegedly made the decision to be sterilised without informing them. The other five participants faced blame and detestation from their families for being sterilised. The communalistic and patriarchal aspect of most African societies, including Namibia, is such that major decisions are not considered by the individual alone but rather through consultations with family and even extended family and in-laws. Therefore, negative effects of cultural diversions are intensely felt by individuals.

Objective four of this study sought to tap into future effective psychological, social and other forms of intervention strategies that are informed by the women who were victims of forced or coerced sterilisation. According to Gcabo and Moleko (2012), effective interventions are those that are planned effectively, considering the input of the targeted population or individuals in determining their needs and priorities. This study used this approach as part of the processes of determining appropriate future interventions that can be implemented to mitigate the negative effects of forced and coerced sterilisation.

All research participants emphasized the need for psychological, medical, social, legal and financial forms of intervention (see Table 4).

The second part of determining recommendations for practice in this study was based on deriving pertinent issues from the results and discussion of the study. The findings on sterilisation and mental health, sterilisation and sociocultural effects as well as sterilisation and meaning making and coping, revealed that psychological and socio-cultural consequences have been adverse and that coping has been mostly ineffective. Therefore, the present study recommends professional psychological interventions for the women. Additionally, interventions targeting the physical well-being of the women are deemed essential.

CHAPTER SIX

CONCLUSIONS, LIMITATIONS AND RECOMENDATIONS

The aim of this thesis was to explore and obtain an in-depth understanding of the psychological and socio-cultural effects of forced and coerced sterilisation on Women Living with HIV in Namibia in order to ascertain the implications for intervention. Thus, the focus in this thesis was on the psychological and socio-cultural effects and how these Influenced meaning making and coping. In addition, this study paid attention to the aspect of future intervention strategies based on the information obtained from the analysis of identified gaps in coping as well as from the suggestions or recommendations given by research participants.

6.1 Conclusions

The work of Lazarus (1993) and Park and Folkman (1997), regarding stress, coping and meaning making, informed this research and formed the theoretical framework for this study. Focus was placed on primary and secondary appraisals (meanings the women attached to sterilisation) of forced sterilisation and how these are linked to stress and other psychological symptoms of anxiety, sadness, isolation, shame, fear, self-blame, anger, feelings of helplessness, feelings of worthlessness, feelings of hopelessness, loss of interest, sleep disturbance and weight changes. Focus was also on how these primary and secondary appraisals of forced sterilisation and its consequences influence coping, with the finding that all participants employ the ineffective problem-focused coping approach. This is because of the primarily negative meanings they attach to forced

sterilisation. These meanings include loss (of fertility, health, family, marriages), injustice, limited marriage prospects, fear of future loneliness, pain due to severe negative health effects, inability to have more children especially boys, unmet and impossible life goals (having more children). This finding pointed to the importance of professional psychological interventions to facilitate healthy coping strategies such as the emotion-based coping strategies and suggested by Lazarus (1993).

Also of focus in this research were the socio-cultural effects of forced sterilisation. The findings showed that in the Namibian patriarchal context, culture and society place a huge value on the women's ability to have children and thus a woman's worth is judged according to her ability to bear children and the number of children she has. Due to this socio-cultural principle, the effects have been that forced sterilisation in the social and cultural context has resulted in loss of marriages, loss of family, loss of respect, loss of dignity, loss of self-worth, verbal and emotional abuse, discrimination and gender-based violence.

The ultimate purpose of this study was to inform psychological and social intervention strategies that could be developed to further support the women to fully reclaim their lives. The required intervention strategies for the women who were sterilised that were gathered from research participants include, professional psychological counselling, quality or professional medical attention to deal with the negative health effects, reversal of sterilisations where possible, compensation by government, financial assistance for victims, apology from government, continued support from NGOs and awareness raising initiatives to stop forced sterilisation. These recommendations were extracted from the

information provided by the women and they correlated to the negative, health, psychological, financial and social repercussions of forced sterilisation.

While the experiences of the research participants were unique, analysis of results noted that for each participant the negative psychological and socio-cultural effects of forced sterilisation were not present before sterilisation; commenced when the women were sterilised or found out that they were sterilised; and to some degree and or at varying intensity, these are still present. This is why all the participants have indicated that counselling is a very important aspect of future interventions.

