*IOSR Journal Of Humanities And Social Science (IOSR-JHSS)*
*Volume 23, Issue 9, Ver. 2 (September. 2018) 89-96*
*e-ISSN: 2279-0837, p-ISSN: 2279-0845.*
*www.iosrjournals.org*

# Factors associated with low uptake and utilisation of reproductive health services by female students in Masvingo Tertiary Institutions.

Masvosva Miriro
*Doctoral Student, Department of Post Graduate Studies (Education), Central University of Technology- Bloemfontein.*
*Corresponding Author: Masvosva Miriro*

***Abstract:*** *The aim of this paper was to explore the factors that are associated with low uptake and utilisation of reproductive health services by students in Masvingotertiary institutions. Despite having various reproductive health services in the tertiary institutions,students are faced with unprecedented challenges related to Adolescent Sexual Reproductive Health (ASRH).These challenges include a severe HIV epidemic, exposing young women to extra ordinarily high rates of new infections, high levels of early and unintended pregnancies and limited access to sexual and reproductive health rights (UNFPA; 2012). In response to the National Reproductive Health policy guidelines of 2004 and the National ASRH Strategy1:2011-2015, Masvingo Tertiary institutions have developed friendly corners as a strategy to address reproductive health issues. Despite services provided in the corners, data fromMasvingoDistrict AIDS Committee 2013/2014 show that there are a number of health problems among students. The study is qualitative, informed by data from interviews with randomly selected peer educators, Focus Group Discussions and colleges' strategic plans. Study concluded that utilisation of services was low. Research recommends that institutions intensify and improve the provision of student friendly services.*

***Key words****: Low-uptake, reproductive-health, female, institutions.*

---

Date of Submission: 31-08-2018 Date of acceptance: 15-09-2018

---

**Background To Study**

Sexual and reproductive health is part of physical and emotional well-being of all normal human beings. As such, female students in tertiary institutions have unique sexual and reproductive health needs. However, the reproductive and sexual health of these people remains a relatively new and sensitive area. This is mainly due to restrictive socio-cultural norms which the students were socialised. The students are still faced with challenges about sex and sexual health including sexually transmitted infections (STIs), HIV and AIDS, unplanned pregnancies, unsafe abortions and gender inequalities despite the provision of services in their institutions (ZNFPC,2004). The provision of youth friendly services continue to be the major factor in attaining good sexual and reproductive health status of female students in tertiary institutions. Taking cognisance of the afore mentioned, the Government of Zimbabwe through the Ministry of Health and Child Care (2002) came up with a draft Reproductive Health Policy to strengthen various other policies in recognition of young people's Sexual Reproductive Health related issues. The aim of the policy is to guide planning, standardisation, implementation, monitoring and evaluation of the reproductive health care provided by various stakeholders in providing the different health services.

According to UNFPA (2012) for students to access ASRH services the Ministry of Health and Child Welfare (MoHCW) in collaboration with other line ministries and various Non-GovernmentalOrganisations, young people as well as UNFPA,UNICEF and WHO offering support in the development of an ASRH Strategy: 2010-2015. The strategy prioritised promotion of adoption of safer sexual and reproductive health practices among young people, creation of a safe and supportive environment for addressing Sexual Reproductive Health (SRH) issues for young people and strengthening coordination for viability of the initiative (UNFPA,2012).

In line with the Ministry of Health's Draft Policy of 2002, Tertiary Institutions in Zimbabwe adopted the in Sexual Reproductive Health Policy, translating into programmes that would help meet the needs of students. Thus in recognition of Sexual Reproductive Health and HIV and AIDS policies, Tertiary institutions in Masvingo urban have also developed student/youth friendly corners, where students can access information. Institutions have a health referral system, linking students to other Sexual Reproductive Health providers within

the local community. Apart from this, institutions also offer Health and Life Skills education in which basic Sexual Reproductive Health issues are discussed.

