

An Assessment of the Adolescent Participation, Adolescent Friendly Health
Service Providers, and Adolescent Friendly Environment components of the AFHS
Standards by Nurses in Otjozondjupa Region of Namibia.

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ABSTRACT

Adolescents are sensitive people who can easily get derailed by a number of challenges which can sometimes lead to detrimental results if they are not taken care of appropriately. Despite the existence of the National Standards for Adolescent Friendly Health Services which is supposed to assist in reducing teenage pregnancy, disturbing figures of adolescents getting pregnant continue to rise.

This study aimed at assessing the implementation of the Adolescent Active Participation, Adolescent Friendly Health Care Provider and the Adolescent Friendly Environment components of the Adolescent Friendly Health Services by nurses in Otjozondjupa Region, Namibia.

A quantitative descriptive, analytical cross-sectional study design was done. The study triangulated data from three data sources. The first population was the 38 nurses at the health centres and clinics who implement the Adolescent Friendly Health Services in Otjozondjupa Region. The second study population were all the 3 health centres and 16 Clinics where the Adolescent Friendly Health Services are implemented. The third study population was the 4 995 school-going teenage girls as potential users of the Adolescent Friendly Health Services in the 21 Secondary Schools of Otjozondjupa Region.

Data for the teenage girls and the nurses was collected using self-administered structured questionnaires of open and close ended questions. A sample of 540 from the teenage girls' population and universal sampling of 38 nurses and 19 health facilities was applied. The data on the third component-the health facilities was collected through a checklist. Variables

which are related to either the use or the provision of Adolescent Friendly Health Services were selected from the questionnaires and the checklist.

A multivariate, analytical descriptive method was followed to analyse the data from the three data sources, using SPSS Version 16 data base. Variables from each of the three components were analysed and described. The relationships of the selected variables were analysed.

The findings indicated that there was limited active involvement and participation of the adolescents in the Adolescent Friendly Health Services as the majority of the adolescents as users of this service did not know about the service. The findings further indicated that almost half of the nurses in the service were not formally trained in Adolescent Reproductive and Sexual Health issues. Additionally, health facility environments were not adolescent friendly.

In conclusion, this study revealed that although the standards for the implementation of AFHS exist, they are not being effectively implemented by Nurses in Otjozondjupa Region.

Based on the conclusions which were drawn from this study, recommendations were made with regard to the improvement of adolescent active participation, marketing strategies for Adolescent Friendly Health Services, training of current and prospect adolescent health care providers in matters of adolescent friendly health services and improvement of the adolescent friendly environment in health care facilities.

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ABBREVIATIONS/ ACCRONYMS

AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immunodeficiency Syndrome
CAH	Child and Adolescent Health
ENM	Enrolled Nurse Midwife
HCT HIV	Counselling and Testing
HFC	Health Facility Committee
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
MoHSS	Ministry of Health and Social Services
RNM	Registered Nurse Midwife
SPSS	Scientific Package for Social Sciences
SRH	Sexual and Reproductive Health
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation

DEDICATION

I dedicate this thesis to all those who will benefit from this knowledge especially the future generation who I hope will find this useful in their academic career. I also wish to dedicate it to all the Adolescent Friendly Health Services programme implementers and service users.

DECLARATION

I Mary Lungowe Muyenga, declare hereby that this study is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any other institution of higher education.

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Mary L. Muyenga

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Date

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CHAPTER 1:INTRODUCTION

1.1 Orientation and overview of the study

Adolescence is a life stage between childhood and adulthood, a time when young adults start realizing the experiences of adulthood. During this time, adolescents are faced with enormous changes in social interactions and relationships. As a result, they may acquire information from different kinds of sources. Usually, the most pleasant information will carry them away. Therefore, the adolescents are very sensitive to most life experiences and need special guidance in order to ensure a smooth transition to adulthood. If special attention is not given to them, the results are mostly devastating (Larke & Cleophas-Mazige, 2010).

Adolescent girls in many countries are at risk of unintended pregnancies while they are not yet ready to face motherhood. Outcome to these pregnancies can be life threatening, with complications which can end their lives. Some adolescents resort to backstreet abortions while others dump their babies after delivery. Even those adolescents who decide to give birth and keep their babies are still faced with challenges. Usually, they are still not ready to give proper care to their babies because they are not yet mature enough to pay necessary attention to their babies. Moreover, they lack economic means to provide for the need of the child. This results in babies born to adolescent mother being economic vulnerable, prone to illnesses and risky health (Kesterton, & Cabral de Mello, 2010).

Over the past years, many researchers have shown interest in studies on adolescent health and a number of recommendations have been made in an effort to improve adolescent health. One of the key recommendations made at the Global Consultation on Adolescent Friendly Health Services (AFHS) organized by the World Health Organization (WHO) in 2001 was to develop

tools to support countries in improving the quality of health services provision to the adolescents (World Health Organisation, 2012).

Adolescent Friendly Health Services Standards were adopted and implemented in the health care services of Namibia in line with the National Policy on Reproductive Health. The standards outline the six components for the essential services package for the adolescents at public health facilities in Namibia to prevent among others, teenage pregnancy. These six components include the Adolescent Active Participation, Community Support and Participation, Adolescent Friendly Health Service Providers, Adolescent Friendly Health Environment, Adolescent Friendly Health Procedures as well as Networking and Collaboration (Ministry of Health and Social Services [MoHSS], 2011).

The goal of these components is to ensure that services are available and accessible to the adolescents at the health care facilities and through a multi-sectoral approach. Many individuals and institutions have important roles to play in order to make the health and development of adolescents a success. The role of the health sector and other stakeholders are distinctively outlined on how they should address the health concerns of adolescents (MoHSS, 2011).

The Adolescent Participation component stresses the need for active participation of the adolescents in health promotion programmes/health interventions which are designed to promote their health. In this regard, the component on Community Support and Participation advocates for the establishment of Health Facility Committees (HFC), of which adolescents should be members, in order to maximize their active participation (United Nations Children's Emergency Fund & Ministry of Health and Social Services, 2008). Programs for adolescents that actively

consult them on their needs and wants, about the content of services and the process of delivery, are more likely to be ‘adolescent-friendly’. Furthermore, involvement can build adolescents’ skills and confidence in decision making and social participation (WHO, 2002).

Apart from being general services providers, health care providers can significantly contribute to promotion of health for adolescents, by preventing illnesses and assisting the adolescents to get back to a state of good health.

Therefore , the component on Adolescent Friendly Health Service Providers advocates for health care providers who are understanding, easy to relate to, non-judgmental towards the adolescents, and trustworthy while being technically competent in the execution of health care interventions for the adolescents. Adolescents place more emphasis on good interpersonal relationships with providers and on confidentiality, than on technical quality of services (WHO, 2002). Such technical quality involves an emphasis on communication skills for providing information and counseling, and clinical skills for problems that often go untreated, such as menstrual disorders, physical and sexual abuse, and mental problems (WHO, 2002).

In addition, the standards emphasize that if the vision for Adolescent Friendly procedures is to be realized, each health care facility should be provided with an “Adolescent Friendly Environment” which is convenient and accessible to most adolescents, with attractive services and minimum risk for stigma. The last component of the standards acknowledges that a successful implementation of the Adolescent Friendly Health Services needs a multi-sectoral

approach through a linkage of service provision with other local stake holders that also provide adolescent health services (MoHSS, 2011).

The components on Adolescent Active Participation, Adolescent Friendly Health Service Providers and Adolescent Friendly Environment are closely related to or directly influence the female adolescents' intention and health seeking behaviours. It was therefore important to assess the efficiency of the implementation of these three components as the measures for prevention among others teenage pregnancy in the health care facilities of Otjozondjupa region.

In its systematic review of the effectiveness of the interventions to improve the use of health services for the adolescents in developing countries, the WHO (2009) department of Child and Adolescent Health and Development (CAH) pointed out to the shortcomings in both the professional capabilities and "human qualities" of health care providers. The report pointed out that health care providers were unable and sometimes unwilling to provide adolescents health services in an effective and sensitive manner (WHO, 2008). By implication, the Adolescent Friendly Health Services Standards in Namibia would have been effective only, if the implementers apply its components appropriately in order to achieve the intended goal.

Furthermore, a report by the United Nations Population Fund and the United National Human Commission for Refugees (2012) indicates that although the term adolescent-friendly health services had been well defined, and checklists and tools existed to guide the program implementation, there had been little documentation of how frequently these services are implemented, and to what extent they had been effective. Such documentation would support program managers and other service providers to better cater to adolescents' sexual and reproductive health needs.

A survey by the MoHSS (2004) on the Namibia School-Based Student Health indicates that for Namibia to comprehensively address the various dimensions of the adolescent's health, it is crucial that student-based surveys be undertaken on regular bases, because regular evaluation can produce timely, valid and comprehensive data on the efficiency of the implementation of the Adolescent Friendly Health Services (AFHS). However, there is limited information on the implementation of these Standards for Adolescent Friendly Health Services to prevent among others, teenage pregnancy in Otjozondjupa Region.

It is in this regard that the researcher considered it necessary to assess the implementation of these three components of the Adolescent Friendly Health Services in Otjozondjupa Region.

1.2 Problem statement

The Implementation of the AFHS Standards required adherence to six (6) components outlining the essential services for adolescents at public health facilities to prevent among others, teenage pregnancy. Three of these six components directly influence the adolescents' intention and health seeking behaviours. The Adolescent Active Participation component stresses the need for active participation of the adolescent girls in health promotion programmes/health interventions which are designed to promote their health. The component on Adolescent Friendly Health Service Providers advocates for health care providers who are understanding, easy to relate to, non-judgemental towards the adolescents, and trustworthy while being technically competent in the execution of health care interventions for the adolescents. The third component emphasizes that each health care facility should be provided with an "Adolescent Friendly Environment" which is convenient and accessible to most adolescents, with attractive services and minimum risk for stigma.

Otjozondjupa Region has implemented the Adolescent Friendly Health Services Standards to prevent teenage pregnancy since 2011. However, the region ranks 4th out of the 14 regions in teenage fertility in Namibia with 120 live births per 1000 women (MoHSS, 2008).

Moreover, the Health Information System of Otjozondjupa recorded a total number of 4 182 pregnant teenagers under the age of 19 years from the year 2008 to 2012 as displayed in the table below (MoHSS, 2012).

Table 1: Teenage pregnancy rates in Otjozondjupa region for the years 2008 to 2012

Year	Total number of teenage pregnancies in the region	Average teenage pregnancy rates
2008	860	5.9%
2009	814	5.6%
2010	839	5.7%
2011	857	5.9%
2012	812	5.3%
Total	4 182	5.7%

(Source: MoHSS, Otjozondjupa Management Information System, 2012)

From the table above, it can be deduced that on average, 5.7% of the teenagers in Otjozondjupa Region stand a greater chance of being at risk for sexually transmitted diseases, teenage pregnancies and potential health and socio-economic problems related to teenage pregnancy. These figures raise concern because 0. 6%, which is the average difference between the rates recorded before the implementation of AFHS standards in the region, and the rates recorded after the implementation of the standards, is very minimal. With the implementation of AFHS

standards from 2011, one expects the average difference to be more than 0.6% to show a considerable drop in teenage pregnancy.

The implementation of the AFHS Standards by nurses in Otjozondjupa Region was not assessed. As a result, there was no research-based evidence on the relationship of the implementation of the AFHS Standards and its intended goal of prevention of teenage pregnancy. It was in this regard that the researcher regarded it necessary to assess the implementation of the Adolescent Active Participation, Adolescent Friendly Health Service Providers and Adolescent Friendly Environment components of the Adolescent Friendly Health Services in Otjozondjupa Region in order to maximize adolescents' benefits from the Adolescent Friendly Health Services (AFHS) approach by the nurses in the Otjozondjupa Region. The researcher also regarded it important to assess the adolescents' awareness and utilization of the existing Adolescent Friendly Health Services in the region because the adolescents, as the recipients of the Adolescent Friendly Health Services play critical roles in promoting their own health.

In this report therefore, the researcher explored the extent to which the three components of the standards of the Adolescent Friendly Health Services initiatives were implemented in the Otjozondjupa region. The awareness of the existence of the Adolescent Friendly Health Services by the adolescent girls and henceforth the utilization of these services which could minimize teenage pregnancy in the region were also assessed and discussed.

1.2.1 Hypothesis of the study

This study assessed the implementation of the three components of the Standards on Adolescent Friendly Health Services in Otjozondjupa Region relating it to its influence on teenage pregnancy. Therefore, the two hypotheses that were tested were:

- The Adolescent Friendly Health Services Standards are effectively implemented by the Registered Nurses in Otjozondjupa Region.
- The teenage girls are not aware of the Adolescent Friendly Health Services in the Otjozondjupa Region.

1.3 Goal and Objectives

1.3.1 Goal

The goal for the study was to describe the implementation of the Adolescent Participation, Adolescent Friendly Health Service Providers and the Adolescent Friendly Environment components of the Adolescent Friendly Health Services in the Otjozondjupa region.

