ORIGINAL RESEARCH ARTICLE

Sexual and reproductive health services awareness and utilisation among young people in a semi-Urban community in Cross River State, Nigeria

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Abstract

Young people's unawareness and poor utilisation of sexual and reproductive health and rights (SRHR) services is one of the contributing variables that increase the susceptibility of youths to many challenges in SRHR. This study sought to assess young people's level of awareness and utilisation of available sexual and reproductive health and rights services in Calabar South Local Government Area of Cross River State, Nigeria. The available SRHR services in the study area were identified. A community-based cross-sectional descriptive design was adopted for the study, whereby a sample of 325 youths aged 15-24 years were recruited from households within the 6 selected out of 12 political wards of Calabar Local Government Area, using a multistage sampling technique. A validated self-developed questionnaire was used for data collection which were analysed using SPSS version 22.0. Findings revealed low awareness (94.8%) of young people to available SRHR services, and the proportion of SRHR services utilisation by youths was also low (21.5%). There was a statistically significant influence of SRHR services awareness on youth's utilisation ($P<0.05$). Also, in the logistic regression, the P-value for all the variables showed that there is no significant influence of the predictor variables (age, religion, marital status, educational qualification, means of livelihood, mother's, and father's educational background) on the outcome variable (awareness and utilization). Limited awareness on SRHR services was a rationale for low utilisation of such services among young people. The study recommended training of health care providers on SRHR services with periodic monitoring to ensure that providers are maintaining standards of care. More community enlightenment through government-community partnership is required to strengthen the concept of SRHR, increase awareness for service utilisation and sustainable development. *(Afr J Reprod Health 2023; 27 [5s]: 58-70).*

Keywords: Young people, sexual and reproductive health and rights (SRHR) services, awareness, Service utilisation

Résumé

La méconnaissance et la mauvaise utilisation des services de santé et de droits sexuels et reproductifs (SDSR) par les jeunes sont l'une des variables contributives qui augmentent la sensibilité des jeunes à de nombreux défis en matière de SDSR. Cette étude visait à évaluer le niveau de sensibilisation des jeunes et leur utilisation des services disponibles en matière de santé et de droits sexuels et reproductifs dans la zone de gouvernement local de Calabar South de l'État de Cross River, au Nigeria. Les services de SDSR disponibles dans la zone d'étude ont été identifiés. Une conception descriptive transversale communautaire a été adoptée pour l'étude, dans laquelle un échantillon de 325 jeunes âgés de 15 à 24 ans ont été recrutés dans les ménages des 6 quartiers politiques sélectionnés sur 12 de la zone de gouvernement local de Calabar, en utilisant une technique d'échantillonnage à plusieurs degrés. . Un questionnaire auto-développé validé a été utilisé pour la collecte des données qui ont été analysées à l'aide de SPSS version 22.0. Les résultats ont révélé une faible sensibilisation (94,8 %) des jeunes aux services de SDSR disponibles, et la proportion d'utilisation des services de SDSR par les jeunes était également faible (21,5 %). Il y avait une influence statistiquement significative de la sensibilisation aux services de SDSR sur l'utilisation des jeunes ($P <0,05$). De plus, dans la régression logistique, la valeur P pour toutes les variables a montré qu'il n'y a pas d'influence significative des variables prédictives (âge, religion, état matrimonial, diplôme, moyens de subsistance, niveau d'instruction de la mère et du père) sur la variable de résultat (sensibilisation et utilisation). La connaissance limitée des services de SDSR était une raison de la faible utilisation de ces services chez les jeunes. L'étude a recommandé la formation des prestataires de soins de santé sur les services de SDSR avec un suivi périodique pour s'assurer que les prestataires maintiennent les normes de soins. Une plus grande sensibilisation de la communauté par le biais d'un partenariat gouvernement-communauté est nécessaire pour renforcer le concept de SDSR, accroître la sensibilisation à l'utilisation des services et au développement durable. *(Afr J Reprod Health 2023; 27 [5s]: 58-70).*

Mots-clés: Jeunes, services de santé et droits sexuels et reproductifs (SDSR), sensibilisation, utilisation des services

Introduction

Reproductive health is central to human identity and imperative for health and well-being[1]. Youth reproductive health is critical due to their gregarious sexual activities, which predispose them to negative sexual and reproductive health outcomes. These negative outcomes include their high risk of acquiring sexually transmitted infections (STIs) including human immunodeficiency virus (HIV)/ acquired immune deficiency syndrome (AIDS), unwanted pregnancies, unsafe abortion, and maternal mortality. These outcomes defy youth's abilities to make significant contributions to the development of their communities and the society at large[2]. Thus, youth sexual and reproductive health and right (SRHR) services becomes necessary to eliminate such negative reproductive health outcomes. The services as advanced for the youths by the World Health Organisation (WHO) range from safe, affordable, and scientifically sound sexual and reproductive health information and services to access to modern contraceptives, non-judgmental counselling, pre- and post-natal care and delivery, post abortion services/care, prevention and treatment of sexually transmitted infections amongst others[3,4]. Such services must be deemed acceptable by youths and provided in an environment that respects their rights to confidentiality, privacy and informed consent[3].

