

**Perceived factors that hinder the acceptance of contraceptives
amongst the young adults in the Outjo district -Namibia**

By

Imelda Katjau:

Student No: 210018720

**Thesis submitted in fulfillment of the requirements for
the M Tech: Nursing**

**in the
Faculty of Health and Wellness Sciences at the Cape Peninsula
University of Technology, Bellville Campus**

Supervisor: Emeritus Prof Doris Khalil

Co-supervisors: Ms. Faiza Kajee & Mr. Shafick Hassan

2014

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DECLARATION

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ABSTRACT

Recent reports suggest that there has been an alarming increase in the pregnancy rate of young adults especially in the Outjo district, the northwestern part of Namibia. No formal studies have been conducted recently to get a better understanding of this phenomenon, which is of great concern to all social and healthcare stakeholders. According to the annual report of the Outjo hospital 2009/2010, 36% of the pregnancies reported at the hospital were youth still at school (Namibian 2011). Negative health outcomes of early pregnancy and sexually transmitted infections (STIs), including HIV/AIDS (Human immunodeficiency virus infection / Acquired immunodeficiency syndrome), threaten the health of these young adults who will become the mature adults and parents of the future. This study aimed to assess factors that hinder young adults both male and female from utilizing contraceptives in Outjo district in the northwestern part of the Republic of Namibia. Some of the objectives of this study were to explore the personal factors that influence the decision to use contraceptives among young adult of the Outjo district; examine socio-economic factors that influence young adult' decision to use contraceptives, and determine pregnancy rate amongst female young adults in the Outjo district. In order to achieve the objectives of the study, a quantitative descriptive survey method and retrospective analysis of the records was used. The study population was young adults 18 to 24 years of age. A semi-structured validated questionnaire was utilized to collect data. Data was analyzed by using SPSS 19 software to generate frequency, percentage, mean and standard deviation. The findings can contribute and play a significant role in developing new strategies by all stakeholders including the Ministry of Health and Education, to approach non adherence of contraceptive use amongst the young adult population in an innovative ways, and ultimately stem the tide against the high rate of youth pregnancies in the Outjo district.

Keywords: Adherence, contraceptives, young adults, youth, teenage pregnancy Namibia, Outjo district, quantitative descriptive survey

ACKNOWLEDGEMENTS

I would like to acknowledge and express my sincere thanks to **My Heavenly Father** through '**Jesus Christ**, for teaching me about faith and patience and granting me perseverance.

I wish to thank:

- My parents and the entire family for prayers and undeniable support
- My husband, Mr. Zacharias Biwa for being the witness of my progress
- My research supervisor (s) Emeritus Prof. Khalil, and Ms. Kajee for guidance, advices as well as inputs and critical review of my drafts. You have been a great source of encouragement, support and inspiration throughout this grueling process.
- Dr. Horn for statistical analysis and guidance during this project.
- Cape Peninsula University management, for the privilege and opportunity to complete the study at your institution
- The Outjo health district management through the Ministry of Health and Social Services for granting me special study leaves to pursue this study.
- The Outjo school principal, Mr. Hamutenya through the Ministry of Education for permission to conduct the study among the learners.
- The office of the Regional counselor, Mr. Job for permission facilitating entry into their setting to use non-learners participants
- The participants of this study, your insight and opinions were the most valuable discovery of this process.

To you all my sincere thanks and I wish you strength and success in all your endeavors. May you find people as caring and helpful to you as you have been to me?

DEDICATION

To my late grandmother (Monika Eva Katjau): Granny, your prayers, inspirations and wisdom are deeply missed and cherished. They say '*the greatest soul is the heart-* RIP.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
CDC	Center for Disease Control
CBS	Central Bureau of statistics
HIV	Human immunodeficiency virus
LAC	Legal Assistance Center
LDHS	Lesotho Demographic Health Survey
NPC	National Planning commissions
OYO	Ombetja Yehinga Organization
PRB	Population References Bureau
SADC	Southern African development Communities
STIs	Sexually transmitted infections
UN	United Nations
UNFPA	United Nation Family Planning Associations
UNICEF	United Nations Program on HIV/AIDS
USAIDS	United State Agency for international Development
MOHSS	Ministry of Health and Social Services
NDHS	Namibia Demographic Health Survey
NPC	National Planning Commission
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Acceptance of contraceptives	acceptance of contraceptives is a process of making use of contraceptives
Family planning services	service that empowers women and men to have access to methods of contraceptives of their choice as well as choice for regulation of fertility, and right to access the appropriate health care services
Reproductive health	physical, mental and social well being in all matters relating to the reproductive system at all stages of life
Sexual transmitted infections	contagious disease that occurs through sexual intercourse or genital contacts, for example gonorrhoea, syphilis, chancroid and HIV/AIDS
Young adult person	Aged between 18 to 24 years old

CHAPTER ONE: INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Chapter one provides an overview of background, problem statement, research question, the aim as well as the objectives of the study. Description of justification and rationale of the study is given. This Chapter also briefly describes the layout of structure of the thesis, as well as the conceptual framework.

1.2 BACKGROUND OF THE STUDY

The UN Millennium Project has called for a massive scale up and expansion of family planning, maternal health, and HIV/AIDS prevention efforts throughout the developing world by mobilizing political will, institutional capacity and technical and financial resources. Millennium Development Goals confirms that combating HIV/AIDS, promoting gender equality, improving maternal and child health, and fighting poverty are all greatly helped by improving the delivery of sexual and reproductive health services in developing nations (UN Millennium Project 2006:122).

Millions of women lack access to family planning services they need and want. The unmet need for contraception is especially acute among adolescents in the developing world, averaging two to four times that of the general population. 1 in 16 women in sub-Saharan Africa died from complications of pregnancy and childbirth. This compares with 1 in every 2,800 in highly-developed countries; and Providing safe, effective, voluntary family planning services prevents death and disability, spurs development, and fights poverty.

In order to meet the challenges with respect to reproductive health in both rural and urban areas of Namibia, we have to be innovative “in ensuring” access to a quality health or health support services (Sachs & McArthur 2005). Young adults are commonly regarded as a relatively healthy period in one’s life, with peaks in strength, fitness and many cognitive abilities. However, at this

stage there are also major shifts in health status takes place around puberty, as new health risks with potentially life-threatening consequences become evident (Patton & R. Viner 2007). Reproductive maturity brings about risks for sexually transmitted diseases including HIV and for women, particularly in low- to middle-income countries risks linked to pregnancy and child birth. Consequently, health profiles change rapidly from early adolescence to young adulthood (Patton et al. 2009). Promoting family planning in countries with high birth rates has the potential to reduce poverty. Furthermore, it would also contribute substantially to the empowerment of women (Cleland et al. 2006).

1.3 RESEARCH PROBLEM

A newspaper report maintained an alarming increase in the pregnancy rate of young adults especially in the north-western redistrict of Namibia (Smit 2011), (Bause 2011). No formal studies have been conducted to get an understanding of this phenomenon. The author of this study who has been working in the north-western part of Namibia, particular in the Outjo district for over of 20 years, has observed that many cultural and societal factors might be the leading causes to the low acceptance of contraceptive use among the young adults. According to Sun newspaper, article 2011 by Smit, *some youth in Namibia as young as 13 years are already sexually active and many have become pregnant at relatively early ages. Youth pregnancy rates in Namibia overall are very high and varies from 20% of 17-year-olds, 35% of 19-year-olds, and 57% of 20-year-olds that have borne a child (Smit 2011). It was also has been estimated that 60% of clients tested HIV/AIDS positive was aged less than 24 years.*

1.4 RESEARCH QUESTION

Does a cultural and societal pressure influence the non-adherence to contraceptive use amongst the young adults of the Outjo?

1.5 AIM

To assess factors that hinder young adults both male and female from utilizing contraceptives in the Outjo district in the Northern region of the Republic of Namibia.

1.6 OBJECTIVES

The objectives of this study were to:

- Explore personal factors that influence the decision to use contraceptives among young adult of the Outjo district.
- Examine socio-economic factors that influence young adult decision to use contraceptives.
- Determine pregnancy rate among young female adults recorded at antenatal clinic in the Outjo district.
- Examine sexual health education programs available in Namibia to educate young adults
- Make recommendations and suggestions towards the improvement of the contraceptives service in the Outjo district.

1.7 CONCEPTUAL MODEL

A conceptual model is a description of the phenomena of interest in terms of abstract (Burns & Grove 2007:534). The conceptual model which is developed to direct the planning and execution of the investigation, was based upon the theory of Bertrand model. The theory comprises three arms including access, quality care and barriers to services. Bertrand framework highlights issues related to accessibility of services, quality care and intervening factors affects individual decision to health care services. Corresponding with the Bertrand theory, the researcher adopted this model as the population under study, faces numerous challenges in accessing contraceptives services. Therefore the study was aimed to explore factors hinder the acceptance of contraceptives amongst the young adults in the Outjo district.

According to the 2009/2010 annual report of the Outjo district, there is a high teenage pregnancies rate (36%) among school goers. As no research has been performed in the Outjo district, it is difficult to ascertain about what influences there are on young people in that district. This is led to further exploration of access issues associated with contraceptives use in the Outjo district. Therefore, conceptual model below discussed barriers that ultimately could lead to poor use of contraceptives among the Outjo district youths (see figure 1.7).

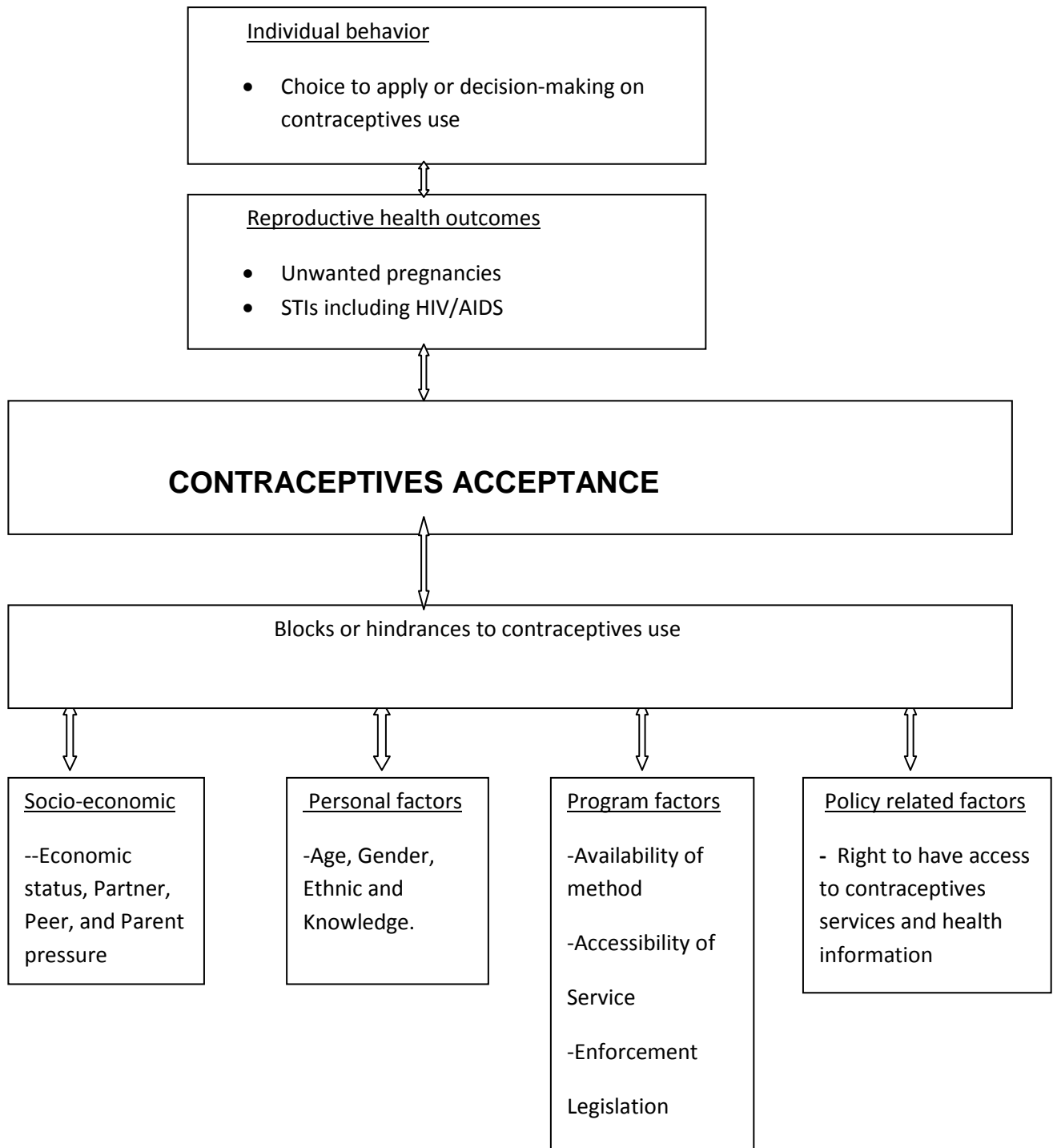


Figure 1.7: Conceptual model developed by writer

1.7.1 Discussion of framework

Individual's behavior represent the extent to which potential individual are taking decision or are constrained by attitudinal or societal factors in seeking contraceptives services. Therefore, in the context of the study, adoption of healthy behavior depends on the youth autonomy in decision-making and youth ability to apply choices in order to prevent unwanted pregnancies and STIs including HIV/AIDS.

The economic factor is the extent to which cost of reaching service delivery points or supply points and obtaining contraceptives within the economic means of large majority of the population can reach the services with an acceptable level of effort. Socio-economic barriers affect contraceptive use both by discouraging potential clients from seeking services and by making contraceptive continuation difficult. In addition, societal background such as partner values, peer group expectations as well as parenting also affecting young people orientations towards and views about sex and contraceptives use.

Personal factors appear to be a major hindrance to the uptake of contraceptives. In this setting, experiences of sexual relationships and contraceptives use differ according to age, gender, ethnic and knowledge. Knowledge in this context means how the contraception works and its benefits. In order for young people to adopt the contraceptives, they must first be aware how a contraceptive works and must have some understanding why they use it. Without adequate knowledge, youth will not really consider to use contraception's.

The programmatic factors represent the extent to which the contraceptives are provided. Many young people find most services as inaccessible, inappropriate, unfriendly, and judgmental as well as lacking in confidentiality. However, this is the major hindrance to the uptake of contraceptives among young people. Youth will be positively about the potential for using the contraceptives if services are more youth-friendly and accessible to them.

Policy related factors represent the extent to which rules and regulations inhibit freedom from contraceptive choice and use. As discussed in this chapter in line with the Children's Act, the

Namibian youth age of 18 years and above have the right to choose the state of their own reproductive health and have free access to contraceptive services. While the youth under the age of 18 years may not obtain contraceptives of their choice independently due to the restriction of the legislations and this may have direct or indirect impact on their contraceptives choice.

1.8 LAYOUT OF CHAPTERS

The layout of the study report has been presented in dimension form using chapters. In each chapter detailed description of activities has been made in accordance with the process conducted. The content of each chapter is presented below:

Chapter one: In this chapter, the research report has looked at introduction, background information to the problem, research problem, research question, aim, and objectives of the study. Others include the research design, and method, validity, ethical consideration, justification, and operational rationale of the study, description of the framework as well as the definition of the key concepts. **Chapter two:** This chapter presents the findings from the review of pertinent literature, discussing the issues facing the youth regarding their non-adherence to contraceptives from global, regional and local perspectives.

