

## CHAPTER FIVE

### Findings and Recommendations

#### 5.1 Summary of findings

The Namibian government introduced the reproductive health and family planning programmes with the overall objective of promoting, protecting and improving the health of family members (especially women and children), reducing maternal and infant deaths, increasing contraceptive use among women of reproductive age and promoting and improving access to reproductive health services at all levels of health care delivery. Teenage pregnancy and unwanted premarital child births have been increasing among young women in Namibia. HIV/AIDS infection among young women who attend antenatal care is also very high. In addition, contraceptive methods are freely offered in hospitals and clinics such that young women who are in need of them do not have to pay for these services. However, young women face other obstacles like judgemental reactions from adult members of the community and health care services when obtaining contraceptives. Furthermore, the family planning policy has clearly indicated that contraceptives must be provided to all women of childbearing ages regardless of their marital status. However, use of contraceptives among sexually active young women in Namibia still stands at 53 per cent, a prevalence which is below the Namibian Vision 2030 rate of above 80 per cent. The low levels of contraceptive use probably reflect the spontaneity of young women's sexual activity as well as the many barriers young women face when they attempt to obtain contraception. To use contraceptives in Namibia, young women must overcome fears about rumoured side effects and 'bargain' with a health system that is not friendly and accommodating to adolescent clients.

Young women in Namibia are entitled to a wide range of choices of contraceptive methods and the freedom to obtain contraceptives without judgments; this contradicts their actual experiences in some areas. Young women in rural areas are also entitled to the same benefits as highlighted in the policies, but services are very poor in rural areas and need the attention of policy makers. There are contraceptive methods which are not offered or not available in rural areas, especially those like IUDs which require the services of professional doctors, and young women need to be referred to other health centres with such services. Referrals are inconvenient for young women as they require transport and permission from parents, which is not easy for young women in all cases. This study is therefore important in informing policy makers on the gaps in the family planning policy, reproductive health policy and other policies that incorporate components of young women's reproductive health and contraception needs. Some issues are clearly highlighted in existing policies, but they are not implemented accordingly.

This study concludes beyond the Health Belief Model parameters, which only provides a framework for understanding factors operating at the individual level to influence the decision to use reproductive health services. It does not examine factors operating beyond the individual level nor does it include the role of community and health system characteristics in shaping this decision. The present study reveals that whilst there is provision, the accessibility of existing reproductive health services for young women is poor in rural areas. Parents, nurses and the broader community are unsupportive and not fully aware of the sexual rights of young women. Nurses, especially in rural areas, are deemed to be judgmental and reluctant to provide contraceptives to young female scholars. Health facilities are also ranked by young women as user-unfriendly as most of them, as public spaces, lack confidentiality and privacy. The negative experiences of young women impact on their utilization

of reproductive health services and their use of contraceptives. Apart from disobliging parents, individual use of contraception is greatly influenced by individual and community characteristics. The educational level, marital status, number of children and work status are among the important individual factors affecting whether and what kind of contraception young women will use, adopting the ideas of Davis and Blake (1956). Other issues related to individual women concern whether she discusses family planning with her partner (spousal interaction) or parent (parental interaction), and whether she has access to the media and to health facilities.

The main questions this study has answered include:

What determines contraceptive use among young women in Namibia? Why is contraceptive use still low among young women in Namibia? Are there cultural, traditional, behavioural, social, economic or demographic barriers in using contraceptives? Do young women in Namibia make choices when considering contraceptive methods, and why? These questions were addressed and answered using the NDHS 2000 data by looking at sexually active non-pregnant young women, identifying barriers and determinants of contraceptive use. The focus groups conducted with young women helped in illuminating answers to a number of “why” questions.