6.2 Limitation of the study

This study cannot be generalized to women who were sterilised in other countries because of different cultural and socio-economic contexts. It also focused specifically on WLHIV, therefore it cannot be generalised to other vulnerable populations that have experienced forced and coerced sterilisation. However, the research results can be used as a reference point to give guidance or can be replicated in these areas if need be.

Since this study required subjects to reconstruct their stressful encounters well after the stressful encounters ended, hence these findings cannot prove the causal relationship of forced and coerced sterilisation and possible negative psychosocial effects. This is due to the presence of other extraneous variables such as negative life experiences, being HIV positive and poverty. However, since this was a qualitative research, it accommodated non-linear causality which does not seek to predict behaviour but rather to understand

life experiences by making tentative interpretations, while keeping in mind the extraneous variables that may be present (Stiles, 1993).

Due to the recently resolved court case on forced and coerced sterilisation, a potential limitation was that the respondents might have felt the need to respond in a certain way with the expectation or thinking that this research is somehow connected to the court case. To minimize this limitation, the researcher thoroughly explained to research participants that this research is in no way linked to the court case and the aim and objectives of the research were clearly outlined during recruitment of participants. In addition, by assuring participants of anonymity, confidentiality and that, no answer is incorrect; pressure to perform in a certain way was eliminated.

A final limitation involves the researcher's role and influence regarding the interpretation and analysis of research data. The researcher is female, has a passion for issues relating to the rights of WLHIV and has previously worked with the target population. While there may have been a possibility of bias, the researcher was fully aware of this and utilized qualitative research principles, which emphasize reflection on the part of researchers, both before and during the research process: a reflexivity requires reflect upon and clearly articulate the researcher's position and subjectivities (Sutton & Austin, 2015). Additionally the researcher used two qualitative techniques of checking for alternative explanations and reviewing findings with peers to ensure reliability of the final findings. Since the present study utilized a qualitative research approach, the final analysis was subjective, informed by the researcher's understanding.

6.3 Recommendations

In light of the results of the study and its limitations, recommendations are made for practical implementation and for future research.

6.3.1 Recommendations for practice and implementation

The present study recommends professional psychological interventions for the WLHIV who were forced and coerced into sterilisation. It is recommended that interventions targeting the health or physical well-being of the women be urgently developed to mitigate the severe negative health effects as this came out as a dominant theme in this study. It is also recommended that civil society organisations continue with legal and social intervention efforts, as this study's findings indicated that these efforts have assisted in minimising the negative socio-cultural effects of forced and coerced sterilisation on the women. While this the results of this study cannot be generalized to other countries in the world, it is recommended that they be made available and used as guidelines in countries that are in the process of fighting for the rights of women who were sterilised around the world..

6.3.2 Recommendations for future research

This study could not make definitive psychological diagnosis and conclusions in terms of the extent of the mental health effects. Future research studies on forced and coerced sterilisation can analyse the presence of psychological symptoms and their severity in relation to specific psychological disorders using established instruments. The scope of this study allowed for an in-depth understanding of the experiences of women in Namibia who experienced forced and coerced sterilisation. However, the delimitation was such that it was difficult to make comparisons of differences in terms of age difference, number of children, comparing the experiences of those who were sterilised

and have no children with those who were sterilised and have children, difference in experiences in terms of marital status or relationship status, differences between the employed and unemployed. These gaps could be addressed by future research initiatives.

Future research is also recommended to assess the structure, contents and implementation of interventions that are aimed to assist the victims of forced sterilisation. This is important as a follow up or to build on to the results of this research which specifies the areas of interventions that are required. This will benefit programmers but most importantly, this will benefit the women who were sterilised, as this will ensure monitoring for quality service provision by stakeholders in their efforts of improving the psychological and social well-being of the women who were sterilised.

In conclusion, the results of this study clearly indicate that due to forced and coerced sterilisation, there are some negative psychological and socio-cultural effects. Forced and coerced sterilisation and its negative, psychological, health, financial and socio-cultural consequences negatively affect meaning making and coping. This means that coping is negative and inadequate and this is why the women continue to suffer because these negative effects. Thus, in addition to medical, financial, social, legal interventions, psychological intervention is critical for the wellbeing of the women who were forced and coerced into sterilisation. The recommendations for future interventions outlined in this research represent the voices of those who have suffered due to this gross human rights violation. They are therefore relevant and appropriate, and, it is strongly recommended for stakeholders seriously consider designing interventions that are aligned to these.

