ACCESS TO AND KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT SCHOOL GIRLS IN GOBABIS, NAMIBIA

A THESIS SUBMITTED IN PARTIAL FULFILMENT

OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS (GENDER AND DEVELOPMENT STUDIES)

OF

THE UNIVERSITY OF NAMIBIA

BY

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APRIL 2019

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Abstract

This study offered unique insight in the challenges and opportunities that exist for adolescent access to sexual and reproductive health services (SRHS) in Gobabis. It focused on exploring adolescent access to reproductive health services through the experiences of adolescent girls and healthcare providers. It was a qualitative case study. The data was collected through interviews with adolescent girls and key-informants who are experienced healthcare providers. This approach provided an in-depth understanding of adolescent reproductive health needs and barriers hindering their access to SRHS in Gobabis. Participating schools and health centres were selected using a purposive sampling technique while the individual girls were sampled using a quota sampling technique. The data gathered from participants was analysed manually using content analysis.

The findings show that the girls have access to SRHS. However, they lack a comprehensive understanding of their sexual and reproductive health rights (SRHR). As such, this could have affected the meaning attached to their reproductive health. Generally, the girls are aware of a variety of SRHS available at their local health centres but needed more information on their side-effects. The most commonly sought after SRHS was the contraceptive 'injection', family planning pills, condoms and the morning after pill. Others included, counselling services and general health information. However, barriers such as the high cost of service in private facilities, the waiting time in government facilities, negative attitudes from nurses and lack of parental support and discussion on issues surrounding sex and sexuality continue to impact access to SRHS. The researcher recommends mother and daughter community health clubs at health centres that can facilitate discussions on SRH among parents, adolescents and health professionals in order to effectively communicate the importance of adolescent reproductive health.

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Acknowledgements

I would like to take this opportunity to acknowledge individuals whose assistance made this study possible.

Firstly, I thank my main supervisor Dr. Lucy Edwards-Jauch, for her support and advice which has been essential in the writing of this thesis. I wish to also acknowledge and offer sincere gratitude to my co-supervisor, Ms. Maria B. Kaundjua, for her contribution.

I wish to thank the Ministry of Education, Arts and Culture and the Ministry of Health and Social Services for granting me permission to conduct this study. I also acknowledge the research participants for their valuable time and expertise.

Special thanks go to my family and friends. My greatest appreciation goes to my parents for their immeasurable support and dedication throughout my academic journey which has been beyond words. I also wish to thank my brothers for making the load more bearable through their constant motivation and support and finally, my friends for making the journey memorable.

Declaration

I, Alice Mubanga Pearce, hereby declare that this study titled "Access to and Knowledge of Sexual and Reproductive Health Services Among School-going Adolescent Girls in Gobabis, Namibia" 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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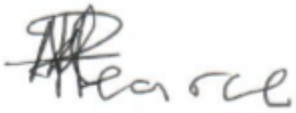

Alice Mubanga Pearce	……	25 September 2018
Name of Student	**Signature**	**Date**

Dedication

To my parents- Dunstan and Joyce Pearce for their unwavering faith and support throughout my academic journey.

List of abbreviations and acronyms

AIDS – Acquired Immunodeficiency Syndrome

AU – African Union

CEWDAW – Convention on the Elimination of All Forms of Discrimination against Women

CRC – Convention on the Rights of the Child

CRPD – Convention on the Rights of Persons with Disabilities

HIV – Human Immunodeficiency Virus

ICPD – International Conference on Population and Development

ICCPR – International Covenant on Civil and Political Rights

ICESCR – International Covenant on Economic, Social and Cultural Rights

MGECW – Ministry of Gender Equality and Child Welfare

MOEAC – Ministry of Education, Arts and Culture

MOHSS – Ministry of Health and Social Services

NDHS – National Demographic and Health Survey

NGO – Non-Governmental Organisation

NPPA – Namibia Planned Parenthood Association

SADC – Southern African Development Community

SRH – Sexual and Reproductive Health

SRHR – Sexual and Reproductive Health Rights

SRHS – Sexual and Reproductive Health Services

STDs – Sexually Transmitted Diseases

STIs – Sexually Transmitted Infections

UNAIDS – United Nations Program on HIV and AIDS

UNFPA – United Nations Population Fund

WHO – World Health Organisation

Chapter 1

Introduction

1.1 Background of the study

This study investigated and explored factors that impact on access to Sexual and Reproductive Health Services (SRHS) from the experiences and perspectives of school-going adolescent girls in Gobabis. The study highlighted the cultural diversity and experiences of adolescent girls on SRH. Issues of Sexual and Reproductive Health Rights (SRHR) and bodily autonomy are considered a political rather than a personal issue by feminists. This is because a lack of political will in ensuring the provision of SRHS tends to disadvantage certain groups even further. Gender equality and justice advocacy includes the recognition of the reproductive health rights of women and the elimination of potential barriers that may impede these rights. Women's groups have over the years made great strides towards the attainment of reproductive rights of women. However, various challenges still exist globally. The recognition of women's rights ensures that SRHR are treated with the same importance as fundamental human rights.

SRHR stem from the Civil Rights movement of the Second Wave of feminism that advocated for individual agency through the right to vote and the exercise of free choice. Sexual and reproductive concerns were in the past treated as 'private issues' due to the private/public dichotomy and lacked a sense of urgency. More recently, there has been a shift in the focus on SRHR through the integration of a human rights approach to bring about reproductive justice by allowing women to have reproductive control of their bodies (Luna, 2009). Feminists argue that

women's bodies are the site through which experience is realized, thus when girls are denied access to SRHS the effects are evident through their bodies. There has been a call for the recognition of intersecting social inequalities that influence the SRH outcomes of individuals based on their social contexts. This is believed to promote greater access of SRHR in an equitable manner regardless of one's positionality. SisterSong (as cited in Luna, 2009 p. 8) defines the intersectional theory of reproductive justice as "the complete physical, mental, spiritual, political, social, environmental and economic well-being of women and girls, based on the full achievement and protection of women's human rights." The intersectionality framework was developed for a more holistic analysis of women's struggles as they are not a homogenous group and their struggles differ. For many girls, SRHR cannot be realised in isolation as they are dependent on other rights such as access to education, employment, information and freedom of choice that act as pre-conditions for their full realisation. This framework was vital in analysing access to SRHS in Gobabis since the participants of the study have different social positions and faced different challenges in accessing these services.

The 1994 International Conference on Population and Development (ICPD) was instrumental in recognising the reproductive needs of women. Garcia-Moreno and Turmen (1995) assert that the declaration shifted the focus on reproduction from concerns about population control to the need to empower women and to improve their quality of life. The ability to make their own reproductive decisions with the aid of services and programs to control their own fertility makes women active agents of change, rather than passive recipients of population control policies and programs. The writers call for more research to be undertaken in the field of reproductive health to understand the legal and socio-cultural contexts in which these rights are accessible to women

and girls. This process is vital in adapting the declaration to their unique environments and to make access to quality SRHS a reality. The ICPD defines SRH as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (1995, p. 40). SRHR recognize free, non-coercive, non-violent and non-discriminative reproductive choice, with the provision of information to attain the highest standard of SRH (ICPD, 1995). While, SRHS refer to a range of safe and affordable amenities that help one avoid, cope and mitigate SRH problems (UNFPA, 2016). Although the Namibian Constitution and other policy documents recognize SRHR, barriers such as denial of access to services, poor quality services and access limited by third party authorization, impede their full attainment.

Access to SRH information and services is believed to be a key determinant of one's sexual health and decision-outcomes. The SADC Protocol on Health under Article 17 recognizes the need to encourage adolescents to delay sexual activities through access to safe, effective and affordable health services and information (SADC, 2008). The implementation of sex-education programs and services could ease access to adolescent friendly SRH information and services that are responsive to adolescent needs. However, Kennedy, et al. (2014) assert that a significant number of programs centring on sex education seemingly incline towards one or two aspects of SRH, making them incomprehensive. Recognizing this gap, there is a need to identify adolescents SRH and information needs and barriers to access in order to improve SRH service delivery among this key group of the population. One of the Sustainable Development Goals (SDG's) is aimed at achieving universal access to sexual and reproductive health (UNFPA,

2016). This necessitates for an understanding of the level of access school-going adolescent girls have to SRHS in Gobabis.

According to Larke, et al. (2010), the period of adolescence is of critical importance in ensuring that young people safely transition into adulthood. During this period, they tend to face unique challenges such as peer-pressure and lack an understanding of the emotional and physiological changes they go through. Kesterton and Cabral de Mello (2010) affirm this argument stating that adolescent girls are at risk of unplanned pregnancies which may be accompanied by life threatening conditions. This puts them at risk of seeking unsafe abortions due to social conditions that may prevent them from providing proper care to their babies. Therefore, providing access to the relevant services and information could assist girls prevent unintended pregnancies and other illnesses.

According to Okonofua (2012), African nations face challenges in effectively designing and implementing programs for adolescent access to SRHS. These challenges include political, economic, religious and cultural factors. He argues that these influences are sometimes intersectional in creating barriers to access and programing. He challenges traditional models of adolescent reproductive health programing and calls for a paradigm shift that could reach a wider range of adolescents. He identifies the use of information and communication technologies (ICTs) and mobile devices as potential means to improve adolescent access. Recognising that African societies are deeply rooted in family structures, he also calls for greater engagement with the family to address and improve the SRH of adolescents. Strengthening programs that address

patriarchal values, norms, traditions and beliefs are also vital in improving the reproductive health of adolescent girls particularly in rural communities.

Socialisation has a bearing on adolescent access to SRHS. Generally, African societies discourage parents from communicating matters of sexual nature with their children. This is a preserve of specific kin and non-kin relations (Moyo & Rusinga, 2017). According to Dune and Mapedzahama (2017), sexuality and sexual health in the Shona context is central to married life, therefore, unmarried people are not to be concerned with such issues. It is this perception that poses a barrier for parents and adolescents to initiate discussion on sexual health. The study found that Zimbabwean parents living in Australia experienced a clash of cultures as they were expected to be the primary source of sex-education to their children. As such, they had to act against their cultural and religious value systems and take up the duty bestowed upon a specific family member responsible for relaying sex-education to their children. The challenges faced by these parents remain similar to those of other African women whose societal and religious norms reject adolescent sexuality and perceive SRH information as irrelevant to unmarried people. It can be argued that this presents a barrier for adolescents attempting to access SRHS for fear of judgment and lack of parental support.

Moyo and Rusinga (2017) found that although adolescents were aware of various contraceptive methods, they still did not use them in preventing pregnancy with the exception of the male condom. The cost of female contraceptive methods in relation to the male condom was found to be expensive and unaffordable for adolescents. The condoms were often sourced from peers, shops and pubs with only 0.3% reporting to have accessed them from the clinic. The lack of

knowledge of other contraceptive methods was attributed to the attitudes and perceptions of parents, health workers, religious and traditional leaders. Adolescents reported not having adequate information on various contraceptive methods available to them. The reluctance by these groups in bridging adolescents to the relevant information on contraceptive usage is an indication of the barriers girls face in accessing SRHS. Social and religious barriers were found to influence access to SRHS and information. Religious teachings were centred on abstinence and cultural norms valued sexual purity, encouraging girls to refrain from any sexual activity until marriage. However, these ideas did not reflect the reality on the ground as majority of the adolescents in this study reported being sexually active but did not access health centres for fear of being stigmatised for being sexually active. As a result, adolescents are exposed to inaccurate information which they reported receiving from their friends whom may also be misinformed. Access to SRHS as found in this study was limited to parental consent for minors below the age of 18 and married women. Hostility, judgement and lack of confidentiality at health centres were reported as barriers to access. The social disapproval of adolescent sexuality resulted into limited knowledge of and access to SRHS among adolescents. This tends to increase the vulnerability to sexual health problems for many girls.

Organisations such as The World Health Organisation have been influential in advocating for the implementation of adolescent-centred services (WHO, 2012). As a result, Namibia has adopted the recommendations provided by WHO through its National Policy on Reproductive Health. The Ministry of Health and Social Services (MoHSS) strives to promote adolescent access to SRHS through increased adolescent participation and community support. They also seek to sensitize health providers to create an adolescent friendly environment in order to increase

accessibility to adolescents. They view collaboration with other sectors as a means to raise awareness and promote access to SRHS (MoHSS, 2011). Collaboration is essential in SRHS promotion as there is a need to transform social norms and societal perceptions of female sexuality and sexual health. WHO reaffirms the importance of adolescent participation in the design and implementation of services and programs that are meant to address their needs. This also gives services providers the opportunity to evaluate their services against the needs and challenges of adolescents. However, the high rates of teenage pregnancy recorded in the Omaheke region could suggest a breakdown in service provision targeted at adolescents (MoHSS, 2014). It is against this background that the researcher considered it vital to investigate the accessibility of SRHS among school-going adolescent girls in Gobabis.

1.2 Problem statement

Adolescent SRH is both important and a widely contested discourse. Although some people may believe adolescents should be excluded from accessing SRHS, some argue that these services are vital to the overall wellbeing of adolescent girls. Eliminating barriers that limit and hinder access to SRHS is said to be a precondition for the advancement of women and girls in society. According to Kennedy, et al. (2014) these barriers tend to heighten adolescent sexual vulnerability and prevent them from attaining their full potential. Despite universal commitments to the ICPD declaration, there are still barriers to the realization of SRHR for all and access to services. Statistics show that the highest demographic of the Namibian female population falls in the 15-19 age group. However, only 24.5% make use of contraception with non-usage at 75.5%. There is also a strong correlation between contraceptive use and level of education with women having no education at 33.7% and those having more than secondary education at 58%.

Similarly, 39.6% women falling in the lowest wealth bracket are less likely to use contraception, than 53.7% in the highest wealth bracket. These statistics propose that there is a challenge in accessing SRHS for adolescent girls in Namibia. The Omaheke Region in which Gobabis falls has a teenage pregnancy rate of 36%. This is the second highest rate in Namibia (MoHSS, 2014). Hence there is a need to investigate SRHS access among adolescent girls and explore the barriers that limit it.

1.3 Objectives of the study

The main research question in this study was "Are adolescent girls able to access SRHS in Gobabis?" This question was addressed by answering the following sub-questions:

1.3.1 Do adolescent girls have SRH needs?

1.3.2 Which sources of information do they consult pertaining to their SRH needs?

1.3.3 Do adolescent girls have access to SRHS?

1.3.4 What are the social-structural and cultural barriers that hinder access to SRHS?

1.3.5 How can these barriers be overcome to ease access to SRHS?

1.4 Significance of the study

This study is aimed at assessing adolescent access to SRHS and understanding the underlying barriers that limit such access and service provision to them. This is an important subject since improved access to SRHS could advance the quality of life for adolescent girls. In addition, access to SRHS plays a central role in the empowerment of women and girls and the realisation of other rights. SRHS help adolescent girls stay in school and further their education which entails better access to the labour market and may translate to better socioeconomic conditions

for them and their families. Furthermore, this study may contribute to literature on adolescent SRHS and access in Gobabis. It may also contribute towards policy discourse on access to SRHS to young girls. Similarly, recommendations from the findings may help improve service delivery and SRH communication to adolescent girls.

1.5 Limitation of the study

The researcher faced challenges in meeting participants at designated locations due to transport constraints. Time constraints resulted in the rescheduling of interviews. Also, the levels of education and experiences of individual participants differed. Some participants decided to drop-out of the study after initially showing interest in taking part. This meant the researcher had to keep looking for new participants to meet the desired sample size. Hence, the data collection process took longer than anticipated.

1.6 Delimitation of the study

The study focused on adolescent girls between 15-19 years of age from Epako High School and Gobabis Gymnasium School, as well as, health staff from Epako Clinic and Gobabis Medical Centre. Thus findings may not be generalized to represent Namibia.

1.7 Outline of the thesis

This section provides an outline of the chapters in this thesis to give the reader a synoptic view.

Chapter One: this chapter provides an overview of the study. It introduces the focus of the study, the study's problem, its purpose, importance and its objectives. It also spells out the extent and delimitations of the study.

Chapter Two: covers the literature review and theoretical framework that shaped the study. **Chapter Three:** focuses on the research methodology, outlining how the study was conducted and the procedures followed by the researcher.

Chapter Four: is the presentation of findings generated during field work.

Chapter Five: is the discussion of the findings and compares it with the literature review. **Chapter Six:** outlines conclusions and makes recommendations based on the study and is followed by a list of references and appendices.

Chapter 2

Literature review

2.0 Introduction

This Chapter draws upon international and regional treaties that affirm sexual and reproductive health rights (SRHR) for all, as a point of departure in the discourse surrounding access to adolescent sexual and reproductive health services (SRHS). The literature suggests that although a variety of SRHS and information are available, adolescents have continued to miss out on the benefits surrounding access to these services. Hence, they continue to suffer from increased SRH vulnerabilities. The literature argues that increasing adolescent accessibility to these services and information could positively influence their wellbeing. Studies indicate that despite a variety of initiatives to ease access to these services, barriers ranging from cultural, individual to structural are still prominent in many societies. Furthermore, the environment in which access is pursued is influenced by a range of barriers that impede access for many adolescent girls. There is evidence that their social identities intersect with various social inequalities that converge to influence their SRH experiences. The literature suggests that adults do not trust adolescents to make good and responsible SRH decisions. The lack of positive adult involvement in assisting adolescent girls build the relevant competencies necessary to make these decisions is a point of contention. There is a need to explore how this evidence may impact on access to SRHS among school-going adolescent girls in Gobabis.

2.1 Definition of terms

2.1.1 Sexual and Reproductive Health and Rights (SRHR)

There are various working definitions of sexual and reproductive health (SRH), most of which include a rights' based approach to SRH. The 1994 International Conference on Population and Development (ICPD) and the World Health Organization (WHO) define SRH as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (ICPD, 1995, p. 40). Furthermore, WHO emphasizes on respect of an individuals' sexuality and sexual relationships. They also call for the respect of the rights of individuals as a pre-condition to attaining and maintaining sexual rights (WHO, 2006). The European Humanist Federation (2015) defines sexual and reproductive health as the capacity for one to have a safe and fulfilling sexual life and the ability to reproduce. Their definition is extended further to include recognition of ones' ability to make a free choice about their sex life and reproductive decisions. Sexual and reproductive health rights (SRHR) recognize free, non-coercive, non-violent and non-discriminative reproductive choice, with the provision of information to attain the highest standard of SRH (ICPD, 1995).

Sexual and reproductive health services (SRHS) refer to a range of safe and affordable amenities that help one avoid, cope and mitigate SRH problems (UNFPA, 2016). Although the Namibian Constitution and other policy documents recognize SRHR, barriers such as denial of access to services, poor quality services, and access limited due to third-party authorization impede their full attainment. In this study, SRHS will refer to any professional information and assistance regarding SRH needs that are conveyed to adolescents such as sex education, contraception,

counselling and testing and referral services. WHO (2002) defines adolescence as a young person falling in the age range of 10-19. However, in this instance, an adolescent shall refer to a person between the ages of 15-19 as the main focus of this study. It is assumed that girls in this age group may already be sexually active. A lack of adequate services and trustworthy information may increase their risk to unwanted pregnancy, disease and poor decision making.

2.2 International instruments and treaties promoting universal access to SRHR and SRHS

Although there is no single human rights instrument that is specific to reproductive rights, the various elements of these rights are protected under the United Nations and regional human rights instruments through various legally binding declarations and protocols to which nations are expected to commit themselves (United Nations, 2014). This is due to the diverse nature of reproductive rights. The various freedoms and privileges contained in the national laws, international human rights instruments and policies are a representation of reproductive rights. Namibia is a signatory to various international and regional treaties that protect the rights of women, particularly their reproductive choice, right to integrity and protection against all forms of violence including sexual violence and female genital mutilation. These treaties are, the International Conference on Population and Development (ICPD), the Beijing Declaration and Platform for Action, the Convention on the Rights of Persons with Disabilities (CRPD), the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). While the regional treaties include the protocol to the African Charter on Human and

Peoples' Rights on the Rights of Women in Africa and the SADC Gender and Development Protocol (Legal Assistance Centre, 2005).

The 1994 International Conference on Population and Development (ICPD) agenda calls for the respect of individual rights of reproductive choice, free from discrimination, coercion, and violence. This also calls for the provision of correct information and services in order to attain the highest possible standard of sexual and reproductive health (ICPD, 1994). The Convention on the Rights of Persons with Disabilities (CRPD) was enacted to protect the rights of persons with disabilities. Article 25 of CRPD specifically addresses their right to sexual and reproductive health without discrimination based on their disability (United Nations, 2006). While Article 6 of the International Covenant on Civil and Political Rights (ICCPR) calls for the enactment of prevention measures of high maternal mortality by recognizing how it violates the right to life (United Nations General Assembly, 1966).

Another international instrument that promotes reproductive rights is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In Articles 12, 14 and 16, it appeals for signatories to guarantee access to health care and family planning services. Also, outlining the need for necessary services in relation to pregnancy and the right to reproductive choice on the number and spacing of children (United Nations, 1988). Similarly, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) promotes the right to attain the highest standard of health (United Nations General Assembly, 1966). Adolescents' reproductive rights are covered by the Convention on the Rights of the Child (CRC) under Article 24 which calls for commitments to ensure adolescents attain the

highest standard of health. It recognizes the sexual and reproductive health needs of adolescents and how access to information is crucial to their involvement in decision making on matters that concern them (United Nations, 1989). These treaties are a reflection of a collective commitment to securing SRHR and keeping SRH on the development agenda for all individuals across the globe.

Equally, regional commitments such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa also known as the Maputo Protocol, promote sexual and reproductive health rights under Article 5 and 14. They call for the elimination of harmful practices, particularly, female genital mutilation, violence, and abuse. In the same vein, Article 3 calls for the protection of human dignity through the prevention of violence, particularly sexual violence (The African Union, 2003). Namibia is also a signatory to the SADC Gender and Development Protocol that also spells out guidelines for reproductive health commitments. According to the National Gender Policy and National Health Policy Framework, Namibia has responded to several issues surrounding adolescent SRHR. These include; maternal health, adolescent pregnancy, HIV/AIDS, reproductive autonomy and the elimination of harmful cultural practices (MGECW, 2010). Others include; the provision of adolescent-friendly services, information, and counselling, raising awareness of adolescent SRH needs, increasing parental involvement and strengthening school health services (MoHSS, 2010). In addition, the Namibian state through the Constitution and the enactment of various policy documents has aligned itself to reflect the states' commitments to these international and regional treaties through which it is held accountable to protect and promote reproductive health rights, particularly those that impact women.

Furthermore, the state is held accountable for its laws and policies that criminalize and prevent any form of discrimination or action that may limit one's SRHR. In order to realize its commitments, the state shall be responsible for ensuring that the adequate budgetary and resource measures are put in place to effectively implement SRHR and action plans that promote these rights (The African Union, 2003). It is the duty of the state to ensure that barriers to SRHR are prevented or minimized and that social norms and practices reflect respect towards an individuals' SRHR. A set of targets were formulated from the goals of the Maputo Protocol surrounding SRHR. These targets have specific action plans to be followed to ensure SRHR are promoted and protected. Progress in the area of SRH is measured with the help of measurement tools such as collecting disaggregated data and the use of scorecards to provide data and statistics to measure set targets. Signatories are mandated to submit periodic reports on the necessary legislative measures they have implemented and the progress they have made in realizing the SRHR of their citizens (The African Union, 2003). In Namibia, the Ministry of Gender Equality and Child Welfare (MGECW) is responsible for compiling progress reports and presenting them to Cabinet and Parliament (MGECW, 2010).

However, the White Ribbon Alliance (2015) argues that a lack of accountability and reporting mechanisms for development agendas make it difficult to monitor progress and state commitments to goals and targets set. In the same vein, poor citizen engagement in policy and program formulation negatively impacts their implementation leading to continued SRHR violations despite state commitments. Thus, it is vital to increase engagement with civil society organizations and citizens in order to promote state accountability through increased social participation, particularly with women who are less likely to have access to SRHR or have these

rights violated. In Namibia, civil society organizations that support SRHR include UNAIDS, UNFPA, Namibia Planned Parenthood Association, Sister Namibia, Galz and Goals only to mention a few. These organizations assist in the advancement and accountability of the state's efforts to promote and protect SRHR especially in hard to reach areas and in situations where budgetary constraints may limit program implementation. Dattler (2016) affirms that civil society organizations are important in promoting SRHR for all and ensuring state accountability. They act as watchdogs of the government, conducting research at national and community level to track progress of SRHR program implementation. Their advocacy role and critic of government actions ensures they uphold their commitment to human rights. Also, their ability to engage with communities helps in giving a voice to key groups. Raising awareness of SRHR ensures they demand respect and recognition of these rights.

2.2.1 Namibian legal and policy instruments on SRHR and SRHS

Namibia through the Ministry of Health and Social Services has developed and implemented a National Reproductive Health Policy. The policy operates at four different levels; national, regional, district and community levels. In order to make this policy more effective, a multi-sectoral approach has been employed in which other line ministries have a stake in its application to efficiently aid service delivery (MoHSS, 2001). These include the Ministry of Basic Education, Sport and Culture, Ministry of Higher Education, Youth and Employment Creation, Ministry of Home Affairs, Ministry of Foreign Affairs, Information and Broadcasting and the Ministry of Gender Equality and Child Welfare. The goal of this policy is to "promote and protect the health of individuals and families through the provision of equitable, acceptable, accessible and affordable quality reproductive health services" (MoHSS, 2001 p. 8). The policy

is guided by the ICPD principles on reproductive health that is recognized as a basic human right for every Namibian. It also promotes equal and equitable access to reproductive health services to all Namibians. Similarly, it recognizes the rights of adolescents to have access to all information on sexual and reproductive health as well as access to quality adolescent friendly services. The policy calls for community involvement in the planning, provision, and monitoring of reproductive services, and on all stakeholders to offer non-biased, quality services with the aid of necessary skills and knowledge to impact service delivery. Setting up such a policy for Namibia is reflective of the states' commitment to the reproductive health agenda. Hence, it is vital that Namibia responds to the needs of adolescents as a key group of the population that possess various SRH needs that may be hindered due to structural and cultural impediments at various levels of the implementation phase of this policy.

In addition, Namibia has over the years implemented various revised versions of the National Gender Policy resulting from the Beijing Declaration and Platform for Action. This was done as a means of reaffirming its national commitments on issues surrounding women and the girl child. The policy is reflective of its support to ensure safe and affordable reproductive health services for all Namibians. In a bid to improve women and girls' reproductive rights, the policy outlines several strategies such as formulating campaigns to raise public awareness and improve knowledge through the dissemination of HIV/AIDS and SRH information to all (MGECW, 2010). Furthermore, these policies have been aligned to already existing rights that are protected by the Constitution such as Article 5 that protects fundamental rights and freedoms for all and Article10 that promotes equality and freedom from discrimination (The Republic of Namibia, 1990). Although Namibia may have a conducive climate for SRHR through various policies and

legislature, Luna (2009) contends that even in situations where policy documents do exist, these policies may not always resonate with the happenings on the ground. A lack of awareness of such Policies and Acts among adolescents and the general public could result in an infringement of SRHR. Therefore, it is vital that policy implementers scale up on sensitization and awareness efforts to make known the importance of SRHR and how they can be infringed upon.

2.2.2 Sexual and reproductive health rights and services in Namibia

In Namibia, statistics from the National Demographic and Health Survey (NDHS) show that the highest demographic of the Namibian female population falls in the 15-19 age group (MoHSS, 2014). However, only 24.5% make use of contraception with non-usage at 75.5%. In spite of them being the highest demographic, their SRH needs are largely unmet. The statistics indicate a strong correlation between levels of education, social class and age as determining factors to accessing SRHS in Namibia (MoHSS, 2014). Contraceptive use and level of education among women having no education is 33.7% and those having more than secondary education is 58%. Similarly, 39.6% women falling in the lowest wealth bracket are less likely to use contraception, than 53.7% in the highest wealth bracket. Thus, it can be argued that in Namibia, girls from poorer households may lack access to good quality SRHS in comparison to their peers. Omaheke Region in which Gobabis falls has a 36% teenage pregnancy rate, the second highest in Namibia (MoHSS, 2014). There is a need to investigate adolescent SRH needs and access to SRHS in order to understand the factors influencing access or a lack of. Applying an intersectional analysis to this study revealed the diversity of school-going adolescent girls' experiences with SRHS in Gobabis. This may be attributed to their unique social identities and how these experiences are influenced by their social differences.