Chapter three: The chapter contains the methodology that the researcher used in the study and it includes the design, the population, sampling techniques and method of data collection. Measures that the researcher used to ensure validity and reliability have also been presented in this chapter. **Chapter four:** This chapter has outlined the research findings from data analysis. The presentation is in form of frequency tables, and graphs where applicable and results was discussed. **Chapter five:** Contains the conclusions and recommendations made from the study, some limitations experienced and bibliography. **Chapter six:** The contains the achievements of the study objectives

The following Chapter will focus on the Literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a review of the literature on the perceived factors that hinder the acceptance of contraceptives among the youth worldwide. To access contraceptives, young people have to feel uninhibited in utilizing health facilities where such services are offered. Furthermore, there may be certain psycho-social practices and beliefs which may influence the acceptability of contraceptive usage. The purpose of this chapter is to review the literature on the young adult's contraceptives, utilization from a Global, Africa and National (local) perspective. A brief overview of findings will be described under the following headings:

2.2 HISTORY AND DEMOGRAPHIC OF NAMIBIA

Namibia has an estimated population of 2.1 million people with an estimated annual growth rate of 3.6% and total fertility rate of 4.8 % (NDHS, 2006). Namibia has an overall young adult's population of 42 %, being less than 24 years of age (MOHSS, 2002a). The country covers total areas of 824 269 square kilometers, that is divided into thirteen (13) regions and districts (MOHSS, 2006a:2). Namibia is also a culturally diverse and multiethnic society, consisting twelve different ethnic groups including the San ethnic group, see appendices H (MOHSS, 2006a).

2.3 NAMIBIA HEALTH SERVICES

Namibia health care system consists of health care departments organized in a pyramidal pattern (MOHSS, 2006b). The National level is situated at the apex, followed by the regional on the second level and district level forming the base (MOHSS, 2006b). The National level sets policies and coordinates the health care activities (MOHSS, 2006b). IT monitors and evaluates the formulation of health care policies as well as formulates and implements the policies in the country (MOHSS, 2006b). The second hierarchy is the regional level, which is an intermediary

between national and district levels (MOHSS, 2006b). The regional level oversees implementation of health care policies at the district level, maintains quality standards, coordinates and controls the district health activities (MOHSS, 2006b). In addition, It monitors and supervisor, the district health management board which further supervise the operations of health activities at the district levels (MOHSS, 2006b). The district health services where Outjo district lies, is third in Namibia hierarchy of health care system delivery (MOHSS, 2006b). The district level in Namibia has the largest number of health facilities (MOHSS, 2006b). These include district hospitals, divisional health centers, dispensaries and health clinics (MOHSS, 2006b). All these health services act as treatment and referral centers (MOHSS, 2006b).

The major role player in the health sector is the government represented by the Ministry of Health and Social Services, private sector and non- governmental organization (MOHSS, 2004a). The government is the major financier and provider of health care services in Namibia (MOHSS, 2004a). Of the 1511 health facilities in Namibia, the government through the MOHSS controls and runs 1474 health facilities, while missions run twenty seven and private sector thirty four health facilities (MOHSS, 2004a). Public sector controls 4 referral hospitals, 30 district hospitals, 40 health centers, 260 clinics and 1150 outreach points (MOHSS, 2006b).

2.4 HISTORY OF FAMILY PLANNING IN NAMIBIA

In Namibia, reproductive health and rights of young adults have since ICPD 1995 gradually gained recognition (MOHSS, 2002). Efforts have been made to promote awareness creation and initiate programs targeting the young adults in Namibia (MOHSS, 2002). This was done through condom promotion programs aimed at reducing the rate of STIs including HIV/AIDS infections (MOHSS, 2002). Youth friendly clinics, reproductive health programs including contraceptives uses, voluntary counseling and testing centers (VCT) have been set up in all thirteen regions (MOHSS, 2002).

In Namibia, ninety percent of all public health facilities offer modern methods of family planning; however the availability of these services varies by facility type and region (MOHSS 2001).

Popular contraceptive methods are pills, injectables and condoms as well as counseling on periodic abstinence. Other methods such as IUCDs, ligation and vasectomy are used very rarely in public health centers as these methods require a higher level of skills and more developed infrastructures. Emergency contraception in Namibia is not considered as a family planning method but rather a back up means of preventing unintended pregnancy after unprotected sexual intercourse (MOHSS, 2001). This can be attributed to the fact that emergency contraception has until now been given only in rape cases (MOHSS 2000).

The access to contraceptives by young adults is a controversial topic in Namibia society. Currently there is confusion in the law and policy regarding the age at which youth may legally access contraceptives (MOHSS 2008). The Namibia government appears unwilling to give guidance on this specific aspect of the right to health (MOHSS 2008). This comment is illustrated by the fact that the Namibian government report does not discuss access to contraceptives despite the fact that Namibia has a high rate of pregnancy at a young age (MOHSS 2008). The question of the legal age for contraceptive use was also raised by the queries the Legal Assistance Centre (LAC) received during consultations on the Child Care and Protection Bill (MOHSS 2008). The public were asked at what age children should be permitted to independently access contraception? Many respond, "*From the age of 12 years*". The new Children Protection Bill still has to be amended accordingly (Gender research and advocacy project report 2008).

2.4.1 Types of services

The directorate manages contraceptive services in line with national policies through the district health system (MHOSS, 2002). Contraceptive service delivery points range from those at community level, mobile units, clinics and community health centers to district hospitals, and referral hospitals (MOHSS, 2002). The private sector contributes significantly to the provision of contraceptive services through the following main providers:

A total of 41 private general practitioners are practicing in Namibia (MOHSS, 2002). Of those, seven are gynecologists whom all providing contraceptive services and 34 urologists that perform male sterilization (MOHSS, 2002). Pharmacies in Namibia that sell condoms and spermicidal jellies over-the-counter, is number two hundred (MHOSS, 2002). Pharmacies with special permits also provide oral contraceptives without prescription but in accordance with strict criteria (MOHSS, 2002).

Traditional practitioners (almost 300) in Namibia provide advices and supply various traditional family planning practices to those seeking their services (MOHSS, 2002). Some national NGO's provide contraceptive services directly through their own clinics for example Namibia Planned Parenthood Association, Global, Nana so, and Red cross. The latter NGO's work closely with government on contraceptive policy-making, information, education, and services management and quality of care (MOHSS. 2002). The Namibia Women Council Association and the Youth Council work at a local level on contraceptive service provision specifically, and within a comprehensive primary health care framework (MOHSS, 2002). The Namibia Catholic churches promote and teach the use of methods based on fertility awareness (MOHSS, 2002).

2.5 NAMIBIA GOVERNMENT POLICIES ON FAMILY PLANNING

In 2006, the Namibian government declared teenage pregnancy as a national disaster and facilitated the development of several policies (MOHSS, 2008). These included the following policies:

2.5.1 Policy on Family planning

Child Care Act No. 33 of 1960 states that persons 18 years of age and older may consent to their own medical treatment, surgical procedures and family planning services without the assistance of parents or a guardian (Namibia constitution Of 1990/ MOHSS, 2008:61). In practical terms, this means that children 18 years of age and older can approach a clinic for sexual and reproductive health information and can be prescribed any form of medical

contraceptive without the assistance or knowledge of their parents (MOSS, 2008). Girls under the age of 18 years need the consent of their parents or guardians before being supplied with the pill or other prescription forms of contraceptive (MOHSS, 2008).

2.5.2 The Condom Policy and Strategy

The strategy was aimed at enhancing access to condoms by all sexually active Namibian young people at affordable prices (MOHSS, 2008). This policy identified youth-friendly condom distribution systems as key in increasing demand for and use of condoms (MOHSS, 2008). The Namibian government hoped to increase access to information especially to young adults on contraceptives, HIV/AIDS, cultural and social development during adolescence, biological changes, and how to respond appropriately to these transitions without endangering their lives or their reproductive health (MOHSS, 2008). The strategy emphasized development and adoption of appropriate behavior and avoidance of exposure to risks of infection (MOHSS, 2008).

In 2001, the government of Namibia facilitated the development of a young adult Reproductive Health and Development Policy (MOHSS, 2008). The policy was published in March 2001 and launched in November 2001 by the National Council for Population and Development, jointly with the Division of reproductive health of the Ministry of Health (MOHSS, 2004). Despite efforts by the government, Namibian young adults have poor access to youth-friendly health services (Indongo 2008). This poor access to reproductive health services is associated with high HIV/AIDS prevalence and teenage pregnancy rate (Indongo 2008). Also, despite the effectiveness of reproductive health services including contraceptives programs, these services may only benefit young adults aged 18 years and above due to restriction of reproductive health policy (MOHSS, November 2008).

2.5.3 Sterilization Act No. 44 of 1998

This act provides for the right to sterilization of any person over the age of 18 years if he/she is capable of consenting (MOHSS, 2002). The Act prohibits sterilization on any person capable of consenting without his/her consent and on any person under the age of 18 years except on medical request (MOHSS, 2002).

2.5.4 Policy Guidelines for Adolescent and Youth Health of 2001

The National Department of Health includes sexual and reproductive health among its six top health priorities for young adults (MOHSS, 2002). Key intervention strategies that relate to contraception include: promoting delayed childbearing, promoting marriage preparedness, facilitating easy, cheap and private access to all forms of contraception including emergency contraception and condoms, using multimedia methods to provide information to young adults and their families about sexual and health matters, building skills especially relevant for sexual health such as negotiating contraceptive use, providing sexuality, counseling, integrating sexual and reproductive health services (MOHSS, 2002).

2.5.5 Policy Guideline on Patient's Rights Charter

The National Department of Health directly upholds and promotes the right of access to health care (MOHSS, 2002). Other rights of particular relevance to contraceptive services that are contained in the Charter are:

Confidentiality and privacy of information concerning patient's health and treatment, choice of health services in the line with normal ethical standards and prescribed service s delivery guidelines, treatment by a named health care provider, and informed consent as well as decision-making on matters regarding their illness, diagnostic procedure, proposed treatment and cost involved (MOHSS, 2002).

Batho Pele (People First) of 1999 is the White Paper on transforming public service delivery, endorsed by the National Department of Public Service and Administration (MOHSS, 2002). The main purpose of the document is the establishment of a culture in which all State employees put the public or customers first and are accountable for the service they give (MOHSS, 2002). The framework consists of the following seven simple principles of public service delivery: consultation, service standards, courtesy, information, openness (transparency, responsiveness and value for money (MOHSS, 2002).

2.5.6 National Health Bill Policy, of 2000

The national health bill priorities maternal, child and women's health (MCWH) and includes the following policy intentions that:

MCWH services should be accessible to mothers, children, adolescents and women of all ages, with a focus on the rural and urban poor (Namibia Government, 2006a). These services should also be comprehensive and integrated (Namibia Government, 2006a). According to Namibia National Health Bill of 2000, women and men should be provided with services that enable them to achieve optimal reproductive and sexual health. Individuals, households and communities should have adequate knowledge and skills to promote positive behavior related to maternal, child and reproductive health (Namibia, Government 2006a).

2.6 FACTORS INFLUENCING USE OF CONTRACEPTIVES.

The socio-economic and demographic factors have important relations to the outcome of the rate of contraceptive usage (Stulhofer 2007. Details of previous studies related to these factors are presented below:

2.6.1 Socio-economic factors

Socio-economic factors such as parents, peers, partners and poverty play an important role in fertility and contraceptives decision making. These socio-economic factors are highly related to personal motivation in maintaining fertility, and to a lesser extent will lead to decision on contraceptive adoption (Stulhofer 2007).

2.6.1.1 Parents

In developing countries existing societal, cultural and external prohibitions affects the young adult's contraceptive use (Stulhofer et al. 2007). Parents, community and religious leaders are divided on issues pertaining to youth contraception and sexuality. Many societies in Sub-Saharan Africa openly reject sex education in schools (Stulhofer et al. 2007). Namibia has only as recently as 2009 permitted the teaching of sex education in schools.

A study amongst a low-income rural colored community in South Africa, found that parents inadvertently contributed to their youth limited sense of sexual agency and lack of contraceptives usage (Lesch and Kruger 2004). Parents presented to their young adult the view that sex was a dangerous activity. This attitude prompted many young adult to tell lies about their own sexual involvement in order to present the good teenage image and maintaining good relationship with their parents. Lesch and Kruger (2004) are of the opinion that this precluded the development of an open discussion between parent and teenager about sexual matters and contraception (Lesch & Kruger 2004).

Mufune (2005) found that in both rural and urban regions of Namibia, young adults do not feel comfortable about discussing sexual matters with their parents. Similarly, parents also feel a high degree of discomfort when discussing sexual matters with their offspring. They believe that, providing information to young adults will encourage an increased in sexual activity. In view of such challenges, many young adult enter into sexual relationship with insufficient insight into the consequences of sexual encounters and with very limited knowledge of protective measures. Consequently, it has contributed to a low prevalence of contraceptive use among young adult (Mufune 2005).

2.6.1.2 Peers

Economic status, and peer pressure have an effect on youth decision to use contraceptives. Youth viewed their peers as more approachable source for information than their parents (Mahmood 2005). Similarly, parents also feel a high degree of discomfort when discussing sexual matters with their children (Mahmood 2005). Such second hand information from peers has resulted in the spread of inaccurate information leading to early pregnancies (Mahmood 2005).

2.6.1.3 Partner pressure

Mufune (2005) found that most female young adults in Namibia are dating older partners for financial security. These place female young adults in vulnerable in situations over contraceptives decision making (Mufune 2005). Young adult boys in the Gauteng province were found not to negotiate any form of protection with their partners (Mfono 2008). The study also highlighted the fact that these young adult boys assumed the girls would use protection, as they regarded it as being a girl's responsibilities to protect herself (Mfono 2008).

2.6.1.4 Poverty

Poverty is another barrier to contraceptives use, and it is a very serious obstacle that needs to be changed. Even though youth obtained free treatment at the most reproductive health clinics and free contraceptives services, adolescents from a low socio-economic status might not have the assertiveness to request services and monetary capabilities to pay alternative providers (MacPhail & Campbell 2001; 1620).

2.6.2 PERSONAL FACTORS

Individual decision to contraceptives usage is influenced by demographic characteristics such as age, gender, ethnicity, and education (Butler 1994).

2.6.2.1 Age

In almost every country, a high proportion of 15-19 year olds compared to 20-49 year olds women reported experiencing contraceptive failure (Blanc 2009). The Author further stated that the mean age as early as 15 years has been found in high pregnancy and abortion rate. A South African national survey (2007) on contraceptive use and pregnancy among young women age 15 to 19 years old showed that 67.9% young women have been pregnant and 50% have used contraceptives (Macphail et al 2007). In Namibia teenagers age 16 years old who used only oral contraceptives at first intercourse were more likely to become pregnant than those reporting using condoms (Mfono 2008).