Despite the knowledge and services provided in tertiary institutions and outside, data from the Zimbabwe Demographic Health Survey (ZDHS) 2013/2014 shows that there are a number of sexual reproductive health related problems among youth in Zimbabwe, including students in Masvingo Tertiary institutions. The researcher therefore seeksto explore factors that could be contributing to low uptake and utilisation of sexual reproduction health services by students in Masvingo Tertiary Institutions.

**Conceptual Framework**

The study used Andersen's Phase Two Model of Health Service Utilisation (Andersen & Newman, 2005) to investigate reproductive health service utilisation among students in tertiary institutions. This behaviour model provides a systems perspective to investigate a range of individual, environmental and provider related variables associated with decisions to seek health care. The model suggests that access to health care services is a result of three categories of determinants, predisposing factors such as age, sex, level of education, et cetera; enabling conditions for example, family and community resources and status, location of resources, and availability of persons for assistance. There is also need of health services and benefits obtained from treatments. Andersen's behaviour model applies in this study in that, the conditions has to be conducive for female students to access health facilities. Failure to be user friendly implies limitation in its accessibility. Unfavourable conditions may prohibit female students to seek of ASRH services though they have need and knowing quite well the importance of accessing the services.

**Purpose of The Study**

This study is meant to draw the attention of all Sexual Reproductive Health stakeholder communities on factors contributing to low uptake and utilisation of sexual reproductive services amongst students in tertiary institutions. The study is meant to sensitise all stakeholders in the health delivery service system to create demand and improve health seeking behaviours of young people including students in tertiary institutions.

**Objectives**

- To explore socio-economic and religious factors contributing to low uptake and utilisation of reproductive health services.
- To reflect on factors related to the health delivery system which determine individual use of reproductive health services.
- To examine existing health policies in tertiary institutions that promote uptake and utilisation of reproductive health services.

**Research Questions**

The study's research questions are:

- ❖ What factors are associated with the low uptake and utilisation of Reproductive Health Services by students in Tertiary institutions?
- ❖ Which socio-cultural factors determine uptake and utilisation of Youth Friendly Sexual Reproductive Health services in Tertiary institutions?
- ❖ What are the factors related to the health delivery system which determine individual use of health services both within the institutions and outside?
- ❖ What are the existing reproductive health policies for students and how do they affect access and provision of services?

## II. LITERATURE REVIEW

Globally existing barriers to the uptake and utilisation of SRH services include poor access, availability and accessibility of the services,(WHO,2004). Sendrowitz, Hainsworth and Solter (2003) cited inNaidoo (2015) highlighted a study on rapid assessment of reproductive health services, where significant barriers posted by the current state of most health providers are presented unwelcoming to the youth.Barriers include lack of clear directions about services on offer, lack of privacy, appointment times that do not accommodate young people's work schedules, limited services and contraceptive supplies and options calling for referral, shyness, poor relations with health staff and low prioritisation by parents and individuals,(WHO,2004,Adra,2007).

Despite efforts put by governments in Sub-Saharan Africa as a follow up to the International Conference on Population and Development (1994)to improve SRH services, youth still encounter significant obstacles to accessing required services.A study to evaluate factors that discouraged the youth from using SRH services in South Africa revealed inconvenient hours or locations, unfriendly staff and lack of privacy, (Federal Health Institute, 2001).Godia,(2010)says youth lack knowledge about these services.In Zimbabwe, studies

carried out by the Ministry of Health (2005) in parts of Manicaland and Mashonaland amongst the general populace, revealed that both young men and women lacked adequate information about SRH including STIs, HIV and AIDS,(Warenius,et.al,2007).

## III. METHODOLOGY

**Research design**

The researcher adopted a qualitative research for this study. The studyfalls under descriptive paradigm which is quite interactive and naturalistic. It allows sharing of experiences and cross pollination of ideas amongst individuals and is usually used where participants' opinions are sought (David and Sutton, 2004). In this study female students' and nurses' views were sought hence the rationale for the adoption of the qualitative research design. A descriptive survey design was used in order to explore the different factors as they exist, prevailing practices, policies, beliefs, perceptions and attitudes that contribute to low uptake and utilisation of sexual reproductive health services amongst students in tertiary institutions.