In an effort to combat high teenage pregnancy and Human Immunodeficiency Virus (HIV) rates, the Namibian government adopted sex education as part of the school curriculum. The Life Skills subject and other extra-curricular programs such as My Future is My Choice arose as a national strategy to address these high rates. The strategy includes SRH education in schools, distribution of condoms and provision of youth-friendly services (Mufune, 2008). However, it was found that teachers and learners did not take the subject seriously because it was ungraded. Although teachers were perceived as credible sources of SRH information, they lacked training and relevant teaching materials to adequately conduct their lessons. Mufune also found that some teachers were reluctant to discuss topics of sexual nature with learners of the opposite sex and in some cases sent out such learners. The study showed that sex-education focused mainly on biological functions and less on typical issues adolescents faced such as relationships, love, emotions, sex, peer pressure and decision making. Parents were sceptical of lessons on sexuality. Sex-education therefore lacked parental support. Consequently, these factors constitute a vast range of barriers that impact access to SRHS and information for many adolescents. Improving access to quality information services surrounding SRH issues could significantly improve adolescents' SRH outcomes and access to these services. Thus he recommended that the subject be graded and teachers are adequately trained in SRH education in order to effectively engage learners and teachers.

Correctly branding SRHS and reducing the stigma surrounding their access was important in encouraging adolescents to make use of them. A study (Jana, Mafa, Limwame & Shabalala, 2012) found that the use of the brand name 'family planning' in Namibia deterred adolescents from accessing SRHS as they seem to refer to married people. Adolescents reported experiencing

stigma and embarrassment from health care staff when they attempted to access contraceptive services. Similarly, it was also found that certain factors discouraged adolescents from seeking medical assistance when a problem arose (Mufune, 2008). These included waiting time, unfriendly clinical staff and the lack of confidentiality. Some adolescents reported being sent away from the health centres and in some cases being reported by health staff to their parents. Such practices and the denial of SRHS was unethical and a violation of an individuals' privacy and right to access information as well as other human rights (Shaw, 2009). Jana, et al. (2012) also identified unfriendly healthcare workers, poor parent-child communication and access limited to third-party authorization for minors as major barriers that impacted access to SRHS among adolescents. Others included distance to health centres particularly in rural areas, the cost of service, waiting time and a lack of gender-sensitive service provision as adolescents were attended to by a staff of the opposite sex. Similarly, Mufune (2008) found that parents, teachers, and nurses were conservative in discussing adolescent SRH due to cultural norms surrounding sexuality and a lack of relevant competencies to relay SRH information. There was an expectation for young people to refrain from any sexual activity before marriage and parents could not actively speak to their children over their sexuality. As a result, such barriers negatively impacted access to SRHS for many girls. Due to the high teenage pregnancy rates, increasing access to contraceptives and sex education may significantly reduce the rates of teenage pregnancy. Jana, et al. (2012) recommends orientating health staff to youth-friendly service provision that is confidential, empathetic, gender and age sensitive. Equally, revising operation hours and cost of services could be beneficial to them. Removing legal barriers to contraceptive use for adolescents by reducing the age of consent which is 18 in Namibia could also help reduce pregnancy rates.

Sexuality and sex is a topic that is framed as private. Culturally, parents and children are uncomfortable to discuss the topic as it is perceived to be inappropriate to adolescents and children. This lack of discussion on the topic can be associated with feelings of shame and embarrassment among parents and children. Open discussion is also discouraged by the morality surrounding its practice by unmarried people. Traditionally in most African cultures, it is considered unacceptable for parents to discuss sex with their biological children. This duty is reserved for grandparents, aunts, and uncles. There is reluctance by parents to engage in SRH discussions. A study by Nambambi and Mufune (2011) affirms this argument. They found that in most Namibian cultures, parents did not discuss sex with their children due to the cultural notion of sexual taboos between parents and children. Also, generational differences impact open discussions on sexuality. Younger people, for instance, tend to be more open to talking about issues surrounding sexuality in comparison to older people. Adolescents interviewed reported they found it uncomfortable to discuss such issues with their parents and most found it embarrassing. It was easier for a mother to address her daughter on sexual matters in comparison to their sons. As observed through this study, it can be seen that age and gender differences impacted discussion. Thus, the stigma surrounding sexuality tends to heighten vulnerability especially in societies that strictly police female sexuality yet deny them access to the relevant knowledge and services to make informed decisions.

Destigmatizing sexuality and societal perceptions of sex could assist in overcoming barriers surrounding access to SRHS among adolescents. Although Nambambi and Mufune's (2011) study argues that cultural barriers impacted parental discussion of sexual taboos with their children and were found to be hindering access to SRH information. The study also suggested a

shift in this trend as some parents reported being open to discussing issues surrounding sex with their children. One of the reasons cited was that they preferred this information come from them and that their children were not ignorant about sexual issues. Thus, normalizing discussions on sexuality could improve parent-child communication on SRH and influence adolescents' sexual health outcomes.

Access to SRHS is essential to an individual's wellbeing. The Namibian Planned Parenthood Association (NAPPA) offers a range of SRHS and has been utilized by many Namibian adolescents. The clinic offers adolescent-friendly SRHS which include rapid HIV testing and referral services to nearby clinics. They also provide adolescents with condoms, information on condom usage, pregnancy and advice on how to protect themselves from unintended pregnancy, HIV and other sexually transmitted infections (STI's). Although much of their work is centred on advocacy and lobbying on SRHR and issues, the organization wishes to include comprehensive counselling and HIV testing services in order to serve their community better. This organization has given many adolescents an opportunity to access free SRHS that otherwise would be a challenge for them to receive. Although they only have three points of service and operate at 2 clinics in the city of Windhoek they intend to expand their accessibility and coverage. Their target population are youth groups. They are also involved in peer education projects aimed at improving the SRH decisions of young people (International Planned Parenthood Federation [IPPF], n.d).

2.3 Theoretical frameworks to sexual and reproductive rights and services

Feminists such as Mary Wollstonecraft, Emma Goldman and Susan Bordo have long been concerned with issues surrounding SRHR and bodily autonomy in the fight towards gender equality and justice. With the recognition of human and women's rights, SRHR places fundamental human rights at the fore. This approach is essential to achieving universal access to SRH (Ritchie, 2012). Since SRHR are embedded in Human Rights principles, adolescents are a key group that need these rights defended and protected due to their lack of social power in society. Adolescents have different positionalities and are faced with varying SRH needs and challenges. As such, they do not constitute a homogenous group. There has been shift in the SRHR debate from one that recognises access to SRHS as a basic human right to one that seeks social justice for individuals and communities that have been disproportionately disadvantaged by various structural and social institutions in fully realising these rights.

Reproduction, like other feminist issues is political, it goes beyond personal choice. Ross (n.d.) in her article "The colour of choice: white supremacy and reproductive justice" argues that contraceptive technologies have historically been used as a means to control the population. China is an example that has imposed a national population control policy. In an attempt to control women's fertility, the government offers incentives and welfare restrictions to ensure that people comply with the policy. However, this control has been targeted at women of colour as a means to control the population growth of certain communities for political reasons. This resulted in forced sterilization and contraception use targeted mainly at women of colour, while white women could access better quality services in order to encourage them to have more children. She argues that men continue to make decisions over the fertility of women. Drawing

on the intersectionality between access to SRHR and race, her article points out that white supremacist ideologies influence reproductive polices that tend to negatively affect the health outcomes of women of colour. These policies tend to be discriminatory towards them, thereby limiting their ability to make reproductive choices. Due to the system of oppression that they face, the rights based framework did not respond to their unique needs. This system of oppression intersects with racism, patriarchy, homophobia and religious fundamentalism to limit their SRHR. She identifies ways in which population control is implemented targeted at women of colour. These include selective movement, migration restriction, incarceration, and various forms of discrimination. She also draws concern to the conditions of the prison system in which pregnant illegal immigrants and incarcerated women have been forced to abort their pregnancies. She argues that the bodies of women of colour continue to be a site of reproductive politics, bearing the consequences of political agendas. Her article cites forms of abuse faced by incarcerated women of colour as denial of adequate health care and pressure to seek an abortion particularly in cases involving prison guards as reported by the Human Rights Watch. These actions generally go against an individual's human rights and reproductive choices.

Concerns have been raised on the application of human rights and their accessibility to all regardless of their racial and economic backgrounds. Ross (n.d.) asserts that the reproduction of women of colour has been left at the mercy of powerful elites that formulate population control policies based on race, class, sexual identity and migration status, thereby, suppressing their rights. Limitations on their SRHR have been through forced contraception, sterilization abuse and welfare restrictions for poor women. Her argument also highlights how a lack of access to contraceptive and abortion services is equally used a means of population control. In Third

World countries, restricting access to contraception and abortion could have a negative impact on the population. This is due to the high infant and maternal mortality and HIV rates. Ross draws attention to two dichotomous sides in the global reproductive debate; the right wing and the left wing. Although these wings may share different views on reproduction, they both seek to control the fertility of women of colour through different means. The left wing views an increase in access to contraception, economic development and education as a means of controlling the population. This may be done through coercion into contraceptive use and sterilization. In contrast, the right wing views warfare and economic control as a means to achieve this. The right wing views poverty as resulting from individual choice and do not recognize the social inequalities that exist among different groups and communities, for instance race as a factor that could influence one's social position. However, a feminist by the name of Zillah Eisentein draws the link between poverty and reproductive outcomes such as teenage pregnancy, lack of access to contraceptive and reproductive rights, lower wages for women, a lack of day care programs for working women, poor quality health care and inadequate education and training opportunities as factors that influence social inequalities in society. She suggests that social inequalities are mutually reinforcing and cannot be viewed as isolated from each other (Ross, n.d.). Ross concludes that both left and right wings do not offer a practical solution to the reproductive violations faced by women of colour. Even though the left wing promotes gender equality and seeks to eliminate racism, economic inequalities and colonialism, their position on population control targeted at women of colour is discriminatory and a violation of their human rights. The right wing is thought to deny women of colour the necessary tools to make their own reproductive choices. Furthermore, Ross argues that the privatization, commodification and deregulation of the public health care system have a negative impact on women of colour. They

limit access to health care services through high costs and increase the rates of mortality and morbidity particularly among vulnerable women. Movements that seek to promote the SRHR of women have been thought to be headed by white middle class women that alienate women of colour from active participation in the fight for their rights. They have been criticised for their potential to be blind to white supremacy and have been accused of conniving with white patriarchal privilege to control the fertility of black women. Due to the social inequalities that prevent equal access to human rights across all individuals, Ross recommends the reproductive justice framework as a means to protect and promote the SRHR of all women with different positionalities.

The recognition of SRHR denotes freedom of choice for every individual. The inclusion of SRHR in Policy frameworks has been essential in promoting and protecting them. However, Morison (2013) argues that not everyone is able to exercise this freedom due to various factors that may limit ones choice. She identifies systemic socio-economic factors, a lack of information on SRH, stigma, violence and sexual coercion as hindering the attainment of SRHR. She argues that due to a lack of information and financial resources, some women find it difficult to access SRHS thereby negatively impacting their SRH decisions and rights. Violence and coercion have been found to limit SRHR for many young women, particularly, those who fall pregnant as a result of rape or force. Accessing abortion services for such women tends to be hindered by a combination of the social factors she has identified. She adds that although South Africa offers legal abortive services, people continue to access unsafe options due to these factors and a lack of awareness. Furthermore, she is critical of the rights based framework as it overlooks the underlying factors that influence freedom of choice. The high cost of health care is an important

limiting factor to consider. The division of the health care system into public and private facilities entails that a higher quality of service is rendered to those that can afford to pay for it. The poor majority however, tends to access poor quality services due to a lack of finances and access to medical aid. Like other scholars she calls for an analysis of SRH that recognizes the intersections of social identities such as age, religion, sexuality, race, socioeconomic status, culture and gender as major factors that impact the full realization of SRHR. Her argument highlights important connections between poverty, access to care and insurance, gender-based/intimate partner violence, and stigma and their elimination as essential to the realization of these rights.

Gurr (2012) highlights the failures of the American government in protecting the reproductive rights of Native Americans. Her article suggests that the solution to the reproductive violations faced by Native American women lies in the reproductive justice framework. Although America is signatory to some human rights treaties on reproductive health, failure to ratify several other treaties makes it difficult to secure the rights of Native women. In the past, the American government signed treaties with the Native people of America that required them to give up their land in exchange for services. It therefore became the states' obligation to ensure their access to healthcare services. However, power imbalances make it difficult for them to demand better quality services since America views this provision of services as an obligation to the people rather than a human right. Even though the right to medical care is explicit in the treaties, America has failed to adequately provide for the health needs of Native people, in some cases directly contributing to them. Gurr's article identifies various violations that impede the SRHR of Native women. These include, "limited access to facilities and services, limited access to

contraception, contraception and sterilization abuse, and limited care for survivors of sexual assault" (Gurr, 2012, p. 9).

Native people access their healthcare services through the Indian Health Services (IHS) differently from other American citizens particularly those with medical cover. This type of service provision was discriminatory and limited the service options of Native people. The services have been found to be outdated and poorly funded therefore impacting quality. Although there is a school-based mobile clinic which provides services to adolescents such as STI and pregnancy screening, the community has few healthcare facilities in the area. They tend to travel long distances to access the closest service points with limited access to private transport while public transport services are non-existent. This acts as a major barrier to access. Under-staffing and operating hours have also been identified as a barrier to access. The study's participants reported that they were unable to access the services they needed on demand. They reported being unsatisfied with the treatment they received at the facilities and having to wait long hours before being attended to with appointments extending to as far as a year for specialised health services. Due to a lack of maternal delivery services at the local clinics, pregnant women faced difficulties in accessing birth facilities having to travel long distances in search of the service. A Catholic health facility that provided these services was reported to have been coercing Native women into taking up induced labour without prior counselling and an understanding of its risks and benefits. The facility would not provide access to any contraceptive methods to women. These violations coupled with a lack of information, are as a result of the government's failure to secure the SRHR of Native women.

A lack of standard contraceptive services across health facilities serving Native women was a major concern. Emergency contraception was reserved solely for victims of sexual assault. Although oral contraceptives were found to be easily accessible, they could only be distributed monthly. There was no dissemination of information on the side-effects of oral contraceptives to Native women such as depression, osteoporosis, sterility, cervical cancer and headaches (Gurr, 2012). This limits the control women have over their fertility. The limited choices on contraceptive methods available forced women to seek tubal ligation and sterilisation. The high rates of these methods being accessed among Native women in comparison to white women was considered as a form of 'sterilisation racism' highly being associated with Native women and women of colour. To curb accusations of coerced sterilisation and tubal ligation, the procedure was made available to Native women under the IHS provided they received adequate information about it, counselling and subject to a thirty-day wait before the procedure was performed. However, critics argue that this also hinders their SRHR as there is no provision for other forms of contraceptives during this period.

According to Amnesty International (as cited in Gurr, 2012), Native women were more likely to experience sexual assault compared to non-Native women. However, the IHS facilities did not have a clear protocol in place to deal with sexual assault victims and conduct forensic examinations. A lack of professional staff needed to administer emergency care was a hindrance to the provision of quality services, with some women being unattended to. In some cases, women did not have the relevant evidence needed to press charges against the perpetrator due to a lack of or incomplete evidence. Sometimes women were forced to access services from facilities located much further from their residences. Also, many medical service providers were

found to be insensitive to their cultural identities. Consequently, such factors discouraged women from accessing the services they required. The American government has failed to minimise the racial disparities in access to SRHS among various groups. Gurr argues that the liberal context in which these rights are formulated requiring individual agency has been identified as a barrier to achieving these rights among Native people who regard community rights as more important than individual rights. She suggests that the reproductive justice framework is essential to protecting and promoting the rights of Native women because they recognise the rights of collective groupings and communities. The framework calls for the reformation of discriminatory racial and economic structures that perpetuate and reproduce social inequalities among women in accessing SRHR. The liberal ideologies surrounding human rights tend to emphasize individual choice, overlooking the social and cultural contexts in which they are to be exercised and individual positionalities.

The diverse social locations and positionalities of individuals necessitate the application of a framework that recognises diversity and accounts for inequalities beyond the individual. The reproductive justice framework encompasses intersections of various social injustices and inequalities that impact how one experiences these rights. The reproductive justice framework just like Kimberly Crenshaw's theory of Intersectionality recognizes the social diversity of individuals and how various forms of oppression or discrimination can converge to oppress people differently based on their positionalities (Crenshaw, 1993). This chapter highlights debates raised by scholars on how various social factors such as levels of education, age, gender-identity, race, class status, cultural and religious affiliation and many others can converge to discriminate or oppress people differently.

In order to secure the SRHR of adolescent girls, it is vital to include a reproductive justice element in the design and implementation of SRHS to make these services accessible to all. According to SisterSong (as cited in Luna, 2009, p. 8) the intersectional theory of reproductive justice refers to "the complete physical, mental, spiritual, political, social, environmental and economic well-being of women and girls, based on the full achievement and protection of women's human rights." Luna further argues that the assumption that people are aware of their human rights may be a barrier to their full application of SRHR since they may not be aware of how these rights apply to their individual social realities. Hence, in order for adolescent girls in Gobabis to fully realize their SRHR, it is essential to empower them through education of their rights, raising SRH awareness and increasing access to services, thus permitting them to make better and informed decisions.

An individuals' legal right to access health care may not always materialize in reality due to a lack of resources and other structural issues that may hinder this access (Luna, 2009). Thus, in order for reproductive justice to occur healthcare services must be made accessible and affordable to all by addressing the socio-structural barriers that impede access. Applying an intersectional analysis provides a deeper scrutiny and understanding of the contexts in which SRHR and justice are realized at individual and structural level. According to Harper, Jones and Watson (2012), reproductive justice entails placing adolescent girls SRH needs at the centre of analysis by recognizing how these needs differ due to their gender, age, socio-economic status and other social identities and how these identities can impede access. It also demands the recognition of how social institutions play a part in the attainment of the SRHR of adolescent girls through discriminatory laws, social norms, practices, and actions. The framework calls for

an understanding of how these factors can lead to further vulnerability of adolescent girls due to social exclusion and restricted opportunities to make informed SRH decisions. Therefore, it is imperative that the government prevent such barriers through policy and action as well as increase adolescent participation in the design and implementation of SRH programs. By giving girls a voice, they would be empowered to exercise agency on their SRH, leading to increased opportunities for reproductive justice and better health outcomes.

The reproductive justice framework demands that all people must have the right to make personal decisions about their life as a part of their human rights. It envisions a world where all people have the social, economic and political power and resources to make healthy decisions about their bodies, sexuality, and reproduction. Thus, adolescent reproductive justice is concerned with how social issues overlap with each other impacting ones' ability to exercise fully their autonomy and rights over their body and sexuality (Ritchie, 2012). Girls falling in the low-income bracket and of a particular race or ethnicity are more likely to have their rights infringed upon due to the social inequalities that surround them. Similarly, they may be more likely to have an abortion due to various social inequalities such as lack of access to healthcare, contraception, and education. This approach draws on the intersectionality theory that recognizes how various social inequalities can impact diverse groups of people differently. The theory proposes that each position or context of an individual or group of people be seen as inextricably linked with all other positions or contexts in order to fully understand ones' identity or social position. Therefore, how adolescent girls experience their reproductive rights is based on their social identities such as race, social class, age, physical ability and many other social elements.

These various elements coverage and impact individuals differently, thus, breeding inequitable access to reproductive health services among girls.

Thus, reproductive justice draws a focus on various social inequalities and calls for their recognition and elimination so as to ensure equitable access to reproductive health services. It can be argued that through comprehensive sexuality education to all, and the provision of affordable services, reproductive justice can be propelled to improve access to SRHS among adolescent girls in Gobabis. Also, providing readily accessible reproductive health services for adolescent girls would ensure that young girls exercise their rights to their bodily autonomy and agency over their bodies. However, accessing reproductive health rights in the absence of effective state and legal frameworks that guarantee gender equity may be a challenge without restructuring reproductive justice into the legal and political frameworks. As such, state legislation and state policy have to reflect reproductive rights. The Namibian situation is one that reflects political commitment to SRHR through its policies and laws, however structural and cultural issues still impact service delivery.

Finally, the state has the obligation to ensure that services are affordable and accessible and that every citizen has access to the right information and services when required. Equally, it is important that adolescents exercise their individual agency to actively seek out information and services available to them (Paiva, Villar, Souza & Lemos, 2015). Therefore, the state must ensure that adolescents SRHR are recognized as stipulated in the various human rights treaties, adolescents are well-educated on these rights and given a platform to participate in policy

development and implementation on matters that involve them as well as scaling up resources where needed most to ensure equitable access to SRHS.

2.4 Debates surrounding SRHR and SRHS

2.4.1 SRH needs of adolescent girls

Although both male and female adolescents have many reproductive health challenges, the latter are faced with unique burdens that are specific to their gender and sex (Atuyambe, et al., 2015). It is vital to note that adolescent girls cannot be treated as a homogenous group as their needs, socio-economic conditions and positionalities differ. A study in Uganda (Chandra-Mouli, Armstrong, Amin, & Ferguson, 2015) found that adolescent girls lacked adequate knowledge relating to their bodies and health. The lack of adequate information posed a challenge in dealing with the numerous changes they faced during puberty. The need for sexuality education at this stage was found to be crucial since it offers ways to cope with one's experience of physiological changes. Kennedy, et al. (2014) and Patel, et al. (2012) concur that there is a need to improve access to sexual and reproductive information so as to meet the SRH needs of adolescents as a critical step towards realizing their rights. These studies indicate that there was generally an unmet need of SRHS targeting unmarried and young people. Thus, the two studies agree that access to SRHS would enable a safe transition into adulthood with reduced risk of SRH problems. As adolescents' needs change, it is vital that relevant information is imparted to them, empowering them with the necessary tools to make informed decisions pertaining to their sexuality and reproductive health.

Another study in India (Chauhan, Solanki, Patel & Singh, 2015) found that adolescent girls desired credible sources of reproductive health information and hygiene. The girls also indicated a need for inexpensive menstrual pads. To address this need, adolescent health friendly services were instituted by the government of Gujarat in three areas that provided public washrooms. However, the study found that a majority of the adolescents were not aware of such services or did not use them, citing reasons such as shyness or embarrassment, financial constraints and no need for treatment among those that did not use the services. On the other hand, those that had visited the centres were generally satisfied. This study suggests that although adolescent girls may be aware of their SRH needs, a lack of knowledge and awareness of the available services to address these needs may heighten their vulnerability. Hence, there is a need to engage adolescents in service provision and implementation in increasing their accessibility and use.

Furthermore, Atuyambe, et al. (2015) highlights various needs that were considered important by adolescent girls. These included free condoms, education on menstrual cycles, information on various contraceptives and their side effects, youth counsellors, teenage medical centres and post-abortion care services. Most important to them was the need for teenage medical centres, citing they were uncomfortable to access services at the same centres as their parents. With regard to condoms, adolescents reported the high cost of condoms as a challenge. Another issue was that health staff distributed condoms without proper instruction on how to correctly use them. They also cited a need for information on how to deal with sexual advances from older men, rape, and defilement. The girls expressed a desire to access safe abortion services as they were aware of its illegality. Yet, many girls had been forced to take up unsafe methods of abortion to terminate unwanted pregnancies sometimes with the help of healthcare staff leading

to death and health complications. This study suggests that a wider range of information is needed by adolescents that not only address their biological needs but also their emotional and social needs. Learning how to deal with intergenerational relationship advances could assist in reducing the number of sexual violations that young girls tend to experience in their communities. Also, building their confidence to communicate these needs could be instrumental in realizing their SRHR.

Hodgson, Ross, Haamujompa and Gitau-Mburu (2012) conducted a qualitative study in Zambia to understand the SRH needs of adolescents living with the human immunodeficiency virus (HIV). The study revealed that adolescents living with HIV had a unique set of needs in comparison to those without. They expressed a desire to speak to someone over SRH issues. Parents and close relatives were identified as the first point of contact for guidance that adolescents could speak to regarding their status. However, due to the stigma surrounding the disease, it limited parent-child communication on sexual issues. It was also found that information in the home was restrictive. The girls in the study expressed a desire to know how to deal with issues surrounding relationships with the opposite sex, safe-sex practices, and motherhood. To combat feelings of isolation and loneliness, some adolescents mentioned they were part of support groups that organized workshops and made available counsellors that they could speak to. This study is indicative of the varying range of SRH needs adolescents have due to their circumstances or contexts. The needs of these participants differ significantly from other adolescents in the same age group due to their health status. Thus, it is vital to provide the relevant information and services that address the specific needs of adolescents at a particular time in their lives to help improve their health status and cope with their unique circumstances.

Contraceptive therapies are a vital service for many women. However, adolescents tend to be left out in the provision and distribution of this vital service by gatekeepers. The low usage of modern contraception methods among adolescents could be attributed to a lack of adequate knowledge on contraceptive use and their effects on the body. A fear of the perceived side-effects tends to discourage adolescents from using these methods. This increases their risk of unplanned pregnancy, unsafe abortions and the contraction of sexually transmitted infections (STIs). Parents and health service providers act as gatekeepers to SRH information, thus there is a need to actively link these important players in meeting the needs of adolescents. A study by Kumi-Kyereme, Awusabo-Asare and Darteh (2014) indicated that Ghanaian parents identified unintended pregnancy, HIV/AIDS, unsafe abortions and STI's as major concerns affecting adolescent reproductive health for many girls. They were also more likely to drop out of school due to adolescent pregnancy. Parents play an important role as sources of information. They act as the first point of reference for many adolescents and determine what age appropriate for their children is. It is vital to engage them in realizing the SRH needs of adolescents.

Moreover, Kumi-Kyereme, et at. (2014) found that some Ghanaian parents were still sceptical of availing SRH information to adolescents. The parents perceived discussing information on condom use and other contraceptive methods with their children would be interpreted as encouraging them to engage in sexual activity. Parents often only spoke to their children on SRH issues to caution them. The discussion was mainly centred on abstinence and morality rather than providing support and dialogue on issues affecting adolescents. This approach by parents could indicate parental denial of adolescent sexuality and their needs. This makes it difficult to address

the issues girls are faced with during this period. Thus, changing parental perceptions of adolescent reproductive health needs could lead to better access to SRHS.

Adolescent sexuality cannot be categorized as solely heterosexual. The categorization of homosexuality as an abnormal practice especially in African societies increases the vulnerability of adolescents. The acknowledgement of the existence and practice of other sexualities by adolescents entails recognizing the SRHR of these groups. Since their needs may differ from those of heterosexual girls, it is important to meet these needs with uniquely tailored services. This group is often stigmatized and discriminated against, resulting in the denial of SRHS based on their sexual orientation or gender identity. Mprah (2016) argues that there is a need to train health workers to not only be gender sensitive but also treat individuals that identify as homosexuals with dignity and compassion. They too have a right to access the highest quality of service and information available for treatment, management, and prevention of negative health outcomes. Mprah's argument is essential in realizing the SRHR of adolescents with differing sexual orientations that because of their social identity are often excluded and discriminated against in many segments of society. Although legal instruments condemn such discriminative practices, the reality for many such adolescents calls for more engagement and awareness of these rights and the importance of service delivery to such communities.

2.4.2 Sources of SRH information available to adolescents

Sources of SRH information accessible to adolescents vary among various studies, indicative of the vast experiences and positionalities of adolescent girls. Their use is highly determined by credibility and trustworthiness as well as privacy and accessibility of a particular source. A

Hodgson, et al. (2012) study cited NGOs, schools, community events, friends, media (TV, radio, and newspapers) and ‘‘experts’’ who were long-term patients at clinics as vital sources of HIV and SRH information among adolescents living with HIV. Conversely, these adolescents expressed caution over the information they got from friends and teachers as it was perceived to be inaccurate. Although the medical staff was perceived as reliable sources of SRH information, they expressed a desire to be spoken to directly and more clearly. Pointing out that, medical staff often spoke to their parents instead of directly to them; and in some cases, the girls reported receiving conflicting messages. This study calls for information providers and disseminators to engage directly with their intended audience in order to put across their message more clearly and precisely. There is a need to acknowledge that adolescents need to be treated as young adults. Hence, availing relevant information accurately could help them improve their decision-making abilities.

Chandra-Mouli, et al. (2015), Kennedy, et al. (2014) and Patel, et al. (2012) recommend that SRH information not only include aspects of sexuality, reproduction and SRH problems but also how to avoid, cope and mitigate such problems. Thus, access to the right and relevant sources of information and services may help improve one’s SRH and could enable adolescents to safely transition into adulthood by reducing their risk to SRH problems.

Lince-Deroche, Hargey, Holt and Shochet (2015) in a South African study on knowledge and access to SRHS found that young women listed doctors or nurses, schools, the media, family, and friends as the most frequently consulted sources of SRH information. Other sources included pamphlets, books and the television. The study’s participants indicated that information on

contraceptives was readily available at health centres and that they mostly confided in family and friends who would advise them to seek professional assistance. Some respondents also indicated that information on abortion services was available in newspapers, pamphlets, and posters in their community. Despite their knowledge of the illegality of these services, they would access such services and share this information with their peers due to desperation. This study suggests that although a vast range of information sources may be available to young women, the necessary services may still be inaccessible to many of them. There is also a danger that adolescents may access inaccurate information that may negatively impact their health.