2.6.2.2 Gender

In many developed and developing countries including Namibia, men are the primary decision makers about sexual activity fertility and contraceptive use (Mufune, 2003). The reason for this is that in most African cultures, upon marriage, a man and his family pay *lobola* (dowry price) to the family of the bride ,on the day getting married, therefore men in this context do not usually favors contraceptives (Mufune, 2003). On the other hand, women's gender identities and societal status in many developing countries particularly in Sub-Saharan Africa play an important role (Namibia, Zambia, Malawi, Kenya, and South Africa). Women are tied to motherhood, and childlessness is highly stigmatized (Dyer,2007). It is also taboo in many traditions for women have sex before marriage and because of this most teenage women find it difficult to access to contraceptives to protect themselves from pregnancy and infections (Dyer 2007). Women are also taught from early childhood to be obedient and submissive to their husbands and most feel helpless to use contraception's even though they perceive the threat of unwanted pregnancies (Benefo, 2004). This resulted in many young women not accessing preventive measures due to negative effect of gender inequalities (CDC 2002).

In Guinea, young women had less knowledge about contraceptives compared to their male counterparts (Center for Disease Control (CDC), 2002). Girls and women in patriarchal societies may not be able to make decisions about contraceptives although they wish to. This resulted in many young women not accessing preventive measures due to negative effect of gender inequalities (CDC 2002).

2.6.2.3 Ethnicity/race

Ethnic background and standards are interrelated factors in shaping young people ideas and behaviors (Mufune 2005). According to the same Author, young people from different ethnic background might be influenced by different factors or by the same factors but in different extents that affects their decisions to use contraceptives.

In the RSA, Popis (2003:58) found that black adolescents engaged in risky relationship but ignored contraceptives that their white counterparts used. In Namibia, youth from ethnic minority are more likely to experience an unintended pregnancy than their non-minority counterparts; this might be due to the socio-economic pressures (Mufune, 2005).

2.6.2.4 Formal education

It must be stressed that in certain situations, the question of contraception may not arise as it suggest a certain social capacity to control the course of one's life (Mishra 2006). Education has an influence on perception, which in turn enables an individual to recognize and interpret events in the environment. Education may also contribute to an increase in accessibility to contraceptives use, and lack of knowledge may affect the contraceptive use. In contrast, those who know more have a greater chance to find the best method that appropriate for them. Research findings in Nepal (2006) have shown that poor education and misconception were important reasons for low use of family planning (Mishra, 2006). In India, lack of information was the major reason why women had no intention to use contraception in the future (Mishra 2006). A Zambian study of 2005 found that adolescents have limited education about reproduction and sexuality as well as contraceptives usage.

Lesotho Demographic Health Survey (LDHS 2004) report indicated that 71.2% of women age 15 to 45 years knew sex education during their secondary schools education, while 13.1% came to know about it through mass media and friends (LDHS 2004). Mufune (2005) found that sexually active young women in Namibia engage in sexual activity without adequate information about reproductive health and contraception.

2.6.3 THE AVAILABILITY OF FAMILY PLANNING PROGRAMS

Family planning programs in most developed and developing countries including Namibia contribute to the increase rate of contraceptive use and in turn the decrease of pregnancy rate. Currently, the focus of family planning programs has been shifted to service delivery measures such as accessibility and availability which are mainly related to the continuation of contraceptive use (Blanc 2009).

2.6.3.1 Preferred sites for contraceptives use

Contraceptive continuation over a sustained period of time is not always assured as discontinuation occurs for various reasons of failure; these include changes in the method of contraception, side effects or inconvenience of use. Currently young people can obtain contraceptive supplies and services from both, the government and at private sectors. There might be differences between government and private sources in terms of quality and cost. Perceptions that the quality of methods and services in private sources are better than government sources do exist (Hong et al 2006). This belief was found by research in Egypt; that the source of contraceptive supply and services was not significantly related to the quality of family planning at public health clinics (Hong et al 2006). In addition, decision on which source the person prefer to use is affected by availability, services quality and personal preferences (Steele 2003). The selection of a contraceptive service is affected by the socio-economic level of the person (Steele 2003). Since the cost of the family planning services in private sectors is higher, a person with low socio-economic status has higher rate of discontinuation if she or he receives family planning services from the private sectors (Kalmus 1996).

Evidence from Nigerian studies showed that most of respondents who used contraception procure it from private sources (Oyeadeniran et al 2005). Research in Morocco found that contraceptives discontinuation rates were higher among users in the private sectors (Steele 2003). However results of studies in Nepal and India revealed differed in that contraceptives discontinuation was higher in those who obtained their contraceptives from government sources than those who obtained from private source (Steele 2003).

2.6.3.2 Contraceptive methods of choice

In Namibia, condom use is higher among childless young women, while those with at least one living child use the injection (Mfono 2008). Among married young women, injection was the preferred method, with the male condom. Young women who live in the Northwest health directorate had a higher probability of 0.682 choosing male condoms than any other contraceptive method. In the northwest part of Namibia, traditional method was the preferred methods indicated by respondents ((Mfono 2008). About 30% of sexually active adolescents in Nigeria were using inject able contraceptives, 15% used oral contraceptives and 6.2% use condoms. Many relied on traditional methods such as periodic abstinence and coitus interruption (Tamire &Enqueselassie, 2007).

2.6.3.3 Sources for contraceptives information

Mosher (2005) finds it disconcerting that taking into consideration the reported high unwanted pregnancies among young people, the contraceptive education that is currently available to the youth's, appears to have limited or no effect on the decision's made by some young people regarding their reproductive health (Mosher 2005).

Exposure to mass media either from electronic media such as television, radio or print media such as newspapers or magazines allow young people to increase their knowledge of family planning and contraceptive methods that influenced their decision on contraceptive adoption (Hossain1996). Several studies suggested that young people who are regularly exposed to electronic media were less likely to report method-related problems or opposition to family planning as their main reason for not using contraceptives or stopping its use (Mishra 2006).

A study among Chinese college students that accessed sources for information on contraceptive use and reproductive health revealed that TV was a valuable source of information, although not easily accessible at college because of limited TV sets (USAID, 2003). Statistics from study conducted by the department of extension at the University of Home Science in California revealed that about 71.7% girls and 62.5% boys had health education on contraception through programs shown on TV's or advertised through the media (Hocklong et al

2003).

Other study regard the contraceptives and sexual risk behavior information among Swaziland adolescents, reported that 62% of respondents indicated that, the printed and broadcast media was their primary sources of information (Tamire & Enqueselassie, 2007). About 85.2% respondents in SA recommended more TV programs on prevention measures (Strydom, 2004:64). In Namibia, Mfono (2008) also found that 53% to 70% of youth listened family planning and reproductive health information through mass media, and radio was widely available in most of the respondent's homes.

2.7 YOUNG ADULTS ATTITUDES TOWARDS FAMILY PLANNING

The way different individuals perceive contraceptives could cause long lasting ways of responding to a particular method and their attitude can have an influence on how other people respond to a method of contraception (WHO 2004). If negative attitudes are developed about a particular method, then it becomes a challenge to effective contraceptive use (WHO 2004). Morrison (2000:187) reported that women in Thailand feared contraceptives because contraceptives were perceived to be causing weight gain, excessive vaginal bleeding and illness. When Thai men were interviewed about their perception of contraceptives, they stated that contraceptives lead to urethral infections (Morrison 2000:187).

Contraceptives in Namibia were regarded as making women weak and destroying men's libido (Mfono 2008). The pill was regarded as an unsafe method since women forget it and end up with unwanted pregnancies (Mfono 2008). In Gauteng Province of RSA, young adults viewed hormonal contraceptives as leading to weight gain and losing muscles tone (Mfono 98:185). Otoide Oronsage and Okonofua (2001:71-81) found that Nigerian women, perceived contraceptives as leading to infertility and injectable's causing frequents periods.

2.8 REPRODUCTIVE HEALTH OUTCOMES

Teenage pregnancies are one of the reproductive health outcomes facing Namibia (Smith 2011). A study among 17 to 24 year old women found that those who had been pregnant before, 72% had unwanted pregnancies (Smith 2011). The study indicated that 60 to 72% of

female school-attending learners were pregnant, with a third of the female learners having given births by 20 years of age (Smith 2011). The Author further postulates that the high rate of these teenage pregnancies was related to coercion sex.

The issue of teenage pregnancy in Namibia, is not adequately addressed or not openly discussed, therefore fellow youths have little opportunity and motivation to learn of the possible negative impact of such pregnancy on their lives (Smith 2011). Clarke (2005) stated that in SA teenage pregnancies is overwhelming. He is of the opinion that teenage mothers are less likely to go on welfare for financial support. Clarke's point of view is supported by the Health Statistics (2007) in SA which reflects the soaring number of pregnant teenagers. The Gauteng Province had the lowest proportion of teenage pregnancy (9.5%) compared to Mpumalanga Province, which had the highest proportion of 25.2% (South Africa Health Statistics 2007).

2.9 SUMMARY

Chapter 2 presents the findings from the literature review, providing an overview of contraceptives practices among young adults worldwide. From the foregoing literature review, it is evident that all over the world that, the young adults indulge in pre-marital sex at an early age. Despite the awareness of some of the risks, young adult's behavior is contrary. An increased interest in contraceptive services can be said to be an outcome of the control of teenage pregnancy rate. The area of the interest for different strategies and services is primarily focused on strategies to encourage and enable young adults to take responsibility for their sexual and reproductive behavior.

When considering the Namibian legislations and reproductive health policies that assuring the contraceptives rights of young people by means of service delivery still awaits adequate implementation. The statistical of unwanted teenage pregnancies is a strong indication of the inadequate access to reproductive health education and contraceptives means. Several other factors were highlighted, which could have impact on contraceptives decision of young people. Based on the evidence from different researchers, attitudes and perceptions towards contraceptives use is a challenge and this indicated the mere fact that contraceptives are freely available, does not imply that young people will use them effectively.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The Chapter 3 provides detailed description of the methodology applied in the study. The chapter outlines the study design, population and sampling, inclusion and exclusion criteria used. Data collection method is described including data management, data analysis and limitations as well as ethical considerations.

3.2 QUANTITATIVE RESEARCH APPROACH

Quantitative approach research is a process in which numerical data is used to obtain information and this approach consists of descriptive, correlation, experimental and quasi-experimental research (Brink 2008: 30). For this study, the researcher used descriptive survey and data was collected for four months.

3.3 STUDY DESIGN

A research design is a plan or blueprint of how one intends to conduct research (Mouton 2006:55). The design also includes the process that the researcher follows in operating the study. A descriptive survey through questionnaires was used with a primarily quantitative approach. The data was tabulated in numbers, characterized by the use of statistical analysis.

3.3.1 Descriptive survey

Descriptive survey research is the description and exploration of phenomena in real situations. Advantages of descriptive survey: This design enabled the researcher to generate new knowledge of the subject by describing characteristics of persons, situations and the frequency with which certain phenomena occur (De Vos &Fourie 2009:30). It also allows the use of the questionnaires to a large sample of the population and it is therefore intent on findings facts which relate to the field of the study, but has a disadvantage of low response rate. Descriptive survey design also probes more by allowing for an in-depth description and exploration of dimensions of the phenomena, including its manifestation and related factors (De Vos &Fourie,

2009:53). Therefore the researcher chosen this method in order to assess and explore factors that hinder young adults both male and females from utilizing contraceptives in the Outjo district in the northern region of the Republic of Namibia. This method was also used to develop and test the reliability and validity of an instrument.

3.3.2 Philosophy underpinning the design

This design describes the variables in order to answer the research question, and there is no intention of establishing a cause-effect relationship (Mouton, 2006:154). Descriptive research utilizes both quantitative and qualitative methods. Cuba (1990) identifies some reasons why the exploration of philosophy may be significant with particular reference to research design. knowledge of research philosophy will enable and assist the researcher to evaluate different methods as well as avoid inappropriate use and unnecessary work by identifying the limitations of particular approaches at an early stage. For the study, the researcher used questionnaire with closed and open-ended questions. To test the reliability and validity of the research instrument, the language used in the questionnaire was clear and well understood by the respondents. The respondents give honest responses as they were not prejudiced because of their responses and their names were not recorded on the questionnaire.

3.3.3 Advantages and disadvantages of the design

According to (Brink, 2006:111) the advantages of the method is that, it is less expensive, permits anonymity and may result in more honest responses. A disadvantage in this method is that it eliminates bias due to phrasing questions differently for different respondents (Brink, 2006:111). For the study, the advantage was that the researcher obtained data from large group of young adults. The questionnaire was clear and respondents were anonymous. It was easier and less expensive, not self-selecting process was done.

3.4 POPULATION AND SAMPLING

The empirical phase of any research begins with the identification of the population from which participants will be selected (Burns & Grove, 2007: 50). When selecting samples the quantitative researches develop a sampling plan that allows the researcher to generate the

results to broader groups. However, the researcher decides in advance how participants will be selected, as well as how many will be included in the study (Burns & Grove, 2007: 50).

3.4.1 Population

De Vos & Fouche' (2009:222) defines population as the total number of units from which data can potentially be collected. The population can be composed of people, animals, objects or events that meet certain criteria for inclusion in a given universe (Burns & Grove, 2007: 40). The population criteria establish the target population that is the entire set of cases about which the researcher would like to make generalizations and who meet the sampling criteria (Polit, 2010: 290). The target population once defined, it becomes the population of interest from whom the data can be collected (Parahoo, 2006:219).

The Outjo district population are accounted to 9 154 with fertility rate of 3.2 children per women (Namibian Government 2006b). About one-third of total populations are classified as young adults which are 3051(Namibian Government 2006b). All young adults were not part of the study due to age constraints. In Namibia, the age of consent to medical treatment and contraceptives is 18 years. This means that children under the age of 18 years must get permission from parent or guardian if they want contraceptives and testing. Therefore, the fewer than 18 years young adults were excluded from the study for that reasons.

3.4.2 Samples

Sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research study (Brink 2008:124). The sample for the current study consisted male and female young adults 18 to 24 years of age. The entire young adults of the Outjo district could not be included due to the age constraints. For this reason, the target sample was thus scaled down to the accessible age group of 18 to 24 year olds. This is the accessible sample that becomes the section of the participants the researcher accessed and from which the researcher obtained data.

3.4.3 Research sites/area

The Outjo district was the place where the research was conducted. The Outjo district was chosen as a suitable study area because it is one of the districts in Kunene region greatly affected by high teenage pregnancy rate. See Map of Namibia (figure 3.1) indicating regions and district as well as where Outjo district is situated.

