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KNOWLEDGE AND UTILIZATION OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS IN SELECTED SECONDARY SCHOOLS IN YENAGOA LOCAL GOVERNMENT AREA OF BAYELSA STATE, NIGERIA

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ABSTRACT

The World Health Organization defined adolescent as persons between 10 -19years of age and were characterized by significant physiological, psychological and social changes that put them at high risk for Reproductive health problem. Globally, most people become sexually active during adolescence. The concern about adolescent sexual and reproductive health had grown following reports that sexual activity, early pregnancies and sexually transmitted infections including human immune deficiency virus infection rates were increasing at unprecedented rates among adolescents. The objectives of this study are; To determine the awareness level of adolescents of sexual and reproductive health services, to find out whether students of selected secondary schools utilize adolescent sexual and reproductive health services, to identify factors affecting utilization of adolescent sexual and reproductive health services and to determine the relationship between knowledge and utilization of adolescent sexual and reproductive health services among secondary school students in Yenagoa local government area of Bayelsa state. A cross sectional descriptive study design was used for the study. Sample size was 320 senior secondary school students from two schools. A multistage simple random sampling technique was used to arrive at the study sample. A self-structured, self-administered questionnaire consists of five sections and 14 items was used for data collection. Data collected were entered into SPSS version 24 statistical package and analysed using simple descriptive statistics like frequency table, percentages and mean. Pearson correlation was used to test relationship between knowledge and utilization of adolescent sexual and reproductive health services. Results of the study revealed the mean age of respondents as 15±1 years and majority 213(68.9%) were within the age of 15-18 years, female 160(51.8%), and in senior secondary level 1 35.9%. Findings also revealed that 275(89%) of respondents have inadequate knowledge of adolescent sexual and reproductive health services and 291(94.2%) have inadequate utilization of reproductive health services. The major factors affecting utilization of reproductive health services among adolescents from the study includes little or no knowledge of reproductive health services, attitude of clinic staff and cost of services. There was a weak positive but significant correlation (r=0.158; P = 0.006) between knowledge and utilization of adolescent sexual and reproductive health services. It can be concluded that there adolescents in the study have both poor knowledge and utilization of adolescent sexual and reproductive health services. It is recommended that sexual and reproductive health education should be included in formal education curriculum; authorities should strengthen Adolescent sexual and reproductive health services and make it available across all levels of healthcare system at subsidized rate. Above all stakeholders should organize enlightenment programs to educate adolescents, parents and the public on the benefits of adolescents' sexual and reproductive health services.

KEYWORDS

Knowledge, Adolescent sexual and Reproductive health services.

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INTRODUCTION

Globally, there are 1.7 billion young people aged 10 to 24 years, representing one-quarter of the world's population, with over 85% living in developing countries[1]. According to World Health Organization,

adolescents are defined as persons between 10 and 19 years of age and are characterized by significant physiological, psychological and social changes that place their life at high risk and making up about 20% of the world's population, of whom 85% live in developing countries[2,3].

International Conference on Population and Development (ICPD) 1994 identified and recommended that, Adolescent, sexual and reproductive health issues are addressed through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence and the provision of appropriate services and counseling specifically suitable for that age group[3]. Countries were encouraged to ensure that programmes and attitudes of health-care providers do not restrict youth access to and utilization of the services and information they need. These services must safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values and religious beliefs as well as the rights, duties and responsibilities of parents[3].

Adolescent sexual and reproductive health (ASRH) is a global public health concern. This is due to the fact that adolescent sexual activity has been on the increase in many countries around the world[4]. Adolescence have been described as a time when young people engage in increasing risk-taking behaviour, that exposes them to many health risks[5,6]. Worldwide, the highest rates of sexually transmitted infections (STIs) occur among 20-24 year olds, followed by 15-19 year olds[7]. Out of an estimated 22 million unsafe abortions that occur yearly, 15% occur among young women aged 15-19 years[8]. Although adolescents in both developed and developing countries face challenges in accessing reproductive health services, regional differences exist with adolescents in developing countries facing greater challenges. Research has shown that in many countries in Sub-Saharan African, young people face significant barriers to receiving sexual and reproductive health services resulting in the under-utilization of the service[9]. In developing countries, more than half of new cases of Human Immunodeficiency Virus (HIV) infections are common among young people aged 15-24 years[10]. Furthermore, sexually transmitted infection (STIs) rates have been seen to be the highest in Africa with sub-Saharan Africa (SSA) having 110 million new cases per year[10]. The International Conference on Population and Development (ICPD)[11] emphasized adolescent sexual and reproductive health with the need to offer sexual and reproductive information and services to adolescents.

