KNOWLEDGE, PERCEPTION AND UTILIZATION OF YOUTH FRIENDLY CENTRE AMONG UNDERGRADUATES OF THE UNIVERSITY OF IBADAN, NIGERIA

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A DISSERTATION SUBMITTED TO THE DEPARTMENT OF HEALTH PROMOTION AND EDUCATION, FACULTY OF PUBLIC HEALTH, COLLEGE OF MEDICINE, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC HEALTH (POPULATION AND REPRODUCTIVE HEALTH EDUCATION)
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DEDICATION

This research work is dedicated to the Almighty and ever sufficient God. To Him alone be all the glory

ABSTRACT

Youth-Friendly Services (YFS) have been identified as one of the most sensitive and effective ways of delivering reproductive health services to young people. Despite the establishment of Youth-Friendly Centres (YFC) in some strategic places in Nigeria including Oyo State, risky sexual behaviours with their attendant consequences such as HIV infection, unwanted pregnancies and unsafe abortion are still prevalent. Anecdotal reports revealed that most students of the University of Ibadan (UI) are not aware of the YFC in UI campus. Therefore, this study was designed to assess the knowledge, perception and utilisation of the YFC among undergraduates of the University of Ibadan, Nigeria.

A descriptive cross-sectional survey was conducted using a four-stage random sampling technique to select 608 consenting respondents from 10 undergraduate halls, blocks and rooms. A validated, semi-structured, self-administered questionnaire was used to obtain information on socio-demographics, knowledge, perception and utilisation of services offered at the UI YFC. A 15-point scale was categorised as ≤7, >7-10 and >10 for poor, fair and good knowledge respectively. Data were analysed using descriptive statistics, t-test and Chi-square test at p=0.05.

Respondents' age was 21.0±2.5 years, 55.3% were males and 99.2% were single. Majority (70.4%) had ever heard of U.I. YFC and their sources of information included friends (50.0%) and orientation programme for fresh students (44.0%). Respondents' knowledge score on the YFC was 5.3±4.6. Some 45.6% of the respondents had poor knowledge of the services offered at the YFC. Some of the respondents did not know that the YFC provides free condom (75.0%) and HIV Counselling and Testing (HCT) (45.6%). The perception of the respondents about the YFC included views that the location is not noticeable (58.9%) and not easily accessible (53.2%). Among the respondents that were aware of the UI YFC, only 41.6% and 34.6% had ever visited and used the centre, respectively. Respondents' reported reasons for use included recreational activities (59.2%), reading (55.1%) and health talk relating to HIV/AIDS (38.1%). Factors perceived to be militating against the use of the YFC were lack of awareness of the centre by many students (85.6%), inadequate knowledge of the services provided (83.7%) and distance

from the hostel (51.7%). The knowledge score for males and females was 5.5±4.8 and 5.1±4.5, respectively. Significantly, more males (22.9%) than females (11.7%) had ever used the YFC.

Despite the fact that most of the undergraduates of the University of Ibadan were aware of the Youth-Friendly Centre, their level of knowledge of the services provided was poor and its utilisation was low. Public enlightenment on the services provided in the Youth-Friendly Centre and health education intervention are advocated to address the current challenges.

Keywords: Youth-Friendly centre, Health service utilisation, AIDs education, University of Ibadan undergraduates.

Word count: 433

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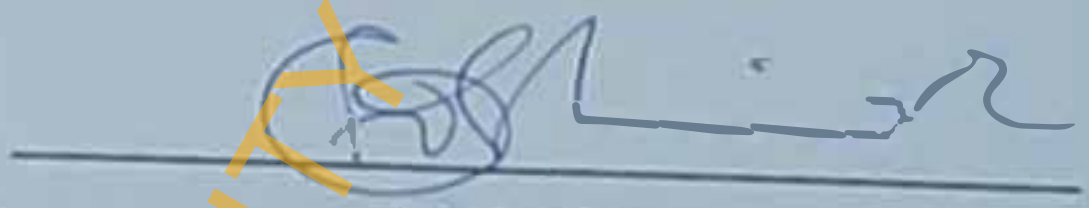
Okainemen Precious OKOSUN

CERTIFICATION

I certify that this study was carried out by OKOSUN, Okainemen Precious in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria.



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LIST OF ABBREVIATIONS

ABH	Alexander Brown Hall
AIDs	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
CEDAW	United Nation's Convention on the Elimination of All Forms of Discrimination Against Women
FMOH	Federal Ministry of Health
HIV	Human Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MYD	Ministry of Youth Development
NARHS	National HIV/AIDs and Reproductive Health Survey
NDHS	National Demographic Health Survey
NYP	National Youth Policy
RH	Reproductive Health
RHS	Reproductive Health Services
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
UI	University of Ibadan
UNAIDS	United Nations Agency International Development
UNCRC	United Nations Convention on the Rights of the Child,
UI/UCH	University of Ibadan/ University College Hospital
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YFC	Youth Friendly Centre
YFRHS	Youth Friendly Reproductive Health Services
YFS	Youth Friendly Services

Operational Definition of Terms

Level of study: Student's year of study in the University

Adolescents : Persons aged 10-19 years

Youths : Persons aged 15-24 years

Young People : Persons aged 10-24 years

The terms adolescents, youths and young people will be used interchangeably in this study.

Youth Friendly Services: Youth Friendly Services are services that have and implement policies that are attractive to youths. They provide a comfortable setting for meeting the needs of young people and encouraging them to repeat their visits.

Youth Friendly Centre: A youth centre is a friendly, supportive and non-threatening environment where young people have access to a variety of services aimed at promoting and protecting their health. A youth friendly centre brings young people in contact with influential peers, provide a connection with an institution, and allow for mentoring.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Young people including adolescents are highly vulnerable to reproductive health problems which can be effectively tackled through the promotion of their access to factual information. An over view of such challenges are worth re-counting. It has been reported that globally, an estimated 4.6 million young people are living with HIV, with an estimated 2300 young people said to be newly infected with the virus each day (UNAIDS, 2013). Furthermore, over half of the 340 million new Sexually Transmitted Infections (STIs) other than HIV which occur annually involve young persons aged 15–24 (UNAIDS, 2010). A common feature of young people in Nigeria is their potential vulnerability to HIV and other STIs, teenage pregnancy, unsafe abortion and its attendant consequences and sexual violence including rape (USAID 2010; Okereke 2010; Ossnyin 2011). Young people are vulnerable to these challenges because of their predisposition to peer pressure, anxiety to experiment with sex, low risk perception, unprotected sex, alcohol and drug abuse.

Nigeria has a population of over 167 million (NPC, 2013). One third of this population is said to consists of persons aged 10-24 years (UNFPA, 2010). More than 60% of new HIV infections in Nigeria occur among young people aged 15-25 (Okudo and Rosa, 2015). It has been reported that 10% – 40% of young unmarried girls have had unintended pregnancy, (NPC, 2009). Teenage mothers are more likely to suffer from serious complications during delivery, resulting in higher morbidity and mortality (Advocates for Youths, 2008 and NPC, 2013). About 760 thousand cases of abortion occur annually in Nigeria, and one third of Nigerian women who obtain abortion each year are young people. Furthermore 80% of patients in Nigerian hospitals with abortion-related complications are young girls (Guttmacher Institute, 2008).

According to the Federal Ministry of Health (FMOH, 2011) lack of accurate information and limited access to adolescent-friendly health services are major contributory factors to the poor reproductive health status of young people in Nigeria. Many young persons do not have adequate knowledge relating to the common risks they face. It was noted by the

FMOH (2011) that only 57% of young people in 2005 knew all the transmission routes for HIV. In addition, only 24% of young women and 34% of young men aged 15-24 years have comprehensive knowledge about HIV (NPC, 2013). Premarital sex is not culturally accepted in Nigeria, yet the median ages of sexual debut for women and men were 17 years and 20 years respectively (NPC, 2009 and NPC, 2013). Among women who had sexual intercourse in the 12 months preceding the National Health Demographic Survey of 2008, the proportion who engaged in risky sex (i.e unprotected sex with multiple partners) was highest among adolescents aged 15-19 years (NPC, 2009). The effects of risky reproductive practices on young persons could be devastating and they make them disproportionately affected by reproductive morbidities and mortalities (Ajuwon, 2013).

The challenges that put young people at risk of reproductive health problems includes judgemental attitude of health workers, unfriendly service delivery, stigmatization and non-confidentiality. (WHO, 2012). Some of the main factors which also influence sexual and reproductive health in Nigeria include: inadequate or lack of access to sexuality information, low risk perception, engagement in multiple concurrent sexual partnership and indulgence in informal transactional sex, (Amanitare Sexual Rights Network, 2013). This creates a need for: prevention, treatment and follow up interventions. The interventions need to include, sexual reproductive health education, counseling, sexually transmitted infections screening, HIV testing and counseling, pregnancy testing, contraceptive services and physical examinations (Senderowitz, 1999 ; WHO, 2002 and WHO 2012). Many of these services can be provided in a youth friendly centre.

Most existing health facilities or health services are designed for adults; as a result young persons are faced with some barriers relating to how to access the needed services such as judgemental or unpleasant attitude of service providers, non-confidentiality and unaffordable fees. Consequently, they get information from inappropriate or uninformed sources on their reproductive health concerns. (WHO, 2002; Ajuwon, Owoaje, Falaye, Osinowo, Aimakhu, Adewole, 2008 and WHO 2012). The barriers to young people's access to reproductive health services can be broadly categorized into those relating to availability and acceptability, (Agampodi, UKD, 2008), as well as those that concern accessibility, confidentiality and equity of health services (WHO, 2001; WHO, 2002;

WHO, 2012; UNFPA, 2013 and Shikuku 2015). Youth friendly services could be designed to overcome these barriers (WHO, 2002 and WHO, 2012).

Viewing adolescents as a group with peculiar needs is a relatively recent practice in the developing world (Senderowitz, 1999, Senderowitz, 2003 and WHO, 2012). Globally, young unmarried people in the past were not expected to need reproductive health services (Senderowitz, 1999; WHO 2002 and WHO 2012). However, significant social changes, which affect all societies such as globalization and other phenomena including decreasing age of menarche, adolescent risky behavior and decreasing age of sexual initiation have necessitated addressing the reproductive health of young people (Senderowitz, 1999 and WHO 2002), before things get too late.

In 1995, WHO, in collaboration with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), agreed on a common agenda for action on adolescent health and development. They called for the implementation of a package of interventions, which includes the provision of relevant information and skills for young people, the creation of a safe and supportive environment and the provision of health and counseling services to meet the peculiar needs of young people (WHO, 1997). In response to this, the Federal Ministry of Health, in her strategic framework seeks to establish youth friendly and gender sensitive services in public and private health care institutions in Nigeria (FMOH 2007). Youth friendly centres could also be established to address the reproductive health needs of young people in Nigeria.

A youth friendly centre is a friendly, supportive and non-threatening environment where young people have access to a variety of services aimed at promoting and protecting their health. Such centres also bring them in contact with influential peers, provide a connection with an institution, and allow for mentoring (Traore, Magnani, Murray, Senderowitz, Speizer and Stewart, 2002 ; WHO, 2002; Ajuwon et al, 2008 and WHO 2012). One of the several services provided by youth centers is reproductive health care. The centers typically have recreational, educational and sometimes vocational components as well as reproductive health information and counseling services (Traore, et al, 2002 ; WHO, 2002; Ajuwon et al, 2008 and WHO 2012).

According to WHO, (2002), adolescents and youth friendly services represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Youth Friendly Services are services that have and implement policies and attributes that are attractive to youths in terms of friendly. respectful and non-judgemental service delivery, convenient time, affordable fees and confidentiality. They provide a suitable and acceptable setting for meeting the needs of young people and encouraging them to repeat their visits (Ajuwon et al, 2008).

The United States Agency for International Development (USAID) has identified three models of youth friendly services for the provision of young people's sexual and reproductive health needs. They are Integrated Youth Friendly Health Services (YFHS), Stand Alone YFHS and Comprehensive Youth Friendly Services (USAID, 2010). The provision of reproductive health services delivered through the youth-friendly services has been identified as one of the most sensitive and effective ways of delivering reproductive health services to young people (WHO, 2002 ; Tylee, Haller, Graham, Churchill and Sanci, 2007).

The. USAID (2010) has identified some programming gaps related to services targeted at young persons. One of them is that the sexual and reproductive health needs of students in tertiary institutions which can be addressed through youth friendly services are largely unmet. Several factors could be responsible for the unmet needs. One of such factors is that university based young people often lack knowledge on where to access reproductive health services to meet their needs as identified by UNESCO (2009). They could also be limited by barriers such as low risks perceptions and services devoid of confidentiality and affordability (WHO, 2002, Erulkar, Onoka and Phiri, 2005, Osayin 2011). The establishment of the Youth Friendly Centre at the University of Ibadan in October 2007, is thus a commendable initiative. However, the services provided at the centre as well as undergraduates knowledge and pattern of utilization of the centre have not been fully investigated through research. In addition, the specific factors which influence utilization of youth friendly health services have not been well explored among young people in Nigerian tertiary institutions. These constitute the stimulus for the design and execution of this study.

1.2 Statement of the Problem

Young people continue to face sexual and reproductive health challenges (FHI, 2010; UNAIDS 2010) due to their vulnerability to peer pressures, experimentation with sex, possession of multiple sex partners, low risk perception, unprotected sex, alcohol and other risky lifestyles. Furthermore, young people encounter difficulties in accessing reproductive health services due to unfriendly, unaffordable, inconvenient timing, judgemental and non-confidential services which results in poor Sexual Reproductive Health (SRH) service use among young people (WHO, 2002 : Senderowitzz, 2003 and Tylee, Haller, Graham, Churchill, Sanci, 2007).

Across a variety of global contexts, it has been demonstrated that Youth Friendly Service (YFS) can address the needs of young people by improving the availability of services (WHO, 2002 ; Senderowitzz, 2003 ; Tylee, Haller, Graham, Churchill, Sanci, 2007 ; Ajuwon et al, 2008 ; Pathfinder International, 2012 and Akiniyi, 2012), acceptability, accessibility and equity of health services for young people (WHO 2002; Tylee, Haller, Graham, Churchill, Sanci, 2007 ; WHO 2012 ; Pathfinder International, 2012 ; Motunu, 2012 and Akiniyi, 2012). The YFS approach addresses the complex drivers of adolescents' poor SRH outcomes by targeting the barriers to health care access at the individual, social, and structural levels (Pathfinder International, 2012 and WHO 2012).

There are a few Youth Friendly Centers in Nigeria, with six in Ibadan metropolis. The YFC of the University of Ibadan was established eight years ago to address some health, social educational and recreational needs of students. The health related needs includes those relating to unintended pregnancy, abortion, sexual assault, HIV and counseling. Furthermore, the centre also provides services and interventions directed at preventing the abuse of alcohol and other drugs. There is a need to investigate the extent to which the services provided at the centre are addressing the needs and concerns of the students. In addition there was the need to determine the knowledge, perception and pattern of utilization of the centre. This study was, therefore, designed to investigate the knowledge, perception and pattern of utilization of youth friendly health services offered at the YFC of the University of Ibadan.

1.3 Justification

There is a growing recognition among reproductive health care providers throughout the world that youth friendly health services are needed to enable young people to be ndequately provided with appropriate reproductive health care services (Senderowitz 1999 and WHO 2012). This realization has made some countries of the world including Nigeria to embrace this lofty idea. Though this is yet to be fully explored in Nigeria considering that a great chunk of the population are young people (Ajuwon. 2013).

The results of the study have potential for throwing light on the knowledge. perception and pattern of utilization of the University of Ibadan YFC. It also holds great promisein contributing to the understanding of antecedent factors which influence the use of the YFC of the University of Ibadan. The results will be useful for the formulation of policies and initiation of programmatic actions aimed at maximizing the utilization of the Centre.

1.4 Research Questions

The research questions framed to guide the study were as follow:

1. What is the level of knowledge of undergraduates relating to the services provided at the YFC?
2. What are the perceptions of undergraduates of the university relating to the YFC?
3. What is the pattern of utilization of the YFC among the undergraduates?
4. What are the factors which facilitate the utilization of the YFC among the undergraduates?
5. What are the factors which militate against the utilization of the YFC among the undergraduates?

1.5 Objectives

1.5.1: Broad objective

The broad objective of this study was to investigate the knowledge, perception and utilizaton of YFC among undergraduates of the University of Ibadan.

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1.5.2 Specific Objectives

The specific objectives were to :

1. Assess the undergraduates' knowledge relating to the services provided at the YFC.
2. Determine the undergraduates' perceptions relating to the YFC.
3. Determine the pattern of utilization of YFC among undergraduates.
4. Identify the factors which facilitate the utilization of the YFC by the undergraduates.
5. Identify the factors which militate against the utilization of the YFC by the undergraduates.

1.6 Study variables

Dependent Variables

The key dependent variables measured included the following: awareness, knowledge, perceptions, pattern of utilization, facilitating factors and militating factors.

Independent Variables

The assessed independent variables included the following : age, sex, level of study, hall of residence, faculties of study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Conceptual issues relating to the Youth Friendly Centres and Services

The concept of "youth" is key to the concept of "Youth Friendly Centre". The term "youth" varies from culture to culture. There could be a variation in the boundaries which define the transition from childhood to youth and from youth to adulthood (Ministry of Youth MYD, (2009). The changes or major milestones that young people must pass through no longer occur as predictably as in the past, therefore, defining youth globally according to some exact age range can be a very difficult task (MYD, 2009). According to the World Health Organization -WHO, (2012), the youthful stage is often characterized by a period when health problems that have serious immediate consequences can and do occur, it is also a period when problem behaviors which could have serious adverse effects on health in the future are initiated (WHO. 2002). The concept of youth is best understood as a period of transition from the dependence of childhood to adulthood's independence and awareness of our interdependence as members of the community (WHO 2002 and WHO. 2012).

Youth is a fluid age related category than a fixed age-group (United Nations, Educational, Scientific and Cultural Organization, UNESCO, 2013). The age range 15-24 is often used by the United Nations, WHO and others to mean the youthful stage for statistical purposes, but in many cases this distinction is too narrow for countries like Nigeria (MYD, 2009). According to the Nigerian National Youth Policy (NYP), the term youth is used to include all young persons aged 18 to 35 years who are citizens of the Federal Republic of Nigeria (MYD, 2009). This is also problematic because it does not seem to be based on a justifiable realm or factor. A challenge in the conceptualization of the youth this way is that the age range is too wide and it comprises of persons with different levels of development and maturation. The concept of young persons is however used by the World Health Organization to refer to people aged 10-24 years (WHO, 1989; United Nations, 1981). According to the NYP young people are characterized by energy, enthusiasm, ambition, creativity, and promise; they are often faced with high levels of socio-economic uncertainty. This situation makes them highly vulnerable to several morbidities and

mortality (MYD, 2009). The morbidities and mortalities include health problems related to reproductive health (Senderowitzz, 2003).

As adolescents transit from childhood to adulthood, they enter a pivotal developmental period when their decisions and the decisions made for them by others substantially influence their well-being and future life course (WHO, 2002 ; Senderowitzz, 2003 ; Tylee, Haller, Graham, Churchill, Sanci, 2007; Pathfinder International, 2012 and WHO 2012). Addressing the sexual and reproductive health needs of young people represents one of the most important commitments Nigeria can make to its future economic and social wellbeing (FMOH. 2009). The realization of the importance of young has brought about efforts to develop and empower the youth to become healthy and productive Nigerians, that are able to contribute to nation building (FMOH. 2009). The concern about the health and development of young people has been addressed in various international instruments, several of which Nigeria is a signatory. These documents include declarations of the Convention of the Elimination of all forms of Discrimination against Women (CEDAW) of 1979 (Emakhu, 2013 and Dada, 2014); United Nations Convention on the Rights of the child. (UNCRC) of 1992, (Federal Republic of Nigeria, 2006; FMOH. 2007 and United Nations 2015) ; International Conference on Population and Development (ICPD), Cairo of 1994, (FMOH, 2009) and Fourth World Conference of Women and the United Nations World Programme of Action for Youth (United Nations, 2015). This has brought the needed paradigm shift for the promotion of sexual and reproductive health of young people. These instruments provide the overarching framework to deliver on promises made regarding Nations' commitment to meet the fundamental rights of all adolescents and young people, including their rights to health and education (FMOH, 2009).

Nigeria launched her first National Adolescent Health Policy in 1995. The framework was to provide the programmatic thrusts that will reduce morbidity and improve the quality of life and well being of all young people in Nigeria (FMOH, 2009). However, according to the 1999 National Strategic Framework on ASRH, efforts must be made to establish youth-friendly and gender-sensitive services in public/private health institutions including Youth Centres (FMOH, 2009). This is also corroborated by the National Response to Young People Sexual and Reproductive Health which recommends that all federal health agencies and facilities must regard the provision of YFHS as a priority. In Nigeria, a study was conducted and geared towards learning about the state of national response to young

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people's sexual and reproductive health services. Some inadequacies in the youth friendly health services were revealed. Activities which promote young people's sexual and reproductive health were found to be minimal (FMOH 2009).

All clients of sexual and reproductive health services such as the YFC should have the right to information about the benefits and availability of services and to access these services, regardless of their race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability (IPPF, 2007). In addition, they have a right to protect themselves from unwanted pregnancy, disease and violence and to decide freely whether and how to control their fertility and other aspects of their sexual health (IPPF, 2007). Youth-friendly services can be provided in a variety of settings, ranging from a clinic reserved exclusively for young people, to adding 'adolescents-only' hours at existing facilities, providing emergency hotline, or offering services in places where young people congregate, such as schools, youth centres, sporting events or work sites (Ajuwon, 2007 and IPPF, 2007).

According to WHO (2002), a WHO consultation in Africa in October 2000 agreed that "adolescents have a right to access health services that can protect them from HIV/AIDS and from other threats to their health and well-being, and that these services should be made adolescent friendly". The consultation recognised that health and development needs cannot be met by health services alone.