There is a perceived inadequate attention to the sexual and reproductive health and right needs of young people in Calabar South Community. The reasons for this are not well-known and if this is left unchecked, Nigeria is unlikely to achieve the vision 2030 of sustainable development in this setting. Observably, young people are frequently snared in alarming magnitudes of sexual activity, yet ill-equipped to protect themselves from the resultant perils[5]. Many youths have unmet sexual and reproductive health needs and are suffering in contemporary times from tragic implications resulting from sexual explorations, some of which are unintended pregnancies, complicated abortions, school drop-outs, STIs/HIV /AIDS, emotional stress and loss of self-esteem[6-8]. In spite of these, the needs of young people regarding sexual and reproductive health and rights seem to be ignored by existing health education and other social programmes in Calabar South Local Government Area of Cross River State. This is apparently evinced by the low turnout of young people for available SRHR services.

It is evident that poor awareness and utilisation of available SRHR services in terms of where to receive care, and availability of human resources for services provision, could lead to young peoples' perils of ignorance and misinformation. This may predispose them to making irreversible errors in their reproductive health decision making[9]. For instance Brhane *et al*[10], reported that youths' lack of awareness and non-utilisation of reproductive health services is one of the contributing factors that accelerate the susceptibility of youths to the trials of reproductive health problems. Also Ayehu *et al*[11], a study to examine the level of sexual and reproductive health and rights service utilisation by young people in Northwest Ethiopia reported low level of utilisation especially among youngsters who were living with their fathers and those that primary level education is their highest educational achievement. Correspondingly, a similar study conducted in Southern Ethiopia[12] , to determine the reproductive health needs and service utilisation among youths in West Badewacho Woreda, Hadiya Zone, showed that within a year, only 29.4% young people used SRHR services. A community based cross-sectional study carried out by Tegegn *et al*[13], in Southwest Ethiopia showed that the utilisation of SRHR services was low due to poor patronage by young people in the available health care facilities.

Youths' limited awareness and poor utilisation of SRHR services as opined by the International Planned Parenthood Federation[8], is a result of inadequate understanding of their shifting biological milieu and requirements. However, substantive literature has attributed young people's lack of responsiveness regarding sexual and reproductive health rights issues and resources to society's preconceived notions and effect of culture which accounts for low – or non-utilization of such services[14]. Although studies on SRHR exist in Nigeria, there are limited studies that examine SRHR awareness and utilisation from the perspectives of youths and what they stand for in the 21st century. This study therefore sought to determine SRHR services awareness and utilisation among young people in a semi-urban community in Cross River State, Nigeria. Also, the influence of awareness of SRHR services on use of

the services, as well as factors that predispose to poor awareness and low use of SRHR services by the youth was also be examined. Findings will direct the necessary recommendations that will alert the government and various non – governmental health agencies to develop policies and re-strategize to guide this population against these disastrous drawbacks that might impede social and economic developments in the future. Promoting efficient utilisation of SRHR services by the youth's population will enhance the achievement of the global goal of 'health for all ages' being the third goal of the 2030 agenda for sustainable development.

Methods

This community-based study utilised the cross-sectional descriptive design to determine SRHR services awareness and utilisation among young people in a Semi-Urban Community in Cross River State, Nigeria. The study was conducted in 6 out of the 12 political wards in Calabar South Local Government Area of Cross River State (CRS), Nigeria. Calabar South is one of the 18 Local Government Areas of CRS in Nigeria. Calabar South has its headquarters in the sub-urban area of Anantigha and it is made up of twelve (12) political wards. Generally, the area is poorly industrialised. According to the Cross River State Government of Nigeria State Primary Health Care Development Agency[15], the area has 14 Primary Health Centres (PHC). There are other privately-owned hospitals in the area with practicing nurses, midwives, medical doctors and Community health extension Workers (CHEWS) who are either employed by the Cross-River State Government or by private medical enterprise.

The target population consisted of all youths aged 15 - 24 in Calabar South Local Government Area, totalling about 49, 110[16] , while the accessible population being the portion of the target population that the researchers can access consisted of 307 Calabar south- based youths aged 15 – 24years, who were willing and able to provide information on SRHR services, irrespective of being in school or out-of-school. Youths who were not within aged 15- 24 years and who were not physically stable and willing to participate in the study were excluded. The sample size for the study was determined on the basis that the total population of residents in Calabar South was 191, 515 with the youth population aged, 15-24 being 49,110[16]. This implies that, the youth population is 26% of the total population. Using the below sample size formula by Leslie Kish for cross-sectional studies shown below:

$$n = \frac{Z^2\,pq}{e^2}$$

Where n = required sample size;

Z = the normal curve constant that represents the level of confidence (1.96);

E = the desired level of precision estimated at 95%;

p = the estimated proportion of attribute that is present in a population is 26% and q is the 1-p = 0.74.