A national representative survey conducted by Biddlecom, Munthali, Singh and Woog[12] in four African countries found that young people aged 12-19 years old underutilized services such as contraception, sexually transmitted infection prevention and treatment including HIV testing. Poor access and low use of reproductive health services by adolescents have been attributed to lack of availability of services, lack of knowledge about the available services, and social and cultural norms forbidding their access to sexual and reproductive services[12,11]. In some countries including Nigeria, barriers to contraceptive use at the community level depend on adolescents' marital status. For adolescents who are not married, community attitudes toward contraception stem from the stigma around sexual activity before marriage[13]. As such, adolescents who are not married are less likely to use reproductive health services.

Reproductive health services (RHS) that are adolescent-friendly have been found to be effective in addressing adolescent sexual reproductive health needs[14]. However, according to the World health organization, most sub-Saharan African (SSA) countries have a dearth of adolescent-friendly health services and inadequate policies to address adolescent health needs[15]. Nigeria showed its commitment to improving adolescent sexual and reproductive health by developing the National Adolescent Health Policy based on the ICPD recommendations[16]. The specific ICPD recommendations were-

Respecting, protecting and fulfilling sexual and reproductive rights for all through enabling public education and legal and policy reforms.

Achieving access to universal, comprehensive and integrated sexual and reproductive health information, education and services.

Ensuring universal access to comprehensive sexuality education for all young people.

Eliminating violence against women and girls and securing universal access to critical services for all victims/survivors of gender-based violence[16].

A national action plan for advancing young people's health and development in Nigeria was also developed[16]. This plan focused on important actions that should be taken to improve the health of adolescents and youth in Nigeria. Many adolescents below the age of 20 years are already sexually active, but many face difficulties in obtaining reproductive health care[1]. In addition, adolescents are typically poorly informed about how to protect themselves from pregnancies and sexually transmitted infections[1].

In Nigeria, a considerable population of adolescents is sexually active and are involved in unprotected sexual activities with multiple partners which expose them to a host of reproductive health problems[17,18,4]. Nigerian adolescents are also faced with cultural and social contexts, which likely affect their access to and use of reproductive health services[19].

Sexuality matters are looked upon as taboo for adolescents because sex is regarded sacred and seen as a topic for the married only[6]. Though the federal government of Nigeria decided that sexuality education be integrated into the national school curriculum in 1999, the significant challenge that continues to threaten its implementation is the opposition from religious organizations and conservative political interest groups. These groups have the belief that sexuality and Human Immunodeficiency Virus (HIV) education encourages children and young people to experiment with sexual activity[8]. These cultural and religious contexts result in adolescents being inadequately informed about sexuality matters, as they rely on their peers for information and often are exposed to incorrect information and myths[3].

When young people have access to health and education, which can be obtained in an adolescent sexual and reproductive health services center, they become a powerful force for economic development and positive change[20]. When adolescents and youths are properly counseled and educated, there will be an improvement in their sexual and reproductive health knowledge and this would encourage them to adopt safer sexual behaviours that will in turn safeguard the health of future generations[10].

Statement of Problem

The concern about adolescent sexual and reproductive health (ASRH) has grown following reports that sexual activity, early pregnancies and sexually transmitted infections (STIs) including human immunodeficiency virus (HIV) infection rates are increasing at unprecedented rates among adolescents worldwide[21].

In Nigeria, 34% of the population is made up of adolescents[22]. Over 30 million Nigerians are between the ages of 10-19 years and nearly one-third of Nigeria's total population is between the ages of 10-24 years with nearly half (48.6%) of Adolescents aged 15-19 sexually active[19]. The median age for first sexual intercourse in Nigeria has been reported to be 15 years for adolescent girls and 16 years for boys[19].

A survey conducted by National Agency for the Control of AIDS (NACA) in Nigeria, showed that the percentage of young men and women aged 15-24 who have had sexual intercourse before the age of 15 increased from 9.8% in 2005 to 11.9% in 2007 and to 15.5% in 2012; indicating a continuous increase in the number of young people who engage in early sex. It was also reported that 56.4% of sexually active boys and 39.6% of sexually active girls had unprotected sex with non-marital sexual partners. The prevalence of abortion among women showed that one-third of those that had abortions were adolescent girls. The HIV prevalence rate among adolescents aged 15-19 years in the Northwest zone (3.3%) is higher compared to the national prevalence rate of 2.9%.