1.3.2 Objectives

The objectives of the study were to:

- Describe the perception of the nurses towards the implementation of the Adolescent Friendly Health Services.
- Assess and describe the teenage girls' awareness of the availability of the reproductive health services in the Otjozondjupa Region.

- Assess and describe the evidence for the implementation of the Adolescent Friendly Environment component of the AFHS at the facilities in Otjozondjupa region.

1.4 Significance of the study

The results of the study will inform policy makers on the implementation of AFHS Standards by nurses at health care facilities in Otjozondjupa region. Additionally, the results will provide information on the utilization of Adolescent Friendly Health Services by adolescents, as a measure to prevent teenage pregnancy.

1.5 Research design and Methods

A quantitative descriptive cross-sectional design was used to describe (De Vos, Strydom, Fouche & Delpont, 2011; Joubert & Ehrlich, 2007) the implementation of the Adolescent Participation, Adolescent Friendly Health Service Providers and the Adolescent Friendly Environment components of the AFHS in the health care facilities of Otjozondjupa Region. Frequency and statistical significance of the responses from the three data sources was analysed. Multivariate analysis was done to determine the relationship of the variables from the three components (Joubert & Ehrlich, 2007). The results are presented through frequency tables and graphs enhance understanding.

1.6 Paradigms and philosophical underpinning of the study

As cited by De Vos et al (2011), a paradigm is a pattern containing a set of legitimated assumptions and design for collecting and interpreting data. De Vos (2011), further states that a paradigm is a viewpoint based on people's philosophies and assumptions about the social world

and the nature of knowledge. A paradigm helps the researcher to be organised in thinking, observing and interpreting processes. It frames the way in which a discipline's concerns is viewed, and the direction that a research project takes, and by so doing it clearly outlines the questions that need to be asked. A paradigm will get rid of the questions which fall outside its conceptual boundaries and it provides a link to certain types of research methods. Moreover, a paradigm suggests the criteria with which the researcher can judge the tools which are appropriate for the research and which can be used to evaluate the quality of the research effort (Brink et al., 2008). Positivists strongly argue that it is important for the researcher to maintain a prejudiced or independent role in conducting research so that analysis and interpretation of data can be done as an outside observer. Every phenomenon can be observed either directly or indirectly with the aid of instruments. Positivists see scientific theories as providing a kind of background to research in the sense that hypothesis which are derived from them are then submitted to empirical test (De Vos et, al, 2011). This study was therefore a positivist one based on the following assumptions:

Epistemology

Epistemology is knowledge of the reality regarding the implementation of the Adolescent Friendly Health Services by the nurses in Otjozondjupa Region (Brink et al., 2008). This study assessed the implementation of the AFHS by the nurses in order to find out the reality as it exists out there. The researcher maintained an objective role throughout the assessment and simply gave out the findings as reflected by the results. Research questions were posed about the phenomena under study and fact finding was done following these questions.

Ontology

Brink et al., (2008), states that ontology refers to a set of assumptions about reality as it predicted. This study had a set of two hypotheses regarding the implementation of AFHS in Otjozondjupa Region. One had to do with the nurses as implementers of the AFHS while the other one regarded the adolescents as service users. The researcher therefore made an assessment to prove the two hypotheses which are the null and the alternative hypothesis.

1.7 Ethical Considerations

This study integrated the ethical principles of justice, autonomy, protection of participants from harm and beneficence. In respect of ethical principle of autonomy, an informed written consent was sought from the nurse participants as well as the parents of the teenage girls (De Vos et. al, 2011). Permission for assessing health facilities was obtained from the Ministry of Health and Social Services. Equally, the three categories of populations were the ones who were well-placed to provide needed information about the implementation of the three components of the Adolescent Friendly Health Services initiative. The participants were ensured of their right to voluntary participation and to withdraw from the study at any time. The principle of beneficence was observed by sharing the findings of this study with all the relevant authorities for necessary improvement in deliverance of Adolescent Friendly Health Friendly Services in the region.

1.8 Definitions of concepts

For the purpose of this study, the following terminologies are defined:

Teenager/Adolescent age

In this study, the concept will refer to young adults aged between 13 to 19 years, who are legible of using the Adolescent Friendly Health Services.

However, UNHCR & UNFPA, (2012), state that the term refers to the lifespan of age 10-19, which is characterised by a continuum of physical, cognitive, behavioural and psychosocial change and is accompanied by a sense of identity, increasing levels of individual autonomy and progressive sexual orientation

Adolescent participation

This means involving adolescents in planning and implementation, and obtaining feedback from them to improve the quality and responsiveness of their care (WHO, 2002). For the sake of this study, this term will refer to the inclusion of Adolescents in services which pertain to the health of people within their age group. In other words, where Adolescents are informed about the services, consulted and allowed to partake in such services.

Adolescent Friendly Health Service Providers

This refers to well-trained service providers who like working with adolescents and treat them as responsible persons, rather than being patronizing or judgmental. It also involves the protection of confidentiality (UNHCR & UNFPA, 2012). The study used the term to mean well skilled and knowledgeable health service providers, who understand and accept adolescents under any circumstances and are ready to support them to overcome their life challenges.

Adolescent Friendly Environment

These are adolescent-friendly services which are well publicized, accessible by public transport, inexpensive, open during hours when adolescents are not at school or work, and offer a pleasant, secure environment. In this environment, issues of parental notification and consent are not considered (WHO, 2002). In the study Adolescent Friendly Environment refers to the creation of a favorable or an appealing situation either materially or spiritual, where adolescents can feel free to open up to the service provider regarding their health issues,

Adolescent Friendly Health Service Standards

These are the expected uniform package of guidelines which are prepared for service providers to follow and adhere to in order to meet the requirement of providing appropriate services to adolescents.

Guidelines which establish the basis for the provision of health services to adolescents within the framework of the National HIV/AIDS and/or Reproductive Health policies and strategies (WHO, 2012).

Accessibility

Ability to obtain the services that are available (WHO, 2012). This means free availability of Health Services by service providers who are welcoming to the Adolescents at any time when such services are demanded.

Health service

Health service shall mean a service provided by a health worker to a client aimed at promoting good health, preventing a health problem, or detecting and treating one, or be able to support a chronically ill patient to accept his/her health problem. It often includes the provision of information, advice and counseling.

Adolescent Friendly Health Services

Services which are offered at a health facility which are accessible to young people, provides a comfortable and appropriate setting for adolescents, meets the needs of young people and are available.

1.9 Division of chapters.

Chapter 1: Deals with the introduction and orientation of the study, problem statement, goals and objectives, methodology, ethical measures of the study as well as the definition of concepts.

Chapter 2: The chapter focuses on literature review.

Chapter 3: This chapter describes the research design and research methods.

Chapter 4: In chapter 4, the data is discussed and analysed.

Chapter 5: Conclusion, limitations and recommendation are addressed in this chapter.

1.10 Summary

This chapter gave an overview of adolescence life stage and what adolescents are likely to go through during this stage. The chapter outlined the six components which form the foundation of the Adolescent Friendly Health Services Standards which were adopted in the health care

services of Namibia in line with the National Policy on Reproductive Health. The chapter distinctively outlines the three components which directly influence the female adolescents' health seeking behaviour. Further on, the chapter highlighted the problem of teenagers in Otjozondjupa Region who could be at risk of potential socio-economic problems related to teenage pregnancy despite the implementation of the standards to prevent pregnancy. Later, the paradigms and philosophical underpinnings of the study are explained in the chapter. The chapter finally provides an outline of the chapters of the thesis.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction transcend

As adolescents transit from childhood, they experience developmental challenges as they try to respond to the biological, cultural and social pressures of life. This chapter presents an overview of the conceptual framework of the Adolescent Friendly Health Services (AFHS) in order to place the study in the context of the existing literature. The chapter further discusses the main components of the AFHS initiative in order to improve health service delivery to the adolescents.

The AFHS initiative was instituted by the World Health Organization (WHO). In the implementation of the AFHS initiative, the WHO calls for governments to invest in social structures like health facilities and health care providers to facilitate provision of proper guidance on how adolescents can approach the challenges of life (World Health Organisation, 2012). In line with this AFHS initiative of the WHO, Namibia developed Standards for the implementation of AFHS in Namibia. These standards advocate for six components of implementation of AFHS namely: Adolescent active participation, Adolescent friendly health care provider, the Adolescent friendly environment, Community support and participation, Adolescent friendly health procedures as well as Networking and collaboration (Ministry of Health and Social Services, 2011).

In conclusion, the chapter gives a detailed literature review on the three components which directly influence the adolescents' health seeking behaviour which are: Adolescent Active Participation, Adolescent Friendly Health Care Providers and the Adolescent Friendly Environment.

2.2 Conceptual framework

Adolescence is an age group of between 10 to 19 years of age in which some adolescents reach cross roads between young age and adulthood (WHO, 2012). As adolescents transition from childhood to adulthood, they typically benefit from the influences of the social structures and community groups. Adolescent-friendly health care purportedly addresses five domains; equity, effectiveness, accessibility, acceptability, and appropriateness of care (WHO, 2002). Equity of care relates to the right of all young people to obtain quality care. Effectiveness corresponds to the expected improvement in adolescent health outcomes when care is delivered in the right way at the right time. The other three domains relate to how health care should be provided in order to engage young people.

The American Academy of Paediatrics and the Society for Adolescent Health and Medicine have suggested indicators of youth friendliness that primarily correspond to domains of accessibility and appropriateness of care (American Academy for Paediatrics, 2008). Although this is a good initiative, the WHO says that the acceptability of health services that is, how well they meet young people's expectations can only be effectively measured by obtaining young people's views (WHO, 1997). The components on adolescent active participation, adolescent friendly health care providers and the adolescent friendly environment formed the conceptual framework for this study since the study assessed the efficiency of the implementation of these three components in the health care facilities of Otjozondjupa region as measures for prevention among others teenage pregnancy

2.3 Literature review on the three Components of AFHS.

This chapter presents the literature review on the three components of the Adolescent Friendly Health Services initiative in order to place the study in the context of existing body of knowledge (Brink et al, 2008).

The National Rural Health Mission of India (2006), states that the key friendly characteristics of services for adolescents are at the levels of the user, provider and the health system. These in turn are the determinants of quality of the services. The three should work hand in hand for a successful Adolescent Friendly Health Service.

2.3.1 Adolescent Active Participation

A fundamental principle of adolescent friendly health services is to ensure participation of young people in identifying their needs and preferences for meeting those needs. Some characteristics, such as privacy, confidentiality, and respectful treatment are nearly always top priorities in adolescent friendly health services (WHO, 1997). Other features, such as the separateness of the clinic from other services and the importance of peer counsellors, may vary according to the overall culture or the specific norms of the target population.

The National Rural Health Mission of India (2006), further emphasise that for Adolescents to be able to use the services, such services must be accessible – ready access to services is provided and acceptable – that is, healthcare meets the expectations of adolescents who use the services.

In addition to creating an environment more likely to meet their needs, involving adolescents in the design of the program and in continuous feedback will enhance the “ownership” of the

program (WHO, 2012). This feeling of ownership will motivate young people to recruit their peers and to advise on needed adjustments. Furthermore, there are roles that young people can play in the clinic program such as assisting with administrative tasks, sitting on advisory boards, and serving as peer counsellors, and assisting with monitoring and evaluation, all that can enhance ownership of the programme (UNHCR & UNFPA, 2012).

Programs use a combination of strategies to increase awareness of adolescent health services, including disseminating information via the community, schools, and mass media. Linking youth-friendly clinics with community-based activities (e.g., youth clubs, street theatre, etc.) and school-based components (e.g., referral systems) has demonstrated greater uptake of services and self-reported condom and contraceptive use among adolescents (WHO, 2006). Using only media messaging or community activities without outreach in schools has not demonstrated similar positive health outcomes. According to the WHO (2012), the goals of promoting healthy development in adolescents calls for the implementation of a package of interventions, tailored to meet the special needs and problems of adolescents, which includes the provision of information and skills, the creation of a safe and supportive environment, and the provision of health and counselling services. This means adolescents' services should be made different from the adult services in a number of ways.

The Ministry of Health and Social Services (2011), emphasizes the fact that when implementing AFHS in Namibia, the strategy for implementation should include provision of appropriate information, counselling, and support services as well as strengthening school health activities. Adolescents learn differently from the way adults learn, therefore, some of the tailor-made

interventions should include peer teaching as this can make them understand their peers more than any other person since they will speak in the language which they all know.

WHO (2012), further states that those adolescents who are well of, tend to see no good reason for visiting a health facility. In most developing countries, including Namibia, the system of periodic check-ups to monitor progress is limited to children under the age of five, and pregnant women. Those adolescents who fall ill with, for example, commonly occurring conditions such as fever or coughs, may have no hesitation in seeking care. On the other hand, they may be less willing to do so for more sensitive matters, such as reproductive health services. As an illustration, adolescent may prefer to turn to her mother for advice and help, rather than to a nurse when she suffers from painful menstrual periods.

In many places, health services such as emergency contraception and safe abortion are simply not available to anyone (WHO, 2012). Considering the fact that adolescents are at risk of unintended pregnancies and other consequences of teenage activities, services for them should be different from the services of adults.