Another study by Siebold (2011) found that Australian adolescents used a variety of sources for their SRH information. The survey revealed that a majority cited peers as the most frequently used source of information. Other sources cited include the media; books, magazines, television and the internet. Also mothers, health professionals and partners were important sources. However, fathers were found to be the least consulted source on SRH matters. Although some sources were related to sexual activity and how to improve one's sexual performance, a significant number of adolescents still found them useful. They provided age-appropriate information on safe-sex practices, sexually transmitted infections (S.T.I's) and screening programs such as pap smears and mammograms. Teenage girls reported feeling less embarrassed to access such information from magazines and books as they did not have to speak to someone about these issues. They also found fact sheets from chemists and doctors, newspaper articles and the internet as useful sources of SRH information. The study identified mothers, partners, and peers as influencing factors on adolescent SRH decisions. Others included knowledge base and family values as positive influential factors. Religious values and fathers were perceived as

the least influential. The use of alcohol and drugs were viewed as negative influencers. Magazines, books, TV, and movies were perceived as somewhat possessing both positive and negative influence on adolescent SRH decision making. Despite having SRH information at their disposal, the girls indicated a need to build their confidence. This was in order to overcome sexual pressure they faced from boys and their choice to say "no". Dealing with the double standards surrounding sexuality was found to be a challenge for many girls. Generally, male sexuality was encouraged and acceptable while female sexuality was scrutinized and judged. Female sexuality is held at a higher standard relative to that of males. As such, providing the relevant information to girls would help them exert bodily autonomy and choice over their bodies with the aid of accurate information available to them.

Macintyre, Vega and Sagbakken (2015) in their study on Chilean pubescents found that adolescents used a range of SRH information sources. There was a general perception that teachers, parents, and healthcare professionals were the most trusted. Other sources used included the internet, friends, and partners. It was reported that teachers placed emphasis on risk and prevention of sexual health outcomes with limited opportunity for interaction during such lessons. Parents were found to only engage in SRH discussions with their children upon request from the school, at the onset of relationships or menstruation and for specific events such as school camping trips. However, these discussions rarely encouraged dialogue between parents and children. The focus was mainly on issues surrounding pregnancy, STI's and contraception. The study also found that teacher and parental discussions were thought to impart fear in adolescents. They also lacked aspects of practicality, negotiation of sexual situations and relationships, often leaving their needs and questions unaddressed. Negative attitudes and

instilling fear when communicating SRH issues may impact girls negatively as they may internalize the stigma surrounding such issues. It may affect their perception of the importance of openly discussing SRH with their peers and others.

In another study in Vanuatu, Kennedy, et al. (2014) found through focus group discussions and interviews with key-informants, that adolescents cited peer educators and health workers as their preferred source of SRH information, since they were thought to be knowledgeable and trustworthy. Reliability and trustworthiness of SRH information were issues of concern to this group. They thought that a large portion of sources provided incomplete and inaccurate information. Adolescents perceived peer educators as approachable, knowledgeable as well as friendly. These factors were important in determining access to such information and services for the girls. Other sources included printed materials, radio, and the internet, citing privacy and anonymity as factors of concern by the group. Although health workers were mentioned as the most trusted and current source, social barriers made them the least accessed. These barriers included negative attitudes from parents and adults, socio-cultural norms and taboos surrounding sexuality, religious norms and a lack of knowledge and communication skills by parents to effectively communicate SRH information.

Cultural barriers also limit discussion on SRH issues. Muhwezi, et al. (2015) argue that, despite age and gender hierarchies that limit discussion on SRH, parents are perceived to be a key source of SRH information. The literature shows that level of knowledge and ability to maintain confidentiality was an important factor in the selection of SRH information sources. Other sources included schools, other adults, the media, and friends. Adolescents were often at risk of

accessing incorrect information from such sources. This study argues that although schools were a good platform to impart SRH knowledge, many teachers were reluctant to address SRH issues due to the cultural contexts in which they operate. The notion that providing access to SRH information would encourage adolescents to engage in sexual activity was prominent among some teachers and parents. Furthermore, the implementation of comprehensive SRH programs faced various challenges such as a lack of coordination, supervision and planning to ensure its sustainability. Although some SRH and HIV issues were integrated into other subjects, a lack of teaching material was a challenge for many teachers. Equally, a lack of standard curriculum programming made it difficult to implement comprehensive sex-education in private schools. Also, HIV/AIDS education in the curriculum was neither examinable nor required (Muhwezi, et al., 2015).

2.4.3 Access to sexual and reproductive health services (SRHS)

There are various international policies and commitments to protect the SRHR of individuals, yet, these rights have remained a highly debatable topic of social and political interest. The ICPD agenda has continued to be stalled by political conservatism and religious fundamentalism (Roseman & Reichenbach, 2010). Various studies suggest that access to information is crucial to aid adolescents in their decision making and to enable them to exercise their individual agency pertaining to their sexuality and reproductive health needs. After reviewing various surveys WHO (2002) concluded that for many adolescents, seeking professional help is often the last resort to resolving their problem. They identified “poor quality service, a lack of awareness by adolescents, as well as legal, physical, economic and psychological barriers” as limiting adolescent access to SRHS (WHO, 2002, p. 21). They contend that young people are often

unaware of the signs and symptoms of serious illnesses that may require medical attention. In some instances, they may not know what services are available and how to go about accessing them. WHO also identified legal and cultural restrictions as important factors that tend to hinder service delivery to adolescents. In African countries, abortion and contraception services remain highly inaccessible due to legal and cultural restrictions even as health workers continue to deal with the consequences of unsafe abortions.

WHO (2002) is critical of the dilemmas cultural implications place on health workers on whether or not to allow adolescents access to condoms. Moreover, adolescents require the consent of an adult to receive medical care. Adolescents have a desire to access SRHS in a timely, private and confidential manner. Unfriendly services often deter them from seeking medical attention particularly when there is a sense of judgement and having their identities compromised while at the clinic. Poor quality services equally hinder service delivery to adolescents. This may be due to a lack of adequate training, supplies, and motivation among health care staff. Similarly, the high cost of service prevents them from seeking attention. Adolescents often require financial assistance from an adult to pay their medical bills. However, this may compromise their privacy and confidence to seek attention. A culture of silence around sexuality prevents discussion of sexuality and the body. It hinders adolescents from speaking up when faced with a problem. This may be due to the judgement and shame placed upon such individuals and the stigma surrounding sexual health problems. In addition, gender barriers impede access to SRHS. Adolescent girls may be reluctant to seek medical attention when they have to be examined by a medical professional of the opposite sex. Girls may also have limited access to information due

to the amount of time spent at home doing house chores. In addition, girls tend to experience more judgement on their sexuality than boys, making them more reluctant to seek SRHS.

Shaw (2009) draws the link between SRH and human rights and recommends an approach that recognizes social differences and inequalities to adequately address the unique situations of individuals. She further asserts that factors such as gender, occupation, location, ethnicity, education levels and socio-economic status should be recognized as key determinants of access to and experiences of SRHS. Her argument calls for the need to remove legal barriers that impede adolescent access to SRHS by limiting parental consent. South African law, for example, permitted anyone 14 years and older the right to access contraceptive services. Shaw is critical of the popular view that providing sex-education could encourage adolescents to engage in sexual activity. Instead, she argues that linking adolescents to accurate sources of information could be helpful in delaying sexual activity and empowering them to negotiate and resist peer pressure and to make informed decisions. She is also critical of societal gender norms that encourage girls to be ignorant and passive about sex. It can be argued that such norms violate the bodily autonomy and reproductive choice of women and girls.

Despite progressive policy regulations on SRH in South Africa, access to these services remains a challenge for many, particularly those below the age of 18. A South African study by Holt, et al. (2012) found that despite the fact that South African regulations permit anyone older than the age of 12 to access SRHS including abortion services, one clinic reported this service was only offered to girls older than 18 years of age. Another clinic reported HIV counselling as only accessible to individuals older than 18 and another to those older than 16. Another hindrance to

access was the fees charged on these services. Two centres reported charging for the female condom and another charged fees for the initiation of HIV treatment. The health workers also reported that they were unaware of policies that governed adolescent SRHS provision or that they had received any training in this regard. This could explain their lack of will to assist adolescents below the age of 18 and subject them to charges for services provided despite services being free and available to all over the age of 12 as stipulated by policy. Thus, as indicated in the study, a lack of up-to-date information and knowledge on adolescent SRHS provision tends to negatively impact access to such services. This leads to denial of services and placing an unnecessary cost on services that should be rendered freely. Furthermore, the health care workers interviewed were of the opinion that young women should not indulge in sexual behaviour due to religious reasons or the belief that they were unable to make responsible decisions in this regard. Although some were knowledgeable about SRHR they did not agree with these rights being applicable to adolescents.

Patel, et al. (2012) also found that SRHS in rural Uganda were targeted at married women over the age of 18. Despite having a liberal family planning policy that permits free contraceptive services at government facilities and low cost at private facilities to every sexually active individual irrespective of age. Most young people still did not use this service (Nalwadda, Mirembe, Tumwesigye, Byamugisha & Faxelid, 2011). Furthermore, some health facilities sought parental consent before the administration of contraceptives to adolescents younger than 18 for fear of parental confrontation. This was due to a disconnection between policy guidelines that do not restrict service provision and the set age of consent which is 18 by the Ugandan constitution. Additionally, health care providers were unwilling to provide modern contraceptive

services to adolescents, stating their moral obligations as parents themselves. Opting to rather advise young people to abstain and at most, use condoms.

Lema (2012) argues that healthcare providers have a moral and ethical responsibility to protect and provide the necessary medical assistance and respect the autonomy of their patients. In circumstances where medical staff are faced with conscientious objections based on their religious or moral beliefs as is in the findings by Nalwadda, et al. (2011). They are recommended to refer adolescents to other providers that do not hold such beliefs or conscientious objections. Lema's argument provides an extension to the debate on adolescent SRHS access in which they are denied access to services because health care providers do not trust them to make decisions over their own bodies and sexuality. Consequently, such objections tend to infringe on an individual's right to bodily autonomy and to decide on their health outcomes. This makes them more susceptible to avoidable, unsafe health solutions and alternatives.

Another South African study by Lince-Deroche, et al. (2015) found that it was not easy to access contraceptives from clinics due to negative attitudes from nurses. There was also a lack of proactive attitude from young women to communicate their needs and act upon the information they got despite having SRH information available and contraceptives being given freely at clinics. This attitude by young women could be attributed to feelings of fear and stigma surrounding adolescent access and usage of SRHS.

An Indian study (Sanneving, Trygg, Saxena, Mavalankar, & Thomsen, 2013) reflected how access to SRHS intersects with factors such as socio-economic status, gender, education, and

age. Adolescents were excluded from accessing SRHS due to their age. Similarly, a lack of education and financial means especially among women and girls could negatively impact access. Another Indian study (Paul, et al., 2017) suggested that young marginalized rural women who had married at an early age were unable to access modern contraceptives due to a lack of knowledge on the options available to them and how they worked. Also, cultural norms did not subscribe to the use of modern contraception. This lack of knowledge and usage limited them to using the traditional method known as "rhythm method". Young women were expected to strictly monitor their menstrual cycle and abstain from sex on their fertile days. As a result, miscalculations lead to unintended pregnancy. As such, they were inclined to resort to abortion and in some cases forced sterilization at a young age in situations where they were perceived to lack control over their fertility. Consequently, this limited their individual agency and choice to make informed decisions on their fertility.

Findings from an Australian survey on factors influencing young women's sexual and reproductive health (Siebold, 2011) indicated a majority of adolescents had sought contraceptive advice from a health professional with at least two-thirds of the respondents having sought general advice on SRH. Over half of the respondents indicated having regular pap smears and approximately half conducted regular breast examinations. With regards to SRHS, adolescents cited female general practitioners as the most frequently sought after service providers because they were easily accessible. Other services included women's clinics and community health centres with the two being perceived as providing a more holistic service with the ability to refer adolescents to health professionals. The girls were mostly concerned with the various forms of pressure they were faced with. These included pressure to have sex and pressure to have

unprotected sex. This study reiterates the need to build the confidence of adolescent girls to be assertive over their sexuality. The constant pressure they experienced to have sex in some cases could be unsolicited. Assisting them to resist this pressure could help them exercises their SRHR.

People with disabilities are an important group that continues to face challenges in accessing SRHS. A study conducted in Uganda by Ahumuza, et al. (2014) argues that although SRHR are meant to be universal and exercised by all, people with disabilities still face various challenges in fully attaining these rights. A lack of sensitivity in service delivery was found to have negative impacts on service access for this group. Barriers identified included; long distance to health facilities, waiting time, unfriendly physical structures, the high cost of service and negative perceptions from health care workers and the public on their sexuality and sex life. These barriers discouraged them from accessing SRHS due to the negative experiences and verbal abuse they faced while at health centres. Although this study focused on the conditions faced by adults with disabilities, these barriers to access can also be applied to adolescents with disabilities. In a society that is intolerant of adolescent sexuality especially female sexuality, it can be argued that these barriers may have greater negative consequences on this groups' SRH outcomes.

Furthermore, it can be argued that a lack of equitable access to SRHS could further marginalize and socially exclude such a group due to societal assumptions about people with disabilities and sexual engagement. Ahumuza, et al. (2014) further highlight how gender intersects with disability and socio-economic status to further discriminate against this group. Although disability was generally stigmatized, it was reported that females experienced more stigma and

challenges in accessing SRHS differently in comparison to males with disabilities. Moreover, a lack of financial resources impeded their SRHR in comparison to those with better financial status. These findings indicate a lack of homogeneity in how people with disabilities experience SRHS. This may be due to their different positionalities and social identities such as their age, gender and socio-economic status. Rather than using a 'one-size-fits-all' approach, there is a need to employ an intersectional analysis in the design of SRH interventions to cater to different social positions and identities equally.

Rusinga (2012) argues that people with disabilities tend to face higher levels of poverty, unemployment, lack of education and many other social inequalities. Rusinga is critical of policy formulation in Zimbabwe on SRH that does not require healthcare providers to interpret SRH information in sign language to be more accommodative and sensitive to people with disabilities and in particular, deaf people. In Zimbabwe, people with disabilities were found to face greater challenges in accessing SRHS, making them a unique group that is met with increased vulnerability due to a lack of access to adequate services. Besides their access being limited by socio-structural, cultural, physical and attitudinal barriers, the amount of SRH information made available to them was equally limited. The favoured media channels used to communicate SRH information to youths and the general public did not meet the needs of these groups. Information on SRH was usually disseminated through plays, songs, and poetry. However, for someone who is deaf, this method of dissemination may hinder this group from accessing such information. They were not able to connect with the message being relayed to them since it was targeted at able-bodied individuals. Findings from this study were indicative of sexual activity among deaf adolescents. Although the study's participants were aware of the vitality of condoms, a

significant number of girls had not used them during their last sexual encounter. Their sexuality was also highly stigmatized and policed due to societal prejudices and expectations that disabled persons should suppress their sexuality and sexual needs (Rusinga, 2012). There is therefore a need to provide adequate information on issues surrounding sexuality and health in order to increase societal awareness of the SRH needs people with disabilities have. Employing a human rights approach could improve access to SRHS and information for such groups, ensuring inclusive access to these services.

Socio-economic status plays an integral part in access to SRHS for many individuals and households. A study conducted in Kenya and India (Haghparast-Bidgoli, et al., 2015) showed that lower income households spend most of their income seeking health care in relation to higher income households. The study showed that the poorest households in India spent twice as much as the least poor and in Kenya ten times more in seeking health care. Money for such payments was sourced through income for those employed while those unemployed especially women depended on money from their partners or family members. These findings show that poorer households may have a larger burden accessing SRHS due to the high costs of health services in relation to households with better financial standings. Such financial barriers could negatively impact on SRHR and SRH outcomes. These findings could suggest that adolescents from poorer households may be more negatively affected by the high costs of access to SRHS due to their lack of financial resources in comparison to those from middle or higher income households. Thus, it may be necessary for governments to subsidize specific health services such as SRHS in order to secure their SRHR, especially for adolescents that do not have a means of earning an income. Haghparast-Bidgoli, et al. (2015) suggest that although eliminating financial

barriers may be a challenge, user fee exemptions for people that may be in dire financial situations could assist to link them to SRHS.

2.4.4 Social-structural and cultural barriers to accessing SRHS

Various studies highlight how certain structural and cultural barriers impact access to SRHS, particularly among adolescents who are often faced with varying situations and challenges. An Iranian study by Khalajabadi-Farahani (2015), reported that most parents did not know how to initiate conversation on SRH discussions with their children, the type of issues to cover and when it was appropriate. In the Iranian community, strong cultural and religious values prevented parent-child discussions on sexuality since engaging in sexual practices before marriage was strictly forbidden. These findings correlate with a Ugandan study conducted by Muhwezi, et al. (2015). Through focus group discussions with adolescents and key-informants, it was revealed that parents were perceived to be too harsh and strict on their children. This type of relationship instilled fear, making it difficult for adolescents to approach parents on SRH issues for fear of being misunderstood or perceived to be engaging in sexual activity. In the same way, most SRH discussions were found to be gendered with female sexuality being strictly policed. Culturally, mothers could speak to their child on SRH matters, while a father's role was often limited to discussing general behaviour and academic performance. Thus, it can be argued that breeding a healthy communicative relationship between children and parents may help ease SRH discussions. Less strict parenting could make adolescents less reluctant to seek advice from an adult.

An Ethiopian study (Ayehu, Kassaw & Hailu, 2016) found that age, residence, education levels and living arrangements of young people strongly correlated with the ability of parents leading the discussion on SRH with their children. Parents that had some level of education were more likely to discuss SRH issues with sons. The study also identified fathers as significant players in leading the discussion in comparison to mothers. The study argues that social taboos surrounding sexual discussion and levels of education among women made females less likely to discuss SRH issues even amongst themselves. It was also found that young people had challenges discussing SRH issues due to fear of parents, parental lack of interest, cultural taboos attached to sex, embarrassment and a lack of SRH knowledge among parents. Nambambi and Mufune (2011) suggest that educated women may be more liberal to discuss SRH issues due to their higher level of knowledge and better communication competencies to relay such information to their children. Furthermore, although Ethiopia has a National Reproductive Health Strategy in place, cultural and religious factors override its implementation in most communities. Finally, for many adolescents, socio-economic status, levels of education and location, particularly among rural girls may pose a barrier to SRHS access as highlighted in a study conducted in India (Malleshappa, Krishna & Nandini, 2011). Consequently, such barriers increase their vulnerability to SRH issues.

In Ugandan, as highlighted by Muhwezi, et al. (2015) as is in most African cultures, parental discussion on sexuality is considered taboo. This task is often relegated to aunties to initiate such discussion with the girl child. This is part of an important cultural socialization practice known as ‘Senga’. Likewise, many African countries have similar socialization practices used to initiate younger members into adulthood. In Namibia, a similar practice by the Oshiwambo tribe known

as ‘Olufuko’ is used to transition girls into adulthood (Nangoloh, 2014). The practice is perceived to be detrimental to adolescent girls and thought to encourage child marriage. Perhaps, these could be traditional platforms to initiate the conversation on sexuality and issues surrounding sexual practices that would otherwise be considered taboo. However, these discussions may not adequately address SRH issues as they are aimed at preparing girls for marriage.

The taboo nature of adolescent sexuality often increases sexual vulnerability among adolescents. It was found that parent-child SRH discussion was triggered by various factors. These include behaviour change, puberty, suspicion of engagement with the opposite sex, observed experiences of girls within the same age-group, falling pregnant and delay in onset of secondary sexual features (Muhwezi, et al., 2015). However, it should be noted that most of the SRH issues discussed were closely aligned to bodily changes, pregnancy or the contraction of HIV and STI’s. This seemed to instil fear in adolescents rather than increase their knowledge. Also, a lack of culturally appropriate words to discuss sexual issues was found to be a hindrance to parent-child communication, a finding similar to a study by Kennedy, et al. (2014).

A South African study by Laser and Francis (2014), examined parent-child communication on SRH issues with a particular focus on human papillomavirus (HPV). The study found that despite some parents expressing the willingness to discuss these issues with their daughters. The majority, however, did not engage in such discussions. A lack of adequate knowledge on HPV prevented such conversation and as a result, parents did not engage in such discussion with their children. The authors further reiterate that the high coverage of information in South Africa on

HIV could have contributed to the willing attitude by parents to discuss certain SRH issues with their children. They recommend that information on a variety of SRH issues be widely spread in order to increase the knowledge-base of parents to prompt them to engage in SRH discussions.

With regards to socio-structural barriers, Shaw (2009) advocates for the removal of legal barriers that impede access to SRHS, such as adolescent services limited to parental consent. The removal of such a legal barrier could lead to better access of SRHS particularly, contraceptive usage among adolescent girls who may already be sexually active and at risk of unintended pregnancy. Shaw (2009) further argues that cultural practices tend to impact government policy implementation. In Nepal, for instance, government family planning services were targeted at married couples only. This was due to cultural practice and not government policy. This resulted in high pregnancy rates with nearly 25% of girls falling pregnant before the age of 19.

Barriers such as distance, negative provider attitudes, and unfriendly service were reported in a study by Nalwadda, et al. (2011). Others included long waiting hours, poor quality services, a limited number of qualified staff, high staff turnover and policy restrictions as structural barriers to accessing SRHS. The study also reported limited funds that hindered community sensitization, outreach, and support supervision initiatives.

It is vital to note that barriers to SRH access may not only be structural or cultural in nature but also a matter of individual agency. Despite an existence of structural barriers, adolescent girls should not be totally passivized as victims of socio-structural contexts. They must be viewed as active participants capable of exerting free will and choice (Paul, et al., 2017). Agency is an individual's capacity to exercise power over their own decisions. In this case, power over their

own bodies and reproductive health (Maxwell & Aggleton, 2010). In some cases, adolescents may be given the opportunity to access SRHS but feelings of embarrassment to communicate their needs may hinder this access. A Zambian study (Hodgson, et al., 2012) reported that adolescents were reluctant to open up in discussing SRH matters, more so, when accompanied by adults. Although some structural issues are evident in this study, improving the communication skills of adolescents could help them relay their SRH needs better, and potentially, even in the company of their parents. Therefore, building the confidence of adolescents may encourage them to be more assertive about their sexuality and exercise agency over their bodies.

Interviews conducted with health care workers revealed a lack of private spaces in clinics and time constraints as factors that compromised confidentiality and service quality. These factors may have negatively impacted adolescent experiences at such health centres. Furthermore, adolescents interviewed expressed discomfort in being addressed as a group with other patients and in some cases frail, sickly patients and adults. They expressed a need for tailored age-specific services that could address their unique needs. It can be argued that adolescent-specific services and programs may improve SRH communication and access for adolescents by granting them a platform to freely express themselves. The study also highlighted a lack of informational material as a barrier to service delivery in remote areas (Hodgson, et al., 2012).

Adolescent attitudes in effectively communicating their SRH needs were not always the same for all SRHS. A Ghanaian study by Thatte, Bingenheimer, Ndiaye and Rima (2016) examined barriers to SRH among youth in Ghana and found that feelings of embarrassment, shame and stigma differed depending on the type of SRHS sought. Youths reported feelings of shame and

embarrassment as being highly associated with accessing HIV/STI testing and contraception services. This was due to the stigma attached to these services if their anonymity or identity was compromised in the process. Abortion services on the other hand, were highly associated with cost, fear of family and friends finding out and the religious beliefs of individuals in relation to accessing abortion services. The authors attributed these feelings and perceived barriers to the space in which these services are accessed. Contraceptive and HIV testing services are accessed in the public domain. Adolescents would need to visit a health facility before utilizing such a service. This could lead to embarrassment and acknowledgment of sexual activity. Abortion services are accessed more privately due to their illegality. There may be less feelings of judgement associated with accessing such a service. Nonetheless, these individual barriers continue to impact the access of vital SRHS among adolescents.

2.4.5 Overcoming barriers to ease access to SRHS

Various strategies have been developed to ease access to SRHS and information. A study in India (Malleshappa, et al., 2011) found that sexual health education was a key factor in improving one's sexual health, particularly, among rural girls with low socio-economic status. Improving one's knowledge and levels of awareness on SRH was seen to be crucial as they were found to be more disadvantaged in relation to girls from urban areas. Sex-education as part of the school curriculum has been thought as a way to address the SRH needs of adolescents. However, such a program may exclude out-of-school adolescents, leaving them vulnerable to barriers that limit access SRHS and information.

According to Kennedy, et al. (2014), although school-based sex education programs are vital, they were found to be under-utilized. This was due to the reluctance by parents and teachers to implement strong sexuality education programs within the education system. It was also found that parents were lacking the relevant competencies in education, knowledge and communication skills on SRH in order to relay such information to adolescents. The study suggests that parental involvement could help increase SRH service use among adolescents by breaking barriers to access. They found that NGO's played a crucial role in providing SRH information through youth centres, peer education programs and community awareness interventions. Furthermore, service providers and policymakers recommended that SRH information is included in the primary school curriculum, noting the importance for boys and girls to receive the same information in order to meet the needs of adolescents. This approach would be instrumental in breaking down the gender barriers that may exist in accessing SRHS since both boys and girls would learn the importance of SRHR and their applicability.

As is the case in Namibia, the Nigerian government through its initiative to curb HIV and teenage pregnancy instituted sex education as part of its curriculum. The program integrates Family Life and HIV/AIDS Education (FLHE) at both secondary and primary school level and teacher training institutions through the Ministry of Education. This was instituted as a means to address the culture of silence surrounding issues of sex. However, it can be argued that such programs tend to exclude those not enrolled in schools. In a study aimed at assessing the extent to which out-of-school adolescents were being served by such initiatives in Nigeria, Isiugo-Abanihe, et al. (2015) found that several non-governmental organizations (NGOs) had taken up the challenge to bridge the gap by providing out-of-school youth with sexuality programs.

Through services such as, the distribution of materials, mentoring and sensitization outreach activities, support in terms of life-skills training, counselling, testing and provision of HIV testing kits and condoms, out-of-school adolescents improved their knowledge of SRH. These organizations relayed such information through the facilitation of workshops, talks and drama activities to raise awareness among the groups they served.

Despite religious and cultural resistance, non-governmental organizations are key stakeholders in SRHS and information provision for hard to reach communities and out-of-school adolescents. Findings of the Isiugo-Abanihe, et al. (2015) study highlighted challenges such as a lack of consistency in adolescent participation. The program was found to be unevenly distributed in various communities and the non-use of local educators could hinder the sustainability of such projects. A community such as Gobabis could benefit from initiatives that target out-of-school youth, acting as an extension of the Life Skills School program. It could also be used as a youth-friendly platform where they can freely share and discuss SRHS issues with their peers outside the school environment. Furthermore, such initiatives would assist adolescents in overcoming the barriers they face in accessing SRHS by building their confidence to be assertive about their sexuality and matters affecting their health.

Adolescents highlighted an appreciation for youth-friendly services, identifying confidentiality, short waiting time, low cost and privacy as important factors that determined the use of health services and facilities. Others included youth-only services, youth involvement and young staff (Shaw, 2009). These findings suggest that adolescents would be willing to access SRHS if they were refined to address their specific needs and ensure that their identities were protected.

However, Woog, Singh, Browne and Philbin (2015) are sceptical of adolescent-friendly services as an intervention to overcome barriers. Rather, they call for greater involvement of stakeholders and adolescents to engage in the design of SRH strategies to increase the usage of such facilities. It is important to note that although adolescent-centred facilities may be implemented, cultural norms may still hinder their usage. Hence, there is a need to involve community members and adolescents in the design of such programs.

Woog, et al. (2015) study calls for the removal of structural and cultural barriers that impede the SRHR of adolescents. These include the provision of service limited to parental consent, payment for services, distance to facilities or a lack of facilities, cultural norms and practices that may be harmful to adolescents' SRH and SRHR and legal and policy restrictions on SRHS. They also call for greater promotion of gender equality as a means to address such barriers. This could be beneficial in addressing certain barriers, particularly among groups that disproportionately have lesser access to services and social power. In many communities, adolescent girls have limited social power due to family and societal structures. This makes them more vulnerable to having their SRHR infringed upon. Thus, there is a need to increase their knowledge on their rights, raise awareness on their SRH and increase their participation in service design and implementation strategies. This could positively influence their health outcomes and address their unique needs. Also, because these impediments occur at community and household level, it is vital to engage various stakeholders in raising awareness on the possible social norms and practices that may negatively impact SRHR of adolescents. This may lead to a better understanding of such rights and their benefits as well as better implementation of intervention strategies aimed at improving adolescent access to SRHS.

According to Atuyambe, et al. (2015), the Ugandan government is set to strengthen adolescent sexual and reproductive health services through increased availability of credible and accurate information and materials targeting adolescent health. Other strategies include the implementation and integration of SRH education in school health programs as well as increasing adolescent friendly facilities. They also recognize the need to train health staff to respect adolescent SRHR in order to make services more accessible to all. The study found that adolescents often did not access SRHS when an immediate need arose, but not until it had persisted or become serious; citing they felt uneasy to answer the many questions they would be confronted with before receiving treatment. As a result, some sought medical care from traditional healers to avoid questioning and secure their privacy while others considered seeking advice from elders and self-medication. They expressed a desire to spend short waiting time at centres. However, this often resulted in them paying an extra "fee" to cut the long queues. In a case where one could not afford such "fees"; they had to endure the long wait even though they were in pain. Finally, the implementation of various youth-friendly services and programs for in-school and out-of-school adolescents could ease access to SRHS among adolescents and possibly assist in overcoming barriers to access. The high cost of SRHS remains an important barrier for many adolescents. Therefore, there is a need for such services to be subsidized in order to make them more accessible to communities that lack financial resources.