Additional essential clinical services which must be prioritized were outlined and these included the following : general health services for tuberculosis, malaria, endemic diseases, injuries, accidents and dental care; reproductive health including contraceptives, STI treatment, pregnancy care and post abortion management; counselling and testing for HIV, which should be voluntary and confidential. The other listed services were : management of sexual violence, mental health services, including services to address the use of tobacco, alcohol and drugs; information and counselling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use.

However, an appropriate range of essential services must be decided by each country, based on outcome of local needs assessments. The Global Consultation on Adolescent

Friendly Health Services held by WHO in Geneva in March 2001, concluded that a core package could not be a 'fixed menu'. Instead, the Global Consultation suggested that each country must develop its own package, negotiating its way through economic, epidemiological and social constraints, including cultural sensitivities (WHO, 2002).

2.2 Characteristics of adolescent / youth friendly health services

The characteristics of adolescent friendly health services which also constitute the basic characteristics of YFC can be organized into 11 elements (WHO, 2002). These are the elements relating to the following: adolescent friendly policies, adolescents friendly procedures, adolescent friendly health care providers, adolescent friendly support staff, adolescent friendly facilities and adolescent involvement. The others are: community involvement and dialogue, community based, outreach and peer to peer services, appropriate and comprehensive services, effective health services for adolescents and efficient services. The provision of these elements will be presented in greater detail starting with availability of adolescent friendly policies.

Adolescent friendly policies are policies that fulfill the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations (WHO, 2002). They take into account the special needs of different sectors of the population, including vulnerable and under-served groups and do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age. The policies pay special attention to gender factors, guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care and ensure that services are either free or affordable by adolescents (WHO, 2002).

Adolescent friendly procedures facilitates easy and confidential registration of patients, and retrieval and storage of records, short waiting times and (where necessary) swift referral, consultation with or without an appointment.

Adolescent friendly health care providers are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances. They have interpersonal and communication skills, motivated, supported and are non-judgmental, considerate, easy to relate to and trustworthy personnels. They devote adequate time to clients or patients and act in the best interests of

their clients. They also treat all clients with equal care and respect as well as provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

Adolescent friendly support staff are understanding and considerate, treating each adolescent client with equal care and respect. They are competent, motivated and well supported.

Adolescent friendly health facilities provides a safe environment at a convenient location with an appealing ambience. They operate convenient working hours, offer privacy and avoid stigma. They also provide information and education material.

Also it includes Adolescent involvement, so that they are well informed about services and their rights, encouraged to respect the rights of others and involved in service assessment and provision.

Community involvement and dialogue to promote the value of health services, and encourage parental and community support. As well as *Community based, outreach and peer-to-peer* services to increase coverage and accessibility.

Appropriate and comprehensive services that address each adolescent's physical, social and psychological health and development needs. It provides a comprehensive package of health care and referral to other relevant services and do not carry out unnecessary procedures.

Effective health services for adolescents are health services that are guided by evidence-based protocols and guidelines, having equipment, supplies and basic services necessary to deliver the essential care package. Including having a process of quality improvement to create and maintain a culture of staff support.

Efficient services are those which have a management information system including information on the cost of resources and a system to make use of this information.

2.3 Appraisal of effectiveness of YFC and services

Evidence on the effectiveness of various ASRH programs elsewhere has grown for the past three decades. A number of research and results have been written to synthesize what is known about what types of interventions work and what types do not (Senderowitz, 2000, Kirby, Obasi and Laris, 2006, Ball, Moore, 2008). However, not all the evidences comes from scientific research. Some best practices arise from extended program experiences. Many lessons can be learnt from the reviews and syntheses that can inform current ASRH

programs (Ball and Moore, 2008). These lessons or experiences include: Youth friendly services as one of such interventions. Young people are not a monolithic group (Ball and Moore, 2008 and UNFPA, 2014). They have varying needs for information and services, and one type of intervention will not address all needs. Nor can one type of interventioo address the unique needs of any single young person. For example, sonie programs are better at reaching one sex than the other (Ball and Moore, 2008). As with any type of intervention, in order to sustain healthy behaviors, prevent risky ones, or promote use of services, it is necessary to deliver multiple messages through multiple modalities, there is no "magic bullet" approach (Butler, Bond, Drew Krelle, Seal, 2006).

According to USAID (2010), evidence based on the effectiveness of youth friendly services is minimal. It was revealed that many organizations do not do comprehensive, external baseline surveys before initiating their work. Many organizations do not keep records about youth participating in their programs. This shows that coverage data and evidence of impact could be scarce (USAID 2010 ; Division of reproductive Health, Ministry of Health, 2013; Chandra-Mouli, Lane and Wong, 2015).

A study in Togo has, however, revealed that Youth Friendly Centres (YFC) have little impact on the reproductive health knowledge and practices of beneficiaries (Traore, Magnani, Murray, Senderowitz, Speizer and Stewart, 2002). According to reports by the Population Council in Ghana, Kenya, and Zimbabwe, Youth Friendly Centres are generally used by males for recreation. The council noted that males and females using the reproductive health services tend to be older than the targeted age (James-Traore, et al, 2002). A review of the effectiveness of interventions to improve the use of health services by young people conducted by WHO (2006) however revealed that actions to make health services user friendly and appealing had led to substantial increases in the use of health services by young people.

In Nigeria, a facility assessment of 88 youth friendly health facilities in 33 states of the country, showed that 80-91% facilities reported that they attended to clients needing STI testing or treatment, an indication that STIs remain a prevalent reproductive health concern among young people (Osanyin, 2011). However, this study reported generally low level of utilization of these facilities and services. What cuts across the appraisal studies so far

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conducted relating to the knowledge and pattern of utilization of youth targeted services in various settings or countries is the dearth of information on youths perceptions, opinions or beliefs relating to services. Yet information concerning their perspectives of the services is crucial for addressing their needs.

There is evidence that many types of interventions can be effective, but effectiveness is usually conditional on certain social contexts. Addressing social and gender norms in program design and messaging facilitates changes in risky behaviors (Ball and Moore, 2006). Several programs have been successful at one site or in one evaluation, but not in another, indicating that curriculum and programming are not the sole elements of a successful intervention. Implementation methods, staffing and tailoring programs to meet the needs of the population being served are all-important considerations (Ball and Moore, 2006)

A review of studies of primary care services identified six categories of youth friendly services, but found little evidence of their effectiveness because of inadequate assessment (Tyler, Haller, Graham, Churchill, Sanci, 2007). The authors conclude that although services designed to meet the needs of young people are important further studies are needed to demonstrate effectiveness. One study on comprehensive youth centers that provide RH found that effect of recreational activities on health outcomes was not clear-cut. Such services were also likely to serve a large portion of the adolescent population, especially in rural areas. It suggested that while these centers did reach boys, their participation was primarily recreational (Erulkar, Beksinska and Cebekhulu, (2001) ; Erulkar, Mekbib, Simie and Gulema (2006) ; WHO, (2009) and Zuurmond, Geary and Ross, 2012).

2.4 Knowledge relating to services provided at the YFC of U.I

According to WHO (2002), most young people do not know much about health services made available to help them. They also have some challenges accessing such services. Elissa, Siula, Jennifer, David, Jayline and Natalie (2013) in " Be kind to young people so they feel at home" : a qualitative study of adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu, revealed that

adolescents described a lack of awareness about SRH as a reason why they did not access services (Elisso et al, 2013).

In a focus group discussion conducted by Agampodi, Agampodi and UKD, (2008), among 32 adolescents aged 17–19 years in Sri Lanka, revealed that knowledge on available services was very poor. Only girls were aware of the availability of services at their doorstep. Not a single boy knew that they could seek help from the youth service clinics for their RH problems and were totally unaware of the availability of the youth corner in the nearby general hospital. Some boys complained that they were discriminated against by the health care providers and policy makers (Agampodi, Agampodi and UKD, 2008). In Nigeria, the FMOH (2009), has noted that the major forms of sexual and reproductive rights violation affecting young people include denial of access to relevant information and services.

Akiniyi (2012), conducted a study on the determinants of utilization of Youth friendly Reproductive Health Services (YFRHS) among school and college youths in Thika West District of Kiambu County, Kenya and noted that utilization of reproductive health services was low largely due to lack of awareness of reproductive health services among the youths. Another study in Zambia on vulnerability and sexual and reproductive health among Zambian secondary school students concluded that boys and girls lacked adequate information about human reproduction and STIs including HIV (Warenius, Faxelid, Chishimba, Musandu, Ong'any and Nissen, 2006). A study done by Motuma (2012) on youth-friendly services (YFS) utilization and factors that affect Youth Friendly Services among youths in Harar, Ethiopia concluded that most youths had positive attitude towards YFS but had poor knowledge on the services. The same study also reported that only one facility provided YFS in Harar thus pointing to the limitations in offering YFRHS in that region. Godia (2010), concluded in his study that utilization of youth friendly sexual and reproductive services in Kenya still face multiple challenges from the youth who have little or lack information on youth friendly reproductive health services.

2.5 Perceptions relating to YFC/services.

Young people's perceptions are not uniform and show variation between boys and girls as well as for the type of service delivery. Perceptions of services can either be positive or negative (Godia, Olenja, Hofman and Broek, 2014). Motuma 2012, in his study noted that

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nearly 88.6% of the respondents were of the perception that YFS were necessary for proper care for young people. The respondents were of the perception that STI/HIV/AIDS-related services (57.8%) and psychological and reproductive health counseling (44.7%) were the most important YFS (Motuma 2012).

In a qualitative study conducted by Elissa et al 2013, on adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu, it was found out that there was a perception that SRH services were only for married people or mothers and not available to adolescents (Elissa et al, 2013). The adolescents also lacked the knowledge about what they would be asked or what would happen at the clinic and not knowing how to talk with nurses were also reasons for not accessing services and lack of experience attending a health service contributed to anxiety, as did misinformation or discouragement from friends (Elissa et al, 2013).

In one study conducted by Rebecca, Emily, Lynda and Shane, (2015) on evaluating youth-friendly health services: young people's perspectives from a simulated client study in urban South Africa. Rebecca et al, (2015), found out that more male than female simulated clients reported that the healthcare worker they consulted knew how to talk to young people and treated them respectfully. This may reflect different experiences by males and females, different expectations or both. More simulated clients reported that the healthcare worker was friendly, knew how to talk to young people, treated them with respect, and appeared to value them seeking information (Rebecca et al, 2015).

According to Godia et al, (2014), who conducted a study on young people's perception of sexual and reproductive health services in Kenya among health care facilities and youth centres across selected urban and rural settings noted that at youth centres, young people value the non-health benefits and perceived that youth friendly centres provided opportunities which included availability of recreational facilities, prevention of idleness, building of confidence, provision of information, improving interpersonal communication skills, vocational training and facilitation of career progression. Boys and girls outlined both health and non-health benefits of youth centres although the majority reported that the benefits of using a youth centre were mainly non-health related. Youth centres were described as good, friendly, open, useful, helpful, with health service providers who were young, friendly, understanding and easier to talk to (Godia et al, 2014).

According to the study conducted by Godia et al, (2014), it was noted in their study that young people perceived youth centres to provide a good environment where privacy was respected and there was friendliness among staff. Also with health service providers who gave advice to young people on how to plan for their future lives and prevent unwanted pregnancy, early marriage and offered good counselling services (Godia et al, 2014).

In the same study the consensus opinion among the study respondents was that young people who came to the youth centre to play games or be involved in other activities eventually would end up using the centre's SRH services if needed (Godia et al, 2014). Activities at the youth centres were linked to building young people's confidence in terms of improving self-esteem, communication skills and general interpersonal interaction with peers and members of society as well as allowing them to evaluate their moral values. Girls and boys appreciated the opportunity to receive computer training, learn how to access the internet and write curriculum vitae (Godia et al, 2014).

There were however conflicting views about the importance of games. While the consensus was that games prevented idleness, it was also felt that games (such as pool) could turn a youth centre into a meeting base for particular groups of boys. Both girls and boys noted that games such as pool only attracted boys and made girls shy away from coming to a youth centre (Godia et al, 2014). Also youth playing games at the same place where health services are provided can be a deterrent to some young persons (Erulkar, Mekbib, Simic and Gulema (2006) and Godia et al, 2014).

2.6 Pattern of utilization of Youth Friendly Health –related services by young people

A study done by Motuma (2012) on youth-friendly services (YFS) utilization and factors that affect Youth Friendly Services among youths in Harar, Ethiopia found out that many of the respondents (63.8%) had used YFS at least once in the last five years. Among these, (96.1%) had visited the services for reproductive health services while the remaining (3.9%) had visited for library and recreational services (Motuma 2012).

Godia, et al, 2014, in their study on the experiences and perceptions of young people in Kenya aged 10 to 24 years with regard to their SRH needs indicates that although young people describe youth centres as having both health and non-health benefits, they particularly value the non-health benefits including general life skills and skills leading to

improved chance of employment received through participation in youth-related activities. The presence of games at health facilities such as a pool table elicits mixed reactions. Games at youth centres seem to favour boys, and may make girls feel unwelcomed. Evidence supporting the association between non-health related activities (such as games, other recreational activities) and an increase in uptake of health services is weak (Zuurmond, Geary and Ross, 2012). Systematic reviews show that although a youth centred-approach is popular in some developing countries, effectiveness with regards to increasing young people's use of SRH still remains low (Speizer, Magnani and Colvin, 2003). Young people using recreational activities and youth centres are often older (Erulkar, Mekbib, Simic and Gulema (2006); WHO, (2009); Zuurmond, Geary and Ross, (2012) and Godia et al, 2014). Godia et al, (2014), also noted that evidence linking the presence of recreational services at youth centres and general health facilities to increased access and utilization of ASRH services is insufficient except with regard to non-health related benefits or to act as a "stepping stone" to future career progression.

2.7 Factors that facilitate the utilization of the YFC / services

There are a number of factors that influence the utilization of YFC positively or negatively. The factors that that influence the utilization of YFC positively are known as facilitating factors and they include; awareness, confidentiality, respectful and non-judgemental treatment, well trained service providers, integrated/comprehensive care, easy access to care, free or low cost of services, short waiting time and short distance to service centers (WHO, 2002 ; Senderowitz, Hainsworth and Solter, 2003; Youth Advocates 2008; Agampodi, Agampodi and UKD, 2008; Akiniyi 2012; Motuma 2012 ; WHO 2012; Elissa et al, 2013 and Kiran et al, 2015). Barrier or militating factors are factors that influence the utilization of YFC negatively and this will be discussed subsequently.

The term "youth friendly" may include how/whether a clinic provides: nonrestrictive services based on age (and potentially gender, disability, religion); easily negotiated access; support staff oriented toward adolescents; appealing facilities with convenient hours; adolescent involvement; and comprehensive services (WHO, 2002).

Adolescents, providers and policymakers described a 'friendly' provider as someone who was non-judgmental and kind, who understood adolescents and their rights, who kept

confidentiality, who gave adolescents adequate time, and who was trained in SRH and counseling (Elissa et al, 2013).

In a study conducted by Agampodi, Agampodi and UKD, (2008), on Adolescents' perception of reproductive health care services in Sri Lanka, it revealed that awareness and knowledge on existing services was very poor. The adolescents were of the view that improving awareness on RH among their age group would be a main strategy in increasing service utilization by them. Previous researches such as; Erulkar et al, (2005); Motuma, (2012) and Elissa et al, (2013), in their studies also noted that many young people in need of RH services did not know where to obtain such services.

Kiran, Fariha, Rajenda, Sophia, Asiful, Rajshree and Ismat, (2015), conducted a study on the Perceived Sexual and Reproductive Health needs and service utilization among higher secondary school students aged 15 to 19 years in urban Nepal found out in their study that awareness about adolescent friendly services and Adolescent Sexual and Reproductive H Healt(ASRH) knowledge were found to facilitate service utilization.

According to the study conducted by Elissa et al, 2013, adolescents were of the view that there is need for more awareness to be provided in communities and schools to increase knowledge about SRH and available services. Many reported that it was easier for adolescents who were well informed to make the decision to seek care (Elissa 2013). They suggested that peer educators and nurses visiting schools and communities, teachers, and a range of media (including comics, pamphlets, posters and radio) could be used to increase awareness (Elissa 2013). Service providers and policymakers agreed that adolescents needed to be better informed about SRH and services (Elissa 2013).

Confidentiality means that the provider keeps an adolescent's sensitive health care issues in strict confidence between the adolescent/young person and the provider. It is important to guard the adolescent's confidentiality and this extends, as well, to every member of the clinic's staff, including receptionists and technicians (Youth Advocates, 2008).

According to Kiran et al, 2015, whose study was to determine the needs and utilization of available adolescent sexual and reproductive health services by adolescents aged 15-19 years found out that the overwhelming majority of adolescents were not utilizing SRH

services, even after initiation of an adolescent-friendly health service program in their district (Kiran et al, 2015). A majority of the participants (71%) reported that lack of confidential services was a significant barrier to utilization of SRH services. Similarly, 30% believed available services were inadequate to meet their SRH needs (Kiran et al, 2015. Among the 9.2% of the participants who had utilized services, the perceived barrier could relate an unsatisfactory quality in their experience of ASRH services and this is a concern for service continuity and expansion of care to more adolescents (Kiran et al, 2015).

Studies shows that teens have generally been unsure that their confidentiality will be guarded, even when it is guaranteed by law (Youth Advocates, 2008). A study conducted by Ford, Thomsen and Compton, (2001), among 53 adolescents to improve physicians' discussions of confidentiality policies with adolescent patients found that adolescents knew far less about the protections than the limits of confidentiality. In fact, clinicians' explanations of the exceptions under which they would break confidentiality made adolescents wary of their assurances of confidentiality.

Adolescents usually trusted their doctor to maintain their confidentiality. However, many youths feel worried that receptionists, technicians, and nurse assistants might be careless with their medical records and, thus, their confidentiality (Michels 2000 and Lane, McCright, Garrett, Millstein, Bolan and Ellen, 1999). In a study conducted on the features of sexually transmitted diseases services important to African American Adolescents in San Francisco revealed study, 88 percent of teens thought it was extremely important that clinic staff kept their business private from the teens' acquaintances. Far fewer, but still a majority, (60 percent) thought it was extremely important that clinic staff kept their business private from parents and family. In fact some adolescents, especially young men, worried that faculty, staff, and other students might learn about it if they sought STI testing and treatment at a school-based health center (Lane, et al, 1999).

According to the study conducted by Elissa et al, (2013), the most important feature of a youth-friendly health service defined by adolescents was a friendly service provider. Pregnant and parenting teens have many fears and worries. They are often scared about: being examined; the pain of delivery; having a secure place to live with the baby; being a good parent; and finishing school, among other things. They need reassurance and

emotional support from clinicians and staff (Youth Advocates, 2008 and Ekefre, 2014). Gay, lesbian, and bisexual youths can be upset by heterosexist assumptions on the part of the clinicians or staff (Ginsburg, Wian, Rudy, Crawford, Zhao and Schwarz, (2002) ; Godia et al, (2014) and Tanner, Philbin, Duval, Ellen, Kapogiannis, Fortenberry, (2014).

HIV-positive youth struggle with all the developmental issues of adolescence and may be overwhelmed, when first diagnosed, with fears about the future, dying, maintaining relationships, establishing intimacy, being abandoned by family and friends, and being stigmatized (Martinez, Bell, Dodds, Shaw, Siciliano, Walker and Southern, (2003) and Tanner, Philbin, Duval, Ellen, Kapogiannis, Fortenberry, (2014). Taking a lot of medications is often difficult for youths who are balancing the normal developmental tasks of adolescence with social life and peer relationships. So being patient, positive, and non-judgmental is particularly important to assuring HIV-positive youths continue with the health care they need (Martinez et al. 2003 and Tanner et al, 2014).

Ethnic minority youth are justly sensitive to discourtesy. Some studies have found out that providers may (intentionally or unintentionally) act differently according to the client's ethnicity. These providers may base their actions on stereotyped beliefs about youth's fundamental values, competence, and deservedness. Clinicians must question their own assumptions regarding youth of an ethnicity different to their own because there is substantial evidence that providers' beliefs, expectations, diagnoses, and treatment are influenced by the race/ethnicity of clients (Michelle and Steven (2003) and Jorgen and Sawitri, (2014)). Youth who are survivors of sexual or physical assault are particularly vulnerable to any disrespect because of the traumatic event(s) they have endured. Respectful treatment is imperative at this time in the life of the adolescent or young adult survivor (Youth Advocates, 2008).

Providers and policymakers agreed that providers need training to work with adolescents (Elissa et al, 2013). Most noted the lack of adolescent SRH education included in pre-service training curricula and limited opportunities to attend in-service training. Specific training needs included updating SRH knowledge, confidentiality, sexual and reproductive rights of adolescents, and communication and counselling skills (Elissa et al, 2013). Many key informants believed that these competencies should be included in basic pre-service

imining of all providers. Positive impacts were reported by those who had attended training (Elissa et al, 2013).

Working to create 'youth friendly' clinics through changes in physical environment such as; space, entertainment, and educational materials and also in social which includes; staff training related to development, gender, sexual orientation may help reduce HIV-infected adolescents' unique barriers to care engagement, thus, helpful in meeting the specialized needs of HIV-infected youths (Tanner et al, 2014).

Ginsburg, Winn, Rudy, Crawford, Zhao and Schwarz, (2002), also recommends that clinicians and service providers avoid assuming that all youths are heterosexuals. Clinicians and service providers need to be trainned regarding sexual orientation so that they know to avoid: saying that an adolescent who has acknowledged being gay, lesbian, or bisexual is just going through a phase, confusing sexual orientation with sexual behaviors. Adolescent's sexual orientation should not be associated with risk or safety regarding STIs or pregnancy, domestic violence, or any other issue that youths may face (Ginsburg, Winn, Rudy, Crawford, Zhao and Schwarz, (2002) ; Godia et al, (2014) and Tanner, Philbin, Duval, Ellen, Kapogiannis, Fortenberry, (2014).

