

# Zimbabwe National Family Planning Council

**Knowledge, Attitudes and Practices of Contraceptive Use among Students in Selected Universities in Zimbabwe**



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Contraceptive Use among Students in Selected  
Universities in Zimbabwe**

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## Abstract

Unintended pregnancies are a major public health issue and continue to burden many countries in the world. Uptake of contraceptives among youth in Zimbabwe is still low at 12% for the 15-19 years and 49% for the 20-24 years largely due to limited access to contraceptive services in both rural and urban areas. Unmet need for family planning among young people remains high at 13% (15-19 years) and 10% (20-24 years). Fertility rate for the young people is also high at 110 for 15-19 years and 204 births per 1000 women for the 20-24 years. Young people continue to miss out on reproductive health services and suffer the consequences of related challenges such as unplanned pregnancies, unsafe abortion, maternal morbidity and mortality that might have been avoided. The study aimed at determining the level of knowledge, attitudes and practices on contraceptive use among young people in selected universities. A cross sectional study design was carried out at four purposively selected universities and a total of 537 young male and female students aged 18-24 years were interviewed along.

The median age was 21 years with 33% of the respondents being Pentecostals followed by Protestants (30%). 95% of the young women had never been married, 3% married while 1% were cohabiting. 33% of the respondents had less than a year at the institution while 25% had over three years. Sexual experience increased with age from 18% among those aged 18-19 years to 63% among those aged 22-24 years. 75% were able to discuss condom use with their sexual partners. More than 85% of the students across all ages said they never had multiple sexual partners, 42% among the 22-24 years said they would have sex with their partners without using a condom. 37% of the 22-24 age group agreed that condoms reduce sexual pleasure. The median age at first intercourse was 20 years. The pill was the most common contraceptive method (85%), while permanent methods had less than 8%. It was observed that long term and reversible contraceptives were not commonly used because their parents could easily notice them. Of note was 3% mentioning that there are traditional methods which prevent people from STIs and pregnancy. 67% reported that those who use contraceptives are responsible while 30% viewed them as promiscuous. Of the 512 sexually active, 52% were using EC 66% were using contraception for spacing while 34% were limiting. Only 32% had used EC once for the past 6 months prior to the survey. 1% stated that they got pregnant after using EC. 73% reported that continuous use of EC causes infertility while 7% said it cause cancers. More than 79% reported they would use EC again. Availability, accessibility, affordability, social norms, religion and health system related challenges were listed as obstacles affecting uptake of FP services.

Use of contraceptives among young women is significantly different from that of older married couples, and it is influenced by a myriad of educational, developmental, social, and psychological factors. Knowledge and awareness do not always increase uptake of contraceptives. There is need to motivate young people to use contraceptives appropriately and effectively and limit the trend of unplanned pregnancy and acquisition of STIs including HIV and AIDS. For effective programming there is need to understand the challenges young people face and come up with evidence based interventions. Service providers need to consider targeted interventions and strategies which can empower and overcome such obstacles. Tertiary institutions should consider amending their academic curricula to incorporate the family planning component as a section in their health related modules for students to acquire current knowledge in this area. There is need to strengthen investment in ASRH&R, strengthen youth friendly referral linkages between tertiary institution clinics and other service providers and family planning programming should utilize innovative strategies to override myths and misconceptions surrounding contraception.

## Acronyms

|         |   |
|---------|---|
| AIDS    | Acquired Immunodeficiency Syndrome                            |
| ASRH    | Adolescence Sexual Reproductive Health                        |
| CPR     | Contraceptive Prevalence Rate                                 |
| CUT     | Chinhoyi University of Technology                             |
| EC      | Emergency Contraceptive                                       |
| FP      | Family Planning   |
| FGD     | Focus Group Discussion  |
| HIV     | Human Immunodeficiency Virus                                  |
| IT      | Information Technology  |
| KAP     | Knowledge, Attitude and Practices                             |
| MICS    | Multiple Indicator Cluster Survey                             |
| MoHCC   | Ministry of Health and Child Care                             |
| MRCZ    | Medical Research Council of Zimbabwe                          |
| MSU     | Midlands State University                                     |
| MSU GC  | Midlands State University Gweru Campus                        |
| MSU ZC  | Midlands State University Zvishavane Campus                   |
| SAYWHAT | Students and Youth Working on Reproductive Health Action Team |
| SRH     | Sexual and Reproductive Health                                |
| SRHR    | Sexual and Reproductive Health Rights                         |
| NUST    | National University of Science and Technology                 |
| UN      | United Nations  |
| UNFPA   | United Nations Population Fund                                |
| UZ      | University of Zimbabwe  |
| WHO     | World Health Organisation                                     |
| ZDHS    | Zimbabwe Demographic Health Survey                            |
| ZNFPC   | Zimbabwe National Family Planning Council                     |

# **CHAPTER 1: INTRODUCTION**

## **1.1. Introduction**

The Government of Zimbabwe introduced contraceptives including emergency contraception to the general population but despite all these commitments, the issue of unintended pregnancies and unsafe abortions still exists. This could be due to limited information as sexual education is rarely taught in schools including tertiary institutions and is regarded as a taboo discussing it at home, and negative attitudes among the adolescents who are primarily those in need of contraception (Bruyn and Mallet, 2011). Adolescent sexual and reproductive health programming in Zimbabwe has targeted in and out of school youth and is weak in tertiary institutions. Thus, this study was conducted in four selected universities to assess knowledge, attitudes and practices (KAP) of contraception use among young people.

In recognition of the reproductive health challenges facing the youth, this study was carried out to establish the utilization of contraceptive services among youth in selected universities. The main issue was to explore the knowledge level, attitudes and practices among young people towards the use of contraceptives. This kind of study has not been conducted before in tertiary institutions in Zimbabwe. The study also helped to assess the magnitude of contraceptive services need for the tertiary students and their difficulties in accessing the same. Many of the previous study reports included little or no detail on the degree of knowledge, attitudes and practices of contraceptives among adolescents especially in tertiary institutions. Therefore, it was unclear which elements specifically contribute to the low uptake of contraceptives among adolescents in tertiary institutions.

The incidence of sexual indulgency and all forms of risk sexual behaviour among students in tertiary institutions is of great concern to the society considering the widespread of sexually transmitted infections, teenage and unintended pregnancies and other reproductive health related challenges which were all explored in this study. College life can be exciting and full of opportunities. It can also be stressful and challenging. Students develop a sense of independence and self-sufficiency as they discover and define themselves as a unique person. With the absence of the usual parental guidance, students are faced with a myriad of sexual and reproductive health challenges.

In collaboration with MoHCC, ZNFPC assessed the knowledge, attitudes and practices on contraceptive use among adolescents in selected universities in Zimbabwe. The results of this study enabled identification of service needs of young people with respect to contraceptive services. Results also provided information on level of awareness; utilization and the difficulties being faced by tertiary students in accessing reproductive health services.

## **1.2. Background**

Contraception is vital, not only because of the statistical evidence of utilisation of the services by women, but for economic and societal reasons as well. Women's ability to control their fertility through preventive care in the short term has long-lasting and far-reaching positive health outcomes. Most women around the world begin sexual relationships between the ages of 15 and 19 and face significant challenges in obtaining services and information to protect themselves from unwanted pregnancy and sexually transmitted infections, including HIV (Bankole and Singh, 2003; UNFPA, 2014; Wellings et al., 2006). As the world's population of 15 to 19 year-olds continues to grow beyond 600 million, countries will need to meet increasing demand for contraceptive services and information that address their specific needs (UNDP, 2015). The availability of, access to and utilisation of family planning (FP) services particularly by women has dual and mutually exclusive benefits of a substantial reduction in the recorded number of unintended pregnancies as well as enabling the advancement of women in their professional and individual spaces.

Historically, programs have supported either stand-alone adolescent clinics that offer contraceptive services, or adolescent-friendly contraceptive services offered in a separate room or in an "adolescent corner" within an existing health facility (Senderowitz, 1999). These programs demonstrate mixed effects (Denno et al., 2015; Tylee et al., 2007). Additionally, scale-up has been challenging for many countries due to complexity of the programs, with resource requirements threatening their long term sustainability (Hainsworth et al., 2014).

An estimated one-quarter of the world's population, 1.8 billion people is between 10 and 24 years of age. Among the population of sexually active adolescents worldwide, a sizeable proportion aim to avoid or delay pregnancy but lack the knowledge, agency or resources to make decisions regarding their reproduction. On average, unmet need for contraception is greater among unmarried adolescents than those who are married, however married

adolescents ages 15-19 experience a higher percentage of unmet need than all married (Peter Decat UGent, Ghent University. Faculty of Medicine and Health Sciences, 2015). Limited evidence is available about which strategies and programs most effectively reach distinct groups of adolescents in their sub-divides namely; married and unmarried, rural and urban, and younger and older youth. However, approaches that boost adolescents' knowledge and awareness of family planning (demand-side), frequently also result in them better knowing where and how to use services. Specifically, creating links or referral systems between schools and reproductive health services can increase adolescents' knowledge of and access to reproductive health services, as can community-based outreach.

In many countries, governments' statements, policies and plans regarding adolescents' access to contraception are forward thinking, but in practice, many government-supported service providers are reluctant to provide contraception to unmarried youth. According to the UN Convention of the Rights of the Child, adolescents enjoy the right to the highest attainable standard of health, including access to contraception information and services. Adolescents are also included in broader reproductive rights supported by a range of human rights treaties and conventions, which nearly all countries have ratified (Cook and Dickens, 2000; UNFPA, 2012; UN General Assembly, 1990). Studies consistently show that sexually active adolescents (married or unmarried) face many barriers to obtaining contraceptive services and products to prevent pregnancy, whether to delay, space, or limit pregnancy (Abdul-Rahman et al., 2011; Bankole and Malarcher, 2010; Biddlecom et al., 2007; ChandraMouli et al., 2014; Decker and Constantine, 2011; Glinski et al., 2014; Godia et al., 2014; Sidze et al., 2014; Tylee et al., 2007). Addressing these barriers within programs and policies is likely to improve the quality of services for all people who need contraception and is of particular importance to adolescents. These barriers include provider biases, lack of confidentiality and privacy, limited contraceptive options, financial constraints, legislative and policy inadequacies, and negative gender norms among others.

These barriers are a generalised component for the majority of adolescent regardless of geographical area, social or economic status as well In Zimbabwe, out of the total population of 13 061 239 million people, 32% are children aged 10 – 24 years (2012 Population Census Results). The unmet need for family planning services among the adolescents in the age group 15-19 is 12.6 % which is the highest among all women of reproductive age and 10% in 20-24 years (ZDHS 2015). The subsequent impact of this evidence guided gap in tertiary

institutions is yet to be holistically determined across the categories of institutions in the country. Anecdotal evidence from silo operations research by Civil Society Organisations indicate that increased sexual activities among young people, unwanted pregnancies, unsafe abortions and secondary infertility have become major reproductive health concerns in tertiary institutions in Zimbabwe. Contraceptive use has increased in Zimbabwe as indicated by the Contraceptive Prevalence Rate (CPR) at 67% (ZDHS 2015), from 59% in 2010 (ZDHS 2010/11) but among the adolescents, especially students in tertiary institutions, there seems to be a persistent gap between high sexual activity and contraceptive use in the presence of high contraceptive awareness. There is the need to understand the sexual behaviour among, knowledge and use of contraceptives among this high risk group in order to contribute to the development and implementation of reproductive health strategies to promote appropriate contraceptive practices amongst the students. Thus the aim of this study will be to assess contraceptive knowledge, attitudes and practices among students (18-24 years) in selected universities in the four provinces of Zimbabwe.

### **1.3. Problem Statement**

Unintended pregnancies which are an estimated 87 million out of the estimated 211 million pregnancies that occur each year contribute significantly to negative global health outcomes of alarming proportions which include among others unsafe and induced abortions, miscarriages, abuse of emergency contraceptives and death. Promising developments have been realised in recent years in a global effort to address the problems of unintended pregnancies, including accessibility and availability of contraceptives to all women and adolescents (WHO, 2009b). However the numbers of unintended pregnancies are set to continue to grow worldwide.

Factors that frequently expose the young people to increased risk of unintended pregnancy include sexual experimentation and risk taking, as well as limited ability to plan ahead. The nature of relationships and frequency of intercourse is often different during adolescent years compared with later in life. For many youth, sex is largely unplanned and sporadic, yet few young people know about the option of contraception including emergency contraception (EC) after unprotected intercourse (Farquharson and Stephenson, 2010). According to Srikanthan (2008), —religions and cultural beliefs can also play a part in the reluctance of using contraception for young people.

In developing countries the lack of knowledge and access to contraception may result in young females resorting to unsafe abortions, which contributes significantly to maternal mortality and morbidity (Allison, Melanie and Andrew, 2005). Ensuring accessibility of contraceptives to adolescents can help to prevent unintended pregnancies. Prevention of unintended pregnancies in turn prevents the risk that adolescent pregnancy poses to mother and child including abortion. In addition, providing contraceptives can provide adolescents with a linkage to other reproductive health services (Parker, 2005).

#### **1.4. Research Questions**

- a) What is the level of knowledge with respect to contraception use among young people in selected universities?
- b) What are their sources of the contraceptives?
- c) How do students in universities use contraceptives (contraceptive practices)?
- d) What are the attitudes towards contraceptive use among students in universities?