Currently, mobile devices and information communication technologies (ICTs) are increasingly present and accessible in many societies. Thus, the information dissemination gap has increasingly been reduced. The ease and affordability of which these devices are used have largely contributed to the ease of access to various kinds of information. According to Edouard

and Edouard (2012), this presents an opportunity for the health sector to explore the use of such technology to ease access to SRH information and overcome potential barriers to access that may exist. These include high cost, cultural norms influencing access, long waiting time, language barriers and negative attitudes from health providers. With the help of the internet and non-internet based platforms such as Facebook, YouTube, Twitter, Blogs, SMS (short message service) and MMS (multimedia messaging services) and many others, age-specific discussions can be initiated to stimulate dialogue on SRH issues adolescents face. Access to such information could be increased without the prejudice and judgment that is often experienced with such conversations in person. Edouard and Edouard (2012) propose the exploitation of such platforms to actively engage adolescents, advocate for adolescent SRHR and disseminate relevant information in a cost effective way through mobile phones. Their article demonstrates how Uganda has harnessed ICTs in their public health programming through the "Text for Change" campaign used to raise HIV awareness in Uganda. Similarly, the use of such initiatives can be replicated to address SRH issues among adolescents in Namibia and Africa as a whole. They further recommend the development of policies that protect and support rights to free access of publically available information in order to increase the benefits of ICT usage in reproductive health programming.

Nigeria equally adopted an initiative that promotes SRH to adolescents through the use of mobile devices. The Education as a Vaccine (EVA) initiative was used as a way to provide SRH information and referral services to adolescents through its program known as My Question and Answer (My Q and A) service. This service provided young people an opportunity to forward questions on issues regarding sexual health and HIV/AIDS through an SMS, online or telephone

hotline. Adolescents had the opportunity to access accurate information in an anonymous, confidential and non-judgmental way regardless of their location through their mobile devices and internet connection (Akinfaderin-Agarau, Chirtau, Ekponimo & Power, 2012). Despite the service being popular among youths, it was found that fewer females than males had access to this service. Even though participants of the study indicated that they had access to mobile phones either their own personal or borrowed phones, it was found that these devices were not particularly used to access health information. Some participants did, however, mention they would search the internet for side-effects of drugs or use the 2go mobile application to contact a doctor. Adolescents preferred to use the SMS service over the calling service for SRH information. This was due to the fact that, they could store the message for future reference, share it with their peers and refer back to it when needed. Also, the SMS service provided an element of anonymity in which they would feel a greater sense of freedom to discuss certain issues rather than if they had a conversation.

An article by Akinfaderin-Agarau, et al. (2012) draws attention on issues pertaining to culture in Nigeria that frowns upon girls openly discussing SRH issues. Despite the service being anonymous, certain barriers were still found to impact girls from using this service. The girls equally reported feelings of shyness to communicate their concerns due to the stigma surrounding access to SRHS and information. They expressed concerns over disclosure of personal information such as their age, location and address as potential factors that limited their use of the service. The girls cited the lack of unlimited access to mobile phones as a limiting factor to service use in cases where parental supervision or permission to access mobile services was required. Furthermore, some girls cited their lack of knowledge of the service. Moreover, the

writers thought that the mobile phone service could be less appealing to adolescents since they would usually consult someone they believe to have had a similar experience or concern as them. In spite of these challenges raised, the use of mobile phones as potential dissemination devices of SRH information and services could positively impact access to these services in communities that constantly police and restrict access to SRHS for many adolescent girls. Therefore, this initiative could be a means of overcoming the various challenges that adolescent girls face in accessing SRHS and information.

2.5 Summary

This chapter reviewed related literature focusing on the needs and experiences of adolescent girls on issues surrounding SRHS access and provision. Reviewed literature recounts the importance of linking adolescent girls with SRHS and the impact they have in improving their health outcomes. A range of challenges have been identified as factors that impede adolescent SRHR. It also highlighted a number of important initiatives that have been employed to overcome such barriers, such as institutionalized sex-education programs, increasing stakeholder participation, and development of adolescent-friendly centres. The literature suggests a considerable understanding of adolescent SRH needs and the ways in which they negotiate access through the use of various information sources and services made available to them. The growing discourse on adolescent SRH brings attention to a need for reproductive justice that recognizes adolescent SRHR in improved service design, implementation, and provision in cognizance of how their individual social identities impact access to SRHR and services. The literature also discussed adolescent SRHS access, highlighted the role of policymakers and implementers in securing the

SRHR of adolescents, and other vulnerable groups in order to ensure better access and exercise of these rights. The next chapter presents the study's methodology.

Chapter 3

Research methodology

3.1 Introduction

The main aim of this study was to establish access to sexual and reproductive health services and the underlying barriers that hinder access among school-going adolescent girls in Gobabis. The methodology of this study was informed by the philosophical assumptions underpinning social research. A qualitative approach using case study design was applied so as to get an in-depth understanding of how the girls uniquely experienced such services. The use of semi-structured in-depth interviews assisted in highlighting the needs of the girls and the opportunities and challenges that exist in the access of SRHS in Gobabis. Ethical measures such as informed consent and assent were obtained before embarking on the data collection process. This chapter also explains the data analysis procedures that were used in this study.

3.2 Philosophical assumptions

The methodology of choice was guided by the philosophical assumptions surrounding social research. These underpinnings are essential in guiding the research process. They provide a distinction on the choice between qualitative and quantitative research methods based on the topic under study and the type of data the researcher wishes to collect.

3.2.1 Ontological and epistemological assumptions

Social research is based on important underlying assumptions of the social world. Therefore, to understand a particular phenomenon under study, it is vital to explore how these ontological and epistemological assumptions influenced this particular study. The term ontology refers to the social construction of reality. According to Denscombe (2010), there are two major ideologies surrounding ontology. These are the realist and the constructionist ideologies. The realists are of the belief that society exists objectively and independently of human belief and subjectivity. However, the constructionists' contend that social realities are dependent on human constructions of these realities, subject to their social interactions, cultural beliefs, and norms. Unlike the realists, they believe in the existence of multiple realities since the social world is a constitution of heterogeneous social beings. Thus, this research subscribes to the ideas held by constructionist ideologies, in that individual experiences and realities of access to SRHS may vary among the girls. How they construct their realities may differ since access to SRHS is perceived differently due to underlying social factors; cultural, structural and individual factors. This ideology ties in with the feminist thought of intersectionality that regards individual experiences as dependent on their social identities. Hence, their positionalities influence their social experiences and realities of access. As such, social realities cannot be universalised or generalised as universal representations of experience.

Another important assumption to consider is epistemology. Stanley and Wise (1993) define epistemology as a term that refers to the knowledge systems that guide one's ontology. It is about what knowledge is available and how people can acquire that knowledge. There are two important debates surrounding how knowledge is acquired. These are positivism and

interpretivism. According to Denscombe (2010), the former refers to the process of gaining knowledge through scientific observation and measurement as a way of understanding social reality and knowing about it. This argument ties in with the realist notion of the objective existence of social reality outside human influences. While the latter refers to the process of gaining knowledge through interpreting social actions and interactions rather than mere observation as a way of knowing and understanding social realities. This view ties in with the constructionist ideologies of social realities. This study employed the interpretive paradigm in order to understand the experiences of adolescent girls in accessing SRHS in Gobabis and the meaning attached to these services. It was essential to apply this paradigm since mere observation and measurement would not adequately capture their subjective realities and the underlying perceptions and meaning regarding access to SRHS by the adolescents themselves.

3.3 Research design

The study was conducted qualitatively using a case study design. The reasons for using case study were, the study attempted to understand participants' views on SRHS and the meaning attached to them (Kumar, 2011). Although other qualitative research designs exist, the case study design was better suited for this study as it attempts to establish the cultural meaning individuals attached to the access of SRHS by adolescent girls. Also, the high teenage pregnancy rates in Gobabis called for a deeper understanding of the relevant services available to adolescents and their use or non-use. Hence, there was a need to employ a qualitative research approach for this study. Qualitative research generally attempts to understand the issues of concern from the viewpoints of the participants, by describing their social setting and interpreting the data collected according to the meaning participants attach to a phenomenon (Peshkin, 1993 cited in

Leedy & Ormrod, 2010). Furthermore, it uses qualifying words or descriptions to record aspects of the world (Bless, Higson-smith & Kagee, 2006).

Although the researcher decided on taking a qualitative approach to this particular study, the researcher is also aware of the quantitative approach and research designs. Quantitative research is aimed at examining variables based on testing hypotheses derived from a theory. It uses a more positivist and deductive approach as it mostly involves experiments and observation as well as establishing causality. Its findings can be generalised when there is a good representative sample (Neuman, 2011). However, these elements do not give an in-depth understanding of the study since it focuses more on quantity and not the quality and richness of information obtained from the participants of the study. Dudwick, Kuehnast, Jones and Woolcock (2006) argue that qualitative research methods allow researchers to explore the views of diverse groups of people, making it possible to understand differing perspectives within a diverse community. As a result, the researcher was able to obtain rich data from the participants and understand their realities from their point of view. Since the town of Gobabis is made up of adolescent girls from different social groups, social identities and faced with various SRH needs and challenges, the experiences of individuals cannot be universalised by treating all girls as a homogenous group. Accordingly, a qualitative approach revealed the diversity of these girls and their unique experiences.

The rationale behind choosing a qualitative approach was meant to explore how various social factors impacted access to SRHS in Gobabis as well as to understand the particular positionalities of the participants. The researcher was mindful of these unique experiences and positionalities in order to arrive at rich data with depth by treating the subject as the expert of

their own social realities and experiences. Moreover, qualitative approaches also focus on understanding the process in which social actions take place (Maxwell, 2013). Therefore, the researcher took the time to understand adolescent SRH needs, the challenges faced and the steps taken by the girls to negotiate access to SRHS and information. Since girls, more so than boys, tend to lack social power to negotiate contraceptive measures; their lack of access to relevant services makes them more vulnerable to undesirable health outcomes than boys such as unwanted pregnancy and risk of unsafe abortions. Similarly, due to the flexible nature of qualitative research methods, it allowed the researcher to explore the strategies participants use to resolve their unique individual SRH needs rather than arriving at generalizations and comparatives (Maxwell, 2013).

3.3.1 Case Study

This was a case study used to capture the realities of school-going adolescent girls in Gobabis in terms of how they negotiated access to SRHS in a community that is culturally oriented. Case study is a research design that generally relies upon participant observation and interaction. It is a methodology whereby the researcher spends considerable time observing and interacting with a social group in order to gain an in-depth understanding of their views and experiences. Interactions with school-going adolescent girls through in-depth interviews enabled the researcher to understand how they perceived SRHS and the cultural constructions surrounding female sexuality and health. According to Creswell (2012), a case study is concerned with making sense of the actions and intentions of people as knowledgeable agents. By using this design, the researcher gained in-depth descriptions of the experiences of adolescent girls and the meaning and interpretation of SRH according to the participants. Case studies differ from other

qualitative designs as their analysis of participants' experiences leads to a richer understanding of a particular social action. Thereby, revealing knowledge and meaning that is held by a community through thick descriptions of their experiences and realities. Thus, it was an appropriate design to capture the realities of school-going adolescent girls in negotiating access to SRHS in Gobabis.

3.4 Population

The population of a study is a set which includes all measurements of interest to the researcher where a sample can be drawn using either probability or non-probability sampling techniques (Struwig & Stead, 2001). It is also referred to as a total collection of elements available for sampling (Kendall, 1952 as cited in Sapsford & Jupp, 2006). The population of this study consisted of school-going adolescent girls between 15-19 years of age in Gobabis. The rationale behind the selection of this age group was based on the assumption that girls in the 15-19 brackets may already be sexually active and the onset of adolescence presented new vulnerabilities to sexual pressure and to their SRH. Thus, providing a need to investigate how these girls coped with their SRH needs through access to SRHS.

3.4.1 Unit of analysis

A unit of analysis according to Welman, Kruger and Mitchell (2005), are members or elements of the population that a researcher intends to examine for a particular study. It also refers to the object or person from whom research data is collected in order to describe a particular grouping or setting. In a qualitative study, this data can only describe that particular unit and thus cannot be generalised to represent the entire population (Bless, Higson-smith & Kagee, 2006). The units

of analysis in this study were female school-going adolescents between 15-19 years of age from Epako High School and Gobabis Gymnasium School. A sample was selected from which the data was collected and analysed.

3.5 Sample

A sample is a group of components selected through various techniques for analysis from a population (Sapsford & Jupp, 2006). It is also defined by Mouton (1996) as elements selected with the intention of finding out something about the total population from which they are taken. In this study, the non-probability purposive sampling technique was used to select the participating schools and health centres. Social demographical factors such as race, ethnicity and social class highly influenced the selection of the research sites. In non-probability sampling, the likelihood of any particular member of the population being chosen is unknown. Therefore, not everyone in the population has an equal chance to make it into the sample (Struwig & Stead, 2001).

Healthcare professionals (4) were selected purposively based on their involvement in SRH programs. Whereas, individual adolescent girls (20) were sampled using a quota sampling technique so as to include learners with different positionalities (Kumar, 2011). Quota sampling is a technique that involves the selection of participants from various strata such as gender, age or ethnicity to make up the sample until the desired sample size is reached (Lapan & Quartaroli, 2009). In this study, the sample consisted of 10 adolescent girls from each school after which, participants were selected based on their age, ethnicity, race and grade as categories of interest. This technique was advantageous, as it allowed the researcher to interview only those that

qualify to be part of the sample from the population while selecting particular categories of interest. Therefore, it was impossible to generalise the findings since subjects were treated as unique individuals with different positionalities and experiences.

3.5.1 Sampling criteria

These were the factors that influenced the selection or inclusion of participants to make up part of the study (Flick, 2011).

The criteria were:

- Female adolescents at Epako High School and Gobabis Gymnasium School
- Mentally sound in order to assent participation
- Parents/guardians must be willing to consent participation of the minor
- Adolescents must be willing to participate in the study
- Of any race, ethnicity and falling within the 15-19 age bracket

3.6 Research instruments

The researcher made use of semi-structured in-depth interview guides with open-ended questions. According to Maxwell (2013), semi-structured in-depth interviews allow a researcher to focus on a particular phenomenon being studied and take into account the differences between individuals and their contexts. Although generalisability and comparability for internal validity were not possible, this method revealed the unique processes that led to a particular outcome or situation under study. The researcher chose this method so as to give room for other outcomes that might have been of interest to the researcher but could have been overlooked during the research process. The use of pre-structured questions helped to reduce the amount of time spent

analysing the data, as well as, granted participants more flexibility and freedom to express themselves.

3.6.1 Interviews

The researcher employed interviews as the data collection method for this study. Interviews are an effective method to capture knowledge from people as they facilitate a face-to-face interaction between the researcher and the participants (Blanche, Durrheim & Painter, 2006). Interviews can be conducted in various forms such as one-on-one interviews or focus group discussions. Conducting an interview is an ideal way to gather knowledge from relevant sources in a community from specific individuals that are perceived to be knowledgeable on a particular subject such as school-going adolescent girls and healthcare staff as in this study. This interaction made it possible for the researcher to gather the relevant information by asking the relevant questions and eliciting further information from participants. It also accorded the participants an opportunity to engage more on the topic and elaborate in depth, giving the researcher the opportunity to clarify where necessary. Similarly, having a face-to-face interaction gave the researcher the opportunity to build a level of trust with the participants. This made it easier for them to express themselves more authentically. The interview process was also an opportunity for the researcher to observe the behaviour and body language of the participants as the interview progressed. This gave the researcher the opportunity to fully grasp the meaning and perceptions assigned to the topic. The researcher made use of a voice recorder to capture the interview process. According to Markle, West and Rich (2011), the use of a voice recorder greatly increases the quality of the data collected during the interview process in comparison to note taking. It allows the researcher to engage more with the participant during the interview

while capturing the exact words of the participant. It also allows the researcher to report the participants' views verbatim without distorting the intended meaning as would occur during note taking. Hence, allowing the researcher to generate accurate, thicker and more in-depth descriptions. However, one should be cautious to ensure that the audio recording is as clear as possible and that all elements of the interview are captured to ease the transcription and analysis process.

The researcher chose to use interviews for the following reasons:

- Responses can be clarified and interpreted
- Ensures that the participants understand the questions
- Getting an understanding according to the participants' construction and views
- Being able to probe for elaboration of incomplete responses
- Being able to read a participants' body language during the interview

3.6.2 Interview guide

The researcher developed two semi-structured interview guides. A semi-structured interview guide was administered to 20 girls and a key-informant interview guide was administered to 4 health care personnel. Since they are less rigid than structured interview guides, participants easily shared their experiences while the researcher explored the topic and probed for clarity (Esterberg, 2002). The two interview guides were administered in the form of face-to-face interviews with the participants. According to Bless, Higson-Smith and Kagee (2006, p. 116), an interview involves direct personal contact with the participant who is asked to answer questions

relating to the research problem. Since the interview guide was developed by the researcher, precautions were taken in order to ensure the validity and reliability of the research instrument.

3.7 Validity and reliability

Validity according to Maxwell (2005, p. 122) refers to "the correctness or credibility of a description, conclusion, explanation, interpretation or other sort of account". While, reliability is the extent to which test scores are accurate, consistent or stable (Struwig & Stead, 2001). To address the issues of validity and reliability, the researcher conducted a pre-test of the instrument with 2 learners and 1 health care personnel before proceeding to conduct the actual study. This also acted as a pilot study, whose purpose was to identify any problems pertaining to the research instrument and what it was intended to measure (Struwig & Stead, 2001). Furthermore, the use of a semi-structured interview guide ensured that the researcher asked the participants the same questions in a similar order. This consistency preserved the reliability of the instrument. However, it must be noted that due to the qualitative nature of the study, responses from individual participants may have differed in some way or the other. This can be attributed to a lack of homogeneity in the research population as the study was intended to capture the unique experiences of individuals in relation to access of SRHS in Gobabis.

3.8 Procedure

Face-to-face interviews with participants were conducted. A voice recorder was used and notes were taken as the interviews progressed. According to Bailey (1982), upon approaching the participant a researcher must first introduce themselves, in this case, performing all the functions

that the cover letter performs for the questionnaire. The researcher introduced herself to the participants as well as the study being conducted, its purpose and objectives. Issues of confidentiality, anonymity and other ethical issues were explained to the participants during the introductory phase. Once the participant was comfortable enough to partake in the study and parental consent was granted, the researcher then commenced with the interview. The interview was conducted in the English language and the researcher took notes and made use of a voice recorder to capture the interview proceedings with the consent of the participants.

The interviews were conducted on school premises in locations that were safe, private and comfortable to the participants. The researcher ensured that they did not dominate the interview and allowed the interviewee to have more time to respond. Similarly, responses were probed on views that were of interest and relevant to the study with the help of an interview guide consisting of semi-structured questions.

A range of general probe questions were used during the interview to elicit further information from participants on the responses they provided (Patton, 1990). These questions were typical for facilitating the procedure of an interview and included:

- Can you tell me more about that?
- Could you explain that further?
- Could you please give me an example?

3.9 Data analysis

According to Bless, Higson-Smith and Kagee (2006), the process of analysing research data is crucial to the research process. It assists the researcher in detecting any forms of bias, distortions and errors in measurements so as to report the data as accurately as possible, reflecting the views and social realities of participants. The researcher employed content analysis as a method to analyse the data collected from the interview process, searching for related themes. Firstly, interview responses were carefully transcribed from the recordings. After which, the data was cleaned and checked for errors and completeness. The next step was to analyse the data manually by scanning it for linkages. Thereafter, codes or categories emerging from the data were assigned in order to categorise the data and identify common themes from which patterns, descriptions and meanings emerged (Sapsford & Jupp, 2006).

3.10 Research ethics

Ethics according to Denscombe (2010) refers to the moral principles that guide individuals through which a dualism of good or bad can be drawn. As such, researchers need to be cautious of how they design and conduct research so as to practice good ethics. Thus, research ethics can be said to refer to what is acceptable in the field of research. Various authors offer a range of ethical principles to be followed by researchers. According to Bless, Higson-Smith and Kagee (2006), these principles include informed consent, anonymity, confidentiality, discontinuance and avoidance of deception. A researcher should, therefore, strive to uphold these principles throughout the research process.

In this study, the researcher recognized that working with minors and issues of adolescent sexuality could have posed an ethical challenge. Hence, matters of confidentiality, anonymity and informed consent were observed (Muzvidziwa, 2004). Firstly, the researcher ensured that permission and ethical clearance were granted by the University of Namibia before commencing with the study. After which, permission from the Ministry of Education, Arts and Culture and the Ministry of Health and Social Services were obtained to conduct the study in the two schools and health centres. Informed consent was obtained in writing from parents/guardians of the participants and assent was obtained from the minors before proceeding with the interview process.

Appointments to conduct the interviews were made based on the availability of the participants. To address issues of anonymity, no names of participants were recorded during the interview and in reporting of the study's findings. Instead, codes were assigned to participants in order to protect their identity. To ensure that confidentiality was observed, information was not shared with a third-party and was used only for the purposes of this study. Interviews were conducted at a location that was private, safe and comfortable in consultation with the participant. Before commencing with face-to-face interviews, participants were made aware of the purpose of the study and how their participation was beneficial to the study. The researcher made it clear to participants that their partaking in the study was free and voluntary and that they were free to withdraw from the study at any stage if they felt uncomfortable or for any other reasons they may have had without any subsequent repercussions.

Also, additional permission to use a voice recorder during the interview was obtained from participants. In a case where the use of a voice recorder was rejected, notes were taken during the

interview. After which, they were assured that the recordings and notes would not be shared with a third-party and would be used solely for the purposes of the study. In the same respect, the researcher ensured that the recordings from the interviews were saved electronically on a laptop protected by a password. This was to guard against unauthorized access to the data. Notes gathered from the field were kept in a lockable cabinet for at least 5 years after the study before being shredded (University of Virginia, 2012). This was to ensure that confidential information is protected. Furthermore, the researcher did not deceive or misrepresent themselves to the participants in order to gain their approval to partake in the study. Participation in the study was voluntary.

3.11 Summary

This chapter covered the methodological issues regarding how the study was conducted. The methodology used was a qualitative approach that involved in-depth interviews with the help of a semi-structured interview guide. The research sites were selected purposively to exhibit social differences among the learners. The learners were selected using the quota sampling technique. A sample of 20 learners between the ages of 15-19 was selected from Epako High School and Gobabis Gymnasium School who acted as the unit of analysis. A total of 4 key-informants were identified to provide information on the accessibility of SRHS to adolescents in Gobabis. The procedure of how the study was conducted was discussed and the data analysis method used was explained. Issues of reliability, validity and research ethics were addressed to ensure that the quality of data collected was not compromised. The next chapter is on data analysis and presentation.

Chapter 4

Data analysis and presentation

4.1 Introduction

This study primarily sought to explore the experiences of adolescent school girls in Gobabis in accessing SRHS. This chapter presents the data gathered from the girls and key-informants through semi-structured face-to-face interviews. The purpose of data analysis was to evaluate the data collected systematically in order to draw conclusions and recommendations. Data analysis entails providing structure and order to the data collected and deriving meaning from it in order to gain an understanding of the participants' experiences (Bless, Higson-Smith & Kagee, 2006). This study was guided by the following research questions;

The main question in this study was "Are adolescent girls able to access SRHS in Gobabis?" The sub-questions were:

- Do adolescent girls have SRH needs?
- Which sources of information do they consult pertaining to their SRH needs?
- Do adolescent girls have access to SRHS?
- What are the social-structural and cultural barriers that hinder access to SRHS?
- How can these barriers be overcome to ease access to SRHS?

The findings from this study are presented in form of descriptions organised by themes arising from the data in line with the research questions. The research questions "Do adolescent girls have access to SRHS?" and "What are the social-structural and cultural barriers that hinder

access to SRHS?" have been combined for analysis and presentation in order to avoid repetition under the sub-heading "Access to and barriers of SRHS". The data was organised under the following sub-headings.

- SRH needs of adolescent girls
- Sources of SRH information
- Access to and barriers of SRHS
- Overcoming barriers to access

4.2 Response rate

All schools and health centres identified for this study participated. However, the response rate for this study was fairly low among adolescent girls. Some adolescents dropped out of the study and some parents rejected consent for the participation of minors. The dropout rates and non-consent from parents could be attributed to both parents and girls being uncomfortable to discuss issues surrounding adolescent sexuality and reproductive health. Nonetheless, in order to reach the desired sample size the researcher sent out constant reminders to participants for scheduling and rescheduling of meetings as well as continuously recruited study participants. A summary of the interviews conducted is depicted in the table below.

Table 1 Response rate

Interviews planned (adolescent girls)	20
Interviews conducted (adolescent girls)	19
Interviews planned (key-informants)	4
Interviews conducted (key-informants)	4

4.3 Demographical data

Demographic data was gathered from adolescent girls and key-informants. This included their age, grade, ethnicity, parents' employment status and parents' highest levels of education. This information is depicted in the table below.

Table 2 Adolescents' demographical data

Age	Grade	Ethnicity	Parents' employment status	Parents' highest levels of education
17	10	Herero	Employed	Not sure
17	11	Damara	Employed	Grade 12
17	11	Tswana	Employed	University
16	10	Damara	Employed	Not sure
17	10	Coloured	Business owner	University
17	11	Herero	Business owner	Not sure
17	11	Herero	Employed	Grade 12
16	10	Coloured	Employed	Not sure
15	8	Damara	Employed	Grade 10
16	8	Damara	Employed	Grade 7
18	8	Nama	Self-employed	Grade 7
15	8	Herero	Employed	Grade 8
16	9	Nama	Employed	None
16	9	Damara	Self-employed	None

15	8	Nama	Employed	Grade 10
15	8	Tswana	Not employed	None
15	8	Damara	Employed	Grade 7
17	9	Damara	Not employed	Grade 9
18	9	Damara	Not employed	Not sure

Table 3 Health staff demographical data

Profession	Years of Experience
Doctor (private practice)	Unknown
Nurse (private practice)	39 years
Nurse (government clinic)	12 years
Nurse (government clinic)	10 years

4.4 SRH needs of adolescent girls

4.4.1 Knowledge of what SRH means

This section covers the perceived SRH needs of adolescents, their perceptions and knowledge of SRHS and what meaning they attach to them. It highlights the importance of awareness and knowledge of their needs and rights for adolescents to seek and demand such services. It appears that many of the girls are not sure on what SRH entails from the findings of this study. Their general understanding when asked what SRH meant to them suggests that they thought it was simply ways in which they could stay healthy while some said they were unsure. Of the 19 girls interviewed, 4 said they had heard of SRH, 7 declined to answer perhaps they could have been

shy to respond while 5 said they were unsure and 3 said they did not know. One girl responded saying *"I think it's the way you protect yourself against pregnancy and sexual intercourse…all that. I really don't know. That's the least I know", (17 year old Herero girl, Grade 10 learner at private school).* Another girl was of the opinion that SRH was, *"I think it's about staying safe, abstinence from sexual activities, keeping healthy and like with a sexual partner…things like that" (17 year old Damara girl, Grade 11 learner at private school).* While another thought, *"I think like regular visits to the doctor and as a minor for me I think abstinence would be the best for me" (16 year old Coloured girl, Grade 10 learner at private school).* Meanwhile, these responses on the understanding of SRH seemed to vary according to age, grade and school. This suggests an intersectional relationship between knowledge and awareness of SRH with age, level of education and location of school. To illustrate this, girls who were much older and had a higher level of education than others seemed to be more aware of SRH than those who were younger. Many of the girls at the government school either declined to answer with a long silence or said they did not know what it meant. Some of the responses included, *"I don't know what it means" (15 year old Damara girl, Grade 8 learner at government school*), *"I have never heard of it" (16 year old Damara girl, Grade 8 learner at government school)*, and *"I heard people talking there at the clinic, sometimes the nurses are standing there at the clinic telling you about SRH. Like we must be careful about men and sex and that we must use condoms if we want to have sex" (18 year old Damara girl, Grade 9 learner at government school)*. These findings show that their lack of clarity on what SRH means to them could affect how they perceive their SRH needs and that an intersection exists between levels of knowledge and awareness and one's social position.