Since the 1994 international conference on population, development (ICPD) in Cairo, Egypt, adolescent friendly reproductive health services (AFRHS) had been recognized as an appropriate and

effective strategy to address sexual and reproductive health (SRH) needs of adolescents. The health care services given to youth in schools mainly focus on services such as school physical environment and sanitation, nutritional status, immunization and treatment of common childhood illnesses. Reproductive health needs get little attention.

The need to have a healthy youth is of great value to nation's socioeconomic development because, if they use adolescent sexual reproductive health services promptly, many health problems will be reduced hence better performance at school and better future adult population.

In Nigeria, the realization of the magnitude of reproductive health problems the youth face prompted the government to make it an issue of national health priority. But, availability of adolescent sexual reproductive health services clinics remains poor in Nigeria. Many sexually-active young people do not use contraception or seek treatment for sexually transmitted infections because of lack of knowledge about places for getting methods or the infection treatment, lack of awareness of the infections themselves or because of perceived barriers in accessing health services. Therefore, this study sought to examine the level of knowledge of adolescents in the study area about available adolescent sexual reproductive health services.

Research Objectives

To determine the awareness level of adolescents of sexual and reproductive health services among students of selected secondary schools in Yenagoa local government area of Bayelsa state Nigeria.

To find out whether students of selected secondary schools utilize adolescent sexual and reproductive health services in Yenagoa local government area of Bayelsa state, Nigeria.

To identify factors affecting utilization of adolescent sexual and reproductive health services among adolescents of selected secondary schools in Yenagoa local government area of Bayelsa state, Nigeria.

To determine the relationship between knowledge and utilization of adolescent sexual and reproductive health services among adolescents of selected secondary schools in Yenagoa local government area of Bayelsa state, Nigeria.

Study Design

The study adopted a descriptive cross-sectional design that aimed at describing the demographic, socioeconomic, school and socio-cultural and health system factors that influenced utilization of Adolescent sexual and reproductive health services among the studied students.

Sample Size

The Krejcie and Morgan (85) formula was used to calculate the sample sizes. This is based on the fact that, for a definite population size the formula can be employed to determine the sample.

METHOD OF DATA COLLECTION

The research visited the schools several times. During the first visit to each of the school, the researcher introduces self to the administrative staff of the schools and purpose of the visit. Letter of ethical clearance obtained from the ministry of education in the state was submitted to the school authorities along with a copy of the detained research document containing purpose and method of data collection for the research study.

Each of the school was allowed to make a choice of a date that will be convenient for data collection from the students without disruptions of school activities.

The researcher used a self-administered questionnaire in order to collect data from the respondents. After explaining the purpose of the study to the students, the researcher distributed the questionnaires to the students who consented to participate in the study. The participants were asked to sit in a classroom and filled in the questionnaires individually to avoid influence from one another. The questionnaires did not bear any names of participants but rather numbers were used to represent the total number of participation. After the questionnaires were filled in, the researcher collected them for analysis.

Method of Data Analysis

Data obtained from questionnaires were coded and entered using Statistical Package for Social Sciences (SPSS) data entry program version 24.

RESULTS AND DISCUSSION

Results are presented in frequency tables and percentages. Mean and standard deviation were calculated where applicable.

Table No.1 shows the mean age of respondents as 15±1 years. The highest age range was 15 to 18 years 213(68.9%). Majority of the respondents are in SS1, 111(35.9%), female 160(51.8%) and Christians protestants 193(62.5%). The parental occupation of majority of the respondents 195(63.1%) are Civil servant.

Table No.2 shows the knowledge mean of respondents was 1.8±1.1 on a 7-point scale. The table also shows that 110(35.6%) of respondents are aware of clinics that provide adolescent sexual and reproductive health services. Of those aware of these clinics majority 59(53.6%) got the information from friends and peers, while the least 8(7.3%), got the information from parent/guardian. The table also shows that the knowledge of services provided by adolescent sexual and reproductive health services among the respondents are family planning /condom use 100(32.4%), VCT 22(7.1%), treatment of all diseases 54(17.5%), treatment of STIs 61(19.7%), care of pregnant woman 44(14.2%), general health information counseling 77(24.9% and pre and post abortion care 61(19.7%). The table also shows that adolescent sexual reproductive health services are not available in either of the two school studied 309(100%). The overall knowledge score shows that 34(11%) have adequate knowledge of adolescent sexual reproductive health services, while majority 275(89%) have inadequate knowledge of ASRHS.