The findings are summarised as follows:

- There was a large gap between knowledge and use of contraceptives among young women. Good knowledge of contraceptive methods did not necessarily result in high levels of contraceptive use. Ninety seven percent of young women knew about contraceptives but only 53% of those who are sexually active used it. Some methods were more known than others, and also some contraceptive methods were used more often or preferred than other methods. The most commonly known contraceptive method was the male condom followed by the

injection. The contraceptive method which women relied on most readily was the injection. This is because the injection can be used secretly, whereas condom use is dependent on cooperation with men.

- There are several determinants of contraceptive use among young women. A key determinant that emerged in this study was communication between parents (especially mothers) and their daughters on sexual issues. Considering the strict culture, tradition and religious influence on reproductive health, it was assumed and hypothesised that the involvement of mothers in the reproductive health of their daughters has negative influences on contraceptive use. Parents were assumed to be more traditional and not in support of their daughters, especially those who were not yet married, using contraceptives. The study, however, demonstrates more positive results towards contraception among young women who communicate with their mothers than was expected. Young women who discuss family planning with their mothers were among those who had a higher probability of using contraceptives. Young women in these cases use contraceptives because their parents discourage them from having unwanted and unplanned births. The study indicates, however, that only a small proportion of young women discuss family planning with their mothers, implying potentially significant possibilities which need to be further probed. This result stresses the importance of educating parents about sexual and reproductive health issues and fostering better relationships between parents and their daughters, which is likely to lead to stronger dialogue and greater social acceptance for girls to use contraceptives.
- Urban-rural differentials in the use of contraceptives were found to exist. Some contraceptive methods were more accessible in some

areas than in other areas. This is an indication of unequal distribution of services in the country. This differential affected the available choices of contraceptives for young women. While in urban areas young women could choose from a wide range of available contraceptives, in rural areas they were limited to specific methods such as the injection and male condom.

- Age differentials in contraceptive use among young women were also significant. The contraceptive needs of teenagers (15-19 years) and adult young women (20-24 years) are not the same. The demand for contraceptives such as the injection and the pill was higher for young adults (20-24 years) than for teenagers' women (15-19 years). This can be explained by the fact that most teenagers are still attending secondary school and still in care of either parents or hostel superintendent, which makes it difficult for them to seek for long term methods like injections or the pill from the nearest health centres. Hence, they opt for short-term methods like condoms, which are also easily accessible for them because they can be bought from shops without necessarily meeting the health provider.
- The influence of friends or peers was another factor that determined contraceptive use among young women. Young women who discussed family planning with their peers indicated a high prevalence of condom use. Talking among peers reinforced the positive value of contraceptive use, encouraging others to possibly learn more in terms of what to use and where it could be obtained. However, there was also a relationship between use of the condom and the age of the woman. Teenage women (15-19 years) had a higher prevalence of condom use than young women (20-24 years). Most teenagers were still in school and interacted more with their friends and peers. Many

were experimenting with sexual intercourse and most were not interested in steady romantic relationships. In comparison, young women (20-24 years) were in more stable relationships which they wanted to last and end in marriage. Some of them were already engaged to get married and others were married and thus not really using condoms in their relationships. The literature also suggests that condom use is higher in relationships that are unstable or transitory. When relationships become more resilient, partners are hesitant to use condoms.

- Whether young women use contraceptives or not was also influenced by whether they had access to the media. Access and ability to read newspapers or magazines was a significant determinant of contraceptive use. Reading newspapers or magazines allows young women to gain additional information. Radio is also a good source of information dissemination because it reaches a lot more people, and less literate, female listeners. In Namibia, the radio broadcasts dramas or programmes which sensitise people to use family planning methods. It broadcasts programmes which promote the use of condoms both because of its pregnancy prevention qualities and its ability to protect against STIs, including HIV/AIDS.
- The choice of contraceptives is determined by the number of children a woman has. Young women with at least one child chose long term contraceptive methods like injection and the pill, while more of those who do not have children chose condom. This can be explained by the fact that young women with at least one child have either experienced unplanned births and are trying to prevent further unplanned births by opting for longer-term methods or they are in marital relationships where condom use is not very common. In light with the above, the

results pointed that married young women who discuss family planning with their partners have a low probability of using condoms. This is attributed to the fact that when couples discuss family planning, they tend to develop trust and be faithful to each other in their sexual relationships.