In this study, the estimated allowable error margin was 5% (0.05). This indicates a confidence interval at 95%. It was also estimated that 26% of the population accesses reproductive health services from Calabar South. $n = \frac{1.96^2}{0.05^2}$ x 0.26 x 0.74

= 295.65

Substituting for n =~ 295.7

10% of n (296) was added to complement for participant's attrition amongst others. Therefore, a total of 325 youths was the desired sample size.

Multi-staged sampling method was used to select wards, streets, houses and households in Calabar South community as described subsequently:

Stage 1: consisted of the selection of wards- Six out of twelve (12) wards were randomly selected without replacement using ballot method.

Stage 2: selection of streets - five streets each from the six wards were selected randomly using the method of balloting without replacement.

Stage 3: selection of houses- Each selected street was mapped out to ascertain the number of houses in each ward. Thereafter, the actual number of houses to be sampled per ward was determined using the proportionate sampling method as given by the formula below:

$$P = \frac{\text{Total number of houses in a ward (x)}}{\text{Total number of selected houses in the six wards}} \text{ X sample size}$$

To obtain the sample interval of houses, the formula, $I = \frac{n(x)}{n(p)}$ was applied.

Then, using a randomly selected starting point, systematic sampling technique was employed to select the houses taking every second house into

consideration. Any house that did not meet the inclusion criteria was skipped and the next interval chosen.

Stage 4: selection of households: Households with youths aged 15- 24 were used for the study. Where there was more than a youth in a household, simple random sampling using the ballot method without replacement assisted the selection of a youth in each household for the study.

Instrument for data collection was a validated self-structured interviewer- based questionnaire. The Cronbach's alpha reliability coefficient for the two sub-scales (reproductive health service awareness and proportion of reproductive health service utilisation) measured 0.8 and 0.7 respectively with 0.8 0n the average.

The questionnaire was administered face-to- face by the researchers and trained research assistants and the time required for completion of each questionnaire was about 40 minutes.

This consisted of self-structured interviewer- based questionnaire spread into four (4) sections. Sections A, B, and C. Section A – consisted of 9 items that provided information on the socio-demographic characteristics of youths. Section B – consisted of 4 major items with 7 sub-items that elicited 'yes' or 'No' information on youth's awareness of available SRHR services. Section C- included 4 major items and 24 sub-items which also provided 'yes' or 'No' information on the proportion of utilisation of SRHR services by youths. The questionnaire was scored in accordance with the response options where applicable. Same was retrieved on- the- spot by the researchers and research assistants.

Data analysis

A total of 307 copies of the questionnaire were retrieved implying, 94 % response rate. Data were entered and analysed using the Statistical Package for Social Sciences (SPSS version 21.0). Results were expressed in percentages and presented in tables and charts. Contingency Chi square statistic was used to determine: the influence of youth's awareness of available SRHR services on service utilisation by youths. The hypothesis was tested at 0.05 level of significance. Logistic regression analysis was also to identify the factors that predispose to poor awareness and use of SRHR services by the youth.

Ethical consideration

Ethical approval was obtained from the Cross-River State Research Ethics Committee with REC No. RP/REC/206/465. Participation in the study was voluntary and written consent was obtained from the participants without coercion and participants were informed about the study and that, they could withdraw from the study at any time without being penalised. To ensure anonymity, names were not recorded on the questionnaire and data obtained were entered into the computer with the aid of code numbers that were assigned to each copy of the questionnaire. To ensure confidentiality, the completed copies of the questionnaire were secured in a sealed envelope. Subsequently, hard copies of data gathered from the study were kept under lock-and-key while the soft copies were protected electronically with a password.

Results

Table I shows the socio-demographic characteristics of the study participants. Respondents representing119(36.6%) under study were males while the remaining 206(63.4%) were females. Data on age range showed that 211(64.9%) were between the age of 15 to 19 years, and 114(35.1%) respondents were between the ages of 20 to 24 years. The frequency count also showed that 315(96.9%) of the subjects were Christians, 8(2,5%) were Muslims and 2 were of other religion. Similarly, 299(92.0%) respondents were singles, 19 (5.8%) were married and 7(2.2%) were cohabiting. In terms of who they live with, 50(15.4%) lived with single parent, 198(60.9%) lived with both of their parents and 77(32.7%) lived with others. Data on respondents' educational status revealed that 7(2.2%) of them had primary education, 151(46.5%) of them which was the highest had secondary education, 113(34.2%) were undergraduates, 43(13.2%) of them were graduates and 8(2.5%) had no formal education while 3(0.9%) had other qualifications. Result of the frequent count on means of livelihood showed that 259(79.7%) of the participants were students, 17(5.2%) were applicants, 26(8.0%) engaged in trade, 9(2.8%) were public servants and 7(2.2%) were sales personnel in shops while another 7(2.2%) were engaged in other means of livelihood

Table 1: Participants' socio-demographic characteristics (n=325)

