

Reproductive Health and the Cost of Being a Female Student: Experiences from Jimma College of Teachers Education

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Abstract: Young people in developing countries face a range of sexual and reproductive health problems. The problems are more complex when we take gender into account. Hence, this study explores the experiences of female college students in relation to sexual and reproductive health in Jimma college of Teachers Education, Jimma town, Southwest Ethiopia. The design follows a qualitative approach using semi structured and unstructured interviews, focus group discussions and observation for data collection, taking place between the 9th of February 2016 and the 9th of April 2016 from purposively selected female students. This study reveals that female students are facing visible sexual and reproductive health problems most of which are due to their gender while others do so because of poor provision of services. Therefore, the sexual and reproductive health packages in the college should take into account the gender dimension of the problem that is contextualized into local settings.

Background

Reproductive health is one of the major concerns featuring on the global agenda, mainly from the 1994 International Conference on Population and Development (ICPD) onwards (Glasier et al. 2006: 1-2). Subsequently, reproductive health has been defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (UN ICPD 1994: 41; WHO 2006: 5).

The ICPD conference emphasized three areas that were assumed to take gender issues a step further. It outlines reproductive health as a universal human right to which every human being is entitled (ICPD; Program of Action, 7.3). Secondly, it entails the concept of empowerment that intends to enable women to achieve healthy reproductive and sexual lives. This point pertains to the necessity to deal with the norms and values which promote gender inequality and undermine the decision-making power of women. The third focus area was on health service provision. This is concerned with the quality of reproductive health services ranging from access to information on family planning and safe sex to the affordability and confidentiality of services, treatment of service providers, and availability of supplies (MacDonald 2004: 2). While the definition of reproductive health at the Cairo Conference was assumed to include sexual health, there has been a tendency to identify sexual health as even broader than reproductive health itself for sexual relations and sexuality may not necessarily lead to reproduction (WHO 2010: V). Equally important is the fact that reproductive health and sexual health are closely related. Hence, the World Health Organization suggested a working definition of sexual health as:

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (WHO 2006, cited in WHO 2010: 3)

Every society has norms about expected sexual behaviors for unmarried adolescents. These norms act as the means to socially control people's behaviors in society in order to discourage young people from becoming sexually immoral (Alonzo/Reynolds 1995: 304). In some societies, provision of SRH information to young people has been challenging because sexual issues are very sensitive in many cultures (Senderowitz 2000: V). The provision of sexual and reproductive health (SRH) services to unmarried adolescents is equated to promoting premarital sex which is a taboo (Chirwa/Kudzala 2001 in Appia et al. 2015: 62; Mbugua 2007: 1080). Because of this, many societies customarily withhold SRH information from unmarried adolescents till it is felt necessary to give it, which usually happens following puberty or marriage (Senderowitz 2000: V). This, however, denies adolescents easy access to sex and SRH information that could empower them for SRH promotion (Irwin et al. 1994: 9).

Studies, for instance, (Emmanuel 2015: 100; Hailegiorgis et al. 2012: XII) have shown that young people in developing countries, especially in Sub-Saharan Africa have low levels of sexual knowledge that affect their attitudes towards sex and sexual behaviors. Some large-scale studies conducted in Africa by Bankole and Malarche (2010: 118), Biddlecom et al. (2007: 2) and Erulkar et al. (2005: 51-58), reveals that the majority of young people in Sub-Saharan African countries frequently mentioned a need for having affordable SRH services to meet their reproductive health needs. Ethiopia is a country in Sub-Saharan Africa that comprises of many young people whose reproductive health needs are poorly understood and ill-served. Haddas and Nilufar (2007: X) noted sexual and reproductive health among adolescents are major concerns in Ethiopia where many adolescents are sexually active at an early age and premarital sex is common among 15-19 years, contrary to the norms of Ethiopian society. According to health experts, most problems faced by adolescents are behavior related. As a result, adolescents face many sexual and reproductive health problems that affect their health and development as well as information related to sexuality and reproductive health. A similar study conducted by Aboma (2012: 15) in Harar region of Ethiopia revealed that current reproductive health services for adolescents are very limited in terms of being youth-friendly, affordable, or confidential. The environment within which the services are provided is often not sensitive to the special needs of this youth population, and youths face several barriers. These barriers include inconvenient locations, limited hours of operation, unsupportive provider attitudes, poor service quality, lack of confidentiality, the gender of the service providers being male for young women, and the high cost of the services. Moreover, the youth tend to be less informed, less experienced, and less comfortable in accessing reproductive health services (RHS) than adults. They often lack basic reproductive health knowledge and access to affordable and confidential health services (Ayalew et al. 2009: 100). In addition, research in this area has indicated an increase in early premarital sex, unwanted pregnancy and unsafe abortion among the youth population (Govindasamy et al. 2002: 27-32; Ayele/Jote 2015: 4-6).