- In church affiliated hospitals, regulations that prohibit or limit provision of contraceptives to young women contribute to the low use of contraceptives among them. However, even where access is not restricted by law, some health care providers have attitudes or prejudices against serving unmarried young women. Thus disconcerted health care providers tend to deter some young women from seeking contraceptives.
- Gender imbalances in relationships lead to poor communication between partners and further to low prevalence in use of contraceptives among young women. Women often feel that they are subordinates to men in relationships and, therefore, abide by men's demands. Some young women reported that they need their partners' approval to use contraceptives or to make the choice of a contraceptive method.
- Young women in the focus groups complained of the physical location of most family planning clinics or sections in health centres. They referred to facilities as not being youth-friendly in terms of place, access and even appearance. Operating hours in rural and urban areas were also inconvenient for young women, especially those who were in school.

- It was also apparent from focus group discussion that the convenience of a particular contraceptive method influence choice. Young women, especially those in urban areas opted for injection because of its convenience of not concerned about remembering to take a contraceptive method everyday like in the case of the pill or carrying a condom every time. In contrast to those living in rural areas, they felt that condoms are convenient for them as they are easy to get without necessarily visiting a health facility.

**Table 5.1: Tabular representation of research findings: Contraceptive use and method choice, Namibia.**

<p><b>A. Determinants of Contraceptive use, ranked from most to least significant.</b></p> <ul style="list-style-type: none"> <li>• Level of education</li> <li>• Place of residence (urban or rural)</li> <li>• Communication with mother on sexually related issues</li> <li>• Communication with partner on sexually related issues</li> <li>• Access to media (print and radio)</li> </ul> <p><b>B. Factors influencing low levels of contraceptive use, ranked from most to least significant.</b></p> <ul style="list-style-type: none"> <li>• Poor communication on sexual and reproductive issues between mother and daughter, especially in rural areas</li> <li>• Negative judgements of elder community members and health care providers</li> </ul> <p><b>C. Factors influencing choice of contraceptives, by rural-urban residence</b></p> <p><i>Rural women</i></p> <ul style="list-style-type: none"> <li>• Access to health facility (in terms of distance and time taken)</li> <li>• Number of living children</li> <li>• Marital status</li> <li>• Age</li> </ul> <p><i>Urban women</i></p> <ul style="list-style-type: none"> <li>• Peer (friends) influence</li> <li>• Level of education</li> <li>• Convenience of a particular contraceptive method</li> </ul>
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Indongo, 2007



## 5.2 Conclusion and policy implications

Parents' reluctance to talk about sexual and reproductive health with their children was a recurring theme in the study. Parents' participation in guiding their children's sexual and reproductive behaviour is not stressed sufficiently in both the national reproductive health policy and the family planning policy. Ideally, parents are expected to provide information and advice to their children about sexual and reproductive matters. However, given the social and cultural context in Namibia, parents are often reticent when dealing with sensitive issues with their children. Most parents especially those in rural areas, would not want their unmarried daughters to become sexually active, nor would they want them to endure an unwanted pregnancy. These findings suggest that parents, in particular mothers, need to be aware of the importance of reproductive health education if they are to play a vital role in avoiding unwanted pregnancies among young women who become sexually active. Higher levels of contraceptive practice by sexually active young women who wish to avoid pregnancy might decrease the incidence of unwanted births in Namibia.