**Population**

The study was done in Masvingo, with five tertiary institutions. The total population came to 6658 students on campus in the five institutions. The researcher targeted students in the 20 to 30 years age group, for these make the bulk of students in tertiary institutions.

**Sampling**

A total of ten (10) volunteering students were interviewed. The sample comprised of 5 married females and 5 non-married female students. An equal number of married and unmarried participant was given as they are both vulnerable to STIs, HIV and AIDS as well as other health complications.Another twenty (20) participants were involved in focus group discussions (FGDs). Four groups of 5 participants from each institution were taken as separate groups of the single females and the married females to accommodate for opening up of participants. Focus group discussions also allow additional information through exchange of ideas.

**Instrumentation**

The primary source of data was mainly the interviews. Ten (10) participants were involved in face to face interviews and twenty (20) others were taken in groups for focused discussions. Interviews were transcribed verbatim and thematic data analysis was conducted. The secondary source of evidence was from a review of institution documents which are the strategic plans, sexual reproductive health policy, HIV and AIDS policy and monthly data reports to DAAC. The secondary evidence also helped to explain some of the factors that are being explored.

**Ethical Considerations**

The researcher was aware that every person has the right to dignity of treatment. It was important therefore to explain the purpose of the study to the participants. Data collected was to be used for educational research purposes only. Only pseudo names were to be used in face to face interviews in order to preserve personal dignity of participants.

**Data analysis technique**

Shastri (2017) defines data analysis as the process of bringing order, structure and meaning to the mass of the collected data. On the other hand data collection technique serves to arrange voluminous data in tandem with the study research question. In this instance the Nvivo 7 was used in sorting out descriptive data into themes.

**Data Analysis**

**Findings from face to face interviews and focus group discussions (FGDs)**

Like the general population, studentsindicated that, they tend to seek medical care as a last resort. They often try traditional interventions, especially when it comes to the treatment of STIs or if it has to do with female reproductive health problems. This is often so because of fear of stigmatisation that normally goes with the treatment of such conditions.

Students also indicated that, sometimes there is low risk perception. It is problematic for a woman in most cases to go to a health clinic to be screened if she is "feeling healthy." People generally feel they do not want to be screened for conditions that would result in them developing anxiety, stress, and depression; for example being told that one is HIV positive or has developed cancerous cells.

Fear is one major constraint to uptake and utilisation of sexual reproductive health services. Cervical screening is related to STI diagnosis. Being screened for breast, cervical or prostate cancer often leads to development of fear about gynaecological care for cancer has been labelled as one of the major killer diseases, especially of young women in the child bearing range. Women are therefore reluctant to be screened and men rarely take up the challenge. Female students also believed that if their cervix is removed, one loses womanhood and sexuality. That is they feel disabled. On the other hand, male students expressed discomfort with male circumcision. Indications were that it would reduce their sexual drive.

Another socio-cultural factor highlighted by female students was that a woman's decision to participate in sexual reproductive health is dependent on the husband's positive emotional support. This view was expressed in responding to the reason why female students fall pregnant during the course of training.

The students admitted that their orientation and life skills lectures equipped them with knowledge about sexual reproductive health, but that culturally they are embarrassed. They are shy to share their sexual health concerns with their lecturers and with familiar health providers, and with providers of the opposite sex. A1(*pseudo name),* highlighted the fact that it was social taboo for an unmarried young person to access sexual reproductive health services, especially family planning or being screened for cancer.

A 2(*pseudo name)*, expressed the fact that the use of condoms made sexual activities less enjoyable. She indicated that man would feel like having lost control of the activity. She also indicated that female students would find the use of the condom difficult for it required male partner cooperation.

In focus group discussions (FGDs), a majority of female students indicated lack of knowledge of the female condom and how to use it. They also expressed the fact that it was not easily accessible like the male condom. Students were not aware that condoms were a family planning option; condoms are generally associated with promiscuity. Female students expressed their fear of the female condom, sounding on the "strangeness and bigness" of the condom which they said was likely to reduce sexual pleasure.