#### **1.5. Objectives of the Study**

The aim of the study was to assess the knowledge, attitudes and practices on contraceptive use among young people in selected universities. The specific objectives of the study were:

- To determine the level of knowledge among young people in selected universities towards the use of contraceptives
- To explore the attitudes and practices among young people in selected universities towards the use of contraceptives
- To determine the health systems related challenges affecting access to and utilisation of contraceptives among young people in selected universities
- To provide possible actionable recommendations to significantly increase contraceptive services utilization among young people in tertiary institutions

## **CHAPTER 2: CONCEPTUAL FRAMEWORK**

### **2.1. Introduction**

The framework of this study was adapted from Bertrand (2006). It hypothesises that reproductive health problems are a complex interplay of the dependent and independent variables (Figure 2.1). While knowledge, attitudes and beliefs determine such practices, they are themselves traditionally inherited cultural, social and religious beliefs. The intervening variables are directly or indirectly influenced by background factors which include inter alia: the demographic, the socio-economic, the behavioural characteristics, the socio-cultural and religious; the community, and support systems (the availability, accessibility, acceptability and affordability of health care services).

The model hypothesises that individual behaviour either exposes or prevents the prevalence of contraceptive use. A positive relationship between knowledge and practices is expected. This relationship either directly influence practices or indirectly affect practices through attitudes, that is, as correct information about contraceptives and their availability increase, women are also expected to use the contraceptives.

Beliefs have an indirect and direct relationship with practices. It is hypothesised that beliefs directly affect practices or indirectly affect practices via knowledge and attitudes. As the belief in the supernatural/and or spiritual aetiology of diseases increases, women would shun modern health care facilities for SRH services. Modern contraceptive methods would logically be lopsided in favour of traditional methods. These methods include the consultation of herbalists, traditional and faith healers.

Age is a background variable which directly and indirectly shapes women's reproductive health knowledge, attitudes, beliefs and practices about contraceptives. Where user-fees are mandatory among women, they are less likely to visit modern health care facilities for contraception; in addition to compromising their knowledge about the basic facts of contraception. As user-fees increase, women are more likely not to use contraception.

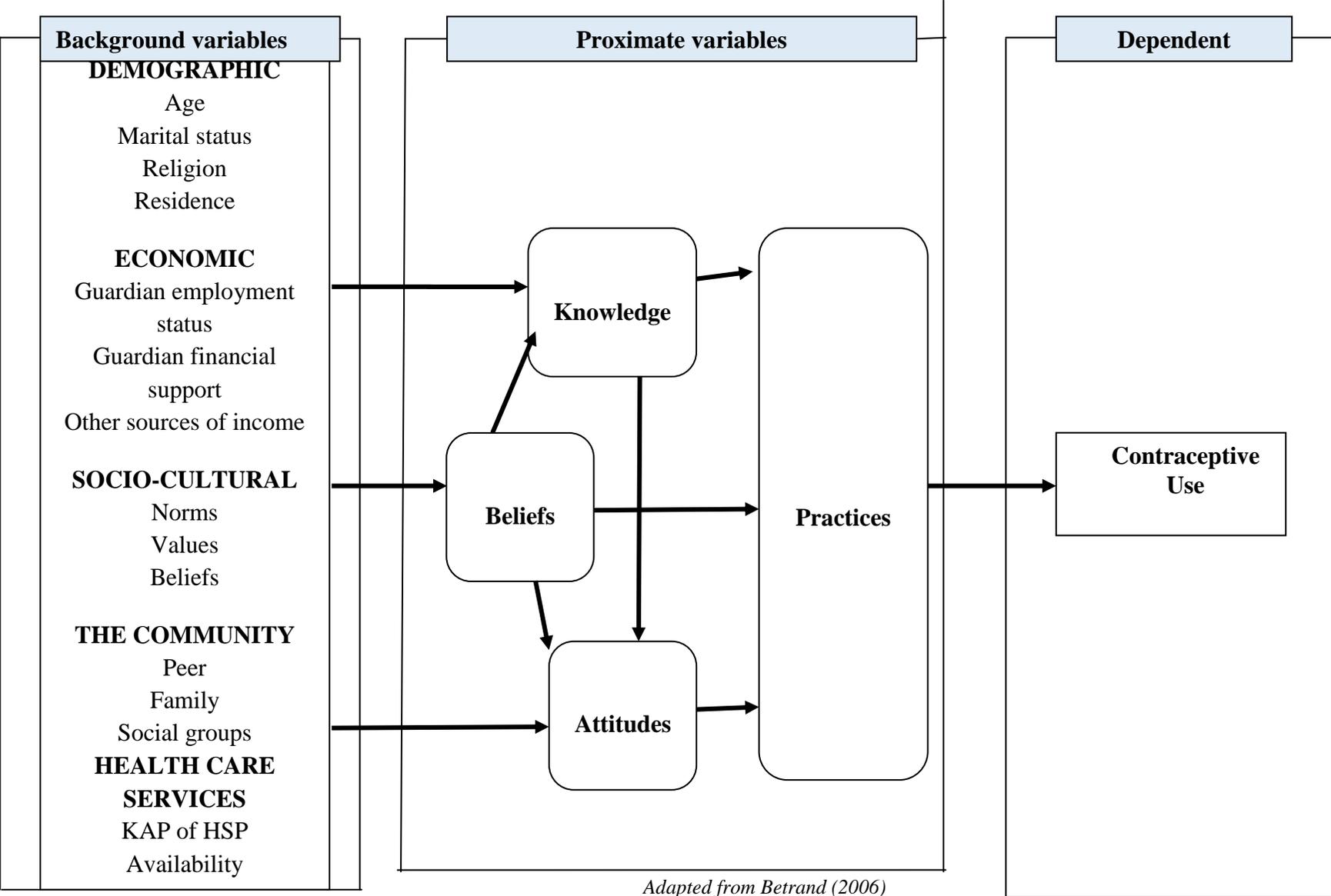
A positive association between marital status and women's contraception use is expected. As the perception of nuptial rights bestowed upon marriage by the payment of the pride prize ('lobola') by men increases, married men are likely to shun condom use with their wives. Hence married women are at a higher risk of pregnancy.

There is a positive relationship between the cultural, community, relationship ideologies about masculinity and women's reproductive health knowledge, attitudes, beliefs and practices. An increase in the perception that contraceptives are associated with a lot of side effects results in a negative attitude in the uptake of the services, a situation which would subsequently expose women to unwanted pregnancies, unsafe abortions and maternal morbidity and mortality.

A positive relationship exists between the origin and sources of contraceptive information and women's knowledge, attitudes beliefs and practices. For instance, as friends, relatives and social groups are the most preferred or consulted sources of such information, there tends to be increases in myths, misconceptions and downright exaggerations about the beliefs and knowledge of contraceptives, the availability, accessibility and affordability of the contraceptives and the benefits of utilising such services. An increase in such misconceptions, results in women nurturing negative attitudes towards the utilisation of modern contraceptives.

A positive relationship exists between utilisation of modern contraceptives and women's reproductive health knowledge, attitudes, beliefs and practices. Where modern contraceptive services are available and accessible, women are likely to be knowledgeable about the options at their disposal. Crucially, misconceptions and myths underlying contraceptive use are likely to be dispelled as a result of the dissemination of correct information by modern health care providers. As correct and accurate information from modern health care services increases, women would nurture a positive attitude towards the utilisation of modern contraceptives, which in turn would be an entry point to health-decision-making and practices. Figure 1 shows the conceptual framework for the study.

**Figure 1: The Conceptual Framework of the Study**



## **CHAPTER 3: STUDY METHODOLOGY**

### **3.1. Study Design**

A cross sectional study design was used. It involved both quantitative and qualitative data collection. It also reviewed existing official documents. Triangulation of information sources and opinions was central in gaining full proof of findings, and also as a means for validation of study information.

### **3.2. Study Sites**

The study was conducted in four selected universities in Zimbabwe covering the two regions; southern and northern. The study participants were drawn from the following selected tertiary institutions: University of Zimbabwe, Chinhoyi University of Technology, National University of Science & Technology, Midlands State University.

### **3.3. Study Population**

The target population consisted of:

- Male and female tertiary students aged 18-24 years from the selected institutions
- Departments responsible for students non-academic affairs such as Health services
- Peer educators/ behaviour change facilitators at the selected universities

### **3.4. Sampling, Recruitment and Data Collection Methods**

#### **3.4.1. Desk Review**

The purpose of a desk review was to gather contextual data to understand the factors that have a bearing on contraceptive use by young people in Zimbabwe. The documents were purposively identified with the help of the MoHCC and partners supporting or implementing health programmes in the country. Documents which were reviewed include:

- Policy documents including Adolescent Sexual and Reproductive Health Strategy, life skills curriculum, international protocols and declarations and laws related to ASRH (e.g. on contraception and abortion). The review gathered information on laws and policies that relate to adolescent sexual and reproductive health and rights including age at marriage, age of consent, ongoing debates around the laws, e.g. compliance with their

implementation and contradictions between the laws (legal age of majority/ marriage versus legal age of consent).

- Studies on contraceptive use conducted in Zimbabwe, the ZDHS and the MICS were reviewed to inform the study design through identifying the strengths and weaknesses of previous studies and also provide a basis for comparison of study results.

### 3.4.2. Sampling Design and Sample Size

Two university tertiary institutions were purposively selected from each of the two regions (Northern and Southern) among the 10 provinces in Zimbabwe. The national modern contraceptive prevalence rate for the young people was used to determine the sample size at 95% confidence level. The total sample size will be **537** young women aged 18-24 years. The young women were proportionately sampled using the distribution of young women by tertiary institution. Table 1 summarizes the sampled tertiary institutions per each of the selected provinces, the proportional to size samples for young women, the number of focus group discussions conducted and key informants interviewed.

### 3.4.3. Study Sites and Sample Size

**Table 1: Study Sites, Sample size Type and Number of Interviews conducted**

| Province         | Institution                                  | KIIs, (health service providers) | Focus Group Discussions (young women and men) |                     | Structured Interviews with young women |
|------------------|--|----------------------------------|---|---------------------|--|
|                  |  |                                  | No. of FGDs                                   | No. of Participants |  |
| <b>Bulawayo</b>  | National University of Science & Technology  | 4                                | 3   | 30                  | 98                                     |
| <b>Harare</b>    | University of Zimbabwe                       | 4                                | 3   | 30                  | 156                                    |
| <b>Mash West</b> | Chinhoyi University of Technology            | 4                                | 3   | 30                  | 98                                     |
| <b>Midlands</b>  | Midlands State University: Gweru Campus      | 4                                | 3   | 30                  | 115                                    |
|                  | Midlands State University: Zvishavane Campus | 2                                | 3   | 30                  | 70                                     |
| <b>Total</b>     |  | <b>18</b>                        | <b>15</b>                                     | <b>150</b>          | <b>537</b>                             |

#### **3.4.4. Data Collection Tool for the Survey**

Interviewer-administered questionnaires were developed and translated Shona and Ndebele. They were then back-translated for content validity and consistency checks. The structured questionnaires were programed into electronic tablets and were administered through face to face interviews. The questionnaire covered the individual knowledge, attitudes and practices with respect to contraception. The questionnaire comprised of the following sections:

- a. Demographic characteristics - age, marital status, education, religion, residence
- b. Knowledge on contraceptives
- c. Attitudes towards contraceptive use
- d. Contraceptive practices – current and ever use, use at first and current sex
- e. Sexual behaviour - ever had sex, age at first sex, alcohol and drug abuse,
- f. Pregnancy history - ever been pregnant, age first pregnancy, pregnancy, whether wanted or not
- g. Self-efficacy - confidence in refusing sex, confidence in accessing contraceptives
- h. Discussion with parents/guardians on SRHR issues
- i. Access and utilisation of SRH information and services within the institutions

***Inclusion/exclusion criteria:*** The following inclusion/exclusion criteria were used to determine the young women to include in the study:

- (i) All tertiary female students aged 18-24 years across the institution's faculties or departments who gave consent to participate in the study in the selected institutions.
- (ii) All tertiary students aged 18-24 years across the institution's faculties or departments who did not gave consent to participate in the study were be excluded.

#### **3.4.5. Focus Group Discussions**

Focus group discussions were conducted among the following groups:

- Young women at tertiary institutions aged 18-24 years to cover factors at interpersonal, organizational, community and public policy level; and
- Young men at tertiary institutions aged 18-24 years to cover factors at interpersonal, organizational, community and public policy level.

**Sample Size:** Three FGDs were conducted at each institution. In total, 5 FGDs were conducted among the young women only, 5 FGDs were conducted among young men only and 5 FGDs were conducted for both young men and women at each Institution.

**Recruitment:** Young women and men aged 18-24 years at the tertiary institutions were selected to participate in the FGDs. Each group consisted of 8-10 participants.

**Inclusion/exclusion criteria:** The following inclusion/exclusion criteria were used to identify young women to participate in the FGDs:

- a. Participants were aged 18-24 years at the tertiary institution
- b. Young men and women were excluded from participating in the discussions if they decline to consent to their participation
- c. Young men and women who had not participated in the survey were selected to minimize respondent fatigue.
- d. Young women and men who had participated in the women or men FGDs were also excluded from participating in the mixed sex FGDs.