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Appendix A: Ethical Clearance Certificate



ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS/343/2017 Date: 20 October, 2017

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy And Guidelines. Ethical Approval Is Given In Respect Of Undertakings Contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Psychological And Socio-Cultural Effects Of Forced And Coerced Sterilisation On Women Living With Hiv (Wlhiv) In Namibia: Implications For Intervention

Researcher: Kudzai Bakare

Student Number: 201601577

Supervisor(s): Dr. Shelene Gentz

Faculty: Faculty of Humanities and Social Sciences

Take note of the following:

- (a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
- (b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
- (c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
- (d) The UREC retains the right to:
 - (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected;
 - (ii) Request for an ethical compliance report at any point during the course of the research;

UREC wishes you the best in your research.

Prof. P. Odonkor: UREC Chairperson

A handwritten signature in black ink, appearing to read "John Odonkor".

Ms. P. Claassen: UREC Secretary

A handwritten signature in black ink, appearing to read "Paula Claassen".

Appendix B: Informed consent form –English

INFORMED CONSENT AGREEMENT

You are invited to join a research study to look at the experiences of women with forced or coerced sterilisation. Please take whatever time you need to discuss the study with your family and friends, or anyone else you wish to. The decision to join, or not to join, is up to you. In this research study, we are investigating the psychological and socio-cultural effects of forced and coerced sterilisation on women living with HIV in Namibia.

Please read this consent agreement carefully before you decide to participate in the research.

Purpose of the research study: The purpose of the study is to understand the psychological and socio-cultural effects of forced and coerced sterilisation on Women Living with HIV in Namibia to determine the assistance that they might need.

What you will do in the study: In this research, you will take part in an interview in which you will share your experiences with forced or coerced sterilisation. You are free to express yourself in your language. The data collected will be mainly on your life adjustment and well-being after experiencing sterilisation specifically, how it affected you emotionally and physically and how it might have affected your relationships with others in your family and your community. The interviews will be audio taped to ensure that we collect the correct information, but the audio tapes will be kept locked up for confidentiality and will be destroyed two years after the research report is finalized. Please feel free to skip any questions that makes you uncomfortable and you can stop the interview at any time.

Time required: The research will require about 1 1/2 to 2 hours of your time.

Voluntary participation: Your participation in the study is voluntary.

Risks: Since this research requires you to share experiences that may be sensitive, the risk is that it may arouse negative emotions. The interviewers are Masters of Clinical Psychology students who will provide counselling sessions for you if need be.

Benefits: There are no direct benefits for participating in this research study, but it will give service providers (for example NGOs) information on the type assistance that the women might need.

Confidentiality: The data obtained in this research will be kept private and confidential and it will be used only for this research. We will use fake names so that no one will be able to identify you. No real names will be used in any report. All the data and recorded tapes will be stored in lockable cabinets and will be discarded two years after completion of the research.

Data linked with identifying information: The information that you give in the study will be handled confidentially. Your information will be assigned a pseudo name. The list connecting your name to this pseudo name will be kept in a locked file. When the study is completed, and the data have been analysed, this list will be destroyed. Your name will not be used in any report. The audio tapes will be destroyed two years after the final research report has been compiled.

Right to withdraw from the study: You have the right to withdraw from the study at any time without penalty. Your audio tape will be destroyed should you decide to withdraw. If you want to pull out from the study, tell the researcher and leave the room or tell the interviewer to stop the interview or documentation related to the research.

Payment: You will receive NO payment for participating in the study. However, you will be reimbursed for your transport and subsistence costs.

If you have questions about the study, please contact Kudzai Bakare, Telephone: 0816 495 216, Email address: kudzikangira@yahoo.com. You will receive a copy of this form for your records.

AGREEMENT:

I understand that the information provided forms part of a master's degree on the "psychological and socio-cultural effects of forced and coerced sterilisation on Women Living with HIV (WLHIV) in Namibia: implications for intervention".

I further understand that the results will be treated confidentially and will only be made available as part of a research report.

I also have been notified that I will be audio taped during the interview and I consent to this.

The research has been explained to me and I understand what it is about.

I further understand that I can withdraw from the research at any stage.