Integrated / Comprehensive care allows youth to obtain different services in a single location. Often known as 'one-stop shopping', integrated care is important to young men and women (Youth Advocates, 2008). Ideally, integrated services offer a multidisciplinary, holistic approach, including primary care, reproductive and sexual health care, STI/HIV testing and treatment, substance abuse treatment, mental health care, and education and counseling (Youth Advocates, 2008).

According to some researches, youths have often felt anxious to receive services in a setting that would not stigmatize them. Integrated service settings, such as school-based health centers, college and community health centers, and adolescent clinics, was a good place for these youth because just coming in did not expose what services they were seeking. This was a particular concern to young men and to youths in need of mental health (Davies, McCrae, Frank, Dochnahl, Pickering, 2002; Kodjo and Auinger, 2004 and Juszczak, Melinkovich, Kaplan, 2003). Adolescents in the studies conducted by Agampodi et al, (2008) and Kiran et al, (2015) also documented similar concerns of adolescents

seeking to access reproductive health services without being stigmatized by friends, relatives and service providers.

Many urban minority youth utilized school-based health centers for medical and mental health care (Jennings, Pearson and Harris 2002). In fact, research showed that school-based health centers see the largest proportion of adolescent males, far more than any other adolescent specific site (Juszczak et al, 2003).

A study conducted by Rogers, Herb, Lappin and Colbert (2000), revealed that young men have often gone without needed health care. In fact, male college students have frequently presented to student health services for evaluation of acute conditions with alarming and long-neglected precursors. The greatest barriers to male college students' seeking care have been their need to be independent and a need to conceal their vulnerability (Davies et al, 2000). Integrated services allow young men to seek care for sensitive issues without their peers' becoming aware of the specific service they sought (Youth Advocates, 2008).

Integrated care is important also to sexual assault survivors because they need immediate prophylaxis for STIs. Women of reproductive age need immediate prophylaxis to prevent pregnancy. Centre for disease control recommends a variety of antibiotics for preventive therapy against gonorrhea, chlamydia, trichomoniasis, and bacterial vaginosis. Centre for disease control also recommends emergency contraception for sexual assault survivors at risk of pregnancy. Youth need clear, gentle explanations of why the medications are important. And they need to be treated gently and respectfully during the examination (Rovi and Shimoni, 2002 and Bell, Martinez, Botwinick, Shaw, Walker, Dodds, Johnson, Friedman, Southeran and Siciliano, 2003).

For years, sexually active adolescent and young adult females aged 15 through 24 years have had the highest rates of chlamydia and gonorrhea of any age group in the United States. Yet, data have shown that only about 22 percent of female health plan members ages 16 to 20 received annual screening for chlamydia. Data also showed that only five percent of all U.S. women under age 25 and only four percent of all 15 to 19 year old women have been screened for STIs (Huppert and Hilliard, 2003).

Studies from Advocates for Youths, (2008), Agampodi (2008) and Elissa et al, (2013) revealed that adolescents felt that their service provider/clinician did not care about them

when he/she rushed through appointments, giving them no time to ask questions and get answers. Adolescent girls in particular described the need to have a provider of the same sex, and some boys also had a preference for seeing a male nurse. Providers and policymakers identified that staff shortages, particularly in rural areas, made this challenging. Having a reliable commodity supply was the second most important feature identified by adolescents, and the most important feature identified by rural groups (Elissa et al, 2013).

Some adolescents reported that having a separate youth clinic would improve access to services by overcoming concerns about privacy at mainstream health facilities (Elissa et al 2013). However, many reported that other features were more important and that a lack of privacy could be overcome by providing separate entrances and waiting areas for adolescents (where youth-oriented activities and resources could be provided) or having separate youth-only clinic hours (Elissa et al 2013). Many providers and policymakers believed that standalone youth clinics were the ideal, but noted that a lack of financial and human resources meant that this was not feasible in all communities (Elissa et al 2013). Some agreed that there was scope to make existing services more accessible (Erulkar et al, 2005 and Elissa et al, 2013).

Easy access to health services is important to youths. Access issues may include: lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up (Youth Advocates, 2008 and Kiran et al, 2015). Access issues can also be related to culture and language. Although access issues can be important to adults as well, they pose especially significant barriers to youth's ability to get the health care services they need (Youth Advocates, 2008).

Elissa et al, (2013) in their study revealed that the costs of services, commodities and transport were barriers for many adolescents due to high unemployment and little access to household resources. Some reported that they would be too embarrassed to ask their parents for money to attend SRH services. Almost all groups said that having to pay for SRH services and commodities would prevent them from seeking care, although some adolescents reported that if it was important they would find the money (Elissa et al, 2013).

According to Mc Cann and Lubman, (2012), inspite of the emergence of mental health problems during adolescence and early adulthood, many young people encounter difficulties accessing appropriate services. Mc Cann and Lubman found out in their study that young people have contrasting experiences accessing the service. School counsellors have an influential role in facilitating access, and its close proximity to public transport enhances access Mc Cann and Lubman, 2012).

According to Kiran et al, (2015), half of the students said they preferred ASRH services on Fridays or Saturdays (off hours), in a setting with other health services. Ability to access services also heavily influenced utilization (Kiran et al, 2015). Kiran et al, 2015, also revealed in their study that the closer services are to where adolescents lived, the greater the utilization of such services. The service needs to become more prominent in young people's consciousness, while the appointment system would benefit from providing more timely appointments with therapists (Mc Cann and Lubman, 2012).

According to a study conducted by Elissa et al, (2013), free services and commodities was the most important feature ranked by adolescent girls, and the fourth most important for boys. Almost all groups agreed that services and commodities (including condoms and contraceptives) should be free for adolescents since they were important for health and wellbeing and many would not be able to afford the fees (Elisso et al, (2013).However, some adolescents explained that some financial contribution was important, particularly for commodities, either because it would encourage them to value the service or in recognition of the limited resources of clinics (Elisso et al, 2013).

Youth Advocates, (2008) advises that to the extent possible, ensure continuity of care by making every effort to have adolescents see the same counselor and/or clinicians at every appointment. Morealso, that the breadth of the facility/clinic's services should be widely advertised. Young people should be aware that the clinic offers primary care and general and recreational services as well as care for more sensitive issues like reproductive and sexual health, STIs, substance abuse, and/or mental health. they can come in for care related to a sensitive issue without worrying that others will know why they are in the clinic (Youth Advocates, 2008). Adolescents often have difficulty negotiating complex medical systems, service providers should make referral appointments for them and ensure that they know exactly where and when to go. Young people should be given clear

directions, assurances of continuing confidentiality, and information about fees, if any. Knowledge can help lessen their anxiety so they will be more likely to keep the referral appointment (Youth Advocates, 2008).

2.8 Militating / Barrier factors of utilization of the YFC

Globally, existing barriers to access and utilization include poor access, availability and acceptability of the services (WHO, 2004). Lack of clear directions, lack of knowledge of services offered, crowding, lack of privacy, lack of skilled service providers, appointment times that do not accommodate young people's work and school schedules, little or no accommodation for walk-in patients, and limited services and contraceptive supplies and options calling for referral are also impediments (WHO, 2004 ; Akuuyi 2012 ; Motuma 2012 ; Eliase et al, 2013 and Kiran et al, 2015). Senderowitz et al (2003) in a study on rapid assessment of Reproductive Health Services reported that significant barriers posed by the current state of most RH services are perceived unwelcoming to the youth.

In a study conducted by Motuma (2012), on the youth friendly health services utilization and factors that affect YFS in Harar among 845 youths of ages 15 to 24 years, it was indicated that barriers to using YFS among youths were; lack of knowledge of where to go for YFS (43.0%), long distance to facility (18.7%), currently feeling healthy (15.1%), poor quality of services (7.9%) inconvenient location (3.3%) and unaffordability of services (0.2%).

A study in Cambodia showed that the barriers to youth access to reproductive health services included lack of confidentiality, shyness, poor relations with health staff, illiteracy and low prioritization by parents for reproductive health services (Adra, 2007). Pathfinder (2001) in a study to evaluate youth friendly services (YFS) in Shanghai found that although there was good infrastructure, equipment, staff and good environment at the city, district, and school level, few youths used YFS due to insufficient publicity, insufficient full time and skilled professional health service providers, poor services and a weak referral system.

Most African countries as a follow up to ICPD (1994) have put up youth friendly health services with the combined partnership between The United Nations Population Fund (UNFPA), Pathfinder International through The African Youth Alliance (AYA) program in

Botswana, Uganda, Tanzania and Ghana (Sonderowitz, 2003) but despite these efforts, most countries in sub-Saharan Africa, youth still encounter significant obstacles to receiving sexual and reproductive health services to obtaining effective, modern contraception and condoms to protect against sexually transmitted infections (STIs), including HIV. In South Africa activities geared towards the youth are being implemented but are still limited (Erulker, et al 2001).

A study conducted in Zimbabwe on factors affecting Africans reproductive health found that 12% of the youth did not visit RH because the distance was too great, 11% were too busy while 11% were shy (Anable, Cabari and Alfard , 2005). Godia (2010) concluded that utilization of youth friendly sexual and reproductive services in Kenya still face multiple challenges which includes; community negative perception youth sexuality and reproductive health services to the youth and health facility perspective where there is no ownership of the services, limited management support and poor funding as well as poor staff attitude.

In Nigeria, a study conducted by One World UK to assess facilities providing Youth-Friendly Services(YFS) found out that gaps existed in provision of YFS and that few facilities qualified to be called youth friendly as they did not meet universally acceptable standards for youth friendly services and such were run by Non Governmental Organizations (NGOs) and the Universities. There was inadequate staffing, lack of clear policies and guidelines on YFS provision and inadequate Information Education Communicatioo (IEC) materials (Osanyin, 2011).

According to USAID, (2010), one of the principal barriers to providing adequate, comprehensive sexual and reproductive health services to young persons is the lack of trained and skilled personnel. There is no recognized career path or credentialing in ASRH for health professionals. An assessment by USAID, also revealed that most Community Based Organizations (CBO's) are not utilizing or are unaware of a recognized health education curriculum. Opportunities for in service training for service providers are few and costly and the term "best practices" was not widely recognized by the interviewee's (USAID, 2010).

Several studies found that poor communication with providers kept adolescents from seeking or continuing the care they needed. Many clinicians' discomfort with and lack of

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Several studies found that poor communication with providers kept adolescents from seeking or continuing the care they needed. Many clinicians' discomfort with and lack of

training to address sexual health and other sensitive issues resulted in lost opportunities to discuss these issues openly and honestly with adolescents and, thus, in lost opportunities for testing and treatment as well, as indicated by Dodds, Blakley, Lizzotte, Friedman, Shaw, (2003) ; Merzel, Vandevasnter, Middlestadt, Bleakley, Ledsky and Messen, (2004) ; Becker, Koenig, Kim, Cardona and Sonenstein, (2007) and Elissa et al, (2013).

A study on the attitudinal and contextual factors associated with discussion of sexual health issues during adolescent health visits found that if the provider did not bring up a sensitive health topic, the adolescent would not bring it up either. Only three percent of adolescents raised the topics of sexual behavior, STIs, and/or contraception on their own (Merzel et al, 2004).

According to Youth Advocates, (2008) and Akiniyi (2012), fear about costs is a major barrier to health care for youths. Poor and uninsured adolescents worry a lot about whether they can afford the care they need. Youth who have health insurance often worry about confidentiality, for example, about information forms going to their parents. So, whether youth have insurance or not, cost can be a major factor in whether they even attempt to get medical care. Pathfinder International, (2012) also revealed that stigma, service costs, and provider bias pose formidable barriers to Ethiopian young people's ability to access sexual and reproductive health (SRH) services.

According to Godia et al, 2014, young people's expressed two main concerns with regard to youth centres; lack of full-time clinical staff and they also questioned the added value of having games at youth centres. Young people were concerned that lack of a full-time clinician resulted in missed opportunities (Godia et al, 2014).

A study done by Rebecca et al, (2015) on the evaluating youth-friendly health services: young people's perspectives from a simulated client study in urban South Africa revealed that judgmental attitudes were often linked to healthcare workers not providing certain information. However, judgmental attitudes were more commonly exhibited towards female than male simulated clients. Other barriers included: information was not given, privacy was lacking and simulated clients experienced unnecessary barriers or negative opinions about seeking information (Agampodi, 2008 and Rebecca et al, 2015).

According to Elissa et al, (2013) who conducted a study on adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu found out that many adolescents and providers described adolescents' fear of others finding out they had attended SRH services. In particular they were afraid of their parents, of being teased or talked about by friends, and being the victim of community 'gossip'. Some were also concerned that their partner would think that they had an STI or had been unfaithful if they knew they had attended SRH services. The lack of privacy at hospitals and government clinics was emphasised, resulting in fear of being seen by friends, relatives or community members (Elissa et al, 2013).

A study conducted by Reddy, Fleming and Swain (2002) in Wiscoosin, on the Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services found that 86 percent of adolescent female family planning clients would be willing to use all the confidential sexual health services offered at local clinics. At the same time, 83 percent would stop using some or all sexual health services if their parents were to be notified. Some 57 percent would stop using prescription contraceptives and begin using condoms instead. Twenty-nine percent would have unprotected sex. About six percent would delay testing or treatment for HIV and other STIs. Only one percent would stop having sex (Reddy, Fleming and Swain, 2002).

A nationally representative study of foregone health care in adolescents found that 14 percent of youth did not get the care they needed out of concerns about confidentiality. These youth were at increased risk for real health problems because those who failed to get needed health care often also participated in health risking behaviors (Ford, Bearman, Moody, 1999 and Wilson, Klein, 2002). Studies elsewhere also found that teens who had no opportunity to talk alone with their provider without their parents present were unlikely to bring up sensitive concerns or to admit to risk-taking behaviors (Martinez et al, 2003).

According to Agampodi, Agampodi and UKD, (2008) who conducted a study on Adolescents perception of reproductive health care services in Sri Lanka, they found out that both boys and girls recognized lack of self-confidence and shyness as barriers in seeking help. Some of the adolescents explained that it was the main barrier for them to seek the services. Among girls, lack of confidence was accentuated due to the inadequate privacy and confidentiality given by health care providers, teachers and parents for these

issues. Both boys and girls mentioned that they needed special clinics in evenings or weekends. Most of them refused to come for services daytime (even for a separate session) when maternal and child clinics were conducted. The boys explained that they needed separate sessions without girls and they liked to have services on a different day (Agampodi, Agampodi and UKD, 2008 and Kiran et al. 2015). However, among boys, the impression of parents and teachers was not a problem but the major concern was about marginalization from their peer groups (Agampodi, Agampodi and UKD, 2008).

Sometimes, well-meaning adults feel a need to express disapproval of adolescents' behaviors, even though such expression is entirely inappropriate in a health care setting (Elissa, 2013 and National Society for the Prevention of Cruelty to Children, 2015). Any youth who has come in for health care deserves respectful treatment. As one adolescent said about rude comments (Michels, 2000). A qualitative study among pregnant and parenting teens found that they had a keen awareness of when they were being respected, listened to, and taken seriously. Some of these teens told about times when they were treated rudely by clinicians who dismissed their concerns, said highly inappropriate things, and/or failed to answer their questions (Michels, 2002).

Some studies reported "being afraid of what the doctor would say" as a barrier to care for adolescents. At least some of this fear was of being scolded, put down, or demeaned. In fact, studies showed that fear of being embarrassed was a major deterrent to adolescents' seeking important health care, including testing for STIs (Huppert and Hillard, 2003 ; Centers for Disease Control and Prevention (2007) and Antti and Pallari, 2015)

Providers have often felt uncomfortable discussing sexual health with adolescents (Huppert and Hillard, 2003). Yet, studies have shown that youth want to discuss sexual health, STI prevention and testing, and/or birth control with their clinician. (Huppert and Hillard, 2003, Klein and Wilson, 2002). However in one study, only three percent of teens brought up a sensitive subject on their own if the provider did not do so (Merrel et al, 2004).

One study found that staff's judgmental attitudes about HIV-infected young women's not adhering closely to their treatment regimen created a significant barrier to the teens' continuing treatment (Dodds, et al, 2003). Whereas youth in their early teens often preferred to have their parents present during a physical examination, high school youth

were much more likely to prefer their parents' absence. In particular, teens with high stress or who used alcohol, tobacco, or other drugs usually preferred being examined alone. Young women who had been physically or sexually abused, were sexually active, or were seriously depressed were most likely to prefer being examined without a parent present (Kapphahn, Wilson and Klein, 1999 and Centres for Disease Control and Prevention, 2014).

In a study conducted by Fiddes, Scott, Fletcher and Glasier, (2003), on attitudes towards pelvic examination and chaperones: a questionnaire survey of patients and providers, 43 percent of women aged 25 and under said that they would be by the presence of a chaperone during n pelvic examination. Most did not want a chaperone present during examination by a female doctor. However, most did want a chaperone present during examination by a male doctor (Fiddes, Scott, Fletcher and Glasier, 2003). For gay, lesbian, and bisexual youth, barriers to care included the fear that disclosing their sexual orientation would provoke judgment and discrimination from providers and staff (Scherzer, 2000 ; Ginsburg et al, 2002 and Centres for Disease Control and Prevention, 2014).

2.9 Conceptual Framework - The PRECEDE Model

The acronym "PRECEDE" stands for Predisposing, Reinforcing and Enabling causes in Educational Diagnosis and Evaluation. The model was initially developed by Green and Kreuter. It has served as a conceptual framework in Health education planning. The model facilitates the diagnosis of the health problems of a community, understanding the factors that influence people's behavior and developing interventioo to promote healthy behavior (Greco and Kreuter, 1999). The factors which influence people's behavior can be differentiated into three categories namely predisposing, reinforcing and enabling factors. These factors are often called behavioral antecedent factors.

The predisposing factors are the behavioral antecedent factors that make any health related behavior more or (less) likely to occur. They are factors which must be present before a behavioral decision takes place (antecedent). Predisposing factors include knowledge, attitudes, perceptions, beliefs and values. (See Figure 1 for details). For instance, lack or little knowledge of YFC and the services the center provides, as well as beliefs and attitudes about the need for such services can influence positively or negatively the

utilization of YFC. Respondents may justify their non-usage of YFC based on their perceptions or misconception of services provided by the centre or based on perceived negative attitude of service providers.

The enabling factors that make any given health-related behavior more or (less) likely to occur are the factors which are related to resources. These factors include time, availability, accessibility and affordability of money or a tangible innovation. In the YFC enabling factors includes: availability of HCT, counseling services, condoms, internet services, games and reading rooms (See figure 2.1 for details). With respect to availability and accessibility, the YFC is situated within the university campus and operates from 8.00am to 4.00p.m officially and at times till 6.00p.m. The hours of operation are fixed to create time for students to use the centre even after school hours.

The reinforcing factors are those related to the influence of significant orders such as peers. For instance peers may encourage or discourage their friends from accessing the counseling services at the YFC. In addition, sexual partner may not believe in HCT and contraceptive use so may discourage their partner from using such services

The PRECEDE framework was used to facilitate the design of the semi-structured questionnaire used for data collection. For instance, questions 10.11,12.1-12.10, 13.1-13.11 were framed to take into consideration issues relating to Predisposing factors relating to the phenomenon. For other questions the PRECEDE framework was used to frame see Table 2.1.