The data provide us with evidence to support arguments that programmes must target the area of limited parent-child communication. There are young women, especially in urban areas, who perceive their parents to be supportive of contraceptive use and those who communicate with parents, especially mothers, about family planning. These women are more likely than others to use contraceptives. However, it was apparent from focus group discussions that mothers discuss family planning with their daughters who have advanced in education, especially at tertiary level, than those who are still attending primary or secondary school. There is need for programmes to stipulate clear guidelines on how mothers could communicate effectively with their daughters on sexual and reproductive health issues at all stages of

schooling, and at different ages. Policies and programmes should adopt several approaches to address the need for more education on reproductive health. In rural areas, most mothers do not teach their children about contraceptives for fear that this will encourage permissiveness and promiscuity. This tendency leaves young women in an information vacuum. It is already argued by earlier researchers elsewhere that sex education does not increase sexual activity and can in fact lead to postponement of sexual initiation and to preventive behaviour once sexual activity begins (Grunseit & Kippax, 1993). Carefully constructed education programmes that address the needs of young women, gain their trust and work through their many misconceptions and fears, would be more successful than the present silence.

Young people in Namibia encounter difficulties when attempting to access services. They were concerned that a family or community member would discover their visit to a clinic. Therefore, protecting privacy and confidentiality is of the utmost importance and programmes have to create opportunities for young people to gather together, with or without adults present, to discuss reproductive health issues. Once again, it should be emphasised that more attention should be paid to parent-child communication on questions of accessing health services. Good communication is an important parenting skill. It is the key to building self-esteem as well as mutual respect. A strong family relationship can help children develop self-esteem, resist peer pressure and act responsibly when making decisions about sexual intercourse. Effective parent-child communication is a cornerstone of strong and healthy families. Parents must learn ways to communicate more effectively with their young children. How and what they communicate about body image, peer pressure, reproduction, sexuality, love and intimacy could make a significant difference in the health and well-being of their children. Therefore, parents must be provided with the skills to socialize their children in sexual matters.

This can be incorporated into various forums such as parent meetings, community meetings and church activities. Programmes that build communication skills on sexual matters may be an important starting point. Thus, communities where either elders or health care providers can work with young women in extracurricular activities should be encouraged.

Although the Namibian government had reacted positively to the difficulties that young women face, the challenge is to ensure the translation of all policy objectives into effective programmes and activities. Current sexual and reproductive health services for young people are popularised through media campaigns, peer education and outreach programmes. Mass media found in Namibia include radio, newspapers, magazines and television. Of them all, the radio has the widest coverage. Thus radio programmes seem to be a suitable means of reaching a large number of people with health information. Fears and myths regarding the use of sexual and reproductive health services can be dispelled by media advertising (e.g. in raising awareness of confidentiality), increased community acceptance of young peoples' needs for special reproductive health services and strengthened links between young people, education and health sectors (Stone & Ingham, 2003). For example, visits to the local sexual health facilities could be incorporated in the school sex education classes, or service providers might consider inviting a young person's drama or media group to produce an educational video to distribute to schools and youth groups. However, embarrassment and fears about lack of confidentiality are sustained only through a social context in which young people's sexuality is stigmatised. Thus, comfort in using reproductive health services effectively will be fully achieved only when familiar and social contexts change. For example, parents and other adults need to be realistic and more open-minded about young people's emerging sexuality.

The teenage years are a time for sexual exploration and tendency to experiment with sex before marriage. Young people are learning about their bodies and experiencing new sensations. Often, it is only after having sex that they think about the possibility that they might be pregnant or infected. Parents may, therefore, benefit from guidance and advice on how to address the topic of sexual behaviour with their children, and schools might consider holding discussions during sex education classes about the consequences of engaging in sex and in taking care of one's sexual health. Comparative research on sexual and reproductive health among young women in different countries has already demonstrated that greater acceptance of young people's emerging sexuality is not associated with increased levels of sexual activity but is associated with improved sexual health (Darrock, 2001). Removing some of the barriers to effective use is as much a challenge to health care professionals as is improving knowledge and skills among young people.

