ORIGINAL RESEARCH ARTICLE

Factors influencing access and utilization of sexual and reproductive health services by adolescents in Namibia: Insights from nurses

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Abstract

The use of sexual and reproductive health (SRH) services by adolescents needs urgent attention worldwide, with a view to improving their health and wellbeing. The aim of the study is to examine and describe the factors that influence the access to, and utilisation of, SRH services by adolescents in primary healthcare facilities in Rundu District, Kavango East Region, Namibia. A qualitative approach with an explorative strategy was used, with data collected via semi-structured interviews. A convenience sampling technique was used to select 15 nurse respondents. Each interview was audio-recorded before being transcribed verbatim, and thematic analysis was used to analyse the data. Two themes emerged: factors influencing access to, and utilisation of, SRH services; and strategies to improve the access to, and utilisation of, SRH services among adolescents. The study's findings showed that the factors include a lack of comprehensive SRH services in many healthcare facilities; cultural factors; distance to health facility; insufficient information about the services provided; stigma; nurses' attitudes; and lack of privacy. The results from this study could assist the Ministry of Health and Social Services and its stakeholders to create strategies to address the factors influencing access to, and utilisation of, SRH services. *(Afr J Reprod Health 2025; 29 [1]: 109-117).*

Keywords: Delivery Of health care; primary health care; health facilities; namibia; reproductive health; adolescent; humans

Résumé

Le recours aux services de santé sexuelle et reproductive (SSR) par les adolescents nécessite une attention urgente dans le monde entier, en vue d'améliorer leur santé et leur bien-être. Le but de l'étude est d'examiner et de décrire les facteurs qui influencent l'accès et l'utilisation des services de SSR par les adolescents dans les établissements de soins de santé primaires du district de Rundu, région de Kavango Est, Namibie. Une approche qualitative avec une stratégie exploratoire a été utilisée, avec des données collectées via des entretiens semi-structurés. Une technique d'échantillonnage de commodité a été utilisée pour sélectionner 15 infirmières répondantes. Chaque entretien a été enregistré audio avant d'être retranscrit textuellement, et une analyse thématique a été utilisée pour analyser les données. Deux thèmes ont émergé: les facteurs influençant l'accès et l'utilisation des services de SSR; et des stratégies pour améliorer l'accès et l'utilisation des services de SSR chez les adolescents. Les résultats de l'étude ont montré que ces facteurs incluent le manque de services complets de SSR dans de nombreux établissements de santé; facteurs culturels; distance jusqu'à l'établissement de santé; informations insuffisantes sur les services fournis; stigmate; attitudes des infirmières; et le manque d'intimité. Les résultats de cette étude pourraient aider le ministère de la Santé et des Services sociaux et ses parties prenantes à créer des stratégies pour aborder les facteurs influençant l'accès et l'utilisation des services de SSR. *(Afr J Reprod Health 2025; 29 [1]: 109-117).*

Mots-clés: Prestation de soins de santé; soins de santé primaires; établissements de santé; Namibie; santé reproductive; adolescents; humains

Introduction

Adolescent sexual and reproductive health appears to be a universal area of concern[1]. Adolescents refers to young people between the ages of 10 and 19 years, who account for approximately 16% of the global population[2]. Mutua *et al.*[3], stressed that adolescents between the ages of 15 and 24 are susceptible to psychological, emotional, physical, and social changes that put their lives at risk. Furthermore, they are at risk because of increased sexual activity[4]. For these reasons, awareness campaigns that equip adolescents with adequate knowledge should be introduced to ensure their safety and productivity.

Ninsiima *et al.*[5], emphasized that despite adolescents being the largest population group, their SRH needs

are often neglected. Woog *et al.*[6], similarly argued that adolescents have widely recognized rights to receive accurate reproductive health education and services, yet few actually obtain the SRH services they are entitled to.

In order to reach and achieve the Sustainable Development Goals pertaining to universal access to SRH, there is a need to overcome contextual barriers by engaging youngsters in underserved areas, as well as adjust SRH services to their particular contexts to ensure efficacy[7]. Universal access includes the right to receive information and services related to safe and timely prevention, diagnosis, counselling, treatment, and care without the need to travel long distances[8]. Abdurahman et al.[8] further noted that when adolescents are going through a phase of growth and development, they often make suboptimal decisions that can cause harm. By exploring the factors that influence access to and utilization of SRH services by adolescents, improved care could be provided to adolescents by healthcare workers, which could also minimize risks.