Table No.3 shows that less than one-fifth 53(17.2%) ever visited an adolescent sexual and reproductive health services clinic. The table also shows that 74(23.9%) of the respondents utilizes adolescent sexual and reproductive health services for counseling, 47(15.2%) for family planning, 43(13.9%) for voluntary counseling and testing for HIV/AIDS and 22(7.1 %%) for treatment of sexually transmitted infections. The overall utilization score was 0.8±0.8 on a five-point scale. The tables also reveals that 291(94.2%) have inadequate utilization of ASRHS, while only 18(5.8) utilize the ASRHS adequately.

Table No.4 shows factors affecting utilization of ASRHS clinics. About three quarter of the respondents 234(75.9%) reported little or no knowledge of ASRHS, 182(58.9%) reported attitude of staff of ASRHS clinics towards adolescent and cost of services 159(51.5%) as factors that negatively influence utilization of adolescent sexual reproductive health services. The table also shows that more than half 183(59.2%) of the respondents did not see distance from clinic to school or home as one of the factor affecting utilization of ASRHS.

Table No.5 shows the results of suggested ways of improving utilization of adolescent sexual reproductive health services identified by the respondents. About one-third 165(34.5%) suggested creating more awareness about ASRHS through public campaign in the communities. Others suggestions made by the respondents are reduction in cost of treatment 75(15.7%), provision of ASRH services in secondary schools 41(8.6%), provision of ASRHS clinics in the communities 76(15.9) and improve the services provided at ASRHS clinics 31(6.5%).

Discussion

The mean age of respondents was 15±1 years. Majority 68.9% are within the age of 15 to 18 years, 35.9% are in SS1, 51.8% are female and Christian's Protestants constitute 62.5%. The parental occupation of majority of the respondents was Civil servant 63.1%.

The findings of this study revealed a mean knowledge of 1.8±1.1 on a 7-point scale. The overall knowledge score was poor as only 11% have adequate knowledge of adolescent sexual reproductive health services, while 89% have inadequate knowledge. This result is similar to 86.7% inadequate knowledge of ASRHS reported by Nagash in a study carried out at Maraka district Dawuro zone, southern Ethiopia but contrary to 67% adequate knowledge of ASRHS reported by Abajobu and Seme[2] and 82% reported, by Ajike and Mbegbu[10] among adolescents in a study carried out at Machakal district northeast Ethiopia and Ikeja, Lagos state, Nigeria respectively. The differences in the results of these studies could be attributed to differences in the categories of respondents. While

this present study uses secondary school adolescents the others studies uses adolescents in the communities, which age ranging from 15 to 24 years. Some of the adolescents in the other studies were married while in this present study all the adolescent are not married. Also using a school as the study setting could make the adolescent to hide some fact about their knowledge of reproductive health because of fear of been identified. This present study finding also revealed that 35.6% of respondents are aware of clinics that provide adolescent sexual and reproductive health services. Of those that are aware of these clinics, 53.6% got the information from friends and peers, while 7.3% got the information from parent/guardian. This is similar to 38.3% awareness of adolescent reproductive health services clinics reported by Abajobu and Seme[23]. The low awareness level may be due to poor knowledge of ASRHS. It could also be due to lack of availability of ASRHS clinic within the study community. This study findings also revealed that adolescent sexual reproductive health services was not available in either of the two school studied. This could be the reason for the high parentage of poor knowledge of ASRHS among the respondents.

This present study revealed that 94.2% of respondents have inadequate (poor) utilization of ASRHS, while 5.8% adequately utilizes ASRHS. The overall mean utilization score was 0.8±0.8 on a five-point scale. Findings from this present study revealed that less than one-fifth 17.2% of respondents ever visited an adolescent sexual and reproductive health services clinic. This is slightly lower than 21.5% reported by Abajobu and Seme[23] in a study carried out at northeast Ethiopia. Both results could be attributed to what Boustra[24] and WHO[15] reported that adolescent in developing countries faces greater challenges in utilization of reproductive health services due to dearth of adolescent sexual reproductive health services clinics and inadequate policies to address all needs of adolescents. This study also revealed that 23.9% of the respondents utilizes adolescent sexual and reproductive health services for counseling, 15.2% for family planning, 13.9% for voluntary counseling and testing for HIV/AIDS and 7.1% for treatment of sexually transmitted infections. From the various percentages of services accessed by the adolescents in this study, it could be said that, the study population is not properly utilizing ASRHS clinic. This could be due to non-availability of adolescent reproductive health clinics in the schools and possible within the community. It could also be due to fear of stigmatization or cost of accessing the treatment in the clinic.