#### **3.4.6. Key Informant Interviews**

Key informant interviews were conducted with key stakeholders and programme managers from institutions implementing ASRH programmes at provincial levels and from those responsible with students' welfare at the tertiary institutions. These interviews provided data on the policies, strategies, provision of ASRH services including contraceptives and interventions to address the low uptake of services. The interviews also were audio recorded to capture all the information and the critical points.

**Sampling:** Key informants at provincial level were purposively selected. At most four (4) key informants were purposively interviewed per each institution. These were drawn from the following:

- Personnel responsible for students affairs especially health aspects
- Programme officers working within the tertiary institutions providing health information and services
- Peer educators/ behaviour change facilitators at the selected tertiary institutions

**Data Collection:** A key Informant interviewer guide was used during the in-depth interviews.

### **3.4.7. Data Collection**

There were two data collection teams. Each data collection team had four (4) members, comprising three (3) enumerators and one (1) team leader. Team leaders participated in data collection as well as sensitisations, obtaining permission from the institutions to conduct the study and spearheading mobilisation of young people at institutions. Four of the enumerators were females within the age group 20 – 24 years from each selected institution with the ability to speak one of the major local languages including Shona and Ndebele. To facilitate the referral process, enumerators provided respondents with information on SRHR services available, closer to the tertiary institution.

The survey took a total of two (3) weeks as follows:

- Two days were spent on training and pre-testing of the study tool. Pre-testing of the tools was conducted in Harare at the Harare Institute of Technology University.

### **3.4.8. Training of Field Staff**

There was a 1-day training workshop for enumerators to administer the questionnaire and FGD guides, and use of the tablet. Mock interviews were carried out during the training. Team leaders and supervisors were also trained on data management techniques in the field.

### **3.4.9. Pre-Testing and Pilot Testing**

Pre-testing of the research tools was conducted in Harare where the training of research assistants took place. Harare Institute of Technology University was selected for the pre-tests as the institution was not part of the sampled facilities for the study. The study was pilot tested to assess the following:

- The feasibility of approaching institutions and asking for permission
- The feasibility of approaching respondents and asking for permission
- The processes of institution entry
- Pre-testing the research tools for sequencing/flow of the questions and content validity of the questions
- Time required to complete the interview
- Identify other field logistical problems that are likely to be encountered during research implementation

### **3.5. Data Management and Analysis**

Data from the field was edited for accuracy, missing data, validity and consistency. Quality controlled questionnaires were programmed into the Tablet using the CSPRo software that allows for electronic data capturing and data validation checks. The datasets were exported from CSPRo to SPSS and STATA for analysis. Specific indicators were generated in SPSS/STATA in line with the list of indicators that have been outlined in the study's conceptual framework. Cross-tabulations were developed and then used so as to enhance data interpretation where necessary.

The data was analysed to assess individual knowledge, attitudes and practices on contraception by the young people. The prevalence of contraception use was calculated as a proportion with 95% confidence. Content analysis was used to analyse qualitative data from the FGDs and in-depth interviews. Thematic analysis in line with study objectives was also used to interpret qualitative data from the FGDs and in-depth interviews. This qualitative data analysis was done and interpreted to support the generated quantitative data.

### **3.6. Quality Assurance**

Supervisors and team leaders were trained to ensure that the survey team strictly adheres to the protocol. Enumerators were trained on how to use the tablets and also trouble shooting any technical problems faced during data collection. An IT expert was always on standby throughout fieldwork to help in trouble shooting data management process using tablets in the field. Field supervisors were further trained on processes of downloading data from tablets to the laptop and quality controlling the data before sending it to the central data management server.

## **3.7. Ethical Considerations**

### **3.7.1. Clearance to conduct the study**

Clearance to conduct the study was sought from Medical Research Council of Zimbabwe (**MRCZ/A/2358**), Joint Research Ethics Committee for the University of Zimbabwe College of Health Sciences and Parirenyatwa Group of Hospitals (**JREC- 278/18**), Ministry of Health and Child Care and the Ministry of Higher and Tertiary Education, Science and Technology Development.

### **3.7.2. Informed Consent**

Written informed consent was obtained from each research participant. The informed consent forms were in English language only since the completed level of education of the target population was secondary or higher. An opportunity to ask questions until they fully understand the study and the implications of their participation was given to the participant. Participants were assured of confidentiality and the right to withdraw from the research at any time of the interviews and FGDs. Confidentiality was maintained by avoiding names and other identifiers.

### **3.7.3. Risks**

Measures were taken to identify, anticipate and minimize any potential long-term effects on individuals or groups as a result of the research. Some participants who felt uncomfortable while relating their experience of pregnancy or sexual abuse in which case interviewers were instructed to either stop recording or stop the interview depending on the wishes of the research participant. FGD participants were informed that the discussions were electronically recorded. Researchers were also trained and advised to refer the young people to specific services as needed.

### **3.7.4. Participant Reimbursement**

Participants were not compensated for their time and involvement in the study. A small gratuity in the form of refreshments was offered to those who participated in focus group discussions (US\$5 per participant).

### **3.7.5. Confidentiality and Anonymity**

All participants' information and records that contain names or other personal identifiers, such as informed consent forms, are being stored securely in a locked cabinet in areas with access limited to study staff to minimize potential breach of confidentiality at ZNFPC head office. The information gathered is being stored in a password-protected computer at ZNFPC offices in Harare that only the study team can access. All names and personal circumstances, which may lead to the identification of research participants, were modified in data transcriptions and translations; respondents were identified through a unique identifying number only. Unique codes were used to identify participants in the quantitative, key informant and in-depth interviews. Pseudonyms were used to identify participants in the FGDs. Except for FGDs; all other interviews were conducted in private.

### **3.8. Potential Benefits**

The results of this study provided tangible and practical benefits to address young people's SRHR needs in Zimbabwe:

- The recommendations helped policy makers to address more appropriately the SRH needs of young people at tertiary institutions, thereby improving services and prevention activities
- The methodologies and extent of the research's target groups offer recommendations adapted to the settings where the research takes place, together with invaluable and highly relevant information for public health policy-makers throughout the tertiary institutions in the country.
- The dissemination plan also offers details on the benefits for programme implementers, policy makers, and government representatives.
- Local stakeholders involved in the study (study sites, research partners, and other institutions linked to the study) received feedback of results and were presented with key findings from the study
- Publications will be produced, and the study will be presented in local, regional and international conferences on SRHR and young people's health.

### **3.9. Study Limitations**

There were inherent limitations in the difficult and delicate nature of working with young people. The study was limited in the selection process to recruit research participants, as it was going to be difficult and possibly unethical to try and recruit young people through snowball, randomised or opportunistic sampling methods. The study therefore selected young people who were already at the institution. Those not in the selected institutions were left out. Those excluded also comprised of those outside the target age bracket.

## **CHAPTER 4: STUDY FINDINGS**

### **4.1. Introduction**

Interviews with young women aged 18-24 years were conducted among 537 participants from all four institutions of higher learning. Focus group discussions with young people involving 77 females and 72 males and In-depth interviews involving 18 key informants were conducted to explore and understand the experiences, perspectives and views of the participants on knowledge, attitudes and practices of contraceptive use among young people in tertiary institutions. The analysis was critical to fully appreciate the meanings of these issues, and as part of the coding process they were ultimately grouped into key themes. The main findings of this study focused on knowledge, attitudes and practices of contraceptive use among young people in tertiary institutions.

### **4.2. Demographic Characteristics of Respondents**

This section presents age, marital status, religion and duration at institution as characteristics which provide a context for the interpretation of demographic and health indices of the survey respondents. A total of 537 young women aged 18-24 years were interviewed. The median age of the respondents (young women) was 21 years. Among religious affiliation, Pentecostals were the predominant group accounting for 33% of the respondents followed by Protestants at 30%. It was also noted that 95% of the young women had never been married. The proportion of respondents who reported being currently married was 3% whereas a percentage of the young women were cohabiting (living together).

Regarding study duration at the institutions, 33% of the respondents reported to be less than a year at the institution, followed by those between one and two years at 29%. The proportion of respondents who had been at the institution for over three years was 25%. Table 2 shows the demographic characteristics of the respondents.

**Table 2: Socio-Demographic Characteristics**

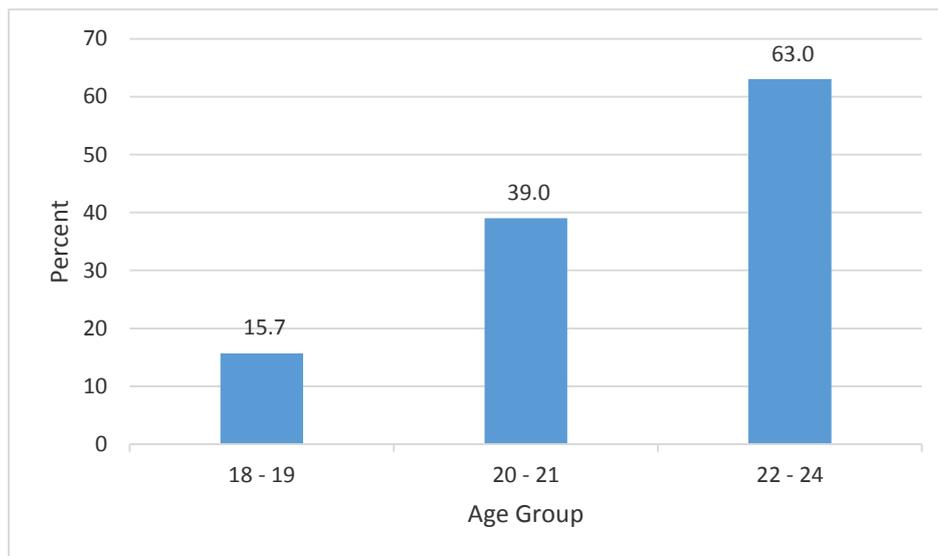
| <b>Background Characteristics</b> | <b>Institution</b> |             |               |               |            | <b>Number</b> |
|-----------------------------------|--------------------|-------------|---------------|---------------|------------|---------------|
|                                   | <b>CUT</b>         | <b>NUST</b> | <b>MSU GC</b> | <b>MSU ZC</b> | <b>UZ</b>  |               |
| <b>Age group</b>                  |                    |             |               |               |            |               |
| 18 - 19                           | 16                 | 25          | 22            | 7             | 38         | 108           |
| 20 - 21                           | 39                 | 48          | 42            | 25            | 82         | 236           |
| 22 - 24                           | 43                 | 25          | 51            | 38            | 36         | 193           |
| <b>Marital Status</b>             |                    |             |               |               |            |               |
| Never married                     | 96                 | 93          | 105           | 65            | 151        | 510           |
| Married                           | 2                  | 3           | 6             | 3             | 4          | 18            |
| Divorced/separated                | 0                  | 1           | 0             | 2             | 0          | 3             |
| Cohabiting                        | 0                  | 1           | 4             | 0             | 1          | 6             |
| <b>Religion</b>                   |                    |             |               |               |            |               |
| African Tradition                 | 16                 | 0           | 0             | 0             | 31         | 47            |
| Roman Catholic                    | 15                 | 16          | 16            | 9             | 23         | 79            |
| Protestant                        | 15                 | 38          | 43            | 25            | 41         | 162           |
| Pentecostal                       | 40                 | 34          | 40            | 24            | 38         | 176           |
| Apostolic                         | 7                  | 9           | 7             | 5             | 22         | 50            |
| Muslim                            | 1                  | 0           | 0             | 2             | 0          | 3             |
| None                              | 4                  | 1           | 9             | 5             | 1          | 20            |
| <b>Duration at Institution</b>    |                    |             |               |               |            |               |
| Less than one year                | 31                 | 31          | 40            | 21            | 53         | 176           |
| Between one and two years         | 16                 | 29          | 32            | 20            | 56         | 153           |
| Between two and three years       | 19                 | 16          | 6             | 5             | 26         | 72            |
| More than three years             | 32                 | 22          | 37            | 24            | 21         | 136           |
| <b>Total</b>                      | <b>98</b>          | <b>98</b>   | <b>115</b>    | <b>70</b>     | <b>156</b> | <b>537</b>    |

### 4.3. Sexual Behaviour by Young Women

Early sexual activity has been cited in many studies as one of the factors contributing to adolescent pregnancies (Baizerman M, 1977; Bumpass, L. L., Rindfuss, R. R., & Tanosik, R. B, 1978). Forty three percent of the respondents reported that they had ever had sexual intercourse. Figure 2 shows that sexual experience increases with age from 18% among young women aged 18-19 years to 63% among those aged 22-24 years. Out of all the age groups, 75% were able to discuss condom use with their sexual partners. More than 85% of the students across all ages said they never had multiple sexual partners, 42% among the 22-24 years said they would have sex with their partners without using a condom. Sexual behaviour includes the perception of the students mainly on condom use. Most female

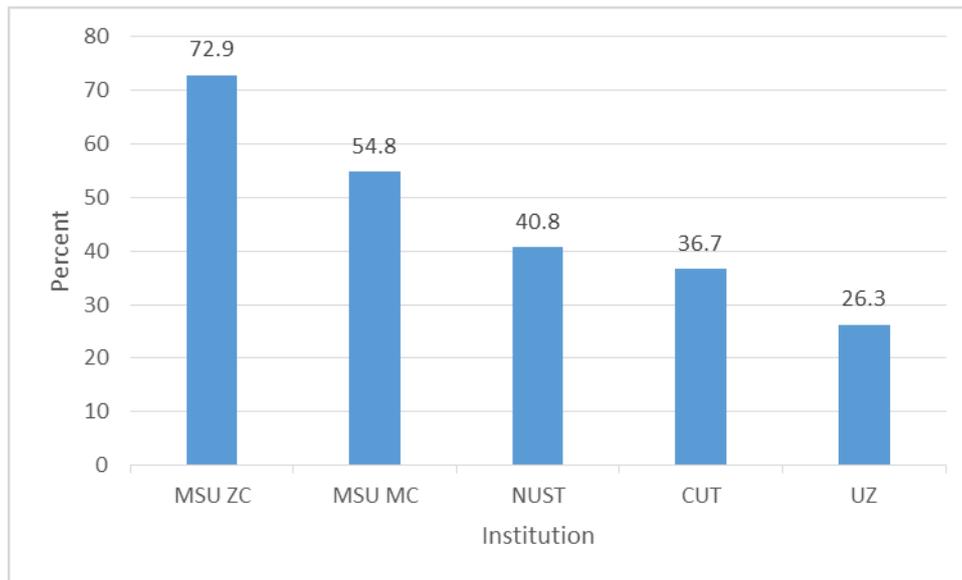
students had a perception that men discontinue condom use sometimes during sexual intercourse. Eighty three percent and 48% of the 22-24 age group agreed that men and women discontinue condom use during sexual intercourse respectively. Fifty four percent of those aged between 18 and 19 years did not know if condoms reduce sexual pleasure. However 37% of those aged between 22 and 24 years agreed that condoms reduce sexual pleasure.