In the delivery of health services for adolescents, it is important to build on what already exists but directing efforts at making existing service-delivery points intended to provide services to all segments of the population (WHO, 2012). These services should be friendlier to adolescents, rather than setting up new service-delivery points exclusively intended for adolescents. Having said that, dedicated health service-delivery points and outreach work could play a useful role in

reaching marginalized and stigmatized groups of adolescents such as injection drug users, who may be reluctant to use a service-delivery point that is open to all.

WHO (2012), recommends that one way to improve adolescent services is specifying standards i.e. statements of required quality is a key first step and once that is done, then actions need to be taken to achieve those standards. A systematic process for scaling-up health service provision to adolescents has been developed by WHO. This process begins with actions at the national level, which are followed by subsequent actions at the district level and the health facility levels. If such actions are followed, it would make a significant difference in the adolescents' lives.

2.3.2 Adolescent Friendly Health Service providers

Studies which were conducted in countries like Kenya and Cote d'Ivoire which recorded high adolescent pregnancies found that unmet needs for adolescent services increased the chances of adolescents becoming pregnant at an early age (UNHCR & UNFPA 2012). Having a specialized staff that is trained to work competently and sensitively with young people is often considered the most important condition for establishing youth-friendly services. This calls for governments to invest in social structures like health facilities and health care providers where adolescents come across in order to receive proper guidance on how to approach the challenges of life (UNHCR & UNFPA 2012).

Skills to be acquired must include familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity (African Youth Alliance/Pathfinder, (2003). At least as important are interpersonal skills so that young people can be at ease and can comfortably communicate their needs and concerns. This objective is

sometimes accomplished when providers are of closer age to adolescents. The ability to communicate fluently in languages that young people who attend a given clinic speak is also important. Therefore, in *High Impact Practices*, (2015) Bankole, Malarcher & Senderowitz indicate that common service delivery elements should include training and supporting providers to offer non-judgmental services to adolescents. This implies that health care providers should display an attitude which makes adolescents feel welcome and free to express themselves without any fear of being victimized in anyway.

In addition to those who provide counselling and medical services to adolescents, other staff members should be positive toward these clients and oriented to young people's special concerns. The Ministry of Health and Social Services (2011) recommends that all health care providers at health facility and support staff should be friendly and considerate towards the adolescents. Adolescents are very sensitive people who can easily be discouraged by the first contact at the health facility if a negative attitude towards them is displayed. Particularly important are the attitude and performance of the receptionist, who is typically the first point of contact for the young person. Refresher courses must be made available to keep staff members informed and their skills current. While respect for young people which is an essential provider characteristic can be fostered within a training exercise to avert some providers from bringing to their job deeply entrenched biases against adolescent sexual activity or find it difficult to relate to adolescents in a respectful way. Given this reality, clinic managers should carefully consider such attitudes as they select those who will work with or supervise staff to work with young peoples (Lindberg et. al, 2001).

The National Rural Health Mission of India (2006) states that from the provider's and manager's perspective, services must be appropriate and required care should be provided. Unnecessary and harmful care should be avoided but comprehensive care provision that covers aspects from prevention through to counselling and treatment is required. Youth-friendly facilities require youth-friendly staff. The most effective programs are those that have provided on-going training and support to health workers to improve their knowledge, attitudes, and skills to more appropriately respond to the needs of adolescents in a non-judgmental manner (Kesterton et al, 2010). Health workers should meet periodically to exchange technical information, and should engage in on-going dialogues with young people. Some adolescent-only clinics have employed young people to welcome and educate clients in the waiting room.

The National Rural Health Mission of India (2006) further explains that one of the technical strategies to reduce teenage fertility rate is to take steps to ensure improved service delivery for adolescents during routine check-ups at sub-centre clinics and to ensure service availability on fixed days and timings at the Primary Health Care levels. This is also supposed to be in tune with the outreach activities. This implies that health service providers should make an effort to reach out to places liked schools where the adolescents spend most of their time. The health care providers must be able to market the services and try to bring services closer to the people. This might overcome certain barriers like long distance that prevent the adolescents from seeking health services at the health facilities.

The Ministry of Health and Social Services (2004), recommends that the provision for health services for the young people is also supposed to be in tune with the outreach activities. This means that when health service providers go out to communities to provide treatment, consideration should be made to include services specific for adolescents. Moreover, the

Ministry of Health and Social Services (2011), requires that health service providers should make an effort to reach out to places liked schools where the adolescents spend most of their time. In that regards, the Ministry of Health and Social Services (2011) direct that “Health care providers should conduct schools visits in their catchment area to conduct health education sessions” (MOHSS, 2011 p. 10). This recommendation by the Ministry of Health implies that it is not enough for the health care workers to sit in the health facilities and wait for the users of Adolescent Friendly Health services to come and use the services. The health care providers must be able to market the services and try to bring services closer to the people by physically going out of the health facility and reach out to places where the adolescents spend most of their time. The World Health Organisation (2012) further emphasises that a large portion of adolescents’ time is spent in school settings which provides significant interests in the role that schools can play in the lives and health of adolescents. This might overcome certain barriers like distance for the adolescents to go the health facilities.

2.3.3 Adolescent Friendly Environment

The service environment may vary with the specific target audience to be served. In general, adolescents prefer a setting that is comfortable, has posters or décor that relate to their tastes and interests, and which does not present an overly sanitized environment. Furthermore, UNFPA, UNICEF and WHO’s Common Agenda for Action in adolescent health and development calls for the implementation of interventions tailored to meet the special needs and problems of adolescents which includes the creation of supportive environment (WHO, 2012). According to a report by African Youth Alliance/Pathfinder (2003), “IEC materials on adolescent sexual and

reproductive health issues should be available at the service delivery points to complement sexual and reproductive health services” (p. 6).

Creating separate space and special hours for adolescents appears more important for certain clients, such as young teenagers, first-time clinic users, non-sexually active clients, and marginalized young people, who are especially suspicious of mainstream health care (United Nations High Commission for Refugees (UNHCR) & United Nations Populations Fund (UNFPA), 2012). A separate service can also facilitate providers’ efficiency in arranging specialized youth-friendly features (WHO, 2012). This means that before considering such a special adjustment, a strong needs assessment among a diverse group of probable clients should be conducted. Young people ranked privacy and confidentiality extremely high among various clinic characteristics (WHO, 2012). Privacy must be arranged for counselling sessions and examinations so that adolescents feel confident that their important and sensitive concerns are not overheard or re-told to other persons. National Rural Health Mission (2006) indicates that this is needed in order to create a supportive environment for adolescent interventions and to improve awareness levels among adolescents. Therefore adequate space is needed for privacy and to assure that counselling and examinations can take place out of sight and sound of other people. This requires separate rooms with doors, and policies that support minimal interruptions and intrusions.

Although not possible in all societies, welcoming male partners can prove beneficial, where feasible. For a young woman, the accompaniment of her boyfriend to the clinic can be an important element in the decision to seek services for reproductive health. This support should not be dampened by his possible feelings of discomfort. Furthermore, opportunities exist to foster shared responsibility for decision-making and contraception when young men are present,

as well as to serve the reproductive health needs of males. It may be necessary to develop clinic programs designed especially for young males that are sensitive to male values, motivations, feelings, and cultural influences, while encouraging equitable male and female relationships (WHO, 2012). Media and community-based activities are also used to build support among parents and community gatekeepers, however further evaluation on the effectiveness of this approach is needed (Speizer et. al, 2003).

Evidence suggests that health facilities and clinics are the most effective locations for providing adolescents with sexual and reproductive health information and services (WHO, 2012). According to the United Nations Convention of the Rights of the Child, “adolescents should enjoy the right to the highest attainable standard of health, including access to contraception information and services” (as cited by High Impact Practices in Family Planning, 2015, p. 1). Furthermore, adolescents are more likely going to retain what they see or read for themselves at their own time than being called for a formal gathering to listen to a scheduled information sharing event. Therefore, to attain a high possibility of them using the reproductive health information available for them, it is better to display such information around the facility in an attractive manner.

In order to make traditional health facilities more appealing to adolescents, effective programs should make adjustments to the services, including extension of operating hours, reducing prices, and/or modifying physical layouts to increase privacy and confidentiality. As a result, elsewhere some health systems have designated clinics or services for adolescent friendly services only (WHO, 2009). Moreover, programs should engage young people in designing youth friendly facilities at all stages. Although adolescent health services are often delivered outside of facilities (e.g., in schools, youth centres, public spaces, pharmacies, etc.), data on the effectiveness of such

services is limited. Some studies show that young people are more likely to obtain commodities like emergency contraception or condoms from pharmacies than from clinics (Lopez et al, 2010). A lot of factors could contribute to this and the way the facility appeals to adolescents could be one of the reasons. Therefore, for an environment to be adolescent friendly, it must be tailor - made to attract adolescents to use the services available. An environment which reduces stigma for adolescents like numbering of service rooms instead of naming the rooms with services provided in them could be ideal (MOHSS, 2011).

2.4 Summary

This chapter presented the literature review based on the three components being assessed by the study. The role of each component in promotion of adolescents' reproductive health is illustrated. The next chapter outlines the research design and methods of the study.

CHAPTER 3: RESEARCH DESIGN AND METHODS

3.1 Introduction

This chapter describes the research design and methodology that were employed for the study. A research design is a specification of the adequate operations to be performed in order to test specific hypothesis under given conditions (De Vos, Strydom, Fouche & Delpont, 2011; Joubert & Ehrlich 2007).

3.2 Research design

The purpose of a research design is to maximize control over factors that can interfere with the validity of the study findings (Burns & Grove, 2011). A research design is the set of logical steps taken by the researcher to answer the research question. It forms the ‘blueprint’ of the study and determines the methodology used by the researcher to obtain sources of information, such as subjects, elements and units of analysis, to collect and analyse the data, and to interpret the results (Brink et. al, 2008).

Every research question has one research design that may be considered the most appropriate to maximise the validity of the research findings (Brink et al. 2008). This study followed a quantitative, descriptive cross-sectional research design (De Vos, Strydom, Fouche & Delpont, 2011; Joubert & Ehrlich, 2007) to describe the implementation of the Adolescent Active Participation, Adolescent Friendly Health Service Providers and the Adolescent Friendly Environment components of the AFHS in the health care facilities of Otjozondjupa Region. The next sessions discuss the applications of the constructs of a quantitative design of the study.

3.2.1 Quantitative design

De Vos et al. (2011) states that a quantitative research is an inquiry into a social or human problem, based on testing a theory composed of variables which are measured with numbers and analysed with statistical procedure so that one can determine whether the predictive generalisations of the theory are true. This is a technique of converting raw data to a numerical form and statistical analysis. The reason is to reduce the data to an interpretable form so that the research problems can be tested and conclusions drawn. Raw data quantitative research does not provide answers to research questions. Answers are found by way of interpreting the data and the results. In a quantitative study, concepts, variables, hypotheses and methods of measurement are defined before the study begins and remain the same throughout (De Vos et. al, 2011).

In this study, a standardised procedure with formal instruments was used to collect data from the three data sources, and then a statistical procedure was used to analyse the data and to draw conclusions from the data about the phenomena under study. The quantitative design was chosen in order to determine the effectiveness of implementing each of these three components and to examine and describe the relationship among them. It was the best option for the researcher to objectively measure the variables of interest and to try and remain detached from the research participants so that unbiased conclusions can be drawn (De Vos et. al, 2011).

A series of questions were posed to all the three components. Data from the component Adolescent Friendly Health Service providers and the component of Adolescent Participation was collected using self-administered questionnaires while the data from the component of Adolescent Friendly Environment was collected using a checklist. The responses were summarized and quantified according to the same responses. Frequency count was then looked at

to determine the weight of the responses. Thereafter, inferences about a particular component were drawn from the responses on that component (De Vos et. al, 2011).

3.2.2 Descriptive design

Brink et. al, (2008), states that descriptive designs are concerned with gathering information from a representative sample of the population with the emphasis being on observation, questionnaires and interviews. These research designs are a scientific method which involves observing and describing the behaviour of subjects without influencing it in any way. The descriptive study is designed to gain more information about characteristics within a particular field of study. Its purpose is to provide a picture of a situation as it naturally happens (Burns & Grove, 2011). Descriptive designs describe the variables in order to answer the research question, and there is no intention of establishing a cause-effect relationship (Brink et. al, 2008). A descriptive study is intended merely to describe phenomena. In these studies, the researcher merely searches for accurate information about the characteristics of a single sample –subjects, groups, or situations or about the frequency of a phenomenon’s occurrence. The variables of interest are conceptually and operationally defined. These variables are classified as opinions, attitudes, needs or facts after which they are described, to provide a complete picture of the phenomenon as it exists (Brink et. al, 2008).

In this study, the researcher used the descriptive statistical analysis strategy in conjunction with graphic strategies to describe and summarise the data. The three components which were examined in this study were the Adolescent Participation, Adolescent Friendly Health Service

Providers and the Adolescent Friendly Environment components of the AFHS in the health care facilities of Otjozondjupa Region (De Vos et. al, 2011).