Map of Namibia

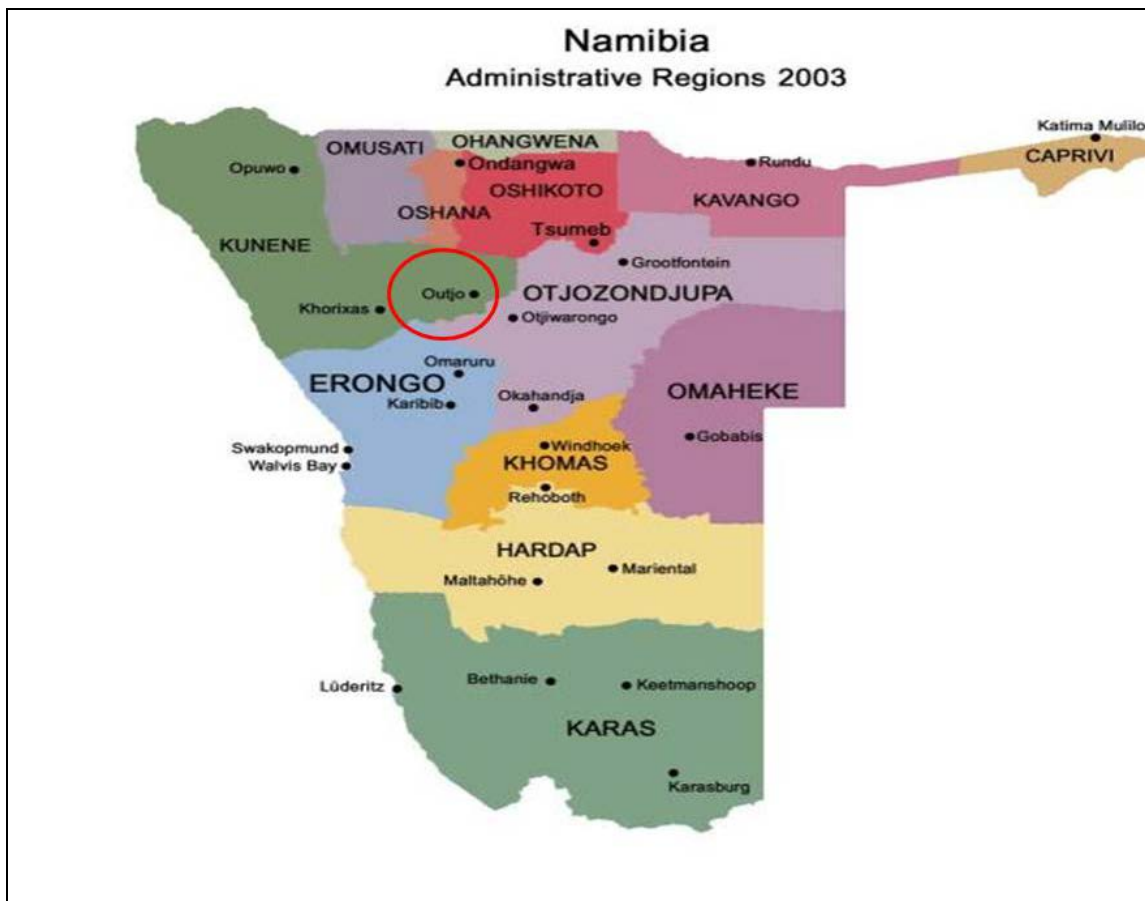


Figure 3.1 Namibia map showing the districts and regions
Source: MOHSS (2008b)

3.5 Inclusion and exclusion criteria

3.5.1 Inclusion

For the purpose of the current study, respondents had to meet the following sample eligible criteria (Inclusion):

- The respondents must be young adult between the ages of 18 to 24 years old.
- The respondents are either male or female residing in the Outjo district during data collection.
- The participants must be young adults who gave written consent.
- Young adults' participating voluntary.
- Young adults attending the Outjo high school and the youth establishment
- Young adults attending antenatal clinics in the district

3.5.2 Exclusion

- None residents of the Outjo district
- Persons above 24 years
- Persons under the age of 18 years

3.6 SAMPLING TECHNIQUE

In this study, a simple random and convenience sampling method was used. In convenience sampling, the subjects are convenient and accessible to the researcher (Brink 2006:132-133). The simple probability sampling elements are drawn in a random way from the sampling frame. (Brink 2008:127).The advantage of convenience sample, it is easier for the researcher to obtain subjects, and the disadvantage is that the risks of bias is greater because sample tend to be

self-selecting (Brink 2006:132-133). Therefore, to avoid this bias, the sampling was conducted by primary researcher and research assistants.

3.6.1 Participants

The subjects in this study were all young adults who were 18 to 24 year olds (both male and female) attended the Outjo high school and the youth establishment during the period of the survey was included equally and independently in the study. Although the study intended to obtain a representative sample of 354 populations, respondents were only 150 participants. Unforeseen circumstances such as yielded poor information and refusal to fill the questionnaire from some participants within the timeframe of data collection presented operational limitations. These unforeseen circumstances limited the expected sample size of participants. Only 150 participants completed the questionnaires, representing a response rate of 42% of which hundred ninety nine (199) non-learners did not fill the questionnaires (demanding government to employ them first before filling the questionnaires) and responses from five (5) participants had yielded poor information and were discarded

3.6.2 Sampling

All young adults 18 to 24 years of age attended the Outjo high school and youth establishment during the period of the survey formed a sampling frame. The sampling frame that is a list of all the units of the target population (Brink, 2006:124) consisted of a numbered of name list of all the young adults (learners and non-learners) in the Outjo district. The school principal identified and provided a list of all eligible learners attended to the Outjo high school at the time of survey to the researcher. To those non-learners who met the eligibility criteria at youth establishment center, the researcher made a list.

3.6.3 Research sites

The sites were the Outjo high school, the youth establishments and antenatal clinic through primary health care services at local hospital. This selected site was aimed to capture both school and non-school going young adults as well as was used to collect information from antenatal records. However, this was the only sites consented to be included in the study (see

appendices b, c and e, page: 83, 84 and 86). The school principal identified and provided a list of all eligible learners attended the Outjo high school at the time of survey to the researcher. To those non-learners who met the eligibility criteria at youth establishment center, the researcher made a list.

3.7 METHOD OF DATA COLLECTION

3.7.1 Questionnaire

A questionnaire is a tool that is used to collect data and elicits the same information from each respondent (Polit & Beck 2004:720-729). In this study, a validated questionnaire of Mc Millan was used and this questionnaire was based on the findings outline from the objectives of the study.

3.7.1.1 Advantages and disadvantages of questionnaire

De Vos & Fouche' (2009:141) describe advantages of questionnaires as follow:

The questionnaire is a quick way of obtaining data from a large group of people and it is less expensive in terms of time and money. The questionnaires are the easiest research instruments to test for reliability and validity. During data collection, the subjects feel a greater sense of anonymity and are more likely to provide honest answers. The format is standard for all subjects and is not dependent on mood of interviewer

The disadvantage of the questionnaire depends on personal reporting and may be biased the results (De Vos & Fouche, 2009:141).The disadvantages stated by De Vos & Fourie (2009:141) is as follow: Mailing of questionnaires may be expensive and the response rate may low. Respondents may fail to answer some of items. However some subjects are literate and the subjects who respond may not be representative of the population.

3.7.2 Official records

The secondary data used in the research study was official records. Records are data sources that are available to the researcher (Brink 2008:154-155). Types of records are hospital records, admission charts, incident reports, care plan statements, students test and examination results as well as sick leave records (Brink 2008:155). For the study, the records of antenatal clinic for 2010/2011 at the local hospital were retrospective analyzed for young female adults, 18 to 24 years. Permission to analyze the records was granted by the clinic supervisor through the Ministry of Health and Social Services (see appendix C page: 84).

3.7.2.1 Advantages and disadvantages of official records

According to Brink (2008:155) records constitute an economical source of information. Records permit an examination of trends over time, and they eliminate the need for the researcher to seek cooperation from participants (Brink 2008:155). The use of records may be exposed to many sources of error (Brink 2008:155). The records may contain institutional biases. Facts may be distorted, and some facts may be omitted. Record-keeping may be erratic, the collection of data may have been stopped for political reasons and some data are not readily available owing to their confidentiality nature

3.8 Selection of instrument

According to Brink (2008:143), there are various data-collection instruments. The ones used most frequently by health care professionals are observation, self-report and physical methods (Brink 2008:143). Observation is a technique used by researcher to observe behavior as it occurs and physical method is used to measure values (Brink 2008:143). Among the most familiar are blood pressure values, blood values, urine values and electrocardiograms. Self-report instruments include questionnaires, scales and interviews (Brink 2008:146). Other instruments such as clinical records and critical incidents are used to collect data through scientific investigations (Brink 2008:154).

For the purpose of this study a validated questionnaire of Mc Millan (appendix H, page; 97-106) and clinical records was used. The questionnaire comprised of mainly closed-ended questions, requiring the study participants to comment retrospectively about their personal and socio-

economic influences. The questionnaire also contained one open-ended question, enabling participants to add further information and offer any suggestions or recommendations. The questionnaire was provided in English (see appendix H page; 97). Additionally, data information from antenatal records through antenatal clinic at local hospital (the only antenatal clinic in the Outjo district) was collected.

Table 3.8: relationships between objectives, questionnaire content and information required:

Objective	Questions	Required information
To explore personal factors influences the decision to contraceptives use	Indicate age, gender, and ethnic groups (see question1, 2, and 3 in appendix H page: 97-106).	Information's required are the age, gender, and ethnic groups.
To examine socio-economic factors influence young-adults decision to contraceptives use	Indicate formal education (see question 4 in appendix H page: 97).	The formal education of participants
To examine sexual health education programs available in Namibia to educate the young adults	<p>Indicate the preferred sources as well as the access points for contraceptive services (questions: 13 and15).</p> <p>Indicate sexual experiences and whether participants did have sexual education before first sexual intercourse and if did, do they considered using contraception (questions 5, 6 and 7).</p> <p>Indicate whether such contraceptives information received did influence their choices for practicing safer sex (question18).</p> <p>Indicate their reasons why they use contraceptives, how often and to indicate their contraceptive methods of choice (question: 9, 10 and 11).</p> <p>Indicate factors prevented obtaining freely contraceptives in the Outjo district (appendix:</p>	<p>Access points to contraceptive services and, information regarding contraceptives use.</p> <p>Information towards sexual intercourse experiences of participants.</p> <p>Perceived standard of the health education received by the participants.</p> <p>Contraceptives methods of choices, several reasons of contraceptives use as well as issues concerning the use of contraceptives.</p> <p>Factors preventing the uptake of contraceptives services in the Outjo district.</p>

	H, page: 97 to 106,question 16	
To make recommendations towards the improvements of contraceptives services in the Outjo district.	Give any recommendations or suggestions regarding the contraceptives services in the Outjo district (question 19).	Suggestions as well as recommendations concerning the contraceptives services in the Outjo district.

3.9 PROCESS OF DATA COLLECTION

The data for this study was collected during the 3rd school term (October 2012 to January 2013), and data collection was completed over four months periods. The data collection team was the school health nurse, community counselor and the researcher. The questionnaire was distributed to study participants who voluntary consented to participate in the study. The purpose and the aim of the study were explained to the participants. Confidentiality and privacy was ensure by the consent form and the area the study participants have been completed. The study participant's at school were allowed to complete the questionnaire in privacy and independently in the school hall while non-learners, at the youth establishment center in the location. The participants were given as much time as they needed to complete the questionnaire. Some participants took almost 20 minutes to complete the questionnaire.

3.10 Data management

The completed questionnaires were collected by the recruitment team (school nurse, community counselor and researcher) on the same day which the questionnaire was stored secured in a safe lock by the researcher. The researcher was the sole person to access the raw data. The records of antenatal clinic for 2010/2011 were accessed retrospective for young female adults, 18 to 24 years. Permission to use records was granted by the clinic supervisor through the Ministry of Health and Social Services (see appendix C, page: 84). To ensure anonymity and confidentiality, no names was noted on the questionnaires, even no reference was made to participant's names.

3.11 PROCESS OF DATA ANALYSIS

The data collected through data analysis is systematically organized, summarized, evaluated and are interpreted (Fisher & Yates 2004:451). Data analysis is the technique used to reduce,

organize and give meaning to data (Burns & Grove, 2007:536). The data analysis in this study was done through descriptive statistics. The Social Sciences Package (SPSS/PC) version 19.0 a statistical computer software package was used to capture responses. The data was analyzed separately and responses were grouped per question. In order to promote consistency or divergence of information obtained, a detailed summary of the information identified was presented in frequency tables and percentages. Nominal variables were cross-tabulated to other variables by means of contingency tables. The chi-square test was used to measure the strength of the relationship between variables.

A thematic approach was used to analyze the qualitative data yielded in response to the open-ended question. During the interpretation of the data from this section, the researcher searched for emerging themes and trends within all the issues, as defined by Burns and Grove (2007:540), in order to identify all the issues raised by the participants. To strengthen the investigation, the qualitative data, within the identified themes, was quantified based on the approach developed by Culp & Pilat (1998). Emerging response categories were identified by topical analyses and then alphabetically organized (Culp & Pilat). The data obtained in this way could then be entered as quantitative data (number of suggestions in each category counted), and subjected to descriptive analysis. The results and findings of the study will be presented in Chapter: 4.

3.12 ETHICAL CONSIDERATION AND FORMAL PROCEDURES

Ethical clearance and approval to conduct the research among young adult in Namibia was obtained from the Ministry of Health and Ministry of Education (see appendix B and C). Ethical clearance and approval to conduct this research was obtained from Research Ethical Committee (REC) at the Cape Peninsula University of Technology (CPUT) (see appendix: A, page: 82). The following specific considerations were safeguarded prior to, and during the study:

3.12.1 Anonymity

In terms of protection of the identities, participants were instructed not to write anything on the questionnaire that could link them to the questionnaire such as their names and surnames, and

it was also explained that all participants would be remain anonymous. None of the questionnaires were tagged or numbered (Appendices H, page: 97 to 106).

3.12.2 Beneficence and Non-maleficence

By adopting sound ethical principles and scientific methods, the researcher should protect the participants from physical, psychological harm and exploitation (Polit & Beck, 2010:102). Appropriate arrangements were made with the Psychologist employed by the Ministry of Health, to provide sufficient support to the study participants, in case any of them experience emotional distress by recalling stressful events during the research process (appendix: D, page: 85).

3.12.3 Confidentiality

Burns and Grove (2004:204) define confidentiality as the researcher's management of the private information disclosed by the participant. In this study, confidentiality was maintained. The study, including all relevant data collection was conducted in the privacy of the participants. The questionnaires were anonymous, with no personal or study site identifying details being recorded. The questionnaires were completed under exam conditions. The respondents were informed prior to participating in the study that the data collected would be used only for the purpose for which it had been approved and collected (Appendices G, page:90).

3.12.4 Justice

The principle of justice includes the respondent's rights to fair selection and privacy (Polit & Beck, 2010:33). In this study the selection of sample was conducted according to eligible criteria. Privacy was a condition where private information was kept from others (Polit & Beck, 2010:33).

3.12.5 Risks and benefits of the study

Risks and benefits of the study was explained to participants and included in the informed consent that each participant signed (see appendix G, page: 90).

3.12.6 Referral

Although there were arrangements made for Psychologist to see participants in case of emotional distress, no referral was done during the data collection process.

3.12.7 Informed consent

Polit & Beck (2010:93) suggests that informed consent forces a researcher to give participants adequate information regarding the research process. Polit & Beck (2010:93) further states that all participants should have the power of free choice and the researcher should enable the participants to consent voluntarily in the research or decline participation. Therefore, the nature of the study including its purpose and the intended data collection methods was explained to the participants before the study starts. The participants were free to choose whether they wished to consent to, or to decline participating in the study as well as to withdraw from the study unconditionally. Written consent was obtained from each participant after they had received an explanation of the study purpose and methodology (see appendix: G, page: 90). The consent forms and the questionnaires were completed under examination conditions, with each person having access to their own information. On completion, the forms and questionnaires were stored separately at the researcher house.