Health information and services for young people, however, tend to be concentrated in urban areas, leaving remote rural areas largely under serviced. Further, current programmes tend to focus more on information provision than on services. In Namibia, programmes and information services are currently offered to young people by a range of governmental and non-governmental organizations. Some are long standing organizations while others operate as short term projects. Although young women understand the information provided to them, parents interpret them differently and this hampers the success of programmes.

Despite the above, several strategies need to be adopted by programme managers and policymakers to improve access to the reproductive health care of young women as well as to enhance the quality of their care by providing services. Focus group participants spoke of service delivery

concerns that indicated a need for moderate changes to clinic infrastructure and reproductive health policy. For example, more facility personnel and equipment could be added to improve service delivery; extended hours of operation could be provided to meet young women's needs and separate waiting rooms could be established for young people so that young women might be encouraged to practice family planning without embarrassment or stigmatisation. In summary, young women felt a need for more service outlets, better training of service providers and sensitisation of their parents. A further topic requiring study is the negative attitude of young men towards contraceptive use. Whilst women placed greater emphasis on parent-child communication there were related concerns about young men and their training needs.

A youth-friendly environment could help attract and serve young women who may be too embarrassed or intimidated to seek services. The convenience of location, clinic hours, degree of confidentiality and style of services are important in accessing services for young women. Thus the study reiterates that there is need to develop broader plans that include ways to link services with other socialising agencies such as youth clubs. Clinic schedules could also be reorganised to serve young women better and train staff in youth counselling. Providers, who are mostly adults, have personal, cultural and religious views about how young women ought to behave and this influences the way they assist young women. Due to this, most young women often hesitate to tell them that they are sexually active and to talk about contraception.

The study further concludes that there is a need to develop and evaluate youth friendly policies and services. Health policies at the national and clinic levels need to be more youth-friendly, and youth-friendly services need to be more carefully implemented, monitored and evaluated. Health care providers

need to be updated on how national health policies and regulations affect young people's care as well as what specific and detailed protocols, guidelines and standards for treating young people exist. Further research work is, therefore, recommended to help determine whether youth-friendly services are cost effective and whether investing in them significantly improves young peoples' reproductive health.

Negative attitudes of health providers were often given as the reason young women avoid clinical services, in particular, for family planning services. Thus, even if the family planning policy has clearly stipulated that contraceptives should be provided to young women, some health providers resist such directives and formulate their own guidelines which effectively limit access to young women. When considering how to address this challenge, it is important to note that service providers are products of societal cultures and that, in most societies, sex between unmarried people is taboo. This deeply ingrained attitude could translate into disapproval or hostility. To help overcome such resistance or inappropriate performance, projects need both to select health providers who are supportive of providing reproductive health services to young people and to ensure their training. Health care providers can be selected according to their attitude, interest and willingness to be trained.

There is also a need to educate health providers about young women's needs. This would improve providers' interpersonal skills for working with young people on sexual and reproductive health issues. Health care providers who are well trained to deal with young people could provide effective counselling to help young people make informed choices about abstinence, contraception, STI prevention and treatment and pregnancy care. Providers' interest in working with young people and their ability to develop respectful relationships with their young clients were, thus, found to be the key to

ensuring young people's utilisation of services. Young women are always active agents who are aware of their needs. They require, however, services that allow them to make these informed choices and, thus, take ownership of their sexual and reproductive lives.

A clinical implication of the findings is that if young women are to choose effective methods, health care providers must become more involved as sources of support, or in suggesting sources of support. For young women who cannot talk to their parents or partners about contraception, providers could suggest alternative sources of support, such as other adult relatives, peer counselling or support groups. Although health care providers support all young women in communicating with parents about contraception, they should be aware that differences in parent-child communication are often influenced by race and ethnicity and by fertility experience, rather than by age.