Phongluxa *et al.*[9], reported in their study that there was a misconception about birth control pills, a sign that sex education was vital, but the current teaching quality remained a challenge. Furthermore, people should be able to choose to get married, but 40.4% of adolescents weren't able to choose who to get married to. Moreover, among sexually active adolescents, only 35.2% used contraception, and access to education and traditional gender roles favoured boys. Gurara *et al.*[1], added that almost a quarter of girls aged 15-19 were married, with an estimated 16 million adolescent females giving birth each year, 95% of whom were from low- and middle-income countries (LMICs).

An Ethiopian study indicated that the use of SRH services was just 34%[1], with Gurara *et al.*[1], explaining that a student's level of education, gender, and awareness of the availability of SRH services affect their use. Kiggundu *et al.*[10], noted that the numbers of unplanned pregnancies, unsafe abortions, maternal deaths, and sexually transmitted infections among adolescents in LMICs are unacceptably high because the majority of adolescents in these countries start to engage in sexual activity between the ages of 15 and 24. Furthermore, the same author stressed that almost all youngsters became sexually active before they turned 20, including 75% of young females in sub-Saharan Africa.

Shatilwe *et al.*[11], explained that long distances to clinics are one of the key challenges for pregnant adolescents, which affects their utilisation of SRH services. In addition, transport costs, inadequate infrastructure, and a lack of transportation worsen the situation[11]. Furthermore, Shatilwe et al.[11], noted that family dynamics, including abuse, can affect the utilisation of SRH services.

Pearce[12] noted that the largest proportion of Namibian females are 15-19 years old, of which only 24.5% use contraception[12]. In 2014, the Namibian government introduced adolescent-friendly programs to health facilities in Rundu district, with health workers being selected at random to run the programs. Despite this, there remains low utilization of these services, and the number of adolescents at risk is still high[13].

Talking about SRH is considered taboo across many parts of Namibia[14], making it difficult for adolescents to access services. This aligns with Gurara *et al.*'s[1] findings that most adolescents do not discuss sex-related issues with their family, friends, or healthcare providers. This is particularly concerning for adolescents who become pregnant, as their risk of maternal mortality compared to women aged 20-24 is five times higher.[9] According to Morris and Rushwan[4], about 16 million girls between the ages of 15 and 19 have a baby every year, which accounts for 11% of all births globally. Of these, 95% take place in LMICs. Shrestha and Awale[15] cautioned that early motherhood not only affects adolescents physically, but it can compromise their educational achievement and economic potential.[4]

Furthermore, Kiggundu *et al.*[10], noted that close to 12 million young people are living with HIV, and many of the approximately 7,000 adolescents who are infected with HIV each day live in LMICs. In addition, up to 100 million adolescents become infected with a curable STD each year[1]. Lastly, infant and child mortality rates are higher amongst children born to adolescents[13].

Methods

Study design

The researchers utilized a qualitative approach for this study, with explorative, descriptive, and

contextual strategies enabling them to gather data on the phenomenon under investigation. According to Hunter *et al*.[16], the aim of explorative research is to "understand the underpinnings of specific phenomena and explain specific and systematic relationships among them so that they are described in rich detail." Maree and Molepo[17] also explained that a qualitative research design is "naturalistic, focusing on natural settings where interactions occur." This paper presents the study design, analysis, and results in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) Guidelines[18].

Study setting and population

The research was conducted in the Rundu district in the Kavango East region. The district has five health centres and 12 primary healthcare facilities. Adolescent Friendly Health Services (AFHS) are provided at no cost, which includes maternal healthcare, childcare, and family planning. Each health centre employs five or six registered nurses, while the clinics employ two. The nurse-to-patient ratio at the facilities is 1:60, with the nurses being taught to provide adolescent-friendly SRH health services. The study population was comprised of registered and enrolled nurses in Rundu District. According to the Rundu District office, they employ 35 registered nurses and 37 enrolled nurses. These participants were conveniently selected from the eight local government areas in the state with plantation farming communities. The criteria for their selection were: 1) a registered or enrolled nurse working in primary healthcare in the district; 2) willing to be involved in the study; 3) available at the time of data collection; and 4) willing to provide written consent.