3.13 CONSTRAINTS AND LIMITATIONS DURING DATA COLLECTION PHASE

According to Burns & Grove (2007:39) limitations are restrictions or problems in a study that may decrease the generalisability of the findings. Although it is assumed that the respondents must be objective and truthful in their responses, this might not be so, for the mere fact that the respondents know that they are under study, they might give responses to questions in a manner which they perceived as being more polite and not really as they felt about or perceived them or they might give answers they thought the researcher expected.

Since the study population was limited to the Outjo district young adults' age 18 to 24 years, the sample was small and homogenous. Young adults younger than 18 years and above 24 years were not part of the study. However, the inclusion of more learners did have some effect on the

results, and had increased the sample size that provided a larger variety of responses compare to their counterparts. Although the sample represented a diverse section of socio-economic and cultural background, generalizing the results could be argued as unreasonable due to the sample size. During the study, several unforeseen circumstances presented operational limitations. Within the timeframe of data collection, many young adults refused to participate and some yielded poor information. Such incidence led the researcher and research assistants having to visit and revisit the school and youth establishment premises in order to include more participants in the study. Thus however limited the expected sample size of participants and delayed data analysis process.

3.14 SUMMARY

Chapter 3 presented an in-depth account of the methodology used in the study. The methodology consisted of a quantitative, descriptive research design. Simple probability with convenience sampling method was used. Sample size used in the study was 150 participants, constituting 42.3% of the study population instead of 354 respondents initially anticipated. After the written consent, the study participants completed the questionnaire in privacy. The data from the completed questionnaires was captured electronically by means of Microsoft Excel, and validated for accuracy by the researcher. The quantitative data were analyzed with the use of the statistical programme, SPSS a computer soft ware, by the assistance of a statistician. The Chapter included a discussion of the key ethical issues taken into consideration prior to, during and following the study.

The questionnaire was also modified in response to suggestions offered by the study supervisors Prof Khalil, and Ms Faiza, in regards to simplifying the questions and structure of the questionnaire. The questionnaire comprised closed and open-ended questions (Appendix: H, page: 103-106). The use of close-ended questionnaire had offered respondents a set of mutually exclusive and jointly exhaustive response options, from which the one most closely approximating the right answer must

CHAPTER 4: RESULTS

4.1 INTRODUCTION

Chapter 4 presents and interprets the results of the analyzed study data obtained among the sampled young adults. The study was primarily quantitative and descriptive in nature. Accordingly, the focus of the analysis was more on descriptive statistics, including frequency and tables. A thematic approach was used to analyze the qualitative data yielded in response to the open-ended question. The results of this study were based on the responses that were obtained from the 150 respondents completed the questionnaires and was categorically divided into the five study objectives.

4.2 Objective 1: To explore personal factors influence decision to contraceptive use among young adults.

4.2.1 Demographic information

The information relating to the demographic distribution of the study sample in terms of age, gender, ethnic and level of educational of the participants was gathered. The demographic information was selected to address the objective of the study.

4.2.1.1 Age group

The respondent's age range included in the study was from 18 to 24years. Only 149(99.3%) respondents answered this question and 1(1.3%) non-response. From the table 4.2a, there is no significant difference among the age group ($p=0.317$) that explains sexually activity.

Table 4.2a relationship between sexuality and age group

Age (years)	Sexually active		
	Yes N (%)	No N (%)	Total
18	48(32.0)	19(12.6)	67
19	37(24.6)	10(6.6)	47
20	22(14.6)	4(2.6)	26
21	3(2.0)	0	3
22	1(1.3)	0	1
23	4(2.6)	0	4
24	1(1.3)	0	1
Non-response	1(1.3)	0	1
Total	117(78.0)	33(22.0)	150

$\chi^2 = 7.034$ df= 6 P-value=0.317

4.2.1.2 Gender

Of the 150(100.0%) respondents, 84(56.0%) respondents was females whereas 66(44.0) were accounted for males. There is no significant difference (p-value=0.823) between genders that explains the sexual activity

Table 4.2b Relationships between sexually active and gender

Gender	Sexually Active		
	Yes N (%)	No N (%)	Total
Male	53(35.3)	13(8.6)	66
Female	64(42.6)	20(13.3)	84
Total	117(78.0)	33(22.0)	150

Chi-square=0.364 df=1 P-value=0.823

4.2.1.3 Ethnic groups

Out of 150 respondents, 74(49.3%) was Damara in race. The majority of the Damara ethnic group was female with 45(53.6) compare to males of 29(43.6%). The Herero tribe was the second large group in the study with 46(30.7%) respondents. 25(16.6) vs. 21(14.0). The remaining ethnic groups are illustrated in table 4.2c. The association is not statistically significant (p-value=0.123) in all ethnic groups.

Table: 4.2c Relationship between sexually active and ethnic groups

Ethnic groups	Sexually active		
	Yes N (%)	No N (%)	Total
Vambo	10(6.6)	13(8.6)	23
Herero	25(16.6)	21(16.6)	46
Damara	29(19.3)	45 (30.0)	74
Kavango	0	3 (0.7)	3
Caprivi	1(0.7)	0	1
Colored	0	1 (0.7)	1
Other	1(0.7)	1(0.7)	2
Total	66(44.0)	84(56.0)	150

$\chi^2=10.020$ $df=6$ $P\text{-value}=0.123$

4.3 Objective 2: To examine socio-economic factors influences the decision to use contraceptive among young adults.

4.3.1 Education level

In the current study, the greater proportion of respondents was learners with 90(60.0%) while non-learners were only 60(40.0%). There is a significant difference ($p\text{-value}=0.031$) between learners and non-learners and deviation of 1.219. Sexually active learners were 46(30.6) while 20(13.3) were expected to be not sexually active. Of 44(29.3) non-learners were sexually active while 40(26.6) was expected to be not sexually active.

Table 4.3a relationships between sexually active and educational level

Formal education	Sexually active		Total
	Yes N (%)	NO N (%)	
Learners	46(30.6)	20(13.3)	66(44.0)
Non-learners	44(29.3)	40(26.6)	84(56.0)
Total	90(60.0)	60(40.0)	150(100.0)

$\chi^2=4.617$ $df=1$ $P\text{-value}=0.031$ $deviation=1.219$

4.4 Objective 3 - To determine pregnancy rate among young female adults recorded at antenatal clinic over specific period of 2010 to 2011 at Outjo state hospital.

4.4.1 Antenatal records of 2010 to 2011

Findings from antenatal records of 2010 to 2011 indicated that pregnant females aged 18 to 24 years were 493 in total. Of those pregnancies, 467 (94.7%) resulted in a live births, 11 (2.2%) abortions while 15 (3.0%) was still births. Of 93 (18.8%) female young adults become pregnant at the age of 18 years which is significantly higher percentages than other. See table below

Table: 4.4a Age versus pregnancy rate

Age	Pregnancy rate N (%)
18	93 (18.8)
19	68 (13.7)
20	89 (18.0)
21	63 (12.7)
22	52 (10.5)
23	51 (10.3)
24	77 (15.6)
Total	493 (100.0)

4.4.2 Pregnancy rate according to the ethnic groups

Teen pregnancy rate for Damara ethnic group age 18 to 24 years was two times higher than the rate of other races of the same age group with 319 (64.7%), followed by Ovambo ethnic group with 83 (16.8%), Herero 53 (10.7%), Kavango 23 (4.6%), Colored 4 (0.8%), Caprivi 4 (0.8%) white 2 (0.4%), and least was Omuzemba and Tswana ethnic group with 1 (0.2%) each. See table 4.4b

Table 4.4b Ethnic group versus pregnancy rate

Ethnic groups	Pregnancy rate N (%)
Damara	31 (64.7)
Vambo	83 (16.8)
Herero	53 (10.7)
Kavango	23 (4.6)
Colored	4(0.8)
Caprivi	4 (0.8)
White	3 (0.6)
Zemba	2 (0.4)
Tswana	2 (0.4)
Total	493 (100.0)

4.5 Objective 4- To examine sexual health education programs available in Namibia

4.5.1 Sex health education in schools

Of the 150(100.0) respondents who did have formal education, 131 (87.3%) indicated that they had received sex health education in schools, while 19 (12.6 %) respondents received no sex health education prior to their sexual debut. There is no statically signification (p-value=0.444) between those who received sexual education in schools then those who did not.

Table 4.5a relationship between sexuality and sex health education

Variables	Sexually active		
	Yes (N)	No (%)	Total
Yes	62(41.3)	69(46.0)	131
No	4 (2.6)	15(10.0)	19
Total	66(43.9)	84(56.0)	150

$\chi^2=0.585$ $df= 1$ $P\text{-value}=0.444$

4.5.2 The impact of contraceptives and HIV/AIDS information

There is a significant association between impact of contraceptives and HIV/AIDS information and sexually activity (p-value=), with a deviation of 3.876.

Table 4.5b relationship between sexuality and impact of contraceptives and HIV/AIDS information

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Never	20 (13.3)	38 (25.3)	58
Sometimes	8 (5.3)	4 (2.6)	12

Mostly	10 (6.6)	9 (6.0)	19
Always	38 (25.3)	23 (15.3)	61
Total	76 (50.6)	74 (49.3)	150

$\chi^2= 5.594$ $df=1$ $P\text{-value}=0.018$ $deviation= 3.876$

4.5.3 Reasons for contraceptives usage

As summarized in table 4.5c, the participants indicated their individual reasons for contraceptives use. The main reason for contraceptives use was the prevention of HIV/AIDS with 114(76.0%) followed by prevention of pregnancy (n=86, 57.3). There is no significant association between the reasons for contraceptives use ($p\text{-value}=2.291$) and sexual activity.

Table 4.5c Association between sexually active and reasons for contraceptives use

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Reasons for contraceptives usage			
Pregnancy prevention	86(57.3)	64(42.6)	150
HIV/AIDS prevention	114(76.0)	36(24.0)	150
Partner request	15 (10.0)	135(90.0)	150
I was taught to do it	31(20.7)	119(79.3)	150
Other	3(2.0)	147(98.0)	150
Total	114(76.0)	36(24.0)	150

$\chi^2=2.291$ $df=4$ $p\text{-value}=0.682$

4.5.4 Contraceptives methods of choice

The respondents were questioned about the type of contraceptives method of choice and they could select more than one response (appendix H: page: 83). From the table4.5d, the most commonly used method were condom with 92(61.3), followed by abstinence (n=26, 17.3%). The

least used methods indicated in table below was pill 5(3.3) and pill +condom combination 5(3.3%). There were no significant difference (p-value=0.131) between contraceptive method of choice and sexuality.

Table 4.5d Relationship between contraceptives method of choice and sexuality

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Condoms	92(61.3)	58(38.7)	150
Two/three month injection	16(10.7)	134(89.3)	150
Pill	5(3.3)	145(96.7)	150
Injection plus condom combination	25(16.7)	125(83.3)	150
Pill plus condom combination	5(3.3)	145(96.7)	150
Abstinence	26(17.3)	124(82.7)	150
Other	9(6.0)	141(94.0)	150

$\chi^2=5.615$ $df=3$ $P\text{-value}=0.131$

4.5.5 Frequency of contraceptives use among young adults

As indicated in table 4.5d, nearly two thirds 92(61.3%) used always contraceptives with every sexual intercourse. Of 33(22.0), indicated that they use contraceptives on occasions, while partner requested 4(2.7%) and access to it 5(3.3%) respondents had the least decision in contraceptives usage (see table below. The association was not statistically significant between (p-value=3.381) the frequency of contraceptive usage and sexual activity.

Table 4.5e relationship between frequency of contraceptive use and sexually active

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Occasionally	14(9.3)	19(12.6)	33
On request	3(2.0)	1(0.6)	4
When my partner and I have access	2(1.3)	3(2.0)	5
Always	47(31.3)	45(30.0)	92
Others	0	1(0.6)	1
No responses	0	15(10.0)	15
Total	66(44.0)	84(56.0)	150

$\chi^2=5.136$ $df=4$ $P\text{-value}=3.381$

4.5.6 Frequent sites for accessing contraceptives by young adults

Table 4.5g shows where respondents regularly accessed contraceptives the most and they indicated more than one response (appendix H: 14:84). The majority accessed contraceptives by means of public health clinics 86(57.3%), whereas 55(36.6%) buy at pharmacy, 18(12.0) relied on friends, 16(10.6%) accessed at private sectors, 9(6.0%) partner supplied it, while other, 5(3.3%), was unspecified. There is no significant association (p-value 0.562) between sites for obtaining contraceptives and sexuality.

Table 4.5f Association between sexuality and frequent sites for accessing contraceptives

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Frequents accessed sites for contraceptive use			
Public health clinic	86(57.3)	64 (42.7)	150
From private sector	17 (11.3)	133 (88.7)	150
From pharmacy	56 (37.3)	94 (62.7)	150
Friends	20 (13.3)	130 (86.7)	150
Partner request	10 (6.7)	140 (93.3)	150
Other	6 (4.0)	144 (96.0)	150

$\chi^2=4.857$ $df=6$ $P\text{-value}=0.562$

4.5.7 Preferred sites for obtaining contraceptives

Participants were given choices to choose a suitable point that they would have liked for accessing contraceptives as well as could selected more than one response (appendix H:15: 84). The majority 103 (68.7%) of respondents indicated public health clinics as their suitable points to obtain contraceptives, followed by other sources not indicated (n=33,22.0%), school nurse accounted to 22 (15.3%) and 10 (6.7%) proposed school -in class as their suitable point for contraceptives. There is no significant association (p-value 0.845) between preferred sites and sexuality.

Table 4.5 g: relationship between preferred sites and sexually active

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Preferred sites for obtaining contraceptives			
Public health clinics	103 (68.7)	47 (31.3)	150
School-in class	10 (6.7)	140 (93.3)	150
School nurse	23 (15.3)	127 (84.7)	150
Other	33 (22.0)	127 (84.7)	150

$\chi^2 = 0.815$ $df=3$ $P\text{-value}=0.845$

4.5.8 Factors hindering access to contraceptives use

The respondents who did not use contraceptives due to peer pressure was 18(12.0%) in total. Of the total respondents who have not access to contraceptives due to school pressure was 8(5.3) Community judgment in both sexually active and not sexually active was 21(14.0). The parent judgment was the second main factor hinders the use of contraceptives. Of 17 (11.3) respondents reported partner prevention. From those 17respondents, 6(4.0) was sexually active and 11(7.3) was not sexually active.

The distances to the health clinics were the main factor cited by the respondents with 87(58.0). Nine respondents indicated lack of enough contraceptives. Other factors than not specified in the table, were13 (8.7), of those respondents, 1(0.6) was sexually active while 12(8.0) was not sexually active. There is a significant association (p-value 0.086) between factors hinders the access to contraceptives use versus sexually active and not sexually active youth with a deviation of 3.665.