Although there was a lack of clarity on the meaning of SRH, many of the girls did admit that they were aware that some of their peers were sexually active. When asked how they were protecting themselves against pregnancy and STDs, one of the girls responded saying *"Yes, I know friends who are sexually active. Most of them go for the 'injection', some use condoms when having sexual intercourse" (17 year old Coloured girl, Grade 10 learner at private school).* Another added, *"Some use condoms and some are using pills (family planning pills)" (18 year old Nama girl, Grade 8 learner at government school).* Nurses at the government clinic confirmed that a significant portion of adolescent girls used the 'injection' as a means to guard against unintended pregnancies. However, they were unsure if the girls understood the implication of this choice on their wellbeing and if they used additional methods to guard against other unintended health outcomes such as HIV/AIDS and STIs.

4.4.2 SRHS provided to adolescent girls

The SRHS offered at the two health facilities included; health education, education on hygiene, pap smears, breast cancer screening, vaccines against Tetanus and the Human Papilloma Virus (HPV), HIV counselling and testing, education on pregnancy and family planning, contraceptive methods that include oral and injectable contraceptives and condoms.

4.4.3 Perceived SRH needs of adolescent girls

When asked about their SRH needs and the type of information and services they desired, the girls mentioned that they needed services that were timely, affordable, non-judgmental, private and confidential. One of the girls said, *"Sometimes you wait in the long queues at the clinic for too long" (18 year old Damara girl, Grade 9 learner at government school)*. On the other hand,

one of the girls thought private health facilities provided timely services compared to government ones. She said, *"At the private clinic you don't wait too long because there are not many people. You can even call to make an appointment so that you don't wait when you go there" (17 year old Tswana girl, Grade 11 learner at private school)*. The waiting time spent before medical attention can be rendered was found to be a factor affecting adolescents that accessed services at government clinics and the reason why some girls preferred to access private clinics. One of the girls said, *"We need an adolescent section at the hospital that just deals with us so that we don't wait in long queues with other adult patients" (17 year old Herero girl, Grade 10 learner at private school)*. These findings demonstrate how girls experienced SRHS differently based on their social class which enabled them to cut down the amount of time spent at health facilities and also determined the type of facility one could access. It was found that girls attending private school were more likely to access timely private health facilities compared to girls attending government school.

The girls perceived private health facilities as quick and timely in the provision of service. However, the cost of services at private health facilities was found to be a limiting factor to addressing the SRH needs of some girls. One of the girls said, *"We can't afford to go to private clinics because the cost is too high" (15 year old Nama girl, Grade 8 learner at government school) another girl added, "It's cheaper when you go to the clinic, you don't spend too much money unless if you have to buy the medicines on your own" (18 year old Damara girl, Grade 9 learner at government school)*. These findings show that girls desire SRHS that are affordable and their class position was a major determinant to access. Girls from poorer households were less likely to access SRHS compared to those from middle class households due to the costs of

service. In cases where they could not afford these services, their access would be limited despite the service being available. Another important need the girls highlighted was a need to access non-judgemental services. The girls perceived judgment received from the nurses as a factor that prevented them from fully expressing their needs. *"We feel shy to tell them why we are there because you don't know how they will look at you" (17 year old Herero girl, Grade 10 learner at private school), "I don't know what they would think of me if I went there to look for such things" (15 year old Nama girl, Grade 8 learner at government school).* These sentiments were shared by many of the girls in this study. They also thought that some nurses were rude and this impacted how they communicate their problems. One of them said, *"Sometimes they just are so rude, maybe it's because they have a lot of people to see" (16 year old Damara girl, Grade 9 learner at government school)* while another added, *"The older ones are usually rude, maybe they get irritated when they see young girls there" (15 year old Herero girl, Grade 8 learner at government school).* The girls thought their age played a major role in determining access to SRHS and attributed the negative attitudes received from some nurses to their age. Among other needs, the girls mentioned a need for comfortable bras, knowledge on how to resist peer-pressure, as well as safe, free and comfortable menstrual pads as a means to maintain their personal hygiene that they thought could impact their reproductive health. They also stated that they needed full information on ways to protect themselves from pregnancy and STIs with opportunities for them to ask questions and really understand. One of the girls said, *"I would like to know a lot more about contraceptives and everything in detail because I don't use them" (16 year old Damara girl, Grade 9 learner at government school).* The girls also needed information on the risks of contraceptive use and greater knowledge and awareness on their reproductive health. The nurses presumed this need was addressed by the general health information provided

at the clinic through posters and pamphlets and the health talks held at the waiting area. However, this could mean that only those visiting the clinic at specific times or are able to read could be able this access this information.

Adolescent friendly services and adolescent only spaces were found to be an important need in addressing SRH issues among adolescent girls. The girls thought these types of services could address their need for privacy, confidentiality, and the provision of timely and affordable services. However, there seems to be a gap that exists in the service provision of SRHS to adolescents that may feel more comfortable if their needs were addressed in an adolescent-specific space. The medical staff were asked if any programs targeting adolescent SRH existed and facilitated by staff that cater to adolescents only. Although there is no adolescent specific clinic or facility in Gobabis, all of the health care staff pointed out that they tried to make SRHS at their facilities as hospitable as they could to adolescents visiting their facilities. They also had an integrated health care service that they presumed would increase the confidentiality and privacy of their clients. One nurse said:

> *We use an integrated service approach. This means a patient can be sent to any of our consulting rooms and then we can assess their needs from there. That way, no one can assume what the patient is here for unlike if we had specific service points for specific services. (Female nurse at government clinic)*

This meant that, by not having a specific space for adolescents and SRHS, they would reduce the stigma surrounding where certain services are accessed and reduce the risk of assumptions made

on their clients by other facility users. On the other hand, one nurse shared her experience with her work in Witvlei village in the Omaheke region which she thought could be replicated in Gobabis. She said:

> *We do have an adolescent friendly clinic, a program that deals with adolescents. It provides mostly information on alcohol abuse and different challenges adolescents have and we teach them how to overcome them. We would meet with adolescents in Witvlei for this program and they were quite active. They were open to share their concerns with their peers and seek advice. (Female nurse in government clinic)*

The SRH needs of the girls in this study seem to converge around a need for adolescent friendly services and provision of adolescent specific spaces at health facilities. They all expressed a desire to access services that were timely, private, confidential and affordable. Although many of the girls shared these needs similarly, how they experienced SRHS differed. This was due to their positionalities. There seems to be an intersection between the types of health facilities accessed, the type quality of service received and one's school location which is indicative of one's social status. Girls at the private school were less likely to experience SRHS at a government clinic. As such, their need for timely services may not be as urgent as that of the girls accessing these services at a government clinic. This also points to one's social status and draws a link between one's social class and the type of health facility one may access. Similarly, the girls at the government school expressed a desire for affordable services particularly in

private health facilities in order for them to equally access services they perceived to be timely and of better quality.

4.4.4 Counselling and education

The girls were asked if they had received any counselling or education on how to use the various contraceptive methods they were aware of and if they were aware of their effects. One of the girls said *"I think they were informed in school but they chose what they want for themselves. If they received any counselling before getting the injection it might be that they got it from the clinic." (17 year old Herero girl, Grade 11 learner at private school.)* While another girl added that, *"Sometimes their mothers are telling them" (17 year old Damara girl, Grade 9 learner at government school).* Many of the girls believed contraceptives had side-effects although not fully aware what these effects are. They did mention that they had limited choices available to them if they wanted to protect themselves from the effects of engaging in sexual activity. Their choices ranged between oral contraceptive family planning pills, the morning after pill, condoms and the injectable contraceptive. One of the girls said, *"I think some know about the side-effects but because they want to protect themselves, they just go" (16 year old Coloured girl, Grade 10 learner at private school).* One nurse from a private clinic was asked about the provision of counselling and education on contraceptive methods available to adolescents. She responded saying:

> *I give them the information they need. I try to make them as comfortable as possible and not judge them so that they can talk to me because I know some do not have anyone to talk to them. I try to assist even those that do not want their parents to find out. I even refer them*

> *to the hospital in cases that they have HIV to receive better services and counselling. You see with many of these girls I try to advise them not to get involved in sexual activity at such a young age, they should be focusing on their school to make their lives better. I try what I can do but it's their choice. (Female nurse in private clinic)*

Another nurse added that adolescent girls did have access to SRHS but were in need of support in order for them to make better reproductive choices. This support could be in the form of parental support or guidance from adults and medical staff. She further identified health education, HIV prevention and protection measures as vital SRH needs of adolescent girls. Services such as counselling on issues that included various forms of abuse, alcohol and drug abuse, HIV testing and family planning services were identified as essential to the development and general health of adolescents. These services were currently being offered at the clinic to adolescent girls. She re-emphasised the SRH needs of adolescent girls saying:

> *They need information. Young girls need support from us and their parents. They need to know about sex, family planning, the dangers of falling pregnant and the importance of ante-natal and post-natal services. They need to know how to protect themselves using condoms, family planning and injectable methods. (Female nurse in government clinic)*

The girls admitted to having received some type of sexuality education from school although not in much detail. The girls all attended the mandatory Life Skills subject offered in their schools and when asked what their thoughts were on the subject, one said *"We do talk about things to do*

with sex but not in much detail…like, we talk about how to keep yourself safe and protect yourself from pregnancy" (17 year old Herero girl, Grade 10 learner at private school).

The study revealed that doctors and nurses perceived adolescent SRHS as important even though some staff was conflicted on the relevance of these services to adolescents. Many of the staff thought adolescents themselves did not take their SRH seriously based on the low numbers of adolescents requesting for the service at their facilities. They did however note that adolescents were in need of services that were private, comfortable, affordable and confidential. They perceived raising awareness on reproductive health among adolescents could be a means to attract them to seek SRHS. Increasing their knowledge would equally aid their decision making competencies on issues surrounding their reproductive health.

4.5 Sources of SRH information

This section covers the sources of SRH information that adolescents perceived to be relevant to them in meeting their SRH needs. It also highlights the criteria they use to evaluate the information they received and when they decide to use particular sources of information. Findings from this study revealed that girls use a variety of sources of information to resolve their SRH needs. Many of them listed school, magazines, books, friends, aunts, the internet, parents, doctors and nurses as major sources of SRH information. Many of the girls thought they would consult with nurses and doctors if it was something they thought to be serious and may need medication or diagnosis. One of them said *"If I just need information on something I will Google it, it's not something I will go to the clinic for" (17 year old Coloured girl, Grade 11 learner at private school).* Some mentioned they were reluctant to ask for information from

nurses because they were perceived to be rude and unfriendly. This made it difficult for the girls to openly consult them until a real problem had developed or worsened. *"Sometimes you only go to the clinic when you are sick. I don't usually go just to ask something"*, shared one of the girls *(16 year old Damara girl, Grade 9 learner at government school)*.

Many of the girls mentioned they were fairly comfortable to talk to their peers because they were the same age and could relate to their concerns. However, some girls refuted this citing they had concerns about trust and judgment they would receive from their friends if they shared their problems. Notably, one of them said, *"I am not very open to talk about sex or a problem I am going through with them because they can judge me and talk about me" (17 year old Herero girl, Grade 10 learner at private school).* The girls thought their school was a good source of SRH information. However, they had concerns with its lack of completeness in addressing all their concerns. One girl said, *"If some of the things I want to know are not addressed in school I would Google the topic on my phone" (16 year old Coloured girl, Grade 10 learner at private school).* This shows that the internet was an important and supplementary source of SRH information for many of the girls that could not publicly ask questions on topics they considered private and personal. The same can be said for books and magazines since they offer adolescents more privacy in reading on topics they would not feel comfortable sharing with others or asking others for fear of judgment. However, it raises the question on access to internet services as many of the girls in government school did not have personal cell phones and as such did not list the internet as a major source of their SRH information. This highlights the differences in social class as a factor that limits one's access to vital sources of information.

The health care staff equally perceived schools as an important source of information and a good initiator on the discussion surrounding adolescent SRH. When asked when it was appropriate for a parent to initiate discussion on SRH to adolescents, one doctor said:

> *As soon as a parent thinks it's appropriate for their child. You see these things it's difficult to say when one should talk to their children. I can say at the onset of menstruation because the age of 9 or even 13 can be too young for a parent to talk to their child and understand what sex is about. It's up to the parent to decide when their child could need such information. (Male Doctor in private clinic)*

One nurse added saying:

> *They come looking for pamphlets. I think from the age of 10 they already start with their menstruation or get sexually active so they need to know and understand. Teachers can also use this information in schools and try to assist the girls understand what is happening to their bodies and how they can go about them. (Female nurse in government clinic)*

Another nurse added that it was appropriate for parents to begin to speak to their children on SRH issues as soon as they recognised a need for sex education. Levels of maturity and the onset of menstruation were found to be cultural markers in initiating the discussion on SRH issues. She noted that the use of age appropriate language could help ease the conversation between parent and child. She emphasised the importance to speak to them as soon as possible or as soon as they begun to understand how their bodies functioned and what changes they were going through. She added that parents should not shy away from talking to their children but instead

should talk to them in a language that they can understand. Phrases such as *"Don't let anyone touch your panties and don't allow anyone to touch your breasts" (Female nurse in government clinic)* were given as culturally appropriate examples parents could use to try and communicate with younger children especially on issues surrounding sexual abuse and child molestation.

The other health staff; three nurses and a doctor added that adolescents now had a wide range of information sources available to them, making it easier for them to have as much information at their disposal. They stressed that there was no excuse for adolescents to lack knowledge on SRH issues or be unaware of what was happening to them even in light of poor parent-child communication on SRH.

4.5.1 Sex-education and culture

The study's findings revealed that a majority of the girls are uncomfortable to talk about SRH issues with their parents. When asked if they would consult their parents on issues surrounding SRH, many of the girls felt they could not go to their parents even if they did consider them as an important and trust-worthy source of SRH information. When asked why not, one responded saying, *"Am not open to talk to my mother, parents are just negative. She will say something just to make me feel bad, like you will fall pregnant" (18 year old Damara girl, Grade 9 learner at government school).* Another girl added, *"I can't speak to my mother, its uncomfortable and I am not free with her when it comes to talking about sex" (15 year old Tswana girl, Grade 8 learner at government school).* It seems that age could be a limiting factor on the discussion surrounding sex as parents tend to be suspicious of adolescent girls and whether or not they are already engaging in sexual activity. A few of the girls said they would substitute parents for aunts as major sources of SRH information saying they found it more comfortable to go to their

aunts instead. One girl said, "*If I have a problem and I am not sure what to do but it seems serious I will talk to my aunt, my mother's sister. She is more understanding and she can advise me to see a doctor". (17 year old Herero girl, Grade 10 learner at private school)*

In many cultures there seems to be a silence on sexuality. In some cultures it was found that it was culturally inappropriate for maternal mothers to talk to their children about sexual issues and sexuality was hardly discussed in the home. Grandmothers and aunts seemed more involved in providing sexual instruction to young people perhaps on the request of mothers. In the Otjiherero culture for instance, it was not allowed for an adolescent to seek out SRHS on their own unless permitted or accompanied by their mothers. It was the mother's responsibility to ensure that their daughter did not fall pregnant and preserved their virginity. One nurse explained:

> *The Herero culture has a sexual practice in which cousins are permitted to have sexual relations in what is called 'Tjiramue[i]'. This practice makes it difficult for girls to negotiate the terms of their sexual experiences as it is culturally acceptable. So both mother and daughter need as much information to protect themselves" (Female nurse at government clinic)*

The limited decision on sexuality may pose challenges to adolescent access particularly in cases where they need to be accompanied by their mothers when seeking SRHS. On the other hand, it seems that some parents are open to discuss sexual issues with their daughters while others are not. One of the girls said, *"Some parents do talk to their children but some don't. For me am not comfortable because my mother talks a lot, I feel more comfortable with my aunt" (15 year old Herero girl, Grade 8 learner at government school).* Adolescents were not expected to be in

relationships with the opposite sex and engage in sexual activity. As such, adolescents accessing SRHS was frowned up as it raised the concern of sexual activity. One girl said, *"We are not allowed to have boyfriends, unless it's done in secret. After school we are expected to be home attending to our chores or studying" (17 year old Herero girl, Grade 11 learner at private school).* This also highlights the standard to which female sexuality is held and policed. It also meant that girls usually spent more time attending to chores around the house and were less likely to access SRH information or services in comparison to adolescent boys. It points out an intersectional relationship between one's gender, societal expectations of female sexuality and possibly their access to information. Some of the girls did highlight that some parents do take their daughters for the 'injection' while some question the relevance of these services to adolescents. Pregnancy out of wedlock was frowned upon. Thus, it seems that mothers taking their daughters to the clinic for the 'injection' may be out of fear of their daughters falling pregnant and not necessarily that they believed such services to be appropriate for them.

On the other hand, Damara/Nama culture was found to be more open to discussion on sexuality. Parents were permitted to guide and teach their children about sex. Upon the first menstruation which acted as a cultural marker of womanhood and maturity, one was expected to inform a female elder such as a mother, aunt or grandmother in order to perform the necessary rituals. One girl shared her experience saying:

> *When you get your first period, you are supposed to tell your mother or aunt. They take you in the house and teach you different things, like how to keep yourself clean, you stay there until you finish. They also*

tell you that if a boy touches you, you will get pregnant. (18 year old Damara girl, Grade 9 learner at government school).

It was found that mothers and kin elders *(female)* were obligated to teach their children about aspects of sexuality and how to take care of themselves. In a case that they could not perform such duties someone could stand in for them.

The Tswana and Coloured girls interviewed said they were unaware of the culturally appropriate ways in which sex-education was supposed to be relied. They thought it could have been the responsibility of mothers and older females in the family. However, they highlighted that it would be uncomfortable for them to talk directly to their mothers on sexual issues unless they had a serious problem that needed their attention. One Tswana girl said, *"I can talk to my mother about anything but not about boyfriends or even sex. I can't tell her that, she would just get upset and think am already doing it" (17 year old Tswana girl, Grade 11 learner at private school).*

4.5.2 Evaluation of information sources

Many of the sources of SRH information mentioned by the girls had the potential to lack trustworthiness and credibility with the exception of the doctors and nurses. It seems that experience and perceived level of knowledge were important criteria in the evaluation of sources of SRH sources. Some girls were sceptical about other sources of SRH information such as the internet and magazines. The girls thought they could trust the information they received in schools, from doctors, nurses, parents, aunts and trusted female adults because they were relayed by people that 'know'. They thought they could trust the information they got from their parents and aunts since they were considered to be more experienced. *"I believe the information I get*

from my mother and aunts, they know more than me and I have to listen to them" highlighted one girl *(15 year old Damara girl, Grade 8 learner at government school).* Some of the girls had various strategies they used to corroborate the information they got from various sources and compared it in order to judge its credibility and trustworthiness. When asked what these strategies were, one girl said:

> *I first search the internet, and then ask my friends. If I don't understand then I can ask my aunt. I will compare what they are all saying to see if it's true. If I can't get help from these sources then I can find out from my doctor because he is open and friendly (17 year old Herero girl, Grade 11 learner at private school)*

It seems friendliness, privacy, anonymity, confidentiality and ease of accessibility were important factors adolescents considered in determining the types of SRH information sources they consult and when to use them.

4.6 Access to and barriers to SRHS

This theme highlights how a range of barriers identified in this study can hinder adolescent access to SRHS in Gobabis. It combines two sub-themes "Access to SRHS" and "Barriers to SRHS" in order to have a holistic view as access cannot be viewed in isolation of the barriers that exist in limiting it. This section covers different social-structural issues that intersect to limit access to SRHS in different ways for many of the girls.

4.6.1 Awareness of SRHR

The study revealed that the girls were unaware of SRHR, what they mean and how they apply to them as adolescents. When asked if they had ever heard of SRHR and what they mean, many of the girls declined to give a response stating they did not know what these rights were. Only two girls responded to this question. One girl's thoughts on SRHR were, *"I think that I have free access to contraceptives and if someone abuses me I have the right to report to the police and all that" (17 year old Damara girl, Grade 11 learner at private school)* and another added that:

> *I am not sure, but I have heard that when one is raped, you don't have to bath and you must go and report to the police and get tested after reporting. I also think that these rights are supposed to protect someone's identity (17 year old Herero girl, Grade 10 learner at private school)*

There was a lack of awareness of SRHR among the girls in this study. This lack of understanding could be a hindrance to access of SRHS for many adolescents that are unaware of their SRHR. This also makes it difficult to know when these rights are being violated and when they need to demand access to services and information that may not be easily availed to them. Raising awareness and knowledge on SRHR could be vital in increasing access to SRHS. Thus there is a need to raise awareness on SRHR among all adolescents and parents in order to improve access to SRHS.

4.6.2 Awareness of SRHS

The girls were asked if they were aware of what services are involved in improving ones SRH, their relevance and availability to them. Many of the girls in private school mentioned they were aware of the cervical cancer prevention campaign that was aimed at vaccinating girls against cervical cancer. While all the girls from both private and government schools stated that they were aware of the availability of the freely distributed 'Smile Condom', the contraceptive injection and family planning pills. These methods particularly, the 'injection' seemed quite popular among all the girls in terms of awareness about it although some mentioned they did not use it as a means to protect against pregnancy. They all thought these were important services for many girls like themselves. One girl emphasised the importance of the vaccination against cervical cancer saying:

> *That's important, I think they should come at schools for girls to be vaccinated because some of them can't go to the hospitals or they are too busy. Some of them don't get the information. Some girls don't get information on SRH because it depends from school to school and with the Life Skills teachers. Some girls may not have access to magazines, books or the internet so if the teacher doesn't give them the information then they will not know (17 year old Herero girl, Grade 11 learner at private school)*

In order to gauge the levels of public awareness health facilities provided to the people of Gobabis on SRHS offered at their facilities, the researcher asked them how they made their services known to the public. It was found that adolescents got to know of SRHS at government clinics through posters around town, around the clinic and in the schools. Others got to know

about the services through friends and family that could have accessed them previously. The clinic also gave sessions of health education every morning at their waiting area. However, the private medical practice seemed to have had a limited scope of public awareness on SRHS they offered. They mainly relied on their digital advertisement boards at the clinic to inform their clients of the services available. The private clinic did not have posters on SRHS pasted on its walls. This could mean that their clients may not be conversant with the available services at the clinic if they did not pay attention to the digital advertisement board in the waiting room. This finding suggests that adolescents that accessed SRHS at government clinics were more likely be exposed to knowledge of other services offered at health facilities than those visiting private clinics. Therefore, this could have increased adolescent awareness and usage of SRHS at government clinics than private ones.

4.6.3 Adolescent perceptions of SRHS

With regards to the relevance of the services offered at the clinic, the girls perceived them to be important to them. One girl said, *"Girls can go for testing, contraceptives and all those things. I think they are accommodating to adolescents, am not sure though cause I haven't been at the hospital in a long time" (17 year old Damara girl, Grade 9 learner at government school).* Despite the relevance of SRHS, some girls pointed out the hostile attitudes of nurses at some government facilities as limiting their access to these services. One girl narrated an encounter with one nurse in which she needed various types of contraceptives for her school project. When she asked the nurse available for assistance, the nurse was hostile towards her. Upon realising it was a school project, she was later assisted. The girl added, *"I don't know how she would have reacted if I told her I wanted them for myself. I could not even ask for further information on how*

to use them" (17 year old Damara girl, Grade 11 learner at private school). In contrast, one girl narrated her positive experience at a private clinic saying:

> *When you go to a private clinic there is no one to talk about you and what you went there for and all. The doctors take their time to explain to you the medications and the side-effects in a way that you understand. When I went there for a problem I had, I was with my mother and he said if he had a daughter like me he would not allow her to get the injection because of the side-effects but it was up to my mother to decide. We had enough time to ask questions. (17 year old Coloured girl, Grade 10 learner at private school)*

Although all the girls in this study perceived SRHS as relevant and important to them, their differences in experiences while negotiating access to these services at health facilities suggests that there could be a relationship between the type of health facility one can access which translates to one's social class and how they experience SRHS. Girls that indicated having accessed SRHS at private health facilities shared positive experiences with these services while some of the girls that accessed these services at government health facilities expressed dissatisfaction with the attitudes of some nurses.

4.6.4 Legal barriers to access

In terms of accessing information and medications regarding contraceptives, pregnancy, STIs and HIV, a doctor at the private practice was of the opinion that these services were widely available, including in state hospitals and clinics. He did however add that children under the age of 18 required the consent of their parents before they could be allowed to fully access SRHS.

This was a legal barrier that was found to have limited access to SRHS for adolescents and prevented some health professionals from delivering the full range of SRHS to them. The reasons for this limitation on adolescents below the age of consent was for both parent and adolescent to fully understand the implications of their decisions. The doctor added that information on the requested services and risks would be fully available and clearly provided to the parent and their child in order for them to make an informed decision. When asked to comment on the relevance of SRHS to adolescent girls his response was, *"Yes it is available, I don't think it's good that it's given to them" (Male doctor at private clinic).* On the other hand, one nurse at the government clinic mentioned that adolescent girls did seek contraceptives especially family planning services. She added that these services were available to them even without the consent of their parents. It was found that in some cases, parents accompanied adolescents to the clinic requesting that they be put on family planning or requesting that they receive sex education at the onset of menstruation. This finding suggests that some parents are supportive of their children accessing SRHS in order to avoid unintended pregnancy and the contraction of STDs. However, there seems to be an intersectional relationship between one's social class and the level of access to SRHS. This finding further suggests that adolescents could have increased access to SRHS at government clinics since parental consent was not always required for many of their services than those offered at private clinics.

The findings of this study show that SRHS are available to adolescents that know about them and perhaps consider the services as relevant to them. Therefore, there is an intersection between SRHS access and usage and levels of awareness. However, barriers such as access limited to

parental consent continue to hinder their access to such services particularly in private health facilities where it was a requirement for minors.

4.6.5 Adolescent experiences of SRHS

In order to gauge the experiences of the girls, they were asked if they had any concerns about seeking SRHS from health facilities. This question focused on the attitudes of the girls and the health staff, communication competencies, confidentiality and privacy offered at the facilities. The experiences of the girls varied on these issues suggesting an existence of intersectionalities between the levels of education of the girls, their social class, levels of awareness of SRHS and their perceptions of SRHS at health facilities.

When the girls were asked about their experiences with SRHS and how easy it was to access these services at their health centres, the girls had different experiences depending on the type of health facility they went to. There is an intersectional relationship between one's social class which translates to the type of health facility one can access, their age and one's experiences of SRHS. This is evident in how some of the girls expressed dissatisfaction with the service delivery in government clinics and hospitals. They cited the rude attitudes of some medical staff, particularly some nurses who were much older. They expressed discontent with the long waiting time spent at the clinic before being attended to. In contrast, some girls that accessed health services at private medical facilities expressed satisfaction with the treatment they received and the timely service delivery. On experience of services at a private clinic, one of the girls said, *"I am very satisfied with the services they provide, I don't have to wait long for a doctor because I make an appointment. Medicines are always right and given so quickly" (16 year old Coloured*

girl, Grade 10 learner at private school). On the other hand, one of the girls that had accessed services at the government clinic said, *"They take long, the queues are always long. If you don't know anyone then you will sit the whole day there and some of the nurses are even rude" (15 year old Damara girl, Grade 8 learner at government school).* Adolescents accessing SRHS at a government clinic had to be at the clinic early in order to reduce the amount of time spent there. This could mean that the waiting time spent while at a government clinic could be a potential barrier that prevents girls from seeking SRHS. This finding also suggests that the amount of time spent seeking SRHS had an intersectional relationship with the social class of the girls. This meant that, those that could afford medical costs of private health facilities spent little waiting time at the clinic in comparison to other girls that could not afford these services. The nurses from the government clinic concurred that waiting time and poor attitudes from nurses was a challenge affecting adolescents and thought reducing the amount of time spent and improving the attitudes of nurses could improve service access to adolescents. Generally, the nurses assumed that adolescents were satisfied with their services because they made use of them and returned to the facilities requesting for SRHS.

These findings suggest that longer waiting times at medical facilities and bad attitudes from medical staff hinder access for adolescent girls and act as major barriers to access for many girls. This finding particularly affects girls falling in lower social classes as they cannot afford the high cost of services at private health facilities. The girls expressed a desire for privacy while at the clinic. The long queues at government medical centres posed a possibility for their privacy being compromised if someone they knew saw them at the clinic or in a particular area that could suggest the type of services they sought. This finding also suggests that social class could impact

one's privacy while negotiating access to SRHS. This means that, girls that spent longer hours trying to access SRHS were at higher risk of their privacy being compromised while in the queue compared to girls that spent less time at private health facilities. This could also result in the girls avoiding these services for fear of being found out.