Characteristics	Response options	Frequency	Percentage
Sex	Male	119	36.6
	Female	206	63.4
	Total	**325**	**100**
Age range	15 – 19	211	64.9
	20 – 24	114	35.1
	Total	**325**	**100**
Religion	Christianity	315	96.9
	Islam	8	2.5
	Others specify ……..	2	.6
	Total	**325**	**100**
Marital status	Single	299	92.0
	Married	19	5.8
	Cohabiting	7	2.2
	Total	**325**	**100**
Living with	A single parent	50	15.4
	Both parents	198	60.9
	Others(specify) ……	77	23.7
	Total	**325**	**100**
	Primary	7	2.2
Present educational status	Secondary	151	46.5
	Undergraduate	113	34.8
	Graduate	43	13.2
	Non-formal education	8	2.5
	Others (specify) ……	3	.9
	Total	**325**	**100**
Means of livelihood	Student	259	79.7
	Applicant	17	5.2
	Trading	26	8.0
	Public servant	9	2.8
	Sales personnel of a shop	7	2.2
	Others (specify) ……..	7	2.2
	Total	325	100
Father's educational status	Primary	20	6.2
	Secondary	88	27.1
	Tertiary	201	61.8
	Has not gone to school	16	4.9
	Total	**325**	**100**
Mother's educational status	Primary	36	11.1
	Secondary	88	27.1
	Tertiary	178	54.8
	Has not gone to school	23	7.1
	Total	**325**	**100**

in the community. With this information, students made up the highest respondents for the research followed by those who were trading, then applicant, public servants, sale representatives and others respectively. The distribution on father's educational status of the respondents showed that 20(6.2%) of the respondent's father had primary education, 88(27.1%) had secondary education, 201(61.8%) had tertiary education making it the highest educational status among the parents and 16(4.9%) of the parents had not gone to school. For information on the respondents mothers educational status, 36(11.1%) of the mothers had primary education, 88(27.1%) had secondary education and 178(54.8%) had tertiary education also making it the highest educational qualification with majority of the mothers while 23(7.1%) respondents mothers had not gone to school.

To assess youths' awareness of available SRHR services, the participants were first asked if they had heard of youth reproductive health services, only those who responded "yes" were to continue the session and those who said "no" were meant to end session. To this end, 18 of the respondents representing 4.8 percent said 'no' and subsequently ended session, leaving 307(95.2%) of

Table 2a: Youths' awareness of SRHR services (n=307)

Items	Options	Yes	No
Ever heard of SRHR services?	Yes…….Go to Q11	307 (95.2%)	18 (4.8%)
	No……END SESSION	18 (4.8%)	307 (95.2%)
What SRHR services is	Services that includes family planning.	145 (47.2%)	162 (52.8%)
	Services that includes prevention and management of sexually transmitted infections (STIs) including HIV/AIDS.	143 (46.6%)	164 (553.4%)
	Treatment of abortion complications.	25 (8.1%)	282 (91.9%)
	Prevention and management of infertility and sexual problems.	48 (15.6%)	259 (84.4%)
	Prevention and management of breast cancer and cervical cancer	26 (8.5%)	281 (91.5%)
	Services for rape or other form of sexual violence.	50 (16.3%)	257 (83.7%)
	Services for child birth (antenatal, intranatal and postnatal services)	30 (9.8%)	277 (90.2%)
Source of information concerning SRHR services ?	School (Teachers)	124 (40.4%)	183 (59.6%)
	Health workers	54 (17.6%)	253 (82.4%)
	Television/Print media	107 (34.9%)	200 (65.1%)
	Friends	126 (40.0%)	181 (59.0%)
Aware of any hospital, health centre or clinic/NGO in the community for SRHR services ?	Yes……..Go to Q14	192 (62.5%)	115 (37.5%)
	No……..Go to Q14	115 (37.5%)	192 (62.5%)

Table 2b: Summary of youth's awareness of SRHR services

Item	No. of respondents	Percentage
Aware of one service	155	50.5
Aware of two services	72	23.5
Aware of three services	46	14.8
Aware of four services	18	5.9
Aware of five services	2	0.7
Aware of six services	2	0.7
Aware of all services	12	3.9
Total	307	100.0

the participants that continued the session and provided information for the study. Thus, the number of respondents after question 10 was based on the 307 of them that proceeded because their response to question 10 was "yes" meaning they had heard of youth reproductive health services. The available SRHR services under study are shown in Table 2a. In terms of respondents' awareness of SRHR services, 145(47.2%) of the respondents' said, SRHR services meant services that includes family planning, 143(46.6%) knows it as services that includes prevention and management of sexually transmitted infections (STIs) including HIV/AIDS, another 25(8.1%) consider SRHR services as management of abortion complications. Again 48(15.6%) knows the services to be prevention and management of infertility and sexual problems, 26(8.5%) of the respondents believed the service is for prevention and management of breast cancer and cervical cancer while 50(16.3%) of the respondents said, it includes services for rape or other form of sexual violence and another 30 representing 9.8 percent of the population said is services for childbirth (pregnancy, labour and puerperium). Of the total youths interviewed, 237(77.2%) were highly aware of SRHR services in the research setting while 70(22.8%) had low level of awareness on SRHR services. Level of awareness was further summarised in Figure 1 where participant's awareness was further grouped into those that have low level of awareness and those highly aware of