Nonetheless, despite the existence of several research outputs on reproductive health in Ethiopia, neither of them had focused on the reproductive health seeking behavior of female college students. Hence, we focused on female college students in Jimma Teacher Training College where many young female students from rural areas are admitted and yet live off-campus without dormitory services which requires them to make dramatic adjustments to the urban way of life. On

the other hand, a study by Ayele and Jote (2015: 1-9) that attempts to focus on female students has limited its focus to the awareness of “female college students in Eastern Ethiopia about the legalization of Safe abortion”. Other than its limited focus (abortion) and geographic difference from our study, the research design itself is cross-sectional which does not bring the lived experiences of female college students to light. Therefore, the aim of this study is to describe the sexual and reproductive health experiences of female college students at Jimma College of Teachers Education and to examine the processes through which female students decide to obtain reproductive health services.

In the meantime, our research draws from critical medical anthropology to make sense of the data. Critical medical anthropologists focus on health problems and healing within a structures framework. They ask what power relations are involved and who benefits from particular forms of healing. They analyze the role of inequality and poverty in health problems. Also the critical approach in medical anthropology focuses on how “political and economic forces, including the exercise of power are used in shaping health, disease, illness experience and health care” (Singer/Baer 1995: 5, cited in Fatma 2005: 8). This framework fits our research because we will examine the power dynamics between patients and providers, the knowledge of individual and groups of female students to obtain reproductive health services, and how these issues are constrained within health systems.

Methods and Settings

Study Design and Data Sources

We employed a qualitative research approach with ethnographic design in order to give qualitative exploratory insights into the problem. We then applied a purposive sampling technique to select four key informants from JCTE: one counselor, two health service professionals and one gender office coordinator. It was believed that these key informants know much about the reproductive health behavior of female students due to their position in the college. As a result, we selected them as key informants. Further, we purposively selected twelve female students for interview from those who attended the student health clinic. On top of this, twenty eight more female students were selected for focus group discussions. These students were organized into three focus groups. The size of each FGD was 8-10 individuals. The discussions were conducted in the college reserved class room. We collected primary data from the 9th February 2016 to the 9th April 2016 through interviews, focus group discussions and observations. But the interviewees did not consent to audio recording during individual in depth interviews. Therefore, we used a notebook to overcome this limitation.

Ethical Clearance

We first presented the official letter to the college administration about the study that we obtained from Jimma University. We also disclosed the purpose of the study together with the official letter to the participants before interviews. The participants were assured confidentiality and anonymity. Similarly, they were asked (and agreed) not to share the groups' information outside of our discussions. The study participants were also briefed on their freedom to discontinue the discussions or interviews at any point they wished in case they felt uncomfortable. Therefore, the data for this article had been collected with the informed consent of the participants.

Background of the Study Area

The Study area is found in Jimma town, 352 km from capital city of the Ethiopia in South Western direction. The area is home to the origin of Coffee Arabica. According to CSA (2007) the total human population of Jimma town is about 149,037 of whom 74,940 are men and 74,093 are women, residing in 18 small administrative clusters or *kebeles (gandaa)*.

Jimma College of Teachers Education is located in the *kebele (gandaa)* of Ginjo in Jimma town about 2.5 km to the North East of down town. It is one of the Regional Colleges established to produce qualified teachers for primary schools in Oromia National Regional State. It runs twelve academic departments clustered under five educational streams with a total of 3490 students (JCTE, 2016 report). The College has a clinic on campus to provide health services, including in-patient bed services for short term admissions and referral services for all students of the college. The clinic shares a roof with the physical education office. It is bordered by the physical education stream office to the North, the student lounge to the East, and with the language stream office, Education stream office and college administration offices to the South, and an old bookstore to the west.