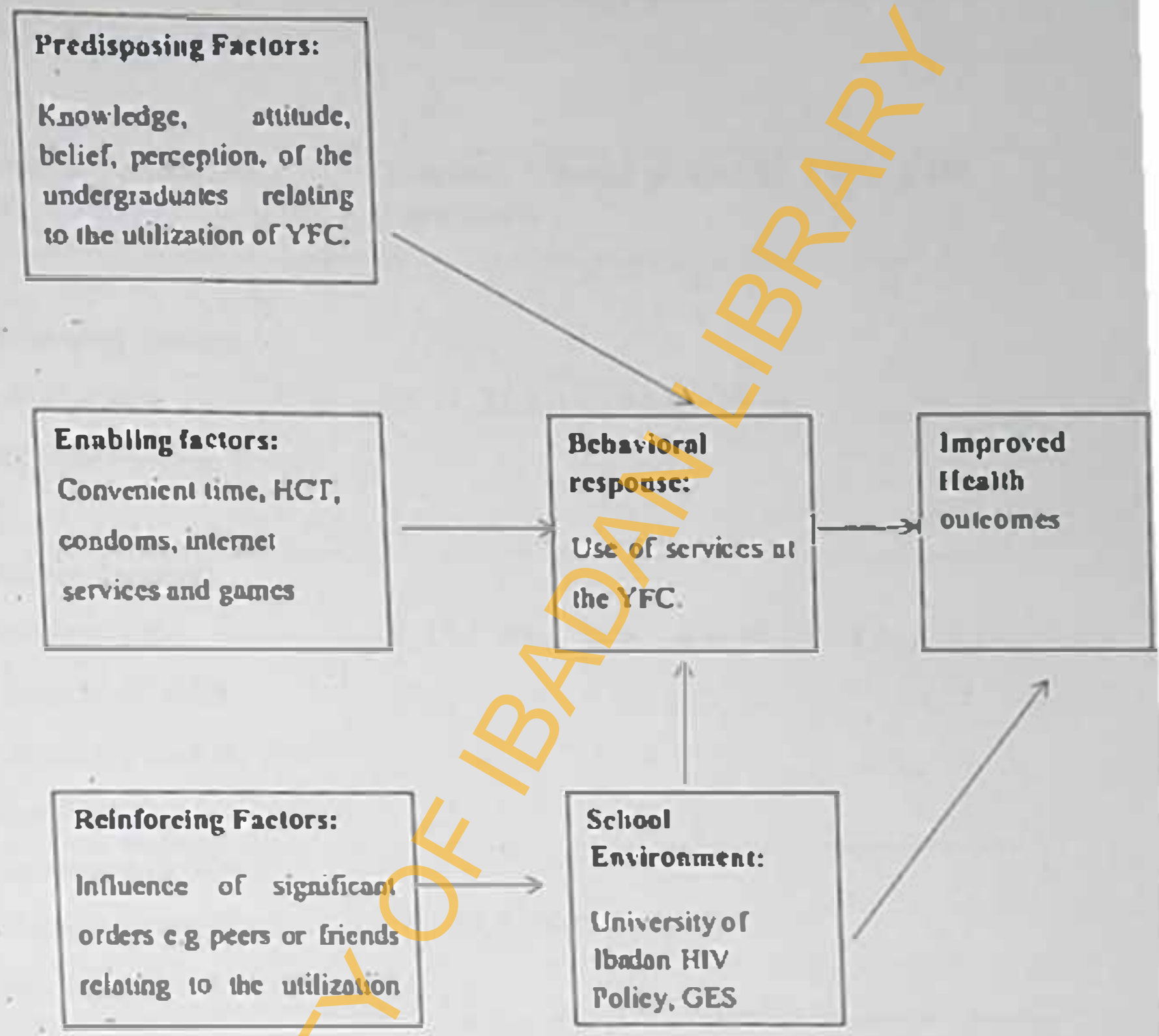

Figure 2.1: Diagrammatic overview of the PRECEDE framework applied to study of the knowledge, perception and pattern of utilization of the YFC among undergraduates of the University of Ibadan

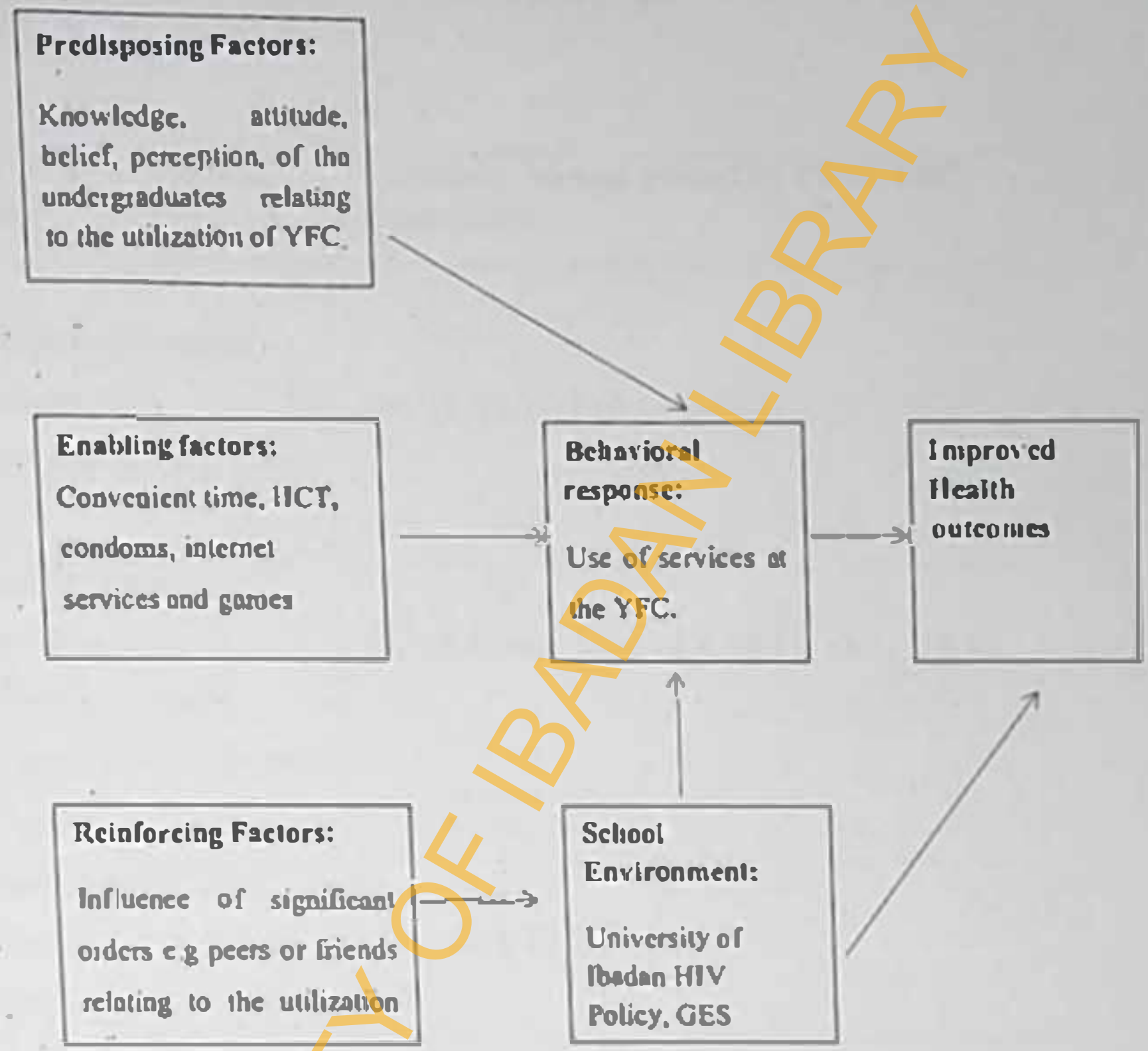

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Table 2.1: Use of the PRECEDE framework is the design of the study instrument (Appendix i)

Behavioral Antecedent factors	Questions framed guided by PRECEDE framework
Predisposing factors : Knowledge and perceptions relating to the YFC.	10, 11, 12.1-12.10,13.1-13.11
Enabling factors : Convenient time, availability of HCT, condoms, internet services and games	6, 18.4, 18.5, 18.6, 18.9, 18.10, 18.11, 18.12, 19
Reinforcing factors : Influence of significant orders e.g peers or friends	9g, 18.9, 20.5, 20.6, 21
Behavioral Responses: Use of services at the YFC	14a, 14b, 15.1-15.13, 17

Questionnaire (see Appendix i) used for data collection.

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CHAPTER THREE

METHODOLOGY

3.1 Study design and scope

This was a cross-sectional study and it is limited in scope to the determination of the knowledge, perception and pattern of utilization of the YFC among undergraduates of the University of Ibadan, Nigeria. The factors that served as determinants of the pattern of utilization were also investigated.

3.2 Description of study setting with special reference to the YFC of the University

This study was carried out at the University of Ibadan located in Ibadan North Local Government Area. The University was initially established on 17th November 1948 as an affiliate College of the University of London. It became a full-fledged University in 1962 (University of Ibadan, 2002).

The institution currently has thirteen Faculties with a population of over 20,000 students. There are 12 halls of residence in the University with ten of the halls of residence reserved for undergraduates. Six halls are exclusively reserved for males while three are reserved solely for the females. The Alexander Brown hall based at the University College Hospital (UCH) campus of the University accommodates male and female undergraduates. The post-graduate students are accommodated in Abdusalam Abubakar and Tafawa Balewa Halls. (See table 3.1 for details of the halls with undergraduate students).

The University operates the Faculty system; currently there are thirteen faculties and 67 Departments. The 13 Faculties are Arts, Education, Law, Basic Medical Sciences, Clinical Sciences, Pharmacy, Public Health, Dentistry, Veterinary Medicine, Technology, Agricultural Sciences, Sciences and the Social Sciences.

A variety of social activities take place in the University campus and the facilities that serve as social rendezvous on the main campus include the following: Student Union Building, swimming pool near the Student Union Building, the University Conference centre, "U and I" eatery and the recreation centre and the University guest houses. Most weekends, some female halls constitute beehives of activities for visitors and male students. Some visitors and male students come to interact with the female students and

take them away from the halls to attend a variety of social activities (Ajuwon, 2013). Much of the interaction and social activities could be riskladen such as involvement in risky sexual practices.

The University of Ibadan has rules and regulations that guide students' social and sexual activities on campus. For instance, male students are not allowed to stay beyond 9pm in the female hostel and vice-versa. Visitors are expected to be out of male and female hostels by 10pm. (University of Ibadan, 2006). In spite of these measures, illicit sexual activities are not uncommon and instances of rape have been documented (Ogunwale, Oshiname and Ajuwon, 2012).

The University of Ibadan has a Youth Friendly Center (YFC) that offers reproductive health, recreational, library and internet services to students. The YFC is located behind the zoological garden, along Appleton road on the University campus. The centre has four staff and a good number of registered volunteer workers. The centre provides services such as, HIV Counselling and Testing (HCT), distribution of condoms, general and career counseling and recreational activities (games). The centre is opened to services between 8a.m - 4.00p.m officially, however it often stays open till 6.00p.m when the need arises The other health services provided on campus include those offered by the ; University Health services and Gender mainstreaming programme.

Table 3.1– Categories of residents in the undergraduate halls of residence of the University of Ibadan for 2012/2013 Academic Session.

S/N	Halls of Residence	No. of Rooms	Number of undergraduates		Total
			Females	Males	
1.	Queen Elizabeth II hall	282	934	0 *	934
2.	Queen Idia hall	296	1256	0 *	1256
3.	Obafemi Awolowo hall	405	1039	0 *	1039
4.	Alexander Brown hall	318	214	347	561
5.	Kuti hall	207	0 **	513	513
6.	Sultan Bello Hall	172	0 **	487	487
7.	Mellanby Hall	208	0 **	509	509
8.	Tedder Hall	195	0 **	512	512
9	Nnamdi Azikiwe Hall	253	0 **	948	948
10.	Independence Hall	967	0 **	935	935
	Total		3443	4251	7994

Source: Obtained from records kept by hall Wardens and hall supervisors (2012/2013).

* These are exclusively female halls.

** These are exclusively male halls.

3.3 Study Population

The study population consisted of male and female undergraduate students of different socio demographic characteristics. The study population spreads across the halls of residence of the University of Ibadan that are duly registered and legally accommodated.

3.4 Inclusion and Exclusion criteria

The criteria for a respondent to be eligible to participate in the study included that; the respondent must be a full time registered undergraduate student presently residing in any of the undergraduate halls of residence. This criterion automatically excluded pre-degree diploma students, students of the distant learning programme, undergraduates not residing in the University hall of residence and postgraduate students of the University of Ibadan.

3.5 Sample Size Determination

The sample size (n) was determined using the following Lwanga and Lemeshow (1991) sample size formula:

$$n = \frac{Z^2 p(1-p)}{d^2}$$

Where n=minimum sample size required

Z= confidence level of survey at 95% (1.96)

P= the proportion of young people utilizing youth friendly health facilities which is 36% (Ossyin, 2011)

d=absolute deviation from true value (degree of accuracy) = 4 %

Therefore, $n = \frac{1.96^2 \times 0.36 \times 0.64}{0.04^2}$ =approximately = 553

A non-response or attrition rate of 10% calculated as follow was added to the sample size:

$$= \frac{553 \times 10}{100} = 55.3$$

Therefore total sample size = 553 + 55.3

=608.3

The sample size for the study was 608 approximately.

3.6 Sampling Procedure

A multi-stage sampling procedure was used to select the respondents for this study from the ten undergraduate halls of residence. The sampling procedure involved the following steps. All the undergraduate halls of residence were involved in the study (see table 3.1 for details).

Step 1

The 10 undergraduate halls of residence were stratified by gender/sex into three female halls, six male halls and one mixed hall (Alexander Brown hall with males and females undergraduates). Proportionate sampling procedure was used to select the number of female or male undergraduates that was interviewed from each of the 10 halls of residence. For instance, the proportion of female students to be selected from all the female halls of residence was determined using the following formula:

Total number of students in all the female halls of residence x sample size

Total number of students in all the selected halls (both female and male)

Using the aforementioned formula, the proportion of females selected was as follows:

Females = $\frac{2443 \times 608}{7694} = 272$

Step 2

All the undergraduate halls of residence was considered in the sampling. Proportionate sampling was used to determine the number of students to be selected per hall. The proportion of female students to be selected from each of the female halls of residence was determined using the following formula:

Total number of students in selected hall / Total number of female students in all the female halls × Proportion of female students selected from all female halls

For Queen Elizabeth hall for instance: $\frac{234 \times 272}{3443}$

$= 74$

This same procedure was used to determine the number of students selected from the remaining female halls of residence (See table 3.2 for details).

Step 3

All the blocks in each hall of residence were considered in the sampling. Proportionate sampling was used to determine the number of students to be interviewed per block. The proportion of respondents selected from each block in the female halls of residence was determined using the formula:

Total numbers of students in the selected block / Total number of female students in the selected the hall × Total number of female students selected from the hall

For instance Queen Elizabeth hall, Block A = $\frac{44 \times 74}{934} = 3$

This same procedure was used to determine the number of students selected from each block in the various female halls of residence (See table 3.2 for details).

Step 4

Rooms were selected in each block using table of random numbers.

Step 5: Recruitment of respondents from the selected rooms

An eligible occupant who happened to be the only one in the room at the time of the visit was purposively selected for the interview. In situations where there were two or more eligible occupants in a room, balloting was used to select the respondent that was interviewed. A selected occupant was interviewed in the room while other room mates were pleaded with to leave the room for a while to allow the interview to be conducted in a conducive atmosphere. In a case(s) where the respondent's room was not conducive or the room-mates were not willing to vacate the room, the common room or an alternative conducive venue within the hall which was mutually agreed upon by the interviewer or interviewee was used for the interview. This was done to ensure privacy of respondents and to provide an opportunity for free disclosure of information during the interview.

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Table 3.2 - Distribution of female undergraduate students in halls of residence in University of Ibadan.

S/N	Halls	No. students in each hall (a)	Number of female undergraduate students /block (a)	Proportion of female undergraduates	Proportion of respondents selected from each hall of residence	Proportion of respondents selected from each block in various halls
1.	Queen Elizabeth II hall •	934	Block A - 44 Block B - 70 Block C - 90 Block D - 100 Block E - 108 Block F - 42 Block G - 108 Block H - 108 Block I - 250 GR Block - 14	Female: 1443 × 608 7694 = 272	934 × 272 3443 = 74	44 × 74 934 = 3 5 7 8 9 3 9 9 20 1
2.	Queen Idia hall •	1256	Block A - 439 Block B - 528 Block C - 208 Flat - 81		1256 × 272 3443 =99	35 42 16 6
3.	Obafemi Awolowo hall •	1039	Block B - 84 Block C - 111 Block D - 198 Block E - 159 Block F - 198 Block G - 100 Block H - 189		1039 × 272 3443 =82	7 9 15 12 16 8 15
4.	Alexander Brown hall +	214	Block A - 86 Block B - 46 Block C - 46 Block D - 16 Block F - 20		214 × 272 3443 =17	7 4 4 1 1
	TOTAL	3443		272	272	272

Obtained from records kept by hall wardens and hall supervisors (2012/2013).

• Exclusively for females

+ For males and females

Proportionate sampling for male undergraduates:

The proportion of male students selected from all the male halls of residence was determined using the following formula:

$$\frac{\text{Total number of students in all the male halls of residence}}{\text{Total number of students in all the selected halls (Both female and male)}} \times \text{Sample size}$$

$$\frac{4251 \times 605}{7694} = 336$$

The proportion of respondents selected from each hall of residence was determined using the formula:

$$\frac{\text{Total number of students in the selected hall}}{\text{Total number of male students in all the male halls}} \times \text{Proportion of male students selected from all the male halls}$$

For Kuti hall, for instance $= \frac{513 \times 336}{4251} = 41$

This same procedure was used to determine the number of respondents that were selected from all the other male halls of residence (See table 3.3 for details).

The proportion of respondents selected from each block in the male halls of residence was determined using the formula:

$$\frac{\text{Total number of students in the selected block}}{\text{Total number of male students in the selected the hall}} = \text{Total number of male students selected from the hall}$$

For instance Kuti hall, Block A $= \frac{67 \times 41}{513} = 5$

This same procedure was used to determine the number of respondents selected from each block in each of the various male halls of residence (See table 3.3 for details).

Table 3.3 - Distribution of male undergraduate students in halls of residence in University of Ibadan

S/N	Halls	No. of students in each hall (u)	No. of male undergraduate students / block (α)	Proportion of male undergraduate	Proportion of respondents selected from each hall of residence	Proportion of respondents selected from each blocks in various halls
1.	Kuti hall •	513	Block A - 67 Block B- 216 Block C - 117 Block D- 65 Block E- 48	4251 = 608 7694 = 336	513 × 336 4251 = 41	67 = 41 513 = 5 17 10 5 4
2	Sultan Bello Hall •	487	Block A- 204 Block B - 104 Block C - 54 Block D- 77 Block E - 48		487 × 336 4251 = 38	16 8 4 6 4
3.	Mellanby Hall +	509	Block A- 270 Block B- 32 Block C - 135 Block D- 72		509 × 336 4251 = 40	21 3 11 5
4.	Tedder Hall •	512	Block A- 207 Block B - 117 Block C - 124 Block D- 64		512 × 336 4251 = 41	17 9 10 5
5.	Nnamdi Azikiwe Hall •	948	Block A- 296 Block B- 300 Block C - 296 Block D- 56		948 × 336 4251 = 75	23 24 23 5
6	Independence Hall •	935	Block A- 291 Block B- 289 Block C - 300 Block D- 55		935 × 336 4251 = 74	23 23 24 4
7.	Alexander Brown Hall +	347	Block D- 78 Block E- 120 Block G - 149		347 × 336 4251 = 27	6 9 12
	TOTAL	4251		336	336	336

Obtained from records kept by hall wardens and hall supervisors (2012/2013)

+ For males and females

• Exclusively for males

The processes adopted for selecting rooms and respondents for interview in the female halls was also used in the male halls of residence.

3.7 Methods and Instruments for Data Collection

The instrument for data collection was a validated, a semi-structured, self-administered questionnaire. The design of the questionnaire was facilitated by review of literature relating to YFC. The designed questionnaire is organized into seven sections labeled A-G: Questions in Section A were used to assess respondents' socio-demographic characteristics. Information on respondents' level of awareness and knowledge relating to the services provided at the YFC was documented using questions in Section B. Questions in Section C were used to determine the perceptions relating to the services provided at the YFC. The utilization of the YFC was assessed using questions in Section D. Questions in Section E were used to determine the reported factors which facilitate the utilization of YFC while those in Section F were used to determine the reported factors that militate against the utilization of YFC.

3.8 Validity, Pre-testing and Reliability of the Instruments.

Validity

Validity describes the ability of an instrument to measure what it is expected to measure (Olayinka, Taiwo, Oyelade and Farai, 2006). The inputs of my supervisor, other lecturers in the Department of Health Promotion and Education and experts in Adolescent and Youth Health were consulted and their inputs were used to enhance the face validity of the instrument.

Pre-testing

The instrument was pre-tested among undergraduates at the Obafemi Awolowo University, Ile – Ife, Osun state. The institution has a Youth Friendly Centre that was founded in 2005. The institution shares similar characteristics with the University of Ibadan. In addition to being located in the same geopolitical zone, both institutions are among the first generation institutions of higher learning in Nigeria. The questionnaires were administered to 61 undergraduate students from different halls of residence in O.A.U., Ife. This figure represents 10% of the calculated sample size for the main study.

The pre-tested copies of the questionnaires were cleaned, coded, facilitated by the use of a coding guide, and entered into the computer. The pretest exercise was used to screen for potential problems in the instrument including and to detect errors and ambiguities and

appropriate measures were taken to rectify them before it was used for data collection during the main study.

Reliability

The Cronbach's Alpha model technique of the SPSS was used to determine the reliability co-efficient of the questionnaire using the data collected during the pretest. In the approach a correlation coefficient of 0.5 and above was used to regard the instrument as reliable. In this study a reliability coefficient of 0.98 was obtained indicating that it was reliable.

3.9 Recruitment and Training of Research Assistants

Four Research Assistants (RAs) were recruited and trained for two days to help in accurate data collection. The training focused on the objectives and importance of the study, sampling process, administration of the study instrument to respondents, ethical consideration, basic interviewing skills and how to review the questionnaire to ensure proper completeness of copies of the questionnaires.

The recruitment of the RA was gender sensitive. Two male RAs were used to administer the study instrument in the male halls of residence while two female RAs administered the study instrument in the female hall of residence. The RAs were involved in the pretest of the study instrument which took place at the Obafemi Awolowo University, Ile-Ife. This was done in order to ensure that they have adequate knowledge and understanding of the provisions of the instruments prior to the commencement of the data collection; the pre-test was thus an experiential learning opportunity for them.

3.10 Data Collection Process

The copies of the questionnaire were administered with the help of four trained RAs. The copies of questionnaire were administered to participants after a written informed consent has been obtained from the participants. Each selected room was visited and the occupants were greeted and the purpose of the visit (research), duration of the interview and the benefits of the research were explained to the participants. The copies of the questionnaires were self- administered since the respondents could read and write in English language. The interviews were conducted in the evenings between the hours of 4.00 and 8.00p.m for about ten days. This period was chosen because a previous research found 4-8p.m, to be

the period that is best for cooducting studies focusing on accommodated students of the uruversity of Ibadan (Ogunwale etal, 2012).

A total of 608 copies of the questionnaire were administered to the respondents. In each block in a hall, rooms were randomly selected using tables of random numbers. Where there were more than one occupant in a visited room, one of the occupants was selected by balloting. If the selected person declines, the balloting process was repeated to select another respondent. If all the occupants in any selected room declined to participate in the interview, another room was re-selected randomly in place of the formerly selected room. The respondents not selected were requested to excuse the respondent and the interviewer before commencing the interview. In a situation where the other occupants refused to excuse the respondent and the interviewer, the respondent was requested to partake in the interview in the common room or any other convenient alternative venue which could guarantee confidentiality and without other persons adding their inputs.

The interviewer remained with the respondent during the completion of the questionnaire to clarify any issue(s) that might not be easily understood by the respondent. A questionnaire was collected as soon as a respondent was through with it. The completed questionnaire was checked for completeness before it was kept in a bag. Attention of respondents was drawn to cases of omissions or incomplete responses in the questionnaire. This procedure was used to facilitate data collection in both male and female halls of residence.

3.11 Data Management, Analysis and Presentation.

The copies of the questionnaires were collated and edited by the researcher with the help of the research assistants. Copies of the questionnaire were re-checked for completeness and a serial number was assigned to each for easy identification and recall. The responses in each copy of the questionnaire were hand coded, facilitated by the use of a coding guide developed by the researcher after a careful review of the responses in all the copies of the questionnaire.