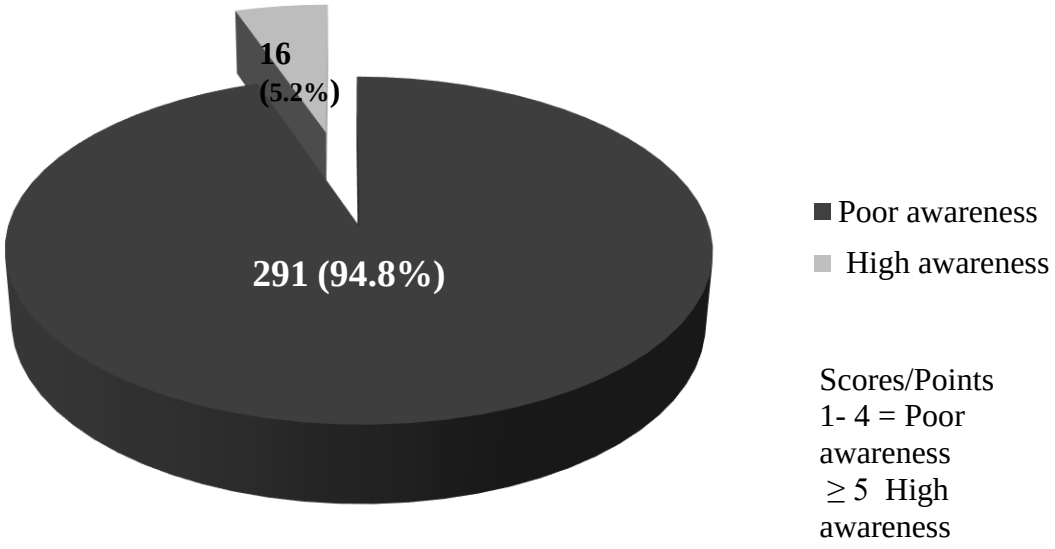

Figure 1: Exploded 3-D pie chart showing final summary of youth's awareness of SRHR services

Table 2c: Distribution of respondents' sources of information

No. of sources	No. of respondents	Percentage
At least one source	169	55.0
Two sources	71	23.1
Three sources	45	14.7
All four sources	22	7.2
Total	307	100.0

the services (1-4 services = poor awareness: five services and above = High awareness), as shown in Table 2b.

On sources of information as shown in Table 2a, which included the use of television, print media friends and health workers, summary of the combined response for source of information showed that 169 (55%) subscribed to at least one source of information (Table 2c)

Proportion of SRHR services utilisation by youths

Data analysis on the proportion of utilisation of SRHR services by youths as indicated in Table 3a revealed that 180(58.6%) of the respondents had not used any SRHR services; 61(19.9%) had used at least one SRHR service; 21(6.8)%) had used two services, 17(5.5%) of them indicated they had used up to three service and 15(4.89%) of them said they had used four of the services while 5(1.63%) of the respondents had used five and 3 (1.0%) used six services. Another 2(0.7%), had used up to eight and nine services respectively, while only one of the respondents had used the available 10 SRHR services. Based on the analysis, the summary presented thereafter in Table 3b further categorised utilisation into users and non-users, (those who have used at least two services and above were considered to be active users while those who attempted the use of just one of the numerous services and those who never used any service were categorised as non-users of SRHR services) Figure 2. Thus, 66(21.5%) of youths used SRHR services while 241(78.5%) did not use SRHR services.

Test of hypotheses

The test of hypothesis as presented in Table 4 shows that there was a significant influence of awareness on reproductive health service utilisation by youths (X^2=55.444; p<.05). The result revealed to be statistically significant since the calculated X^2 value of 26.631was higher than the critical X^2 value of 55.44 (p= .000) at 1 degree of freedom. The null hypothesis which states that, there is no significant influence of youth's

Table 3a: Proportion of utilisation of SRHR services (n=307)