This study finding revealed that factors hindering the utilization of ASRHS include little or no knowledge of ASRHS 75.9%, attitude of staff of ASRHS clinics towards adolescent 58.9% and cost of services 51.5%. This finding is similar to Biddlecom *et al*[5], that reported inadequate knowledge of reproductive health services as a barrier towards utilization of services. Erulkar *et al*[22], in a study carried out in Kenya and Zimbabwe reported that adolescent could not afford the cost of reproductive health services as they depend on their parents for financial assistance thus affecting utilization of ASRHS. Morris and Rushwan[13] supported the findings of the study that talk about attitude of staff of the clinic towards adolescents been a barrier to it utilization. More than half (59.2%) of the respondents did not see distance of adolescent sexual and reproductive health clinic to school or home as one of the factor affecting utilization of ASRHS. This finding is contrary to what was reported by Biddlecom *et al*[5], that distance and location of ASRHS clinic is a barrier to its utilization.

This present study revealed that there is a significant relationship between knowledge and utilization of adolescent sexual reproductive health services ($r = 0.158$; $P = 0.006$). In the study majority 89% has, inadequate knowledge similarly 94.2% had inadequate utilization of ASRHS. Which means knowledge of ASRHS translates to utilization of the services. This finding is similar to Abajobu and Seme[2] that reported that knowledge of ASRHS is significantly associated with its utilization in a study carried out among adolescents at Machakal district northeast Ethiopia. It is common to associate knowledge with practice or utilization. The more knowledge one has about services the more

likelihood the person would access the service if all other factors were kept constant. This can be seen in this study where majority have inadequate knowledge of ASRHS thus, it translate to equally large percentage not utilizing the ASRHS clinic.

Table No.1: Sociodemographic data of respondents (n=309)

S.No	Variable	CSS Kpansia (n =155)		Central Epie SS (n=154)		Total = 309)	
		F	%	F	%	F	%
Age (years)							
1	12 – 14	5	30.3	49	31.8	6	1.1
2	15 – 18	08	69.7	105	68.2	13	8.9
3	Mean = 15±1 years	-	-	-	-	-	-
Education Level							
4	SS1(senior secondary)	7	6.8	54	35.1	11	9
5	SS2 (senior secondary)	53	4.2	54	35.1	07	4.6
6	SS3 (senior secondary)	45	9	46	29.9	91	9.5
Gender							
7	Male	85	4.8	84	54.6	49	8.2
8	Female	70	5.2	70	45.4	60	1.8
Religion							
9	Christian catholic	43	7.7	9	8.3	02	3
10	Christian protestant	110	71	3	3.9	93	62.5
11	Traditional	2	1.3	2	.8	4	.5
Parental Occupation							
12	Self	46	29.7	0	6	6	7.8
13	Employed/Business	96	61.9	9	4.3	95	3.1
14	Civil Servant	8	5.2		.8	7	.5
15	Farmer Fisherman	5	3.2		.9	1	.6

CSS; Community secondary school. SS; secondary school

Table No.2: Knowledge of adolescent sexual reproductive health services among respondents (n = 309)

S.No	Variable	CSS Kpansia (n =155)		Central Epie SS (n=154)		Total = 309)	
Knowledge of ASRHS clinic							
1	Yes	51	32.9	9	8.3	10	5.6
2	No	04	67.1	5	1.7	99	9.4
Source of information of ASRHS							
3	Parent/ Guardian	2	3.9	7	0.2	9	.3
4	Friends/Peers	4	62.7	4	5.8	8	3.6
5	Teachers	-	5.9	-	.4	-	.5
6	Media	-	27.5	-	0.7	-	4.6
ARSHS is available in your school							
7	Yes	55	00	54	00	09	00
8	No	-	-	-	-	-	-
Knowledge of services provided at ARSH Family planning							
9	Yes	61	9.4	9	25.3	00	2.4
10	No	94	0.6	15	4.7	09	7.6
Voluntary counselling							
11	Yes	10	.5	2	.8	2	.1
12	No	145	3.5	42	2.2	87	2.9
Treatment of all diseases							
13	Yes	27	7.4	7	7.5	4	7.5
14	No	128	2.6	27	2.5	55	2.5
Treatment of STIs							
15	Yes	33	1.3	8	8.2	1	9.7
16	No	122	8.7	26	1.8	48	0.3
Care of pregnant woman							
17	Yes	24	5.5	0	3	4	4.2
18	No	131	4.5	34	7	65	5.8
General health information/ counseling							
19	Yes	44	8.4	3	1.4	7	4.9
20	No	111	1.6	21	8.6	32	5.1
Pre and post abortion care							
21	Yes	37	3.9	4	5.6	1	9.7
22	No	118	6.1	30	4.4	48	0.3
Grading of knowledge score **(mean = 1.8±1.1)**							
23	Adequate	15	.7	9	2.3	4	1
24	Inadequate	140	0.3	35	7.7	75	9

