



## Assessment of Perceived Quality of Reproductive Health Services and its Determinants among Young Adults in a Tertiary Health Facility in Southwestern Nigeria

Oluwaseun Eniola ADEGBILERO-IWARI<sup>1</sup>, Olaoye Michael FALEKE<sup>2</sup>

<sup>1</sup>Department of Community Medicine, Afe Babalola University, Ado-Ekiti, Nigeria

<sup>2</sup>Department of Community Medicine, Federal Teaching Hospital, Ido-Ekiti, Nigeria

### Abstract

**Context:** Challenges with reproductive health (RH) and poor perception of its services significantly define the outcome of an individual's reproductive health status. Previous studies on the subject in south-western Nigeria have largely assessed the perception of young adults towards RH without paying attention to the determinants of their perception toward its services.

**Objective:** This study aimed at investigating young adults' knowledge of RH and the determinants of their perceptions towards reproductive health services (RHS) at the Federal Teaching Hospital Ido-Ekiti, Ekiti State, Nigeria.

**Methods:** A cross-sectional survey was conducted among 326 respondents aged 18-26 years. Selection was done using the multi-stage sampling technique. A semi-structured, interviewer-administered questionnaire that assessed RH knowledge, RHS perception and utilization was used for data collection. Frequencies and percentages were used to describe variables while the chi-square test and binary logistic regression were employed for inferential data analysis. Statistical significance was set at p-value less than 0.05.

**Results:** Majority 205(62.9%) of the respondents had a good knowledge ( $\geq 50\%$  score) of RH while a minority 148(45.4%) had a good perception of RHS. Significant determinants of RHS perceptions included age ( $p = 0.04$ , AOR = 2.51, 95% CI = 1.098-4.904), gender ( $p < 0.001$ , AOR = 3.93, 95% CI = 1.569-7.191), marital status ( $p = 0.011$ , AOR = 3.49, 95% CI = 1.426-6.478), education level ( $p = 0.026$ , AOR = 2.97, 95% CI = 1.214-7.578), relationship duration ( $p = 0.03$ , AOR = 3.74, 95% CI = 1.333-6.375), degree of comfort in discussing sexual issues with partner ( $p < 0.001$ , AOR = 4.34, 95% CI = 2.044-10.258), frequency of discussing RH issues with partner ( $p = 0.034$ , AOR = 3.67, 95% CI = 1.379-8.001), shared understanding of RH between partners ( $p = 0.027$ , AOR = 4.99, 95% CI = 1.236-12.363) and knowledge of RH ( $p = 0.002$ , AOR = 4.21, 95% CI = 1.931-9.889).

**Conclusion:** This study concluded that while over three-fifth of the respondents had an overall good knowledge of RH, only a little above two-fifth had a good perception of its services. The study highlights the need for improvement in targeted educational initiatives to address misconceptions especially among the early young adults, males, unmarried, the less educated, those in relationships of less than 6 months, those having partners and those with poor knowledge of RH.

Keywords: Determinants, Perception, Knowledge, Nigeria, Reproductive health, Young Adults

### Introduction:

In recent times, reproductive health (RH) has received widespread attention, leading to global consciousness

#### Corresponding Author:

Olaoye Michael FALEKE

Department of Community Medicine, Federal Teaching Hospital, Ido-Ekiti, Nigeria.

lekelaoye@gmail.com | ORCID: 0000-0002-1620-1523

DOI: 10.61386/imj.v19i1.920

and varying degree of information diffusion. Reproductive health as described by the World Health Organization (WHO) is 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. Reproductive health implies that people are

able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.<sup>1</sup>

A young adult is defined as an individual between ages 18 - 26 years. It is a period between transitioning from gaining independence from parental confines to stepping into the fully functioning role of adulthood. The period includes but is not limited to leaving home, choosing a career path, integrating into new families and society.<sup>2</sup>

Globally, young adult's perception of reproductive health varies from region to region as a result of environmental, religious, social, and cultural systems. In sub-Saharan Africa, challenges with reproductive health and poor perception of its services has adversely affected many young adults causing high rates of mortality and morbidity from reproductive tract infections, sexually transmitted diseases, unwanted pregnancies and unsafe abortions, the high prevalence of these continues to be a serious public health concern.<sup>3,4</sup>