Expansion of contraceptive method choice is important because the effectiveness of the injectable method depends on proper administration and injections can only prevent pregnancy but cannot halt the spread of sexually transmitted infections including HIV/AIDS. Young women who rely on injectables may also become pregnant inadvertently in the intervals between doses if they have poor access to services as is the case for many young women living in remote rural areas who may rely on mobile clinics which may be poorly stocked. Thus reliance on injectable contraceptives, which is found to be particularly high among sexually active young women in this study sample, may help to explain why a large proportion of young women especially adolescents, still give birth as teenagers.

Condoms protect against unplanned pregnancies as well as STIs, including HIV/AIDS. Therefore, the study concludes that condom promotion

programmes could play an important role in efforts to reduce the incidence of reproductive health problems among young women. The use of condoms should be encouraged so as to promote safe sex among young women. Knowledge of facilities such as where to get condoms and other sexual and reproductive health services available for young women should also be strengthened. To achieve this, however, there is need for government agencies and NGOs to strengthen teacher training, introduce parent education and community outreach programmes. There is also need for vibrant dialogue on the cultural constructions that shape the gender norms determining sexual and reproductive health of young women. Many prevailing gender norms negatively affect access to reproductive health knowledge, information and services.

Changing existing gender norms can improve the quality of reproductive health care, particularly for young women. Incorporating gender into reproductive health programmes for young people can be an opportunity to develop programmes and services for them. Gender can be incorporated in SRH by developing sex education programmes that address the specific needs of girls, educating young women about their bodies and fertility cycles, encouraging males to become involved in reproductive health education programmes and services and providing men with information about male and female biologies and sexual rights and opportunities to discuss sexual issues. Young women are usually less experienced than their partners and they often experience greater pressure to please them. Thus, teaching young women how to resist pressure to have sex and how to negotiate contraceptive use will help them to protect themselves.

Young women and their parents are facing a culture radically different from that in which previous generations grew up. When most of today's older generation were adolescents, social roles and expectations were better



defined by the community-appointed teacher. It is, thus, impossible to return to those days or to protect young women from modern sexual influences. Therefore, it is vital that policymakers and programme planners and managers become responsive to these changing circumstances. The role played by community-appointed teachers must now be assumed by government agencies, non-governmental organisations, church groups, parent groups and youth groups. Although dissension is inevitable, these agencies and groups must work together to develop programmes to deal with the issues facing today's young people.

The study also concludes that female education beyond primary school should be encouraged. This is important because women's education has a great impact on contraceptive use. If women are encouraged to obtain higher levels of education, they are likely to be more knowledgeable on sexual issues and have the ability to make decisions on their sexual behaviour. Thus, increasing female education is, not only good in itself, but also, for improving the general status of women in Namibia.

The results suggest multiple policy approaches to improving contraceptive use and reducing the risk of unintended pregnancy and STDs among young women. Programmes should emphasize choices. One choice is to delay having sex for as long as possible because young women who delay sexual intercourse with their partners may be more likely to plan their first sexual encounter and thus be more prepared to practice contraception. For this to happen, young men also have to be engaged. Young women who discuss contraception with their parents or partners are more likely to use a method in the long run. This suggests that teaching young women to be vigilant about, and comfortable with, such discussions may be an effective way to improve contraceptive use. Indeed, sex education programmes that actively engage

young women in role playing to learn to negotiate contraceptive use are likely to show positive results.

The results also point to several potential areas for programming, policy and research aimed at improved sexual and reproductive health services, including contraceptive use among young women. Programming could be strengthened by paying attention to gender-specific socio-behavioural norms that influence their ability to control sexual decision-making and negotiation. Regarding pregnancy prevention, emphasis should be placed on behaviours such as unprotected sexual intercourse and poor communication between partners as well as poor communication with their mothers. Another important point of programmatic focus, as mentioned above, is increased male involvement in sexual and reproductive health matters. Male involvement has a potential influence on young women's reproductive well being. By involving males in sexual and reproductive health programmes, they will learn to practise healthy gender roles and responsibilities, including the responsibility to practise safe sex to protect their health and that of their partners. Sexuality and other emerging issues such as human rights should be integrated into population education and reproductive health education programmes. They are currently not emphasised sufficiently in Namibian programmes.