Table 4.5h Association between sexuality and factors hindering access to contraceptives use

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Peer pressure	18 (12.0)	132 (88.0)	150
School pressure	8 (5.3)	142 (94.7)	150
Community judgment	21 (14.0)	129 (86.0)	150
Parent judgment	28 (18.7)	122 (81.3)	150
Partner preventing	17 (11.3)	133 (88.7)	150
Bad attitudes of nursing staff	26 (17.3)	124 (82.7)	150
Distances to health clinics	87 (58.0)	63 (42.0)	150
Lack of enough contraceptives	9 (6.0)	141 (91.0)	150
Others	13 (8.7)	137 (91.0)	150

$\chi^2 = 13.826$ $df = 8$ $P\text{-value} = 0.086$ $deviation = 3.665$

4.5.9 Reasons for not using contraceptives

Of 145 (96.7%) respondents indicated reasons for not using contraceptives. As tabulated in table 4.5i, did not have access to it was the highest with 53(35.3), followed by other reasons than that was not indicated with 27(18.0), condom reduces sexual sensations 18(12.0), not aware of advantages 18 (12.0), partner pressure 17 (11.3%) while peer pressure was only 12 (8.0%). From other reasons than not indicated, was 27(18.0). The results show that there are no significant ($p\text{-value} = 0.846$) differences between reasons for contraceptives use and sexuality.

Table 4.5i Association between sexuality and reasons for not using contraceptives

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Not aware of advantages	7(4.6)	11(7.3)	18
No access to it	26(17.3)	27(18.0)	53
Peer pressure	5 (3.3)	7(4.6)	12
Partner pressure	5(3.3)	12(8.0)	17
Condom reduces sexual sensation	11(7.3)	7(4.6)	18
Other	6(4.0)	21(14.0)	27
Non-response	0	5(3.3)	5
Total	60((40.0)	90(60.0)	150

$\chi^2=2.017$ $df=5$ $p\text{-value}=0.846$

4.5.10 Availability of contraceptive services

Respondents were asked whether the contraceptives listed in table below (table 4.5L) were freely accessible to them or not. The majority 27(84.7%) reported that their access to contraceptives was freely without any cost involved, while 15(10.0) said it was not freely. There is significant association ($p\text{-value}$ 0.018) between availability of contraceptives services and sexuality. Between those who indicated availability of services and those who said the services is not freely available and not sexually active there is a deviation of 3.876.

Table 4.5j relationships between availability of contraceptives and sexuality

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
Availability			
Yes	127 (84.7)	8 (5.3)	135
No	15 (10.0)	0	15
Total	142 (94.7)	8 (5.3)	150

$\chi^2=5.594$ $df=1$ $P\text{-value}=0.018$ deviation=3.876

4.5.11 Sources for contraceptive information

In table 4.5i, the respondents were asked whom they would have preferred to provide information about contraceptives. This question allowed respondents to choose more than one answer. 39(26.0%) indicated public clinic, 61(40.7%) respondents required more information from parents, school teacher 21(14.0%), from another sources than that what was not indicated in the table was 17(11.3%) and school nurse with 12(8.0%). There is a highly significant association ($p\text{-value}=0.005$) between sources for contraceptive information and sexuality. Of those who receiving contraceptives from indicated sources and are not sexually active, there is a deviation of 4.152.

Table 4.5k Association between sexuality and source for contraceptives information

Variables	Sexually active		
	Yes N (%)	No N (%)	Total
By Parent at home	27 (18.8)	34 (22.6)	61
Public health clinics	13(8.6)	26(17.3)	39
School teacher	9(6.0)	12(8.0)	21
School nurse	5(3.3)	7(4.6)	12
Others	12(18.0)	5(3.3)	17
Total	66 (44.0)	84 (56.0)	150

$\chi^2=14.687$ $df=4$ $P\text{-value}=0.005$ $deviation=4.152$

4.6 Objective 5: To make recommendations towards the improvement of contraceptive services in the Outjo district.

The study yielded several recommendations and suggestions, grounded in the empirical findings, towards the improvements of the contraceptive services. The recommendations were identified by the study participants and thus specific to the needs of young adults in the Outjo district. This recommendations and suggestions discussed in section 4.6.

4.6.1 Suggestion for school-based contraceptives health education.

Of 18.1% respondents suggested contraceptives health education and counseling services within the schooling system, means a subject period to be dedicated. Some suggestions were made regarding the need for more intensive training to the teachers and school nurses, so that they can provide correct and accurate information, ability to talk openly and to apply good counseling services to the youth in the Outjo district. Further they suggested separated guidance and counseling offices at school to ensure privacy. They noted that they feel uncomfortable to talk to their guidance and counseling teachers in the staff room in the presence of other teachers. They further requested regularly school visits by health care providers. The views of respondents regarding the contraceptives education at school is presented in table below.

Table: 4.6a Suggestion for school-based contraceptives health education

Contraceptives health education programs in school	Frequency N (%)
Request condoms at schools and hostels	3(27.2)
Schools visits by health care providers	2(18.1)
Contraceptives and HIV/AIDS to be dedicated as a subject in schools	2(18.1)
Request health education regarding contraceptives use	2(18.1)
Request training for teachers regarding contraceptives	2(18.1)
Total	11(100.0)

4.6.2 Suggestions for improving contraceptives educations at the community and parent level.

As alluded in table below, the youth suggested the need to improve the social environment in which they lived. The need of community and parental support as a source of contraceptives information was requested. Of 6 (31.5%) respondents mentioned that parent and community should have adequate knowledge and skills in what to say regarding contraception and sex, when to say and how to approach the situation, because they perceived that most parents are not knowledgeable in sex topics and contraception. Therefore youth suggested parents and community to participate in sex and contraceptives education as well as other activities aimed at preventing unintended pregnancy and STIs including HIV/AIDS. However they suggested that topics regarding sex and contraception should be addressed more regularly at homes. Suggested parents and community also to be always open, good role model to their children, and to be non-judgmental regard sexual matters. They feel such intervention will likely to increase subsequently communication between parent and child.

The respondents again raised the issue of teenage pregnancy, school dropouts, rape, and unemployment as well as alcohol abuse as a societal issues threaten the Outjo district youth. Therefore, most youth suggested government to address such issues through campaigns and workshops. They feel government intervention together with the community will likely to be effective solution in reducing the impact. The views of youths on improvement of sex topics and contraception at community and parent level are presented in below.

Table: 4.6b Request health talks regarding sex and contraceptives use with community and parents

Health talks with community and parents	Frequency N (%)
Request support and involvement from community and parents	8(42.1)
Request education of the community and parents	6(31.5)
Request parents to be open-minded	4(21.0)
Involvement of government in	

societal issues	1(5.2)
Total	19(100.0)

4.6.3 Suggestions for improving the existing contraceptive services

From table 5.6c, it is clear that there are programmatic barriers hindering the effectiveness of contraceptives use cited by the respondents. Youth highlighted areas such as distances to clinic, nursing staff and quality of service and delivering system to be improved. The youth raised concern that the services are not easily accessible and available to them. Of 30 (35.2%) respondents suggested government to bring the sexual and reproductive health services near to the community because the clinic is far from the community. They need nurses to do home visits and outreach on regular basis because most youths are lack of contraceptives and HIV/AIDS information. Of 4 (4.7%) respondents perceived nurses to be rude, highly judgmental and unhelpful, equating their treatment with harassment, therefore they requested government to train the nurses regarding communication skills. They feel health workers should be sensitive to the needs of clients, should show interest in serving sick people and not necessarily to be rude, judgmental and bully them. They feel that bad attitude of nursing staff will not make services youth-friendly. Of 15 (17.6%) stressed poor quality of condoms. They mentioned breakage of condoms during sexual intercourse. They acknowledged the encouragement of condom use but they mentioned that government condoms are unsafe. Therefore, they suggested government to provide them with quality condoms such as 'Rocks, Sense and Cool riders, but not Smiles. Of 2(2.3%) suggested private sectors (pharmacies) to provide contraceptives free of charge or at least to reduce the cost to N\$5-00. Other suggested condoms to be distributed in churches where many people are gathering the most, school hostels especially boys hostel and night clubs. The views of young adults on improvement of public health care clinics are presented in table below.

Table 4.6c Suggestions for improving the existing contraceptive services

Improving contraceptives services	Frequency N (%)
Request quality service delivery	3(3.5)
Bad attitudes of nursing staff	4(4.7)
Request for training for the nurses	3(3.5)
Request quality condoms	5(17.6)
Request contraceptives and HIV/AIDS information	22(25.8)
Request home visits and clinic outreach	4(4.7)
Request condoms at churches and night clubs	2(2.3)
Concerns over long distances to the clinics	30(5.2)
Private sectors cost to be reduced	2(2.3)
Total	85(100.0)

4.6.4 Suggested for youth development programs

Of six respondents had raised concerns regarding the high rate of crime, alcohol abuse, HIV/AIDS and teenage pregnancies in the Outjo district. Therefore, they suggested regional counselor of the Outjo district to establish a youth development programs for the youth. They suggested that programs should include education on HIV/AIDS, contraception, topics on rape, alcohol abuse, self-esteem build, sports and arts activities as well as voluntary work in condom distributions. They perceived that such approaches will be more promising in reducing crime, HIV/AIDS, alcohol abuse and teenage pregnancies. Moreover, they also perceived that such multi-faceted programs will be influential to them to have a sense in maintaining positive sexual health and well being.

Finally, young adults in the Outjo district expressed gratitude for the study. They indicated that they had benefited from the study, and that it gave them a chance to share their concerns. They expressed that they had lacked of someone to freely talk to and wished that such forums should be regular and involving the entirely youth of the Outjo district. They also requested to be informed about the study results

CHAPTER 5: DISCUSSIONS

5.1 Introduction

Chapter 5 presents discussions regarding factors influences the decision to contraceptives usage, teenage pregnancy rate and sexual health education services. This discussion however will be based according to the study objectives. Recommendations towards the improved provision of contraceptives accessibility to the young adults in the Outjo district will be also presented.

5.2 Objective 1: To explore personal factors that influences the decision to contraceptive usage among young adults of the Outjo district

The socio-demographic findings in this study are presented in tables 4.2a, 4.2b, and 4.2c. A total of 150 respondents participated in the study. The ages of the respondents were from 18 to 24 years. Many of the respondents were sexually active between the ages of 18 to 20yrs than the other age groups indicated in the table. Irrespective of their sexual activity, 18 (5.0%, see table 4.5i) respondents were not taking responsible behavior, since they indicated that condoms reduce sexual sensations and 4 (2.6%) did not even know how often contraceptives should be used see table 4.5e. These findings resonate with those of Mfono (2008) who reported that young people in Namibia were not using contraceptives consistently due to perceptions. Therefore, consistent and correct use of contraceptives is important to prevent unwanted pregnancies and STIs including HIV/AIDS.

More than half (n=84, 56.0%) of the respondents were female and male were 66 (44.0%). There was no significant difference between gender that explain sexual activity. The predominant ethnic group in the Outjo district was Damaras, as 74 (49.3% of respondents were Damaras in total.

5.3 Objective 2: To examine socio-economic factors that influence young adults decision to use contraceptives

The socio-economic findings in this study are presented in table 4.3a. Of 44.0% respondents were learners and non-learners 56.0%. The relationship between the respondents' level of school education against sexuality was investigated and findings proved statistically significant (p -value=0.031. Sexually active learners were 30.6% while 13.3% were expected to be not sexually active. Of 29.3 non-learners were sexually active while 26.6 were not sexually active.

5.4 Objective 3: To determine pregnancy rate among young female adults recorded at antenatal clinic in the Outjo district.

Teenage pregnancies are one of the reproductive health outcomes facing young people, globally. From the findings in table 4.4a, a total of 493 teenage pregnancies were recorded since 2010 to 2011 in the Outjo district. Out of those pregnancies, 94.7% resulted in live births, 2.2% abortions, and 3.0% in still births. As shown in the table 4.4a, teen pregnancy rate for the age of 18 to 20years was higher than the other age groups. Smith (2011), who was of the opinion that the high rate of teenage pregnancies in Namibia was alarming, indicated that 60 to 72% of female school-attending learners are being pregnant and a third given births by the age of 18 to 20yrs. South Africa had also high teenage pregnancies(South Africa Health Statistics 2007). The Gauteng Province was reported with the lowest proportion of teenage pregnancy (9.5%) compared to Mpumalanga Province, which had the highest proportion of 25.2% (South Africa Health Statistics 2007).These reflect a serious omission on the part of government to make contraceptive services more accessible and available to young people in order to use the services effectively.

5.5 Objective 4: To examine sexual health education programs including contraceptives services available in Namibia to educate the young adults

5.5.1 Sex health education in schools

As shown in table 4.5a, only one third of respondents 131 (87.0%) received contraceptives health education prior to their first sexual intercourse in schools and 19 (12.7%) did not. It is in agreement with findings from the Lesotho Demographic Health Survey of 2004 (LDHS) which showed that about 71.2% of women age 15 to 45 years knew sex education during their

secondary schools education, while 13.1% came to know about it through mass media and friends (LDHS 2004).

5.5.2 The impact of contraceptives and HIV/AIDS information

In table 4.5b respondents were asked whether the sexual health education received did influence their decision to practice safer sexual intercourse. They were given the options to select always, mostly, sometimes or never. Of 61(40.6%) respondents indicated that such information that they received always influenced their behavior, causing them to make safer sexual choices, while 12 (8.0%) selected sometimes and 19 (12.7%) mostly. Thirty eight point seven percent 58(38.7%) indicated that the sexual health education received did not influence their decision to practice safer sexual intercourse. There is a significant association between impact of contraceptives and HIV/AIDS information and sexually activity (p-value=). Between those who indicated their responses , there was a deviation of 3.876.

5.5.3 Reasons for contraceptives usage

The knowledge about pregnancy and STIs prevention among the respondents was high. Condom method in this study was proven to uniquely reduce the risk of HIV/AIDS infection and pregnancy. Of 114 (76.0%) respondents knew that condom use is for HIV/AIDS prevention, while 86 (57.3%) respondents indicated that contraceptives use is for pregnancy prevention. The additional reasons like when partner requested was 15 (10.0%), taught to use it was 31 (20.7%) and unspecified source than indicated was accounted to 3 (2.0%). The level of reasons for using contraceptives in this study was similar to the level of reasons indicated by American students regarding reasons for contraceptives use (Vahratian 2008).

5.5.4 Contraceptives methods of choice

Among family planning methods selected by respondents, condoms were the most 92 (61.3%) method used by sexually active group, followed by abstinence with 26 (17.3%), and injection+ condom combination with 25 (16.7%). Other methods of modern contraceptives used by sexually active respondents were two/three month injection 16(10.7%), and the least methods were pill 5 (3.3%) and pill+ condom combination method 5 (3.3%). This low proportion of pill

might be due to side-effects, lack of knowledge or not easily accessible to users while condoms method might be easily accessible to most. This findings reflecting to contraceptives of choices found among young women in the northern Namibia from a study by Mfono (2008). The results indicated that the condom (0.6%) was the preferred choice followed by injection (0.3%). Among married young women, the injection was the preferred choice combination with condoms. Educated young women preferred male condoms (Mfono 2008). Although condom and injection were the most preferred methods by most young respondents, in the northwest part of Namibia, traditional method was the preferred methods indicated by respondents. This area is the most underdeveloped with poor health facilities and has a high proportion of indigent people, therefore traditional practices and staunch religions play a role in those areas (Mfono

5.5.5 Frequency of contraceptives use among young adults

How often the respondents used contraceptives was indicated in table 4.5e. Nearly two thirds 92 (61.3%) used contraceptives always with every sexual intercourse. Taking into consideration of high teenage pregnancy and HIV/AIDS rate in Namibia, some of the respondents 33 (22.0%) indicated that they use contraceptives occasionally; while partner requested was 4(2.7%) and access to it 5(3.3%) respondents had the least decision in contraceptives usage. Although the majority youth in the current study are knowledgeable regarding contraceptives use, it is disconcerting that there are some who have limited effect on contraceptives use. Therefore the challenge remains to get all sexually active young adults to use contraceptives every time that they have sex.