Among young adults in Nigeria, when the phrase "reproductive health" comes to mind, the general perception of the average young person is that there is nothing to worry about as long as one can produce an offspring.<sup>5</sup> Very few consider the implications and aftermaths of the act including safety practices. Generally, the most popular fear for safe practice is the big names of sexually transmitted diseases including HIV/AIDS, gonorrhea, chlamydia and syphilis.<sup>6</sup> Furthermore, recent studies conducted in Tanzania and south-western Nigeria have associated the high rate of unprotected sex among young female adults with poor knowledge of the risk of exposure to sexual and reproductive health problems, the lack of adolescent-centered reproductive healthcare services among others.<sup>3,4</sup> An Ethiopian study revealed gaps in understanding basic concepts of reproductive health, contraception, and sexually transmitted infections (STIs).<sup>7</sup>

Cultural and religious beliefs significantly shape young adults' perception towards reproductive health. In many conventional societies, discussing sexual health is considered a taboo, which can result in negative perception towards reproductive health services. In sub-Saharan Africa for instance, societal norms often discourage open discussions about sex, leading to misinformation and negative perceptions about using reproductive health services.<sup>8</sup> Peer-group influence also play a significant role in shaping young adults' perceptions towards reproductive health. It was

observed that peer-led interventions in South Korea have been effective in significantly improving young adults' knowledge and attitudes towards reproductive health and also increasing their utilization of its services.<sup>9</sup>

Several factors have been seen to dissuade many young people from utilizing reproductive health services.<sup>10</sup> In the United States, it was observed that adolescents highly valued confidentiality and were more likely to seek reproductive health services if they trusted the healthcare provider to keep their information private.<sup>11</sup> Being too young to access reproductive health services and lack of awareness have been reported in studies done in pacific island territories. For instance, information about reproductive health services, was not always available to young unmarried adults because their parents believed that they were too young to receive such information.<sup>12,13,14</sup> While there are reproductive health services available in Nigeria, stigma, discrimination, inadequate manpower/resources have been linked with poor utilization of reproductive health services, particularly in the rural communities.<sup>15,16</sup>

Hence, this study assessed the determinants of young adults' perception of reproductive health services at a tertiary health facility in south-western Nigeria.

## Materials and Methods

### Study setting

The study was conducted at the Federal Teaching Hospital, Ido Ekiti (FETHI). FETHI is a government-owned tertiary health facility and clinical training institution in Nigeria.

### Study design/population

A cross-sectional study design was used for this study. The study population consisted of individuals aged 18-26 years. Young adult patients who were currently attending the tertiary health facility were eligible to participate, those that were too ill or unwilling to participate were not eligible.

### Sample size determination

The sample size was calculated using Fisher's formula.<sup>17</sup>

$$n = (z^2 pq) / d^2 ;$$

where n = desired sample size, z = standard normal deviation (1.96), p = prevalence from a previous study (70.6%) 18 = 0.71, q = 1-p = 0.29, and d = degree of

accuracy desired = 0.05. The estimated sample size obtained was 332 respondents after adjusting for a 10% non-response.

### Sampling technique

The Multi-stage sampling technique was used to recruit eligible participants for this study. For the first stage, five locations were selected by employing the simple random sampling by balloting. The locations selected were; general out-patient department (GOPD), plastic surgery clinic, microbiology, hematology and chemical pathology departments. At the second stage, the stratified sampling technique was used. Each of the locations selected was made a stratum and questionnaires were allocated to them proportionately. For the final stage, the systematic sampling technique was employed. The total number of expected participants for two months for each location was taken as sample frame. Sample interval was determined by dividing the sample frame by the sample size. A sample interval of 3 was obtained. Therefore, at each location one of every 3 eligible respondents was selected until the sample size was reached. Data collection was done within a period of 4 weeks.