There is a small open green space between the students' health clinic and the students launch. The clinic has, in total, seven rooms including a reception room (patient's waiting room), one examination room, one bed room for emergency cases, one nurse office, one injection room, one storeroom and one toilet room. The staff of the clinic repeatedly report problems about its poor facilities arguing that less attention is given to the clinic, especially in terms of budget allocation, and shortage of materials to provide services according to the students' individual health needs. The staff members of the clinic are two: one nurse who is coordinating the clinic's activities and one health assistant.

Results and Discussion

This study was carried out in Jimma town at Jimma College of Teachers Education which is one of the oldest higher institutions in Oromia, Ethiopia. Female students that participated in the study joined the college from different Zones of Oromia Regional State. Currently, there are no dormitories and related services in the college. They live off campus in individually rented rooms. The majority of college students live in a cohabited living arrangement that involve a sexual relationship. We shall present experiences of these female students in relation to sexual and reproductive health in the following pages.

Female Students' Experiences with Sexual and Reproductive Health Problems

From the focus groups, discussion and in-depth interviews, we tried to learn the participants' experiences about reproductive health, sexually transmitted infections and abortion. Some of the participants in every group, as well as in-depth interviews perceived sexual health as one of the important aspect of human life. On the other hand, most of the informants related sexual health only with sexual intercourse. These informants appear less aware of the importance of sexual health. Most of them experienced their physical and emotional changes without clear information about how to develop a healthy, responsible, and positive attitude towards sexuality. They attribute this gap to the lack of clear communication with parents due to the social norms

that categorize talking openly about sexual issues as a taboo. An interviewee shared her experience stating: “When I saw menarche for the first time, I thought one of my internal organs was bleeding. I was totally shocked. Then, I told my elder sister. She informed me what happened including what to do and what not to do. I felt negative about being female at that time.” (in-depth interview One, February 2016). Another participant added “When I experienced the first menstruation, I was ashamed to tell about it and I used to wash several times within a day because I thought that menstruation occurs after sexual intercourse only to women.” (in-depth interview Two, February 2016). The female participants repeatedly underscored similar experiences with regard to communications about sexual health with their parents. They recount vague expectations of their parents requiring them to remain modest. One of the informants described her experience in this regard:

Nobody ever told me about sexuality in my family. They simply advise me to avoid any relationship with girls and friends, who had active sexual life. The intention was to protect themselves from stigma of having a girl that has begun sexual intercourse before marriage. Like many of my friends, I am confused. I used to talk about it and the idea in my mind was simply sexual health means sexual relation. (in-depth interview Three, March 2016)

Moreover, the informants indicated that fear and misinformation have influenced their understanding of sexual and reproductive health. Female students were advised by their families and relatives to stay away from sexual relations so that they would not be judged by society as “bad” girls. But they did not advise them how to protect themselves. Girls are simply expected to remain virgins until they are married, as virginity symbolically represents purity and strength among the communities from which they came. This family expectation without proper guidance on the issue of sexual behavior has influenced the sexual and reproductive health of young females.

In this regard, the study is in agreement with Chirwa and Kundzala (2001); Mbuguna (2000) and Senderonze (2000) where the provision of appropriate information about SRH to unmarried adolescents is a taboo and one which is arguably equated with initiating them in sexual activities. However, our study further reveals the gender dimension of the problem where female students are affected more than their male class mates.

Sexually Transmitted Infections

Regarding sexually transmitted infections, participants were asked to name sexually transmitted infections that they know. Besides this, they were requested to explain the symptoms. All of the informants had heard of diseases that can be transmitted through sexual intercourse, mainly HIV/AIDS. The main symptom of HIV/AIDS they mentioned was getting thin and contracting tuberculosis. But they failed to mention the symptom of STIs during FGDs. Only a few participants had mentioned the symptoms of STIs by saying *Dhukkuba dhiiraa* or “male’s disease” as a genital problem, smelling discharges and aburning sensation during urination. They believe that the problem affects males more than females (FGD One, February 2016). This understanding is an extension of the term “*Dhukkuba dhiiraa*”, a vernacular term which literally means male’s disease. A conversation during an in-depth interview with one of our student informants is relevant here:

Sexually Transmitted Infections (*dhukkubni dhiiraa*) are common challenges facing many young people in the college. However, even if I sought treatment for the problem, I was ashamed to tell the problem to my friends, because I was afraid of labeling and

discrimination by students. Many students that contracted STIs keep it secret like me. (in-depth interview One, February 2016)