Population policy should be the responsibility of governments, and in designing policy measures to help officials cope with the problems arising from a society's particular fertility pattern, it is important to distinguish between those behavioural and biological factors that have a direct impact on fertility and those socio-economic and cultural factors that affect fertility only indirectly through the proximate determinants. An understanding of the relationship between the direct and indirect fertility determinants permits a clearer perception of specific opportunities for effective policy interventions. A young woman's education is one major socio-economic variable that has a

great impact on the intermediate variables and hence on fertility. It should, therefore, be considered seriously in fertility related policies.

### **5.3 Recommendations**

The study has shown that use of contraceptives among sexually active young women is quite low, according to the 2000 data. Urgent policy issues should, therefore, be addressed if the Namibian vision 2030 contraceptive prevalence rate is to be achieved. The following are some recommendations that can be implemented, monitored and evaluated through relevant policy interventions.

- The Government of Namibia should initiate the Parent Education Programme on young peoples' sexual and reproductive health to enable parents to effectively communicate with their children.

The main purpose is to break down the poor communication between parents and children on sexual issues. A Parent Education Programme should be an educational programme that helps parents and other adults in the family to effectively educate young people about sex, changes of the body and pregnancy prevention. The Parent Education Programme should have a goal to improve parents' skills for educating and communicating with young people about sexual and reproductive health. This programme should be able to provide parents with the communication skills needed to respond to young peoples' questions, convey sexual values and attitudes and seize appropriate opportunities to initiate discussions about sexuality and other reproductive health issues.

The programme should also support parents to examine the positive and negative myths and values that influence their own and their children's attitudes and behaviour as they relate to gender equity, forming sexual

relationships and other reproductive health issues. The Parent Education Programme may be implemented within an institutional framework, which can exist within both the public and private sectors, to ensure broad impact and a high level of support for staff implementing these policies.

Appropriate settings for educational programmes should include parent-teacher associations, social or civic clubs, labour unions, religious groups and other organizations whose members are likely to be parents of young people. Brochures and simple booklets on key themes are also important resources to distribute to parents for them to refer to.

- Provision of reproductive health services to young women must be within the relevant country's legal framework. Laws should be clearly interpreted as to what services can be provided, under what circumstances and to whom. Cultural perspectives should also be considered in policy formulation.

When ambiguities exist, service providers can find themselves uncertain about particular actions, such as providing contraceptives to young unmarried clients. Although this research shows that a lot is known about young women's sexual and reproductive health, much at the same time remains unclear. Namibian young women remain vulnerable to HIV/AIDS because they do not believe they are at risk or their understanding of these risks does not prompt them to take action to protect themselves.

- The Government of Namibia needs to design youth friendly health services to make it easier for young women to obtain the sexual and reproductive health services they need. More mobile clinics should be established to reach underserved populations. A balance should also be established for resource allocation between urban and rural areas

(health directorates) so that service provision is comparable in all settings.

Considerable work remains to be done in Namibia to fully implement national policies on young peoples' health services. Priorities include ensuring the capacity to provide key services, strengthening the quality of care standards and orienting clinic staff to young peoples' sexual and reproductive health care, particularly in the area of counselling and appropriate ethical behaviour. This will require special training for clinic staff on young people's sexual and reproductive health needs, with special emphasis on the need for confidentiality. Thus, the Government of Namibia needs to improve Ministry of Health staff morale and motivation through measures such as appreciation, recognition, better wages and improved training opportunities. The Government of Namibia through the Ministry of Health and Social Services also needs to mobilise resources for expanding youth friendly health services to all regions of the country for implementation, monitoring and evaluation.