### Data analysis

The statistical analysis was done using IBM SPSS Statistics version 27.0 for Windows, (IBM Corp., Armonk, N.Y., USA). Seven questions each assessed respondents' knowledge of reproductive health and perception of its services, respectively. Every correct response, either a 'yes' or a 'no' was awarded 1 point to obtain a total score of 7 points each for knowledge and perception, respectively. A total score lesser than the 50th percentile (<50%) was categorized as poor knowledge or perception while a total score greater than or equal to the 50th percentile ( $\geq 50\%$ ) was categorized as good knowledge or perception. Frequencies and percentages were used to describe categorical variables. The chi-square test was used to determine the associations between each categorical independent variable and perception of reproductive health services. A binary logistic regression analysis was used to explore the relationships among variables while controlling for potential confounders. A p-value less than 0.05 was considered statistically significant.

### Ethics

With regard to the principles governing research involving participants, the researchers took steps to

uphold respondents' ethical rights. Participation in the study was voluntary and informed consent was obtained before the questionnaire administration began. The confidentiality of their anonymity was fully assured as no names were recorded. The purpose and benefits of the research were clearly explained to the participants before the questionnaires were administered. Ethical approval to conduct the study was sought and obtained from the Ethical and Research Committee of Federal Teaching Hospital, Ido-Ekiti, (ethical no: ERC/2024/09/11/1166B) before the respondents were approached.

### Results

A total of 332 questionnaires were administered to young adults who met the inclusion criteria and gave consent, 326 were satisfactorily filled out, giving a response rate of 97%. Table 1 shows that a high proportion 191 (58.6%) of the respondents were in the late young adulthood age group (22-26 years). The mean age of the respondents was  $21.8 \pm 2.3$  years. Majority of the respondents were females 210 (64.4%), single 206 (63.2%), Christians 282 (86.5%) and of the Yoruba ethnic group 213 (65.34%). Also, most of the respondents had completed secondary education 250 (76.7%) and were unemployed 219 (67.18%).

Table 2 reveals that majority of the respondents 178 (54.6%) didn't have the opportunity to ask their parents questions about sexuality. Concerning knowledge about the male body's capability to

Table 1: Socio-demographic Information of Respondents

Variable	Frequency N=326	Percent (%)
<b>Age group (in years)</b>		
Early young adulthood (18 – 21)	135	41.4
Late young adulthood (22 – 25)	191	58.6
Mean age $\pm$ SD	21.8 $\pm$ 2.3	
<b>Gender</b>		
Male	116	35.6
Female	210	64.4
<b>Marital Status</b>		
Single	206	63.2
Married	109	33.4
Divorced/Separated	11	3.4
<b>Religion</b>		
Christianity	282	86.5
Islam	38	11.7
Others	6	1.8
<b>Tribe</b>		
Yoruba	213	65.34
Igbo	50	15.34
Hausa	18	5.52
Others	45	13.80
<b>Level of education</b>		
Primary	17	5.2
Secondary	250	76.7
Tertiary	59	18.1
<b>Occupation</b>		
Unemployed	219	67.18
Self-employed	41	12.58
Civil/public servant	39	11.96
Privately employed	27	8.28

Table 2: Respondents' knowledge of reproductive health

Variable	Frequency N=326	Percent (%)
<b>Have the opportunity to ask your parents questions about sexuality</b>		
Yes	148	45.4
No	178	54.6
<b>At what age does the male body become capable of impregnating</b>		
From puberty	154	47.2
From the moment of the first sexual attraction/desire towards the opposite sex	77	23.6
Don't know	95	29.2
<b>Do you feel that the sexual health education you received (if any) adequately prepared you to handle issues related to sexual and reproductive health</b>		
Yes	140	42.9
No	156	47.9
A little	30	9.2
<b>At what age does the female body become biologically capable of bearing children</b>		
From birth	3	0.9
From the first menstruation	270	82.8
From the moment of the first sexual attraction/desire towards opposite sex	29	8.9
Don't know	24	7.4
<b>A girl can get pregnant during her first sexual intercourse</b>		
Yes	208	63.8
No	66	20.2
Don't know	52	16.0
<b>A girl can get pregnant during her period</b>		
Yes	66	20.2
No	208	63.8
Don't know	52	16.0
<b>When is the fertile period in a girl considering a 28-day cycle</b>		
Immediately after menstruation	35	10.7
Approximately mid-cycle	177	54.3
Just before menstruation	56	17.2
During the whole month	58	17.8