Data collection

Data collection took place in August and September 2022. The researcher approached potential participants and described the intent of the study; those who agreed to take part were asked to sign a consent form. Before data collection began, a pilot test was undertaken with four subjects, with the intention of amending the interview guide where necessary. The pilot interview did not reveal any need to amend the interview guide.
Following the pilot, the details for each interview were agreed to with each interviewee. Data were collected via semi-structured interviews as per the interview guide, according to the research objectives, the literature review, and the research questions. Field notes were made by the researcher to note nonverbal cues and body language. Locations that were suitable for the interviewees were selected and lasted 40-45 minutes.
The research questions posed were: (1) What factors might influence access to and utilisation of sexual and reproductive health services among adolescents in primary healthcare facilities in Rundu District; (2) What strategies should be used to improve adolescents' access to and utilisation of sexual and reproductive health services in the district?

Data analysis

The thematic analysis technique was used to focus on the participants' views, experiences, and perceptions of the phenomenon under investigation[19]. Braun and Clarke's[20] six phases of thematic analysis were employed, i.e., "Step 1: Familiarisation (getting to know the data); Step 2: Coding; Step 3: Generating themes; Step 4: Reviewing the themes; Step 5: Defining and naming themes; and Step 6: Writing up the analysis and generating a report."

Prior to collecting the data, the researcher took note of their personal views as well as their extant knowledge in order to achieve 'bracketing', i.e., to note and set aside their "a priori knowledge and assumptions, with the analytic goal of attending to the participants' explanations with an open mind". The study's trustworthiness was established through the use of Lincoln and Guba's[21] model, which confirms credibility, dependability, confirmability, and transferability.

Ethical considerations

Approval for this study came from the University of Namibia's Health Research Ethics Committee (ref: 37/2023), as well as the Ministry of Health and Social Services' Research Ethics Committee (Ref: 22/3/1/2). Written consent was provided by all interviewees, and the data collected will remain anonymous and confidential.

Results

Participants' characteristics

The 15 interviewees were all registered nurses based in northeast Namibia, ten of whom were female and five males. All of the interviewees were under 50, with most being between 25 and 47 years old. Seven of the participants had diplomas, while eight had an honours degree.

Theme 1: Factors influencing access to and utilisation of sexual and reproductive health services

This theme contains seven sub-themes: cultural factors, distance to health facility, lack of information, stigma, nurses' attitudes, facility/structure, and privacy.

Subtheme 1: Culture of silence/taboo

The nurses felt that adolescents do not utilize SRH services because they were not taught about sexual and reproductive health due to cultural beliefs:
"It might be these adolescent girls and boys; they grew up in certain cultures, whereby in this culture they are not taught about sexual reproductive health." (P4)

Subtheme 2: Distance to health facility

The participants emphasized that health facilities may be far away, and adolescents cannot afford the transportation costs.
"And also, I'll say structural barriers also. This will include maybe the place where the health facilities are located is maybe far from the people who are seeking the services." (P8)

Subtheme 3: Lack of information

The participants highlighted that the age group in question has no knowledge of the services offered at a particular health facility, sometimes because of misinformation:
"You know, these are the people that don't know what are the services being offered at the facilities, or most of them, they don't know the services that are offered at the facility that are targeting them." (P2)

Subtheme 4: Stigma

Adolescents are ashamed to be seen by the community or their family going for family planning services.
"Yeah, maybe when they were at home they decided that no, okay, the team is coming today to our area, I will go for family plan, but then reaching a point where we are operating from and then they see maybe someone that they know okay, maybe their brother, uncle, or what, what also are there, they say now if I will opt for this service they are going to tell others that no, I saw her." (P5)
"Yes, they will end up avoiding, and the other thing, also, the negative perceptions of individuals on reproductive health, they think that maybe it's just meant for those people who are doing sex." (P11)

Subtheme 5: Nurses' attitudes

The participants highlighted that nurses do not give adolescents the special attention they require and instead present negative attitudes and judgement.
"Because when these adolescents are coming, we end up judging them; you are too young, you are supposed not to have sex, you are supposed not to have a boyfriend, and you are supposed not to do this, that saying a lot of things instead of us accommodating them, telling them, okay, if now you are dating, this is what you have to do, so that you can live a healthy life." (P1)
"Our behaviour changes, and then when adolescents come in and tell you that I need this and this, maybe because you are busy or tired, you start shouting to that person, and then they will decide to leave and go instead of getting what they came for." (P10)