In relation to this, a key informant from the Gender Office of the college surmised that “There is evidence that STIs are caused by unsafe sex among students. An appreciable number of young people have contracted STIs mainly gonorrhoea and syphilis.” (Gender office coordinator, March 2016). The nurse of the College also supports the above ideas:

Of the total young people that visited us for treatment, some of them come up with gonorrhoea. But according to the rules and regulation of the college, our clinic could not provide treatment in this regard. So we refer them to nearby hospital and Family Guidance Association of Ethiopia for treatment free of charge. However, female students prefer private clinics assuming that the service is more confidential in these clinics. (March 2016)

Further, a female student narrated, “Many times you happen to seek advice on a serious health challenge such as abortion or having a STI disease. You feel the need for help but feel shy and shameful to tell an older person who will investigate you more.” One of the participants on FGDs also added: “To me some girls lack specific information about STIs, how to make use of existing sexual and reproductive health services. Most of us are not worried about STDs but about pregnancy. I do not know the symptoms of STDs for sure.” Others on FGDs agreed that female students in the college do not have basic information concerning the symptoms, transmission, and treatment of STIs, since there is no sexual health education. On the contrary, students often have multiple, short-term sexual relationships and do not consistently protect themselves. The reluctance to utilize available SRH service is also documented in other studies such as Aboma (2012) when the services are less sensitive to needs of the youth in terms of location, the unsupportive attitude of the providers and the gender of the service provider. But what makes the problem worse in our study is the fact that the students are facing challenges in new environments very far from their communities in which they were socialized about the dos and don'ts of sexual health.

Similarly, the Gender Coordinator of the college indicated that female students of the college have multiple problems with sexual health. They live in rented rooms in the town. Most female students come from rural villages in the region. They have a very low level of skills of negotiation to protect themselves. They are influenced by peer pressure to have sex before they are ready for safe sex and they often confuse sex with love. As a result, they are enticed into unsafe sex or influence their peers by claiming that sexual intercourse is a way to demonstrate love to their boyfriends. Moreover, even resistance may not guarantee the sexual health of female students for there are times when they are raped by male students. A case in point is a student that was raped during fieldwork for this study and referred by the college students' clinic to the nearby hospital for blood test and treatment. Consequently, female college students are easily exposed to unwanted pregnancy and sexually transmitted infections. In general, most of the female students had multiple sexual partners and at times were susceptible to sexual violence that put their sexual and reproductive health at risk.

Unwanted Pregnancy and Abortion

We also asked our informants about their experiences with unwanted pregnancy and their take on abortion. It was raised during FGDs that unwanted pregnancy is common in the college which often leads to an abortion. They stressed the fact that the majority of female students come

from rural communities where every aspect of sexuality is considered taboo to the extent that girls are not allowed to talk in front of elderly people. Many female students broke these norms through cohabitation with their classmates. They are also easy prey to other people in the town. The female students are often confused and mistakenly think of themselves as “civilized” hence (they believe) they are exempt from the traditional thinking of remaining (*durbummaa*) a virgin. In the process, female students engage in unsafe sexual activities (FDG One, February 2016).

The participants were also asked about abortion in relation to their religious affiliations. Almost all participants interviewed said: “Abortion is not allowed in their religious teachings.” One of the informants in an in-depth interview added “even sex before marriage is prohibited. Abortion is killing the fetus created by God. It’s sinful and breaking the commandments of God.” (in-depth interview Four, February 2016).

Another aspect of abortion raised among the female students was the legal status of abortion. It was learnt that most of the participants hold wrong assumptions about the legality of abortion. They reported that they do not have reliable information. But they said:

We heard abortion is illegal, prohibited, totally forbidden in the country except in private clinic where they secretly conduct it. Hence, many female students choose private clinic for safe and unsafe abortion to keep their own security. Students who seek abortion in student health clinic are those who have no option, very poor and may have been raped. But female students mostly prefer private clinics for their sexual health issues for they are more confidential even if they are costly. (FGD Two, March 2016)

A key informant from students’ clinic substantiates the above case on abortion. The key informant said:

Abortion is one of the major problems among female student in this college. Even repeated abortions are common. But students choose private clinics in this regard. They prefer private clinics to make their experiences confidential from the college community. Those who come to this clinic seeking abortion are referred depending on the case (legal issues) of the country to Family Guidance Association of Ethiopia and Jimma University Specialized Teaching Hospital. Even during the field work for this study, about five female college students with abortion case were referred. I think this results from lack of free communication and negotiation skill with their boyfriends to use contraceptives. Perhaps, economic problem of students is another challenge facing female students that force them to engage in sexual activities with adults who are not willing for safe sex. (March 2016)

Moreover, another key informant (Coordinator of Gender Office) supported the above ideas as follows:

Abortion is really the major challenge in this college. The majority of female college students came from rural areas of the region with strong cultural norms that expects them to remain virgin until marriage. However, as they join this college, there is no dormitory for female students. They are forced to live rent rooms available in the town. Hence, many of them have got the freedom to establish relationships. They start testing sexual intercourse without adequate knowledge of contraceptives and safe sex that lead to unwanted pregnancy and abortion. (March 2016)

The above cases illustrate that the environment in which the female students live, and a lack of adequate awareness on sexual and reproductive health and how to seek help with abortions, have affected their reproductive health.

Help Seeking Behavior and Use of Sexual and Reproductive Health Services

When female student participants in the FGDs and in-depth interviews were asked about available services in the students' clinic, they indicated that the clinic has a shortage of services in general, and reproductive health in particular. They mentioned that it is difficult to get the basic services from the clinic. The referral system itself is cumbersome in the eyes of the female students. For instance, one of the informants complained: "I visited the clinic three times in this semester to seek care from professionals in this clinic but I did not get a meaningful treatment and advice except some anti-pain. To tell you frankly, if I had money, I would have not come back three times without any solutions." (in-depth interview Five, March 2016). The informants reported the absence of appropriate services except condoms (male) that were simply put in the boxes on occasion. Information about appropriate methods of contraception and for the prevention of sexually transmitted diseases is very scarce in the college. In particular, students had the expectation of adequate guidance and counseling services including SRH services. But they hardly find any guidance and counseling services provided to the young people in the college except during their first year entry of the first week, but not for more than one hour.

Others reported a critical shortage of health professionals having the patience to listen to students' problems. They indicated that when students go to the health clinic of the college seeking services mainly for sexually related health problem, they are often refused information. In addition, many students refuse to go to the clinic due to the fear of assuming that the clinic health professionals will report their case to the college administration. As a result, most of the students rarely seek sexual and reproductive health related advice from them. Advice or services from the clinic, mainly about pregnancy or sexually transmitted infections, were very low. Participants of the FGDs for example, indicated that they dare not ask the health professionals questions on sexuality because the responses are not respectful. This lack of smooth communication and limited youth friendly services discouraged female students from seeking sexual and reproductive health services at the students' clinic.

Regarding guidance and counseling services to students in general and female students in particular, one of our key informants underscored: "I am assigned to provide this service before a year. But, I am sure that students had not get relevant services in this regard due lack of attention to the service. There is no independent office to provide such services to keep confidentiality and privacy of the clients in the college." (interview with College Counselor, March 2016).

Moreover, the health professionals interviewed regarding the sexual and reproductive health services in the college health clinic stressed the impediments posed by lack of sufficient funds. They often expressed their belief that lack of adequate funding limits their ability to operate the clinic as they wished. They believe the financial strain obstructed their services on weekends and at night, including emergency services. The nurse of the college health clinic further explained that it is difficult to provide services on reproductive health because the government allocates budgets mainly for general health and does not particularly focus on the youth reproductive health services. Hence, the clinic prepared a proposal to collaboratively work with NGOs like Family Guidance Association of Ethiopia (FGA) before a few years so that the clinic could get

support such as contraceptives and a referral system for reproductive issues including abortion. As a result, the clinic is now working with FGAs. But some female students are still reluctant to use these opportunities due to fear and they prefer the private clinic for reproductive health problems although they may suffer from the economic costs of these services.