Items	Response options	Yes	No
Ever used SRHR services in a health facility	Yes	127(41.4%)	180(58.6%)
	No	180(58.6%)	127(41.4%)
Reason for using services in the above place mentioned	Close to home	101(32.9%)	206(67.1%)
	The services are affordable	114(37.1%)	193(62.9%)
	The workers are friendly	55(17.9)	252(82.1%)
	Others (specify)……	21(6.8%)	286 (93.2%)
Service(s) utilised	**Family Planning**		
	Oral pills	54(17.6%)	253(82.4%)
	Injectables	45(14.7%)	262(85.3%)
	IUCD	9(2.8%)	298(97.1%)
	Barrier method (example, condom)	22(6.8%)	284(92.5%)
	Implants	4(1.3%)	278(98.7%)
	Natural method (calendar, body sign and others)	28(9.1%)	279(90.9%)
	Prevention and Treatment and treatment of STIs/STDs		
	Counseling on the ABC of prevention of STIs/HIV (abstinence, being faithful, condom use).	85(27.7%)	222(72.3%)
	HIV counseling and testing	95(30.9%)	212(65.2%)
	Treatment for HIV/AIDS such as drugs.	6(2.0%)	301(98.0%)
	Treatment for genital ulcers.	10(3.3%)	297(96.7%)
	Treatment for genital discharges	31(10.1%)	276(89.9%)
	Services for infertility and other reproductive problems	9(2.9%)	298(97.1%)
	Prevention and treatment of cancers	7(2.3%)	300(97.7%)
	Counseling on how to do breast self- examination	35(11.4%)	271(88.6%)
	Cervical screening	2(0.7%)	305(99.3%)
	Services during pregnancy	10(3.3%)	297(96.7%)
	Services during child birth or labour	14(4.6%)	293(95.4%)
	Services after delivery (Post-natal)	7(2.3%)	300(97.7%)
	Services for rape or other form of sexual violence	12(3.9%)	295(96.1%)
	Post abortion services.	8(2.6%)	299(97.4%)
Frequency of SRHR services utilisation in the last 12months	Thrice and more	15(4.9%)	292(95.1%)
	Twice	44(14.3%)	263(85.7%)
	Once	74(24.1%)	233(75.9%)
	Never	174(56.7%)	133(43.3%)

Table 3b: Summary of proportion of SRHR services utilisation by youths

Proportion of utilisation	Frequency	Percent (%)
Did not use any service	180	58.6
Use at least one of the services	61	19.9
Two services	21	6.8
Three services	17	5.5
Four services	15	4.9
Five services	5	1.6
Six services	3	1.0
Eight services	2	0.7
Nine services	2	0.7
Above ten services	1	0.3
Total	307	100.0

awareness to available reproductive health services on reproductive health service utilisation by youths was rejected.

Logistic regression analysis to identify the factors that predispose to poor awareness and use of SRHR services by the youth

Logistics regression Table 5, was used by the researchers to determine the factors that predispose to awareness/ utilization and non-awareness/utilization of SRHR services. The dependent variable encoding table shows the coding for the criterion variable. In this study, those that were unaware/non-utilization were coded as 0 while those that were aware/utilization were coded as 1. The Omnibus test of model coefficients was used to test the goodness of fit of the model. The table showed that the model is fit as the sig value is less than .05 to further confirm the goodness of fit of the model, the Homer and Lemeshow test was used. As it is enshrined in the rule of thurm, for the

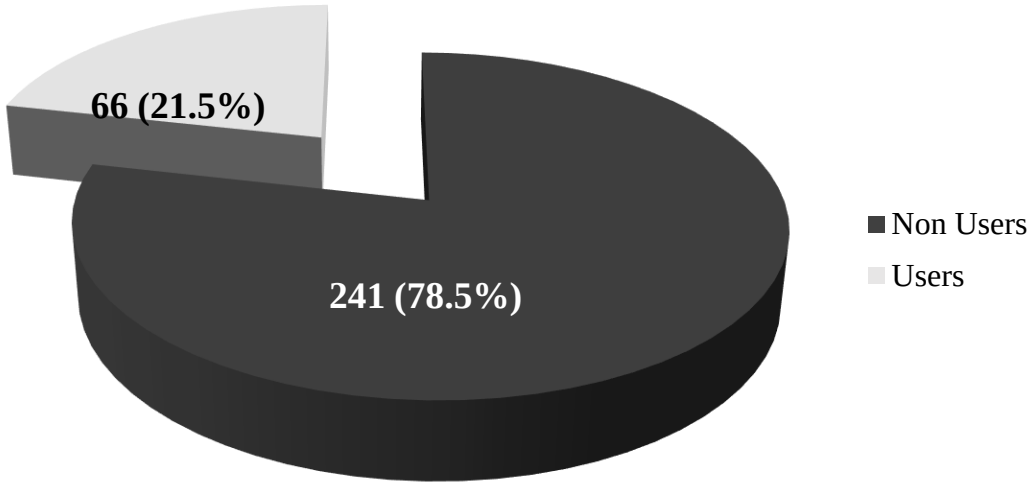

Figure 2: An exploded 3-D pie chart showing summary of proportion of SRHR services utilisation by youths

Table 4: Summary of Contingency Chi-Square analysis of the association between youth's level of awareness on SRHR services and utilisation (n=307)

Level of awareness	Proportion of utilisation of YRHS		Total	X^2	p-level
	Non-users	Users			
Low awareness	68	2	70	55.444[a]	.000
	(97.1%)	(2.9%)	(100%)		
High awareness	112	125	237		
	(47.3%)	(52.7%)	(100%)		
Total	180	127	307		
	(58.6%)	(41.4%)	(100%)		