4.6.6 Cost of SRHS

The cost of services at private health facilities was found to be a major barrier for adolescents seeking to access services they perceived to be of higher quality. Some girls mentioned they were on their parents' medical aid and as such did not consider the cost of service as a challenge to them. However, all the girls acknowledged the high cost of service at private facilities for people not on any medical aid and perceived it as a barrier that could hinder other girls from receiving timely SRHS. On the contrary, SRHS offered at the government clinics were found to be affordable for the majority of adolescents that depended on cash payments while at the clinic. Although many of the girls stated that their parents were employed, a majority of the girls in the government funded school had parents that were working casual jobs as domestic workers or farm labourers and did not have access to medical aid benefits. This acted as a barrier for adolescents that require such services. Many of these girls said that they visited government clinics because they were affordable. The cost of service ranged between N$8.00 to get a clinic card and N$4.00 if one already had a clinic card. These girls also added that it was much cheaper for them if they went in their school uniforms and got a 'school pass' to present at the clinic then they would be treated free of charge. This finding suggests an intersection between social class through the employment status of parents and access to health facilities. Children of parents that were working full time jobs with medical aid benefits and salaries high above the minimum

wage were more likely to access higher quality SRHS through their medical aid schemes in comparison to those whose parents did not have access to such benefits. Although the cost of service at government health facilities may be classified as affordable, there may be a possibility that some families could not afford to spare such costs on SRHS for their daughters until a serious issue arouse.

4.6.7 Communication on SRH

Although some of the girls claimed they did not have first-hand experiences with trying to access SRHS, they had heard experiences of other girls and they shared these perceptions. One of the girls said:

> *I don't know how they would react if I was to go there for condoms, injection or pills. I have heard from my friends that some of the nurses are cool with it but some their attitudes are just so weird…like they wonder what you are using it for. It's good for you but they wonder why you are using it at a young age. (15 year old Damara girl, Grade 8 learner at government school)*

The ability to communicate SRH issues was an important aspect in resolving SRH problems. Many of the girls expressed how difficult it was for them to communicate their problems because they were shy or unsure how the health care staff would react to it or perceive them. This was found to be a major individual barrier for the girls. One of the girls responded saying:

> *Sometimes it's difficult to communicate your problem, because you don't know how to ask or sometimes you are afraid of how the person*

will react towards it. You just don't know how to put it in words. You end up feeling shy and embarrassed to ask a lot of questions. (15 year old Tswana girl, Grade 8 learner at government school)

The nurses and doctor also acknowledged that adolescents had challenges in communicating SRH issues or concerns. They cited shyness as a major issue affecting adolescents in properly communicating their problems at the clinic. One nurse said:

First timers are always shy when they come for family planning services because we ask them questions in order to know how best we can help them. I need to know whether this girl has a boyfriend or if she is sexually active then I can know what type of sex education is required. After some time they start to feel more comfortable and begin to open up and even ask questions. Nurses just have to probe more to find out if the services or medication is working for them. If you don't ask them then they will not tell you. I ask them "Are you spotting? Is your period consistent? How is the family planning working for you? Are there any changes you are going through?" those type of things. (Female nurse at government clinic)

Another nurses commented on the willingness of adolescent girls to seek SRHS saying:

They are not willing. Some girls only come for follow ups. I talk to them and inform them to understand better but they don't really open up. They think nurses talk too much because we have to ask a lot of questions. They listen but they don't open up. (Female nurse at government clinic)

This finding suggests that ability to communicate one's SRH concerns was intersectional with one's age and levels of awareness. Notably, younger girls and those accessing SRHS for the first time were found to be less at ease in expressing their concerns that those that had previously accessed such services.

4.6.8 Language barriers

The girls were asked if there were any language barriers they thought could affect them in relaying their concerns and understanding their diagnosis or advise from the doctors. Many of the girls thought that spoken language was not a barrier for them but mentioned that sometimes they had difficulties understanding the technical language used by doctors. It was reported that many of the doctors tend to switch between English and Afrikaans as Gobabis is largely an Afrikaans speaking population. One girl emphasised this saying:

> *At the private doctors it's so easy to communicate because many people can talk Afrikaans and English but sometimes some of the words they will be using make it difficult to understand what the problem is. Like some illnesses or sometimes people just don't understand what the illness is all about (17 year old Herero girl, Grade 11 learner at private school)*

The girls stressed that the technical language barriers could depend on the health facility one goes to. They mentioned that private doctors did take time to explain to the girls and ensure that they understand. In contrast, they felt doctors and nurses at government facilities could be overwhelmed with the amount of patients coming in and as such did not spend enough time with the girls or give them much opportunity to ask questions. One of the girls gave their perception

of government clinics with reference to language barriers saying, *"Not really that there are language barriers because they have nurses speaking different languages at the hospital. If one doesn't understand, another nurse can be called to help" (18 year old Damara girl, Grade 9 learner at government school).* The nurses agreed that they used languages the girls could understand, in some instances using the help of a translator to effectively communicate with their patients. This finding suggests an intersection between ability to communicate one's problem with levels of knowledge and awareness of SRH issues and one's social class. It could further suggest that girls with lower levels of education and health literacy may have challenges in properly communicating and understanding professional advice. Similarly, the amount of patients at a medical facility may impact the amount of time medical staff spend properly communicating SRH issues with their clients.

4.6.9 Confidentiality and privacy

Many of the girls that went to private health facilities were not concerned with their confidentiality and privacy being compromised while at the facility. They felt that the short waiting time made it easy for them to seek attention quickly without being noticed or worry that someone they know could see them there. They also felt there was a lesser chance of the doctors or nurses discussing their problems with other people in contrast to those at government clinics. Some girls mentioned that they felt uneasy disclosing the full details of their problem while at government hospitals for fear of gossip or someone else finding it out. They also thought that in a case that they had to be attended to by someone they knew it would make them highly uncomfortable and increase the possibility of compromised confidentiality and privacy. One girl said, *"Obviously if the nurse is your relative or neighbour and they see you there, they would*

want to know what the problem is and tell your parents about it or what your sickness is. They will tell your parents and all that" (18 year old Nama girl, Grade 8 learner at government school). The girls also expressed discontent with the placement of condoms at the counter in a highly public place. They felt this would make them uncomfortable to pick them while others could be looking. One girl said:

> *I would be shy to get them and I think it would affect other girls too because you will be thinking of what other people will say about you. It's better to just go in the office with the nurse and ask for the condoms or things that you want instead of them being placed in the corridor or at the counter. (17 year old Damara girl, Grade 9 learner at government school)*

A nurse at the private clinic expressed awareness on adolescent concerns of compromised confidentiality and privacy. She said:

> *The girls are worried that some nurses know their parents. Gobabis is a small town. Everyone knows everyone. I think they are afraid of that. I tell them it's just between you and me. Even the doctors don't share things with us" (Female nurse at private clinic)*

A nurse at the government clinic also emphasised the importance of confidentiality and privacy in providing SRHS to adolescents. She noted that the implementation of integrated health services was crucial in guaranteeing confidentiality and privacy since a patient could talk to any nurse in any consultation room without fear of someone suspecting what a patient is in for. She added, *"To prevent discrimination, each room provides all the services. This increases patient*

confidentiality and privacy" (Female nurse at government clinic). Another nurse pointed out that she was aware of some concerns the girls had about opening up and sharing their problems while at the clinic. She said:

> *The concerns are mostly that they fear nurses might be sharing their information or tell their parents. We talk to them and make them feel at ease. We keep the door closed and make them understand that whatever they tell us will not leave this room. (Female nurse at government clinic)*

These findings draw an intersection between social class and perceived levels of confidentiality and privacy. The girls are of the view that private health facilities offer higher levels of confidentiality and privacy than government facilities due to the short amount of time spent at the facility and reduced chances of the nurses there knowing them personally. This means that ensuring these aspects could increase adolescent access and comfort in seeking SRHS.

4.6.10 Distance to health facilities

Some girls thought the distance from their homes to the clinic was not much of a barrier to them personally. Some of the girls highlighted that they were able to take a taxi to the clinic or have their parents drop them off. Some of them said, *"My parents take me" (17 year old Coloured girl, Grade 10 learner at private school), "I always go with my parents, they take drop me and pick me up" (17 year old Herero girl, Grade 10 learner at private school)* and *"Sometimes I go with a taxi" (17 year old Tswana girl, Grade 11 learner at private school).* All the girls at the private school indicated that they did not consider the distance to health facilities as a barrier to them. However, they still perceived it to be for other girls that had to walk quite a distance to get

to the clinic and be referred to the hospital. Many of the girls at the government school thought that distance to the clinic was a barrier depending on where one lived. Some had this to say, *"For me it's not a problem, I stay near the clinic" (15 year old Nama girl, Grade 8 learner at government school), "I can just walk because it's not far for me" (16 year old Damara girl, Grade 9 learner at government school)* and *"I am staying far from the clinic and I can't take taxi. We always walk there" (17 year old Damara girl, Grade 9 learner at government school).* In the same vein, some of the girls expressed a desire for clinic services to be closer to them as the Epako clinic was not centrally located to ease access for residents living further from Epako. One girl said, *"Sometimes you are not feeling well and don't have taxi money so you will have to walk to the clinic. My house is far from the clinic, I live down in Kanaan."(16 year old Damara girl, Grade 9 learner at government school).* This finding suggests that distance to the clinic was a barrier that was experienced differently for some girls based on their social class and location. This was dependent on one's proximity to the health facility and their ability to get transport to the clinic. While the girls at the private school relied on transportation provided by their parents to health facilities, many of the girls from the government school indicated that they had to walk to the clinic, in some cases further distances and with no means of transportation. As such, access to SRHS is affected by distance to health facilities through one's social class to afford transport costs.

4.6.11 Cultural impacts on SRHS access

In order to determine if any cultural barriers existed that could prevent the girls from discussing sex with their parents or in the home, the girls were asked how comfortable they were to talk to their parents about sex or if their parents would initiate the conversation. Many of them stated

they would be uncomfortable to discuss such issues with their parents even if some girls felt they were open and comfortable to talk to their parents on other matters. They mentioned that they were unsure how their parents would react as some parents did not seem too keen to bring up the topic. The girls said they did not know why they did not talk about sex in their home with their parents. They assumed that perhaps it could be the belief of their parents that talking about sex could encourage them to engage in it or that it was not good to talk about sex. In terms of the existence of cultural barriers that could limit open discussion on sex between parents and children, the girls stated that they were unaware of the existence of such barriers in their respective cultures. One of them added saying, *"I don't know much about my culture, we usually don't follow those things" (17 year old Tswana girl grade 11 learner at private school)*. The girls attributed this lack of discussion to feelings of unease and maybe a lack of knowledge on the side of parents on the importance of initiating the discussion with their daughters. They also thought finding the right words to explain what could be relevant to them as young women could have contributed to the situation. They felt their parents did not engage in the discussion with them in order not to raise their curiosity. One girl said, *"I think that parents would be avoiding the topic thinking that we might want to know more and start experimenting" (17 year old Coloured girl, Grade 10 learner at private school)*. Some of the girls thought it would have been easier for their parents to talk to them about sex if they themselves had discussed it with their parents. *"I think maybe their parents also did not talk to them about sex that's why they can't talk to us also. Maybe it is how they grew up",* expressed one of the girls (16 year old Damara girl, Grade 8 learner at government school). Although the girls mentioned they were unaware of any cultural beliefs or norms that hindered parental discussion, these findings suggest that there

could be unspoken taboos that act as a barrier. In turn, these taboos impact adolescent access to SRHS.

Some medical staff interviewed were unsure of the existence of cultural barriers that limited parents from discussing issues surrounding sexuality with their children. There seems to be an intersection between one's cultural beliefs, race and how one perceives access to SRHS. It was found that the white medical staff at the private clinic valued individual agency over cultural beliefs, noting that people could transcend cultural beliefs in order to make decisions that were appropriate to them. One doctor said, *"There could be cultural aspects but that can't be an excuse. If a parent feels the need to talk to their child they can. They can use a variety of information sources if they can't talk about it" (Male doctor at private clinic).* On cultural practices that impact one's SRH, one nurse said:

> *You see some cultures it's like that, and they can't open up. You find one man is having 4 or 5 wives and that's the culture they are growing up in. Maybe it's difficult for them to get out of that then you end up with all these infections. That's the problem; the culture is the problem (Female nurse at private clinic).*

On the other hand, some nurses attributed feelings of unease between parents and children to the lack of communication competencies and knowledge to properly address such issues with young people. The study found that the levels of education of parents did not play a significant role in initiating discussion on sexuality in the home. Despite some parents having attained higher levels of education, the girls still indicated that there were was still a lack of engagement until at a time that a problem or concern arose. In such instances the discussion would be centred on a lack of

trust and instilling fear rather than dialogue and understanding. One of the girls narrated, *"We don't really talk about sex. Only when she sees you with a boy then she will talk about falling pregnant and that we must stay away from sexual activities. Even if you are just walking with him", (17 year old Tswana girl, Grade 11 learner at private school).* Another added, *"She will just be telling you that you must not fall pregnant and to stay away from boys. Even if you tell her you are not doing it she will not believe you", (18 year old Damara girl, Grade 9 learner at government school).* The nurses added that in this age of teenage pregnancies and HIV, cultural barriers should no longer be an issue that hinders access to information and services to young people. They emphasised that although parents and children may be uncomfortable to talk about issues affecting the SRH of adolescents, there were many other ways a parent could try to communicate to their child through pamphlets and magazines. The findings also show that adolescents themselves were reluctant to open up to their parents about their SRH. Although no clearly defined cultural barriers were identified, these findings suggest the existence of such barriers. There seems to be an existence of unspoken taboos surrounding sexuality that limit open discussion on the topic and make it uncomfortable for both adolescents and parents to talk about it. The availability of various informational sources was considered a starting point as a means to transcend cultural barriers. These findings suggest a lack of socialisation through cultural norms on the importance of talking about reproductive health and issues surrounding sexuality with adolescents. Therefore, cultural norms on adolescent sexuality intersect with race or ethnicity and age to impact adolescent access to SRHS.

Similarly, one nurse strongly believed that cultural norms and a lack of appropriate language to refer to the human reproductive organs were still eminent across cultures and impacted adolescent access to SRHS. She said:

> *Most cultures don't talk about sex and call the names like penis or vagina. It's still a taboo topic. Some cultures don't allow people to even go out when they are on their 'periods', they just stay in the house. Due to cultural beliefs, they don't really talk about it and that makes it uncomfortable also for girls to ask. There is a lack of age appropriate language or words to use in vernacular to refer to male and female sexual organs. (Female nurse at government clinic)*

What stood out from the interviews was that across all cultures discussion on sexuality was uncomfortable and restricted even among parents with higher levels of education. Socialisation was found to be the primary factor impacting discussion. Although mothers, sisters and older female kin were considered the first point of contact for adolescent sex-education, discussion was still limited. The nurses at the government clinic highlighted that in the Herero culture teenagers and parents were not open to discuss issues surrounding sex. Some form of discussion would be initiated at the onset of menstruation for the girls and at the age of 18 which was considered a marker for maturity and womanhood. In some cases they would be accompanied by their mothers to the clinic where a nurse would facilitate sex-education in the presence of their mothers. While in the Damara/Nama culture mothers were permitted to guide and teach their children about sex because mothers were considered responsible for the sexuality of their daughters. In a case that they could not do it, someone else; close kin could stand in for them. *"Upon the first menstruation, the girl must inform an elderly female; mother, aunt or*

grandmother so that they can perform the necessary rituals. The girl is put in a room and she will be told that she is now a woman and she must look after herself" (18 year old Damara girl, Grade 9 learner at government school). Although the facilitation of sex-education was similar between the Damara/Nama and Tswana cultures, in the Tswana culture it was not typical of mothers to talk to their daughters directly on sexual issues. Grandmothers and older aunts were usually tasked with this responsibility and the girls felt more at ease to talk to them. One nurse said:

> *When a girl gets her first menstruation period she must tell her grandmother or her mother, a female adult. She will be put in a room to be taken care of by her grandmother till the period stops. This is when they tell her how to take care of herself and the impact of sex, like pregnancy or STIs. (Female nurse at a government clinic)*

On the other hand the nurse felt that it was difficult for parents to encourage their daughters to use SRHS, particularly among Herero women as it may be interpreted as permission for them to engage in sexual activities. She shared how the Tjiramue[i] practice was impacting the SRH of adolescents saying:

> *The practice makes it easier for adolescents to engage in sexual activities at a young age. The parents can't do anything about it because it's an acceptable cultural norm for cousins to have sexual intercourse. This also makes them more likely to access SRHS because mothers know about it and bring the girls to the clinic for these services (Female nurse at government clinic)*

These findings highlight how age, cultural norms and beliefs impact access to SRHS. The beginning of menstruation in various cultures marked maturity and was a passage into womanhood. This was significant in the initiation of various forms of sex-education and for some girls marked the beginning of a certain level of access to SRHS. Although discussion between mother and daughter was found to be limited, grandmothers, aunts, sisters and close older kin were considered as appropriate facilitators of adolescent reproductive health education.

4.6. 12 Moral and ethical dilemmas on adolescent SRHS access

All the medical staff were asked if they experienced any moral or ethical dilemmas in providing SRHS to adolescents. One nurse noted that it was necessary for medical staff to avoid imposing their personal morals and let them affect service delivery. She responded that, *"There are no moral limitations on my side. I just offer the services because it's their right. I do offer advice on advantages and disadvantages of their choices but they need to know how to make their own decisions" (Female nurse at government clinic)*. Some of the medical staff noted that sometimes it was not easy to provide such services especially when parental consent was required and the girls did not want their parents to find out. However, one nurse mentioned that not all SRHS required parental consent. It was easier to provide family planning services to adolescents for instance without the consent of parents as a means to assist the girls to prevent unintended pregnancies. On the other hand, SRHS such as HIV testing required the consent of parents or guardians and in some cases the presence of a partner to provide support to the adolescent. She said:

> *One of the challenges we face is poor adherence. They don't turn up on time or don't come for follow ups. We need to talk to all of them to understand the importance and involve the significant other mostly for those who are HIV positive. They can be fragile and are affected the most because they fear judgment, stigma and discrimination, they end up stopping treatment. If the parent is aware they can remind them to take their medication or come for follow ups and provide support to them. (Female nurse at government clinic)*

The nurse attributed poor adherence to fear of stigma and judgment especially from their friends. She thought that parental support could help in such instances to encourage the girls to take their health seriously and continue with their medications.

Two nurses narrated a time they were faced with the moral dilemma of providing SRHS to adolescents that they felt they should have rather encouraged to abstain. These dilemmas are an important barrier to consider in determining adolescent access to SRHS. One said:

> *When I started working in Namibia I had a challenge. Where I came from you don't find a child in a school uniform taking family planning. It was difficult for me at first to provide this service to them. I tried to encourage them to abstain and focus on their school. With time, I had to accept and adjust to provide these services otherwise they get pregnant and they don't want the baby anymore. Girls as young as 15 were already taking family planning because their friends were taking it or their parents forced them to. (Female nurse at government clinic)*

Another nurse added;

> *Sometimes when am drawing blood I talk to these girls and they listen. I tell them to focus on their school and read their Bibles. I also ask them to stay away from going out at night because that's when bad things happen. I encourage them to protect their bodies because if they fall pregnant that will change their lives. But it's not really a problem to me, if they come to me, I will be glad to help. (White female nurse at private clinic)*

These findings suggest that in some cases the age of the girls converged with the personal and religious morals of the health care providers and the requirement of parental consent to limit their access to certain SRHS.

All in all, the findings suggest the existence of unspoken cultural taboos and social-structural barriers such as distance, cost of services and service provider attitudes that continue to impede adolescent access to SRHS. The girls all felt these are barriers that converged with their positionalities such as their age, social class, location and cultural beliefs to impact access and prevent them from seeking SRHS from government clinics and in cases that they could not afford to go to private clinics they would completely avoid these services.

4.7 Overcoming barriers to access

This section looks at the suggestions and possible solutions that the girls made to the services available in order to increase and ease their access to SRHS. Many of them thought it would be a good initiative for nurses to visit their schools and inform them about contraceptives and other methods that they can use to prevent pregnancy and the contraction of HIV. They felt this would also give the girls an opportunity to learn more about SRHS offered at the clinics and any

programs targeted at adolescents. Health care staff were in agreement with this suggestion; stating the importance for them to reach out to as many young girls as possible. They noted the feasibility of a school program that could provide them an opportunity to deliver their messages through seminars and workshops at schools. Private medical personnel were willing to volunteer their time to speak and counsel adolescents at such initiatives in schools. One girl said, *"I think it would be good for them to visit the schools because the learners can get some information they may be shy to ask for and also share it with their friends that may not be in school" (17 year old Herero girl, Grade 10 learner at private school).* Another added saying:

> *I think they need to get people like you, social workers and psychologists to talk to girls on these things because some parents don't. It would be nice if we had our own space at the clinic where they just attend to adolescents with our own doctors and nurses so that we don't have to wait in the same queues as older patients (17 year old Tswana girl, grade 11 learner at private school)*

A nurse at the government clinic also noted the importance of reaching out to as many adolescents through the school-health programmes; an outreach service they provide to schools. The importance of engaging parents into SRHS access and delivery was emphasised by the nurses as parental support was vital in ensuring access to these services. Programmes such as the National testing day and school health-programmes were girls are immunized against Tetanus were listed as opportunities to reach as many adolescent girls as possible and provide them with the necessary information and services they require. She said:

> *Reproductive health is about family planning. As nurses we have much work to do especially at schools. We need to talk to them about teenage pregnancy and if we can give sex education, family planning education, health education and the dangers of teenage pregnancy and HIV, it would help. Parents also need to be involved because traditionally, families don't talk about sex. That needs to change to make them also understand their role. (Female nurse at government clinic)*

Some of the girls also suggested that private clinics offer certain services for free to adolescents as government clinics charged very minimal fees for their services. They perceived clinical service fees as a major barrier to accessing quality services for many of the girls that could not afford these charges or were not medical aid beneficiaries. They felt this would help a significant number of girls to access better services when needed. This suggestion highlights the depth of how social class impacts access to a variety of quality and timely SRHS. Others suggested that private and government clinics find better ways of programming services for adolescents by assisting each other in conducting special monthly programs for them at a minimal cost or desirably at no cost at all. Although the removal of medical fees charged on SRHS may be a challenge as stated by private medical practice owners, one doctor from a private health facility suggested that the government subsidise the procurement of their medication in order to reduce the cost of service for adolescents and make it more affordable for them. He specifically pointed out the high cost of the cervical cancer vaccine that was crucial to adolescent reproductive health as one of the medications that needed to be considered for subsidisation in order to make it more accessible to adolescents that may not be covered by medical aid programs.

To address challenges with distance to health centres, some of the girls suggested that the clinics provide outreach programs to residents of the community by going out to different townships providing these services. The town of Gobabis has one government hospital located on the outskirts of town and one government clinic located in Epako township. This meant that many girls that could not afford transportation costs had to walk to the clinic and sometimes referred to the hospital which is much further for residents living in other residential locations such as Epako and Kanaan. The girls were of the opinion that it could be easier for them to access SRHS if they were provided closer to them. This also highlights how one's social positionality such as their socio-economic status and place of residence impacted access to SRHS among various adolescent girls.

One of the barriers to accessing SRHS was in relation to negative attitudes held by nurses in facilitating adolescent access to SRHS. The findings show that the girls would be more willing to seek SRHS if they felt comfortable and were treated in a non-judgmental and respectful manner. These factors were found to be instrumental in building trust between health care providers and adolescents. They also highlighted a need to feel secure and confident that their privacy and confidentiality would be upheld while accessing these services. Many of the girls noted a need to change the attitudes of nurses in how they relate to adolescents as a means to transcend the communication barriers that existed among them. They thought this would help them gain more confidence in communicating their concerns to medical professionals. One nurse was in agreement with this view and was of the opinion that a change of negative attitudes could encourage the girls to be more assertive and seek out SRHS more regularly. She said:

I think we should improve on our attitudes. We need to have a positive, non-judgmental attitude and deal with the situation individually based on their needs. We have to equip them with information so that they can make informed decisions. (Female nurse at government clinic)

In relation to opening hours, many of the girls felt it was inconvenient for them to spend most of their day at the clinic or hospital trying to access SRHS. One nurse added that reducing the amount of time spent at the clinic could encourage adolescents to visit the clinic more frequently in search of SRHS and information. She noted that the long queues at the government clinics could be a challenge for girls that do not wish to spend the whole day at the clinic for consultation, follow ups and counselling services. In the same vein, one of the girls suggested that they make special hours to attend to adolescents because they are in school and have chores and duties to attend to after school and during the weekend. She said *"Maybe they can open for adolescents only at certain hours" (17 year old Herero girl, Grade 10 learner at private school).* When probed further to highlight the feasibility of her suggestion she added, *"Some nurses could be taken to an adolescents section or something like that so when you go to the hospital you only have to go to your section and not where the adults are where it's always full"*. The girls noted that government facilities were cheaper and the cost made it more favourable for the majority of them that could not afford consultation and medical fees at private medical facilities. They thought reducing the amount of time spent at government clinics could encourage girls to visit them more often and could help improve adolescent access to SRHS. One girl added:

If you go to the clinic it's cheaper you can always go there and wouldn't worry about the cost and if you are attended to quickly you

can save time and do other things instead of being at the clinic the whole day. (18 year old Nama girl, Grade 8 learner at government school)

This shows that reducing the amount of time spent at the clinic for adolescents could be instrumental in facilitating adolescent access to SRHS. It also shows how various structural issues such as long waiting hours, cost of services and social class impact adolescents in accessing SRHS.

The importance of parental engagement in ensuring better access to SRHS and improved adolescent decision making was emphasised in this study. The medical staff were of the perception that parents had a greater role in securing the reproductive health of adolescent girls. They emphasised there was a need for parents to talk about issues surrounding sex and the challenges adolescents face during puberty in the home. They also highlighted a need to strengthen a multisector approach stating the Ministry of Education should strengthen peer education programmes and provide comprehensive sex education in schools through the "My Future is My Choice" programme. They called for a greater partnership between the Ministry of Health, Ministry of Education, adolescents, parents and other stakeholders concerned with issues facing adolescents to increase their reach to this group and provide greater awareness, support and health information in communities. This was presumed to be a way to have greater impact on adolescent SRHS delivery and access. This was also thought to be a means to transcend intersectional social-structural and cultural barriers that may exist in limiting adolescents from accessing SRHS through greater engagement with parents and other stakeholders.

4.8 Summary

This chapter focused on the analysis and presentation of the qualitative data gathered from adolescent girls and key-informants using semi-structured in-depth interviews. The data was analysed using content analysis. Demographical data was then presented in tables while the experiences, attitudes and perceptions surrounding access and service provision of SRHS were presented in narrative format. Adolescents' experiences of SRHS access were categorised into a variety of themes: SRH needs of adolescent girls, sources of SRH information, access to and barriers to SRHS and overcoming barriers to access. It was found that the girls did have access to SRHS in Gobabis. However, barriers such as parental consent, waiting time, cost of service, perceived negative attitudes from nurses and lack of parental support were found to limit access to some SRHS. It was found that adolescents desired services that were private, confidential, non-judgmental, affordable and timely. These factors were found to influence ones desire to seek professional help and services. The study also revealed the heterogeneity of the girls and how they positionalities converged to impact access to SRHS in various ways. Intersectional factors such as age, levels of education, social class and ethnicity were found to be instrumental in impacting access to these services. The next chapter presents a discussion of findings of this study.

Chapter 5

Discussion of research findings

5.1 Introduction

This chapter discusses the findings of the study presented in Chapter Four. The girls offered a unique insight into their experiences with SRHS, the various ways they negotiated access and their perception of SRHS in Gobabis. The discussion is guided by the study's main research question and sub-questions as outlined in Chapter One. The purpose of this chapter is to answer the research questions by adding meaning to the data collected in an attempt to resolve the research problem. The findings from this study are discussed under the following themes arising from the data in line with the research questions. The research questions "Do adolescent girls have access to SRHS?" and "What are the social-structural and cultural barriers that hinder access to SRHS?" have been combined for discussion in order to avoid repetition under the sub-heading "Access to and barriers to SRHS". The data was discussed under the following sub-headings: SRH needs of adolescent girls, sources of SRH information, access to and barriers to SRHS, overcoming barriers to access. The Intersectionality theory provided the theoretical background for this study and hence shall be referred to in the discussion section to highlight if the situation of the girls in Gobabis is consistent with what the theory holds.

5.2 SRH needs of adolescent girls

An intersectional analysis entails recognising diversity while also showing an appreciation for similarities. This approach brings about greater equity and reproductive justice. Atuyambe, et al. (2015), assert that adolescent girls are faced with unique burdens that are specific to their gender and sex. This argument also holds true for one's socio-economic status. Although adolescent girls may have similar needs and challenges, their experiences of these issues tend to vary broadly due to one's social position in society as highlighted in this study's findings. This argument is supported by Mprah (2016) and Hodgson, et al. (2012) who asserts that the needs of adolescent girls may vary based on their HIV status and their sexual orientation. Thus, they may require SRHS that are specialised in addressing their unique needs. The girls in this study expressed their desire to access information and SRHS that are adolescent-friendly, private, confidential, timely, anonymous and affordable. However, the ability to secure these pre-conditions was highly dependent on one's individual attributes and where they are socially located in the nexus of power relations. Girls from wealthier households opted to access private health facilities for their privacy, timely and perceived confidentiality they offer rather than government facilities because of their social status. Recognising how this difference in social power affects adolescent access to SRHS highlights the heterogeneity of social experiences held by the intersectionality theory.