5.5.6 Frequent sites for accessing contraceptives

Table 4.5f shows where respondents regularly accessed contraceptives the most. The majority sexually active respondents accessed contraceptives by means of public health clinics 86(57.3%), whereas 56(37.3%) buy at pharmacy, 20 (13.3) relied on friends, 17(11.3%) accessed at private sectors, and the less preferred site in this section was partners with 10 (6.7%). Other, 6(4.0%), was unspecified. There is no significant association (p-value 0.562) between sites accessing contraceptives and sexuality.

5.5.7 Preferred sites (points) for obtaining contraceptives

The findings show those sites from the participants in the study would have liked to obtain contraceptives. Such findings are presented in table 4.5g. The most preferred suitable point mentioned by sexually active respondents were public health clinics with 103 (68.7%), followed by school nurses 23 (15.3%)

Although public health clinic appears to have high proportion of percentages, there were concerns among respondents about services delivery (table 4.5h). Out of 33 (22.0%) respondents from sources that were not indicated, revealed that pharmacies were their best source points for contraceptives. The reason was that pharmacies do not expose clients than public health clinics did in services delivery system. Evidence from Nigerian studies showed that most of respondents who used contraception procure it from private sources (Oyeadeniran et al 2005). Some respondents indicated school hostels, sheebens, nightclubs and friends as their second suitable choice points in accessing condoms.

5.5.8 Factors and reasons hinders the uptake of contraceptives

The factors and reasons prohibiting the use of contraceptives were identified. As shown in table 4.5h, the main factor among other factors cited by the sexually active respondent's was distances to the public health clinic with 87(58.0%) . Some respondents identified bad attitudes of the nursing staff, followed by lack of enough contraceptives methods. The findings indicated clearly that the accessibility and availability to free contraceptives in public health clinics was hindered by hostile and judgmental treatment by the health care providers, with the clinic being far from the community. Mfono (2008) indicate that family planning services should be in line with client's expectations, put clients first, and treat the clients as they want to be treated. Therefore from the findings there is a need for change in the provision of contraceptives services in the Outjo district,

Young people need to be provided with information about contraception so that they are able to make an informed decision. Lack of open-communication increases risky sexual behavior. In this study, some respondents displayed negative attitudes towards contraceptives as they could not engage in a discussion with their parents. Parental judgments and insufficient information

from parents was one of the main factors hinders the contraceptives use among young adults in the Outjo district. Mfono (2008) concur with the fact that young people across ethnic groups have a myriad of concerns related to morality as they feel demeaning and embarrassing to discuss contraceptives issues with their parents openly. Similarly, parents also feel a high degree of discomfort when discussing sexual matters with their children. On the other hand, young people viewed their peers as more approachable sources for information than their parents and some indicate partner pressure in contraceptives decision making, that have place many young women in vulnerable situations leading to early pregnancies.

5.5.9 Reasons for not using contraceptives

Ninety six point seven percent of the respondents were not utilizing the contraceptive services and cited some reasons. Not have access to contraceptives was the highest for not using contraceptives 53 (35.3%). Even when the contraceptive means necessary were accessible to the respondents concerned, they were not always used. Of 18(12.0%) of respondents were not using contraceptives due to perceptions that condoms reduces sexual sensations. From other reasons than not indicated in the table 4.5i, was the religion regarding the contraceptives use, some desire children, pride and ignorance to use contraceptives, still young to use contraceptives, abstinence from sex, and some were pregnant the time of the study.

In terms of religion background, religious to sexuality can pose difficulties particularly for those young people who face dissonance between the dominant social norms of wider society and faith group. However, this can lead to problems of acquiring knowledge about sexual health and accessing contraceptive services. In this study, the researcher actually did not measure the level of religiosity, but the religion information was emerging from yielded responses.

Contraception can be a threat to cultural values and norms. Women are tied to motherhood, and childlessness is highly stigmatized. These findings supported by Mfono (2008) which reported that Namibia society in general leans towards and desire large family. Most women feel that conception proves a women's fertility and sometimes seen as a bargaining instrument through which to obtain favor from the male partner, and also possibly to demonstrate the capacity to

have a child. It is therefore in the current study, some respondents indicated desire children and this might be by means of those perceptions.

Of 2(1.3%) respondents indicated that they are still young to use contraceptives, they preferred abstinences from sexual debut. It is acknowledged that abstinences have an important role in preventing unintended pregnancies and STIs including HIV/AIDS, but there is no strong evidence to support the view of effectiveness of abstinences. Little is known about the abstinences by most young people. It is therefore important for young people to understand the impact the method have as a preventive measure and also to recognize that its use might also have significant negative effects by making them ignorant of risks when they become sexually active.

The non ready availability of contraceptives in friendly and accessible environment, the shyness is associated with procurement of contraceptives openly and the misconception of its effect on future fertility may all be factors limiting the uptake of contraceptives (Millan 2010). It is noteworthy that 2 (1.3%) of respondents indicated that they did not use contraceptives because they were shy to use contraceptives.

5.5.10 Availability of contraceptive services

Respondents were asked whether the contraceptives listed in table below (table 4.5L) were freely accessible to them or not. The majority 127(84.7%) sexually active respondents reported that their access to contraceptives was freely without any cost involved, while 15(10.0) said it was not freely. There is significant association (p -value 0.018) between availability of contraceptives services and sexuality. Between those who indicated availability of services and those who said the services is not freely available and not sexually active there is a deviation of 3.876.

5.5.11 Sources for contraceptives education/information

The respondents in the study clearly stated that they preferred to receive contraceptive education from public health clinic 39 (26.0%) and this education to be made available at homes by their parents and teachers at schools. It is clear from the table 4.5k that the majority of respondents 61 (40.7%) have preferred to received information provided by parents in their own homes. From evidence supported by Mfono (2008) research findings, most young people whose parents discuss sexual matters with their children in an open and non-judgmental manner are more likely to delay early sexual activity and when they do become sexually active, they use contraception. However, such a finding is significant and not surprising. Although parents expected to play a significant role in providing accurate knowledge regarding contraceptives use to their children, some young people found it difficult to discuss with their parents due to communication barriers that resulted them choosing their peers and friends as their best sources for information. Of 17 (11.3%) respondents from other source than that was indicated, preferred friends/peer as their best sources for information. Young people have that perception that their peers/friends are more approachable and non-judgmental than their parents. This evidence is supported by Mfono (2008) research findings.

Teachers were the 3rd most popular source for contraceptives information, indicated by 21 (14.0%) respondents. Although teachers are accessible to most learners and expected to teach them about contraceptives issues, they may not be always be available as they teach a number of subjects or they may be busy in other classless, or may lack of accurate knowledge about contraceptives compared to school nurse that dealing with such conditions every day in health care environment. Only, 12 (8.0%) respondents mentioned school nurse as their source of information. From another sources (media) than that what was not indicated in the table was 17 (11.3%). Exposure to mass media either from electronic media such as television, radio or print media such as newspapers or magazines allow young people to increase their knowledge of family planning and contraceptive methods that influenced their decision on contraceptive adoption (Hossain1996). Several studies suggested that young people who are regularly exposed to electronic media were less likely to report method-related problems or opposition to family planning as their main reason for not using contraceptives or stopping its use (Mishra 2006). About 85.2% respondents in SA recommended more TV programs on prevention measures (Strydom, 2004:64). In Namibia, Mfono (2008) also found that 53% to 70% of youth listened family planning and reproductive health information through mass media, and radio was

widely available in most of the respondent's homes.

5.6 Objective 5: To make recommendation towards the improvements of contraceptive services in the Outjo district

The recommendations grounded in the findings of the study, are presented under headings, according to the themes that emerged from the data. Each of the themes, namely contraceptives accessibility, a need for a new model, enhancing awareness about contraceptives use, enhance of communication between young people and health care providers, enhance youth participation and involvement in decision making, enhance parent and community guidance, ethical and policy barriers and implications for further study.

5.6.1 Contraceptive accessibility

Better quality condoms and wider choices regarding contraceptives use should be offered in a confidential setting that is not threatening the youths and which is within easy reach of every youth in the Outjo district. Health care professionals such as nurses should involve in providing contraceptives means to youths. The provision of such means comes with the obligation adequately to inform the youth in order for them to be able to apply the method correctly.

5.6.2 Need for a new model in contraceptives provision

A new approach regarding the contraceptives services for the Outjo district youth was suggested. The evidence from the research findings that there were no youth-friendly services, long distances to the public health care clinics, lack of sexual and contraceptives information among youth and poor outreach programs in the Outjo district implies the need for government to provide the youth with accessible, acceptable, confidential, flexible and friendly services that the youth can identify with. The government through the regional and district management needs to allocate all the preventive health services in the community for easier accessible reach. Government should strengthen the outreach programs by designate specific staff to oversee and coordinate the outreach programs within and outside the community.

Contraceptive subject period to be dedicated within a school system was advisable by the youths. The adoption of such an approach would ensure the understanding of preventive reproductive health matters. Contraceptives service and counseling programs would have to be made available on the premises of schools which are the easiest access point for the learners. Teams of health care professionals should be assigned to such schools which should be responsible for operating a full reproductive health care clinic that would be made accessible to all students.

In addition, departments dealing exclusively with young people health issues need to be established at the national, regional and district level. The aim should be: to ensure continuity of health preventive programs, availability of skills staff, and provision of logistical support to departments dealing with such programs. The government also needs to establish a national coordinating council to monitor and coordinate youth health programs in the Outjo district. The council should help to eliminate unnecessary duplication of efforts, reduce gaps in provision of contraceptives services to the youth and enhance cost effectiveness by mobilizing and pooling available resources. The council should have nationwide representation with branches at the regional and district level to ensure a smooth link between the national and the grassroots levels. In order to confront the challenges facing the Outjo district youth, the study suggested for the council to be multi-sect oral and multidisciplinary, comprise representative from the public and private sectors such as teachers, law enforcement members, health professionals, policy makers, researchers, social workers, district councilors, religious and community leaders as well as parents.

5.6.3 Enhancing awareness of sexual and reproductive health including contraceptives services

Government needs to intensify efforts to inform and educate young people about sexual and reproductive health problems. Brochures containing information about sexual and reproductive health, needs to be published and disseminated to the youth, parents, schools, and community at large. This is to ensure the correct and complete information about availability of sexual and contraceptives services. To provide such information will reverse the perception that contraceptives services are only for adults and married couples but not for young people.

5.6.4 Enhance good communication between youth and health care providers

There is a need to foster greater interaction between youth and health care providers in order to eliminate communication barriers. To enhance open sharing, the socio-cultural factors that impede open communication should be addressed. To do this, the following needs to be done:

The government needs to encourage health care providers serving young people to demonstrate some sense of cultural and professional sensitivity when serving the youth. Health care providers should be flexible and create a friendly environment to encourage young people to approach them and share their sexual health concerns with them.

The government should enhance health care providers about the need to be non-judgmental and they should be spearhead open sharing on sexual issues with young people without showing them an attitude and those health care providers who are lack of communication skills should be trained.

5.6.5 Enhance youth participants and involvements in the health care activities.

There is a need to recognize that young people are partners in their own health. The government, policy makers, researchers, teachers, and other professionals serving the youth, need to involve the youth actively in planning and making decisions about their sexual and reproductive health matters. By means of including them in the sexual and reproductive health committees. Youth should be actively involved in planning, designing, formulating and implementing youth sexual and reproductive health programs policies. This approach is supported by evidence from other countries that have lower teenage pregnancies and STIs (for example Sweden and Holland) (UNICEF2010).

5.6.6 Establish parent and community guidance and involvement in sexual activities and contraceptives use

The government needs to educate parents and community members through workshops about the sexual and reproductive health issues of young people. The aim should be sensitize parents and community understanding about issues related to young people sexual and reproductive

health. Youth in this study stressed the need for parents and community guidance and counseling in sexual issues and contraceptives use. Therefore the majority of respondents wished that their parents and community could openly discuss sexual reproductive health matters with them and be less suspicious of their sexual behavior. This study has shown that good and open communication with trusted and non-judgmental adults can significantly influence young people ability to openly access and utilize sexual and reproductive health services, and to freely open up their views to the health care providers.

5.6.7 Addressing ethical/policy barriers

Evidence in this study suggested that youth have no adequate access to confidential preventive reproductive health care services. There is a need to streamline policy, practice and ethical issues to ensure that a safe and supportive environment is provided by young people seeking services. Young people need to be guaranteed and accessed their rights to confidential services. Legal and eligibility requirements based on attainment or reproductive health age or legal age of consent are 18 years and above and this age group have freely access to contraceptives services without parent consent. The restriction of services to specific age group affects most young people contraceptives use. This implies that many young people defined by WHO (2009) as persons aged 10 to 24 years, under 18 years are ineligible to access and utilize contraceptives services on their own. However this had created high teenage pregnancy in the Outjo district. Thus legal requirements or parental consent and restrictive regulations that resulted in breach of youth right to contraceptive services needs to be assessed and revised.

5.6.8 Implication for further research study.

This study has addressed an important public health topic by focusing on young people contraceptives use. It has contributed vital information that can help to bridge the knowledge gaps about contraceptives services for young people. By focusing on Outjo district as a rural area in Namibia, the study has highlighted challenges the youth face in the Outjo district. Despite the contributions, the study has identified teenage pregnancy that merit further research. Quantitative and qualitative research is needed for the entire youth of the Outjo district. Such research is especially applicable in relation to the entire Outjo district youth, among whom an alarmingly high incidence of teenage pregnancy occurs. However, no data are available on teenage pregnancy in the Outjo district

CHAPTER 6: Conclusions and Recommendations

6.1 EVIDENCE OF ACHIEVEMENTS OF THE OBJECTIVES OF THE STUDY

The study objectives were:

6.1.1 To explore factors influence the decision to contraceptives use among young adults of the Outjo district.

Achievements: The findings showed that the 18 to 20years of age were more sexually active than the other age groups (see table 4.2a). A significant higher number of female respondents than male were in the study (table 4.2b). Majority respondents were Damara in race (table 4.2c).

6.1.2 To examine socio-economic factors influence young adult decision to use contraceptives.

Achievements: Formal education of the respondents in the study was identified. The results revealed that more learners than non-learners were participated in the study (see table 4.3a).

6.1.3 To determine pregnancy rate among young female adults recorded at antenatal at Outjo state hospital.

Achievements: An evaluation was done to determine the pregnancy rate among young female adults recorded at antenatal at Outjo state hospital. Specifically, the evaluation measured the pregnancy rate according to the age and ethnic groups. The results revealed that teen pregnancy rate for the age of 18 to 20yrs was higher than the other age groups (see table 4.3a and 4.4b).