Table 3: Current relationship history of respondents

Variable	Frequency N=326	Percent (%)
<b>Current relationship duration</b>		
Less than 6 months	53	16.2
6 months - 1 year	84	25.8
1 - 5 years	89	27.3
More than 5 years	100	30.7
<b>Discussing sexual health topics with your partner is</b>		
Very comfortable	159	48.8
Somewhat comfortable	52	16.0
Neutral	69	21.2
Somewhat uncomfortable	22	6.7
Very uncomfortable	24	7.3
<b>Frequency of discussing RH with partner</b>		
Regularly	116	35.6
Occasionally	81	24.8
Rarely	41	12.6
Never	88	27.0
<b>Partner &amp; I have a shared understanding of RH issues</b>		
Yes, completely	160	49.1
Yes, somewhat	97	29.75
No, not really	52	15.95
No, not at all	17	5.2
<b>Both partners need to be equally informed about RH</b>		
Very important	200	61.35
Important	81	24.85
Neutral	45	13.8

impregnate, majority 154 (47.2%) believed it occurs from puberty. Regarding the adequacy of sexual health education, 140 (42.9%) felt it adequately prepared them for issues related to sexual and reproductive health while a majority 156 (47.9%) felt it didn't. When asked at what age the female body becomes capable of bearing children, the majority 270 (82.8%) correctly answered "from the first menstruation". In terms of knowledge about pregnancy risks, 208 (63.8%) correctly believed a girl could become pregnant during her first sexual intercourse. When asked whether pregnancy is possible during menstruation, 66 (20.2%) believed it was possible. Finally, when asked about the fertile period in a 28-day cycle, 177 (54.3%) correctly answered "approximately mid-cycle."

Table 3 shows that a high proportion 100 (30.7%) of the respondents had been in their current relationship for more than 5 years. In terms of comfort in discussing sexual health topics with their partner, 159 (48.8%) felt very comfortable. When asked how often they discussed reproductive health and family planning with their partner, 116 (35.6%) reported doing so regularly while 88 (27.0%) never did. Additionally, 160 (49.1%) of them felt that they and their partner had a completely shared understanding of reproductive health issues, while a few 17 (5.2%) said "not at all". Regarding the importance of both partners being equally informed about reproductive and sexual health, majority 200 (61.35%) considered it very important, while 45 (13.8%) of them were neutral.

Table 4 shows that a minority 63 (19.3%) of the respondents faced difficulties accessing reproductive health services. The most common barrier was the high cost of services 41 (65.1%), followed by stigma or embarrassment 25 (39.7%), lack of transportation 10 (15.9%) as the least cited barrier. Most respondents 159 (48.8%) rated reproductive health services in their community as accessible, 21 (6.4%) rated them as very accessible, while 7 (2.1%) of them found them inaccessible.

Furthermore, a high proportion 199 (61.0%) of the respondents had visited a health facility to receive services or information related to reproductive health. Among those who had visited, topmost of the reasons for their visit was pregnancy testing 87 (43.7%), followed by STDs 40 (20.1%),

Table 4: Utilisation and Perceived Quality of RHS

Variable	Frequency	Percent (%)
<b>Ever faced difficulties in accessing RHS (n = 326)</b>		
Yes	63	19.3
<b>If yes, what are the barriers (n = 63)*</b>		
Lack of availability of services	14	22.2
High cost of services	41	65.1
Stigma or embarrassment	25	39.7
Lack of transportation	10	15.9
Insufficient information or guidance	16	25.4
<b>Rate the accessibility of RHS in your community (n = 326)</b>		
Very accessible	21	6.4
Accessible	159	48.8
Neutral	12	3.7
Inaccessible	7	2.1
<b>Ever visited any health facility to receive RHS (n = 326)</b>		
Yes	199	61
<b>Most prominent purpose of your visit (n = 199)</b>		
Contraceptives	39	19.6
STDs	40	20.1
Gynaecological exams	33	16.6
Pregnancy test	87	43.7
<b>Were your questions during the consultation answered adequately (n = 199)</b>		
Yes	161	80.9
<b>Was there enough confidentiality (n = 199)</b>		
Yes	159	79.9
<b>Rate the overall friendliness of the RHS providers (n = 199)</b>		
Very unfriendly	25	7.7
Unfriendly	42	21.1
Neutral	57	28.6
Friendly	36	11
Very friendly	39	61
<b>Rate the overall quality of the RHS provided (n = 199)</b>		
Very poor	17	8.5
Poor	47	23.6
Average	60	30.2
Good	27	13.6
Excellent	48	24.1