A descriptive statistical analytical design was selected for this study to describe the extent to which the nurses are implementing the Adolescent Friendly Health Services Standards in Otjozondjupa Region and to describe the relationship of the participants' characteristics and the implementation of the three components of the Adolescents Friendly Health Services initiative (Brink et al, 2008). The researcher desired to describe the relationship among the selected variables without making any attempt to determine cause-and effect relationship (Brink et. al, 2008). There was no manipulation of the variables involved and conceptual definitions of the variables from all the three components used were done. Descriptive designs are described according to the time sequence in which the data are collected. The emphasis in the collection of data in descriptive studies is on structured observation and questionnaires (Brink et. al, 2008). This design was therefore the most suitable and enabled the researcher to reduce, summarise, organise, evaluate and interpret the raw data appropriately so that it can have meaning for the readers of the research report.

3.2.3 Analytical

In order to be meaningful, the results obtained from data analysis require that the researcher interprets, draws conclusion based on the results obtained. (Brink et al, 2008). This interpretation is usually done in terms of what the results actually mean. Analysis of data is about what is to be done to the data once it has been collected. Analysis techniques conducted in quantitative research include descriptive and statistics analysis (Brink et. al, 2008). In this study, selected key variables of the three components were identified and analysed in terms of how they can be

associated with teenage pregnancy in the region. The multivariate, analytical descriptive method was used to analyse the data from the three data sources. Multivariate is where three or more variables are analysed with the aim of testing the interaction of the three variables (De Vos et al., 2011). The statistical method in conjunction with graphic strategy to analyse the data which was collected from the three data sources was used. The responses were categorized, quantified and analysed using SPSS Version 16 data base.

3.2.4 Randomised Cross sectional survey design

This study was a randomised cross-sectional survey design. Cross-sectional studies describe those studies in which the researcher conducts in the present to examine that which currently exists. The study was cross-sectional because it examined the implementation of the three components of the Adolescent Friendly Health Services within Otjozondjupa region at one point in time. The information was collected from all the subjects at the same point in time (De Vos et al, 2011).

Furthermore, this study was a randomised study in that every subject was randomly selected from the target population. Randomization refers to giving every subject under study an equal chance of being selected (Brink et al., 2008).

3.3 Population

A study population refers to all members of a specific group or the subjects who possess the attributes that the researcher aspires to study and about whom the researcher draws conclusions with regard to the findings of the study (Babbie & Mouton, 2001 & De Vos et al., (2007). For this study, there were three study populations, based on the three components of the Adolescent

Friendly Health Services that were evaluated. The first population was the nurses at the health centres and clinics who implement the Adolescent Friendly Health Services in Otjozondjupa region. This means that all the 13 Registered Nurse Midwives and 25 Enrolled Nurse Midwives at the 16 clinics and 3 health centres in the Otjozondjupa Region constituted the first population for the study (MoHSS, 2014). The second study population were all the 3 health centres and 16 Clinics where the Adolescent Friendly Health Services are implemented. The third study population was the school-going teenage girls as potential users of the Adolescent Friendly Health Services in the Otjozondjupa Region. These were the 4 995 adolescent girls in the 21 Secondary Schools in Otjozondjupa Region (Otjozondjupa Regional Council, 2014).

3.4 Sampling and sample size

According to Brink (2008), a sample is a fraction, or a subset of a larger set, selected by the researcher to participate in a research study as representative for the study population. In this study, for the health care facilities and nurses, there was no sampling done. A universal sampling of all 3 health centres, 16 clinics, and all thirty-eight (38) nurses at the 3 health centres and 16 clinics who provide the AFHS was done (De Vos et. al, 2011). Since the total study populations for the components on Adolescent Friendly Health Service Providers and Adolescent Friendly Environment were included in the study, there was no need of sample size calculation.

The sample of the school-going teenage girls was drawn from the total number of 4995 adolescent girls in the 21 Secondary Schools within (all) the six districts of the region, (one school per district) thus giving a total number of 6 schools. Epi Info program was used to calculate the sample size. Using Epi Info program, the number 4995 was entered in the slot of

population size. Then 95% was selected in the program as the confidence level. The Epi Info program automatically calculated the sample size of 540. Therefore, using Epi Info Version 7, at 95% confidence level, a total sample of 540 learners for the entire region was drawn. Considering the fact that there were six districts, dividing 540 by 6 thus gives 90 students per school.

The adolescent girls who participated in the study from each school were randomly sampled until the sample size of 540 was reached (Joubert & Ehrlich, 2007) and the following procedure was used:

Each class at the selected secondary school was assigned a number. The numbers were put in a container and then random sampling of the numbers of the classes to participate was done. Random sampling of the adolescent girls in that particular class was again done. If the number of the adolescent girls in the selected class was lesser than the number required, then a second class was again randomly selected and this was continued until the required number of 90 learners at the school was selected.

3.5 Data collection instruments

The data gathering instrument was developed based on the three components of the Adolescent Friendly Health Services which was assessed. Questionnaires of close and open-ended questions were developed for collection of data on the Adolescent Active Participation and the Adolescent Friendly Health Care Providers components, for self-administration by the participants.

The questionnaire for the adolescents at school was based on the component of Adolescent Active Participation. The questionnaire for the nurses at the health centres and clinics was based on the component of Adolescent Friendly Health Service Providers.

A check list was developed for collection of the data on the Adolescent Friendly Environment by the researcher to assess evidence of the availability of Adolescent Friendly Health Environment in the health facilities.

3.6 Pilot testing of the data collection instrument/tool

The questionnaires for collection of the data on the components of Adolescent Active Participation, and of Adolescent Friendly Health Service Providers were first piloted. The questionnaire for Adolescent Friendly Health Service Providers was piloted on 2 Registered Nurses and 3 Enrolled Nurse Midwives at Nkarapamwe clinic in Kavango Region, while the questionnaire for Adolescent Active Participation was piloted on 10 adolescent girls at Grootfontein Secondary School which did not participate in the actual study but is within Otjozondjupa Region. The reason for piloting the data collecting instrument was to determine if the questions are understandable to the respondents and to make necessary changes to the instrument to ensure reliability of the data from the study (Joubert & Ehrlich, 2007).

3.7 Inclusion and exclusion criteria.

The following were the inclusion criteria for the study:

a) Adolescents

Only adolescent girls who attend secondary school in Otjozondjupa Region were included in the study regardless of the grades so long they were within the age group of 13 to 19 years.

b) Adolescent Friendly Health Service Providers

Study included only those nurses in clinics and health centres within Otjozondjupa Region.

c) Adolescent Friendly Health Environment

Only the clinics and health centres in Otjozondjupa Region were included in the study.

The study exclusion criteria were as follows:

a) Adolescents

Adolescent girls who did not attend school despite the fact that they were within the boundaries of Otjozondjupa Region, were excluded from the study.

Adolescent boys who attend school within the region were excluded.

b) Adolescent Friendly Health Service Providers and Adolescent Friendly Health Environment

Adolescent Friendly Health Service Providers working outside Otjozondjupa Region were excluded from the study.

The Clinics and Health Centres that were outside Otjozondjupa Region were excluded from the study.

One of the clinics in Grootfontein District could not form part of the data generating facilities because it was found closed even after repeated attempts.

3.8 Data collection method

Data collection was done through the use of self-administrated questionnaires that had questions on each variable of the different components of Adolescent Friendly Health Services. In this

study the self-administration of the data collecting instruments ensured the non-influence of the researcher on the data (De Vos et al, 2011).

The questionnaires that were administrated to the adolescents contained questions about whether the adolescents were using the service as well as the details of the kind of services they were receiving. The questionnaires were anonymous and the adolescents in selected schools had to fill in the responses or chose from the choices provided.

The questionnaire that targeted the Adolescent Friendly Health Services Providers assessed whether the nurses at health facilities provided the Adolescent Friendly Health Services to the adolescents as well as the types and frequency of this service. These questionnaires were distributed by the researcher at the health facilities without any influence from the researcher. The questionnaires were completed at the health facilities where the health care providers were working.

The data about the Adolescent Friendly Environment was collected by the researcher using a checklist. This was done through the observation of the facilities to determine the availability of supportive evidence to Adolescent Friendly Services, like Information, Education and Communication (IEC) materials or records in the facilities as the indicators of the implementation of this component.

The three data sets from self-administered questionnaires by the nurses and teenage girls and from the checklist were triangulated to assess the implementation of the three components of Adolescent Friendly Health Services in Otjozondjupa Region. Triangulation of the data from the three sources provided verification on the implementation of the three components of the standards of Adolescent Friendly Health Services by the health care providers (Simons, 2010).

3.9 Data analysis.

Raw data from a quantitative research does not provide answers to research questions. Answers are found by way of interpreting the data and the results. Babbie & Mouton, (2001), stated that quantitative data analysis can be regarded as the technique of converting data to a numerical form and subjecting it to statistical analysis. The reason is to reduce the data to an interpretable form so that the research problems can be tested, and conclusions drawn (as cited in De Vos et al. 2011, p. 249). The data in this study were analysed using the quantitative data analysis method.

A multivariate, analytical descriptive method was followed to analyse the data from the three data sources. In this process, a number of variables which are related to either the use or the provision of AFHS were identified and selected from the questions in the questionnaires and the checklist. These variables were then entered in the Excel spread sheet and analysed using SPSS Version 16 data base. Some variables in the questionnaires were nominal. Nominal variables indicate to which group a subject belongs or the absence or presence of some quality. Therefore, no arithmetical operations were performed on such data (De Vos et al, 2011). In this study for example, district and gender of the participant are nominal variables. The measurement levels of these variables were then determined. The nominal data variables were divided into two broad classes. Some variables denoted categories (categorical data), while other variables were counts or measurements (numerical data) (De Vos et al, 2011).

The two broad data variable categories that were assessed and analysed were categorical data and numerical data.

Categorical data variables included knowledge of AFHS by adolescents, the use of AFHS by the adolescents, adolescent sexual activeness, consistency condom use by adolescents, adolescent

level of participation in key AFHS attributes, service providers' technical competencies in AFHS and adolescent Friendly Health Environment attributes.

The second category of data variables was numerical. These included service providers' qualifications and key adolescent health attributes and service providers' years of practice and key adolescent health attributes.

After determining the measurement levels of the variables, all categorical data were arranged together according to cause or association of meaning. Descriptive statistics was used to describe numerical data by organizing and summarizing as well as interpreting the raw data according to frequency and statistical significance.

Furthermore, analytical statistics was also done to analyse the relationship of the variables of each of the three components to either the provision of AFHS by the nurses or the use of AFHS by the adolescents. The study analysed the relationship between the variables in the adolescent participation component and its influence on the use of the AFHS by the adolescents (for example, whether the adolescents' knowledge about the availability of AFHS has any influence on their use of this service).

The relationship between the variables in the component of Adolescent Friendly Health Services Providers and their provision of the AFHS was also analysed.

Finally, the variables of the third component, Adolescent Friendly Environment, was analysed in terms of its relationship with whether it attracted the adolescents to use the AFHS or not (De Vos et al, 2011). Since data on this component was collected using a check list, the responses gave either the presence or absence of what was being asked for in the question. Therefore the

responses for selected questions were simply quantified and proportions were calculated using the number of health facilities which is 18 as the denominator.

Triangulation of the data from the three data sources (teenage girls, nurses in the clinics and health centres) was then done to provide verification on the relationships between these three data sources regarding the implementation of the standards of Adolescent Friendly Health Services by the nurses in Otjozondjupa region (Simons, 2010). The results are presented through tables and graphs of frequencies and percentages to enhance understanding. Conclusions were then drawn according to the findings and recommendations were written.

3.10 Validity and Reliability

Validity and reliability of the data refers to the quality of the information collected by using reliable data collection instrument respectively (Joubert & Ehrlich, 2007).

Reliability: For the purpose of this study, reliability of the data was ensured by pilot testing of the study data collecting instrument for Adolescent Active Participants and of Adolescent Friendly Health Service Providers on a smaller sample which was of similar context to that of the study participants in the actual study area. There were 2 Registered Nurse midwives and 3 Enrolled Nurse Midwives who participated in the pilot study to test the instrument for Adolescent Friendly Health Service Providers. The instrument for Adolescent Active Participants was piloted on 10 teenage girls. This ensured that the data collecting instrument is likely to provide similar responses from the participants of the main study (Joubert & Ehrlich, 2007). Where necessary, modifications to the data collecting instrument were effected to ensure reliability of the data from the main study (De Vos et al., 2011).

Validity: Content validity was ensured through the data collection instruments that contained only questions pertaining to the three components of the AFHS. Additionally, validity of the data pertaining to Adolescent Active Participation was guaranteed by universal sampling of all the nurses at the health centres and clinics, all health centres and all clinics in the Otjozondjupa region. Furthermore validity of the data was also ensured by application of a simple random sampling of the teenage girls to participate in the study. Random selection of the teenage girl participants maximized the probability that the sample was representative of the target population (Babbie & Mouton, 2001; Brink, 2008; De Vos et. al, 2005). Triangulation of the data from the three sources was done to strengthen the validity of the data from the study as the different source may have provided information of different perspective about the implementation of the three components of the Adolescents Friendly Health Services in the Otjozondjupa region.