**Figure 2: Ever Had Sexual Intercourse by Age Group**



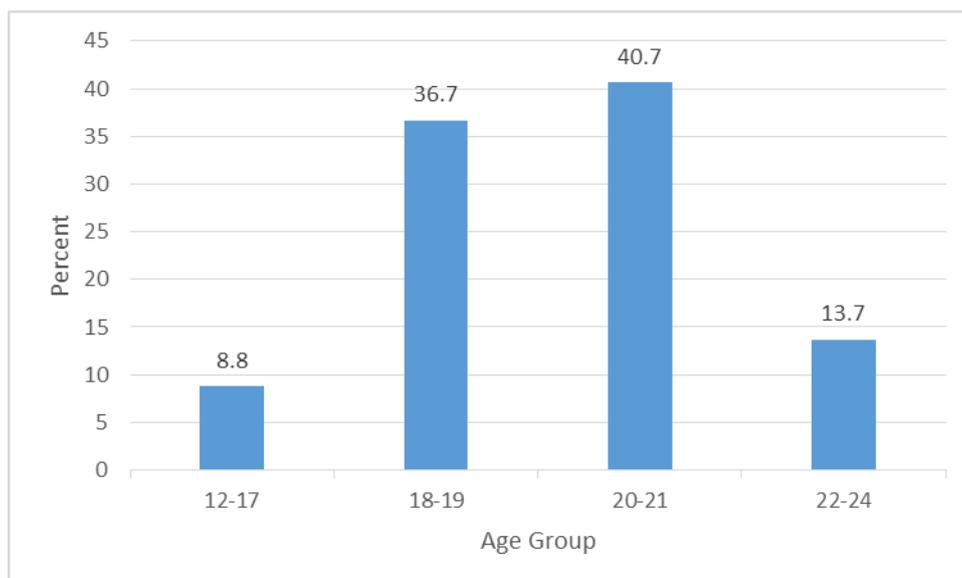
Exposure to SRHR education and information is critical to empower young people to make informed decisions about their sexual life. Figure 3 shows that the highest proportion of young women sexually experienced was recorded at MSU ZC (73%) and the least was reported at UZ (26%).

**Figure 3: Ever Had Sexual Intercourse by Institution**



Age at first marriage can be used as a proxy for the beginning of exposure to the risk of pregnancy. However, because some women are sexually active before marriage, the age at which women initiate sexual intercourse more precisely marks the beginning of their exposure to reproductive risks. The median age at first intercourse for the young women was 20 years. Of the proportion who reported having had sexual intercourse, 9% reported having had sexual intercourse before the age of 18. Figure 4 shows the proportions of respondents reporting having had sexual intercourse by age groups.

**Figure 4: Age at First Sexual Intercourse**

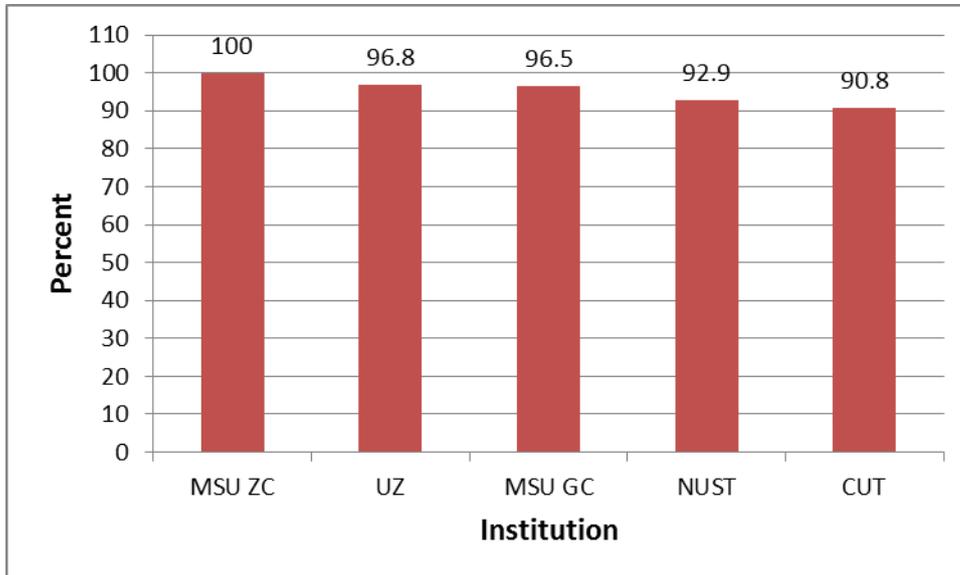


FGDs with young men revealed that circumcised young men do not use the condom as a method of protection because the penis would be very dry therefore putting a condom will reduce sexual pleasure. Exposure to SRHR education and information is critical to empower young people to make informed decisions about their sexual life for them to know the benefits of delaying sexual debut

#### 4.4. Knowledge about contraceptives

Demand creation for contraceptives is essential for knowledge and consequently for uptake of the services. One of the key issues explored in this study was the knowledge of contraception by young women in tertiary institutions. Use or non-use of contraception depends on the knowledge about contraceptives of an individual. Ninety five percent of the young women in tertiary institutions had knowledge of contraception. Information from the focus group discussions with both young men and women showed universal knowledge of contraceptives. The highest proportion of young women who reported knowing about contraceptives was highest at MSU ZC (100%) with CUT having the lowest percentage at 91 as shown in Figure 5.

**Figure 5: Knowledge about Contraceptives by Institution**



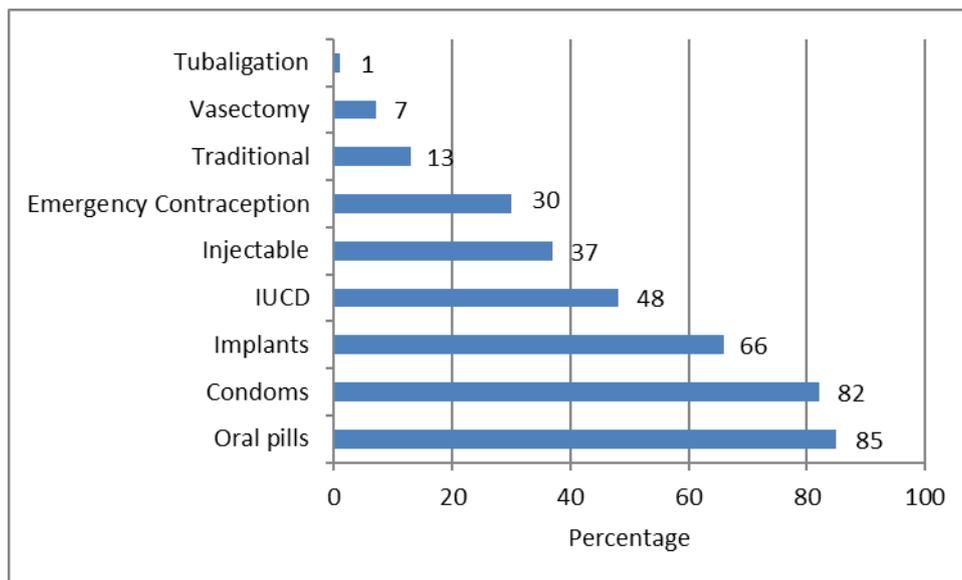
Young men and women who participated in focus group discussions managed to name both the traditional and modern contraceptives they knew including abstinence and even highlighted their most preferred methods which included the male condoms and emergency contraception.

*“I know quite a number of these contraceptive methods. These include male and female condoms, morning after pills, jadelle, control and secure pills, Depo-Provera, tubal ligation, vasectomy and abstinence”(FGD Mixed\_MSU MC).*

#### 4.4.1. Methods of Contraceptives Known

The study tried to explore the types of methods of contraceptives known by young men and women in tertiary institutions. Upon asking them the possible contraceptives they were aware of, the questions were not specific to a particular method but wanted to establish if the respondents had any FP methods they were aware of despite the type. The most known method was the pill with 85% of young women mentioning it, followed by condoms, implants and IUCD at 82%, 66% and 48% respectively. The least known methods were the permanent methods (vasectomy with 7% and tubal ligation with 1%) as shown in Figure 6.

**Figure 6: Knowledge about Contraceptives**



One of the key components of FP programmes is to integrate with HIV services. The study tried to unearth if young women and men in tertiary institutions know any contraceptive which prevent pregnancy and STIs including HIV. The majority of the young women (92%) indicated that they were aware that condoms act as a dual protection method while a significant 3% mentioned that there are also traditional methods which prevent people from STIs and pregnancy. Analysis by age, marital status, religion and duration at institution shows that knowledge about contraceptives is consistent. There are no significant variations noted.

#### **4.4.2. Knowledge about emergency contraception**

This study was also motivated by the continued anecdotal reports showing a common occurrence in the high consumption of emergency contraceptive among young people in tertiary institutions. Knowledge about emergency contraceptives was nearly universal at 92% among young women in all institutions. It can be observed that the older the participants were, the more knowledgeable they were about emergency contraception.

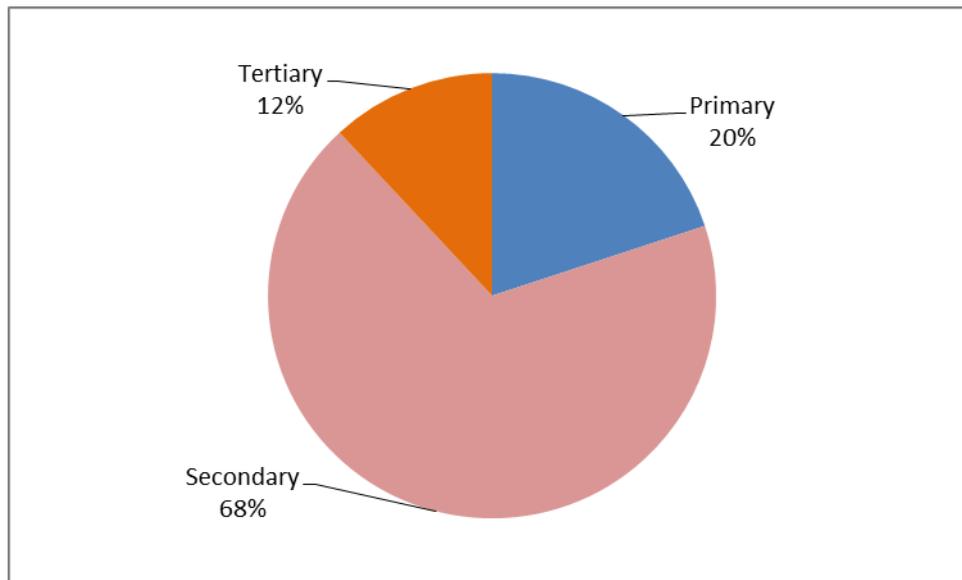
#### **4.4.3. Knowledge of contraception by schooling level**

Exposure to formal education is a factor that contributes to knowledge level about contraceptives. This study revealed that the knowledge level about contraceptives increased as the duration of an individual at the institution increased. The proportion of young women who reported knowledge about contraceptives ranged from 91% for those who had less than one year at the learning institution to 99% for those with more than 3 years at the institution. Knowledge about contraceptives also varied with age. The highest proportion (98%) of respondents aged 22-24 reported knowing about contraceptives, whereas for the lower age groups it was 94%.

The study revealed that initial knowledge about contraceptives is acquired at lower school levels. The majority of young women (68%) got to know about contraceptives at secondary school while only 12% got to know about contraceptives at tertiary institutions (Figure 7). This concurred with the findings that the teacher is the main source of contraceptive information despite the majority of them highlighting that it was at their secondary level when they were exposed to contraception issues in their learning curricular as indicated during the focus group discussions conducted. Findings from the focus group discussions indicated that, health workers at the institutions through their health talk sessions, peer educators (SAYWHAT) and other different civil society organisations from outside institutions are also providing formal teachings about contraceptives at Tertiary institutions unlike in the formal teaching by lecturers.