*significant at ($p<.05$); df= 1; critical $X^2 = 6.63$

Table 5: Logistic regression analysis showing the variable in the equation table

Variables		**Coef (B)**	**S. E**	**Odds Ratio (Exp (B)**	**95% CI Lower/Upper**	**P-value**
Age		-20.591	10718.688	.000	.000	.998
Religion	Ist					1.000
	2nd	.000	26709.583	1.000	.000	1.000
	3rd	.000	42944.548	1.000	.000	1.000
Marital Status	1st					1.000
	2nd	.000	18628.655	1.000	.000	1.000
	3rd	.000	35476.579	1.000	.000	1.000
Edu	1st					1.000
	2nd	.000	20801.835	1.000	.000	1.000
	3rd	-47.905	18973.797	.000	.000	.998
	4th	-46.781	23092.117	.000	.000	.998
	5th	-46.781	28408.679	.000	.000	.999
Means of Livelihood		.000	4169.218	1.000	.000	1.000
Father's education		13.209	5672.161	545313.608	.000	.998
Mother's education		23.383	2710.056	1.430	.000	.998

Source: SPSS version 23.

model to be considered fit the Homer and Lemeshow test must be greater than .05, therefore the model for this study was further confirmed to be fit as the Homer and Lemeshow was greater than .05. The model summary table is that 98.3% change in the dependent variable can be explained or accounted for by the predictors variables. The classification table indicates that there is an improvement in the model as compared to the classification table in Block 0 as the model increased from 77.2 % to 99.7% showing a 22.5% improvement. The table further shows the specificity and the sensitivity of the model in terms of predicting group membership on the dependent variable. The specificity of the model is 98.6 per cent. This implies that 98.6% of the respondents will not utilize the SRHR services because they are not aware. The sensitivity of the model shows 100%. This connotes that 100% of the respondent will utilize the services of SRHR because they are properly informed. Overall, the accuracy of the model is 99.7%. The model exhibits good sensitivity among the persons that will use the SRHR services because of awareness over those that will not use the SRHR services because of unawareness is 100%.

Finally, the variable in the equation table shows the relationship between the predictor (age, religion, marital status, educational qualification, means of livelihood, father's educational qualification, and mother's education qualification) and the outcome (Awareness/utilization and unawareness/non-utilization). the Beta value for age, educational qualification is negative, this implies that 1 unit change in these predictors brings about change in the probability of the outcome negatively. While mother's and father's educational background have positive Beta value which connote the 1 unit change in these predictors brings about positive change in the probability of the outcome. The predictor variables whose odd ratio is greater than 1 means that there are greater chances of these variables influencing the respondents to use SRHR services based on awareness. Other variable with the odd ratio value less than one implies that these variables have less probability of causing the respondents to use SRHR service. The P-value for all the variables showed that there is no significant influence of the predictor variables (age, religion, marital status, educational qualification, means of livelihood, mother's and father's educational background) on the outcome variable. This implies that these factors do not influence the awareness and utilization of the SRHR services.

Discussion

This study revealed that - although the majority of the youths were aware of the existing reproductive health care services in the community, the majority of them were not aware of the diversity of services available. This finding is not surprising since most youths subscribed to at least one source of information which included teachers, health workers, television, print media and friends. Moreover, information from health care providers was the least preferred having a low response rate while that from friends was the most preferred source of information. These results are consistent with findings of previous studies as Okonta PI[17] posited that, young people do not see health care workers as a source of information. This is because the youths often perceive that such information are usually censored based on traditional customs and morals that prohibit open chat about SRHR to young people. In their study to determine the knowledge and perception of sexual and reproductive health services among young people in Ile-Ife, Osun State, Nigeria, they found that a significant number of young people engaged in sexual relationship with the opposite sex, acknowledged the mass media as their dominant source of information and were more comfortable discussing sexual and reproductive issues with their peers[18]. As documented by the[19], majority of youths are disposed to information from friends and media with resultant misinformation or misinterpretation of information. The inclination to information from peers is probably due to the social and cultural implications of sexual and reproductive health and rights concerns such as stigmatisation.

This finding also corroborates the outcome of a study conducted in Iran by Roudsari *et al*[20] , that determined the socio-cultural challenges of sexual health education among female youngsters. It was discovered that it is culturally inappropriate for single youths to be knowledgeable of SRHR services for fear that, they will want to try-out sexual activities which might destroy them[20]. In this study also, a few youths, yet, significant never

knew of the available reproductive health services in the community[20]. Though few, this is still considered significant because of the global call for 'health for all'. The third goal of the 2030 agenda for sustainable development states that no one is to be left behind in the pursuit for health care.

The findings of this study seem to disagree with the result of a study carried out in three Bolivian cities by to identify barriers to young peoples' use of reproductive health services. The results of the study showed that, majority of young people were aware of reproductive health resources available in their community[21]. An editorial of the University of Chicago Medical Centre[22], propose that young people require information to be aware about their ability to search for needed reproductive health services. The editors of this institution also maintained that young people would use SRHR services to improve their reproductive health when they are informed of the available reproductive health resources. These findings suggest that the proportion of utilisation will increase with increasing awareness on reproductive health resources.