Subtheme 6: Facilities

Many of the participants highlighted insufficient facilities as a factor preventing them from rendering adolescent-friendly health services:
"They are not able to buy enough or purchase enough family planning [supplies], *so at the end of the day, the young women or the young adolescents*

become discouraged to always come in looking for service, but it's not available. And long queues at the facilities also." (P6)

Subtheme 7: Privacy

The structure of the health facilities may not allow for privacy.
"…in my case, in outreach, seeing people just under the tree where everyone is hearing what someone is telling them." (P1)

Theme 2: Strategies to improve access to and utilisation of sexual and reproductive health services among adolescents

This theme contains three subthemes: strengthen outreach programs; train health workers on SRH services; and raise awareness among adolescents.

Subtheme 1: Strengthen outreach programs

The participants highlighted that to strengthen outreach programs, they should provide SRH services at schools and bring services closer to communities. Sufficient family planning supplies should also be provided to schools, with adequate structures and screening.
"I think more effort needs to be put in terms of mobilizing these projects of the adolescent health services, like if the ministry could purchase enough [supplies]*."* (P12)

Subtheme 2: Training of health workers on sexual and reproductive health services

The ministry should train healthcare workers on adolescent-friendly services, as well as increase the number of facilities and nurses, and ensure the availability of supplies.
"So at least if the person gives an in-service training at the health facility, the other healthcare worker may also pick up some of the knowledge and skills." (P1)

Subtheme 3: Raise awareness among the adolescents

Participants highlighted that there should be promotional family planning activities and awareness campaigns for adolescents:
"…there should be more promotion of family planning [among] *adolescents."* (P13)
"I think awareness needs to be created more; maybe we need to go on the radio and have healthy talks about all the things so that at least our people know." (P12)

Discussion

The study revealed that due to cultural values, some adolescents have never received SRH services, are not able to talk about sex in front of adults, and are not allowed to seek family planning services. This is corroborated by Muhwezi *et al*.[22], who observed that adolescents never want to discuss their sexual and reproductive health concerns with their parents. Further, the study noted that girls in certain cultures have no freedom of expression and therefore cannot voice their concerns to family members regarding SRH. Stålberg *et al*.[23] similarly found that shyness and fear of family members influence access to SRH services, while early forced marriages, kidnapping, and rape resulting in unwanted pregnancies are further issues girls face in patriarchal societies. Furthermore, the participants in the study stated that adolescents also refrained from using preventive SRH services due to fear of discovery by their families. This was corroborated by Nduba *et al*.[24] who pointed out that although many adolescents know about family planning methods, they do not use them due to cultural beliefs, sexual norms, stigma, fear, and male dominance in decision-making. Bhatt *et al*.[25], similarly reported that adolescents lack access to family planning due to familial and religious beliefs, myths, and misconceptions. This is as per Nmadu *et al*.[26] who said that cultural and religious norms and taboos were the most significant barriers for adolescents.

This study showed that health facilities are often located far from people and also lack privacy, which is as per Stålberg *et al*.[23], who shared that adolescents need a place where they feel comfortable and secure, which they can afford to access. Geleto *et al*.[27] agreed that long distances affect the access and utilisation of healthcare services. Misinformation is another factor, with Pearce[12] agreeing that a lack of knowledge about available services and how to access them, including insufficient awareness about the side-effects of contraceptives, also contributes to these factors. Nmadu *et al*.[26] also found that most adolescents lack adequate knowledge about SRH, particularly as school health programs are on hold.

The findings of this study show that nurses do not give adolescents the special attention they require and do not attend to them in a timely manner. Nmadu[28] also found that some adolescents complain about the attitude and behaviour of healthcare providers, reporting that they are dissatisfied with the care they receive because of the judgmental attitude and the unprofessional behaviour of the nursing staff. The participants also indicated that some adolescents end up avoiding SRH services because of negative perceptions of individuals who use reproductive health services, and they think that they are just meant for people who are having sex. This was corroborated by Nmadu[28], who highlighted adolescents' fear of being stigmatised by society when expressing concern about being seen at SRH centres, which could result in them being labelled promiscuous. A study by Hall *et al.*[29] expressed that "sociocultural and religious norms that frame sex and its consequences as immoral and problematic may mark or taint sexually active adolescent females within their communities," leading to subsequent shame, mistreatment, and stigma.