*“Our lecturers here are not bothered about teaching us about contraceptives. They are always focused on their core lectures. After their time lapses, they will leave the lecture rooms without mentioning anything about contraceptives. However a few will teach about health and life skills at colleges in passing as orientation to new students”.*  
(Female FGD\_CUT)

**Figure 7: Knowledge about Contraceptives by Schooling Level**



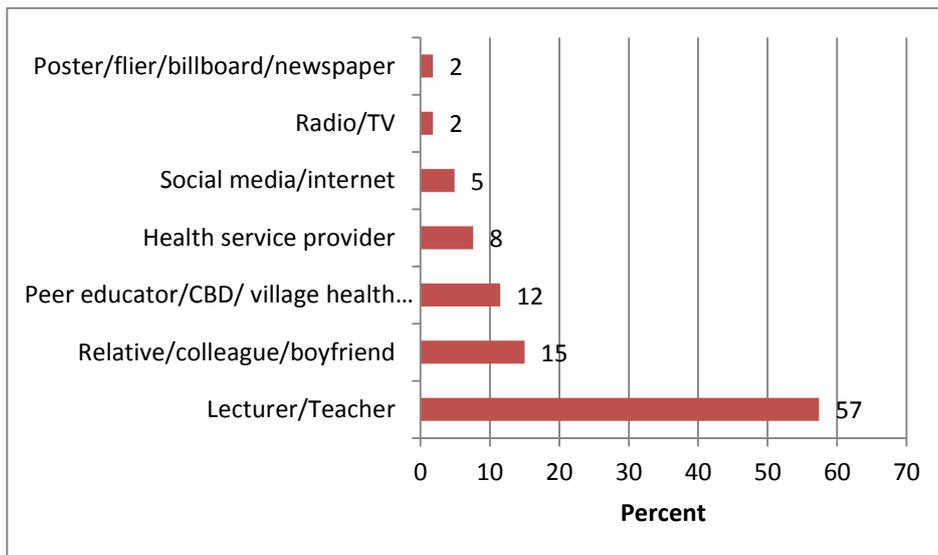
The view from focus group discussion participants also reflected that they had known about contraceptives from secondary school education.

*“Specifically I myself, I started to know about family planning methods from our form 2 science teacher during a lesson on reproduction. Almost everyone was interested about the subject of reproduction. I believe that most of my colleagues here really enjoyed this topic as I did”. (Male FGD\_MSU MC)*

#### **4.4.4. Sources of contraceptive information**

Information about contraceptives is vital in influencing decision making towards contraceptive use. This study brings out that the majority of young women respondents’ (57%) main source of contraceptive information was the teacher/lecturer with a remarkable proportion (15%) highlighting their main source as a relative, colleague or boyfriend. Peer educators, community based distributor and village health workers (12%) also were other respondents’ main source of information.

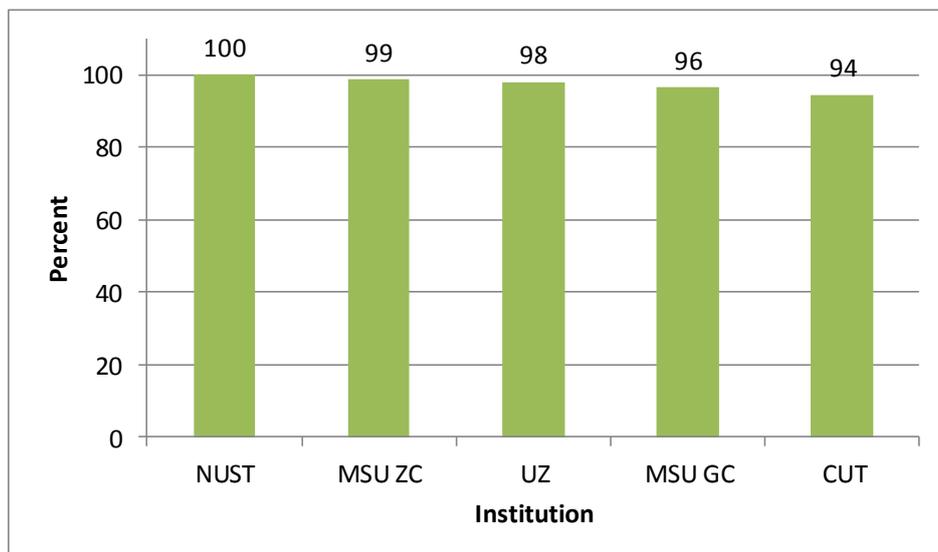
**Figure 8: Main Source of Contraceptive Information**



#### 4.4.5. Knowledge about Sources of Contraceptives

Knowledge about where to find contraceptives has a direct impact on the uptake of the services. The knowledge about where to access contraceptives was almost universal (98%). For the NUST respondents, knowledge of where to access contraceptives was universal, followed by MSU ZC and UZ with 99% and 98% respectively. MSU GC recorded 96% whilst CUT reported 94% as illustrated in Figure 9.

**Figure 9: Knowledge about Sources of Contraceptives**

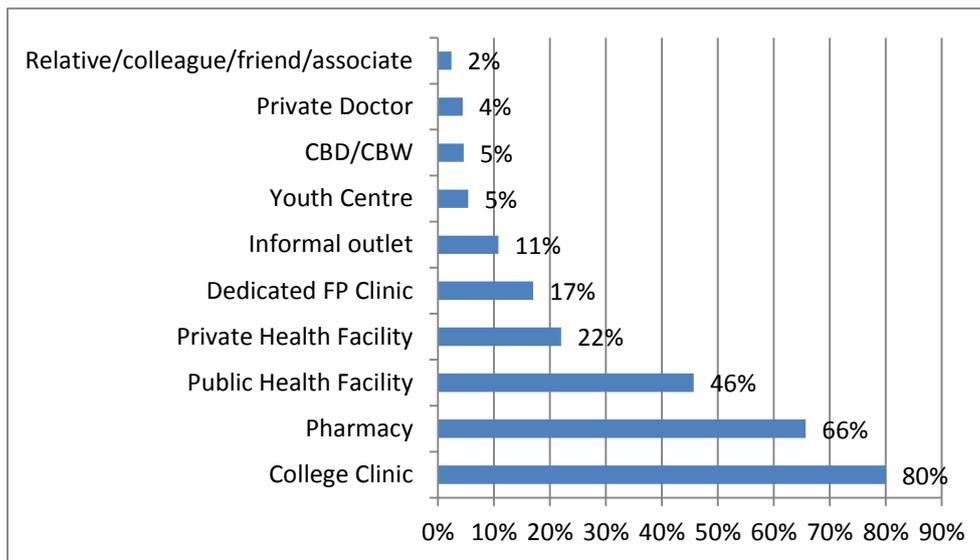


Knowledge of where to access contraceptives by age, marital status, duration at institution and religious affiliation was consistent.

#### 4.4.6. Knowledge about where to access contraceptives

The college health facility is the most popular source of contraceptives for young women. A significantly proportion (80%) of the respondents reported that contraceptives can be sourced from the college clinic followed by pharmacy (66%) and public health facility (46%) as illustrated in figure 10.

**Figure 10: Known Sources of Contraceptives**



The above pattern was uniform across age groups, religion, duration at the learning institution and marital status. However a different pattern was revealed on analysis by institution. The majority of young women at NUST reported that contraceptives can be accessed from pharmacy (76%) followed by college clinic (69%).

During focus group discussions, it was revealed that the college clinic was the first port of call followed by pharmacy where contraceptives can be accessed. This clearly depicted that the college clinics are significantly serving their purpose.

*“It’s an obvious case that when it comes to issues to do with contraceptives at this institution, one has to visit the college clinic where he or she will be assisted using the medical aid facility. However options are there to visit private pharmacies but it comes with some financial costs. At the college clinic you can access most methods like EC, Condoms, Jadelle and Depo (Female FGD\_UZ)”.*

*“Whenever a student at this institution feels like using a contraceptive method other than the condoms which are always available in corridors and toilets, he or she can just rush to the college clinic where he/she will be served without any hustles”(Mixed FGD\_UZ).*

#### **4.4.7. Benefits of using contraceptives**

In order to understand the knowledge about contraceptives by the young women and men in tertiary institutions, the study tried to unearth the benefits and negative effects of contraceptives known by the young people. For an individual to use a contraceptive method, she or he should be aware of the benefits or negative effects associated with the use. It was noted that the majority of young women respondents (93%) reported that contraceptives prevent unwanted or unplanned pregnancies and 77% reported that contraceptives prevent STIs while 18% reported that contraceptives control number of births. This information was also revealed during focus group discussions.

*“Contraceptive use at colleges is primarily for prevention of STIs and pregnancy. To those who prefer using condoms, they will be protected from these two snags at once”.  
(Female FGD\_NUST)*

Generally, contraceptives are associated with a myriad of myths and misconceptions which require demystification. Side effects are perceived as a major problem associated with the use of contraceptives. Problems of infertility to young women were also highlighted during both focus group discussions and one on one interviews. Young tertiary students believed that continued use of modern contraceptives will have adverse side effects which can extend to infertility.

*“I have heard that continued use of contraceptives like EC, Jadelle and Depo will delay a woman’s return to fertility. You will have problems of conceiving in future because you would have suppressed it for a long time”. (Female FGD\_MSU MC)*

*“Emergency Contraception affects a woman’s hormonal balance to the extent that she will fail to conceive in future. This in-turn results in marital imbalances and quarrels”.  
(Male FGD\_MSU MC)*

*“...continued use of some contraceptives by young females will result in giving birth to disabled or deformed babies. Some will even fail to have the babies”. (Male FGD\_CUT)*

The use of hormonal contraceptives by young unmarried women, in some situations was regarded as one of the causes of cervical cancer.

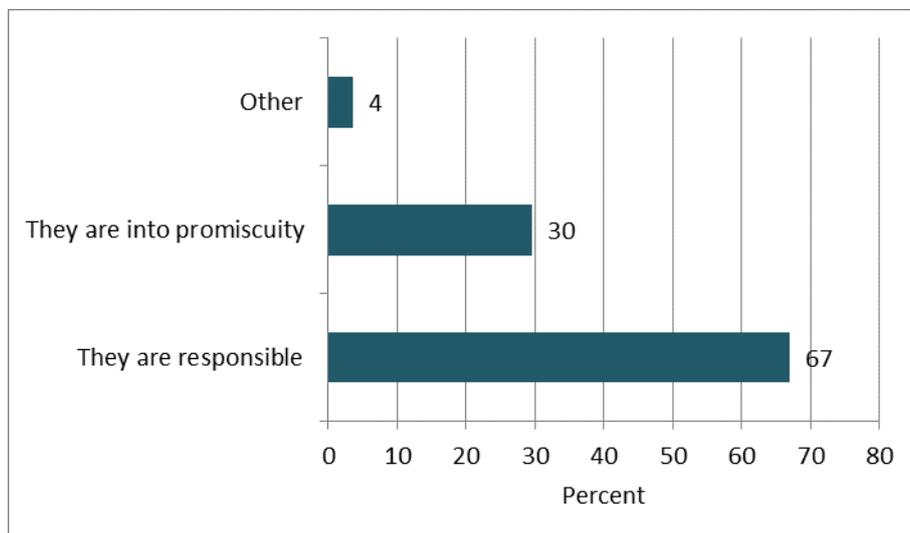
*“Use of contraceptives like EC and Jadelle is known to cause cervical cancer, increase in weight and development of a big stomach”. (Mixed FGD\_UZ)*

#### **4.5. Perceptions on young unmarried women on contraceptive use**

Perceptions on the use of contraceptives especially for unmarried women vary from one individual to another. It was discovered that 67% of the respondents perceived young unmarried women who use contraceptives as responsible, whereas 30% viewed young unmarried women who use contraceptives as promiscuous. This was consistent across age, marital status, religion and duration at the learning institution. However, the highest proportion (34%) of respondents from UZ viewed young unmarried women who use contraceptives as promiscuous compared with other institutions.

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**Figure 11: Perceptions on Young Unmarried Women on Contraceptive Use**



There were mixed reactions on the issue of one's perceptions towards a young unmarried woman who uses contraceptives. Some respondents viewed young unmarried women contraceptive users as being very responsible, wise and lovable.

*“Contraceptive users are responsible women who are always fighting the spread of STIs and unwanted pregnancies. Reduced unwanted pregnancies will also culminate in low levels of baby dumping”. (Female FGD\_UZ)*

*“Women who use contraceptives are wise and better placed in society because they have a foresight of preventing future consequences attached to unwanted pregnancies”.(Female FGD\_CUT)*

*“A woman who uses contraceptives is good, she knows what is right or wrong, she is also responsible through knowing her rights hence always protect herself”.(MSU\_MC)*

On the contrary, sentiments of a negative perception towards young women who use contraceptives were also put forward during focus group discussions. Some young men and women perceived young unmarried women who use contraceptive as irresponsible and promiscuous.