Name of research participant:

Signature of research participant:

Name of UNAM student researcher:

Student number:

Signature of researcher:

Date:

Appendix C: Informed consent form –Oshiwambo

**OMAKONAKONO GOPAMADHILADHILO NOMAYIUV
MOSHIGWANA KOMBINGA YUUWINAYI WOKU THIMINIKA
AAKIINTU MBOKA TAYA UNGAUNGA NOMUKITHI YOHIV YA
PATHITHE IILYO YOLUVALO YAWO KAASHILI PEHALO LYAWO.**

OKUTSEYITHILA OWUVATHANO TSOKUMWE

Owashiwa opo wukuthe ombinga moku konga uuyeletele nontseyo maakulukadhi mboka ya thiminikwa opo ya patwe iivalelo yawo shaaheli pamahalo gawo. Kutha ethimbo lya gwana ndyoka wa pumbwa opo wuye moonkundathana naapambele yoye, okuuume nenge kehe tuu ngoka wa dhiladhila. Etokolo wukuthe ombinga nenge waakuthe ombinga oli li momake goye mwene. Meilongo lyepapeko muno otwahala tukaninge omakonakono gopamadhladilo nomayiuv noshigwana nkene shina uuwinayi woku thiminika aakiintu yapatithe iilyo yawo yoluvalo shaaheli pamahalo gawo.

***Oto indilwa nesimaneko opo wuleshe nawa ewuvathano-tsokumwe ndino
omanga ino kutha etokololoku kutha ombinga mepekapoko ndika.***

Elalakano lyoku ninga ekonakono: okuuva omadhladilo nomayiuv moshigwana nomo mu thigululwakalo uuwineyi woku thiminika aakiintu mboka taya lumbu nombuto yoHIV moNamibia opo yapatithwe iivalelo yawo shaaheli pamahalo gawo, yo ya kuthe etokolo lyekwathelo ndyoka ya pumbwa.

Shono wapumbwa oku ninga meilongo ndika: otokutha ombinga momapulapulo moka toka topolelathana ontseyo yoye mokuthiminika nokupatitha iivalelo. owa

manguluka okupopya omauvu goye Melaka lyoye. Uuyelete mboka toke tupa otawu kala oshinima shoka tashi ke etele elunduluko monkalamwenyo yoye. Nomoku kala koye konima yonsteyo mokupatwa oshivalelo unene tuu ngele tali ku etele ewuvo lyo nayi palutu noshowoo nkene tashi eta uupyakadhi we kwatathano pokati koye naapambele yoye noshowo momuthingoloko gweni. Omapulapulo otaga kwatelwa mokangalo opo tu kwalishipaleke kutya otwa gongela uuyelete wuli omondjila. Nonando ongaaka, okangalo otaka kala kapatelwa moshiholekwa nota kaka shanagulwapo konima yoomvula mbali uuna omapekaeko gamanithilulwa. Oto indilwa nesimaneko opo wukale wa manguluka noku nukapo omapulo gamwe ngoka kuga uvitile ombili, na otovulu oku hulithapo omapulapulo.

Ethimbo lyapumbiwa: omapekaeko og a ka kutha uule wethimbo dhoowili yimwe netata sigo oowili mbali.

Okwiyyamba mokukutha ombinga: ekuthombinga lyoye meyilong ndika oshinima wuna okwiyyambela ngoye mwene.

Omaudhigu gwokwiidhopamo

Iponga: oshoka epekaeko ndika otali kupula wu topolelathane ontseyo yoye, ota shiv ulu oku kuuvitha nayi noshowoo otashi vulu oku kupa omauvu omawinayi. Aapulapuli oya pyokoka nokuungaunga naayilongi mboka taya kapumbiwa eetundi dhehungomwenyo.

Omauwanawa: kamuna omauwanawa guukilila mokukutha ombinga moma pekaeko, Ihe otashi gandja omayakulo noshiholelwa kooNGO moNamibia. Omauyelele ngoka otaga pumbiwa moku kwathela aakulukadhi..

Iinima yopaumwene: uuyelete mboka twamona momapekapeko otawu pungulwa meshala lya gamenwa paumwene, ota wuka longithwa ashike momapekapeko ngoka ganuninwa. otatu ka longitha omadhina giifundja opo kapukale nando ogumwe tavulu oku ku dhimbulula. Kapena edhina lyomondjila tali ka longithwa moku gandja uuyelete. Uuyelete awushe naambu wa kwaterwa mokangalo otawu pungulwa mosikopa hayi patwa na otawu ka ekelwahi konima yoomvula mbali shi omapekapeko gamanithilulwa.