This study shows that nurses do not give adolescents the special attention they require, including attending to them timeously. Aventin et al.[30] also stated that the negative attitudes of nursing staff at local clinics stop adolescents from accessing free condoms. Furthermore, many young women do not go to local clinics after having unpleasant experiences with staff. In addition, the study's findings corroborate those of Geleto *et al.*[27], who reported that many healthcare facilities lacked the requisite medical equipment and resources, which makes providing services challenging.

The participants argued that nurses should promote family planning for adolescents on social media platforms, radio, and television, as well as raise awareness among communities. This finding is in line with that of Nmadu[28], who said that adolescents believe there is a need to increase awareness about SRH in local communities. Handbooks and pamphlets that contain reproductive health information were suggested by adolescents, along with educational campaigns and seminars. Stålberg *et al.*[23] also stipulated that despite SRH services being a fundamental human right, many adolescents are not able to realize these rights. Lastly, Njenga[31] found that a focus on life skills in school is critical, arguing that sex education is vital, along with a focus on the broader social issues affecting adolescents. This, they argued, would instil confidence, build awareness of SRH, improve adolescents' negotiation and communication skills, and encourage them to be assertive in their decision-making about their SRH..

Strengths and limitations

The study addresses an important topic and provides a thorough exploration of the factors affecting the provision of AFHS in the north-east of Namibia. Thus, this study offers crucial insights into the factors influencing adolescents' access to and utilisation of SRH services in Rundu district. The use of qualitative methods allows for a deep understanding of the issues from the perspective of nurses working in the district. The scope of the study was restricted to nurses who provide services to adolescents in the urban area of Rundu district; therefore, the findings may not be applicable to other settings. It was not the researcher's intention to generalise their findings, however. The use of convenience sampling may introduce bias, as participants may not be fully representative of all nurses working in the region. Additionally, the study's reliance on self-reporting through interviews may lead to social desirability bias, where participants provide responses they perceive as socially acceptable. Triangulation of data from multiple sources or methods could enhance the credibility and validity of the findings. The study could benefit from incorporating perspectives from adolescents themselves, healthcare administrators, and other stakeholders involved in AFHS provision.

Conclusion

The purpose of the study was to assess and describe the factors that influence adolescents' access to and utilisation of SRH services in Rundu district. The findings of this study revealed that nurses have both positive and negative experiences when working with adolescents. The positive experiences include that nurses learn a lot and gain more knowledge about working with adolescents and feel good about their impact on the lives of adolescents. The negative experiences include services not being utilized by the intended target group and adolescents not knowing about the health services available to them. The adolescents' access to and utilisation of SRH services were influenced by individual factors,

social factors, and system-level factors. Individual factors included a lack of information/knowledge, while social factors included community and family norms, as well as cultural and/or religious beliefs that are against sexual activity and the use of AFHS. The system level factors included nurses' poor attitudes, a lack of contraceptives for adolescents, long distances to health facilities, and an inadequate number of nurses, leading to the poor provision of health services. Furthermore, the study identified some recommendations to increase access to and utilisation of adolescent-friendly programs, including training healthcare workers better, raising SRH awareness among the adolescents, strengthening outreach programs so that the services reach everyone, and providing adolescent-friendly healthcare services to all schools within Rundu district by re-starting the school health program.

Availability of data and materials

All the data, transcripts, and supporting documents used for this current study are available from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

The author contributions are as follows: DOA designed the study, developed the tools, undertook data collection and data analysis Writing original draft-DOA; Writing review and editing-DOA. VK designed the study, developed the tools, undertook data collection and data analysis. Both the authors proofread the manuscript and approved the final version.

Ethical approval and consent to participate

This study was approved by the University of Namibia Health Research Ethics Committee (HREC) (ref: 37/2023), as well as the Ministry of Health and Social Services' Research Ethics Committee (Ref: 22/3/1/2). Written consent was provided by all interviewees, and the data collected will remain anonymous and confidential.

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