\*: Multiple responses

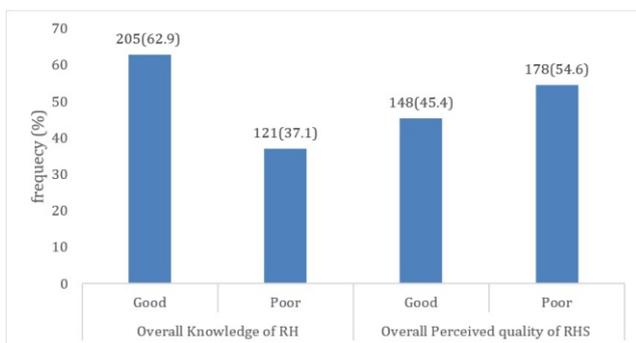


Figure 1. Overall assessment of respondents' knowledge of RH and perceived quality of RHS

contraception 39 (19.6%) and gynecological exams 33 (16.6%). Among those who asked questions during their consultation, 161 (80.9%) respondents felt their questions were adequately answered while 159 (79.9%) respondents reported sufficient confidentiality during their consultation.

In terms of overall friendliness of RHS providers, being neutral 57 (28.6%) was the most common response followed by unfriendliness of personnel 42 (21.1%), with very unfriendly 25 (7.7%) as the least cited response. The quality of RHS was also evaluated with most 60 (30.2%) agreeing that it was of average quality, 17 (8.5%) respondents were of the view that it was very poor.

Figure 1 shows that based on a general assessment, majority of the respondents 205 (62.9%) had a good knowledge of reproductive health while a minority 148 (45.4%) had a good perception of reproductive health services.

Table 5 shows that age group (p=0.011), gender (p<0.001), marital status (p<0.001), and level of education (p=0.032) significantly associated with young adults' perceived quality of RHS

Table 6 reveals that the duration of respondents' current relationship (p < 0.001), comfort in discussing sexual health topics with partner (p < 0.001), frequency of discussing RH issues with partner (p < 0.001), having a shared understanding of RH (p = 0.005), partners being equally informed about RH (p = 0.019) and knowledge of RH (p = 0.012) were significantly associated with perceived quality of RHS.

The impact of respondents' socio-demographic information, current relationship history, and knowledge of RH on perceived quality of RHS was assessed using a binary logistic regression

Table 5: Association between respondents' socio-demographic information and perceived quality of RHS

Variable	Perceived quality of RHS		Chi square	p-value
	Good n (%)	Poor n (%)		
<b>Age group (in years)</b>				
Early young adulthood (18 – 21)	50(37.0)	85(63.0)	6.499	0.011**
Late young adulthood (22 – 25)	98(51.3)	93(48.7)		
<b>Gender</b>				
Male	31(26.7)	85(73.3)	25.335	<0.001**
Female	117(55.7)	93(44.3)		
<b>Marital Status</b>				
Single	66(32.0)	140(68.0)	40.404	<0.001*
Married	75(68.8)	34(31.2)		
Divorced/Separated	7(63.6)	4(36.4)		
<b>Religion</b>				
Christianity	123(43.6)	159(56.4)	2.948	0.229
Islam	21(55.3)	17(44.7)		
Others	4(66.7)	2(33.3)		
<b>Tribe</b>				
Yoruba	97(45.5)	116(54.5)	0.462	0.927
Igbo	24(48.0)	26(52.0)		
Hausa	7(38.9)	11(61.1)		
Others	20(44.4)	25(55.6)		
<b>Level of education</b>				
Primary	5(29.4)	12(70.6)	6.855	0.032*
Secondary	108(43.2)	142(56.8)		
Tertiary	35(59.3)	24(40.7)		
<b>Occupation</b>				
Unemployed	96(43.8)	123(56.2)	0.49	0.488
Employed	52(48.6)	55(51.4)		