According to Kennedy, et al. (2014) and Patel, et al. (2012), knowledge and awareness of ones' SRH needs are essential to resolving SRH problems. This study revealed that adolescent girls had a poor understanding of SRH and what it entails. As a result, this could have influenced how they perceive their SRH needs and what meaning they attach to them. These findings closely

relate to those by Chandra-Mouli, et al. (2015) who found that adolescent girls lacked adequate knowledge relating to their bodies and health. The researcher asserts that a better understanding on SRHR is crucial in accessing, demanding and defending these rights. Even though the girls highlighted that they were able to access contraceptive methods such as the oral family planning pills, injectable methods and condoms, they desired a greater understanding of these contraceptives and their side-effects in order to make better-informed decisions. Some of the girls reported using contraceptives without adequate understanding of their side-effects. This decision was based on a fear of falling pregnant and the need to protect oneself with limited information on their preferred choices. The experiences of these girls show an intersectional relationship between their age, levels of awareness and knowledge or educational background that undermine their ability to make informed decisions and exercise agency over their bodies. Perhaps the poor understanding of SRH could account for the high teenage pregnancy rates experienced in the Omaheke region and the low rates of contraceptive use particularly among uneducated, poor women as recorded in the National Demographic and Health Survey (MoHSS, 2014).

The reproductive justice theory calls for greater understanding of SRHR and what SRH entails and how it applies to adolescents. There seems to be an intersectional relationship between age, knowledge of SRH, SRHR and levels of education. In this study, girls who were much younger had a limited understanding of SRHS and many of them that attended government school were poorly informed or lacked information on SRHR. Thus, these girls were less likely to use SRHS in relation to older girls and those who had a better understanding of these services and rights. Raising awareness and knowledge of SRH among the girls, parents and within communities is

key to transforming barriers that impact access and limit adolescents from seeking solutions to their SRH needs. Morison (2013) supports this argument saying that not everyone is able to exercise their SRHR due to various factors that may limit one's choice. She identifies systemic socio-economic factors, a lack of information on SRH, stigma, violence and sexual coercion as hindering the attainment of SRHR. She argues that due to a lack of information and financial resources, some women find it difficult to access SRHS thereby negatively impacting their SRH decisions and rights. Violence and coercion are challenges many young women face, often stemming from gender inequalities and power differences among individuals. The universality of these rights in addressing the needs of individuals is thus questioned. Particularly, among poor girls who fall pregnant as a result of rape or force and have these rights violated. A lack of knowledge and access to abortion services entails that they bear the consequences on their own and sometimes in silence. Atuyambe, et al. (2015) found that abortion and post-care services were important needs adolescent girls expressed. The lack of political will to legalise abortion services on demand increases the vulnerability of many girls that fall prey to unsafe termination methods, often leading to serious health complications and even death. Although abortion services were not explicitly listed as a desired service by the girls in this study, it remains a concern for many girls that continue to experience unintended pregnancy and seek out unsafe termination methods. Therefore, tackling the socio-economic and cultural contexts in which these rights are exercised could improve service use among adolescents. This is crucial as some of the girls may already be engaging in sexual activity and lack clarity on the services available and what SRHS are relevant to them at this critical stage of their lives.

All the girls in this study desired services that were confidential, private, affordable and timely. However, these factors were experienced differently among the girls. Socio-economic factors highly influenced how one experienced and resolved their SRH needs. Girls that accessed services at the government clinic were more concerned with these issues and fear of judgment and stigma impacted their access to SRHS. On the other hand, girls that came from wealthier households were able to secure their need for privacy and timely services as they could afford the services offered at private clinics. Although the need for counselling and education were met by service providers, many of the girls reported that feelings of embarrassment often limited their ability to engage in meaningful discussions and ask questions even when opportunities arose. This was a concern that many of the girls accessing services at government clinics shared. Their apprehension was based on the thought that service providers and other clients could recognise them and potentially report them to their parents. This finding was similar to that of a Namibian study by Nambambi and Mufune (2011). Thus, destigmatising adolescent use of SRHS could have a positive impact on the overall wellbeing of adolescent girls. The researcher argues that facilitating counselling and education services that bring together parents and daughters to openly discuss these issues could have a greater impact in soliciting parental support and engagement in discussions surrounding SRH issues. Similarly, addressing levels of knowledge and understanding of adolescent SRH issues among parents themselves could assist adolescents in identifying their needs and resolving them in a timely manner. This also entails breaking cultural barriers that discourage parents from openly discussing what may be termed as sexual taboos. Although Nambambi and Mufune's (2011) study concurs that cultural barriers impacted parental discussion of sexual taboos with their children and were found to be hindering access to SRH information in Namibia. Their study also suggests a shift in this trend as some parents

reported being open to discussing issues surrounding sex with their children due to concerns about the high levels of HIV infections. This could mean that these parents may be well equipped with the relevant competencies to relay such information. However, this study reported that parents were reluctant to engage in discussion and support their daughters to seek SRHS for fear that it may translate into encouragement and support of sexual deviance. Findings by Kumi-Kyereme, et at. (2014) also highlight this concern among Ghanaian parents who generally act as gatekeepers to SRHS in the home and strictly police the sexuality of girls. Thus, normalizing discussions on sexuality could significantly improve parent-child communication on SRH and offer the needed support to adolescents wishing to access SRHS.

5.3 Sources of SRH information

This study revealed that girls desired credible and trustworthy sources of SRH information to address their needs and concerns. Other factors influencing their decision to use specific sources of SRH information included anonymity, privacy and confidentiality. In this regard, the girls favoured books, magazines, and the internet for the anonymity they offer. On the other hand, the internet as a source of SRH information was highly related to one's social class as the girls attending private school indicated that it was fairly easy for them to access such information on their mobile phones. Meanwhile, the girls attending government school indicated that they did not have access to personal mobile phones hence limiting their sources of information. The findings also revealed that the girls found it easier to trust the information they got from sources they regarded as knowledgeable and experienced on the challenges they were facing. They perceived the school, aunts, friends, parents and healthcare providers as important sources that could relate to their situation, similar to findings by Macintyre, Vega and Sagbakken (2015).

However, many of the girls regarded ‘parents’ specifically, mothers as a last option due to fear of judgment and a perceived lack of trust in the capabilities of the girls to make good decisions. This was due to the fear of ridicule and reluctance by some parents to engage in the discussion on SRH issues with their daughters. A study by Siebold (2011) found that fathers were cited as the least consulted and least influential sources of SRH information. Similarly, the girls in this study did not regard their fathers as a source of SRH information. These findings suggest that mothers were solely responsible for the sexuality of their daughters and that male engagement in such discussion was considered a taboo. Negative attitudes in communicating SRH information tend to discourage dialogue between parents and children and instil fear in adolescents (Macintyre, Vega & Sagbakken, 2015). This in turns makes adolescent girls reluctant to open up to their parents on any SRH challenges they could be facing. Generally, female sexuality tends to be held in high esteem. As such, girls that engaged in sexual activity or seek SRHS may be perceived in a negative light. Thus, the stigma surrounding SRH issues is internalised by the girls and this prevents them from seeking SRHS for fear of judgment and ridicule.

The study’s findings suggest that both parents and the girls across various cultures were reluctant to engage into the discussion on issues surrounding sexuality and SRH. Although levels of maturity and the onset of menstruation acted as markers for parents to discuss such issues with their children, there was contention on the appropriate age of full disclosure. Key-informants of the study indicated that perhaps it was a challenge for parents to engage in such discussions due to a lack of appropriate language to use in effectively communicating SRH issues to adolescents. The concern raised was with regards to levels of maturity and a lack of proper terms used to refer to male and female sexual organs, particularly in one’s vernacular. This could mean that the age

of the girls intersected with cultural norms surrounding adolescent sexuality that prevented open discussion of sexual issues. These findings substantiate the claim by Muhwezi, et al. (2015) on the existence of cultural barriers that prevent open discussion on matters surrounding sexuality and ultimately issues affecting adolescent sexuality.

Many of the girls indicated that they were fairly comfortable to share their SRH concerns with their peers due to their age and possibly shared experiences. However, the fear of judgement and gossip prevented such discussions in some instances. These finding closely relate to that of a study by Hodgson, et al. (2012) that found that in addition to other sources of information such as NGOs, schools, community events, friends and media (TV, radio, and newspapers). People perceived to be ‘‘experts’’ based on their personal experiences with a particular issue were considered as equally important sources of SRH information. In this study, experts could include aunts, parents and peers as they are perceived to be in a position to offer better advice based on their experiences. These findings are also similar to that of a study by Lince-Deroche, et al. (2015) in which adolescents mostly confided in family and friends who would later advise them to seek professional assistance. The girls indicated that trust was a major issue for them in seeking SRH. As such, they felt the nature of their relationships with their aunts made them a considerably relevant source of SRH information and a substitute for motherly advice. In cultures such as the Herero and Tswana cultures, there was a culture of silence on adolescent sexuality between mothers and their daughters. Adolescent engagement in sexual activity was generally frowned upon across cultures, breeding potential stigmatisation on girls that could be seeking SRHS. In the Herero culture, the practice of ‘*Tjiramue* [i'] is found to have an influence on early engagement into sexual activity and possible exposure to SRH problems among young

girls. These girls could easily be sexually active with male family members who may even be much older than them in order to appease culture. On the other hand, it also could have aided young girls in seeking out SRHS much earlier than girls from other cultures due to parental awareness and acceptance of this norm and practice. Among the Damara and Tswana tribes, aunts and grandmothers were found to be vital links in bridging the gap between mother and daughter as they were perceived to be more understanding and capable of offering the girls the necessary advice and assistance. This finding corresponds to that of Dune and Mapedzahama (2017) in which Zimbabwean women bestowed the duty of imparting sex-education on their children to close kin such as an aunt or grandmother as a primary source of socialisation. However, the researcher is sceptical of the credibility and trustworthiness of the SRH information that may be imparted to the girls by such sources. Although these aunts and grandmothers may have a considerable amount of experience, they too may be misinformed through a circle of harmful cultural practices and norms and use non-factual information to offer advice and assistance to the girls, increasing their vulnerability even further.

The girls also perceived schools as an important source of SRH information but thought the information received from them lacked completeness in addressing the concerns of adolescent girls. These findings correspond to those of other researchers such as Chandra-Mouli, et al. (2015), Kennedy, et al. (2014) and Patel, et al. (2012) that indicated that adolescents desire SRH information that not only includes aspects of sexuality, reproduction and SRH problems but also ways on how to avoid, cope and mitigate such problems. This calls for a holistic approach in addressing SRH concerns of adolescents that move beyond abstinence and prevention strategies but also look into the day-to-day challenges adolescents face in exercising their SRHR. Aspects

such as resisting peer-pressure and assertive decision making could be beneficial and empowering to adolescent girls. Muhwezi, et al. (2015) argue that a lack of standard curriculum on subjects addressing HIV/AIDS in schools which tend to be neither examinable nor required, pose a challenge for many schools implementing such curriculums. Although the Life Skills subject offered across all schools in Namibia has a standardized curriculum it still remains a non-examinable subject and teachers often lack teaching materials and training as found by Mufune (2008). Therefore, there is a probability that the learners themselves may not take it seriously. Also, there is a concern of the cultural context in which this subject is offered that may prevent teachers from adequately addressing SRH issues in their classes particularly if they are of the opposite sex. In spite of these concerns, the subject covers many other issues and is not limited to sex-education. However, it tends to consist of a wide range of general topics and may lack a comprehensive view in adequately addressing issues affecting adolescents, particularly, their reproductive health.

Although key-informants were of the opinion that adolescents had a variety of information sources covering SRH issues, the concerns on their credibility and trustworthiness could pose a challenge to many adolescents (Kennedy, et al., 2014). The vast amount of information available, particularly on the internet, could be overwhelming to girls that may already be unsure and confused by their experiences. The researcher argues that there is a need to properly orient adolescents on ways to determine credibility and trustworthiness to help reduce risk and exposure to harmful and mythical information. The girls used an information comparison strategy to evaluate the information they received from various sources. They compared the information from various sources to check for similarities before deciding to trust and make use

of it. Although this strategy could pose risks to some, it seemed to be a more viable one for them. The researcher further argues that basic health information literacy is essential to adolescents. Schools could incorporate these information evaluative skills into their curriculum and perhaps address these concerns in the Life Skills and Basic Information Skills classes.

Medical health professionals were found to be the most credible and trustworthy sources of SRH information. However, attitudinal and cost barriers prevented adolescents from frequently consulting these sources unless a real problem had arisen or even worsened. The girls perceived some nurses to be rude and unfriendly. As such, adolescents were reluctant to visit clinics and consult health experts. Also, the cost of visiting the clinic to seek SRH information on a problem or concern they were experiencing seemed to be a barrier among some girls when they perceived their concerns as not being serious enough to warrant professional services. This could also make them more vulnerable to seeking and making use of less credible SRHS and information to resolve their issues.

5.4 Access to and barriers to SRHS

The study's findings revealed that barriers such as a lack of knowledge on the services available and how to access them, lack of knowledge on the side-effects of contraceptives, lack of parental discussion on SRH in the home, fear of judgment and stigma from health providers and peers, fear of compromised privacy and confidentiality, distance to health facilities and costs of service have negative impacts on access to SRHS. These factors are intersectional in impacting access to SRHS among adolescents. An intersectional analysis suggests that poor girls with lower levels of education are less likely to exercise and defend their SRHR in comparison to girls from middle-

class backgrounds due to a lack of awareness and knowledge of these rights (Ritchie, 2012). This is evident in the findings that show that the majority of girls attending government schools had little to no awareness and understanding of these rights in comparison to those attending private school who claimed to have somewhat heard about them. A lack of awareness of these rights poses a potential barrier for the girls, making them vulnerable to having these rights violated and unable to defend themselves appropriately. Likewise, younger, unmarried girls are less likely to access SRHS due to restrictive laws and policies that require parental consent for minors, concerns about privacy and confidentiality, as well as the stigma associated with adolescent engagement in accessing SRHS which raises suspicion on sexual activity as illustrated in the study's findings. These findings also relate to those by Jana, et al. (2012) in which stigma associated to adolescents accessing SRHS in Namibia discouraged them from seeking and using these services as they were perceived to mainly apply to married women.

Reproduction and control of the means of reproduction is a highly political issue in societies (Ross, n.d.). Political will entail the recognition and elimination of social-structural barriers that undermine the reproductive health outcomes of adolescent girls from various positionalities. Gurr (2012) draws the link between limited access to SRH information and poor SRH outcomes. She argues that limited access to SRH information acts as a means to control the fertility of uneducated and poor women of colour who are at the receiving end of policies that are influenced by racist and political agendas. Thus, the researcher contends that strengthening awareness strategies on SRHR ensures that adolescents have a voice on matters pertaining to their bodily autonomy as this is essential in securing access to SRHS among adolescent girls in an equitable manner. Dattler (2016) and Luna (2009) affirm this argument emphasising that the

development and implementation of policies alone is not enough to secure adolescent access. Similarly, Holt, et al. (2012) and Patel, et al. (2012) found that the removal of legal barriers that sought the need for parental consent for minors did not guarantee adolescent access to SRHS in South Africa and Uganda. Nalwadda, et al. (2011) concurs that young people still did not use these services as other multidimensional factors converged to influence access. This is due to the disconnections between policy and practice and the intersectional nature of factors that impact access to SRHS such as lack of education on SRHR, unfriendly healthcare providers and the cultural contexts in which these rights were to be exercised. Although Lema (2012) and Nalwadda, et al. (2011) call for healthcare providers to limit their conscientious objections from impacting the choices of their patients, these disconnections in theory and practice tend to create moral and ethical dilemmas for healthcare providers. Thus, education and awareness among others are essential elements in the recognition and respect of these rights, bringing about high conscientisation among individuals and communities.

Intersectional feminist theorists argue that barriers surrounding access to SRHS are experienced differently among adolescent girls due to their positionalities. Zillah Eisentein (as cited in Ross, n.d.) draws the link between poverty and reproductive outcomes such as teenage pregnancy, lack of access to contraceptive and reproductive rights, lower wages for women, a lack of day care programs for working women, poor quality health care and inadequate education and training opportunities as factors that influence social inequalities in society. Her intersectional analysis suggests that the ability of these girls exercising agency over their SRHR lies within their socio-economic positions, their levels of knowledge and education on these rights and how they apply to them as adolescents. Furthermore, socio-economic inequalities are mutually reinforcing and

act as a serious barrier to equitable access of SRHS among girls. As highlighted in the study's findings, girls who were from well-off households accessed SRHS from private medical facilities that offered higher levels of confidentiality and privacy to the girls. In contrast, those who were from seemingly poorer backgrounds accessed SRHS from government health facilities with longer waiting time, thereby increasing their risk of compromised privacy and confidentiality. Likewise, adolescent girls may be reluctant to seek medical attention when they have to be examined by a staff of the opposite sex. The researcher further argues that girls may also have limited access to information due to the amount of time spent at home doing house chores. In addition, girls tend to experience more judgement on their sexuality than boys, making them more reluctant to seek SRHS. Thus, Shaw (2009) asserts that societal gender norms that encourage girls to be ignorant and passive about sex converge with other social inequalities to increase their vulnerabilities further.

The reproductive justice theory advocates for the elimination of social, economic and cultural inequalities that undermine the quality of life of adolescent girls. The researcher argues that women's bodies bear the experiences of limited access to SRHS and this is evident in their reproductive health outcomes. Thus, when girls are denied access to SRHS due to converging factors that limit it, the effects are evident through their bodies. Study's by Haghparast-Bidgoli, et al. (2015); Sanneving, et al. (2013); Rusinga (2012); Khalajabadi-Farahani (2015); Ahumuza, et al. (2014); Muhwezi, et al. (2015); Ayehu, et al. (2016); Paul, et al. (2017) agree that access to SRHS intersects with factors such as socio-economic status, cultural and religious norms and beliefs, gender, education, marital status, physical ability, place of residence; rural or urban, and age. Therefore, recognising these intersections in policy development and implementation brings

about greater reproductive justice. To illustrate this, girls who have limited control over their reproductive capabilities the results are often evident through their bodies through unintended pregnancies, health complications due to unsafe abortions and sexual and physical violence. These girls are generally unable to realise their full potential in society. They tend to miss out on opportunities due to increased risk of teenage pregnancy which leads to high dropout rates among school going girls and in turn affects their ability to enter the workforce. These factors also tend to perpetuate a cycle of poverty and gender inequalities among women and girls as their ability to participate in meaningful employment is limited in comparison to that of boys and men. Thus, poor control of one's reproductive health tends to reinforce already existing social inequalities among various groups of people and individuals. The researcher argues that these inequalities are complex, intersectional in nature and perpetuate vicious cycles of generational poverty in households and among communities. Furthermore, the outcomes of these inequalities go beyond individual limitations; their effects are widespread at community, national and global levels. Also, these issues tend to disadvantage and heighten the vulnerability of girls from poorer backgrounds and further limit their educational and employment opportunities. Moreover, unequal access to SRHS and SRHR contribute to higher dropout rates among school girls who later remain unemployed or underemployed in comparison to men. This also widens the gender inequalities between men and women in society.

Access to safe and affordable contraception is intersectional in nature. Girls who are poor, uneducated, and live in rural areas or belong to marginalised communities are less likely to make better-informed decisions and have full control over their reproduction. Negative healthcare provider attitudes and lack of parental support in adolescent access to SRHS among unmarried

girls are factors that heighten adolescent vulnerability and exposure to unintended SRH outcomes (WHO, 2002). Similarly, girls who lack access to contraceptive methods of their choice have higher rates of unintended pregnancy. In the same way, girls from poor and rural households are also more likely to access unsafe abortion services and dump their babies after birth because they may not be able to provide for their child. They may also be unable to access safe delivery services as well as post-natal services which increase their vulnerability even further. In spite of these challenges, accessing safe and legal abortions continues to be highly political, particularly in Namibia where it is not performed on request. This argument is affirmed by Roseman and Reichenbach (2010) who argue that the ICPD agenda has continued to be stalled by political conservatism and religious fundamentalism. This raises concern on the universality of fundamental human rights of free choice and reproductive rights. In addition, early exposure to sex-education has been argued to be a good way to impart valuable knowledge and information that aids decision making (Kennedy, et al., 2014). Thus, girls lacking these abilities are at increased risk of falling pregnant and getting married early which exposes them to complications during delivery, resulting in high maternal mortality. These girls are also more likely to have less social power in their sexual relationships, thereby preventing them from negotiating their sexual experiences and individual agency to make use of an assortment of contraceptive methods available.

5.5 Overcoming barriers to access

The study revealed an existence of a range of barriers that impede adolescent access to SRHS in Gobabis. Overcoming barriers to access of SRHS entails recognising individual SRHR and how these rights can be limited by social-structural and cultural barriers. A variety of initiatives were

explored by the girls as a means to increase their access to these services. School health programs aimed at increasing knowledge and awareness on contraceptives and other preventative methods of pregnancy and safe sex were found to be vital needs of the girls. This presents an opportunity for healthcare staff to reach out to adolescent girls and strengthen their programs in schools and ease access to safe, credible and trustworthy information and services. Namibian schools already have a platform for sex-education through the Life skills subject (Mufune, 2008). However, there is a need to strengthen the dissemination of comprehensive sexuality education that centres on a rights approach as the majority of the girls were not aware of their SRHR. The participation of healthcare providers in such programs could also help build trust among adolescents and healthcare providers, particularly with nurses who are often perceived to be unfriendly and judgmental towards adolescents (Jana, et al., 2012). Similarly, school health programs are vital in bridging the socio-economic barriers that exist in perpetuating unequal access to SRHS particularly among poorer girls that may have limited opportunities to seek out professional medical services. A study by Malleshappa, et al. (2011) asserts that sexual health education is a key factor in improving one's sexual health, particularly, among rural girls with low socio-economic status. The researcher concurs that improving knowledge and levels of awareness on SRH among adolescent girls is crucial in addressing social inequalities that prevent access and breed negative SRH outcomes. These outcomes not only affect the individual but equally affect their families and impact their participation in decision making at a societal level. Thus, increasing partnerships and raising support for these programs is equally crucial in sustaining them and imparting life-skills not only in schools but to out-of-school girls equally, an argument supported by Isiugo-Abanihe, et al. (2015).

There is a need for parents to actively support SRH programs in order to encourage more girls to participate and access them. Nambambi and Mufune (2011) and Muhwezi, et al. (2015) argue that parental discussion on sex is perceived as taboo in many African cultures, including those in Namibia. The key-informants of this study concur that parental support is essential in increasing access to SRHS among adolescents. Raising awareness among parents on the importance of engaging in sex-education in the home was crucial since the girls revealed that they did not engage in these discussions with their parents. This reluctance can be attributed to cultural norms and expectations surrounding adolescent sexuality and discussion in the home. This could mean that parents themselves are ill-equipped in addressing SRH issues with their children until a time that a real concern arose. Woog, et al. (2015) also call for increased parental support that could encourage adolescent girls to seek out information and reproductive health services thus reducing the stigma and barriers that prevent girls from using these facilities. Breaking educational and cultural barriers through increased awareness and knowledge of SRH is essential in providing the necessary support parents and girls need to actively engage in SRH discussions in their homes. A study by Kennedy, et al. (2014) supports this notion and argues that parents tend to be reluctant in providing support to SRHS because they equally lack vital information on the importance of these services and how they influence decision making among adolescents. The study contends that a lack of parental support leads to the under-utilisation of SRHS among adolescents. Thus, addressing and transforming cultural barriers is instrumental in encouraging schools and health facilities to strengthen their programs and provide quality comprehensive sex-education among adolescents.

The cost of services was found to have a differential impact on some girls based on their social positionalities. The reproductive justice theory envisions social transformation as dependent on the ability to reach marginalised girls and give them a voice (Harper, Jones & Watson, 2012). Addressing inequalities in SRHS access entails increased budget allocations and community participation in adolescent SRH programming. This is vital in addressing the unmet need for comprehensive SRHS that are affordable and inviting to adolescent girls. This is of particular importance, in improving access to safe contraception and comprehensive sex-education to girls in and out of school. There is a large gap in the cost of service between government and private medical health facilities which in turn limits an individual's exercise of free choice an argument supported by Morison (2013). A majority of the girls that indicated they sought medical services from private facilities were beneficiaries of medical aid programs. These girls also attended private school. Ross (n.d.) argues that the privatisation and commodification of the medical service protect the interest of the white middle class and those that can afford the cost of such services, excluding those who cannot. These are often women of colour, members of marginalised societies, the poor, and women who often do not have a source of income. This means that adolescents coming from poor households are less likely to make use of private health facilities due to the high cost of service. Consequently, limiting the type of services and facilities one can access due to their social class (Ritchie, 2012). Perhaps the subsidisation of adolescent SRHS by the government to private medical facilities could help lower the cost of service and make them more accessible to adolescents from various backgrounds to broaden their choices.

In this study, girls attending government schools generally visited government medical facilities because the cost of service was categorised as affordable. The cost ranged from N$8.00 to N$4.00. Although this may seem affordable to many, adolescent girls generally depend on their family members as a source of financial assistance (Haghparast-Bidgoli, et al., 2015). This presents a potential barrier for those whose parents may be unemployed or do not have a stable source of income to provide medical fees. This therefore, delays one's ability to seek professional SRHS that may otherwise be less prioritised in the household. Similarly, girls accessing SRHS at private health facilities may need approval from their parents to settle their medical bills which in turn can discourage girls from seeking these services for fear of their parents finding out. Haghparast-Bidgoli, et al. (2015) and Isiugo-Abanihe, et al. (2015) argue that providing youth-friendly services entails the removal of fees for adolescent SRHS as a means to transcend socio-economic barriers. This could be beneficial in providing them a space to interact and seek support from healthcare providers in realising their SRHR. Shaw (2009) advocates for a youth-friendly space in which girls feel safe, confident and assertive to share their experiences. In this study, some of the girls desired adolescent only spaces that are friendly and sensitive to their need for privacy and confidentiality. The girls bemoaned unfriendly attitudes from nurses as factors that negatively impact their experiences of SRHS, a concern to which Atuyambe, et al. (2015) and WHO (2002) call for greater respect of SRHR of adolescents in the provision of SRHS by service providers.

Akinfaderin-Agarau, et al. (2012) argues that African cultures tend to frown upon the open discussion on SRH issues and adolescent access to these services is stigmatised. This was evident in the findings of this study in which there was a limited discussion on SRH issues in the

household and the girls feared judgment and gossip from peers. However, forming partnerships with various stakeholders is instrumental in blurring these barriers. The use of ICTs could be harnessed to address the need for anonymity and privacy. Edouard and Edouard (2012) argue that these platforms should be exploited further in bridging the gap to access of SRH information and reducing the stigma surrounding access to these services. However, this also provides challenges for adolescents that may not have access to internet connectivity and mobile phone devices, particularly among poor and rural girls. Paiva, et al. (2015) argues that every citizen has the right to access the right information and services when required. On the other hand, such initiatives provide an opportunity for partnerships with mobile service providers that can increase the accessibility of internet services at lower rates in schools. Building partnerships with local public libraries are essential in increasing access to information on SRH and SRHR. Public libraries also offer free ICT training that covers various topics such as the use and evaluation of informational resources while also providing free internet access to the public. The provision of SRH information and services could positively impact access to these services in communities that constantly police and restrict access to SRHS for many adolescent girls. Therefore, this initiative could be a means of overcoming the various challenges that adolescent girls face in accessing SRHS and information. Similarly, healthcare providers can partner with public libraries to provide meeting space and opportunities for workshops and seminars that can raise awareness on SRHR of adolescent girls among public library users and communities. Finally, public libraries are responsible for disseminating information aimed at improving the quality of life of the communities they serve. They could be vital players in raising awareness and disseminating information on SRHR to aid adolescents to exercise individual agency over their reproductive health.

5.6 Summary

In summary, linking how other social issues such as alcohol abuse, drug abuse and tackling unhealthy relationships impacting the SRH outcomes of adolescents would lead to greater agency among girls who tend to have lesser social power to negotiate their sexual relationships. Recognising the broader social inequalities that exist among adolescent girls and how their positionalities influence access to SRHS could improve program planning and implementation. Drawing linkages to greater social outcomes of limited access to SRHS could encourage individuals and communities to actively transform cultural and structural barriers that undermine the SRHR of adolescent girls in their communities. Furthermore, strengthening the subject matter in the Life Skills program offered in the school curriculum is crucial. The sex-education in schools is necessary and it needs to tackle broader social issues affecting adolescents such as, addressing power dynamics in relationships, confidence building and awareness rising on SRHR, negotiation and communication skills, gender norms and inequalities that exist between men and women and encourage girls to be more assertive in their decision making and issues affecting their SRH.

Chapter 6

Summary, Conclusions and Recommendations

6.1 Introduction

This chapter summarises the research findings, draws conclusions and offers recommendations to improve access of SRHS among school-going adolescent girls. This chapter is divided into three sub-sections: summary, conclusions and recommendations.