Another barrier raised in focus group discussions was that of gender roles and power dynamics between males and females, resulting in women failing to initiate discussion about sex, sexuality, HIV and AIDS and family planning and for women to refuse sex without a condom even if they suspect risk. Their views also reflected the fact that they had low risk perception such that they did not want to imagine that their partners back home could expose them to risk or that their behaviours could also expose partners to risk.

Strict religious/denominational beliefs in two of the Church-run institutions constrained young students from accessing and utilising the different sexual reproductive health services. Such beliefs made them feel guilty even if their conditions required some form of reproductive health service. Again, views raised in focus group discussions showed that it was religious taboo to talk about pre-marital sex and sexuality issues and the use of the condom in their institutions.

**Factors on health-related factors associated with low uptake and utilization of sexual reproductive health services**

With the current 2-5-2 programme that is tightly packed, students can hardly afford to access sexual reproductive health services at convenient times due to the long queues that are witnessed at many health institutions. Students can only think of getting health care during the weekend and when the situation is probably critical.

Students therefore felt they could only be assisted meaningfully if they were to be served as a special group that would need emergency attention then go back for lectures. One problem raised was the clashing of working time tables which means that at the end of the day when a student would be free to access services, the hospital/clinic will have closed. Queues are too big and sometimes they were turned away because they had no money. Female students also expressed concern that the female condom should be affordable and easily accessible like the male condom.

In focus group discussions, students complained generally about the judgemental attitudes of health workers. Of major concern was the lack of confidentiality, especially among the service providers at the college or local clinic. They expressed that the perception of and experiences with the health care system was critical in influencing service utilisation. Such environments made most of the students reluctant to seek for services at other nearest health facility, thereby delaying access to critical health care. Students claimed that health providers asked too many questions and were sometimes harsh.

Three of the institutions in this study have clinics; but students opt to get services from elsewhere. Generally students spoke of judgemental attitudes and professional bias among health providers. A 3*(pseudo name),*highlighted that students were hesitant to access sexual reproductive health services because the service providers were not friendly. "When you ask for a service or seek clarification in some area, the nurse sort of interrogates you and this scares away a number of students", she said.

In focus group discussions, students generally felt there were challenges in health worker-client communication. They claimed as lay people in health issues, sometimes they needed more information on available sexual reproductive health services for them to make informed choices, but often times the service

providers are impatient and hurrying. As a result, students indicated that they talk to their peers about issues of sex and sexuality, despite the fact that the information they get from them is sometimes misleading or inadequate.Students also suggested integration of services at one health unit to make referrals easy and to minimise wastage of time.

A 4*(pseudo name)* indicated that at their campus clinic, there was only one qualified nurse and an assistant. This results in heavy workloads for the staff. In the absence of the qualified nurse, students have no assistance; they have to go elsewhere.

In focus group discussions students from one of the institutions expressed concern over the distribution of condoms on campus. Students indicated inappropriate and non-confidential condom outlets. They also revealed that they that there were inadequate consulting and counselling rooms and space as in some cases, some counsellors has to go out to allow the other member to have a session with a student seeking help.

Students suggested for more of the opt-out provider initiated services and mobile services to improve uptake. Uptake would improve in the sense that students are generally not comfortable with services offered by a familiar person as already highlighted.

**Findings related to how colleges can improve uptake and utilisation of sexual reproductive health services amongst students.**

The students highlighted the need for right information about sexual reproductive health services during orientation and from Health and Life Skills lecturers and the nurse to minimise some of the risks they often encounter. The suggestion was to have more of reproductive health sessions.

From the focus group discussion, was raised the need for positive influence on young people's sexual behaviour as well as orienting health systems to offer youth friendly sexual and reproductive health services. They said they wanted more clarification on some of the don'ts often instilled in them by society at large.