Uuthemba wokwiikuthamo meilongo: owuna uuthemba wokwiikuthamo meilongo ethimbo kehe. nokangalo koye ha walongitha otaka shanagulwapo ngele owa tokola okwiikuthamo . Ngele owa hala okwiikuthamo ,tseyithila omuningi gwomapekapeko ,ngoye tozimo mongulu . Nenge wu tseyithile omupeha konakoni ashulithepo omapulapulo niikwambapila ayihe yinashe noma pekapeko.

Ofuto: Ito ka pewa nando ofuto yasha molwekuthombinga lyoye meilongo ndika. Ihe oto pewa olupandu lolweendo lwoye mwa kwaterwa woo iilongitho iishona.

Oshipalanyolwe shepekapeko:

**OMAKONAKONO GOPAMADHILADHILO NOMAYIUV
MOSHIGWANA KOMBINGA YUUWINAYI WOKU THIMINIKA
AAKIINTU MBOKA TAYA UNGAUNGA NOMUKITHI YOHIV YA
PATHITHE IILYO YOLUVALO YAWO KAASHILI PEHALO LYAWO.**

Ngele owuna omapulo kombinga yepekapeko ndika, kwaterathana na Kudzai Bakare, Onomola yongodhi: 081 649 5216, Email : kudzikangira@yahoo.com.

Oto pewa okopi yofoloma ndjika opo wu yi pungule.

EWUVATHANOTSOKUMWE

Ondiinekela kutya uuyelele nda pewa owuli onga oshitopolwa sho “master’s degree” kombinga yuuwinayi pamadhiladhilo noshowoo pamuthigululwakaldo-hingoloko wokuthiminika aakiintu mboka taya ungaunga nombuto yoHIV ya thitike iilyo yoluvalo yawo kaashili pomahalo gawo moNamibia ;naashoka tashi vulu oku ningwa po

Onduuviteko kutya iizemo yepekapoko ndika otayi kala ya holekwa nota yi ka longithwa ashike monzapo yepekapoko ndika.

Onda tseyithilwa kutya otandi ka kватва okangalo moonkundathana nota ndi gandja epitikilo.

Onda fatululilwa ,nonduuviteko nawa combing yepekapoko ndika.

Onduuviteko woo kutya ota ndi vulu oku hulithapo omapulapulo.

Edhina lyomukuthimbinga :

Shaina mpano (omukuthimbinga) :

Esiku :

Edhina lyonasikola konakoni gwokoUNAM :

Onomola yomulongwa :

Shaina mpano (omulongwa wokoUNAM) :

Esiku:

Appendix D: Interview Schedule-English

INTERVIEW GUIDE

SECTION 1: OBJECTIVES OF THE INTERVIEW AND INFORMED CONSENT

SECTION 2: DEMOGRAPHIC INFORMATION / BIOGRAPHICAL INFORMATION

Age, Language, Education level, Employment status, Marital/relationship status, Area of residence, Number of biological children, Number of fostered children and Household composition.

SECTION 3: EXPERIENCES WITH STERILISATION

Case

Ndeshi is 39 years old. She is HIV positive. Ndeshi is pregnant with her first child and she is very excited. Her boyfriend is very happy too because he wants to have many children. She goes to a local hospital to have her baby. The doctor tells her that the baby is not in the right position (breach baby) so they have to operate her immediately in order to save her life and the child's life. She is given forms to sign while in the theatre room. Ndeshi is in a lot of pain, she is told by the nurse that the papers are for the operation and she signs. She also cannot read so she just signs because she wants to save her baby's life. Ndeshi gives birth to a healthy baby girl and she is so happy. After six weeks, Ndeshi goes to the local hospital again, this time to collect her family planning pills. When her turn comes, the nurse tells Ndeshi that she does not need family planning anymore. Ndeshi does not understand what the nurse means and she tells the nurse that she has always used the pill and she needs family planning because she does not want to get pregnant because her baby is still too young, she is only one and half months old. The nurse explains to Ndeshi that it is written BTL on her health passport, which means that she was sterilised when she gave birth and that she will never be able to fall pregnant again, so she does not need family planning anymore. Ndeshi is very shocked to hear this.