3.11 Study limitation/ delineation

The data on the component of the Adolescent Participation was collected from school attendee teenage girls only and non-school attendee teenage girls were excluded. Therefore, the findings on this component cannot be generalized to all teenage girls in the region. Moreover, because of the sensitive perspective of the study, the teenage participants may have given limited information which may have influenced the findings.

The findings on the components of the Adolescent Friendly Health Services Provider and Adolescent Friendly environment were limited to all nurses and health care facilities for AFHS in the Otjozondjupa region and cannot be generalized to other regions. An extensive study covering

the entire region or all the regions in the country could not be conducted because of limited resources on the part of the researcher.

Since the data was collected through self-administered questionnaires, the quality of the data may have been minimized, in contrast to the data that is collected through face-to-face interviews.

3.12 Ethical measures

De Vos et al (2011) states that “research should be based on mutual trust, acceptance, cooperation, well-accepted conventions and expectations between all parties involved in a research project” (p. 113). Since this is an empirical study involving humans, ethical principles of justice, autonomy, protection of participants from harm and beneficence was observed.

As regards ethical principle of justice or a fair treatment of the study participants, the study was conducted accordance to approved procedures that are in place to protect the study participants (White, 2001). Permission to conduct this study was sought from the University of Namibia’s Post Graduate Committee on Research and the Research Committee of the MoHSS through the Permanent Secretary for this ministry, all who are the regulatory bodies to ensure the safety of the research participants. Equally, the three categories of populations were the ones who are well-placed to provide needed information about the implementation of the three components of the Adolescent Friendly Health Services initiative.

In respect of ethical principle of autonomy, an informed written consent was sought from the nurse participants to participate in the study (De Vos et. al, 2011). Participants were informed about the purposes of the study, research method and methods of feedback of the research

outcomes. The participants were ensured on their right to voluntary participation and to withdraw from the study at any time. Confidentiality was maintained at dissemination of the study results (Parahoo, 2006 & Streubert Speziale & Carpenter, 2007).

Adolescent participants were protected from any harm that can be occasioned by the research activities. In this regard, permission to conduct the research in the schools in Otjozondjupa Region was sought from the Regional Director of Education in the region. Consent to interview the teenage girls were sought from the teenage girls' parents. The questionnaire for the Adolescent Active Participation did not contain intrusive questions (Joubert & Ehrlich, 2007).

The principle of beneficence was observed by sharing the findings of this study with the authority of the MoHSS, the nurses at the district offices, the facility nurses at the health centres and clinics for necessary improvement in deliverance of Adolescent Friendly Health Friendly Services in the region (Joubert & Ehrlich, 2007).

3.13 Summary

This chapter explained the study design that was used to describe the implementation of the three components of the Adolescent Friendly Health Services in Otjozondjupa region. The chapter further outlined the study populations and streamlined the three data sources of the study. The method of data collection and analysis was also explained as well as the method of presenting the results. The study limitations and the applications of ethical measures were discussed in this chapter. The next chapter presents the study findings.

CHAPTER 4: THE FINDINGS

4.1 Introduction

This chapter presents the findings of the study during the assessment of the Adolescent Participation, Adolescent Friendly Health Service Providers as well as the Adolescent Friendly Health Service Environment.

The chapter begins by presenting the sample achievement of the three components of the Adolescent Friendly Health Services which were assessed. The characteristics of the samples are also summarized and further on in the chapter, the findings of the assessment are presented. Tables and figures were used to enhance the understanding of the variables which were selected in the study.

4.2. Findings

This section summarizes the results of the study on the provision and utilization of AFHS in Otjondjupa region. It is important to note that minimal demographic information was collected for this study to protect the identity of study participants for both the adolescents and health care providers.

4.2.1 Sample Achievement

The following table shows the study estimated sample against the actual achieved sample. The actual study sample yielded above 80%, for all the data collection sources (respondents), of the estimated study sample (Table 2).

Table 2: Data Collection sample Achievement

Study Data Collection Source	Study Estimated sample	Actual Achieved Sample	Estimated Percentage Yield
Adolescents	540	437	81%
Registered Nurses	14	12	86%
Enrolled Nurses	24	23	96%
Health Facilities	19	18	95%

4.2.2 Sample Characteristics

Adolescents

The age range of the adolescents that participated in the study was 13 – 19 years. One in four (25 percent) of the participating adolescents were 17 years old (figure 1), with the mean age of 16 years. Most (53.1 %) of the adolescents who participated in the study were in grades eight (8) and nine (9). There were relatively low numbers of grades 11 and 12 adolescents who participated in the study (Figure 1).

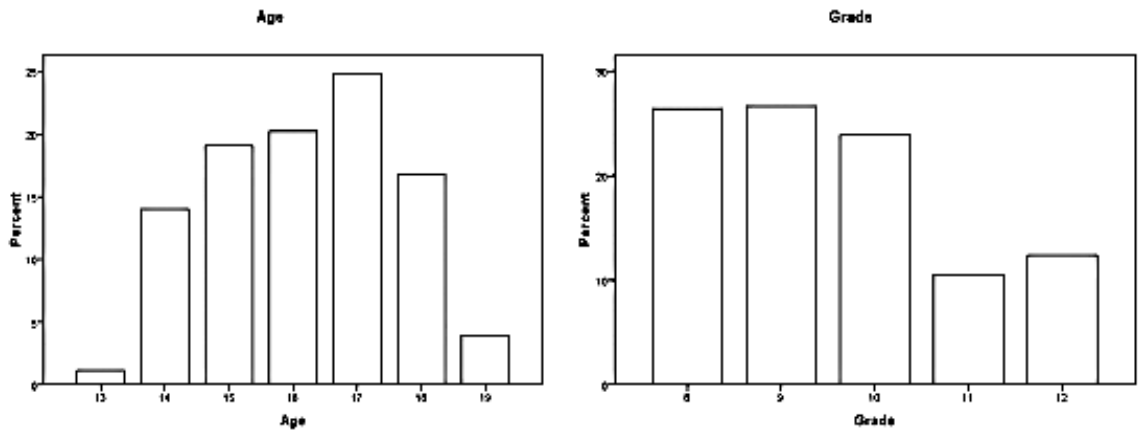


Figure 1: Age and Grade of Adolescents

Adolescent Friendly Health Services Providers

This study revealed that there were more clinics (83%; n =15) than Health Centres which participated in the study. Out of the 35 nurses in the study, the majority (71, 4%) were female. Moreover, there were more (66%) enrolled nurses than registered nurses who participated in the study. The study also indicated that more than half (54%) of the nurses have been in service for between 6 to 10 years. The next variable that was analysed was the characteristics for Adolescent Friendly Health Service Providers per Facility, as explained in table 3, on the next page.

Table 3: Sample characteristics for Adolescent Friendly Health Service Providers per Facility

Variable		Facilities				
		Grootfontein	Okahandja	Okakarara	Otjiwarongo	Total
Type of Health Facility	Clinic	5 (83.3%)	2 (100.0%)	6 (100.0%)	2 (100.0%)	15 (93.8%)
	Health Centre	1 (100.0%)	0 (0.0%)	0 (0.0%)	2 (100.0%)	3 (100.0%)
Gender	Females	8 (66.7%)	4 (57.1%)	6 (100%)	7 (70%)	25 (71.4%)
	Males	4 (33.3%)	3 (42.9%)	0 (0.0%)	3(30.0%)	10 (28.6%)
Years of Practicing	1 – 5 Years	3 (25.0%)	0 (0.0%)	0 (0.0%)	3 (30%)	6 ((17.1%)
	6 – 10 Years	6 (50%)	4 (57.1%)	5 (83.3%)	4 (40.0%)	19 (54.3%)
	More than 11 Years	3 (25%)	3 (42.9%)	1 (16.7%)	3 (30.0%)	10 (28.6%)
Rank of Health provider	Enrolled Nurse	4 (33.3%)	3 (42.9%)	5 (83.3%)	8 (80.0%)	20 (57.1%)
	Enrolled Nurse Midwife	3 (25.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (8.6%)
	Registered Nurse	5 (41.7%)	4 (57.1%)	1 (16.7%)	1 (10.0%)	11 (31.4%)
	Registered Nurse Midwife	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (10.0%)	1 (2.9%)

Adolescent Friendly Service Environment

There were more clinics (83.3%; $n=15$) that participated in the study than health centres (16.7%; $n=3$). The health facilities that participated in the study were from Grootfontein (6), Okakarara (6), Otjiwarongo (4) and Okahandja (2) districts (Table 3).

Table 4: Number and Health Facility Type Participated in Study by District

		Facility	
		Clinic	Health Centre
District	Grootfontein	5 (27.8%)	1 (5.6%)
	Okahandja	2 (11.1%)	
	Okakarara	6 (33.3%)	
	Otjiwarongo	2 (11.1%)	2 (11.1%)
Total		15 (83.3%)	3 (16.7%)

4.2.3 Adolescent Active participation

The study revealed that a higher proportion (80.8%, $n=353$) of the female adolescents interviewed did not know about Adolescent Friendly Health Services. Furthermore, less than 5% ($n=15$) of the adolescents reported to have used the adolescent friendly health services (see table 5). Those adolescents who indicated that they use the AFHS, obtained services related to healthy eating, prevention of STIs and safe use of condoms.

Table 5: Knowledge and use of Adolescent Friendly Health Services by the adolescents.

Knowledge on Adolescent Friendly Health Services			Use of Adolescent Friendly Health Services		
	Frequency	Percent		Frequency	Percent
Do not Know	353	80.8	Do not Use Health Services	420	96.1
Know	84	19.2	Use Health Services	15	3.4
Total	437	100	Total	437	100

Use of Adolescent Friendly Health Services.

The findings from the study showed that very few adolescents visited the local health facility to seek some health services. About 3% ($n= 15$) of adolescents in the study population visited the health facilities, while more than 96% ($n= 420$) did not (Table 5). Those who reported to have had visited the local health facility, about 10% of them did visit the health facility for at least twice in a year.

Sexually Active and Use of Condoms

Out of a sample of 437 adolescents, 2% ($n = 9$) did not respond to the question on whether they were sexually active. Therefore, out of the remaining 428 respondents who attempted the question, a mere 32% ($n = 137$) said they were sexually active. Furthermore, 27% ($n = 37$) from this 137 did not proceed to answer the question on consistency use of condoms. Therefore, from the remaining 100 respondents who attempted the question on consistency condom use, only 33% ($n = 33$) of them reported to consistently always use a condom when having sex (Figure 2). The majority of adolescents 67% ($n = 67$) who were sexually active but who did not use condoms, reported to be using other methods of contraceptives (Figure 3).

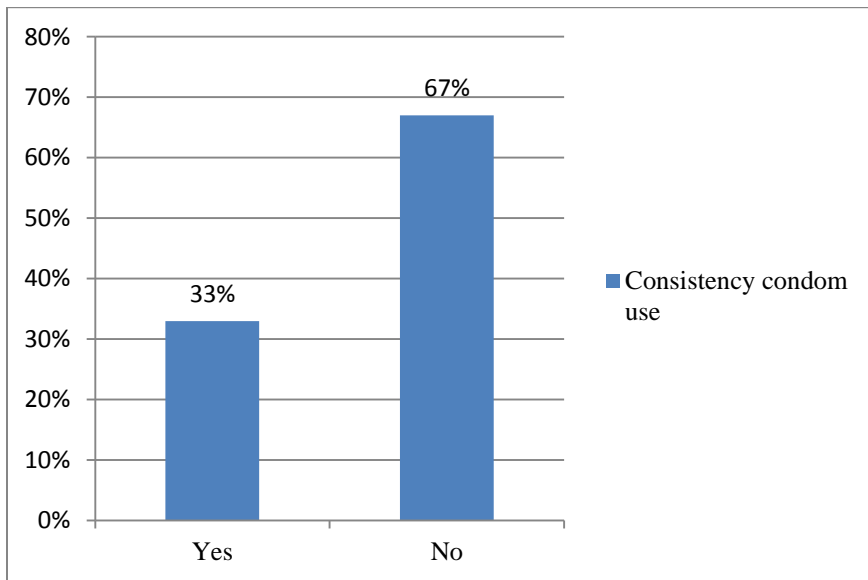
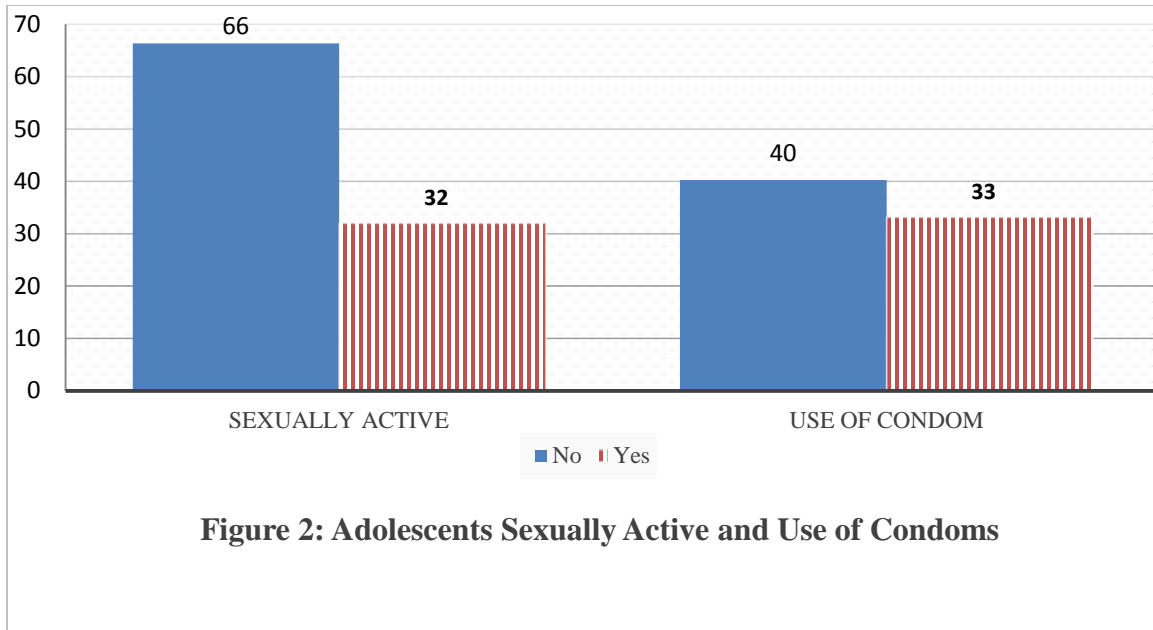


Figure 3: Consistency Condom Use

Adolescent Participation in Health Facility Committee (HFC), and Designing of Information, Education and Communication (IEC) Materials.