\*: p-value <0.05; y: yates' correction

Table 6: Association between current relationship history, knowledge of RH and perceived quality of RHS

Variable	Perceived quality of RHS		Chi square	p-value
	Good n (%)	Poor n (%)		
<b>Current relationship duration</b>				
Less than 6 months	15(28.3)	38(71.7)	23.135	<0.001*
6 months - 1 year	26(31.0)	58(69.0)		
1 - 5 years	52(58.4)	37(41.6)		
More than 5 years	55(55.0)	45(45.0)		
<b>Discussing sexual health topics with your partner is</b>				
Very comfortable	94(59.1)	65(40.9)	31.660	<0.001*
Somewhat comfortable	12(23.1)	40(76.9)		
Neutral	31(44.9)	38(55.1)		
Somewhat uncomfortable	4(44.9)	38(55.1)		
Very uncomfortable	4(18.2)	18(81.8)		
<b>Frequency of discussing RH issues with partner</b>				
Regularly	77(66.4)	39(33.6)	37.744	<0.001*
Occasionally	31(38.3)	50(61.7)		
Rarely	7(17.1)	34(82.9)		
Never	33(37.5)	55(62.5)		
<b>Partner &amp; I have a shared understanding of RH</b>				
Yes, completely	71(44.4)	89(55.6)	12.694	0.005*
Yes, somewhat	49(50.5)	48(49.5)		
No, not really	27(51.9)	48(48.1)		
No, not at all	1(5.9)	16(94.1)		
<b>Both partners need to be equally informed about RH</b>				
Very important	103(51.5)	97(48.5)	7.931	0.019*
Important	30(37.0)	51(63.0)		
Neutral	15(33.5)	30(66.7)		
<b>Knowledge of RH</b>				
Good	104(50.7)	101(49.3)	5.770	0.016* <sup>y</sup>
Poor	44(36.4)	77(63.6)		

\*: p-value <0.05; y: yates' correction

model. Age group was a significant predictor, with respondents in late young adulthood (22-25 years) being about thrice more likely to have a good perception compared to those in early young adulthood (18-21 years) (AOR = 2.505, 95% CI = 1.098-4.904). Gender was also a significant predictor, with females being about four times more likely to have a good perception compared to males (AOR = 3.934, 95% CI = 1.569-7.191). Marital status showed significant results as well, with married respondents being about thrice times more likely to have a good perception compared to single respondents (AOR = 3.488, 95% CI = 1.426-6.478). Educational level was another predictor, with respondents having a tertiary education being about 3 times more likely to have a good perception than those with primary education (AOR = 2.972, 95% CI = 1.214-7.578). Relationship duration was a significant factor, with respondents in relationships longer than 5 years being about 4 times more likely to have a good perception than those in relationships of less than 6 months (AOR = 3.740, 95% CI = 1.333-6.375). Also, respondents

who were very comfortable (AOR = 4.342, 95% CI = 2.044-10.258) and somewhat comfortable (AOR = 3.678, 95% CI = 1.189-8.111) with discussing sexual health topics were about 4 times more likely to have a good perception compared to those who were very uncomfortable. Respondents who regularly discussed reproductive health issues with their partners were about 4 times more likely to have a good perception of reproductive health services compared to those who never discussed these topics (AOR = 3.668, 95% CI = 1.379-8.001). Additionally, those who felt that they and their partner had a completely shared understanding of reproductive health were 4.988 times more likely to have a good perception (AOR = 4.988, 95% CI = 1.236-12.363). Similarly, knowledge of sexual and reproductive health (SRH) was a strong predictor, with those having good knowledge being