Findings as regards the proportion of SRHR services utilisation by young people showed that, although most of the young people were aware about where to obtain SRHR services, a good number of young people had never utilised those services from a health care facility. This is related to the fact that most youths offered their patronage to SRHR services rendered by chemist, pharmacist, health workers at home, roadside vendors and traditional healers. Reasons for using these services varied as most youths ascribed their use of services to affordability of the services. Among the various SRHR services listed, a significant number of youths did not use any of the services while majority of the youths used at least one of the services. These findings corroborate with the work of Ayehu *et al*[11], which sought to determine the utilisation and accessibility of sexual and reproductive health services among young people in Jimma city, Southwest Ethiopia. Findings of the study revealed that the turnout for SRHR services by young people was low. It is also in agreement with a similar study conducted in Southern Ethiopia by Cherie *et al*[12], which sought to determine the reproductive health needs and service utilisation among youths in West Badewacho Woreda, Hadiya Zone. The study showed that within a year, only 29.4% young people used SRHR services. Additionally, the study finding is at par with that of Bam *et al*[23], who assessed the perceived sexual and reproductive health needs and service utilisation among Higher Secondary School students in urban regions of Nepal. The authors indicated that, youths who utilised SRHR services within the last three months were one in four and majority reported using these services between one and six times within one year prior to the study period. The finding of this study is at variance with result from a study carried out in Nigeria by Abiodun *et al*[24], to assess the sexual and reproductive health knowledge and service utilisation among young people in rural residents. Abiodun et al. discovered that 51% of young people were using sexual and reproductive health services. Thus, based on the general findings of this study, it might be inferred that, increase in the proportion of utilisation of SRHR services may be a product of reduced environmental limitations that would prevent positive health seeking sexual and reproductive health behaviour. Such environmental limitations would include lack of finance.

The influence of awareness of SRHR services on the proportion of utilisation of these services by youths in hypothesis showed that, SRHR service utilisation by youths was associated with their awareness of available SRHR resources. As discussed previously Cherie *et al*[22], in a study to determine youth's awareness of independent access to reproductive health services revealed that, young people were of the opinion that when provided with information and made aware of where to seek SRHR services, they will utilise these services when needed. The United States Agency for International Development. Youth in Development[19], documented that, majority of youths are disposed to information from friends, media and print with resultant misinformation or misinterpretation of information. The implication of these is that, if youths get information from the right sources, their awareness can enhance the use of SRHR services by youths.

From the logistic regression analysis to identify the factors that predispose to poor awareness and use of SRHR services by the youth, the P-value for all the variables showed that there is no significant influence of the predictor variables (age, religion, marital status, educational qualification, means of livelihood, mother's and father's educational

background) on the outcome variable (awareness/utilization and unawareness/non-utilization). This implies that these factors do not influence the awareness and utilization of the SRHR services among the youths in our study setting. This findings is not in tandem with the study of Phongluxa *et al* and Nmadu *et al*[25,26], whose studies identified strong positive association between knowledge and autonomy in knowledge and use of SRHR services, where 40.4% lacked autonomy in marriage hence among sexually active adolescents only 35.2% used contraception. Inadequate knowledge about SRHR services and poor attitudes of adolescents towards SRHR services; social factors such as parental influence, community and religious norms, financial constraints and stigma hindered adolescents from utilising RHS. Also, study by[27], revealed that Adolescent-parent communication on sexual and reproductive health was significantly associated with the level of knowledge regarding sexual and reproductive health ($X^2 = 5.809$, $p = 0.01$, $df = 1$). Similarly, there was a significant association with the perceived parenting style ($X^2 = 3.932$, $p = 0.04$, $df = 1$), living arrangements ($X^2 = 6.376$, $p = 0.01$, $df = 1$), and adolescent-parent communication. Furthermore, findings from study by Ninsiima *et al*[28], revealed that facilitators of utilisation of the services were mostly structural in nature which included community outreaches, health education, and policy recommendations to improve implementation of the quality of health services and clinics for adolescents/youth to fit their needs and preferences. This variance in the findings may occur as a result of the contextual differences. Our study revealed that majority of young people in the study setting were exposed to one 169(55%) or two 71 (23.1%) sources of information on SRHR services. Hence, it is likely that other health system factors such as poor attitudes of service providers and inconvenient health facility opening hours, lack of awareness campaigns by care providers, lack of confidentiality as well as misconceptions must have hindered young people awareness and use of SRHR services.

Conclusion and recommendations

In this study, it was concluded that there is poor knowledge and use of SRHR services by young people in the study setting, indicating a need to further integrate intensive training of health workers and put in place quality implementation standard guidelines in clinics to offer services according to youth's needs and preferences. In addition, educating the youth through community outreaches and health education programs for those in the community and schools respectively, can create awareness and facilitate utilization and scale up of the service.

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Conflict of interest

The authors have no conflicting interest regarding this study.

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