We learnt from the nurse that the college health clinic has a shortage of resources used for voluntary counseling and the testing of STIs including HIV/AIDS. On the other hand, unplanned pregnancy, unsafe abortion and STIs are the most common problems of students. Particularly, female newcomers were more common victims of the problems. A key informant in our study, stated that many of the students worry only about pregnancy rather than STIs. Hence, they come up with questions of STIs for help. But, the college health clinic never renders services in this affair. Besides, it was pointed out that very high abortion records among young female students of the college could be found in Jimma University Specialized Hospital. But students prefer private clinics over the hospitals for abortion. Private clinics are preferred for confidentiality of information. In general, repeated abortions were common among female students of this college. (Interview with the College nurse, February 2016). The Gender coordinator has also emphasized a shortage of adequate sexual and reproductive health services in the college, including the absence of professional counselors. As a result, female students in the college are prone to different forms of SRHs problems mainly unwanted pregnancy and abortions (Interview conducted with Gender coordinator of JCTE, March 2016).

We asked the female student informants of FGDs and in in-depth interviews about client satisfaction with the services offered at JCTE health clinic. Almost all of the respondents reported a lack of satisfaction with the services provided by the clinic due to many reasons such as absence of drugs even for general healthcare, lack of tolerance of the service provider and their approach to clients and a lack of materials, including STI tests. In general, the above mentioned shortage of services and dissatisfaction with the available ones influence the reproductive health seeking behavior of female students.

Use of Contraceptives

Decision Making Process on Use of Sexual and Reproductive Health Services

We explored which contraceptives female college students commonly decided to obtain from sexual health services. We interviewed twelve female students and four of the participants answered they had used different methods such as injections, pills, condoms and natural methods. Of the twelve female college students, eight were sexually active, two were having sex at least once a month, and two were still virgins and have not tried any sexual practices. Out of the sexually active female students, four were using some form of contraception. Seven out of twelve sexually active female students had never used medical contraceptives due to the fear of side effects which they had heard from peers. This concern was in line with the concerns of other students in FGDs during the group discussion. (interview with twelve informants, February-March 2016).

The informants also shared their experience of emergency contraceptive pills and the circumstance under which they opt for it. One of the informants described:

Sometimes, female students are forced into sexual acts by their boyfriends and other men. This happens when maybe you have just gone to visit your boyfriend at his home. By the time you realize this man has forced you into unsafe sex, you are afraid

to access such pills in this students' clinic. Since we are likely to see the health worker on church services or somewhere else, we usually fear to go to the clinic for emergency contraceptive pills. (FGD Two, March 2016)

Other informants share similar experiences and concerns with the use of the emergency contraceptive pill. They stressed that it is difficult for them to ask for emergency contraceptive pills in the student health clinic even if it's available. This is because soon after the student requests those pills, the health worker inquires into how the student has ended up having sex. Other "embarrassing" questions which make students shy away and leave the clinic could also be raised. In fact, this idea was substantiated by a key nurse informant in the college health clinic. The nurse indicated that emergency contraceptive pills are available in the clinic but few female students are using them. The nurse suspected the reason for this could be the fact that the majority of female students in the college are from rural areas and they are afraid of disclosing their sexual activity to the college health workers (the College nurse, February 2016).

In terms of condom use all of the participants in this study had heard and know about the male or, external condom. But the participants didn't know what a female condom looks like or how to use it. All of the informants agreed that male condoms were more available than any other contraceptive methods in the college. They are always freely available in the college. However, female students could not try to collect this condom due to fear and labeling by others as being sexually active. We observed the availability of male condoms during the fieldwork in the wooden boxes under the teaching blocks. But no female student was observed collecting these condoms. Other than fear of labeling, another participant from our in-depth interviews revealed that she tried to inquire as to the experiences of condom use among her male classmates and realized that they do not use condoms. This is congruent with what her boyfriend told her. The rationale is the belief that true lovers do not use condoms in addition to the belief that condoms affect sexual pressure (in-depth interview Six, March 2016).

Most of the student participants in FGDs and in-depth interviews revealed that oral contraceptives (pills) are not their first choice due to fear of their side effects, on their skin (face) and long term effects on fertility. One participant said: "I have grown up thinking that contraceptives cause infertility to women. By the time you wish to have a child, it's impossible because they destroy your womb; that's what I hear from colleagues and other people about contraceptive pills." (in-depth interview Seven, March 2016). The common belief among female students was that this contraceptive causes black spots on their face, increases body weight and that long term use could result in infertility.