Table 7: Predictors of respondents' perceived quality of RHS

Variable	AOR	95% CI		p-value
		Lower	Upper	
<b>Age group (in years)</b>				
Early young adulthood (18 – 21) <sup>REF</sup>				
Late young adulthood (22 – 25)	2.505	1.098	4.904	0.04*
<b>Gender</b>				
Male <sup>REF</sup>				
Female	3.934	1.569	7.191	<0.001*
<b>Marital Status</b>				
Single <sup>REF</sup>				
Married	3.488	1.426	6.4789	0.011*
Divorced/Separated	3.47	0.897	4.366	0.169
<b>Level of education</b>				
Primary <sup>REF</sup>				
Secondary	2.011	0.711	3.607	0.202
Tertiary	2.972	1.214	7.578	0.026*
<b>Current relationship duration</b>				
Less than 6 months <sup>REF</sup>				
6 months - 1 year	1.145	0.498	2.369	0.448
1 - 5 years	2.075	0.776	4.39	0.166
More than 5 years	3.74	1.333	6.375	0.03*
<b>Discussing sexual health topics with your partner is</b>				
Very comfortable	4.342	2.044	10.258	<0.001*
Somewhat comfortable	3.678	1.189	8.111	0.038*
Neutral	3.963	0.973	6.722	0.059
Somewhat uncomfortable	1.247	0.168	2.997	0.741
Very uncomfortable <sup>REF</sup>				
<b>Frequency of discussing RH issues with partner</b>				
Regularly	3.668	1.379	8.001	0.034*
Occasionally	1.978	0.764	3.366	0.345
Rarely	1.224	0.125	2.411	0.639
Never <sup>REF</sup>				
<b>Partner &amp; I have a shared understanding of RH</b>				
Yes, completely	4.988	1.236	12.363	0.027*
Yes, somewhat	2.117	0.548	6.48	0.679
No, not really	2.691	0.612	5.105	0.345
No, not at all <sup>REF</sup>				
<b>Both partners need to be equally informed about RH</b>				
Very important	2.665	0.925	5.69	0.063
Important	1.945	0.487	3.47	0.417
Neutral <sup>REF</sup>				
<b>Knowledge of RH</b>				
Good	4.212	1.931	9.889	0.002*
Poor <sup>REF</sup>				

AOR: Adjusted odds ratio; 95% CI: 95% confidence interval; REF: reference category; \*: p-value <0.05

about 4 times more likely to have a good perception compared to those with poor knowledge (AOR = 4.212, 95% CI = 1.931-9.889).

## Discussion

The results revealed that 62.9% of the respondents had an overall good knowledge of RH, aligning with similar findings from previous studies in LMICs, where youth generally have basic awareness of sexual health issues, largely due to exposure through schools, social media, and community-based initiatives.<sup>19,20</sup>

Despite this, nearly half of the respondents (47.9%) reported feeling inadequately prepared by the RH education they received. This highlights a critical gap in comprehensive sexual education, a trend often observed in sub-Saharan Africa, where formal RH education programs are frequently underdeveloped or inconsistently implemented.<sup>10</sup> This shortfall may lead to misinformation and a lack of confidence in making informed decisions regarding RH.

Gender differences significantly influenced RH perceptions, with females displaying higher levels of knowledge and more favorable perceptions of RH services compared to males. Specifically, only 26.7% of males reported good perceptions of RH services, in contrast to 55.7% of females. This disparity underscores the impact of societal norms, where women are often encouraged to seek out health services due to maternal health needs and the higher expectation placed on them regarding reproductive responsibilities.<sup>21,22</sup> Conversely, cultural stigma often discourages men from engaging in RH discussions, limiting their knowledge and comfort with available services.<sup>23</sup> These barriers can lead to poorer health outcomes for men and their partners, emphasizing the need for targeted interventions to engage men in RH education and services.<sup>24</sup>

Marital status was another key determinant, with married individuals displaying more favourable perceptions of RH services compared to their single counterparts. Among married respondents, 68.8% reported good perceptions, compared to just 32.0% of singles. This trend indicates that marriage may facilitate access to family planning services, enhancing familiarity and comfort with RH resources. This notion has been supported in a study suggesting that married individuals, especially women, are more likely to seek family planning and maternal health services.<sup>5</sup>