After the entire copies of the questionnaire had been hand coded, a template was designed on the SPSS for entering of the coded data. Responses were entered into the computer using the SPSS software version 16. The data were analyzed using descriptive statistics, Chi-square, T-test, F-test (or ANOVA) and logistics regression. A p-value less than 0.05

was considered statistically significant. The results are presented using tables and charts in chapter four of this dissertation.

3.12 Ethical Considerations

The ethical principles guiding the use of human participants in research were taken into consideration in the design and conduct of the study. Ethical approval was obtained from the joint University of Ibadan/University College Hospital Ethics Review Committee (see Appendix ii). In addition, permission was sought from the Students' Affairs Division of the University of Ibadan. A letter of introduction from the Department of Health Promotion and Education (see Appendix iii) and evidence of ethical approval were tendered to the authorities of the various halls to facilitate permission to conduct the study.

In addition, permission was obtained from hall Wardens, hall supervisors and student hall executives of the various undergraduate's halls of residence to use the common rooms. A written informed consent was developed and used during data collection. It contained relevant information about the focus of the study, objectives of the study, study methodology, inconveniences that might be experienced and the potential benefits of the study to the society (see Appendix iv). Participation in the study was voluntary and there were no identifiers such as name or matriculation number of participants. Participants were assured that all information provided would be kept confidential.

3.13 Limitations of the study

The strike embarked upon by University based unions affected the data collection as students who had just resumed after the strike did not want to give much attention to an interviewer as a result of piled up workloads. This was however handled by being patient with them and administering questionnaires to respondents at their convenient time.

Another limitation was that some students were reluctant in divulging information on their visits to the YFC to receive reproductive health related services. Sexual and other reproductive health issues such as unwanted pregnancies, contraceptive uptake, STIs including HIV Counseling and Testing (HCT) were perceived to be sensitive issues which one should not divulge anyhow. These limitations were reduced by assuring respondents of confidentiality of all information provided by them. Research participants were informed that the data collected would be used for research purpose only. The study was done among

accommodated students only. The implication is that the generalizability of the results will be limited to accommodated undergraduates.

CHAPTER FOUR

RESULTS

4.1 Respondents' Socio-demographic characteristics

The results presented here describes the basic socio-demographic characteristics of the respondents. The 608 respondents comprised 55.3% male and 44.7 % female undergraduates residing in all the undergraduate halls of residence of the University. The ages of the respondents ranged from 17-33 years with a mean of 21.38 ± 2.5 and median age of 21.0 years. The highest proportion of respondents consisted of young persons aged 20-24years (65.6%), followed by those who were adolescents (23.2%); majority (86.2%) of the respondents were Christians (see Table 4.1).

The levels of study of the respondents are highlighted in Table 4.1b. Overall, more respondents (32.1%) were in 400 level and the lowest group of respondents (2.5%) was at the 600 level. The highest proportion of males (16.9%) were in 300L while the highest proportion of females (19.2 5) was at 400L (See table for more details). Respondents were selected across the 10 undergraduate halls of residence with the highest proportion (16.1%) being from Queen Idia Hall and the lowest (5.3%) was from Mellanby Hall (Table 4.1c). The respondent's Faculties are presented in Table 4.1d. Respondents from the Faculty of science topped the list (15.6%), followed by those in the Faculties of Arts (13.7%), Social sciences (12.5%) and technology (12.5%) (See table for details).

Table 4.1a: Respondents' socio-demographic information.

N = 608

Demographic Information	Frequency By Gender		
	Males (%)	Females (%)	Total (%)
Gender/ Sex			
	336 (55.3)	272 (44.7)	608 (100)
Age in years :			
17 – 19*	71 (11.7)	70 (11.5)	141 (23.2)
20 – 24**	221 (36.3)	178 (29.3)	399 (65.6)
≥ 25***	44 (7.2)	24 (3.9)	68 (11.2)
Religious Affiliation:			
Christianity	279(45.9)	245(40.3)	524(86.2)
Islam	47 (7.7)	29 (4.8)	76 (12.5)
Traditional or African religion	8 (1.3)	0 (0.0)	8 (1.3)

Mean age of respondents = 21.4 ± 2.5

Key:

*Respondents who were adolescents

**Young persons but not adolescents

***Respondents who were adults aged 25-30 years

The concept of adolescents, young persons and adults were based on WHO's definition (WHO, 1989)

Table 4.1b: Respondents' level of study by gender

N = 608

Gender	Frequency by levels of study				
	200 L (%)	300 L (%)	400 L (%)	500 L (%)	600 L (%)
Male	98 (15.8)	102 (16.9)	76 (12.8)	49 (7.9)	11 (1.8)
Female	66 (11.2)	46 (7.4)	119 (19.2)	37 (6.2)	4 (0.7)
Total	164 (27.0)	148 (24.3)	195 (32.1)	86 (14.1)	15 (2.5)

Note: L = Level

Table 4.1c: Respondents' Halls of Residence

N = 608

Halls	Males (%)	Females (%)	Total (%)
Obafemi Awolowo•	0 (0.0)	85 (14.0)	85 (14.0)
Queen Elizabeth •	0 (0.0)	71 (11.7)	71 (11.7)
Alexander Brown•••	26 (4.3)	18 (3.0)	44 (7.2)
Independence Hall••	81 (13.3)	0 (0.0)	81 (13.3)
Nnamdi Azikiwe Hall ••	77 (12.7)	0 (0.0)	77 (12.7)
Queen Idia Hall•	0 (0.0)	98 (16.1)	98 (16.1)
Mellanby Hall••	32 (5.3)	0 (0.0)	32 (5.3)
Kuti Hall••	38 (6.2)	0 (0.0)	38 (6.2)
Tedder Hall••	45(7.4)	0 (0.0)	45 (7.4)
Sultan Bello Hall••	37 (6.1)	0 (0.0)	37 (6.1)

Key :

- • Female halls of residence
- •• Male halls of residence
- ••• Mixed hall

Table 4.1d : Respondents' Faculties

N = 608

Faculties	Male (%)	Female (%)	Total (%)
College of medicine	42 (6.9)	27 (4.4)	69 (11.3)
Veterinary medicine	20 (3.3)	1 (0.2)	21 (3.5)
Basic medical sciences	12 92.0)	14 (2.3)	26 (4.3)
Public health	4 (0.7)	8 (1.3)	12 (2.0)
Sciences	53 (8.7)	42 (6.9)	95 (15.6)
Pharmacy	14 (2.3)	2 (0.3)	16 (2.6)
Agriculture	23 (3.8)	29 (4.8)	52 (8.6)
Arts	21 (3.5)	62 (10.2)	83 (13.7)
Education	18 (3.0)	28 (4.6)	46 (7.6)
Social sciences	50 (8.2)	26 (4.3)	76 (12.5)
Technology	69 (11.3)	7 (1.2)	76 (12.5)
Law	10 (1.6)	26 (4.3)	36 (5.9)

4.2 Awareness and Knowledge relating to the YFC in U.I.

The results relating to awareness and knowledge of Youth Friendly Centre are presented in Table 4.2. Majority (70.4%) of the respondents had heard of the YFC based in the University. More males (38.3%) than females (32.1%) had heard of the YFC. There was however no significant difference between males and females who had heard of the centre. Friends were more common (49.8%) sources of information of the YFC in U.I, followed by orientation programme for new students (44.0%), sign board (40.5) and lectures (22.8%) Television was the least (2.1%) mentioned source of information of the YFC in U.I (Details are highlighted in Table 4.3). Majority of the respondents (89.3%) gave accurate description of the location of the YFC; few (7.7%) did not know where the YFC is located in U.I. while 3.0% provided inaccurate description. Overall, more males (50.1%) than females (39.2%) gave accurate descriptions of the location of the YFC, but with no significant difference (see Table 4.4 for details).

The reported broad typologies of services or opportunities available at the YFC of U.I. are highlighted in Table 4.5. The available service that topped the list was "General counseling" (64.9%), followed by "recreational services" (59.5%), HCT (42.8%) and "reading facilities" (18.1%). Other services which were listed by the respondents that were not necessarily part of the services offered at the centre were catering service/snacks (3.2%), urine test (2.3%), blood and genotype test (1.7%), as well as eye test / screening (1.4%), (see table for details).

Table 4.2 : Respondents' level of awareness relating to the YFC in UI.

N = 608

Ever heard of the YFC in U.I.	Males (%)	Females (%)	Total (%)	
Yes	233 (38.3)	195 (32.1)	428 (70.4)	$X^2 = 0.40$
No	103 (16.9)	77 (12.7)	180 (29.6)	p = 0.53 (p > 0.05)
Total	336 (55.3)	272 (44.7)	608 (100)	

Table 4.2 : Respondents' level of awareness relating to the YFC in UI.

N = 608

Ever heard of the YFC in U.I.	Males (%)	Females (%)	Total (%)	
Yes	233 (38.3)	195 (32.1)	428 (70.4)	$X^2 = 0.40$
No	103 (16.9)	77 (12.7)	180 (29.6)	p = 0.53 (p > 0.05)
Total	336 (55.3)	272 (44.7)	608 (100)	

Table 4.3: Respondent's sources of information of the YFC in U.I.

N = 428

Sources	Males (%)	Females (%)	Total (%)
Television	7 (1.6)	2 (0.5)	9 (2.1)
Internet	9 (2.1)	4 (0.9)	13 (3.0)
Radio	14 (3.3)	6 (1.4)	20 (4.7)
Fliers/Posters	35 (8.2)	38 (8.9)	73 (17.0)
Service providers	9 (2.1)	4 (0.9)	13 (3.0)
Lectures	57 (13.3)	41 (9.6)	98 (22.8)
Friends	115 (27.7)	99 (23.0)	214 (49.8)
Sign Board	91 (21.2)	83 (19.3)	174 (40.5)
Campaigns	23 (5.3)	14 (3.3)	37 (8.6)
Orientation programme for fresh students	113 (26.3)	76 (17.7)	189 (44.0)
Registration for health services in U.I.	2 (0.5)	8 (1.9)	10 (2.3)

"No response" was excluded

Multiple response included

Table 4.4: Accuracy of description of the location of the YFC in U.I. among respondents by gender.

N = 401

Description	Males (%)	Females (%)	Total (%)	p-value
Accurate	201 (50.1)	157 (39.2)	358 (89.3)	$X^2 = 2.97$
Inaccurate	8 (2.0)	4 (1.0)	12 (3.0)	p = 0.23 (p > 0.05)
Don't know	13 (3.2)	18 (4.5)	31 (7.7)	

"No responses" were excluded

Table 4.5: Listed broad typologies of services or opportunities available at the YFC of U.I.

N = 348

Lists of services or opportunities	Responses		
	Male (%)	Female (%)	Total (%)
HIV Counselling and Testing*	72 (20.7)	77 (22.1)	149 (42.8)
Provision of free condoms*	15 (4.3)	9 (2.6)	24 (6.9)
Reading services*	36 (10.3)	27 (7.8)	63 (18.1)
General Counselling *	121 (34.8)	105 (30.2)	226 (64.9)
Health talks on HIV/AIDs*	25 (7.2)	23 (6.6)	48 (13.8)
Education on sex related matters*	6 (1.7)	1 (0.3)	7 (2.0)
Recreation services*	130 (37.3)	77 (22.2)	207 (59.5)
Internet services*	23 (6.6)	9 (2.6)	32 (9.2)
Registration for Health Services*	5 (1.4)	8 (2.3)	13 (3.7)
Catering service/snack sales	7 (2.0)	4 (1.1)	11 (3.2)
Weight measurement*	3 (0.9)	0 (0.0)	3 (0.9)
Eye test/ screening	4 (1.1)	1 (0.3)	5 (1.4)
Blood / genotype test	5 (1.4)	1 (0.3)	6 (1.7)
Urine test	6 (1.7)	2 (.6)	8 (2.3)
Social networking*	4 (1.1)	6 (1.7)	10 (2.9)
Pregnancy test*	1 (0.3)	1 3 (0.3)	2 (0.6)
HIV Post exposure prophylaxis*	0 (0.0)	1 (0.3)	1 (0.3)
Don't know	11 (3.1)	11 (3.1)	22 (6.3)

* Correct responses

"No responses" were excluded

Muluple responses included

4.3 Respondents' level of knowledge relating to the services provided at the YFC by some selected socio-demographic characteristics.

This section presents respondents' knowledge scores. Table 4.6 contains the categorization of the knowledge scores relating to the services provided in the YFC by sex. Overall 45.6% had poor knowledge relating to the services provided at the YFC, while 24.8% had good knowledge. More males (16.4%) than females (8.4%) had good knowledge; similarly more males (23.4%) than females (22.2%) had poor knowledge. There was a significant difference between knowledge relating to the services provided at the YFC by sex (see table for details).

The comparison of respondents' mean knowledge scores by age is shown in Table 4.7. The mean knowledge scores by respondents aged ≤ 19 years was 7.7 ± 3.7, followed by respondents aged ≥ 30 years with a mean score of 7.5 ± 2.1. Respondents with the lowest knowledge score were those aged 20-24 years with a mean score of 7.4 ± 3.8. Overall, there was no significant difference in respondents' mean knowledge scores by age (see table for details).

Table 4.8 highlights the comparison of respondents' mean knowledge scores relating to the services provided at the YFC by level of study. Respondents in 600 level were more knowledgeable relating to the services provided at the YFC with a mean score of 8.1 ± 3.9, followed by those in 300 level with a mean score of 7.9 ± 3.5; the mean score by those in 200 level was 7.93 ± 3.8; the least mean score of 6.7 ± 3.9 was obtained by those in 400 level. There was a significant relationship between respondents' mean knowledge scores by level of study (see Table for details).

The comparison of respondents' mean knowledge scores relating to the services provided at the YFC by halls of residence are shown in Table 4.9. Respondents in Nnamdi Azikiwe Hall were more knowledgeable about the services provided at the YFC with a score of 8.6 ± 3.9. They were followed by those in Tedder Hall with a mean score of 8.08 ± 3.4, Mellanby Hall (8.05 ± 3.6) and Independence Hall (7.8 ± 3.4). The lowest mean knowledge score was recorded by Sultan Bello Hall (6.6 ± 3.8). Overall there was no significant difference between respondents' mean knowledge scores relating to the services provided at the YFC by halls of residence (see table for details).

The comparison of respondents' mean knowledge scores relating to the services provided at the YFC with male and female halls of residence is contained in Table 4.10. Respondents in male halls had a mean score of 7.88 ± 3.7 while the mean score among those in the female halls was 7.0 ± 3.7. There was a significant relationship in respondents' mean knowledge score relating to the services provided at the YFC by male and female halls of residence (See table for details).

Table 4.11 shows the comparison of the mean knowledge scores relating to the services provided at the YFC by gender among respondents' in Alexander Brown Hall (a hall that accommodates only medical students). The male respondents had a higher mean knowledge score of 8.2 ± 3.5 while females had a mean score of 6.8 ± 4.3. There was however, no significant difference between respondent's mean knowledge scores by gender in Alexander Brown Hall (See table for details).

Table 4.6: Categorization of Respondents' knowledge scores by gender

N = 428

Sex	Categorization of scores				
	Good (%)	Fair (%)	Poor (%)	Total (%)	p-value
Male	70 (16.4)	63 (14.7)	203 (23.4)	336 (54.4)	$X^2 = 7.73$
					p = 0.02
Female	36 (8.4)	64 (15.0)	172 (22.2)	272 (45.6)	(p < 0.05)
Overall total	106 (24.8)	127 (29.7)	375 (45.6)	428 (100)	

Knowledge assessed using a 15-point scale (See appendix 1 for the scale)

Significance set at p < 0.05

Table 4.7: Comparison of respondents' mean knowledge scores by age.

N = 428

Age in years	N	Mean	S.D	F	p-value
17-19	98	7.71	3.73	0.14	p = 0.93
20-24	287	7.43	3.81		(p > 0.05)
25-29	41	7.46	3.66		
≥ 30	2	7.50	2.12		
Total	428	7.50	3.76		

Table 4.8 : Comparison of respondents' mean knowledge scores by level of study.

N = 428

Level of study	N	Mean	S.D	F	p-value
200 level	111	7.93	3.80	2.45	p = 0.05
300 level	124	7.98	3.59		(p< 0.05)
400 level	118	6.69	3.90		
500 level	63	7.16	3.57		
600 level	12	8.08	3.92		
Total	428	7.50	3.76		

Table 4.9 : Comparison of respondents' mean knowledge scores by halls of residence

N = 428

	N	Mean	S.D	F	p-value
Obafemi Awolowo Hall	60	6.92	3.75	1.28	p = 0.25
Queen Elizabeth Hall	40	6.93	4.08		(p> 0.05)
Alexander Brown Hall	34	7.50	3.90		
Independence Hall	63	7.79	3.63		
Nnamdi Azikiwe Hall	55	8.64	3.94		
Queen Idia Hall	79	7.18	3.50		
Mellanby Hall	20	8.05	3.63		
Kuti Hall	19	7.74	4.01		
Tedder Hall	26	8.08	3.45		
Sultan Bello Hall	32	6.56	3.84		
Total	428	7.50	3.76		

Table 4.10: Comparison of respondents' mean knowledge scores by male and female halls of residence.

N = 394

Halls of residence	N	Mean	SD	t	p-value
Male Halls	215	7.88	3.70	-2.24	p = 0.02 (p < 0.05)
Female Halls	179	7.03	3.77		

Table 4.11: Comparison of respondents' level of knowledge by gender in Alexander Brown Hall (Medical Students Hall)*.

N = 34

Sex	N	Mean	SD	t	p-value
Male	18	8.17	3.52	1.06	p = 0.29 (p > 0.05)
Female	16	6.75	4.28		

*Medical students' hall which is mixed.

(Note : Other halls are not mixed)

4.4 Respondents perception relating to the YFC in U.I.

This section is subdivided into three segments namely; respondents' perception relating to the location of the YFC in U.I, respondents' perception relating to reproductive health-related services offered at the YFC in U.I and respondents' perception relating to general/non-reproductive health-related services offered at the YFC in U.I

The respondents' perception relating to the location of the YFC in U.I. by gender is highlighted in Table 4.12a. Overall, a higher proportion of respondents (58.9%) were of the opinion that the location of the YFC is not noticeable; 18.7% respondents were of a contrary view. More males (32.1%) than females (26.8%) were of the view that the location of the YFC was not noticeable.

Slightly over half (53.2%) of the respondents' were of the view that the YFC is located in a place where it cannot be easily accessed by students. More males (28.6%) than females (24.6%) expressed this view but the difference was, however, not significant. Overall, a greater proportion (42.5%) of respondents disagreed with the view that the environment of the youth friendly centre is not conducive; only 9.5% were of the view that the environment is not conducive (see the table for details).

Table 4.12b presents respondents' perception relating to the reproductive health related services offered at the YFC by gender. Majority (60.1%) of the respondents had no opinion or were undecided on whether it is safe to discuss issues of rape with a youth friendly service provider. Respondents who were of the view that it is safe to discuss rape related issues with a service provider at the centre constituted 33.7%. More males (20.8%) than females (12.9%) were of the view that it is safe to do so but the difference was not significant. A majority (59.9%) of the respondents did not share the view that the centre is only for students who experience sexual assault. More males (33.9%) than females (26.0%) shared this perception, with a significant difference. Overall 56.7% did not share the view that the centre is only for students who want to know their HIV status (see the table for details).

Respondent's perception relating to the general/non-reproductive health related services offered at the YFC in U.I. are summarized in Table 4.12c. Few (13.1%) respondents opined that the YFC is only good as a recreational centre. Respondents who were undecided and those who disagreed with such a view constituted 43.4% each. The difference in perception

4.4 Respondents perception relating to the YFC in U.I.

This section is subdivided into three segments namely; respondents' perception relating to the location of the YFC in U.I, respondents' perception relating to reproductive health-related services offered at the YFC in U.I. and respondents' perception relating to general/non-reproductive health-related services offered at the YFC in U.I.

The respondents' perception relating to the location of the YFC in U.I by gender is highlighted in Table 4.12a. Overall, a higher proportion of respondents (58.9%) were of the opinion that the location of the YFC is not noticeable; 18.7% respondents were of a contrary view. More males (32.1%) than females (26.8%) were of the view that the location of the YFC was not noticeable.

Slighily over half (53.2%) of the respondents' were of the view that the YFC is located in a place where it cannot be easily accessed by students. More males (28.6%) than females (24.6%) expressed this view but the difference was, however, not significant. Overall, a greater proportion (42.5%) of respondents disagreed with the view that the environment of the youth friendly centre is not conducive; only 9.5% were of the view that the environment is not conducive (see the table for details).

Table 4.12b presents respondents' perception relating to the reproductive health related services offered at the YFC by gender. Majority (60.1%) of the respondents had no opinion or were undecided on whether it is safe to discuss issues of rape with a youth friendly service provider. Respondents who were of the view that it is safe to discuss rape related issues with a service provider at the centre constituted 33.7%. More males (20.8%) than females (12.9%) were of the view that it is safe to do so but the difference was not significant. A majority (59.9%) of the respondents did not share the view that the centre is only for students who experience sexual assault. More males (33.9%) than females (26.0%) shared this perception, with a significant difference. Overall 56.7% did not share the view that the centre is only for students who want to know their HIV status (see the table for details).

Respondent's perception relating to the general/non-reproductive health related services offered at the YFC in U.I are summarized in Table 4.12c. Few (13.1%) respondents opined that the YFC is only good as a recreational centre. Respondents who were undecided and those who disagreed with such a view constituted 43.4% each. The difference in perception

4.4 Respondents perception relating to the YFC in U.I.

This section is subdivided into three segments namely; respondents' perception relating to the location of the YFC in U.I. respondents' perception relating to reproductive health-related services offered at the YFC in U.I. and respondents' perception relating to general/non-reproductive health-related services offered at the YFC in U.I.