Cut off point: Adequate = 3.5 – 7; Inadequate = 0-3.4. CSS; Community secondary school. SS; secondary school

Table No.3: Utilization of adolescent sexual reproductive health services among respondents (n = 309)

S.No	Variable	CSS Kpansia (n =155)		Central Epie SS (n=154)		Total = 309)	
		F	%	F	%	F	%
Ever visited any ASRHS clinic							
1	Yes	21	13.5	2	20.8	3	7.2
2	No	134	86.5	22	78.2	56	2.8
Services accessed in ASRHS clinics counseling							
3	Yes	35	22.6	9	25.3	4	3.9
4	No	120	77.4	15	74.7	35	6.1
Family planning/condom use							
5	Yes	28	18.1	9	12.3	7	5.2
6	No	127	81.9	35	87.7	262	4.8
Voluntary counseling and testing							
7	Yes	19	12.3	4	15.6	3	3.9
8	No	36	87.7	30	84.4	66	6.1
Treatment of STIs							
9	Yes	11	7.1	1	7.1	2	.1
10	No	144	2.9	43	92.9	87	2.9
Overall Utilization score (Mean = 0.8±0.8)							
11	Adequate	5	3.2	3	8.4	8	.8
12	In adequate	150	96.8	41	91.6	91	4.2

Cut off point; Adequate = 2.5 -5; Inadequate = 0-2.4. CSS; Community secondary school. SS; secondary school

Table No.4: Factors affecting utilization of adolescent sexual reproductive health services among respondents (n = 309)

S.No	Variable	CSS Kpansia (n =155)		Central Epie SS (n=154)		Total = 309)	
		F	%	F	%	F	%
Little or no knowledge about ASRHS clinic							
1	Yes	125	0.6	109	70.8	34	5.7
2	No	30	9.4	45	29.2	5	4.3
Distance from clinic or home							
3	Yes	60	8.7	66	42.9	26	0.8
4	No	95	1.3	88	57.1	83	9.2
Attitude of clinic staff towards adolescents							
5	Yes	95	1.3	87	56.5	82	8.9
6	No	60	8.7	67	43.5	27	1.1
High cost of service							
7	Yes	85	4.8	74	48.1	59	1.5
8	No	70	45.2	80	51.9	50	8.5

CSS; Community secondary school. SS; secondary school

Table No.5: Suggested strategies for improvement of use of adolescent sexual reproductive health services by respondents

S.No	Suggestions	CSS Kpansia (n =155)		Central Epie SS (n=154)		Total = 309)	
		F	%	F	%	F	%
1	Create awareness of ASRHS	1	3.1	4	36.1	65	4.5
2	Reduce cost of treatment	0	6.3	5	15	5	5.7
3	Provision of ARSHS in schools	0	.2	1	9	1	.6
4	Provision of materials for the clinics	0	0	0	17.2	0	8.8
5	Improve ASRH services	8	.3	3	5.6	1	.5
6	Provide more clinic closer to the people	6	4.7	0	17.2	6	5.9

CSS; Community secondary school. SS; secondary school

CONCLUSION

The findings from this study revealed that more than four-fifth of adolescent from the study population have inadequate knowledge of adolescent sexual and reproductive health services and that utilization of the services was also poor among majority. This shows that poor knowledge translate into poor utilization of adolescent sexual and reproductive health services in the study population. Factors such as little or no knowledge of ASRHS, attitude of reproductive health services clinics and cost of services are the major causes of poor utilization of adolescent sexual and reproductive services in the study population. The suggested ways of improving utilization of ASRHS by the respondents include creating awareness about ASRHS among the adolescents and the community at large; reduce cost of treatment, provision of ASRHS in secondary schools and improving the services of ASRH in the community.

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CONFLICT OF INTEREST

We declare that we have no conflict of interest.

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