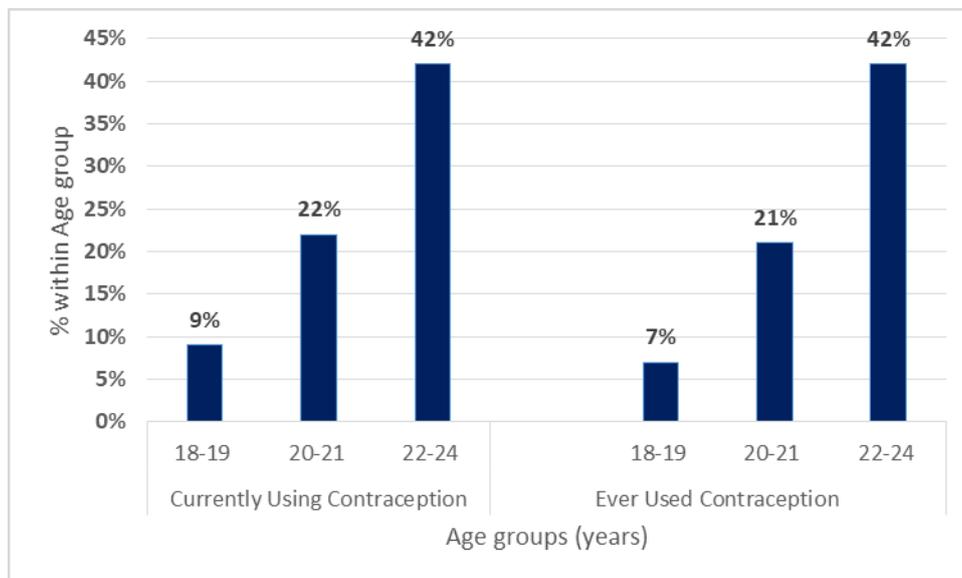
*“Some of the ladies who use contraceptives like depo, EC and Jadelle will become promiscuous because they will be ready to use contraceptives to prevent pregnancies” (Male FGD\_CUT).*

*“Those girls who uses contraceptive other than condoms are easily perceived as lovers of unprotected sex because they know they will be protected from pregnancy. Such girls will be sleeping around with a lot of male partners”. (Female FGD\_UZ)*

## 4.6. Experience Using Contraceptives

This section addresses personal and interpersonal knowledge, attitudes and beliefs that can affect emergency contraceptive use among students in tertiary institutions. It summarizes key determinants on how uptake of contraceptives is influenced by source, knowledge about the contraceptives and attitudes towards use of the Emergency Contraceptives. The largest proportion of those currently using emergency contraception as a family planning method was 42% for those aged between 22 and 24 years while 10% of the sexually active young women aged 18-19 years were currently using contraception.

**Figure 12: Experience Using Contraceptives**



Respondents were asked if they have ever used any contraception in the past 12 months prior to the survey. Of those who reported that they were not currently using any contraceptive method, 25% indicated that they once used family planning method before. The largest proportion of participants who stated that they have ever used any contraceptive method before was among the 22-24 age group at 42%, followed by 20-21 years at 21%.

### 4.6.1. Contraceptives currently used

For those who were using contraception, their most favoured contraceptive was condom followed by oral pills and natural methods which included withdrawal. Young people indicated that other long term and reversible contraceptives were not highly used because of fear of their parents. This shows that young unmarried young people are using contraception in secrecy from their parents and they wouldn't want them to know. Hence they preferred using FP methods which one cannot notice.

#### 4.6.2. Reasons for using contraceptives

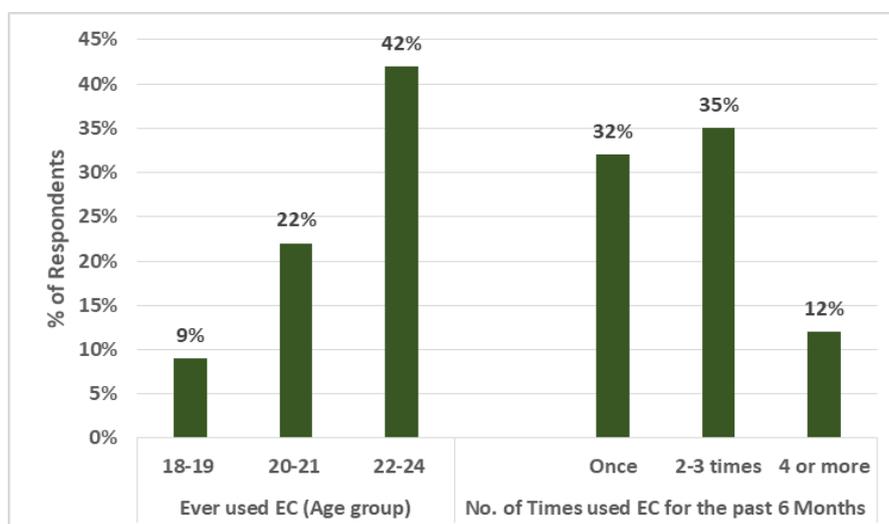
Family planning has multiple health and social benefits which vary from using family planning either for spacing or limiting. The availability and use of family planning services can improve the health, status of women, children, and the overall well-being of societies. A total of 66% of the young women who are currently using contraception are doing that for spacing, that is they either want to delay getting pregnancy or they need to have children in future. The other 34% said they were limiting and are not willing to have a pregnancy in the future. The 20-21 year olds had the highest proportion of participants at 73% who stated that their reason for using family planning was for spacing purposes while 40% of those aged 18-19-years stated that their reason for family planning was for limiting.

This study explored beyond the aggregate benefits of contraceptive use to examining the individual-level benefits and reasons for using contraception reported by respondents. The majority of the respondents (93%) stated that they were not currently using any contraceptive method because they were not sexually active.

#### 4.6.3. Use of emergency contraception

The study also gathered information on the knowledge, attitude and perception of young people who reported to have used emergency contraception in the past 12 months prior to the survey. It was observed that, the use of EC proportionally increases with an increase in age. Hence, EC use was more prevalent among the older age groups as compared to their counterparts. The 18-19 year age group had the highest proportion of respondents who stated that they had limited knowledge about EC.

**Figure 13: Use of emergency contraception**



Out of the 140 respondents 35% reported that they had used EC between two and three times for the past 6 months prior to the survey followed by 32% who had used EC once. Twelve percent (12%) highlighted that they had used EC more than 4 times in the last six months prior to the study.

#### **4.6.4. Problems encountered while using emergency contraceptive**

Most of the young women (59%) who had used emergency contraception indicated that there did not encounter any problems from using the contraception. The main problem encountered by 28% of those who used emergency contraception was headache (pain) while 6% reported that the contraceptives were difficult to use. One percent (1%) stated that they got pregnant after using EC. Young women who participated in the survey were also asked about the possible side effects they had ever heard or knew of which may be caused from using emergency contraception. Seventy three (73%) of the respondents highlighted that they had heard that continuous use of EC causes infertility to young women who do not have children. They may fail to conceive in future. Seven percent (7%) also mentioned cancer as one of the side effects caused by using EC.

#### **4.6.5. Perception towards using emergency contraception again**

Young people who had used emergency contraception also had the perception that they would use it again especially those who had encountered no problem with using EC before. Forty percent (40%) and 39% of the 22-24 years and 20-21 years reported that they would use EC again respectively. Maintaining and improving services to the clients, highly depends on equitable access to and the provision of quality health services. The young women who had used EC highlighted that will recommend their friends in future to use EC with 86% amongst the 18-19 year olds

#### **4.6.6. Sources of emergency contraceptive**

Source of emergency contraception was one of the proxy indicators which determined the consumption pattern of emergency contraception among students in tertiary institutions. Ninety five (95%) of the young women interviewed indicated that their major source of emergency contraception was pharmacies with CUT and MSU Zvishavane Campus students relying on pharmacies completely (100%). Family planning clinics (4%) and private doctors (9%) were only reported at UZ as some of the sources where students are getting emergency contraception. The college clinic was the least source mentioned by young people.

#### **4.6.7. Sources of Information about emergency contraception**

Promoting use of emergency contraceptive requires an assessment of what women who desire contraception know about the effectiveness and benefits of the available methods. The objective of this analysis was to determine the source of information about emergency contraceptives among students in Tertiary Institutions. Fifty nine percent of the young people highlighted that their major source of knowledge was through a relative or a colleague. Seventeen percent (17%) cited social media or internet as the source while peer educators and CBDs constituted 14%. Only 5% of the students across the selected Universities reported that their source of knowledge about EC was through a health service provider while both radio and TV constituted the least percentage (1%).

#### **4.7. Barriers to contraceptive access and use**

Knowledge, attitudes and perceptions of contraceptive use among young people in tertiary is determined by barriers to use contraception. The study investigated the barriers to contraceptive use among young women in tertiary institutions. Availability, accessibility and affordability were among the assessed attributes that affect the uptake of FP services by students. Social norms and their effects on FP services in tertiary institutions were also assessed. Religion and the involvement of family members, peers as well as other relatives were among the factors contributing to barriers of FP services uptake.

##### **4.7.1. Health Systems related Challenges**

###### ***a) Availability of Contraceptives***

The study tried to assess the health systems challenges faced by young women and men in tertiary institutions to access contraceptives. There were mixed reactions from interviews from young women, focus group discussions for young men and women as well as in-depth interviews with key informants on the availability of contraceptives in all tertiary institutions. Young women from across highlighted that some contraceptives are being offered but there is not enough choice of methods on offer. Only orals, injectables and condoms were the available contraceptives in tertiary institutions health facilities. Key informants interviewed highlighted that contraceptives are available on offer although they were experiencing some stock outs prior to this study.

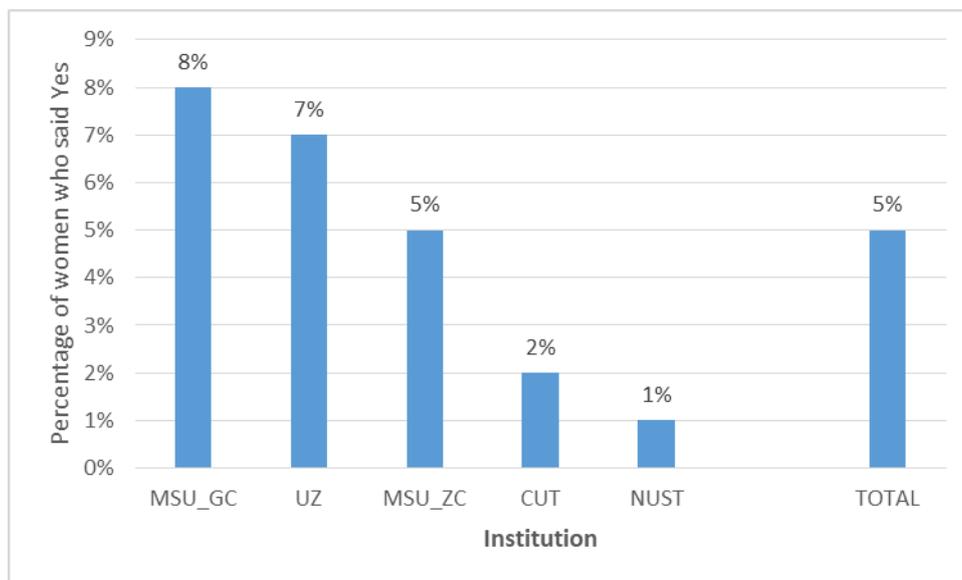
*“Yes we do provide contraceptives at this institution, unfortunately these days we don’t have, we have Depo only, control and secure we don’t have” (Clinic Nurse\_CUT)*

Students prefer using emergency contraception although they highlighted that it was not readily available within the college clinics. Condoms are available in rest rooms as well as college clinics. However, the type of condoms being provided through the public sector is not preferred by the young people across all institutions. “*Poor quality*”, “*bursts during sex*” and “*bad smell*” were some of the reasons cited by students as to why they do not prefer them. Family planning services are being offered in all institutions; however there is need to ensure availability of and access to all family planning methods for the young women to have choice of contraceptive to use.

**b) Accessibility of contraceptives**

Students are easily accessing the FP services across all institutions. More than 70% young women interviewed across all institutions highlighted that the services are available when they need them. The nearest service delivery points in all facilities were less than 500m. Most of the facilities referred by the students were the college clinics which were within the institution.

**Figure 14: Ever Denied Access to FP Services within the Institution**



More than 90% across all age groups in all institutions had never been denied access to FP services. However about 5% of all the students across institutions had been denied access to FP services within the past 12 months. Some of the reasons highlighted were that the by time they were able to visit the health facility (after their lecturers) they would in most cases find the clinic closed because it will be after hours or they would not find the specific method of their choice especially EC. The EC was not available in most of the facilities hence the young

women were referred to use other methods. . This resulted in some participants concluding that they have been denied access to contraceptives of their choice.