Involving adolescents in the design of their own health program and in continuous feedback enhances awareness and the programme ownership by the adolescents. This feeling of ownership and awareness is known to motivate adolescents to recruit their peers and to advise on needed adjustments, where necessary, to ensure that their health requirements are met, respectively.

The study further explored the participation of adolescents in health facility committees and their involvement in designing, development and distributing IEC materials. In addition, adolescents were also asked if they conducted health education sessions among themselves at school and which topics they usually covered during these sessions.

Table 6 shows that a mere (6%) of adolescents knew any of their colleagues being members of the local Health Facility Committee. The study also revealed that less than 10% of adolescents did participate in designing and development of IEC materials and involved in the distribution of the IEC materials and condoms at schools (Table 6).

Furthermore, the study also revealed that about 20% of the adolescents were involved in conducting health education sessions at schools (Table 6). Common topics that used to be covered during adolescent health education sessions at school (not in order of importance) include family planning, prevention of teenage pregnancy, condom use and prevention of STIs and HIV.

Table 6: Adolescents level of participation in key AFHS .

Variables	Responses	Frequency	Percent
Colleagues who are members of the Health Facility Committee (HFC)?	No	402	92,0
	Yes	25	5,7
Involved in the design and development of the Information Education and Communication (IEC) materials	No	397	90,8
	Yes	27	6,2
You or your classmates - involved in the distribution of IEC materials and condoms at school?	No	405	92,7
	Yes	20	4,6
Do you conduct health education sessions among yourselves at school	No	322	73,7
	Yes	85	19,5

The findings from the study further revealed that nurses from the local health facilities were visiting the schools (26%) and were reported to conduct health education sessions in schools (14%) as displayed in figure 4.

4.2.4 Adolescent Friendly Health Services Providers

The second component of the AFHS that was assessed was the Adolescent friendly Health Services Providers. The specific variables that were assessed include: services providers technical competencies such as their qualifications and adolescent health attributes.

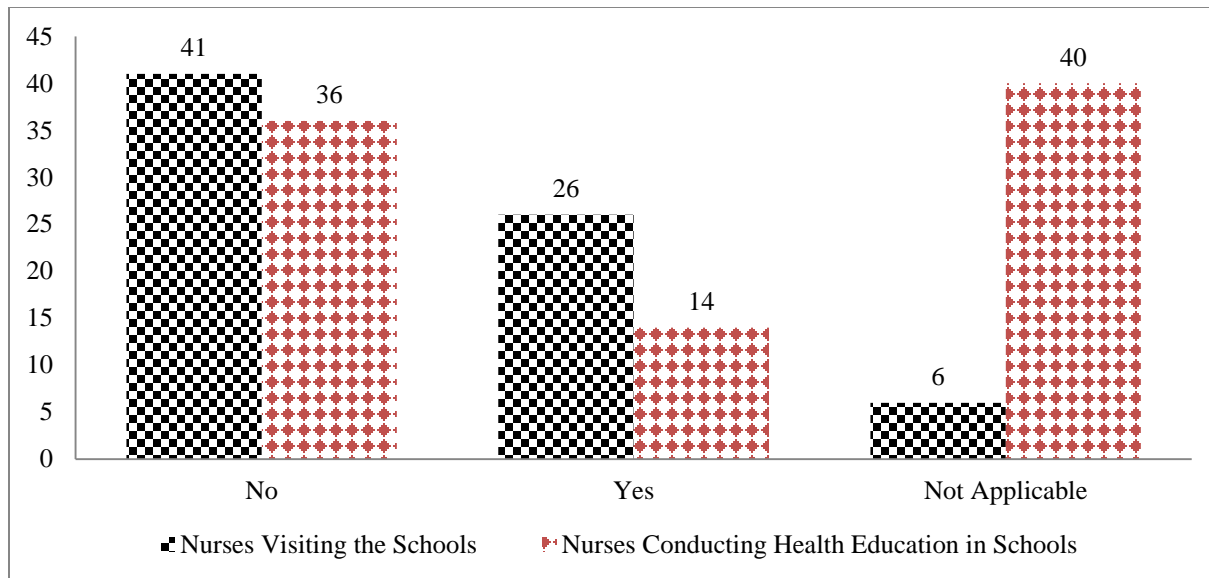


Figure 4: Nurses’ visit to schools and conducting of health education.

Service Providers Technical Competencies

Out of the sample estimate of 14 Registered Nurses, 12 participated in the study. The sample estimates of the Enrolled Nurse Midwives was 24, and 23 of them participated in the study. The findings from this study showed that 25% ($n = 3$) of the Registered Nurse Midwives who participated were not formally trained in adolescent sexual and reproductive health issues and none of them reported to have ever received some orientation on how to handle Adolescent sexual and reproductive health issues. Furthermore, the study discovered that 70% ($n = 16$) of the Enrolled Nurse Midwives who participated in the study were not formerly trained in adolescent sexual and reproductive health issues, and out of these, only about 13% ($n = 2$) of them said they received some orientation on how to handle Adolescent sexual and reproductive health issues.

Table 7 shows that the majority of health providers who were formally trained in adolescent sexual and reproductive health issues were Registered Nurse Midwives by rank.

It was also observed that 75% ($n = 9$) of the Registered Nurses, and 87% ($n = 20$) of the Enrolled Nurse Midwives reported to be conducting adolescent health outreach activities at local schools. All the 8 (100%) Registered Nurse Midwives (4 out of the 12 did not respond to this question) who responded to this question said they conducted health education sessions to local schools during their outreach visits to the schools. Out of the total number of 23 Enrolled Nurse Midwives, 4 did not respond to the question on giving health education during outreach services to local schools. Therefore, 19 Enrolled Nurse Midwives responded to this question and 95% ($n = 18$) of them said they also give health education during their outreach visits to local schools. The majority of the health care providers who indicated that they were conducting adolescent health outreach activities to local schools were Enrolled Nurse Midwives (Table 7).

Table 7: Health Provider’s Qualifications and Key Adolescent Health Attributes

Variable		Health Provider’s Rank	
		Enrolled Nurse Midwife [ENM]	Registered Nurse Midwife [RNM]
Trained in Adolescent sexual and reproductive health issues	No	16/23 (70%)	3/12 (25%)
	Yes	7/23 (30%)	9/12 (75%)
You/ your colleagues conduct outreach to local schools	No	3/23 (13%)	3/12 (25%)
	Yes	20/23 (87.0%)	9/12 (75.0%)
AFHS outreach to schools, do you give health education*	No	1/19 (5%)	0 (0%)
	Yes	18/19 (95%)	8/8 (100%)

* Note that 4 (17.4%) and 4 (33.0%) of ENM and RNM, respectively, did not respond to the question about giving health education sessions.

Out of the 12 Registered Nurse Midwives and the 23 Enrolled Nurse Midwives who responded to the question of being trained, it came out clearly in the study that 68% ($n = 6$) of the health

care providers who were not trained in Adolescent Sexual and reproductive health issues were Enrolled Nurse Midwives with experience of between 6 – 10 years. The study also showed that all 100% ($n = 3$) of the Enrolled Nurse Midwives who said they never conducted outreach to the local schools within their area had between 6 – 10 years working experience. One Enrolled Nurse Midwife with a working experience of between 6 – 10 years reported that she never conducts health education during outreach services to local schools (Table 8).

Table 8: Health Services Provider’s years of practicing and key Adolescent health attributes

Variable		YEARS OF EXPERIENCE					
		Registered Nurse Midwives			Enrolled Nurse Midwives		
		1 - 5	6 - 10	11 – 20+	1 - 5	6 – 10	11 – 20+
Trained in Adolescent sexual and reproductive health issues	YES	1/12 (8%)	6/12 (50%)	2/12 (17%)	4/23 (17%)	3/23 (13%)	0/23 (0%)
	NO	2/23 (9%)	1/23 (4%)	0/23 (0%)	2/23 (9%)	6/23 (26%)	8/23 (35%)
You/ your colleagues conduct outreach to local schools	YES	3/12 (25%)	4/12 (33%)	2/12 (17%)	11/23 (47%)	7/23 (30%)	2/23 (9%)
	NO	3/12 (25%)	0/12 (0%)	0/12 (0%)	0/23 (0%)	3/23 (13%)	0/23 (0%)
AFHS outreach to schools, do you give health education*	YES	1/8 (13%)	2/8 (25%)	5/8 (63%)	6/19 (32%)	1/19 (5%)	11/19 (58%)
	NO	0/8 (0%)	0/8 (0%)	0/8 (0%)	0/19 (0%)	1/19 (5%)	0/19 (0%)

4.2.5 Adolescent Friendly Health Environment

Out of an estimated sample of 19 health facilities (16 clinics and 3 health centers), one health facility (clinic) was closed and could not be part of the data generating facilities. The study revealed that more than 90% of health facilities had no room or space designated for adolescent

related health services and the rooms were not clearly marked with numbers instead of labeling the services which are being given (Table 9). The study showed that all the health facilities had adolescent friendly IEC materials on health issues displayed. However, there was limited information on where to get condoms displayed in the facilities and that there were no records of the activities of the Health Facility Committee in the facility (see Table 9, below).

Table 9: Adolescent Friendly Health Environment Attributes (n=18)

Adolescent Friendly Health Environment Attributes	Response	Frequency	Percent
Is there any room or space designated for adolescent at the facility	No	17	94.4%
	Yes	1	5.6%
Room location accessible for adolescent accessible	Yes	1	5.6%
	No	17	94.4
Are the consulting rooms clearly marked with numbers instead of labeling the services which are being given?	No	15	83.3%
	Yes	3	16.7%
Are there any adolescent friendly IEC materials on health issues displayed in the facility?	Yes	18	100.0%
Is information on where to get condoms displayed in the facility?	No	17	94.4%
	Yes	1	5.6%
Are the condoms accessible in the health facility?	Yes	18	100.0%
Are there any records of the activities of the Health Facility Committee in the facility?	No	18	100.0%
Are there any records of school visits kept in the health facility?	No	11	61.1%
	Yes	7	38.9%

4.3 Summary

This chapter presented the findings on the three components of the Adolescent Friendly Health Services initiative which were assessed by the study. The next chapter presents the discussions of the findings conclusions, study limitations and also outlines the recommendations based on the findings of the study.

CHAPTER 5:DISCUSSION, CONCLUSIONS, LIMITATION AND RECOMMENDATIONS

5.1 Discussion

This chapter presents the discussions of the findings. Findings pertaining to the three components of the Adolescent Friendly Health Services (AFHS) are placed in the context of the existing literatures.

5.1.1 Adolescent Active Participation

Adolescent friendly service delivery is about providing services based on a comprehensive understanding of what young people in that particular society or community want, rather than being based only on what providers believe are needs for the recipients. It is also based on an understanding of, and respect for, the realities of young people's diverse sexual and reproductive lives. It is about creating a service which young people trust and feel is there for them and their needs (International Medical Advisory Panel Statement, 2005). Variables that were assessed under this component of the AFHS are adolescents' knowledge of AFHS, the use or utilization of AFHS, sexually active and the use of condom by the adolescent participants. Adolescents' participation in the Health Facility Committee (HFC), designing of Information, Education and Communication (IEC) materials were also assessed as the indicators of adolescent active participation. The findings are explained in the next sections.