This study also revealed that partner communication played an important role in shaping perceptions of RH

services. Respondents who regularly discussed RH issues with their partners were significantly more likely to have positive perceptions of RH services. Among those who communicated regularly, 66.4% had a good perception, while only 17.1% of those who rarely engaged in such discussions felt similarly. Open dialogue between partners about sexual health has been shown to improve engagement with RH services, and reduce the likelihood of risky sexual behaviours.<sup>7</sup> Partner communication has consistently been highlighted as a key strategy for improving RH outcomes, as shown in studies by Davies et al.<sup>25</sup> and Asekun-Olarinmoye et al.<sup>26</sup>, which found that couples who regularly discussed sexual health were more likely to utilize contraception and seek RH services.

Another serious issue identified in this study was the lack of confidentiality in matters that bother on RH. Twenty percent of respondents who had ever used RHS reported insufficient confidentiality during their RH consultations, which is consistent with studies on the importance of privacy in healthcare, especially for sensitive topics such as RH.<sup>23</sup> Some studies have reported that young adults are particularly reluctant to seek RH services if they fear their confidentiality will not be respected.<sup>5,11</sup> To enhance service utilization, healthcare providers must prioritize creating a private and non-judgmental environment, ensuring young adults feel safe discussing their concerns without fear of exposure.

While a majority of respondents (61.0%) had utilised Reproductive Health Services (RHS), nearly one-fifth (19.3%) reported difficulties in access, with high cost and stigma emerging as the most prominent barriers. Despite moderate accessibility ratings, perceived service quality was mixed, as only 37.7% rated RHS as good or excellent, although most users reported adequate consultation responses (80.9%) and confidentiality (79.9%). This suggests that utilisation does not necessarily translate to positive service perception, a pattern consistent with evidence that financial, informational, and provider-related factors strongly shape adolescents' and young people's assessment of RHS quality<sup>27-29</sup>. Furthermore, although overall reproductive health knowledge was high, perception of RHS quality remained comparatively low, underscoring the gap between awareness and satisfactory service experience<sup>30</sup>.

As with any study, this study is not exempt from limitations. The study relied on self-reported data from the respondents, which may have introduced biases such as under-reporting or over-reporting of

responses. Also, the cross-sectional nature of the study only provides a snapshot of young adults' perceptions at a point in time. It does not allow for the examination of changes in perceptions over time. Finally, since the research was conducted at a single tertiary health facility, the study outcomes may not be generalizable to other settings, especially in regions with different cultural or healthcare contexts. All the same, the findings of this study add additional knowledge to the growing body of research in this field.

### Conclusion

This study concluded that while well over three-fifth of the respondents had an overall good knowledge of reproductive health, only a little above two-fifth had a good perception of its services. Significant predictors of good perceptions of reproductive health services included higher education levels, longer relationship duration, open partner communication about reproductive health and good knowledge of reproductive health among others. These findings highlight the need for improvement in targeted educational initiatives to address misconceptions about reproductive health services. Strategies to promote outreach programs focused on the less educated, males, the unmarried and early young adults is recommended. Open partner communication about sexual health could also be integrated into community health programs, promoting open dialogue that supports healthier behaviours.

**Declaration of Conflicting Interests** The author(s) declared no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

**Authors contribution:** OEA conceived the study and led data collection. OEA and OMF were involved in literature review and drafted methodology, OEA conducted data analysis. OEA and OMF contributed equally to the interpretation of findings, writing and reviewing of the manuscript

**Funding** The author(s) received no financial support for the research, authorship, and/or publication of this article.

### Acknowledgement

The authors wish to thank students of the Afe Babalola University in community medicine group 9 (2023/2024 set) (Ayotomiwa Success Sadiq, Valere Wabomate Tamunowari, Joyce Ayomide Toluse, Fidel Ketandu Uzoma, Amarachi Daniel Uyanwanne,

Chioma Joy Wechie, Faith Jemima Obilom, Ebubechukwu Deborah Akaniro, Osabuohien Olivia Aguebor, Charles Ugochukwu Ogwuegbu) for their role in this study

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