A5 (*pseudo name)*had this to say, young people require rigorous awareness drives to sensitise them about the available reproductive health services. He indicated that this could be done by increasing the involvement of important stakeholders on campus and also those bringing services from outside. A 5 further reiterated that for example, with HIV testing and treatment of STIs students were generally not free to be attended to by the local service provider, so colleges needed to open doors to other stakeholders like New Start Centre, Regai Dzive Shiri.

In focus group discussions, it was suggested that institutions could increase awareness and understanding of sexual reproductive health services if they could think of using information packs and brochures. Reading and keeping the information packs would make a very big difference, instead of just lectures.

In line with sensitisation of students, focus group discussions also suggested the need for regular training of health providers, counsellors and lecturers in the college (Continuous Professional Development), if they are to effectively serve the students. Students said they dreamt of a situation when students could consult any of the stakeholders highlighted above and get appropriate information and services. This would make students more comfortable, rather than just having a short list of personnel.

Students also indicated the need for suggestion boxes, where they (students) would post sexual reproductive health issues to be addressed. That way institution authorities would get to understand the needs of the students. A 6(*pseudo name)* said "We need Peer Educators. Condoms are being distributed here and awareness campaigns are sometimes given, but I also think the college clinic could provide Anti-Retroviral Therapy (ART). Moral support is also needed; hence, the need to create support groups, as well as enforcing policy, especially the HIV and AIDS policy more effectively."

**Policy issues and regulations to do with sexual reproductive health in colleges: Information from college documents.**

Tertiary Institutions have HIV and AIDS Policies and a Sexual Harassment Policies. The HIV and AIDS Policy seeks to guide, reinforce and secure a healthy future for all. It stresses on standard medical rules of confidentiality to cases of students with HIV and AIDS; that is the privacy of the student will be protected. The Sexual Harassment Policy in institutions seeks to provide supportive environment free of sexual harassment and to protect the rights of persons in institutions. Institution Strategic Plans spell out the need to safeguard the welfare of students. The institutions Policy Document talks of an Aegrotat pass for a candidate affected by illness or other reasons judged sufficient by institutions Academic Board (CAB) with supporting evidence to the chair of the concerned Departments. The institutions as a preventive college, as a prevention task force in HIV and AIDS programmes works closely with DAAC in providing statistics about peer education activities in institutions as well as statistics on STI treatment and HIV testing and other sexual reproductive health services. Institutions have also included in the curriculum HIV/ AIDS and Life Skills education which address issues of sexuality and reproductive health.

Despite initiatives and intervention strategies given above, students felt there are gaps. The policies are not being effectively implemented. Students demonstrated a poor understanding of the policies and felt there were a few enabling factors in the way they are being implemented. One student, Richard (28) *pseudo name* wondered whether the college stakeholders ever considered evaluating the effectiveness of sexual reproductive health services programmes offered to students. He thought an evaluation could help them to review their practices in order to improve uptake and utilization. In June 2014, the media reported high incidences of STIs among students in Masvingo colleges and one would question the negative scenario, when sexual reproductive health services are said to be accessible and affordable.

The issue of confidentiality was strongly disputed as students claimed that health service providers in the college did not maintain privacy. Students, therefore seek services outside the campus. Students also expressed their reservations about sexual harassment indicating that individuals were often harassed by lecturers, but were afraid to report. On issue of the Aegrotat pass in the college policies, female students felt they did not protect them in issues to do with antenatal care and labour. They said the policy is silent about the fate of a female student who goes into labour during the period of assessment; say one goes into labour a night before examinations. It looks like college authorities do not protect them as much as they do with other health conditions. This therefore reflects the unfriendliness and unsupportiveness of the policies.

## IV. DISCUSSIONS AND CONCLUSIONS

Young people including those in teachers colleges are faced with challenges of orientation and discovery about sex and sexuality and this puts them at high risk of STIs, HIV and unplanned pregnancies, resulting in unsafe abortions, deferment and even dropping out. It is therefore important to support young adults, particularly young women in making informed decisions about sex, sexuality and reproductive health choices.