6.1.4 To examine sexual health education programs in Namibia to educate young adults.

Achievement: Sex health education in school identified (table 4.5a). Information regarding the conveyance of concepts relating contraceptives and HIV/AIDS found lacking (table 4.5b).

The findings revealed further that there was increase in knowledge of HIV/AIDS and pregnancy prevention. HIV/AIDS and pregnancy prevention was value reason that encourages the uptake of contraceptives and safer sex choices by respondents (table 4.5c). The condoms were the most preferred method for HIV/AIDS prevention (table 4.5d). However some of the respondents have limited effect on contraceptives usage (table 4.5e).

Regular access sites and preferred points for contraceptives were identified (table 4.5g). The results also revealed factors hinder the uses of contraceptives (table 4.5h). Reasons for not using contraceptives, contraceptives not freely available by some respondents and alternative sources for contraceptives information identified (see tables 4.5i, 4.5l and 4.5k).

6.1.5 To make recommendations regarding the improvements of contraceptives services in the Outjo district.

Achievement: The respondents stated a preference for more adequate and specified contraceptives education in schools (table 4.6a).

Recommendations:

- ✓ More education regarding contraceptives and sex topics requested from parents or home (table 4.6b).
- ✓ More open communication regarding contraceptives use with community and parents requested (table 4.6b).
- ✓ Stronger condoms were requested by respondents in the study (table 4.6c).
- ✓ Some respondents requested that the contraceptive services should be accessible and affordable to all and should offer by health care providers in a good manner (table 4.6c)

- ✓ Quality services delivery at points like churches, hostels and by outreach services were also requested (table 4.6c).

6.2 CONCLUSION

As discussed in chapter 2, the high rate of teenage pregnancy among the Outjo district youth indicate a negative outcome of the provision of the current contraceptive services. The provision of new Namibian Children's Act must be implemented, allowing the expansion of sexual and reproductive health care rights to persons as young as 12 years old. The researcher recognizes certain limitations that presented potential problems during the study. However, such problems were accounted for and strategies employed, minimize the respondent's potential impact.

The contraceptive education regarding the concepts of sexual intercourse and contraceptive received from the age 18 to 24 years was found to be inadequate by most of the respondents. Such fundamental shortcomings were confirmed in the literature which notes the misconceptions of young people regarding their risk to unwanted pregnancies and STIs infections. This situation cause concern since most young people was not equipped with the basic knowledge to make safe sexual choices.

The study indicate that the respondents would have preferred different sources for contraceptive information and care as well indicated inadequate accessibility of contraceptive services. Young people in the Outjo district felt judged when attempting to contraception. Findings also indicated long distances to health care facility. This situation is not acceptable, as this might be exposing young people to high-risk reproductive health decisions cause them to unwanted pregnancies and STIs infections.

Suggestions and recommendations identified by respondents should be considerate as valuable input in order to improve the contraceptive acceptance among the youth in the Outjo district. The chapter six indicated the achievement of the study objectives.

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Appendix A: Ethical approval



HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HW-REC)

Registration Number NHREC: REC- 230408-014

P.O. Box 1906 • Bellville 7535 South Africa
Symphony Road Bellville 7535
•Tel: +27 21 959 6352 • Fax +27 21 953 8490
Email: danielso@cput.ac.za

17 October 2012
CPUT/HW-REC 2012/H13

Faculty of Health and Wellness Sciences
Nursing and Radiography Department

Dear Ms I Katjau

YOUR APPLICATION TO THE HW-REC FOR ETHICAL CLEARANCE

Approval was granted on 12 October 2012 by the Health and Wellness Sciences-REC to Imelda Katjau for your application (pending corrections that have been received and reviewed). This approval is for research activities related to an MTech: Nursing at this institution.

TITLE: Perceived factors that hinder the acceptance of contraceptives amongst young adults in rural district, Outjo in Northern Namibia.

INTERNAL SUPERVISOR: Mr S Hassan
INTERNAL CO-SUPERVISORS: Ms F Kajee

Comment:

Approval will not extend beyond 17 October 2013. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

Note:

The investigator(s) should understand the conditions under which they are authorized to carry out this study and they should be compliant to these conditions. **It is required that the investigator(s) complete an annual progress report that should be submitted to the HW-REC in December of that particular year, for the HW-REC to be kept informed of the progress and of any problems you may encounter.**

Kind Regards

A handwritten signature in black ink, appearing to read "JL Marnewick".

Prof JL Marnewick
CHAIRPERSON: HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE

Appendix B: permission letter



OUTJO SECONDARY SCHOOL
MINISTRY OF EDUCATION

P O Box 104
Outjo

Tel: 067-313154
Fax: 067-313151



Enquiries: MR. N. HAMUTENYA

28 June 2012

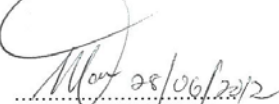
Cape University of Technology
Faculty of Health and Wellness
School of Nursing and Radiography
Faiza Kajee
P O BOX 1906
Bellville
7535

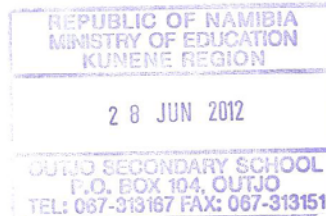
TO WHOM IT MAY CONCERN

I, Nahas Hamutenya as a principal at Outjo Secondary School would like to give permission to Ms. Katjau Imelda to do her research at Outjo Secondary School.

Should you need any assistance do not hesitate to contact me.

Yours in Education


N. HAMUTENYA
PRINCIPAL



"Ensuring that every learner has access to quality education"

Appendix C: MOH permission letter

9-0/0001



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198	Ministerial Building	Tel: (061) 2032510
Windhoek	Harvey Street	Fax: (061) 222558
Namibia	Windhoek	E-mail: eshaama@mhss.gov.na
Enquiries: Ms. E.N Shaama	Ref: 17/3/3	Date: 28 June 2012

OFFICE OF THE PERMANENT SECRETARY

Ms. Imelda Katjau
Private Bag 2557
Outjo
Namibia

Dear Ms. Katjau

Re: Perceived factors that hinder the acceptance of contraceptives among teenagers in rural Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for completion of your M-Tech in Nursing;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


MR. ANDREW NDISHISHI
PERMANENT SECRETARY

"Health for All"

Appendix D: assistance for referral of study participants



REPUBLIC OF NAMIBIA
Ministry of Health and Social Services
Developmental Social Welfare Services
Office of the District Social Worker
P/bag 2567, Outjo

Inquiries: Florida Faburada
0817392298

Tel: 067-313250
Fax: 067-313721

July 10, 2012

Ms. Imelda KAtjau
Private Bag 2557
Outjo
Namibia

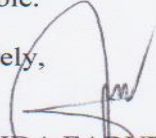
Re: Perceived factors that hinder the acceptance of contraceptives among teenagers in rural Namibia

Dear Ms. Katjau,

This letter is in connection with your letter through email dated July 4, 2012 requesting the Social Worker's assistance in dealing with teenagers needing psychological support while conducting study on the above-mentioned in Outjo district.

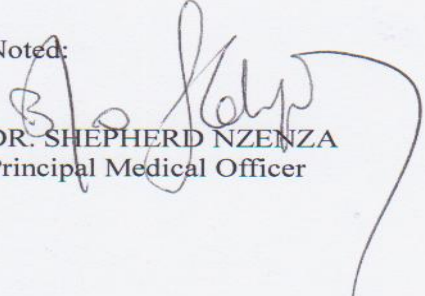
Within the course of the study should you need assistance, rest assured that I will make myself available.

Sincerely,


FLORIDA FABURADA
Social Worker
Outjo District



Noted:


DR. SHEPHERD NZENZA
Principal Medical Officer

"Health for All"

Appendix E: permission letter



Kunene Regional Council Outjo Constituency

Tel: 067-313622 -
Fax: 067-313422-
Cell: 0816205433

P.O. Box 410
Outjo

Namibia

TO WHOM IT MAY CONCERNS

15/08/12

Re: AVAILABILITY OF YOUTH CENTER TO MS N. KATJAU

Ms N. Katjau is well known to the office of the Regional Councilor. The youth centre at the Constituency office is herewith availed to her for activities as required by your institution.

I hope that you will find this arrangement in order.

Yours Sincerely

Signed

Hon. Cllr. A. Job

Outjo Constituency

Appendix F: permission to use questionnaire

Forwarded Message -----

From: lauren McMillan <laurenmcmillan.za@gmail.com>

To: Imelda Katjau <nkatjau@yahoo.com>

Sent: Wednesday, June 13, 2012 4:44 PM

Subject: Re: permission to utilize the questionnaire

Good day

Apologies for the delay, I have just started a new study and the preparation has been all consuming. Firstly congratulation on your decision to complete your Masters degree. I commend your choice and wish you all the best for the process. Under no circumstances lose hope and determination. It is worth every lesson and bump in the road. Secondly, I am quite flattered at your request. I have verbally requested some more information regarding the study you propose. Can I do so officially from you? I would love to read your proposal if I may. For any official study supported and cleared by an official South African Educational Institution, you are most welcome to use my questionnaire. Please note that at the time of my study, the questionnaire was designed from scratch, and my study thus far is the only validation for it. Additionally, I request that it is referenced your work accordingly.

All the best with your work

Kind regards

Lauren

on Tue, Jun 12, 2012 at 11:17 PM, Imelda Katjau <nkatjau@yahoo.com> wrote:

Appendix G: information sheet and informed consent



School of Health and Wellness
Nursing Division
Email:nkatjau@yahoo.com
Cell: +27 719 598 636
24 October 2012

THE CONTRACEPTIVE STUDY NAMIBIA, CONSENT FORM

Principal Investigators: Ms. I. Katjau

Co-investigators: Mr. F. Kajee (CPUT)
Mrs. G. Lourens (CPUT)

Address: Faculty of Health and Wellness Sciences, Cape
Peninsula University of Technology (CPUT), Bellville Campus
Symphony Way, 7535

Contact Numbers:

Ms. I. Katjau	0812530572
Mrs. F. Kajee	021 953 8426
Mrs. G. Lourens	021 860 2684

Dear Participant,

You are being invited to take part in a research project. Kindly spend a few minutes to read the information presented here, which will explain the details of this project. Please feel free to ask any questions about this project that you may not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research entails and how you could be involved. Furthermore, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you initially agreed to participate.

This study has been approved by the Committee for Human Research at Cape Peninsula University of Technology and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

This study aims to assess the factors that hinder the acceptance of contraceptives in order to provide solutions for the high rate of teenage pregnancies. The primary research objective is to assess the factors that hinder the acceptance of contraceptives among teenagers. When a large group of teenagers with similar concerns has been collected, meaningful research into the understanding of the teenage acceptance for contraceptives may become possible.

Why have you been invited to participate?

There are free contraceptives available at the health facilities in Namibia, but there appears to be very high teenage pregnancy rates in rural Namibia. In order to assess the factors that hinder teenagers from accepting the free contraceptives, you have been approached to participate in this project to determine the knowledge level of contraceptive use among teenagers. You also meet the criteria used to select participants into this study.

What will your responsibilities be?

You are requested to provide information based on your own knowledge. This means, you are requested to complete the questionnaire which will take no longer than 10 minutes.

Will you benefit from taking part in this research?

The responses from you and all the other participants will add great value to the research field of promoting contraceptive use, and it will bring imperative benefits to the health care facilities that serve teenagers within the community. On the other hand, it will also provide necessary knowledge to the teenagers for future improvements on the understanding and use of contraceptives among teenagers.

Are there any risks involved in my taking part in this research?

There is no risk involved if you participate in the research study. The questions do not require any personal details such as your name, address or identity card or passport details. You will only to provide your age.

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

Your participation is voluntary and you are not expected to pay anything.

DECLARATION BY PARTICIPANT:

I declare that:

I have read the information and that consent form is written in a language which I am fluent and comfortable.

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

I understand that taking part in this study is voluntary and I have not been pressurized to take part.

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

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

I also consent that my information may be:

◆ **Used and discarded**

Signed at (*place*) on (*date*) 2012

Signature of participant----- Signature of witness-----

Appendix H: questionnaire

Please answer the following questions as clearly and honestly as possible

1. Indicate your age:

.....

2. Gender (Circle please).

Male

Female

3. Please indicate your ethnic group (circle)

a. Oshiwambo

b. Omuhherero

c. Damara>Nama

d. Kavango

e. Caprivi

f. White

g. Colored

h. Other.....

4. Are you a learner? (Plases circle)

a. Yes

b. No

5. Are you currently sexually active?

Yes

No

6. Have you had sexual education before your first sexual intercourse?

Yes/ No

7. If yes, did you consider using contraception before your first sexual intercourse?

Yes/ No

9. If yes what did you use?

- a. Condom (male/female condom)
- b. Two or three month injection
- c. Pill
- d. The injection + condom combination
- e. The pill + condom combination
- f. Abstinence

9. What was your reason for using contraception? (Circle more than one).

- a. Pregnant prevention.
- b. Infection prevention (HIV/STIS).
- c. My partner requested it.
- d. I was taught to do so during contraceptive/sex education.
- e. Other (please explain)

10. How often do you use contraception? (Choose only one).

- a. On occasion
- b. When my sexual partner requested it
- c. When I or my partner had access to it
- d. Always
- e. Other (Please explain).

11. What is your contraceptive method of choice? (You may choose more than one).

- a. Condom (male/female).
- b. Two or three month injection
- c. The pill
- d. The injection +condom combination
- e. The pill +condom combination
- f. Abstinence

(Definition: Abstinence: Is a method of refrain from any sexual activity).

g. Other (please explain).....

12. Were these contraceptives freely available?

Yes

No

13. If not using contraception during your teenager's age, what was your reason?

- a. I was not informed about its advantages.
- b. I did not have access to it.
- c. Peer pressure.
- d. Partner pressure.
- e. Condoms reduce sexual sensation.
- f. Other (please explain).

14. Where do you most regularly access the contraception? (You may choose more than one).

- a. Public health clinics
- b. Private sectors
- c. Pharmacy
- d. Friends
- e. My partner supplied it.
- f. Other (please explain).

15. Where would you liked to obtain contraceptives of your choice? (You may choose more than one).

- a. Public health clinics
- b. School-in class
- c. School nurse
- d. Other (please explain).

16. If no, what hindered/prevented you from freely obtaining contraceptives? (You may choose more than one).

- a. Peer pressure (friends).
- b. School pressure
- c. Community judgments
- d. Parents judgments
- e. Partner preventing
- f. Bad attitudes of the nursing staff
- g. Distances to the clinic
- h. Lack of enough contraceptives methods
- j. Others (please explain)

17. Who would you prefer to provide the information about the use of contraceptives?

- a. Parents at home
- b. Public health clinic
- c. School-Teacher
- d. School-Nurse
- e. Other (please explain)

18. Do you think the contraception and HIV/AIDS information will influence your choices for a safer sexual practice during your teenager's age?

- a. Never
- b. Sometimes
- c. Mostly
- d. Always

19. Do you have any further suggestions/recommendations for methods to improve acceptance to contraceptive services in your district?

.....

Thank you very much for your participation in this study, which aims to explore factors hinder the acceptance of contraceptives among the teenagers of the Outjo health district