6.2 Summary of the findings

This sub-section summarises the findings on access and knowledge to SRHS among school-going adolescent girls in Gobabis. The rationale for undertaking this study was to examine the access to SRHS among adolescent school girls in Gobabis. This was done by investigating their SRH needs, how they resolve these needs through the sources of information they use, what barriers exist to limit access and use of SRHS and how these challenges can be resolved to ease the access to these services.

6.2.1 SRH needs of adolescent girls

The study established that adolescents had various SRH needs. Among them was the need for privacy, confidentiality, anonymity, timely, affordable and non-judgmental services. An equally important need that arose was that of parental support. It was discovered that many of the girls were unsure of how their parents would react if they were confronted with the discussion on adolescent sexuality. This study also sought to investigate their levels of knowledge of these

services and how that impacted their access. It was found that many of the girls lacked vital information and understanding of SRH and SRHR. They were unclear on these subjects and that greatly impacted their perceptions on their SRH needs and how they resolved these needs. It was also discovered that counselling and education were offered in health facilities. However, some of the girls were too shy and embarrassed to ask in-depth questions for fear of judgement and stigma.

6.2.2 Sources of SRH information

This study revealed that a variety of information sources were consulted to resolve the SRH needs of adolescent girls. These included; schools, magazines, books, friends, aunts, the internet, parents, doctors and nurses. However, the internet was mostly accessed by girls from private school who could be categorised as coming from wealthier households. Although parents, particularly, mothers were an important source of SRH information, many of the girls shared that they did not feel comfortable to engage in discussion with them. This was attributed to the negative attitudes of parents towards adolescent sexuality and norms that frowned upon adolescent engagement in sexual activity and strictly policed female sexuality. What stood out was the role aunts played as an important source of information and facilitator of sex-education. They bridged the gap between mothers and daughters, offering motherly advice through their own experiences. Also, the criteria to evaluate sources of this information involved comparing information gathered from various sources to determine its trustworthiness was explored.

6.2.3 Access to and barriers to SRHS

The study uncovered various barriers that exist in impacting access to SRHS among school-going adolescent girls in Gobabis. These included; a lack of knowledge and understanding of SRHR, poor awareness on SRHS offered; mainly information on contraceptive methods and their side-effects, negative experiences with nurses, parental consent on some SRHS in private health facilities, longer waiting time in government facilities, the cost of services, a lack of communication competencies among adolescents, concerns on confidentiality and privacy, distance to health facilities, cultural norms surrounding discussion on SRH and to a lesser extent, moral and ethical dilemmas faced by service providers. The study also draws intersectional linkages between various social inequalities that converge to impact the experiences of adolescents in accessing SRHS. These included age, cultural beliefs, levels of knowledge and education and the socio-economic class of individual girls.

6.2.4 Overcoming barriers to access

This section revealed a need to secure the confidentiality and privacy of adolescent girls in order to build the confidence of the girls in seeking SRHS. This also meant changing the negative attitudes and stigma that surround adolescent access to SRHS. Increasing awareness and knowledge of SRH and SRHR among the girls and within communities could be beneficial in improving access. Similarly, addressing social-structural barriers such as the cost of services, distance to health facilities and cultural norms is vital. Also, strengthening school-health programs, offering adolescent-specific facilities and subsidising costs of private health facilities could improve access and offer a wider choice of service.

6.3 Conclusions of the findings

This sub-section draws conclusions that offer answers to the research questions under investigation. It is from these conclusions that recommendations are made in light of the study's findings in order to improve adolescent access to SRHS.

6.3.1 Conclusions on SRH needs of adolescent girls

This study concludes that adolescent girls have various SRH needs but many lack knowledge and awareness of SRH and SRHR. Offering support through information provision and increased levels of awareness is essential to the recognition of these needs and the realisation of their SRHR. Similarly, satisfying their desire to access adolescent-friendly services that recognise and respect their unique needs, experiences and positionalities is vital in bringing about equitable access to SRHS among adolescents.

6.3.2 Conclusions on sources of SRH information

There are many sources of SRH information available to adolescents. However, some of these sources may be non-factual and put the girls at increased risk of vulnerability. Strengthening their skills in information searching and evaluation is critical in an age where an overwhelming amount of information is available. Similarly, parents remain a vital yet, an under-utilised source of SRH information in the home. Thus, challenging cultural norms that influence this practice could encourage parents and children to openly discuss SRH and offer support and guidance during this critical period of development.

6.3.3 Conclusions on access to and barriers to SRHS

The study concludes that school-going adolescent girls in Gobabis do have access to SRHS. However, a range of intersecting barriers converges to impede this access. Adopting the reproductive justice framework in the planning, implementation and provision of SRHS is critical in offering adolescent girls a voice. Girls coming from poorer households were more likely to have limited choices on the types of facilities they could access and this translated into limited access and higher vulnerability than those from wealthier or middle-class households. Recognising how various social inequalities continue to negatively impact various groups of girls is essential to improving access and offering tailor-made services that are aimed at addressing their unique needs and experiences. Acknowledging the inter-connections of various social inequalities such as access to income, education and information are fundamental to improving access and quality of life among the most vulnerable girls in the community.

6.3.4 Conclusions on overcoming barriers to access

Strengthening multi-sectoral approaches and engaging with grassroots stakeholders is critical in seeking solutions that could ease the barriers adolescents face. Offering adolescent-specific spaces that acknowledge the intersectionalities that influence access to SRHS could lead to improved access and use of these services. Engaging parents and raising their awareness of adolescent SRH could blur sexual taboos and cultural limitations on discussions about sex in the home and among girls.

6.4 Recommendations

In light of the findings reported by this study and those reviewed in the literature surrounding adolescent access to SRHS, the researcher offers recommendations based on the conclusions drawn from this study. These recommendations offer opportunities to ease the barriers that hinder adolescent access to SRHS in Gobabis. These are:

6.4.1 The researcher recommends that programs targeting adolescent SRH adopt a rights-based approach that raises awareness and knowledge of SRHR. This needs to be an all-inclusive approach targeting not only adolescent girls but also boys, women and men in the community.

6.4.2 The researcher suggests that adolescent-specific health centres be implemented to cater to the unique needs of adolescents. Offering adolescent only spaces could encourage girls that may be concerned with accessing SRHS together with adults. This may ease their concerns about confidentiality, privacy and anonymity.

6.4.3 The researcher suggests the introduction of peer-education groups, a toll free call line and social clubs that may act as support groups on adolescent SRH. This gives adolescents a platform to share their experiences and challenges and offer support to one another. The toll free call line can attend to SRH queries, crisis and provide referrals.

6.4.4 The researcher recommends the facilitation of platforms that bring mothers and daughters together to openly discuss sexual taboos and issues surrounding adolescent sexuality. This may help ease the tensions that exist between children and parents and build trust and communication competencies among them.

6.4.5 Strengthening health literacy skills among adolescent girls is equally critical in aiding their decision-making abilities. A higher level of knowledge and awareness on issues surrounding general health is vital in recognising one's needs and exercising agency in improving one's quality of life and SRH outcomes.

6.4.6 Strengthening partnerships with libraries and information disseminators could ease access to credible and trustworthy SRH information. Public libraries in Namibia offer free access to internet services and computer training, offering adolescents the relevant critical information search and evaluation skills necessary to navigate the overwhelming amounts of information available.

6.4.7 The researcher recommends developing a mobile phone application that provides specialised, credible and trustworthy information on SRH to adolescents in Namibia in various local languages.

6.4.8 There is a need to further investigate access to SRHS among adolescents in this culturally diverse community in order to capture the cultural beliefs and perceptions of adults and parents. This will provide a clearer understanding on the cultural influences surrounding adolescent access to these services.

6.4.9 Finally, there is a need for future research with a wider scope of adolescents and various stakeholders in order to draw more generalised conclusions in this area of study.

6.5 Implications for practice

One of the key lessons learnt from this study is that Namibia as a country has taken great strides to secure the SRHR of individuals through its policies and laws. However, there seems to be a

disconnection between policy and practice. This is due to the various social inequalities that exist in society between individuals and among various sub-groups. These social differences entail that policy implementers translate these policies to their social contexts and foster tailor-made solutions to meet their community needs. Conversely, this poses a challenge in monitoring and evaluating progress at national level due to a lack of standardised indicators and implementation processes. In light of this challenge, it is essential to strengthen stakeholder partnerships, continuously share best practices in adolescent SRHS provision, and develop community-centred activities that meet specific national objectives without compromising them.

6.7 Final Conclusion

This study achieved its aim to investigate access to and knowledge of SRHS among school-going adolescent girls in Gobabis. Although it found that adolescent girls were able to access SRHS, the study also revealed that various social-structural and cultural barriers played a major role in determining the differential access to these services among the girls and in some cases, potentially hindering it. Overcoming these barriers entails a variety of interventions that include bringing about social change in how female sexuality is viewed and destigmatising adolescent use of SRHS. In spite of the major policies and rights that support adolescent SRH in Namibia, a lack of knowledge on these rights and policies could converge with other social factors to potentially limit access. Opportunities exist however, for partnerships to improve adolescent access and bridge discussions between parents and children to communicate on issues surrounding SRH. Transforming cultural norms that prevent discussion on sexual taboos is pivotal in realising the SRHR of adolescent girls. Although this study is not generalizable, it provided a unique insight in the experiences of adolescent girls across various positionalities in

Gobabis. Finally, the study highlighted the heterogeneity of adolescent girls and why the reproductive justice framework is necessary in securing the SRHR of school-going adolescent girls in Gobabis.

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End notes

[i] Tjiramue- A cultural practice by the OvaHerero cultural group of Namibia in which cousins are permitted to have sexual relations.

Appendices

Appendix A: Ethical Clearance Certificate

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneers Park
☎ +264 61 206 3111; URL.: http//www.unam.edu.na

UNAM
UNIVERSITY OF NAMIBIA

RESEARCH PERMISSION LETTER

Student Name: **Alice Pearce**

Student number: **201055660**

Programme: **MA Gender and development (Sociology)**

Approved research title: Access to knowledge of sexual and reproductive health services among adolescent school girls in Gobabis, Namibia

TO WHOM IT MAY CONCERN

I hereby confirm that the above mentioned student is registered at the University of Namibia for the programme indicated. The proposed study met all the requirements as stipulated in the University guidelines and has been approved by the relevant committees.

The proposal adheres to ethical principles as per attached Ethical Clearance Certificate. Permission is hereby granted to carry out the research as described in the approved proposal.

Best Regards

Dr M. Hedimbi
Director: Centre for Postgraduate Studies
Tel: +264 61 2063275
E-mail: directorpgs@unam.na

15 June 2017
Date

Appendix B: Research Permission Letter

Appendix B: Research Permission Letter

REPUBLIC OF NAMIBIA

MINISTRY OF EDUCATION, ARTS AND CULTURE

Tel: +264 61 -2933200/02
Fax: +264 61- 2933922
Enquiries: C. Muchila/ G. Munene
Email: Cavin.Muchila@moe.gov.na/gm12munene@yahoo.co.uk

Luther Street, Govt. Office Park
Private Bag 13186
Windhoek
Namibia

File no: 1/1/1

Ms Alice Pearce
P. O. Box 48 Gobabis, Namibia
Cell: 081 587 9019
Email: mary.alice.pearce@gmail.com

Dear Ms Pearce

SUBJECT: PERMISSION TO CONDUCT RESEARCH IN OMAHEKE REGIONS

Kindly be informed that permission to conduct research for your Master's Degree in Omaheke regions on the topic: "*Access to and knowledge of sexual and reproductive health services among adolescent girls in Gobabis*" is herewith granted. You are further requested to present the letter of approval to the Regional Directors to ensure that research ethics are adhered to and disruption of curriculum delivery is avoided.

Furthermore, we humbly request you to share your research findings with the ministry. You may contact Mr C. Muchila/ Mr. G. Munene at the Directorate: Programmes and Quality Assurance (PQA) for provision of summary of your research findings.

I wish you the best in conducting your research and I look forward to hearing from you soon.

Sincerely yours

SANET L. STEENKAMP
PERMANENT SECRETARY

13-9-2017
Date

All official correspondences must be addressed to the Permanent Secretary

Appendix C: Research Permission Letter

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198	Ministerial Building	Tel: 061 – 2032150
Windhoek	Harvey Street	Fax: 061 – 222558
Namibia	Windhoek	Email: shimenghipangelwa71@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 **AP**
Enquiries: Mr. J. Nghipangelwa

Date: 07 September 2017

Ms. Alice Pearce
P.O. Box 48
Gobabis
Namibia

Dear Ms. Pearce

Re: Access to and knowledge of sexual and reproductive health services among adolescent school girls in Gobabis, Namibia.

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purposes;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects' should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
3.4 A quarterly report to be submitted to the Ministry's Research Unit;
3.5 Preliminary findings to be submitted upon completion of the study;

Appendix D: Semi-structured Interview Guide: Learners

NO. ----------

ACCESS TO AND KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT SCHOOL GIRLS IN GOBABIS, NAMIBIA

Administration Block

Name of interviewer	
Name of note taker	
Others	
School	
Date:	Starting time--------Finishing time--------- Total time----------
Interviewer Self-check	

My name is Alice Pearce, I am an MA student from the University of Namibia. I am currently conducting research on access to sexual and reproductive health services for teenagers at different schools. I have identified you as one person who could enlighten me on the subject and would like to request that you share your knowledge and experiences with me. I know that some of the information I will be asking may be difficult for you to share. Although I would like to know as much as possible, you have the right to decide what information you wish to share. I assure you that I will observe anonymity, confidentiality and privacy. I will therefore not reveal your name or what you have told me to any other persons and this information will only be used solely for this research.

Demographic data

Age:

Grade:

Home Language:

Who do you live with?

Who supports you and your studies?

Socio-economic Data

Are your parents employed or unemployed

If employed, what type of work- Mother:

Father:

Parents highest levels of education- Mother:

Father:

1. Have you ever heard of SRHR? *If so, what is your understanding of SRHR?*
2. What does sexual and reproductive health mean to you?

SRH Needs:

3. Do you know some of your school mates are sexually active?
4. If so, how do they protect themselves against pregnancy and sexually transmitted diseases? (*Probe on contraceptive usage, if they have ever obtained counselling and education on Sexual and reproductive health).*
5. Tell me about your sexual and reproductive health needs. *(Probe on SRH information and services and how these needs are met)*

Sources of SRH information:

6. If you had a SRH need, where would you go first for help/advice and why? *(Probe on the various sources of SRH information and when they are used)*
7. Do you trust the information you get from these people and if so why? if not, why not? *(Probe on how to determine trustworthiness)*
8. When do you speak to a health professional? *(i.e. when a need arises, condition worsens)*

Access of and barriers to SRHS:

9. How did you experience their services? *Would you go back? (Probe on service delivery and satisfaction).*
10. Do you know what services are involved in SRH? *If yes, are they available at your clinic? (Probe on their relevance and availability of adolescent friendly services)*
11. Have you ever had concerns about seeking/using SRHS? If yes, tell me about them. *(Probe on attitudes, communication, confidentiality and privacy)*
12. Can you tell me about your experience with health workers on SRH issues? *(Probe on feelings and attitudes towards health staff)*
13. How comfortable are you to visit the clinic? *Would you go with someone or alone?*
14. How easy is it to access SRHS? *(i.e. waiting time, language, distance and monetary cost)*
15. Have you ever had a problem with accessing SRH information and services? *If yes, can you tell me about your experiences?*
16. Do you talk about sex at home? *If yes, how comfortable are you. If not, why not? (Probe on attitudes towards sex)*
17. Are there any cultural beliefs that limit open discussions on sex? *If yes, tell me about them.*

Overcoming barriers to access:

18. How do you think these challenges can be resolved?
19. What do you suggest can be done to improve SRHS to adolescents? *(Probe on how best their needs can be met)*

End of interview.

Thank you for your time.

Do you have any questions that you would like to ask me?

Appendix E: Semi-structured Interview Guide-Key-informants

NO. ----------

ACCESS TO AND KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT SCHOOL GIRLS IN GOBABIS, NAMIBIA

Administration Block

Name of interviewer	
Name of note taker	
Others	
Health Facility	
Date:	Starting time--------Finishing time--------- Total time----------
Interviewer Self-check	

My name is Alice Pearce, I am an MA student from the University of Namibia. I am currently conducting research on access to sexual and reproductive health services for teenagers at different schools and two health facilities. I have identified you as one person who could enlighten me on the subject and would like to request that you share your knowledge and experiences with me. Although I would like to know as much as possible, you have the right to decide what information you wish to share. I assure you that I will observe anonymity, confidentiality and privacy. I will therefore not reveal your name or what you have told me to any other persons and this information will only be used solely for this research.

Demographic data

Gender:

Job title:

Years of experience:

1. What is your opinion of SRHR? *(Probe on their applicability to adolescents)*
2. What is your opinion of adolescent SRH?
3. Do adolescent girls have SRH needs? If yes, what are they? *(Probe on how these needs are met)*
4. When is it appropriate for an adolescent to seek SRH information and services?
5. What are their attitudes towards SRH? *(Probe on their willingness and openness to use SRHS)*
6. What type of SRHS do you offer to adolescents? *(Probe on appropriateness, relevance, cost of service, waiting time and average distance to facility)*
7. Is there any procedure to accessing such services to an adolescent client?
8. Are there any requirements for adolescents receiving these services? (*i.e. age, marital status, parental consent)*
9. Are there any services that make referrals to other services, particularly dealing with SRH issues?
10. What are the opening hours of the facility?
11. Are you aware of any concerns that adolescents may have towards seeking SRHS? *(Probe on communication and how they ensure confidentiality and privacy)*
12. Are there any challenges in adolescent SRHS delivery? *(Probe on what they are and how they can be resolved)*
13. Are there any moral or ethical dilemmas you are faced with in ensuring access to SRHS among adolescents? *(Probe on what they are and how they are resolved)*
14. How best can SRHS be accessed by adolescents?
15. Do you have any programs or adolescent specific services that you offer? *If yes, are they aware? (Probe on language, format of information and how the service is made known)*
16. Is there a designated staff member that deals with specific adolescent SRH programs?
17. How often do adolescent girls visit your facility with SRH concerns? *(Probe on levels of satisfaction, met needs and their return to the facility.)*

18. Are there any barriers that could limit adolescents from accessing SRHS? Can you tell me about them?
19. What do you suggest can be done to improve SRHS delivery to adolescents?

End of interview.

Thank you for your time.

Do you have any questions you would like to ask me?

Appendix F: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM (PARENT/GUARDIAN OF A MINOR)

TITLE OF THE RESEARCH PROJECT: ACCESS TO AND KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT SCHOOL GIRLS IN GOBABIS, NAMIBIA.

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: MS. ALICE PEARCE

ADDRESS: P.O Box 48, GOBABIS.

CONTACT NUMBER: 0815879019

My name is Alice Pearce a student from the University of Namibia. I am conducting a research as partial requirement of the M.A Gender and Development Studies program. Your daughter is being invited to take part in this research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, her participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you or her negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

1. **What is this research study all about?**

   This study will be conducted at 2 Schools and 2 health centres. A number of 20 adolescent girls have been identified to be interviewed as research participants from Epako High School and Gobabis Gymnasium School. The study has a total number of 24 participants. This study aims to explore the access and knowledge of sexual and reproductive health services among school going adolescent girls in Gobabis. It will help highlight the opportunities and challenges that exist in Gobabis surrounding adolescent access to these services. She has been selected based on criteria set for this study (i.e age). She will be asked to share her knowledge and experiences with me in the form of a short interview expected to last about an hour.

2. **Why have you been invited to participate?**

   I have identified your daughter as one person who could enlighten me on the subject and would like to request that you permit her to share her knowledge and experiences with me. As an adolescent herself, it is hoped that her participation in this study will help highlight the current situation surrounding adolescent sexual and reproductive health service provision and access in Gobabis.

3. **What will her responsibilities be?**

   She will be expected to share with me as honestly as possible her experiences relating to the questions asked for purposes of this study. An interview will be conducted with her and it is anticipated to last at least 1 hour. However, further communication may be made with her to clarify any issues that may arise after the interview is completed.

4. **Will she benefit from taking part in this research?**

   There are no personal benefits from participating in this research. However, her participation will be helpful in improving access to adolescent friendly sexual and reproductive health services for girls in Gobabis.

5. **Are there any risks involved in her taking part in this research?**

   No risks have been identified for this study. The information requested will be based on her experiences as an adolescent and shall be kept private and confidential. Measures have been put in place to ensure her identity is protected and that this interview is kept private and confidential. Furthermore, the researcher shall adequately communicate with the Life Skills teacher to assist in case of any emotional distress that may result from the interview.

6. **If you do not agree to take part, what alternatives do you have?**

   Participating in this study is voluntary and there will be no repercussions for declining or choosing to withdraw from it.

7. **Will she be paid to take part in this study and are there any costs involved?**

   There is no monetary reward for her participation in this study. No personal costs are foreseen from her side. However, her time and expertise shall be highly appreciated.

8. **Is there anything else that you should know or do?**

   You can contact my supervisor **Dr. Lucy Edwards-Jauch** at tel. **061-206 3139** if you have any further queries or encounter any problems. Alternatively, you can contact the **Health Research Ethics Committee** at **+264 061 2063061** if you have any concerns or complaints that have not been adequately addressed by the researcher. Should you sign this form, your daughter will be asked to fill in a separate form for this study. You will receive a copy of this information and consent form for your own records.

9. **Declaration by participant**

By signing below, I ……..……. agree that my daughter take part in a research study entitled **Access to and knowledge of sexual and reproductive health services among adolescent school girls in Gobabis, Namibia.**

I declare that:

a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
b) I have had a chance to ask questions and all my questions have been adequately answered.
c) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
d) I may choose to withdraw my daughter from the study at any time and will not be penalised or prejudiced in any way.
e) She may be asked to leave the study before it has finished, if the researcher feels it is in her best interests, or if she does not follow the study plan, as agreed to.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2017.

..... **.....**

Signature of parent/guardian Signature of witness

10. Declaration by investigator

I Alice Pearce declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2017.

..... **.....**

Signature of investigator Signature of witness

Appendix G: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM (KEY-INFORMANT)

TITLE OF THE RESEARCH PROJECT: ACCESS TO AND KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT SCHOOL GIRLS IN GOBABIS, NAMIBIA.

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: MS. ALICE PEARCE

ADDRESS: P.O Box 48, GOBABIS.

CONTACT NUMBER: 0815879019

My name is Alice Pearce a student from the University of Namibia. I am conducting a research as partial requirement of the M.A Gender and Development Studies programme. You are being invited to take part in this research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

11. What is this research study all about?

This study will be conducted at 2 Schools and 2 health centres. A number of 2 participants have been identified and interviewed as key-informants from your institution. The study has a total number of 24 participants. This study aims to explore the access and knowledge of sexual and reproductive health services among school going adolescent girls in Gobabis. It will help highlight the opportunities and challenges that exist in Gobabis surrounding adolescent access to these services. You have been selected based on your expertise. You will be asked to share your knowledge and experiences with me in the form of a short interview expected to last about an hour.

12. Why have you been invited to participate?

I have identified you as one person who could enlighten me on the subject and would like to request that you share your knowledge and experiences with me. As an expert working with adolescents and in the health service sector, it is hoped that your participation in this study will help highlight the current situation surrounding adolescent sexual and reproductive health service provision and access particularly at your facility.

13. What will your responsibilities be?

You will be expected to share with me as honestly as possible your experiences relating to the questions asked for purposes of this study. An interview will be conducted with you and it is anticipated to last at least 1 hour. However, further correspondence may be made with you to clarify any issues that may arise after the interview is completed.

14. Will you benefit from taking part in this research?

There are no personal benefits from participating in this research. However, your participation will be instrumental to improving access to adolescent friendly sexual and reproductive health services for girls in Gobabis.

15. Are there any risks involved in your taking part in this research?

No risks have been identified for this study. The information requested will be based on your experience as a service provider and shall be kept private and confidential. Measures have been put in place to ensure your identity is protected and that this interview is kept private and confidential.

16. If you do not agree to take part, what alternatives do you have?

Participating in this study is voluntary and there will be no repercussions for declining or choosing to withdraw from it.

17. Will you be paid to take part in this study and are there any costs involved?

There is no monetary reward for your participation in this study. No personal costs are foreseen from your side. However, your time and expertise shall be highly appreciated.

18. Is there anything else that you should know or do?

You can contact my supervisor **Dr. Lucy Edwards-Jauch** at tel. **061-206 3139** if you have any further queries or encounter any problems. Alternatively, you can contact the **Health Research Ethics Committee** at **+264 061 2063061** if you have any concerns or complaints that have not been adequately addressed by the researcher. You will receive a copy of this information and consent form for your own records.

19. Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled **Access to and knowledge of sexual and reproductive health services among adolescent school girls in Gobabis, Namibia.**

I declare that:

f) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

g) I have had a chance to ask questions and all my questions have been adequately answered.

h) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

i) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

j) I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2017.

....

Signature of participant Signature of witness

a. Use of voice recorder during the interview

If you agree to your interview being recorded for the purpose of this study please sign below

....

Signature of participant Signature of witness

20. Declaration by investigator

I Alice Pearce declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2017.

....

Signature of investigator Signature of witness

Appendix H: PARTICIPANT INFORMATION LEAFLET AND ASSENT FORM- (MINOR)

TITLE OF THE RESEARCH PROJECT: ACCESS TO AND KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT SCHOOL GIRLS IN GOBABIS, NAMIBIA.

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: MS. ALICE PEARCE

ADDRESS: P.O Box 48, GOBABIS.

CONTACT NUMBER: 0815879019

My name is Alice Pearce a student from the University of Namibia. I am conducting a research as partial requirement of the M.A Gender and Development Studies program. You are being invited to take part in this research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

21. What is this research study all about?

This study will be conducted at 2 Schools and 2 health centres. A number of 20 adolescent girls have been identified to be interviewed as research participants from Epako High School and Gobabis Gymnasium School. The study has a total number of 24 participants. This study aims to explore the access and knowledge of sexual and reproductive health services among school going adolescent girls in Gobabis. It may highlight the opportunities and challenges that exist in Gobabis surrounding adolescent access to these services. You have been selected based on the criteria set for this study (i.e age). You will be asked to share your knowledge and experiences with me in the form of a short interview expected to last about an hour.

22. Why have you been invited to participate?

I have identified you as one person who could enlighten me on the subject and would like to request that you share your knowledge and experiences with me. As an adolescent yourself, it is hoped that your participation in this study will help highlight the current situation surrounding adolescent sexual and reproductive health service provision and access in Gobabis.

23. What will your responsibilities be?

You will be expected to share with me as honestly as possible your experiences relating to the questions asked for purposes of this study. An interview will be conducted with you and it is expected to last at least 1 hour. However, further communication may be made with you to clarify any issues that may arise after the interview is completed.

24. Will you benefit from taking part in this research?

There are no personal benefits from participating in this research. However, your participation may be helpful in improving access to adolescent friendly sexual and reproductive health services for girls like yourself in Gobabis.

25. Are there any risks involved in you taking part in this research?

No risks have been identified for this study. The information requested will be based on your experiences as an adolescent and shall be kept private and confidential. Measures have been put in place to ensure your identity is protected and that this interview is kept private and

confidential. Your name will not be used in any way in this study. Furthermore, the researcher shall adequately communicate with the Life Skills teacher to assist in case of any emotional distress that may result from the interview.

26. If you do not agree to take part, what alternatives do you have?

Participating in this study is voluntary and there will be no repercussions for declining or choosing to withdraw from it.

27. Will you be paid to take part in this study and are there any costs involved?

There is no monetary reward for your participation in this study. No personal costs are foreseen from your side. However, your time and expertise shall be highly appreciated.

28. Is there anything else that you should know or do?

You can contact my supervisor **Dr. Lucy Edwards-Jauch** at tel. **061-206 3139** if you have any further queries or encounter any problems. Alternatively, you can contact the **Health Research Ethics Committee** at **+264 061 2063061** if you have any concerns or complaints that have not been adequately addressed by the researcher. This assent form shall only be valid with proof of parental consent from your parent/guardian that will be obtained on another form. You will receive a copy of this information and assent form for your own records.

29. Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled **Access to and knowledge of sexual and reproductive health services among adolescent school girls in Gobabis, Namibia.**

I declare that:

k) I have read or had read to me this information and assent form and it is written in a language with which I am fluent and comfortable.

l) I have had a chance to ask questions and all my questions have been adequately answered.

m) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

n) I may choose to withdraw from the study at any time and will not be penalised or prejudiced in any way.

o) I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....….....…….. on (*date*) ……...…….. 2017.

.....	.....
Signature of minor	Signature of witness

9.1 Use of voice recorder during the interview

If you agree to your interview being recorded for the purpose of this study please sign below

.....	.....
Signature of participant	Signature of witness

30. Declaration by investigator

I Alice Pearce declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2017.

.....	.....
Signature of investigator	Signature of witness