The respondents' perception relating to the location of the YFC in U.I. by gender is highlighted in Table 4.12a. Overall, a higher proportion of respondents (58.9%) were of the opinion that the location of the YFC is not noticeable; 18.7% respondents were of a contrary view. More males (32.1%) than females (26.8%) were of the view that the location of the YFC was not noticeable.

Slightly over half (53.2%) of the respondents' were of the view that the YFC is located in a place where it cannot be easily accessed by students. More males (28.6%) than females (24.6%) expressed this view but the difference was, however, not significant. Overall, a greater proportion (42.5%) of respondents disagreed with the view that the environment of the youth friendly centre is not conducive; only 9.5% were of the view that the environment is not conducive (see the table for details).

Table 4.12b presents respondents' perception relating to the reproductive health related services offered at the YFC by gender. Majority (60.1%) of the respondents had no opinion or were undecided on whether it is safe to discuss issues of rape with a youth friendly service provider. Respondents who were of the view that it is safe to discuss rape related issues with n service provider at the centre constituted 33.7%. More males (20.8%) than females (12.9%) were of the view that it is safe to do so but the difference was not significant. A majority (59.9%) of the respondents did not share the view that the centre is only for students who experience sexual assault. More males (33.9%) than females (26.0%) shared this perception, with a significant difference. Overall 56.7% did not share the view that the centre is only for students who want to know their HIV status (see the table for details).

Respondent's perception relating to the general/non-reproductive health related services offered at the YFC in U.I. are summarized in Table 4.12c. Few (13.1%) respondents opined that the YFC is only good as a recreational centre. Respondents who were undecided and those who disagreed with such a view constituted 43.4% each. The difference in perception

relating to the assertation that the centre is only good for recreational purposes was significant by gender. Overall, 56.6% were undecided or could not make up their minds concerning the statement that the services provided at the centre are affordable. Only 39.5% were of the view that the services were affordable. In addition, table 4.12c reveals that majority (64.4%) of the respondents' were undecided in respect of whether the hours of operation of the centre were convenient or not (see the table for details).

Table 4.12a: Respondents' perception relating to the location of the YFC in U.I. by gender.

Location related variables	Agree (%)	Undecided/Have no opinion (%)	Disagree (%)
The location of the YFC is not noticeable (n= 418)			
Male	134 (32.1)	47 (11.2)	44 (10.5)
Female	112 (26.8)	47 (11.2)	34 (8.1)
Total	246(58.9)	94 (22.5)	78(18.7)
The YFC is located in a place that cannot be easily accessed by students(n= 419)			
Male	120 (28.6)	48 (11.5)	58 (13.8)
Female	103 (24.6)	51 (12.2)	39 (9.3)
Total	223 (53.2)	99 (23.6)	97 (23.2)
The YFC is located in a place where other people will see those who visit (n= 419)			
Male	29 (6.9)	76 (18.1)	121(28.9)
Female	20 (4.8)	85 (20.3)	88 (21.0)
Total	49 (11.7)	161 (38.4)	209(49.9)
The environment of the youth friendly centre is not conductive (n= 419)			
Male	24 (5.7)	92 (22.0)	110(26.3)
Female	16 (3.8)	109 (26.0)	68 (16.2)
Total	40 (9.5)	201 (48.0)	178(42.5)

Table 4.12b: Respondents' perception relating to specific reproductive health related services offered at the YFC in U.I by gender.

Reproductive Health services related variables	Agree (%)	Undecided /Have no opinion (%)	Disagree (%)
It is safe to discuss issues of rape with a youth friendly service provider (n= 419)			
Male	87 (20.8)	125(29.8)	14 (3.3)
Female	54 (12.9)	127(30.3)	12 (2.9)
Total	141(33.7)	252(60.1)	26(6.1)
The YFC is set up for only students who experience sexual assault (n= 419)			
Male	12 (2.9)	72 (17.2)	142(33.9)
Female	4 (1.0)	80 (19.1)	109(26.0)
Total	16 (3.8)	152(36.3)	251 (59.9)
The youth friendly centre is only for students who want to know their HIV status (n= 418)			
Male	14 (3.3)	71 (17.0)	141(33.7)
Female	7(1.7)	89 (21.3)	96 (23.0)
Total	21 (5.0)	163(38.3)	237(56.7)

Table 4.12c: Respondent's perception relating to general / non-reproductive health services by gender.

Services related variables	Agree (%)	Undecided/ Have no opinion (%)	Disagree (%)
The YFC offers services that many students do not like (n=419)			
Male	11 (2.6)	98 (23.4)	117(27.9)
Female	5 (1.2)	102 (24.3)	86 (20.5)
Total	16 (3.8)	200 (47.7)	203(48.4)
The YFC is operated in a manner that does not make students who have problems to feel free to share experiences (n= 419)			
Male	28 (6.7)	108 (25.8)	90 (21.5)
Female	13 (3.1)	130 (31.0)	50 (11.9)
Total	41 (9.8)	238 (56.8)	140(33.4)
YFC is only good as a recreational centre (n= 419)			
Male	37 (8.8)	83 (19.8)	106(25.3)
Female	18 (4.3)	99 (236)	76 (18.1)
Total	55(13.1)	182(434)	182(43.4)
Services provided at the youth friendly centre are affordable (n= 418)			
Male	113(27.0)	104 (24.9)	8 (1.9)
Female	52(12.4)	132 (31.6)	9 (2.2)
Total	165(39.5)	236 (56.5)	17 (4.1)
The hours of operation of the youth friendly centre are not convenient (n= 419)			
Male	17 (4.1)	131 (31.3)	78 (18.6)
Female	13 (3.1)	139 (33.2)	41 (9.8)
Total	30 (7.2)	270 (64.4)	119(28.4)

4.5 Pattern of Utilization of the YFC in U.I.

Table 4.13a presents the information relating to the proportion of respondents who had ever visited the YFC. Only 41.6% of the 428 respondents who had heard of the YFC in U.I. had ever visited the centre. More males (26.6%) than females (15.0%) had ever visited the YFC with a significant difference. The proportions of respondents who had ever used the YFC in U.I. among those who had ever heard of the YFC are shown in Table 4.13b (i). Among the respondents who had ever heard of the YFC, only 34.6% had utilized any of the services provided at the centre. More males (22.9%) than females (11.7%) that had ever heard of the YFC in U.I had ever utilized at least one of the services or opportunities available at the centre, with a significant difference by gender.

Table 4.13b (ii) reveals the proportions of respondents who had ever used the YFC in U.I. among only those who had visited the centre. Overall, 83.1% of the 178 respondents who had ever visited the YFC had utilized the services provided at the centre. More males (55.1%) than females (28.1%) had ever used the YFC with no significant difference (see table for details).

The reproductive health and STIs related services ever utilized by gender are presented in Table 4.14a. Many respondents (38.1%) used the centre for health talk relating to HIV/AIDs. More males (23.8%) than females (14.3%) using the centre for health talk relating to HIV/AIDs with no significant difference by gender. Overall 37.4% of the respondents, used the centre for HCT, with more males (23.1%) than females (14.3%) used the centre for HCT services but the difference was not significant. Few 31.3% of the respondents accessed the centre for information on sexually transmitted infections (STIs) services. More males (19.0%) than females (12.2%) used the centre for this purpose with no significant difference.

The proportion of respondents that used the centre for Counselling relating to Sexual Harrasement was 14.3%. More males (8.2%) than females (6.1%) used the centre for this purpose, but the difference was not significant. Free condoms was used by 10.3% of the respondents with more males (6.8%) than females (3.4%) obtaining free condoms from the centre but the difference was not significant. The least utilized reproductive health service was counseling on rape. Overall, only 6.8% used the centre for this purpose. More males (4.1%) than females (2.7%) obtained counseling on rape cases at the centre. However, there

was no significant difference between the utilization of this service by gender (see table for details).

The educational and recreational services ever utilized by respondents at the YFC are contained in Table 4.14b. Recreational activities (59.2%) topped the list of educational and recreational services utilized at the YFC. More males (46.9%) than females (12.2%) used the service, with no significant difference by gender. This was followed by use of the centre's reading room (55.1%). Similarly, more males (34.7%) than females (20.4%) used the centre for reading purpose, however, there was no significant differenceby gender. Overall, 25.2% respondents use internet services at the centre. More males (25.2%) than females (5.4%) use this service, but the difference was not significant by gender. Only 9.5% of the respondents used the centre for medical registration. More males (4.4%) than females (5.1%) used the centre for this service but there was no significant difference by gender (see Table 4.14b for details).

The reproductive health and STIs related services ever utilized by respondent's by age categories are presented in Table 4.14c. Many respondents (37.4%) used thecentre for HIV Counselling and Testing (HCT). Most were respondents aged 20-24 years (23.1%), followed by 17-19 years (8.8%) and 25-33 years (5.4%) that used the centre for HCT but there was no significant difference by age categories. The proportion of respondents that used the centre for health talk relating to HIV/AIDs was 38.1%. Respondents aged 20-24 years were (25.2%), followed by 17-19 years (7.5%) and 25-33 years (5.4%) with no significant difference by age categories (see Table 4.14c for details).

The educational and recreational services ever utilized by respondents at the YFC by age categories are contained in Table 4.14d. Career counseling was (17.0%) with 8.2% of respondents aged 20-24 years having used the centre for this purpose, respondents 25-30years (4.8%) and 17-19 years (4.1%) for career counseling. There was a significant difference in the use of this service by age categories (see Table 4.14d for details).

The proportion of respondents who had ever encouraged someone to use the YFC by gender is presented in Table 4.15. Overall, over half (55.4%) had encouraged someone to use the YFC. More males (35.1%) than females (20.3%) had encouraged someone to use the YFC, however, there was no significant difference by gender (see table for details).

Table 4.13a : Proportion of respondents who had ever visited the YFC of U.I. by gender

N = 428

Ever visited YFC	Male (%)	Female (%)	Total (%)	X^2
Yes	114 (26.6)	64 (15.0)	178 (41.6)	$X^2 = 10.28$
No	121 (28.3)	129 (30.1)	250 (58.4)	df = 1
Total	235 (54.9)	193 (45.1)	428 (100)	p = 0.00 ($p < 0.05$)

"No responses" were excluded.

Table 4.13b (i): Proportion of respondents who had ever used any services provided at YFC of U.I. among those who had ever heard of the YFC by gender

N = 428

Ever used YFC services	Males (%)	Females (%)	Total (%)	X^2
Yes	98 (22.9)	50 (11.7)	148 (34.6)	$X^2 = 12.7$
No	135 (31.5)	145 (33.9)	280 (65.4)	df = 1
Total	233 (54.4)	195 (46.6)	428 (100)	p = 0.00
				($p < 0.05$)

"No response" were excluded.

Table 4.13b (ii): Proportion of respondents who had ever used services provided at the YFC of U.I. among only those who had ever visited the centre by gender

N = 178

Ever used YFC services	Males (%)	Females (%)	Total (%)	X^2
Yes	98 (55.1)	50 (28.1)	148 (83.1)	$X^2 = 2.83$
No	15 (8.4)	15 (8.4)	30 (16.9)	df = 1
Total	113 (63.5)	65 (36.5)	178 (100)	p = 0.93
				(p > 0.05)

"No responses" were excluded

Table 4.14a: Reproductive health and STIs related services ever utilized by respondents at the Y.F.C. by gender

Services ever utilized at the Y.F.C.	Males (%)	Females (%)	Total (%)	Chi-square (X^2) Test
HIV Counselling and Testing (HCT) (n= 147)				
Yes	34 (23.1)	21 (14.3)	55 (37.4)	$X^2 = 0.68$ p = 0.41
No	63 (42.9)	29 (19.7)	92 (62.6)	(p > 0.05)
Free condoms (n= 146)				
Yes	10 (6.8)	5 (3.4)	15 (10.3)	$X^2 = 0.00$ p = 0.98
No	87 (59.6)	44 (30.1)	131 (89.7)	(p > 0.05)
Follow up counseling for HIV/AIDs (n= 147)				
Yes	7 (4.8)	6 (4.1)	13 (8.8)	$X^2 = 0.94$ p = 0.33
No	90 (61.2)	44 (29.9)	134 (91.2)	(p > 0.05)
Counselling on rape cases (n= 147)				
Yes	6 (4.1)	4 (2.7)	10 (6.8)	$X^2 = 0.17$ p = 0.68
No	91 (61.9)	46 (31.3)	137 (93.2)	(p > 0.05)
Counselling on Sexual Harrasement (n= 147)				
Yes	12 (8.2)	9 (6.1)	21 (14.3)	$X^2 = 0.85$ p = 0.36
No	85 (57.8)	41 (27.9)	126 (85.7)	(p > 0.05)
Health talk relating to HIV/AIDs (n= 147)				
Yes	35 (23.8)	21 (14.3)	56 (38.1)	$X^2 = 0.49$ p = 0.48
No	62 (42.2)	29 (19.7)	91 (61.9)	(p > 0.05)
Information on sexually transmitted infections(STIs) (n= 147)				
Yes	28 (19.0)	18 (12.2)	46 (31.3)	$X^2 = 0.78$ p = 0.38
No	69 (46.9)	32 (21.8)	101 (68.7)	(p > 0.05)

Table 4.14b: Educational and recreational services ever utilized by respondents at the Y.F.C.

Services ever utilized at the Y.F.C.	Males (%)	Females (%)	Total (%)	Chi-square (X^2) Test
Counselling on relationships (n= 147)				
Yes	17 (11.6)	12 (8.2)	29 (19.7	$X^2 = 0.87$ $p = 0.35$
No	80 (54.4)	38 (25.9)	118 (80.3)	(p >0.05)
Career counseling (n= 147)				
Yes	18 (12.2)	7 (4.8)	25 (17.0)	$X^2 = 0.49$ $p = 0.48$
No	79 (53.7)	43 (29.3)	122 (83.0)	(p > 0.05)
Counselling on drug use (n= 147)				
Yes	17 (11.6)	12 (8.2)	29 (19.7)	$X^2 = 0.87$
No	80 (54.4)	38 (25.9)	118 (80.3)	$p = 0.35$ (p > 005)
Used the centre's reading room (n= 147)				
Yes	51 (34.7)	30 (204)	81 (55.1)	$X^2 = 0.74$ $p = 0.39$
No	46 (31.3)	20 (13.6)	66 (44.9)	(p > 0.05)
Internet services (n= 147)				
Yes	29 (19.7)	8 (5.4)	37 (25.2)	$X^2 = 3.38$ $p = 0.06$
No	68 (46.3)	42 (286)	110 (74.8)	(p > 0.05)
Recreational activities e.g. games (n= 147)				
Yes	69 (46.9)	18 (12.2)	87 (59.2)	$X^2 = 16.86$ $p = 0.00$
No	28 (19.0)	32 (21.8)	60 (40.8)	**(p < 0.05)**
Medical registration (n= 137)				
Yes	6 (4.4)	7 (5.1)	13 (9.5)	$X^2 = 2.23$ $p = 0.12$
No	83 (60.6)	41 (29.9)	124 (90.5)	(p > 0.05)

Multiple responses included

"No responses" were excluded.

The numbers (n) vary depending on the number of persons that responded on the services ever utilized.

Table 4.14c: Reproductive health and STIs related services ever utilized by respondents at the Y.F.C. by age categories.

Services ever utilized at the Y.F.C.	Age				Chi-square
	17-19 (%)	20-24 (%)	25.33 (%)	Total (%)	(X^2) Test
HIV Counselling and Testing (HCT) (n= 147)					
Yes	13 (8.8)	34 (23.1)	8 (5.4)	55 (37.4)	$X^2 = 0.78$ p = 068
No	22 (15.0)	61 (415)	9 (6.1)	92 (62.6)	(p > 0.05)
Free condoms (n= 146)					
Yes	1 (0.7)	11 (7.5)	3 (2.1)	15 (10.3)	$X^2 = 0.00$ p = 0.98
No	33 (22.6)	84 (57.5)	14 (9.6)	131 (89.7)	(p > 005)
Follow up counseling for HIV/AIDs (n= 147)					
Yes	2 (1.4)	7 (4.8)	4 (2.7)	13 (8.8)	$X^2 = 5.23$ p = 0.07
No	33 (22.4)	88 (59.9)	13 (8.8)	134 (91.2)	(p > 0.05)
Counselling on rape cases (n= 147)					
Yes	1 (0.7)	6 (4.1)	3 (2.0)	10 (6.8)	$X^2 = 4.05$ p = 0.13
No	34 (23.1)	89 (60.5)	14 (9.5)	137 (93.2)	(p > 0.05)
Counselling on Sexual Harrasement (n= 147)					
Yes	4 (2.7)	13 (8.8)	4 (2.7)	21 (14.3)	$X^2 = 1.45$ p = 0.49
No	31 (21.1)	82 (55.8)	13 (8.8)	126 (85.7)	(p > 0.05)
Health talk relating to HIV/AIDs (n= 147)					
Yes	11 (7.5)	37 (25.2)	8 (5.4)	56 (38.1)	$X^2 = 1.27$ p = 0.53
No	24 (16.3)	58 (39.5)	9 (6.1)	91 (61.9)	(p > 005)
Information on sexually transmitted infections(STIs) (n= 147) Yes	9 (6.1)	30 (20.4)	7 (4.8)	46 (31.3)	$X^2 = 1.28$ p = 0.53
No	26 (17.7)	65 (44.2)	10 (6.8)	101 (68.7)	(p > 0.05)

Table 4.14d: Educational and recreational services ever utilized by respondents at the V.F.C. by age categories.

Services ever utilized at the V.F.C.	Age			Total (%)	Chi-square (X²) Test
	17-19 (%)	20-24 (%)	25-33 (%)		
Counselling on relationships (n= 147)					
Yes	17 (11.6)	12 (8.2)	29 (19.7)	29 (19.7)	$X^2 = 0.87$ p = 0.35
No	80 (54.4)	38 (25.9)	29 (19.7)	118 (80.3)	(p > 0.05)
Career counseling (n= 147)					
Yes	18 (12.2)	7 (4.8)	29 (19.7)	25 (170)	$X^2 = 0.49$ p = 0.48
No	79 (53.7)	43 (29.3)	29 (19.7)	122 (83 0)	(p > 0.05)
Counselling on drug use (n= 147)					
Yes	17 (11.6)	12 (8.2)	29 (19.7)	29 (19.7)	$X^2 = 0.87$ p = 0.35
No	80 (54.4)	38 (25.9)	29 (19.7)	118 (80.3)	(p > 0.05)
Used the centre's reading room (n= 147)					
Yes	51 (34.7)	30 (20.4)	29 (19.7)	81 (55.1)	$X^2 = 0.74$ p = 0.39
No	46 (31.3)	20 (13.6)	29 (19.7)	66 (44.9)	(p > 0.05)
Internet services (n= 147)					
Yes	29 (19.7)	8 (5.4)	29 (19.7)	37 (25.2)	$X^2 = 3.38$ p = 0.06
No	68 (46.3)	42 (28.6)	29 (19.7)	110 (74.8)	(p > 0.05)
Recreational activities e.g. games (n= 147)					
Yes	69 (46.9)	18 (12.2)	29 (19.7)	87 (59 2)	$X^2 = 16.86$ p = 0.00
No	28 (19 0)	32 (21 8)	29 (19.7)	60 (40 8)	(p < 0.05)
Medical registration (n= 137)					
Yes	6 (4.4)	7 (5.1)	29 (19.7)	13 (9.5)	$X^2 = 2.23$ p = 0.12
No	83 (60.6)	41 (299)	29 (19.7)	124 (90.5)	(p > 0.05)

Multiple responses included

"No responses" were excluded.

The numbers (n) vary depending on the number of persons that responded on the services ever utilized.

The numbers (n) vary depending on the number of persons that responded on the services ever utilized.

Table 4.15 : Respondents who ever encouraged someone to use the YFC by gender.

N =148

Ever encouraged someone to use the YFC	Male	Female	Total	Chi-square (X^2) Test
Yes	52 (35.1)	30 (20.3)	82 (55.4)	$X^2 = 0.65$ df = 1 p = 0.44 (p > 0.05)
No	46 (31.1)	20 (13.5)	66 (44.6)	

4.6 Factors perceived by respondents that can facilitate the utilization of the YFC in U.I.

The factors perceived by respondents that can facilitate the utilization of the YFC by gender are highlighted in Table 4.16. Overall, the facilitating factor that topped the list was provision of free services for clients (91.1%). More males (57.5%) than females (33.6%) were of the view that free services could facilitate the use of the centre with a significant difference. Provision of recreational activities for students who visit the centre was mentioned by 89.7% of the respondents. More males (56.8%) than females (32.9%) were of the opinion that the provision of recreational activities for students who visit the centre could facilitate the use of the centre but the difference by gender was not significant. The respondents who opined that convenient operating hours could facilitate the utilization of the YFC constituted 89.0%. More males (58.9%) than females (30.1%) were of this opinion, however, there was no significant difference by gender. The presence of fellow young people who attend to one's needs at the centre was mentioned by 72.4% of the respondents. More males (43.4%) than females (29.0%) were of this view. There was however no significant difference by gender (See Table 4.16 for details).

Information relating to reproductive health related factors or services that facilitate the utilization of the YFC are revealed in Figure 4.2. More males (41.1%) than females (18.5%) were of the view that availability/provision of contraceptive pills could facilitate the utilization of the YFC. In the same vein, more males (37.75) than females (19.9%) opined that provision of free condoms at the centre could promote the utilization of the YFC. There was, however, no significat difference by gender in both opinions (see figure 4.2 for details).

Table 4.16: Factors perceived by respondents that can facilitate the utilization of the YFC in U.I.