From the focus groups it was apparent that some of the more significant barriers to health service utilisation among Namibian young women appear to be psycho-social in nature. Increasing health service use will require changes in the attitudes and perceptions of young people at community level as well as some changes in values held by Namibian parents and adults in general. The need to enhance sexual and reproductive health education programmes in and out of school, is urgent to counter the high level of misunderstandings noted with regard to contraceptive use. This necessitates educational efforts outside the traditional classroom and clinic realm and within the structures of broader society.

Protecting the reproductive health of young people is of critical importance for the worlds' future economic and social well-being. Research and programme

experiences show that policy-makers and health care providers can increase young peoples' use of sexual and reproductive health services by supporting youth-friendly services within health facilities and by removing legal and institutional restrictions on unmarried young peoples' access to health services. However, although the making of youth-friendly services is important, other factors may have a more profound impact on young women's health-seeking behaviour. In particular, psycho-social and cultural beliefs might take precedence when young people are deciding where and when to go for reproductive health care. Therefore, before youth-friendly services projects are designed, it is critical to first examine the health seeking behaviour and beliefs, not only of young people but also of adults who influence young peoples' decision-making and, thereafter, any behaviour and belief found to conflict with project objectives should be addressed at community level as part of the larger project. Further efforts need also to be made to sensitize health professionals to young peoples' particular needs and to acknowledge their social and reproductive rights and abilities to make autonomous decisions and exhibit specific choices.

- The Namibian government must seek to expand educational opportunities for girls at least up to the secondary school level. The successful fulfilment of this need may require that education be made compulsory for all until the secondary school level. Such requirements will not only help to increase the age at marriage for women and promote more accurate perceptions concerning their fertility, but will also enhance women's capacity for fuller and more meaningful lives. Such compulsory education would necessitate a greater investment in education by the government but such an investment makes more sense than a non-qualitative expansion of maternal and child welfare services.

- There is an urgent need for interventions that can improve young women's abilities to address their sexual and reproductive health concerns. In addition to the parent education programme, school-based sexual and reproductive health education is one way to reach young women with the information that they need. If these initiatives incorporate community and parental involvement in both rural and urban areas, school based programmes would enable parents to contribute to their children's sexual and reproductive health education in partnership with schools. Young women could then get much reliable information and guidance that they themselves know they need.

One of the huge gaps identified in the Namibian case is that young women have nowhere to turn to for information and guidance. Despite the fact that there are basic services and initiatives in place, this need was repeatedly expressed by young women in this study. They fear talking to their parents, health care providers and to other adult members and, in most cases, their peer group discussions leave many questions unanswered. The fact that most information about reproductive health issues come from TV, radios and peers further highlights the lack of authoritative personal guidance in this matter. What is needed to fill the knowledge-use gap are interventions that offer appropriate messages with an emphasis on 'risk reduction'.

- There is generally high awareness of the family planning publicity presented through posters, television, health centres and films shown in local theatres. However, a perceived need exists for a medium that affords clear explanations with an opportunity to ask questions. Pamphlets and other materials available at hospitals, clinics and health centres are seen as less useful because they are impersonal and people have only limited time to read in those settings. It appears that

media coverage has created a widespread awareness of the national family planning programme. This does not, however, appear to be enough. Communication efforts should also inform people about methods and facilities, present choices and transmit messages that support child spacing, legitimize contraception and discourage early unwanted childbearing among young women.

Apart from emphasising parent-child initiatives, the findings of this study also suggest that reproductive health programmes need, and should, continue to create greater awareness of the risks of pregnancy and HIV infections among young women, and provide counselling on these risks. Traditionally, pregnancy prevention and STDs prevention have been addressed separately, but given the role of some contraceptives in protecting against both risks, providers should address them as interrelated problems. In addition, the challenge is to have health facilities with adequate medical staff and reproductive health services within easy reach of people in urban and rural places.