The study managed to identify a number of socio-cultural, religious and health system related factors that determine low uptake and utilization of reproductive health services, among students in Masvingo tertiary institutions. In analysing health-related factors, it has been noted that low uptake and utilization of sexual reproductive health services is largely due to the unfriendliness of the reproductive health facilities to young people. This is a confirmation of Wahone (2010), contention that perhaps it is the negative or judgemental attitude of the health services providers, their lack of confidentiality that will influence further utilisation of the services, which even good technical care, may not remedy. There is therefore need to train service workers on how to handle young people.

From the voices of the students in focus group discussions, concern was that students in teachers' colleges have acquired knowledge about available sexual reproductive health services and their benefits, but naturally find it difficult to open up and seek services. As indicated by Alice (28) *pseudo name* it is embarrassing for a young person to expose their genitals or to be touched by a stranger of the opposite sex, even though they may be a service provider. In addition to the above, discussions in focus group discussions, generally indicated that at church-run institutions, there were limits as to what could be shared relating to sex and sexuality for some issues could be termed taboo and sharing that kind of information was assumed to influence the so-called "innocent young people" negatively. This observation concurs with Squeller et.al (2006) findings in assessing progress of youth reproductive health that young people's health is influenced by parents and religious leaders. It therefore calls for more process evaluation to be carried out to assess the success and failures of reproductive health service delivery among students and identify more effective strategies to address the structural problems/constraints.

A general consensus from the female students indicated that they lacked knowledge of the female condom and how to use it. The finding is in concurrence with Hendriksen, Peltifer, et.al (2007) findings that the use of the female condom can serve as an entry point to building community capacity in sexual reproductive health issues and that women need to be trained on how to use it (behavioural intervention). The male students also demonstrated lack of understanding that they could be screened for penile and prostate cancers. The study therefore concludes that youth utilization of reproductive health services is low and creating awareness of these services to them is important to enable them to increase their knowledge and understanding and in turn scale up utilization.

It was observed that though student teachers might acquire knowledge about reproductive health services, their strong socio-cultural background might impact negatively on issues to do with sexual reproductive health. They are more inclined to believing and keeping some of the socio-cultural norms and values about sex and sexuality, as well as reproductive health. Responses from students generally showed that both the males and females were not very comfortable with procedures like screening tests for STIs and cancers and with some family planning options like jadelle and loop. These fears and anxieties often lead to people accessing medical health services very late and in most cases when other traditional known means will have failed. Such beliefs and attitudes often block the concept of prevention and early diagnosis (AIDS Care, 2005).

This calls upon all stakeholders to create more opportunities that help in passing this crucial information to the youth and young people in college.

The students fail to access services because of unfavourable conditions like having to join long queues, finding the clinic having closed and sometimes meeting relatives or neighbours. This therefore indicates that students need to be given separate facilities as most of them are shy and for them to be served in good time. The study therefore concludes that there be increased separate facilities for students.

Results showed a number of policies and strategies colleges have employed in trying to meet sexual and reproductive health needs. The students, however, often encounter challenges as the various policies and guidelines seem not to translate into actual programmes and measures on the ground. This, therefore, suggests that those who are involved in planning and delivering services must have a clear understanding of the needs, concerns and beliefs of the consumers, the students. This will be in line with the WHO (2004) guidelines that spell out that provision of good quality health services to the youth can be achieved through favourable policy environments, improved clinical and communication skills of providers and their supportive attitudes. This study concludes that a lot needs to be done in teachers' colleges to translate written policies into actual practice.

## REFERENCES


[1]. ADRA (2007). *LDP youth friendly services in Cambodia: Leadership management sustainability.*

[2]. Cambodia: Management Sciences AIDS Care: Psychological and Socio-media Aspects of AIDS/HIV Volume 17, Issue 7, 2005.

[3]. Akinyi , O.P. (2009), Determinants of Youth Friendly Reproductive Health Services among School and College Youth in Thika West District Kiambu country, Kenya.

[4]. Am J, Public Health 2007; (7): 1233-1240, Contextual Influences on Modern Contraceptive use in Sub-Saharan Africa.