Facilitating factors	Males (%)	Females (%)	Total (%)	Chi-square (X^2) Test
Awareness creation about the centre (n= 146)				
Yes	78 (53.4)	42 (28.8)	120 (82.2)	$X^2 = 0.17$
No	18 (12.3)	8 (5.5)	26 (17.8)	p = 0.68
				(p > 0.05)
Publicity of the services provided at the centre (n= 146)				
Yes	73 (50.0)	42 (28.8)	115 (78.8)	$X^2 = 1.25$
No	23 (15.8)	8 (5.5)	31 (212)	p = 0.27
				(p > 0.05)
Location of the centre in a place that can be easily accessed by clients (n= 146)				
Yes	67 (45.9)	41 (28.1)	108 (74.0)	$X^2 = 2.25$
No	29 (19.9)	9(6.2)	38(26.0)	p = 0.11
				(p > 0.05)
Short time of waiting before being attended to by a service provider (n= 146)				
Yes	68 (46.6)	42 (28.8)	110 (75.3)	$X^2 = 3.07$
No	28 (19.2)	8 (5.5)	36 (24.7)	p = 0.08
				(p < 0.05)
Provision of free services for clients (n= 146)				$X^2 = 4.47$
Yes	84 (57.5)	49 (33.6)	133 (91.1)	p = 0.03
No	12 (8.2)	1 (0.7)	13 (8.9)	(p < 0.05)
Convenient operating hours (n= 146)				$X^2 = 0.08$
Yes	86 (58.9)	44 (30.1)	130 (89.0)	p = 0.77
No	10 (6.8)	6 (4.1)	16 (11.0)	(p > 0.05)
The services provided to students at the centre are confidential, not disclosed to other people (n= 146)				$X^2 = 0.81$
Yes	79 (54.1)	44 (30.1)	123 (84.2)	p = 0.37
No	17 (11.6)	6 (4.1)	23 (15.8)	(p > 0.05)
Presence of fellow young people who attend to one's needs (n= 145)				$X^2 = 5.13$
Yes	63 (43.4)	42 (29.0)	105 (72.4)	p = 0.02
No	32 (22.1)	8 (5.5)	40 (27.6)	(p < 0.05)
It is difficult for people to know what one goes there to do because there are many services provided (n= 146)				$X^2 = 0.49$
Yes	70 (47.9)	36 (24.7)	106 (72.6)	p = 0.12
No	26 (17.8)	14 (9.6)	40 (27.4)	(p > 0.05)
Provision of recreational activities for students who visit the centre (n= 146)				$X^2 = 0.49$
Yes	83 (56.8)	48 (32.9)	131 (89.7)	p = 0.12
No	13 (8.9)	2 (1.4)	15 (10.3)	(p > 005)

- Multiple responses (more)
- "No response" were excluded

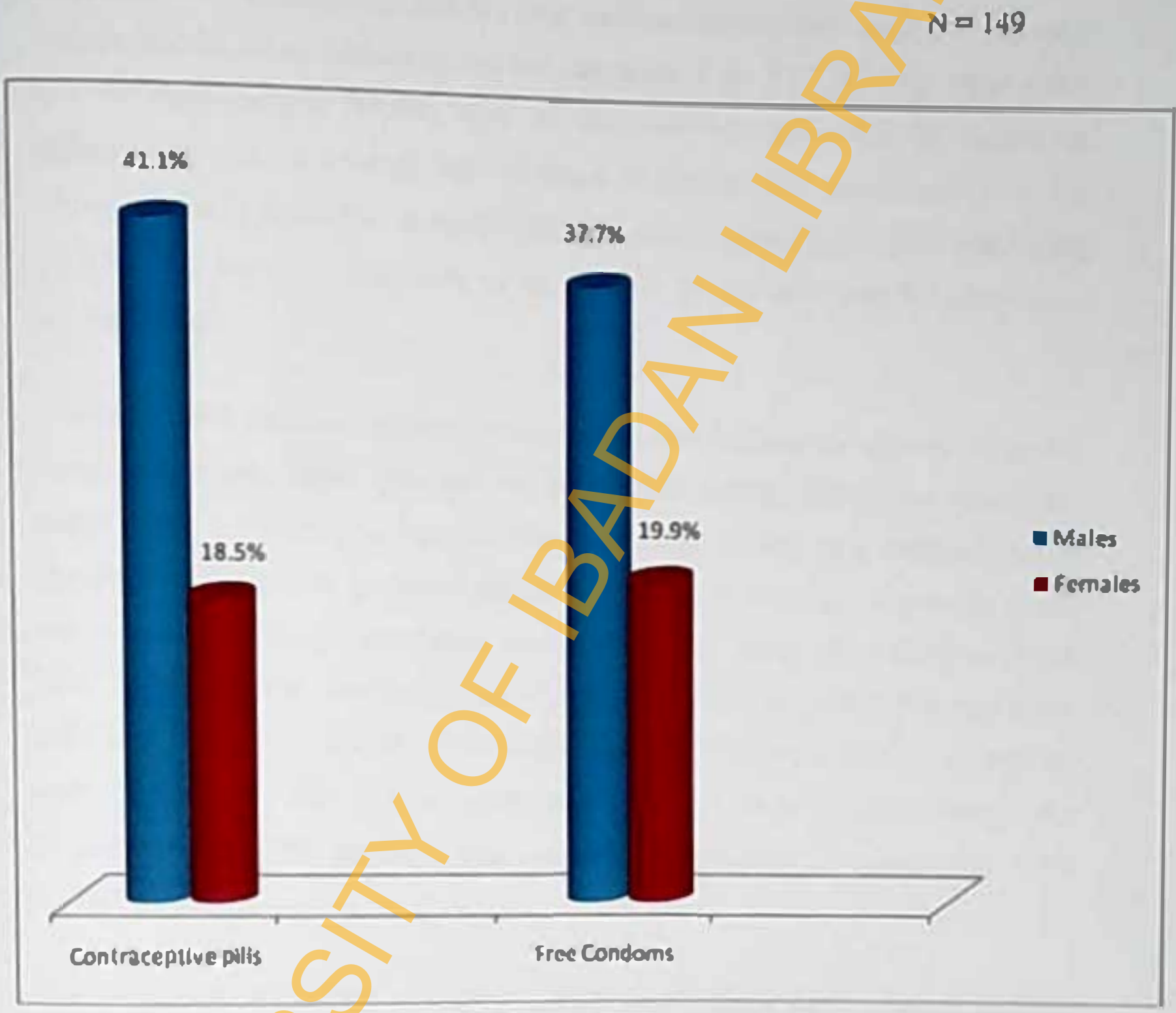

Figure 4.2: Perceived/reported reproductive health related services / factors which can facilitate the utilization of the YFC in U.I.

4.7 Factors that militate against the utilization of the YFC in U.I.

Table 4.17a contains respondents' perceived resource-related factors which could militate against the utilization of the YFC. The list was topped by the view that respondents with the opinion that the long distance between the centre and students' hostels or halls, could militate against the utilization of the YFC (51.7%). More males (32.7%) than females (19.0%) were of this view but there was no significant difference by gender. Overall, lack of drugs or supplies was mentioned by 29.9% respondents as a factor that could militate against the utilization of YFC. More males (21.1%) than females (8.8%) were of this opinion but the difference by gender was not significant.

Overall, 27.9% respondents were of the opinion that making clients wait in places where people who know them can see them could militate against the use of the centre. More males (22.4%) than females (5.4%) were of this view and there was a significant difference by gender. Long time of waiting to be attended to at the centre was perceived by 23.1% as a factor that could militate against the utilization of the YFC. More males (18.4%) than females (4.8%) were of this opinion with a significant difference by gender. Overall, 14.3% respondents, (12.2% males and 2.0% females) were of the view that lack of contraceptive service could militate against the utilization of the YFC but there was a significant difference by gender (see table 4.17a for details).

The awareness related and perceived psycho-social related factors which militate against the utilization of the YFC in U.I. are presented in Table 4.17b. Lack of awareness of the centre (85.6%), topped the list, with more males (55.5%) than females (30.1%) sharing this view that lack of awareness could militate against the utilization of the YFC. There was, however, no significant difference by gender. This opinion was followed by mention of lack of in-depth knowledge of what is done at the centre (83.7%). More males (53.1%) than females (30.6%) shared this view

but there was no significant difference by gender. Overall, 34.0% of the respondents were of the view that fear that ones friends might know why one visits the centre could militate against the utilization of the centre. More males (23.8%) than females (10.2%) shared this view but there was no significant difference by gender.

Lack of confidentiality of service provided was mentioned by 25.2% of the respondents as a factor that can militate against the utilization of the centre. More males (20.4%) than females (4.8%) were of this view and the difference was significant by gender. Overall, 24.5% of respondents were of the opinion that judgemental attitude of service providers could militate against the utilization of the YFC. More males (20.4%) than females (4.1%) were of this opinion, with a significant difference. Many respondents (27.9%) stated that procedures that do not make the centre user-friendly could militate against the utilization of the centre. More males (23.8%) than females (4.1%) shared this view and there was a significant difference by gender. Overall, 16.3% of the respondents reported that the ridiculing of students who visit the centre could militate against the utilization of the centre. More males (14.3%) than females (2.0%) were of this opinion with a significant difference.

Respondents' views relating to what they thought their friends would think about the motive behind their visiting the YFC are shown in Table 4.18. The highest proportion (24.1%) said their friends would be indifferent about it; this was followed by 23.2% who were of the view that friends would think they went for fun/relaxation purpose (see table 4.18 for details).

The details relating to respondents' perceived satisfaction with the services provided at the YFC by gender are presented in Table 4.19a. Majority (85.6%) of the respondents stated that they were satisfied with the services provided at the YFC. More males (57.6%) than females (28.0%) shared this view; however there was no significant difference by gender. Few (14.4%) of the respondents however reported that they were not satisfied with the services provided at the YFC. (see table 4.19 for details).

Table 4.19b summarises the reasons adduced for respondents' lack of satisfaction with the services provided at the Y.F.C. Overall, 22.2% of the respondents stated that the services at times are clumsy and needs to be more professionally conducted, equal proportions of males (11.1%) and females (11.1%) were of this view, however there was no significant difference by gender.

The proportion of respondents who stated that many students do not know that the centre is functional constituted 16.7%. More males (11.5%) than females (5.6%) were of this view but the difference was not significant by gender. Few (16.7%) of the respondents were of the view that the facility is not well equipped; more males (11.1%) than females (5.6%) were of this view but the difference was not significant by gender (see table 4.20 for details).

Table 4.17a Perceived resource-related militating factors against the utilization of YFC in U.I.

Perceived Militating Factors	Males (%)	Females (%)	Total (%)	Chi-square (X^2) Test
Long time of waiting to be attended to at the centre (n= 147)				X^2 = 3.55
Yes	27 (18.4)	7 (4.8)	34 (23.1)	p = 0.05
No	70 (47.6)	43 (29.3)	113 (76.9)	(p < 0.05)
Making clients wait in places where people who know them can meet them (n= 147)				X^2 = 0.53
Yes	33 (22.4)	8 (5.4)	41 (27.9)	p = 0.02
No	64 (43.5)	42 (28.6)	106 (72.1)	(p< 0.05)
Lack of drugs/supplies (n= 147)				X^2 = 0.56
Yes	31 (21.1)	13 (8.8)	44 (29.9)	p = 0.46
No	66 (44.9)	37 (25.2)	103 (70.1)	(p > 0.05)
Lack of skilled service providers (n= 146)				X^2 = 2.17
Yes	28 (19.2)	9 (6.2)	37 (25.3)	p = 0.14
No	68 (46.6)	41 (28.1)	109 (74.7)	(p > 0.05)
Lack of contraceptive services (n= 147)				X^2 = 4.25
Yes	18 (12.2)	3 (2.0)	21 (14.3)	p = 0.03
No	79 (53.7)	47 (32.0)	126 (85.7)	(p < 0.05)
Long distance between the centre and students' hostels or halls (n= 147)				X^2= 0.56
Yes	48 (32.7)	28 (19.0)	76 (51.7)	p = 0.45
No	49 (33.3)	22 (15.0)	71 (48.3)	(p > 0.05)
The centre not opened at convenient times (n= 147)				X^2= 0.14
Yes	28 (19.0)	13 (8.8)	41 (27.9)	p = 0.71
No	69 (46.9)	37 (25.2)	106 (72.1)	(p > 0.05)
Lack of referral service for students to alternative places where they can get necessary help (n= 147)				X^2 = 2.83
Yes	30 (20.4)	9 (6.1)	39 (26.5)	p = 0.09
No	67 (45.6)	41 (27.9)	108 (73.5)	(p > 0.05)
The centre is not well equipped (n= 147)				X^2 = 0.84
Yes	5 (3.4)	1 (0.7)	6 (4.1)	p = 0.36
No	92 (62.6)	49 (33.3)	114 (95.9)	(p > 0.05)

Table 4.17b: Perceived awareness and psycho-social related factors which militate against the utilization of the YFC in UI

Perceived Militating Factors	Males (%)	Females (%)	Total (%)	Chi-square (χ²) Test
Lack of awareness about the centre (n= 146)				
Yes	91 (53.5)	44 (30.1)	135 (83.6)	$X^2 = 1.05$
No	16 (11.0)	5 (3.4)	21 (14.4)	p = 0.31
				(p > 0.05)
Lack of in-depth knowledge of what is done in the centre (n= 147)				
Yes	78 (53.1)	45 (30.6)	123 (83.7)	$X^2 = 2.22$
No	19 (12.9)	5 (3.4)	24 (16.3)	p = 0.14
				(p > 0.05)
Unfriendly attitude of service providers to [illegible] (n= 147)				
Yes	17 (11.6)	3 (2.0)	20 (13.6)	$X^2 = 3.73$
No	80 (54.4)	47 (32.0)	127 (86.4)	p = 0.53
				(p > 0.05)
[illegible] *of service providers* (n= 147)				
Yes	30 (20.4)	6 (4.1)	36 (24.5)	$X^2 = 6.38$
No	67 (45.6)	44 (29.9)	111 (75.5)	p = 0.01
				(p < 0.05)
Lack of confidentiality of services available (n= 147)				
Yes	30 (20.4)	7 (4.8)	37 (25.2)	$X^2 = 5.02$
No	67 (45.6)	43 (29.3)	110 (74.8)	p = 0.02
				(p < 0.05)
Procedures that do not make the centre user-friendly (n= 147)				$X^2 = 9.51$
Yes	35 (23.8)	6 (4.1)	41 (27.9)	p = 0.002
No	62 (42.2)	44 (29.9)	106 (72.1)	(p < 0.05)
Ridiculing students who visit the centre (n= 147)				$X^2 = 5.92$
Yes	21 (14.3)	3 (2.0)	24 (16.3)	p = 0.02
No	76 (51.7)	47 (32.0)	123 (83.7)	(p < 0.05)
Students are asked embarrassing questions by service providers (n= 140)				$X^2 = 4.32$
Yes	24 (16.4)	5 (3.4)	29 (19.9)	p = 0.03
No	73 (50.0)	44 (30.1)	117 (80.1)	(p < 0.05)
Fear that friends might know why one visits the centre (n= 147)				$X^2 = 0.54$
Yes	35 (23.8)	15 (10.2)	50 (34.0)	p = 0.46
No	63 (42.2)	35 (23.8)	97 (66.0)	(p > 0.05)
Most students think the centre is for [illegible] *services only* (n= 147)				$X^2 = 1.54$
Yes	3 (2.0)	0 (0.0)	3 (2.0)	p = 0.21
No	94 (63.9)	50 (34.0)	144 (98.0)	(p > 0.05)

Table 4.18: Respondents views relating to what they think friends would likely think about the motive of their visit to the YFC of the University

N = 109

Friends' perceived views	No	%
Indifferent	27	24.5
Fun/relaxation purpose	26	23.9
Reading purpose	21	19.3
For HIV/AIDs test/issues	11	10
Others *	7	6.7
That I need counseling	7	6.4
Suspicious/curious	5	4.6
Various services offered make it difficult for others to one's intention for visiting the YFC	5	4.6
Don't know	4	4.0

*Others – They may think I am HIV/AIDs positive (1.8%), they will think I am pregnant (9%) and Don't care (4.0%)

Table 4.19a : Perceived satisfaction with services provided at the YFC in U.I. among the respondents by gender.

N = 125

Perceived satisfaction with services provided at the YFC in U.I.	Male	Female	Total	Chi-square (X^2) Test
Yes	72 (57.6)	35 (28.0)	107 (85.6)	$X^2 = 0.003$ df = 1
No	12 (9.6)	6 (4.8)	18 (14.4)	p = 0.95 (p > 0.05)

- "No responses" were excluded

Table 4.19b : Reasons adduced for lack of satisfied with the services provided at the Y.F.C.by gender.

Adduce reasons for lack of satisfaction	Male (%)	Female (%)	Total (%)	N = 18 Chi-square (X^2) Test
Many students do not know the centre is functional				
Yes	2 (11.5)	1 (5.6)	3 (16.7)	$X^2 = 1.00^*$
No	10 (55.6)	5 (27.8)	15 (83.3)	p = 1.00
				(p > 0.05)
Most students do not know what is done in the centre				
Yes	5(27.8)	0 (0.0)	5(27.8)	$X^2 = 0.11^*$
No	7(38.9)	6 (33.3)	13 (72.2)	p = 006
				(p > 0.05)
The place is not big enough				
Yes	0 (0.0)	2 (11.1)	2 (11.1)	$X^2 = 0.98^*$
No	12 (66.7)	4 (22.2)	16 (88.9)	p = 0.03
				(p < 0.05)
The facility is not well equipped				
Yes	2 (11.1)	1(5.6)	3 (16.7)	$X^2 = 1.00$
No	10 (55.6)	5 (27.8)	15 (83.8)	p = 1.0
				(p > 0.05)
Their services at times is clumsy, it needs to be more professionally conducted				
Yes	2 (11.1)	2 (11.1)	4 (22.2)	$X^2 = 0.6$
No	10 (55.6)	4 (22.2)	14 (77.8)	p = 0.42
				(p > 0.05)
The area is always dissected				
Yes	0 (0.1)	1 (5.6)	1 (5.6)	$X^2 = 0.33^*$
No	12 (66.7)	5 (27.8)	17 (94.4)	p = 0.14
				(p > 0.05)
There are no enough seats for students in the facility				
Yes	1 (5.6)	0 (0.0)	1 (5.6)	$X^2 = 1.00^*$
No	0 (0.0)	6 (33.3)	17 (94.4)	p = 0.46
				(p > 0.05)

Multiple responses included

" No responses" were excluded

* (X^2 of sex value $\leq$ 1 = fisher's exact)

4.8 Suggestions for improving the YFC at the University of Ibadan

Respondents' suggestions related to awareness and resources for improving the YFC are summarized in Table 4.20a. Overall 41.0% of the respondents were of the view that more awareness creation about the centre could improve the centre. More males (24.1%) than females (16.9%) were of this view however, the difference was not significant by gender. The view that the centre should be expanded was shared by 7.2% respondents. More males (4.8%) than females (2.4%) were of this view with no significant difference by gender. Overall 7.2% of respondents opined that all personnels should be skilled and passionate workers. More males (6.0%) than females (1.2%) were of this view but there was no significant difference by gender (see table 4.20a for details).

Table 4.21b highlights the respondents suggestions relating to the delivery of services provided at the YFC. The suggestion that topped the list was that services should be improved. More males (10.8%) than females (4.8%) offered this suggestion but there was, however, no significant difference by gender. Overall, 2.4% respondents were of the view that there should be proper coordination and monitoring of the centre. The same proportion (1.2%) of males and females were of this view with no significant difference as highlighted in Table 4.21b.

Table 4.20a: Suggestions offered by respondents for improving the delivery of services provided at the YFC by gender.

Suggestions	Males (%)	Females (%)	Total (%)	Chi-square (X²) Test
Change of location of the centre (n= 83)				
Yes	6 (7.2)	0 (.0)	6 (7.2)	X² = 0.17*
No	53 (63.9)	24 (28.9)	77 (92.8)	p = 0.12
				(p > 0.05)
Creation of more centres close to residential halls (n= 83)				
Yes	3 (3.6)	2 (2.4)	5 (6.0)	X² = 0.32
No	56 (67.5)	22 (26.5)	78 (94.0)	p = 0.57
				(p > 0.05)
Expand the centre (n= 83)				
Yes	4 (4.8)	2 (2.4)	6 (7.2)	X² = 0.61
No	55 (66.3)	22 (28.6)	77 (92.8)	p = 0.80
				(p > 0.05)
More awareness creation about the centre (n= 83)				
Yes	20 (24.1)	14 (16.9)	34 (41.0)	X² = 4.21
No	39 (47.0)	10 (12.0)	49 (59.0)	p = 0.40
				(p > 0.05)
All personnels should be skilled and passionate workers (n= 83)				
Yes	5 (6.0)	1 (1.2)	6 (7.2)	X² = 0.47
No	54 (65.1)	23 (27.7)	77 (92.8)	p = 0.49
				(p > 0.05)
Provide more counselors (n= 83)				
Yes	1 (1.2)	1 (1.2)	2 (2.4)	X² = 0.44
No	58 (69.9)	23 (27.7)	81 (97.6)	p = 0.51
				(p > 0.05)
The service providers should be more friendly (n= 83)				
Yes	5 (6.0)	0 (0.0)	5 (6.0)	X² = 0.31*
No	54 (65.1)	24 (28.9)	78 (94.0)	p = 0.14
				(p > 0.05)
The centre should be made more beautiful and attractive (n= 82)				
Yes	1 (1.2)	0 (0.0)	1 (1.2)	X² = 1.00*
No	57 (69.5)	24 (29.3)	81 (98.8)	p = 0.52
				(p > 0.05)
The environment should be very conducive (n= 83)				
Yes	1 (1.2)	1 (1.2)	1 (2.4)	X² = 0.49*
No	58 (69.9)	23 (27.7)	81 (97.6)	p = 0.51
				(p > 0.05)
More seats should be provided (n= 81)				
Yes	1 (1.2)	0 (0.0)	1 (1.2)	X² = 1.00
No	56 (69.1)	24 (29.6)	80 (98.8)	p = 0.51
				(p > 0.05)

* (X^2 of sex value ≤ 1 = fisher's exact)

Table 4.20b: Services delivery related recommendations on improving the services provided in the YFC by gender.