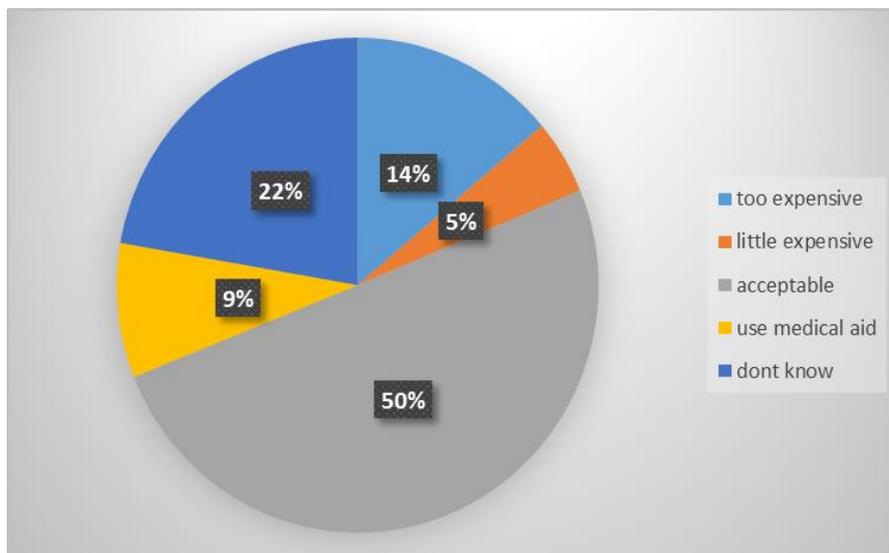
*“I went to the college clinic in dire need of morning after pills but I returned empty after the nurse refused to give me and she only told me to go for depo or implant.”*  
(female FGD, UZ)

*“I went to the clinic around 4pm to obtain emergency contraceptives but I was told to come the following day during working hours.”* (female FGD, MSU)

### c) Affordability of contraceptives

Fifty percent (50%) of all young women students said the costs of obtaining FP services were acceptable. However about 22% said they did not know, 9% were using medical aid insurance and as a result were not aware of the prices. For those who highlighted that FP contraceptives were too expensive (14%), they were accessing the services outside the institution (at Pharmacies and private health facilities).

**Figure 15: Perception on the cost of obtaining Contraceptives at the Institution**



The young men and women also had different views on the issue of cost, they also highlighted that it depends with the type of contraceptive that an individual wants to use.

*“Now it depends with the type of contraceptive that you want to take, from this institution, if you want to use protection like protector plus condoms, they are for free”*  
(Female FGD\_CUT)

Ninety one percent (91%) of the students said money had never hindered them from obtaining FP services within the institutions. A proportion of those who access FP services especially from pharmacies and private institutions where exorbitant prices were being charged reported that fees and contraceptive prices were a major barrier.

#### **4.7.2. Social norms and Barriers to contraception use**

Several factors were put forward by students as barriers to contraceptive use. Fears of side effects, discrimination as well as religion were commonly identified factors. Females cited also that in some situations, girls might want to use contraception, but men will use their powers to dictate what they want.

*“Some of the boys use power over girls, you end up being coerced into unprotected sex”. (FGD Females\_UZ)*

*“The issue of protection, especially on the so called “blessers” they will tell you they don’t want to use any protection even the condom, and we ladies we don’t have power over that, I just know I will be given money so my duty is to provide sex and get money, girls fear losing the “blesser” since “blessers” may leave anytime to look for others”. (FGD mixed\_MSU Zvishavane campus)*

Fear of parents, friends and discrimination as well as were major concerns of young women and men not using contraception

*“I want to tell what my friend told me, health service providers suggested for her that she uses Depo, but she loves wearing vests and other fancy clothes she denied because people can notice that you are using Depo, so she fears that when she gets home her mother will notice that.”(Female FGD\_UZ)*

##### **a) Type of contraceptives available (condoms)**

Students had reservations about the type of condoms being provided for free within institutions. Condom is the main contraception method mainly preferred by students, but the panther brand that is readily available is not preferred hence students end up not using any contraception even though they would want to use it.

*“The problem which I saw is, it’s not that the condoms are not available, they may be stock out for just a week but the following week they will be provided, but the type of condoms that are being provided are not preferred, students don’t prefer them. Sometime ago in social media platforms (Whatsapp groups) there was a comment that,*

*he is failing to buy you something, they he wants to have sex with you using “panther”, you see, then you want to continue in a relationship with that person do you think you will have a bright future? with such information at the end of the day, the boy do not have the money even 50cents to buy the flavoured condoms, hence instead of the boy to go and get the condoms from the clinic or even in the toilets he can’t, because he has to maintain his status and would only say I have forgotten” (Mixed FGD\_MSU ZC)*

The panther condom brand was also reported to smell in a manner that enables people to identify that one has had a sexual encounter. As a result students do not prefer it.

*“The issue which is there is that they produce bad smell, the smell sometimes doesn’t end” (Male FGD\_UZ).*

### **b) Religion**

Religion also is an important factor which acts as a barrier to contraception use among students.

*“There is also another dimension of religion, in some churches they don’t accept contraception, and they say people should have sex without any disturbances or protection since this is done for procreation purposes”. (Mixed FGD\_UZ)*

Pentecostal and the protestant affiliated members had the highest proportion of students who said religion acts as barrier to contraception use with 32% and 30% respectively.

### **c) Fear of side effects**

Students had also myths and misconceptions about side effects caused by contraception. Both known and unknown side effects were mentioned by the students. They also highlighted that most of the side effects are undesirable hence most students opt not to use contraception

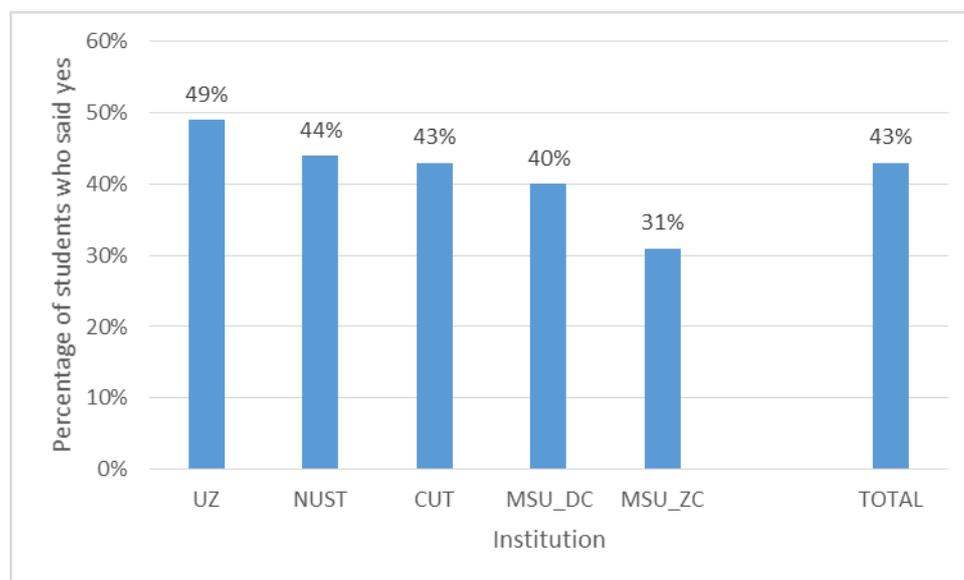
*“If you look at the available contraceptives, (Depo, Jadelle, Copper T and staff), they all have side effects which are undesirable hence everyone would say I don’t want to use contraception because of these side effects”. (Female FGD\_UZ)*

**d) Lack of knowledge**

Some students had the perception that knowledge is lacking on types of contraceptives. The proposed side effects of contraceptive use were just myths and misconceptions. This deters most of the students in the use of contraception

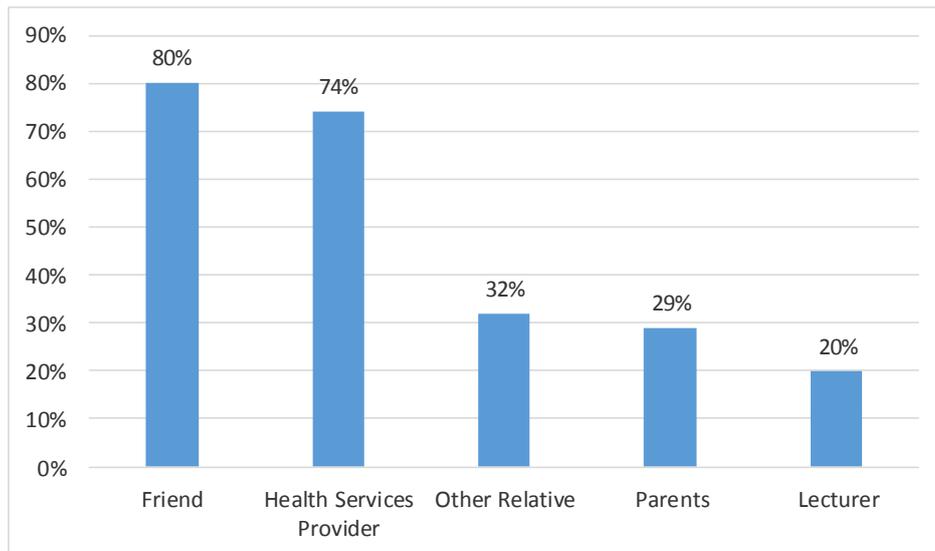
*“The other issue is on lack of knowledge, people may want to use contraception ,but that fear of lack of knowledge on what type of after effects does the contraception has or what will be the result at the end, will I manage to conceive in future or not?  
“Female FGD\_CUT”*

**Figure 16: Family Support of FP use among tertiary students**



Family planning discussions among families were also assessed among students to determine whether these can be barriers to contraception use. Most students across all age groups and institutions highlighted that their parents are not aware of them using contraception hence they do not know if they support contraceptive use or not. For those whose parents know and aware, 41% of the 20-21 years said their parents are in support of them using contraception while 44% said the parents do not support.

**Figure 17: Cadres whom students feel comfortable to discuss Contraceptive issues with**



Young men and women also highlighted that they sometimes discuss family planning issues among their peers

*“Us as boys we normally discuss these issues about girls when we are just relaxing or drinking, especially when one of our colleagues brings out the issue” (Male FGD\_MSU MC)*

*“These issues are being discussed, we had our group known as Web for Life with girls only, someone may bring out an issue she encountered with her boyfriend on how to prevent pregnancy and STIs” (Female FGD\_MSU MC)*

Young people had mixed reactions on discussing Family planning issues with their parents, with some highlighting that it’s a non-starter issue.

*“In other situations it’s a non-starter issue, for example myself, I grew up in a Apostolic Christian family, my parents are elders in the church I cannot discuss such issues with them” (Male FGD\_UZ)*

*“Parents just tell us please don’t use that, no sex before marriage that’s their counselling they gave us” (Female FGD\_UZ)*

*“Parents are very difficult to talk to. Even if you are not using them, they will just suspect and sometimes they over react and you may end up being given some sanctions at home”(Female FGD\_UZ)*

## **CHAPTER 5: DISCUSSION AND RECOMMENDATIONS**

### **5.1. Discussion**

This is among the first of comprehensive studies to evaluate knowledge, attitudes and practices of contraceptive use among university students in Zimbabwe. The study findings reveal that sexual experience increases with age with the median age at first intercourse for the young women at 20 years which also is consistent with the ZDHS 2015 findings. There is a possibility in the current study that some of the women who were currently pregnant did not report their pregnancies because of social norms that are against pre-marital sex. The under-reporting of sexual activity, not only undermines attempts to document and explain sexual activity by young women, but also compromises policy interventions to address the problem. The high level of sexual activity among the students is not correlated to the various efforts from stakeholders to address the issue of risky sexual behaviour among young people especially those in higher institutions of learning in the recent past. Risky sexual practices are still common occurrences among students in higher institutions of learning.

#### **5.1.1. Knowledge and sources of Information about contraception**

Young people in tertiary institutions were aware of contraceptives and, generally, knowledge of modern contraceptive methods was high. The majority of respondents knew at least one modern method of contraception. This is in line with findings from the ZDHS (2015) that demonstrated knowledge of contraceptives was almost universal. Yet despite this high level of knowledge, use of contraception particularly among young women remains low. Other researches have also revealed that high knowledge of contraception does not necessarily correlate with high use (Oindo Missie L (2002) and Rozina M, Uzma A, Haleema HA (2008)).

Young people in tertiary institutions initially learnt formally about contraceptives whilst in secondary school level. This clearly revealed that the secondary school curriculum contains detailed content about contraceptives. Information about contraceptives is disseminated through various media sources. The main source of information unearthed in this study was the teacher/lecturer. This finding correlates with the issue on knowledge of contraceptives where young people in tertiary institutions initially get to know about contraceptives in secondary school level. In line with the quantitative findings, qualitative data also supported the idea that teacher/lecturer had a significant role to play when it comes to disseminating

contraceptive information to the students. The pill was the most known contraceptive method followed by condoms and implants which is also consistent with findings from the 2015 ZDHS. These findings are consistent with the results from the study by Nsubuga et al (2016) in Uganda which revealed that the most common contraceptives were condoms and oral pills as reported by 88% and 87% of respondents respectively. A study by Waheeda K. Kara, Benedicto M, and Mao J (2019) in Tanzania shared the same results that is the majority of their respondents, (84%) mentioned oral pills as the main contraceptive method known.

Findings from this study revealed that female tertiary students know that the condom is a contraceptive method which provides dual protection. Such high knowledge levels are expected to translate into action by tertiary students so as to minimise their chances of getting STIs, HIV and unwanted pregnancies. Since knowledge about where to find contraceptives has a direct association with accessibility, it is widely expected that if one knows where to get contraceptives, he or she can easily get them. Knowledge about where to access contraceptives was almost universal. It was also consistently high across other background variables like institution, religion and age group.