Injectable contraceptives are the other available but not popular contraceptive among female students. The key nurse informant from the student health clinic reported that few female students choose injectable contraceptives to manage their sexual and reproductive health. For example, from the total female students only seven female students had decided to use the service from September 2015 to March 2016. The majority of female students in the college do not choose this contraceptive due to misinformation about the contraceptive by their boyfriends and lack of decision making power to use it. Moreover, most of the female students participated in focus group discussion did not understand the issue of injectable contraceptives. Only four of them choose this method. One of the participants in the first focus group discussion who got the service said "to me, injectable contraceptive is very important. You know you are free from any fear of pregnancy even if you are raped. But I have no information on the side effect of this method. I was simply using this method for the past three months." (in-depth interview Eight, March 2016). Another participant also added, "Injectable contraceptive appears good choice for me. It

is available here in the college health clinic for free. I used it for the past four months, yet it has its own health problem.” (in-depth interview Four, February 2016). On the other hand, a student informant during in-depth interviews has mentioned her experience with injectable contraceptives stating absence of menstruation, mood swings and fever after which she decided to stop using it. (in-depth interview Nine, March 2016). It can be noticed from the discussions with students that modern contraceptives are often perceived by many female college students as having side effects such as vomiting, headache, irregular bleeding, absence of menstruation, weight fluctuations. Besides, contraceptive intake is perceived as the cause for black spots on their face.

The students indicated that “natural birth control methods are important and it is practiced by many sexually active female students. If one can negotiate and convince one’s boyfriend, the natural method is better rather than modern contraceptives.” However, the use of the natural method by female college students tends to rely on incomplete information on how, when and with whom they use natural contraceptive methods. Their focus is mostly to protect themselves from unwanted pregnancy by ignoring the life challenging issues of STIs including HIV/AIDS (FGD Three, April 2016).

However, the reluctance to use modern contraceptives due to the fear of its side effects and the common belief among students that “true lovers” should not wear condoms made female students bear the cost of unsafe sex mainly in terms of unwanted pregnancy and abortion. For instance, the key nurse informant of the college reported five female students were referred to FGA clinic for abortion in two months during fieldwork (interview with the College nurse, March 2016).

Providers-Client Communication

Communication matters especially on sexual issues, either in encouraging the use of available services or in discouraging clients. The interaction between female students and health care officers in the student’ clinic appears incongruent at the study area. On the one hand, the health professional key informant said, “Whenever they come here in the student’s clinic, we appreciate them especially female students who tend to talk openly about their problem and provided the services they need.” On the other however, most of the female college students participated in in-depth interview and focus group discussions stressed: “the approaches of health professionals in this college clinic are harsh to the clients particularly in the case of pregnancy and sexual transmitted disease. As a result, the majority of female students choose private clinics in the town because of fear of the inappropriate behavior and lack of confidentiality.” Another informant added “they should have recognized that mistreatment of the clients (especially female students who seek help from them) would not be considered as entertainment.” To some extent, what we observed during the fieldwork was similar to the concerns raised by female students. Nevertheless, clear and effective communication is the starting point in helping young female students to achieve healthy sexual and reproductive health. Being able to understand the perspective of young female students will enable the provider to respond appropriately, creating a positive and effective service experience. Positive provider-client interaction benefits the young female students because they will feel more comfortable expressing their concerns or problems, thereby enabling the provider to more effectively serve the female students of the college, but this was not observed. Lack of effective provider-client communication affected the sexual and reproductive health seeking behavior of female students even if the services are free of charge as indicated by most of the college female students of JCTE.

Conclusion

This study attempted to explore and describe the experiences of female college students in relation to sexual and reproductive health. We found that female students had a limited understanding of sexuality and sexual health. The issue is a taboo in their communities such that they do not discuss sexuality and sexual health with their parents, as well as elders. Moreover, a low level of understanding about sexual health, fear of the side effects of contraceptives, the social-cultural expectations of a “good girl” had negatively affected female students’ use of contraceptives. Female college students have been taking risks in order not to lose their partners. They were not decision makers on their sexual relations including the use of contraceptives. They usually give up decision making to their boyfriends. Unfortunately, these risks had undesirable consequences. Among the major risks taken by these students was engagement in unsafe sex which in turn led to unwanted pregnancies and sexually transmitted infections. In sum, female students are facing visible sexual and reproductive health problems most of which are due to their gender while others are because of poor provision of services. Therefore, the sexual and reproductive health packages in the college should take into account the gender dimension of the issue that is contextualized into local settings.

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Notes

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