With reference to youth involvement and development, a distinction needs to be made between youth participation as a means and participation as an end. In the first, participation is needed for effective project implementation, necessary for needs assessment and determination of services offered. Furthermore, it implies setting up the clinic according to priorities of adolescents, using

adolescents for peer education and outreach and promotion of services. Participation is also seen as a means to empower the adolescents and has a developmental objective beyond AFHS, but aiming to increase self-esteem and taking responsibility, building capacities for decision making, programming and planning and negotiation – and crucially, giving adolescents an explicit role in the monitoring of their own services.

In spite of the availability of information, young people have insufficient access to information and services to make informed choices and this is to a large extent the result of a culture of silence around youth sexuality, the taboo on talking about sexual matters in many cultures, and the belief that information about sex will lead to sexual experimenting. Concurrently, in Kenya, young people were found to have little knowledge on sexual matters, although they are sexually active, while the adults are unable to discuss sexual matters with their children (Njoroge et al., 2010).

This study observed that there was limited involvement and participation of higher proportion (80.8%, $n=353$) of the female adolescents' participants in Adolescent Friendly Health Services.

However, the availability of on-line information and social networking sites will change the possibilities to obtain information as is noted in the editorial of *Reproductive Health Matters* by Berer (2013), which states: “the introduction of social media has changed the relationship between the source of a message and the audience, where the audience no longer passively consumes media content, but actively engages in creating it” (p 4-8).

WHO (2012) further says that Adolescent participation and engagement is critical to building adolescent buy-in and increasing demand for services. Adolescent programmes have succeeded

greatly by actively engaging adolescents in designing, implementation, monitoring and evaluation of their own programmes. Therefore, contrary to what literature suggests on how to run adolescent health services, there was limited involvement of adolescents in Otjozondjupa Region in AFHS.

Use of Adolescent Friendly Health Services.

Adolescent Friendly Health Services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO Expert Advisory Group in Geneva in 2002. Some of the key requirements that are to be met include the fulfilment of the rights of youth as outlined in the United Nations (UN) Convention on the Rights of the Child and other instruments and declarations. The services should also take into account the special needs of different sectors of the population, including vulnerable and under-served groups (UNHCR, & UNFPA, 2012). The AFHS procedures should facilitate easy and confidential registration of youth, and retrieval and storage of records and short waiting times and (where necessary) swift referral. This study showed that less than 3.43% ($n=15$) of the adolescents reported to have used the adolescent friendly health services. Literature suggests that engaging program users facilitates usage of the programme. This study observed limited involvement and participation of adolescents in their own programme. Therefore, because of limited engagement of adolescents in AFHS, it can be concluded that usage of AFHS is low.

Sexually active and use of condoms

A study in Namibia by UNICEF, (2011) found that 60% of adolescents aged 16–19 years were already sexually active and that 6% of girls and 12% of boys stated that they became sexual active before the age of 15. Youth have been targeted in the Namibian government's HIV prevention programme through school-based HIV education programmes (UNICEF, 2011) which operates in rural as well as urban settings. Youth also have access to HIV Counselling and Testing (HCT) centres, which have been established at all primary care facilities and which run outreach community mobilisation activities.

A study in a rural province of South Africa describes some of the reasons why condoms are not used consistently: perceived and real physical side-effects, including reduced pleasure; distrust in the efficacy of condoms; gender-related reasons; and trust in relationships (Speizer et. al, 2003). Dual protection, defined as any strategy that prevents both unwanted pregnancy and sexually transmitted infections, including HIV, has long been promoted as an important preventive approach in reproductive health (Njoroge et. al, 2010)). In the family planning setting, promotion of condoms as dual protection might facilitate condom use.

Literature has proven that modern contraceptive use among adolescents is generally low. Despite high levels of knowledge about these methods, many young people do not use contraception and some use contraceptives inconsistently and incorrectly. Some of the obstacles to that adolescents face in obtaining contraceptives are related to availability, accessibility and acceptability (Lopez, 2010). Despite high levels of knowledge about the variety of contraceptives like condoms and many other methods, many young people do not use contraception and some use contraceptives

inconsistently. WHO (2012), clearly states that even where health services are available, adolescents may be unable to obtain them for a variety of reasons and one of the reasons might be that adolescents may not know where they can obtain them when need arises. This can easily lead to inconsistency use of condoms.

The High Impact Practice in Family Planning (2015) suggests tailoring health communication to the needs and interests of adolescents. Considering where and from whom adolescents get information on sexual and reproductive health, it is very crucial to engage young people in order to avoid misguided information dissemination among the adolescents which can lead to issues of inconsistency condom use among the adolescents.

Actions to overcome these barriers to contraceptive use at various levels have recently been recommended by WHO and include: reforming laws and policies to enable all adolescents to obtain contraceptives and information; reducing the cost of contraceptive services; educating adolescents about contraceptive use; and, increasing community support for contraceptive provision to adolescents (Blank, Baxter, Payne, Guillaume & Squires , 2012). Aiming to increase correct and consistent condom use among both sexes is critical, as condoms offer dual protection from both pregnancy and STI (including HIV) and as such, condom may be the most appropriate method for young people. Improving both supply and demand is critical. In 2011, donor support contributed to making only nine male condoms available for every adult male aged 15–49 in sub-Saharan Africa (High Impact Practices, 2015).

This study revealed that only 33% (n = 33) of sexually active female adolescents consistently always use a condom when having sex (figure 3). The majority of adolescents (67%) who were

sexually active and did not use condoms, reported to be on other methods of contraceptives such as pills and injections (figure 3). These findings are on higher side compared to the adolescent use of condoms in the southern African region and the study results are similar to the results obtained by the survey conducted in 2013 by UNESCO.

5.1.2 Adolescent Friendly Health Service Providers

Well-trained, sensitive providers are often considered to represent the most important ingredient of a truly youth-friendly service. All publications reviewed address the issue of providers' skills, attitudes and knowledge, as well as the need for (on-going) training and support of providers. Apart from the existence of relevant training curricula, it is important that different methods of capacity building are used that go beyond initial training such as for instance refresher training (orientation), mentoring support, on the job training and internships.

The study showed that 25% of the Registered Nurse Midwives, and 70% of the Enrolled Nurse Midwives who participated in the study were not formally trained in adolescent sexual and reproductive health issues. This implies that almost half (54%) of all the health care providers who participated were not formally trained in adolescent sexual and reproductive health issues. Moreover, none of the Registered Nurse Midwives who were not formerly trained in adolescent sexual and reproductive health issues indicated to have received some form of orientation, and only 13% of the Enrolled Nurse Midwives who were not formerly trained, reported to have ever received some orientation on how to handle adolescent sexual and reproductive health issues.

The High Impact Practice in Family Planning (2015), gives a list of criteria, including experience of working with young people, understanding of the principles underlying adolescent sexual and reproductive health rights (pro-choice, non-discrimination, respect etc.), positive attitude towards young people's sexuality, age, gender and diversity so that young clients from diverse backgrounds feel comfortable consulting health service providers. According to the WHO review, training of service providers (and in some cases, other clinic staff) was the most frequently implemented intervention used to increase service use by young people (WHO, 2006).

Evidence from this study indicated that 75% Registered Nurse Midwives, and 87% Enrolled Nurse Midwives conducted adolescent health outreach activities at local schools. Out of these, a high proportion of 100% of the Registered Nurse Midwives, and 95% of the Enrolled Nurse Midwives reported to have been conducting health education during their visit to local schools.

Although clearly every individual working at a health care facility has a right to his or her values about adolescent sexual behaviour, it is imperative that providers recognize that adolescents, like adults, are entitled to basic sexual and reproductive health rights. These rights, such as the right to dignified, respectful treatment, the right to a full range of accessible, affordable services, and the right to private, confidential services, require that providers must, at times, separate their personal values from their professional duties in order to offer quality reproductive health care to youth.

Many service providers do not fully understand the psychosocial context in which adolescents live because they may not have had sufficient interaction with youth or have not had training specifically related to young people. The quality of care given to youth may increase substantially when providers understand cross-cultural issues of adolescent development. These include autonomy, identity development, body-image concerns, and peer-group identification.

When providers have a basic understanding of both these issues and health needs specific to youth, such as the risks of pregnancy at an early age, the increased biological vulnerability of young women to HIV and other STIs, and the unique factors that influence decisions about contraceptive methods during adolescence, they can build communication and counselling skills to establish a better sense of trust between the client and service provider. In isolation, training and guidelines will not foster the change health care facilities need to provide quality services. Ultimately, facilities must mobilize themselves to provide youth friendly services.

5.1.3 Adolescent Friendly Environment

With regard to facility characteristics, there is a general agreement on the elements relating to location, design, hours and privacy /confidentiality conditions. In the literature, these elements are often combined under the heading accessibility (WHO, 2012). However, accessibility is also dependent on how issues of gender, stigma, legal barriers and language are dealt with (HIPs, 2015). The availability of educational and information materials in waiting rooms is necessary. WHO (2012) stated that some of the barriers that adolescents face in obtaining the health services they need are that health services may be delivered in a way that adolescent do not feel comfortable to obtain them even if they can. One such example is where they have to go and wait in a place where they could be seen by people they know.

The findings of this study therefore are in agreement with the statement by WHO because the study revealed that more than 90% of health facilities had no room or space designated for adolescent related health services and the rooms were not clearly marked with numbers instead of labeling the services which are being given. This clearly indicates that the health service environment is not acceptable to them.

The Pathfinder tool, for instance, mentions that: “some young people prefer to learn about sensitive issues on their own, using written or audio-visual materials, because their discomfort level can be too great to retain information during a face-to-face session. Such learning can occur while clients are waiting to be seen, as with educational videos or computer-based health education” (Pathfinder International, 2002, p. 32). This study showed that all the health facilities had adolescent friendly Information Education and Communication materials on health issues displayed. However, there was limited information displayed on where to get condoms in the facilities and that there were no records of the activities of the Health Facility Committee in the facility. WHO, (2012) reiterated that some of the barriers which adolescent face in obtaining the health services which they need were related to lack of information. Even where health services are available, adolescents may be unable to obtain them because they may not know where the services are provided. The study findings are in agreement with what WHO said because adolescents are very sensitive people and would not feel free to approach a health care provider to ask about where to find condoms. What this means is that health services are not accessible to them.

Active promotion of services is the subject of the WHO review which stresses the link between adolescent friendly services and other services and networks in the community (WHO, 2009). The review mentions outreach to schools, community organisations and through peer education activities, as some of the important youth friendly health service interventions (Larke et.al, 2010).

5.2 Conclusions

The following revelations came out clearly during this study regarding the implementation of the Standard of Adolescent Friendly Health Services by nurses in Otjozondjupa Region:

There was limited active involvement and participation of the adolescents in the Adolescent Friendly Services. Despite the fact that nurses reported to have been providing outreach services to schools, the findings indicate that the majority of the adolescents as users of this service did not know about the service.

The study also indicates that almost half (54%) of the nurses (both Registered Nurse Midwives and Enrolled Nurse Midwives) in the service were not formally trained in Adolescent Reproductive and Sexual Health issues. Moreover, only less than 10% of these had received some orientation on how to handle Adolescent Reproductive and Sexual Health issues.

The other conclusion from this study was that the health facility environments were not adolescent friendly. More than 90% of the health facilities had no room or space designated for adolescent related health services and the rooms were not marked with numbers instead of labelling the services which are being given. In addition, there was limited information displayed on where to get condoms in the health facilities and there were no records of the activities of the Health Facility Committee in the health facilities.

Thus the result of the study confirm the hypothesis that the teenage girls in Otjozondjupa region are not aware of the Adolescent Friendly Health Services as the majority (80.8%, $n=353$) of them were not involved and never participated in the Adolescent Friendly Health Services. Therefore, the study accepts the null hypothesis which states that the teenage girls are not aware of the Adolescent Friendly Health Services in Otjozondjupa Region. Furthermore, it came out from the study that 54% of the nurses (both Registered and Enrolled Nurse Midwives) were not formerly

trained in AFHS, and none of the Registered Nurse Midwives reported to have ever received some orientation on how to handle Adolescent Sexual and Reproductive Health issues. Without sufficient training and orientation in AFHS, nurses would not be able to implement the AFHS effectively. This statistical evidence therefore shows that the study rejects the alternative hypothesis which states that the Adolescent Friendly Health Services Standards are effectively implemented by the Registered Nurses in Otjozondjupa Region.

In conclusion, the implementation of the standards for Adolescents Friendly Health Services is very important if the health needs of the adolescents are to be met. This study revealed that the standards for the implementation of AFHS although existing, are not being effectively implemented by Nurses in Otjozondjupa region. It is one thing to have a document in existence but it is another thing to actually follow the recommendations of that document. This means a close monitoring of the use of the Standards for Adolescents Friendly Health Services is required for the success of the Adolescent Friendly Health Services.

5.3 Limitation

The data on the component of the Adolescent Participation was collected from school attendee teenage girls only and non-school attendee teenage girls were excluded. Therefore, the findings on this component cannot be generalized to all teenage girls in the region. Moreover, because of the sensitive perspective of the study, the teenage participants may have given limited information which might have influenced the findings.

The findings on the components of the Adolescent Friendly Health Services Provider and Adolescent Friendly environment was limited to all nurses and health care facilities for AFHS in

the Otjozondjupa region and cannot be generalized to other regions. An extensive study covering the entire region or all the regions in the country could not be conducted because of limited resources on the part of the researcher.