The presence of a college clinic at each tertiary institution has significant benefits as young people in tertiary institutions know that they can get contraceptives from the college clinic while others access them from pharmacies although with limited choice determined by cost and availability of a trained service provider to offer. These findings are similar to those from a study conducted in Tanzania by Waheeda Shokat K, Kara, Benedicto M, and Mao J (2019). Qualitative findings from this study shows that youth in tertiary institutions prefer to purchase contraceptives at pharmacies rather than the public health facilities so as to circumvent long procedures and requirements at public institutions. This was also noted from a study in Tanzania by Waheeda Shokat K. Kara Benedicto M, and Mao J (2019), Somba M. J, Mbonile M, Obure J, Mahande M. J (2014) and Sweya M. N, Msuya SE, Mahande M. J, Manongi (2016)

The study also gave evidence that young people always think of preventing unwanted pregnancies rather than STIs or both as they prefer to use emergency contraception and not condoms which offer dual protection. The majority of the respondents reported that contraceptives prevent unwanted pregnancies. These results are similar to the findings by Waheeda Shokat K. Kara, Benedicto M, and Mao J (2019).

### **5.1.2. Contraceptive use**

Access to accurate information about contraceptives could assist young people to realise that effective utilization of family planning can successfully delay unplanned pregnancies, prevent STIs including HIV until they have completed their schooling and are financially stable. In other studies, it was noted that female students need knowledge for them to be able to make informed decisions as well as to evaluate their attitudes and beliefs about contraception. Similar to the findings by Watt (2001:226), this study also realised that students were ashamed to use condoms with the assertion that condoms are difficult to use and interfere with sexual pleasure.

Previous studies emphasised that the moderating factors that could influence students' non utilisation of contraceptives include demographic factors such as age, gender, socio-cultural, religious and traditional factors. Thus the behaviours and attitudes of people towards use of the services are hinged on the doctrines they believe in. Some respondents indicated that they had ever used contraception in the past 12 months prior to the survey with the greater proportion of them being aged between 22 and 24 years. When asked on the reasons for using contraceptives, the majority of the young people stated that they were mainly using FP for spacing with a notable percentage (40%) of those who wanted to limit among the 18 – 19 years. It is clear from the findings that age is a very critical aspect in the utilisation of contraceptives which programmers need to consider when identifying the high risk age groups and coming up with target specific interventions. It is possible that students may not use contraceptives out of ignorance, unavailability (access or affordability) of the services, or lack of adequate information about the benefits and effects of contraceptives. These among other reasons greatly impact on the use and decisions to engage in sexual intercourse and contraceptive non utilisation. In a study by Watt highlighted that besides age there is also gender differences in FP knowledge, attitudes and behaviours among students at Universities. Similarly, McBurney (2001:320) stated that social values, beliefs and practices influence decision making about the use of contraceptives among young people.

The study also noted that students are coming from different backgrounds with different beliefs, cultural backgrounds, religion or traditional beliefs influenced by different norms and values which spell what should be done and not done in certain settings. This impacts on the use of contraceptives. In many cultures and doctrines, young people or unmarried people are encouraged to abstain until they attain a certain level of education while in other cultures they

are not allowed to engage in sexual intercourse without following some traditions. Delay in sexual debut also gives parents dignity in the society and as such they become strict ensuring that their children are not indulging. This poses the dilemma that parents will not be comfortable to discuss about contraceptives and sexual issues with their children; neither will they be comfortable to encourage them to use contraceptives if they are sexually active. In a study conducted in South Africa, it was noted that most educated women fetch high bridal wealthy compared to their counter parts which may encourage them to support schooling. In such cases, encouraging their children to use contraceptives was found to be problematic. One student confessed during focus group discussion that, when they are on vacation their parents will check if they are using any contraception and that discussing anything related to sexuality is a taboo in the family. Very few students indicated that sometimes they do discuss sexual issues with their parents. Fathalla (1997:64) emphasised that family planning is one of the means to empower women to be able to control their fertility and achieve their desires. In relation to this, Gama (2008) added that students should be informed about the advantages and benefits of using contraception. Use of family planning saves women's lives while improving their health by allowing them to prevent unplanned pregnancies, furthering with education among other benefits.

About 43% of undergraduate students at higher educational institutions are sexually active and knowledge about emergency contraceptives was nearly universal at 92%. It is important that they have access to safe, accessible and adequate contraceptive services. Despite the immense contraceptive benefits for students in higher educational institutions, there is no direct positive relation between the universal awareness, knowledge and use of contraceptives despite knowing about the contraception. The poor utilisation of contraceptives in tertiary institutions is associated with many interrelated factors ranging from personal to institutional setbacks. In a study amongst 15 to 24 year old South African women, it was estimated that only 52.2% of sexually experienced women are using contraceptives. Only twenty six percent of the total respondents indicated that they had used EC at some point in the last six months prior to the study. Therefore, having knowledge about family planning does not necessarily translate into utilization since the respondents had varied reasons for and against using family planning which included its effectiveness, related unpleasant side effects, or belief that the bible is against family planning. In this study, it was observed that, the use of EC proportionally increases with an increase in age.

Additionally, findings also shows that there are some students at university who knew that one could get pregnant by relying on the withdrawal method yet some preferred it as a family planning method. In other studies, it was explained that some adolescent girls feel that a partner's use of condom suggest that they (the girls) might be classified as commercial sex workers or seen as engaging in extra-relationship sexual activities if they negotiate for condom use during sexual intercourse. The discernment that 'if you have sexual intercourse with your partner more often, you build trust and eventually you stop using condoms' further explains the frequency of withdrawal methods being a regular family planning method on campus.

Various sources of family planning information were highlighted by the young people in which the teacher was the most reported source of information followed by relative/colleague or boyfriend. This observation informs that, there are some efforts being made at tertiary institutions to mainstream sexual and reproductive health issues in their curriculum. Peer educators are also there, on-campus to support the system educating their peers on reproductive health issues. However, in one of the focus group discussion conducted with both male and female students, it was pointed out that the majority of them are not comfortable discussing sexual issues with their lecturers or teachers. This shows that students are only receiving the information formally in classrooms as a course or topic embedded in a module. This observation is quite worrying since anecdotal evidence from university campuses shows that majority of student rarely have confidence to discuss at personal level with their lecturers on the various campuses. Therefore, it is very critical and useful to devise innovative ways of educating students on family planning methods whilst on campus.

The study revealed mixed reactions among students on continuation of using EC and even recommending others to use EC. This is an indication of them understanding the importance and benefits of family planning to studies and improved health. This observation shows the quality of services and client satisfaction to students and there are still gaps and areas to be improved so that uptake of the services increases among all age groups.

### **5.1.3. Barriers to contraceptive use**

Barriers to FP uptake are common in different populations, but adolescents in tertiary institutions have their own characteristics which make them a special population subgroup. The study shows that there are certain barriers to contraception use among tertiary institution students. Adolescents in tertiary institutions do need to use contraceptives and some are using them, however the barriers affecting their usage need to be addressed.

Although the majority of young people correctly understood that condoms offered dual protection, some felt that the type of condoms which were provided for free were not reliable and they were not comfortable to use them as they produced a bad odour. Furthermore, some participants who used condoms were of the opinion that, condoms reduce sexual pleasure and hence were not comfortable to use them.

Many participants reported hearing about health related problems from the use of contraceptives, including: total or temporary infertility, birth defects and abnormalities, disruption of their normal body processes or inability to menstruate regularly. Most of the health concerns were myths and misconceptions as they had not encountered the problems themselves. Similar findings of health related concerns in are reported in a qualitative study on IUCD uptake in Zimbabwe (2016). The ZDHS 2015 reports health related concerns as the second most common reason for non-use or contraceptive discontinuation.

Contraceptive use among young women is hampered by some related side effects coupled with a number of myths and misconceptions especially on hormonal contraceptives Side effects is one of the greatest fears revealed in this study for which young people do not want to use modern contraception. The main side effects mentioned were weight gain, excessive bleeding, irregular menstrual cycle and headaches. These results are supported by the ZDHS 2015 that women report discontinuation within the first 12 months of using a method due to side effects, and women currently not using contraception were not doing so due to fear of side effects. Disruption of menstrual cycle was the most common reported reason for discontinuation of hormonal methods among women in Nyando district, Kenya. Myths and misconceptions regarding infertility after use of contraceptives were the major concerns of young people due to the fear of being infertile or delays in conceiving hence most young women shun some of contraceptives especially the LARCs. These findings of a study in

Tanzania by Waheeda Shokat K. Kara, Benedicto M, and Mao J (2019) also found fear of side effects as the main reason for discontinuation and non-use of family planning.

Our findings support evidence that young women in tertiary institutions sometimes do not make decisions to use contraceptives, but their male counterparts do while in some circumstances they do so in consultation with their partners and through social networking. Partner's influence was found to be a key barrier to contraceptive use for young women who are in intergenerational relationships. Male partners were reported not to accept use of condoms especially citing that they reduce sexual pleasure. Both information and misinformation are spread through social networks. In this way, networks provide an opportunity to encourage or discourage use; a way of sharing potentially positive information on contraceptive technologies but also a channel for rumours, which may negatively influence use of contraception among tertiary students. Social networks influence contraceptive use by exaggerating side effects and spreading myths. The spread of myths and misconception by social networks in the community is demonstrated by a longitudinal study in Nyanza, Kenya.

The main barriers to modern contraceptive uptake among young women in tertiary institutions are myths and misconceptions, with both users and non-users exhibiting lack of factual information on the different contraceptive methods. The data from this study highlights the social nature of beliefs and behaviours around family planning. The decision to use or not is primarily influenced by others from within the social network, whose views and perceptions are often more important than an individual's own. Therefore, family planning campaigns should look beyond the individual - to social networks - in order to drive demand and remove barriers. Partner influence also remains key and so it is important that myths and unfounded concerns raised by male partners are addressed, for example, by designing male friendly interventions.

These study findings indicate that religion has an influence in the use of family planning services as evidenced by the limited number of Apostolic and Catholics reporting that they were currently using family planning services. FP service consumption was higher among those aged between 22 and 24 years with the majority of them being Pentecostal followed by Protestants. The least users were among those who reported that they believe in African Tradition.

The study realised that opposition to contraception use by young people in tertiary institutions was either by partner or parent/guardian. They played a major role in not using the contraceptives as most students highlighted that they cannot discuss such issues with their parents, or if they come to know it will cause misunderstandings between them and the parents. Young people in tertiary institutions are not open enough on their use of contraception as they are afraid of the reaction from their parents/ guardians should they discover that they are using family planning services. Similar to study findings by M. Makhaza and K.D. Ige, a couple of challenges such as fear of parental disapproval, distrust in the efficacy of the methods, religious beliefs and peer pressure all pose possible barriers to utilisation of contraception by young people in tertiary institutions.

However, despite the fact that the adolescents' knowledge on contraception needs to be strengthened, one interesting pattern observed was that the young women and men did not feel embarrassed to talk about contraceptive services and sexual issues. During the study, the young people showed great interest in the subject of sexuality issues and contraceptive use. This shows that contraceptive awareness and acceptability is increasing among the students.

## **5.2. Recommendations**

The following recommendations are therefore being proffered:

### **Policy Level**

- Tertiary institutions in Zimbabwe should consider amending their curricula to incorporate the family planning component in the academic programmes as a section in one of the health related modules (e.g. communication skills) for students to acquire current knowledge in this area.
- Tertiary institutions should strengthen investment in Adolescent Sexual and Reproductive Health & Rights (ASRHR) education services so as to expand availability and access to quality, safe, adolescent and youth responsive friendly SRH services.
- The reproductive health education programs should include the importance of using dual contraceptive method as a means to prevent HIV transmission and pregnancy, as well as information on how to make an informed decision relating to contraceptive choices.
- Tertiary institutions to implement targeted interventions for SRHR information dissemination through demand generation interventions/activities for uptake of SRHR services including FP
- There is need to train more health service providers at tertiary institutions on the provision of all methods of family planning in collaboration with ZNFPC and MoHCC.

### **Health Facility Level**

- Referral linkages between tertiary institution clinics and other service providers should create youth friendly environment through implementing the Youth Friendly Service Guidelines (MoHCC, 2016) to enable young people to access and afford family planning services of their choice on campus.
- The Student Representative Council (SRC) should also make family planning education a part of their program in collaboration with the University health/ clinic services department.
- Health service providers including lecturers should encourage parent to child communication on sexuality and sexual and reproductive health issues

## **Program Level**

- Family planning programming should utilize innovative strategies to override myths and misconceptions, for example, intensive peer counselling. There is also need for programmers to craft strategies to demystify the myths and misconceptions.
- There is need for a national mixed method study targeting other tertiary institutions in Zimbabwe for a better understanding for informed policy decision making with regards to contraceptive security in tertiary institutions in the country.

## **5.3. Conclusion**

The use of contraceptives among young women is significantly different from that of older married couples, and it is influenced by a myriad of factors which include educational, developmental, social, and psychological. The study highlights that knowledge and awareness do not always lead to a positive attitude towards the use of contraceptives hence there is a need to motivate the young people for effective and appropriate use of contraceptives and arrest the trend towards unwanted pregnancy as well as acquisition of STIs and HIV. It is therefore essential to organise educational campaigns on the awareness of family planning services with emphasis on the benefits of the services as it will help reduce misconceptions and increase access and utilization of family planning services. To help adolescents to have better access and use family planning services, there is need to understand the challenges they encounter which hinder them from accessing and using the services. Service providers also need to consider target specific interventions and strategies which can empower and overcome such obstacles. Provision of information and ease of access to the services empower young people to engage in appropriate health decisions and sexual behaviour.

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