[5]. Anable, S., Cabarl, J. and Alfard, P(2005).Factors affecting Africanson reproductive health. *Journal of African Reproductive health (9)25-45* Andersen, R., & Newman, J. F. (2005). Societal and Individual Determinants of Medical Care Utilization in the United States. *The Milbank Quarterly, 83(4),* 1-28.

[6]. Biddlecom, A.E., Munthali, A., Singh, S and Woog,V(2004).Adolescents‟ „views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda, *African Journal of Reproductive Health* 2007 11(3): 99-110.

[7]. Braeken, D and Rondinelli, I (2012).Sexual and reproductive health needs of young people: Matching needs with systems. International Federation of Gynaecology and Obstetrics
FHI (2006), Meeting the Health Needs of Young Clients: A Guide to Providing Reproductive Health and Services to Adolescents.

[8]. Glasier, A. and Gulmezoglu, A.M. (2006), Putting Sexual and Reproductive Health on the Agenda: The Lancet, Volume 368, Issue 9547, 4-10 November 2006, pg. 1550-1551.

[9]. Glasier, A., Gulmezoglu, A.M.,Schmid, G.P., Moreno, M.D. and VanLook, F.A. (2006), Sexual and Reproductive Health: A matter of life and Death. The Lancet, Volume 368, Issue 9547, 4-10 November (2006), pg.1595-1607.

[10]. Godia, P (2010).Youth friendly sexual and reproductive health service provision in Kenya: What is the best model? Nairobi, MOH IPPF (2007). A guide for developing policies on sexual and reproductive health and rights of young people in Europe. Brussels: IPPF EN Joint United nations Program on AIDS:UNAIDS World AIDS day Report, Geneva: UNAIDS 2011.

[11]. Ministry of Health and Child Welfare (2016). *Standard National Adolescent Sexual and Reproductive Health (ASRH)Training Manualfor Service Providers:Strengthening Designing, Provision,Monitoring, Evaluation and Sustainability of Adolescent Friendly Sexual and Reproductive Health Services in Zimbabwe*. Harare: UNFPA

[12]. Ministry of Health and Child Welfare (2012). *Standard NationalAdolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers:Strengthening Designing, Provision, Monitoring,*

[13]. MoH (2005), National Guidelines for Provison of Adolescent Youth Friendly Services(YFS) in Kenya, Nairobi: Government Printers.

[14]. MoH (2007), National Reproductive Health Policy: Enhancing Reproductive Health Status of allKenyans, Nairobi: Ministry of Health.

[15]. Naidoo, P. (2015). *Evaluation of clinics on the provision of Youth Friendly Services in the Ethekweini Metro of Kwazulu Natal*. International Journal of Health and Medical Science, 1:1 1-7.
National Adolescent Sexual and Reproductive Health (ASRH) Advocacy Package and Implementation Plan: 2014–2015 for Zimbabwe, Harare, Zimbabwe.

[16]. Pathfinder International (2005).Integrating Youth-Friendly Sexual and Reproductive Health Services in Public Health Facilities: A Success Story and Lesson Learned in Tanzania. Daresalam: FHI SAYWHAT

(2015), Standard Guidelines on College Responses to Sexual Harassment in Three Tertiary Institutions, Harare: SAYWHAT.

[17]. Tilahun, M., Mengistie, B., Egata,G and Reda, A. (2010). Health workers'attitude towards sexual and reproductive health services for unmarried adolescents in Ethiopia.USA: Population studies and training Centre Wahone, A.M.M. (2010), An Assessment of Factors Determining Access and Utilization of Reproductive Health Care Services by Adolescents in Nairobi City, Nairobi: Kenya.

[18]. Warenius et al.,(2006). Vulnerability and sexual and reproductive health among Zambian secondary school students. Karolinska Institute, Stockholm,Sw eden.

Masvosva Miriro'' Factors associated with low uptake and utilisation of reproductive health services by female students in Masvingo Tertiary Institutions." IOSR Journal Of Humanities And Social Science (IOSR-JHSS). vol. 23 no. 09, 2018, pp. 89-96.