Since the data was collected through self-administered questionnaires, the quality of the data might have been minimized, in contrast to the data that is collected through face-to-face interviews.

5.4 Recommendations

Based on the conclusions which were drawn from this study, the following recommendations were made regarding the three components which were assessed in order to improve the implementation of Adolescent Friendly Health Services in Otjozondjupa Region:

With regards to the Adolescent Active Participation, the Ministry of Health and Social Services should diversify sources of the Information, Education and Communication system through introduction of on-line information services and social networking system for adolescents in order to increase adolescent audience.

Moreover, the marketing strategy of the Ministry of Health and Social Services regarding Adolescent Friendly Health Services should be improved by targeting places where adolescents spend most of their time, like schools in order to increase the number of adolescents using the Service.

With regards to the Adolescent Friendly Health Service Providers, the curriculum of training nurses (both Registered and Enrolled) must include a detailed module of Adolescent Friendly

Health Services. Additionally, the package of the nurses conducting outreach to local schools must spell out the part of giving health education to adolescents.

With regards to the component of Adolescent Friendly Environment, the Ministry of Health and Social Services should make it a standard that all health facilities should have a room designated for Adolescent Friendly Health Services activities and ensure a standard for all plans of constructing new health facilities to have such a room.

5.5 Summary

Chapter 5 discussed the findings of the study with regards to the Adolescent Active Participation, the Adolescent Friendly Health Service Providers and the Adolescent Friendly Environment components the AFHS in Otjozondjupa region. The findings were contextualized with the existing body of literature. Conclusions were outlined. Relevant recommendations were stated and the study limitations were explained.

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ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SONPH/9/2015

Date: 10 February, 2015

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: An Assessment of the adolescent participation, adolescent friendly health service providers, and adolescent friendly environment components of the AFHS standards by nurses in Otjozondjupa Region

Nature/Level of Project: Masters

Researcher: MARY LUNGUWE MUYENGA

Student Number : 9312218

Host Department & Faculty: School of Nursing and Public Health

Supervisor : Dr K. Amakali ; (Main) (Co) Dr. W. Wilkinson

Take note of the following:

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

UREC wishes you the best in your research.

Prof. I. Mapaire
UNAM Research Coordinator

19 February 2015

TO WHOM IT MAY CONCERN

RE: RESEARCH PERMISSION LETTER

1. This letter serves to inform that student: **Mary Lunguwe Muyenga** (Student number: **9312218**) is a registered student in the School of Nursing and Public Health at the University of Namibia. Her research proposal was reviewed and successfully met the University of Namibia requirements.
2. The purpose of this letter is to kindly notify you that the student has been granted permission to carry out postgraduate studies research. The School of Postgraduate Studies has approved the research to be carried out by the student for purposes of fulfilling the requirements of the degree being pursued.
3. The proposal adheres to ethical principles.

Thank you so much in advance and many regards.

Yours truly,

Name of Main Supervisor: **DR K Amakali**

Signed: 

Dr. C. N.S. Shaimemanya

Signed: 

Director: School of Postgraduate Studies

Tel: 2063523

E-mail: cshaimemanya@unam.na

ANNEX 3

Consent Form (Section 1: Teenage girls' participation)

Dear parent

My name is Mary Lungowe Muyenga, a Masters of Public Health student at the University of Namibia, Faculty of Health Sciences, under the auspices of the School of Nursing and Public Health. I am conducting a research on the following topic:

An Assessment of the Adolescent Participation, Adolescent Friendly Health Service Providers, and Adolescent Friendly Environment components of the AFHS Standards by Nurses in Otjozondjupa Region.

The goal for the study is to assess and describe the extent of the implementation of the Adolescent Participation, Adolescent Friendly Health Service Providers and the Adolescent Friendly Environment components of the Adolescent Friendly Health Services in Otjozondjupa Region

Your child will be selected to complete a self-administered questionnaire which the researcher will administer at school. Your child's participation in this research is voluntary; she/he may withdraw from the interview at any time if she/he is not comfortable with it without any consequences.

The results of the study may be published but your child's name will not be revealed and no individual identification information will be provided. Although there may be no direct or immediate benefit derived from the study, the result of the study is valuable in assessing the effectiveness of the implementation of the Adolescent Friendly Health Services at the health care facilities in Otjozondjupa Region

I thank you for your consent to the participation of your child.

Consent

I have read the above informed consent, the nature, demands and benefits of the study.

I understand that my child may withdraw my consent and discontinue participation during interview without any penalty or loss of benefit to myself.

Signature of the Parent: Date.....

I certify that I have explained to the above parent the nature, purpose, and potential benefits and risks associated with participation of their child in this study.

Signature of the researcher Date.....

ANNEX 4

Consent Form (Section II: Adolescent Friendly Health Service Providers)

Dear Nurse,

My name is Mary Lungowe Muyenga, a Masters of Public Health student at the University of Namibia, Faculty of Health Sciences, under the auspices of the School of Nursing and Public Health. I am conducting a research on the following topic:

An Assessment of the Adolescent Participation, Adolescent Friendly Health Service Providers, and Adolescent Friendly Environment components of the AFHS Standards by Nurses in Otjozondjupa Region.

The goal for the study is to assess and describe the extent of the implementation of the Adolescent Participation, Adolescent Friendly Health Service Providers and the Adolescent Friendly Environment components of the Adolescent Friendly Health Services in Otjozondjupa Region

You will be selected to complete a self-administered questionnaire which the researcher will administer at your health facility. Your participation in this research is voluntary; you may withdraw from the interview at any time if you are not comfortable with it without any consequences.

The results of the study may be published but your name will not be revealed and no individual identification information will be provided. Although there may be no direct or immediate benefit derived from the study, the result of the study is valuable in assessing the effectiveness of the implementation of the Adolescent Friendly Health Services at the health care facilities in Otjozondjupa Region

I thank you for your consent to participate in the study.

Consent

I have read the above informed consent, the nature, demands and benefits of the study.

I understand that I may withdraw my consent and discontinue participation during interview without any penalty or loss of benefit to myself.

Signature of the Nurse: Date.....

I certify that I have explained to the above nurse the nature, purpose, and potential benefits and risks associated with his/her participation in this study.

Signature of the researcher Date.....

ANNEX 5

DATA COLLECTION INSTRUMENT

Section 1: Adolescent participation (For Teenage girls)

Demographic Information

Grade.....

Age of the participant.....

Gender of the participant.....

Questions

1.1 Do you know about Adolescent Friendly Health Services

YES	NO

1.2 Do you use the services of the Friendly Health Services?

YES	NO

1.3 If yes, explain in which way you use the Friendly Health Services

.....
.....
.....
.....
.....

1.4 Do you ever visit the local health facility for information sharing and health education? Please tick

YES	NO

1.5 If yes, how many times per month? Please tick the one which is applicable.

Every second month	Twice a year	Other (specify)

1.6 Are you sexually active

YES	NO

1.7 If yes, do you /consistently always use a condom when having sex?

YES	NO

1.8 If you do not use a condom consistently (always when having sex), indicate what you use?

.....
.....

1.9 Do you know of any of your colleagues who are members of the Health Facility Committee (HFC)?

YES	NO

1.10 Do you get involved in the design and development of the Information Education and Communication (IEC) materials?

YES	NO

1.11 Do you know anyone from your class (you or your classmates) involved in the distribution of IEC materials and condoms at school?

YES	NO

1.12 Do you conduct health education sessions among yourselves at school?

YES	NO

1.13 If yes, please fill in the topics which are usually covered.

1.14 Do the nurses from the local health facility conduct school visits at your school?

YES	NO

1.15 If yes, do they conduct health education sessions?

YES	NO

1.16 What were the topics of health education which you heard from the nurses?

ANNEX 6

DATA COLLECTION INSTRUMENT

Section 2. Adolescent Friendly Health Service Providers (For Nurses)

Demographic Information of the participant

Gender of the participant.....

Rank.....

Years of practice/experience.....

Facility type:.....

District:.....

1.1 Have you ever been formerly trained in Adolescent sexual and reproductive health issues?

1.2 If no, did you ever receive any orientation on how to handle Adolescent sexual and reproductive health issues?

YES	NO

2.3 Do you or any of your colleagues conduct outreach to local schools?

YES	NO

2.4 If yes how often do you or any of your colleagues conduct Adolescent Friendly Health Services (AFHS) outreach services to the local schools?

Monthly	Every third month

2.5. During the AFHS outreach to schools, do you give health education?

YES	NO

2.6 List some of the health education topics which you usually give during AFHS outreach to local schools?

2.7 Does your health facility have a Health Facility Committee?

YES	NO

2.8 If yes are you a member of the Health Facility Committee?

YES	NO

2.9 Are there any adolescents in this Health Facility Committee?

YES	NO

2.10 How often does the Health Facility Committee meet? (Please tick)

Monthly	Every two months	Never

ANNEX 7

DATA COLLECTION INSTRUMENT

Section 3. Adolescent Friendly Environment (For health facility assessment)

Demographic Information

Facility.....

District.....

Questions

3.1 Is there any room or space designated for adolescents at the facility?

YES	NO

3.2 If yes is the location in which the services provided for adolescents accessible?

YES	NO

3.3 Are the consulting rooms clearly marked with numbers instead of labelling the services which are being given?

YES	NO

3.4 Are there any adolescent friendly Information, Education & Communication materials on health issues displayed in the facility?

YES	NO

3.5 Is information on where to get condoms displayed in the facility?

YES	NO

3.6 Are the condoms accessible in the health facility?

YES	NO

3.7 Are there any records of the activities of the Health Facility Committee in the facility?

YES	NO

3.8 Are there any records of school visits kept in the health facility?

YES	NO



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2125
Fax: 061 – 222558
E-mail: msimasiku@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3

Enquiries: Mr. M. Simasiku

Date: 19th November 2015

Mrs Mary Lungowe Muyenga
P.O. Box 282
Rundu
Namibia

Dear Mrs. Muyenga

Re: An Assessment of the Adolescent Participation, Adolescent Friendly Health Service Providers, and Adolescent Friendly Environment components of the AFHS Standards by Nurses in Otjozondjupa region.

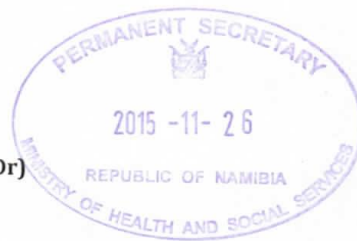
1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for academic purpose;
 - 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;
- 3.6 Final report to be submitted upon completion of the study;
- 3.7 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,



Andreas Mwoombola (Dr)
Permanent Secretary



"Health for All"



REPUBLIC OF NAMIBIA

MINISTRY OF EDUCATION, ARTS AND CULTURE

Enquiries: Mr C. Muchila
E-mail: Cavin.Muchila@moe.gov.na
Tel: +264 61 2933200
Fax: +264 61 2933922

Private Bag 13186,
WINDHOEK
Namibia

File no: 11/1/1

Date: 09 April 2015

To: Mrs Mary L. Muyenga
Cell: 0812476028
m_muyenga@yahoo.com

Dear: Mrs Muyenga

SUBJECT: PERMISSION TO CONDUCT A RESEARCH STUDY IN OTJOZONDJUPA REGION

Your correspondence regarding the subject above, seeking permission to conduct a research study in the schools of Otjozondjupa Region has reference.

Kindly be informed that the Ministry does not have any objection to your request to conduct a research study at identified schools in the region concerned.

You are, however, kindly advised to contact the Regional Council Office, Directorate of Education, for authorisation to go into the schools and for proper information coordination.

Also take note that the research activities should not interfere with the normal school programmes. Participation by either teachers or learners should be on a voluntary basis. Should you involve minors in your research activities, consent for participation should first be obtained from the parents/guardians of the minor(s).

By copy of this letter the Regional Education Director are made aware of your request.

Sincerely yours


.....
Mr. Alfred Ilukena
PERMANENT SECRETARY
cc: Director of Education, Otjozondjupa



All official correspondence must be addressed to the Permanent Secretary



**REPUBLIC OF NAMIBIA
OTJOZONDJUPA
REGIONAL COUNCIL**



DIRECTORATE OF EDUCATION, ARTS AND CULTURE

Tel no: 264 67 308000
Fax no: 264 67 304871

Private Bag 2618
Otjiwarongo
NAMIBIA

22 June 2015

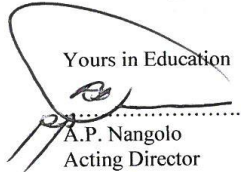
**TO ALL PRINCIPALS
ALL SCHOOLS
DIRECTORATE EDUCATION
OTJOZONDJUPA REGIONAL COUNCIL**

SIR/MADAM

PERMISSION TO CONDUCT A RESEARCH STUDY IN OTJOZONDJUPA SCHOOLS

Permission is hereby given for Ms. Mary L. Muyenga to conduct her research in schools in the Otjozondjupa region.

We would appreciate you giving her the necessary support.

Yours in Education

A.P. Nangolo
Acting Director