1. What do you think Ndeshi did after being told that she was sterilised?
2. How did Ndeshi feel when she found out that she will never be able to have children again?
3. Why do you think Ndeshi was sterilised?
4. Tell me about the day you found out that you were sterilised. What happened that day?
5. How do you think has being sterilised changed your life (family, work, relationships, and health)

6. Were any of these problems in your life before you were sterilised?
7. Now, can you think back and try to recall the people who helped you or made you feel better when you found out that you were sterilised. Who gave you the most support or help when you were trying to deal with being sterilised?
8. Do you think Ndeshi ever felt isolated or estranged from her immediate family, community or society because you were sterilised?
9. In your culture, what do people think of a woman like Ndeshi who is sterilised and is unable to have children?
10. Do you think that Ndeshi would face any negative or hostile reactions in her community because she can no longer have children? (Probe to find out from whom)

SECTION 4: COPING AND ESTABLISHING THE MEANING OF BEING STERILISED

11. It has been 10 years since Ndeshi was sterilised. Do you think it still bothers her, that she was sterilised?
12. Why do you think Ndeshi was sterilised without her knowledge?
13. What does the fact that you were sterilised without your knowledge mean to you now at this moment?
14. How often do you still ask yourself ‘why did this happen to me?’ Do you have any goals or plans for the future?
15. How has being sterilised influenced or changed any of these goals?
16. Do you consider yourself a religious or spiritually oriented person?
17. Does God or religion influence the way you look at certain things happening in your life? Tell me more.
18. Have there been any positive or good changes in your life ever since you found out that you were sterilised? Please tell me more.

SECTION 5: STERILISATION AND MENTAL HEALTH PROBLEMS

19. Did you ever experience changes in your sleep, after you found out that you were sterilised? Tell me more about this.
20. After you found out that you were sterilised, did you ever feel isolated by others or alone? Did you isolate yourself from others or feel lonely? Why?

21. Did you notice significant changes in your weight after you found out that you were sterilised?
22. Did you experience excessive crying after you found out that you were sterilised? Tell me more.
23. Did you ever experience feeling sad all the time after you found out that you were sterilised? Tell me more about this
24. Did you ever blame yourself for being sterilised? Tell me more about this. Do you still blame yourself for being sterilised?
25. Did you ever experience fear of contact with health centres or health professionals (nurses or doctors) after you found out that you were sterilised? Tell me more about this.
26. Did you ever experience loss of interest in activities that you enjoyed after you found out that you were sterilised? Tell me more about this.

SECTION 6: CONSEQUENCES OF FORCED STERILISATION

27. Do you think Ndeshi still wishes to have more children?
28. Do you think that women who were sterilised like Ndeshi experience violence, physically, emotionally or verbally from others?
29. What kind of help do you think is necessary for you and other women like Ndeshi who were sterilised?
30. What suggestions would you give to those who would want to continue to assist you and other women like Ndeshi who were sterilised, for example, NGOs like Namibia Women's Health Network?

Appendix E: Non-disclosure form

RESEARCH ASSISTANTS CONFIDENTIALITY AGREEMENT

PSYCHOLOGICAL AND SOCIO-CULTURAL EFFECTS OF FORCED AND COERCED STERILISATION ON WOMEN LIVING WITH HIV (WLHIV) IN NAMIBIA: IMPLICATIONS FOR INTERVENTION

I, _____ [name of research assistant], agree to assist the primary investigator with this study by interviewing participants, transcribing and translating (from Oshiwambo to English) the interviews. I agree to maintain full confidentiality when performing these tasks.

Specifically, I agree to:

1. keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the primary investigator;
2. hold in strictest confidence the identification of any individual that may be revealed during the course of performing the research tasks;
3. not make copies of any raw data in any form or format (e.g., disks, tapes, transcripts), unless specifically requested to do so by the primary investigator;
4. keep all raw data that contains identifying information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession. This includes:
 - keeping all digitized raw data in computer password-protected files and other raw data in a locked file;
 - closing any computer programs and documents of the raw data when temporarily away from the computer;
 - permanently deleting any e-mail communication containing the data; and

- using closed headphones if transcribing recordings;
5. give, all raw data in any form or format (e.g., disks, tapes, transcripts) to the primary investigator when I have completed the research tasks;
 6. destroy all research information in any form or format that is not returnable to the primary investigator (e.g., information stored on my computer hard drive) upon completion of the research tasks.

Name of research assistant_____

Address:_____

Telephone number:_____

Signature of research assistant_____

Date _____

Name of primary investigator_____

Signature of primary investigator_____

Date _____