Suggestions	Males (%)	Females (%)	Total (%)	Chi-square (X^2) Test
Improve on the services provided (n=83)				
Yes	9 (10.8)	4 (4.8)	13 (15.7)	$X^2 = 0.00$
No	50 (60.2)	20 (24.1)	70 (84.3)	$p = 0.97$
				($p > 0.05$)
Services should be highly confidential (n= 83)				
Yes	1 (1.6)	0 (0.0)	1 (1.6)	$X^2 = 0.55^*$
No	58 (67.5)	27 (32.5)	85 (98.4)	$p = 0.26$
				($p > 0.05$)
Improve and provide free internet browsing (n= 83)				
Yes	6 (7.2)	0 (0.0)	6 (7.2)	$X^2 = 0.17^*$
No	53 (63.9)	24 (28.9)	77 (92.8)	$p = 0.11$
				($p > 0.05$)
Operating hours should be elongated/weekend services (n= 83)				
Yes	3 (3.6)	0 (0.0)	3 (3.6)	$X^2 = 0.31^*$
No	54 (63.1)	24 (28.9)	78 (94.0)	$p = 0.14$
				($p > 0.05$)
The services are okay, keep up the good work (n= 83)				
Yes	2 (2.4)	0 (0.0)	2 (2.4)	$X^2 = 1.00^*$
No	57 (68.7)	24 (28.9)	81 (97.6)	$p = 0.36$
				($p > 0.05$)
There should be reminder phone calls (n= 83)				
Yes	0 (0.0)	1 (1.2)	1 (1.2)	$X^2 = 0.28^*$
No	59 (71.1)	23 (27.7)	82 (98.8)	$p = 0.12$
				($p > 0.05$)
There should be proper counselling and monitoring of the clients (n= 83)				
Yes	1 (1.2)	1 (1.2)	2 (2.4)	$X^2 = 0.49^*$
No	58 (69.9)	23 (27.7)	81 (97.6)	$p = 0.51$
				($p > 0.05$)

* (X^2 of sex value ≤ 1 = fisher's exact)

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Socio-demographic characteristics and related issues

Respondents ages ranged from 17-33 years with a mean age of 21.0 years. This implies that the target population consists of mainly young persons. According to WHO (1989) young persons are those between the ages of 10-24 years. A previous study conducted among undergraduates of the University of Ibadan similarly revealed a mean age of 21.0 years (Ogunwale, Oshiname and Ajuwon, 2012). The age range in this study suggests that some of the respondents may have completed their secondary education before the statutory age of 18years as contained in the National Policy of Education (Federal Ministry of Education, 1983). The restructuring of the Nigerian educational system has created an opportunity for secondary school leavers to proceed to tertiary institutions including university after passing the Joint Admission and Matriculation Board Examinations. It is therefore not a surprise that most undergraduates at the University of Ibadan are predominantly young persons. It is pertinent for educational interventions to take into consideration these socio-demorgraphic characteristics.

5.2 Awareness and Knowledge relating to the YFC in U.I.

Majority (70.4%) of the 608 respondents had heard of the Youth Friendly Centre of the University of Ibadan. This was in contrast with findings from Akiniyi, (2012), who conducted a study on the determinants of Utilization of Youth friendly roproductive health services among 390 school and college youths in Thika West District of Kiambu County, Kenya. Akiniyi found that majority of the school, college youths (74%) had not received any information on Youth Friendly Reproductive Health Services (YFRHS). Friends constituted the major source of information on the YFC. Several studies have shown that peers or friends are the usual or

common sources of information on youth focused programmes in terms of location (Osaiyin, 2011) and reproductive health related issues (Obare, Agwanda and Magadi 2006; Zhang, Shah and Baldwin, 2006; Akiniyi, 2012; Ogunwale, et al 2012 ; Onyeonoro, Emelumadu, Chuku, Kanu, Ebenebe, Onwukwe, Uwakeme and Ndukwe, 2014). The finding is indicative of the pivotal role young persons can play in the promotion of youth friendly activities.

Most of the respondents provided accurate description of the YFC in U.I. This is probably indicative of the popularity of the centre. However, of the 428 respondents who had ever heard of the YFC, only 3.0% could not give accurate description of the YFC. In addition 7.7% did not even know the location of the YFC despite their awareness of the programme. The implication of this is that the dissemination of information relating to the YFC should include a disclosure of the location of the centre on campus.

Most of the respondents were aware of at least one or some broad typologies of services or opportunities available at the YFC. The listed services included General counseling, recreational activities, HCT, reading services, health talk on HIV/AIDs, provision of free condoms, education on sex related matters, informal intervention with the staff of the centre corroborated these claims by the respondents. These typologies of services or opportunities at the centre have been documented by previous reports and researches such as those of Senderowitzz (1999 ; 2003); WHO (2002); WHO (2012) and UNESCO (2013).

Other services available at the centre include; weight measurement, HIV post exposure prophylaxis and pregnancy test. According to WHO (2002), an appropriate range of essential services to be provided in a YFC must be decided based on local needs assessments. The Global Consultation on Adolescent Friendly Health Services held by WHO in Geneva in March 2001, concluded that a typical core package should not be a *'fixed menu'*. It was suggested instead that each country must develop its own package, negotiating its way through economic, epidemiological and social

constraints, including cultural sensitivities (WHO 2002).

The YFC in U.I, was first initiated by AGAH, a group that was mainly comprised of medical students in the University of Ibadan. This action was necessitated by the need to address issues relating to unintended pregnancies, unsafe abortions, sexually transmitted infections including HIV/AIDs, violence, abuse of alcohol and other drugs' The YFC eventually became full-fledged entity in October, 2007 with it's core package of services (Informal communication with Higher Programme Officer Youth Friendly Centre, UI).

The results showed that detailed knowledge of the YFC lagged behind awareness of the centre and its services. Only 24.8% of the respondents had good knowledge relating to the services provided at the centre. The mean knowledge score on YFC among the respondents was 7.50 ± 3.7 out of a maximum score of 15.0. This indicates a rather low level of knowledge about the YFC. Educational interventions needed to upgrade students knowledge of the service as provided by the centre is therefore an issue which needs to be handled as a matter of top priority.

A study conducted in Burkina Faso, Ghana, Malawi, and Uganda in 2004 among adolescents aged 12 -19 years, showed that contraceptives, STI and VCT services were still under utilized by the youth due to lack of knowledge about the services (Biddlecom, et al, 2007). Transgud (2001) ; Godia, (2010) and Elissa et al, (2013) also found out that lack of understanding of the importance of sexual health care and knowledge of where to go for care could discourage young people from using health services designed for young persons.

However, respondents level of knowledge was pretty high among adolescent respondents aged 17-19 years but there was no significant difference in respondents level of knowledge by age. This suggests that age should not be solely relied upon in the selection of knowledge related content element of educational interventions targeted at young persons.

Respondents in 600 level had the highest level of knowledge and this was statistically

significant. Their high level of knowledge about the YFC may have been influenced by the long duration of their stay in the University and their level of exposure to programmes and opportunities available at the centre.

Male respondents had a higher knowledge of the YFC compared with their female counterparts. This could be due to the proximity of male halls of residence especially Nnamdi Azikiwe and Independence halls to YFC than the female halls. Educational programmes aimed at upgrading students knowledge about the centre should take this relative disparity in knowledge into consideration.

5.3 Respondents perception relating to the YFC in U.I.

The study has revealed some of the location-related perceptions which can influence the utilization of the YFC in U.I. The location-related perceptions include those that concern visibility. In this regards many respondents were of the perception that the centre is not noticeable and cannot be easily accessed by students. It should be admitted that the centre is not strategically located. It is located along Appleton road, after the Department of Zoology, towards the Faculty of Technology. The centre is thus far away from hostels such as Queen Elizabeth, Obafemi Awolowo, Queen Idia, and Kuti halls. Previous researches such as, WHO (2004); Weir, Figueroa, Byfield, Hall, Cummings and Suchindran (2008), have noted that location and clear directions are important to utilization of services by young persons.

Few of the respondents were of the view that it is safe for students to discuss issues of rape with a YFC service provider while a higher proportion of respondents were undecided or had no opinion on this issue. The perceived social stigma associated with rape (Ogunwale et al 2012, 2015) and a feeling of lack of confidentiality of information divulged could lead to this state of affairs.

A few of the respondents were of the view that the YFC is set up only for students who experience sexual assaults while a reasonable proportion of them (36.3%) were

undecided or had no opinion. More males than females were of this view and there was a significant difference by gender. This pattern of perception-related resources are indicative of lack of indepth knowledge of the services offered at the YFC.

Some of the respondents were of the opinion that the services provided by the YFC are affordable. This is at variance with the findings from Kalo, (2006) ; Pathfinder International, (2012) and Biddlecom et al, (2007) which revealed that cost was a barrier to young people accessing reproductive health services.

This study revealed that some of the respondents were of the opinion that stigmatization prevents many young people from using the YFC. The results of previous studies such as those of Senderowitz, (1999); Erulka, Onoka and Phiri, (2005); Kalo, (2006) ; Youth Advocates, (2008) and Pathfinder International, (2012) also had similar findings.

5.4 Pattern of Utilization of the YFC in U.I. among the respondents.

The study reveals that the proportion of respondents who had ever visited the YFC was 41.6% among those who had ever heard of the YFC while the respondents who had ever heard and utilized at least one of the services provided at the centre constituted 34.6%. One thing is to visit the YFC and utilization of the services available at the centre is another. Among the 178 respondents who had visited the YFC only 83.1% had utilized any of the available services. The findings indicates that visitation to the centre among the respondents was not encouraging and the implication of this is that the level of utilization of the centre is generally low, a situation that is worrisome. These are major obstacles which need to be overcomed with a view to addressing the objectives for which the centre was established by the University.

Low utilization of YFC has also been revealed by several previous researches. An example is the study designed and conducted for One World UK by Yemi Osanyin. (2011), on the assessment of facilities providing Youth Friendly Health Services in

Nigeria. A total of 88 facilities were assessed and of this number 32% were youth centres, 32% were YFHS clinics, and 36% were general health clinics. Osamyin noted generally that the level of utilization of facilities and services by young people was low in the month preceding the exercise. Only 36% of facilities reported above 50 clients and an additional 6% of facilities reported 30-49 clients. Some facilities (16%) reported 15-20 client, 6% fewer than 15 clients, and 4% of facilities reported zero clients. He noted that, the low utilization of facilities and services by young people is of concern and suggests that services may not be youth friendly enough or the availability of services is unknown among the general public, or there are accessibility challenges which needs to be addressed (Osamyin, 2011). Similarly, a study carried out among 1000 adolescents aged 10-19 years in slum areas of Addis Ababa, Ethiopia, revealed that only 20% of boys and 7% of girls had ever visited a youth center within the year preceding the study. In addition, it was noted that boys were also more likely to utilize programs in this centre than girls (Erulkar, Tekle-Ab, Negussie, Taclai and Gulema 2006).

Godin (2010) similarly observed low level of patronage of YFC and the reason adduced for the state of affairs was lack of knowledge of the service offered among the centre by the study population. Akiniyi (2012) has noted that there is a significant association between awareness/knowledge of reproductive services and utilization of reproductive health services provided by the YFCs. This therefore means that increasing the knowledge base of the youth by creating awareness concerning the services provided by YFC can greatly improve or scale up utilization among them. The other factors that can promote under utilization of YFC includes : unfavourable operation hours which do not accommodate the youth's school schedules, lack of clear directions, unfriendliness of reproductive health services, crowding and lack of privacy (FHI, 2006; Akiniyi, 2012; Godia et al, 2014). Akiniyi, (2012), specifically noted that knowledge about existence of a reproductive health facility and knowledge about particular services being offered had significant positive influence on utilization of services.

In this study it was observed that the utilization of the services provided at the YFC was high among respondents who had ever visited the center and relatively more males than females had ever used the services available at the YFC. This pattern of use of the centre implies that educational efforts should promote visit of the centre by the target population and extra efforts should be made to target females. The reproductive health services that were utilized by the respondents are HIV counselling and testing, free condoms distribution, follow up counseling for HIV/AIDs, counseling on rape cases, counseling on sexual harassment, health talk relating to HIV/AIDs and information on sexually transmitted infections (STIs). Educational interventions such as public enlightenment and peer education are needed to promote awareness of these services. The utilization of reproductive health services is poor among the respondents with more males being users of the services although there was no statistically significant relationship between sex and utilization of reproductive health services at the UI YFC.

The major reproductive health services at the YFC are: health talk relating to HIV/AIDs, HIV Counselling and Testing (HCT) and information on sexually transmitted infections (STIs). The use of reproductive health services in this study was quite low compared to the use of other non reproductive health services like educational and recreational services. This correlates with findings from Akiniyi, (2012), who conducted a study on the determinants of Utilization of Youth friendly reproductive health services among 390 school and college youths in Thika West District of Kiambu County, Kenya and the results of his study indicates that utilization of reproductive health services was low. According to his study, some (47.9%) of the youths utilized counselling services, 38.7% utilized VCT and 29.5% utilized family planning.

Counseling on rape cases was the least utilized reproductive health services at the centre in U.I, this could be as a result of several factors including social stigma and sense of shame associated with being raped (Ogunwale et al, 2012; Ogunwale, Oshinaike and Ajuwon, 2015). A recent study conducted among female

undergraduates of the University of Ibadan revealed that the health seeking behavior of rape survivors was poor. Many of the rape survivors did not seek for help so as to avoid being blamed or discriminated against (Ogunwale et al, 2012; 2015).

Other services utilized by the respondents who had ever visited the center included: Counselling relating to relationships, career choices, drug use, reading services, recreation and internet use. Recreational services (e.g games), reading and internet services were the most utilized of these services. More males utilized the educational and recreational services compared with the females although the difference was not statistically significant. Senderowitz (2003); Osanyin (2011) and Godia et al, (2014), also noted in their studies that more males utilize recreation services of YFCs compared with females. There is the need therefore to promote YFC among female students. This will, however, require the design and inclusion of services that are relevant to their needs.

5.5 Factors perceived to facilitate the utilization of the YFC in U.I.

The study revealed some factors proposed by the respondents that could facilitate the utilization of the Youth Friendly Centre, the most common factors included; provision of free services to clients, sustained provision of recreational services, provision of confidential services, awareness creation about the centre and adoption of convenient period or hours of operation.

Provision of free services to clients has emerged as a major determinant of the utilization of the Youth Friendly centre. Previous studies such as WHO, 2002; Erulkar, Onoka and Phiri, (2005) ; Youth Advocates (2008) and Elissa et al, (2015) have revealed that young people want to obtain free reproductive health services. This is understandable when it is noted that young people are highly dependent persons because many of them are not working. In addition some of them would find it embarrassing to request for money from their parents for procuring reproductive health services.

Majority of the respondents were of the view that the adoption of convenient operating hours would facilitate the utilization of the YFC. Previous studies relating to the factors which promote the utilization of youth friendly services included operation of flexible hours (Erulka, Onoka and Phiri, 2005) and provision of evening, night and weekend services (Agampodi, Agampodi and UKD, 2008 ; Youth Advocates, 2012; Kiran et al, 2013; Godia et al, 2014 and Elissa et al, 2015). Flexibility relating to the service design in terms of hours of operation is particularly crucial because undergraduates are in very different programmes, different levels and have varying levels of academics demands or workload.

The confidentiality requested for by the respondents is one of the most highly valued characteristics of Youth Friendly Centres. Previous researches and reports including those of Lane, McCright, Garrett, Millstein, Bolan et al, (1999); WHO, (2002) ; Erulka, Onoka and Phiri, (2005); Agampodi, Agampodi ; UKD, (2008); WHO (2012) ; Kiran et al, (2013) ; Godia et al, (2014) and Elissa et al, (2015) stress the indispensability of confidentiality in the provision of YFS.

5.6 Factors that militate against the utilization of the YFC in U.I

The study reveals that some resource related factors could militate against the utilization of the YFC. A typical example is the location of the centre too far away from where students reside. This finding was in agreement with the findings of Erulka, Onoka and Phiri, (2005) ; Mansouri and Skrbis, (2013); Elissa et al, 2013 ; Godia et al, (2014) and Kiran et al, (2015). Godia et al, (2014) also noted in his study that even young people themselves suggested that accessibility of the location of a youth centre and it's closeness to public transport can improve the utilization of Sexual and Reproductive Health (SRH) services. At the University of Ibadan, the YFC is located behind the zoological garden, along Appleton road; the facility is therefore not clearly accessible. Taxis and buses do not often go through that road. Vehicles most times stop at the Zoology Department junction or at the Faculty of

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Technology, this situation poses a bit of challenge to students who would have wanted to utilize services at the centre.

The study also reveals the non-operation of the Centre at convenient times could be a barrier to utilization of the YFC. Undergraduates are often busy with their academic work and may not find it convenient to visit the YFC during the opening hours which is between 8.00am-4.00pm. At the University of Ibadan this period unfortunately collides with lecture times. According to Erulka, Onoka and Phiri, (2005); Agampodi, Agampodi and UKD, (2008) ; Youth Advocates, (2008); Akiniyi 2012; WHO (2012) ; Godia et al, (2014) and Kiran et al (2015), youths prefer more convenient hours of operation including weekend services to enable them use the range of services and opportunities available in YFC.

The study reveals some challenges relating to awareness and psycho-social factors which could militate against the utilization of the YFC. These included lack of awareness about the Centre and lack of in-depth knowledge of what is done in the Centre. The findings are similar to what Erulka, Onoka and Phiri, (2005); Biddlecom, et al (2008); Khalat, Moghli and Frolicher, (2010); Akiniyi 2012; Maesouri and Skrbis, (2013) and Godia et al, (2014) noted in their various studies.

The perceived psychosocial factors included; unfriendly attitude of service providers, their perceived judgemental attitude, lack of confidentiality of services were listed as factors that can militate against utilization of the centre. According to some previous researches including those by WHO (2002); Biddlecom, et al (2008); Pathfinder International, (2012) and WHO (2012) factors such as unfriendly and judgemental attitude of service providers, lack of privacy or confidentiality and long waiting time, can adversely affect utilization of services by young people. Confidentiality, friendliness, short time of waiting and free or low cost constitute some of the most important characterisucs of services that young people want (Erulka, Onoka and Phiri, 2005 and Godia et al, (2014)).

Only a few respondents were of the view that the questions asked by service

providers were embarassing or could discourage young people from using the YFC of U.I. This result is at variance wilb what Biddlecom, et al 2008 noted in their study. Biddlecom, et al 2008 who conducted a study among adolescents aged 12-17 years on adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda noted that feeling afraid, embarrassed or shy to seek reproductive health services was a barrier to the utilization of services. More females than males reported feeling afraid, embarrassed or shy about obtaining either contraceptive services or STI treatment. Biddlecom, et al 2008 study was carried out among adolescents aged 12 – 17 years who were younger than students in U.I. study, younger persons may feel uncomfortable to discuss sensitive issues with older service providers.

5.7 Implications for Health Promotion and Education

Findings from this study have health promotion and education implications and suggest the need for multiple interventions directed at addressing the challenges relating to the use of the YFC at the University of Ibadan. The findings in this study have revealed the fact that utilization of the YFC is low. The levels of awareness and knowledge about the YFC are inadequate among undergraduates of the University of Ibadan. There is urgent need to create awareness and upgrade their knowledge relating to the available reproductive health services at the YFC.

Despite the awareness of the existence of YFC, many of the respondents had poor/low knowledge of the services offered in the centre. This situation may have in turn makes the utilization of the centre low. Tbis connection between low level of knowledge relating to the services provided at the YFC and utilization of the centre becomes understandable when it is realized that knowledge is a powerful behavioural antecedent factor (Green and Kreuter, 1999).

Studies conducted elsewhere have revealed that lack of knowledge by youth was a major factor that caused under-utilization of youth-friendly reproductive/sexual services (Godia, 2010 ; Elissa et al, 2013 and Godia et al, (2014)). In a study carried

out by Akiniyi (2012), it was noted that there was a significant association between awareness/knowledge of reproductive services and utilization of the services offered. This therefore means that increasing the knowledge base of young people and creating awareness concerning the services offered can greatly improve or scale up utilization. However, it should be borne in mind that increasing knowledge among graduates alone is not enough. Several other strategies or interventions are needed. A holistic or ecological approach is best for promoting adoption of YFC among the U.I. undergraduates.

There are several opportunities for promoting the adoption of YFC and the services rendered at the YFC in U.I. The University's students' handbook of information and the University of Ibadan website could be used to disseminate information on the YFC, the YFC can create its own websites and create a page in other social media like *whats app*. In addition, the University radio station (the Diamond FM) could be used to disseminate information about the YFC.

Fresh students are particularly vulnerable to some of the risky practices that can compromise their health such as risky sexual practices and unhealthy lifestyles. Fresh students need to be aware that available services at the YFC such as counseling services, HCT, library and internet services, recreation services as well as social networking. Fresh students can be reached through orientation programmes and the integration of YFC into the existing general studies programme of the University as currently done in the institution. In order to carry out the social marketing of the centre and its services among the freshers effectively; mandatory participation in the orientation programme for freshers maybe necessary. During the orientation, students could be taken to the centre so that they could be acquainted with facility and its services.

The other segment of the University community with special reference to the older undergraduates should be well informed about the centre. Public enlightenment should be used to promote the centre and its services among them. Public

enlightenment should take into consideration the following: location of the YFC, services / opportunities available major characteristics of the services provided at the centre including friendliness, confidentiality, short time of waiting before being attended to by a service provider and convenient opening hours. Well informed older students have pivotal roles to play in helping fresh students to adopt the utilization of the centre.

Public enlightenment programmes including awareness campaigns have the potential for reaching large numbers of people (UNICEF, 2011). Public enlightenment can create awareness and influence knowledge, perception (UNICEF, 2011 and Elissa et al, 2013) and foster political will for action, evidence of its effectiveness as an educational strategy in changing behavior remains insufficient (Whitaker, Baker and Arias, 2007). However, efforts must be made to combine it with other strategies such as peer education and policy intervention to effectively address the challenges faced by the YFC. Public enlightenment techniques could involve the use of posters, leaflets, documentaries, jingles and bill boards (Whitaker, Baker and Arias, 2007 and UNICEF, 2011). Findings from Elissa et al (2013) and Godia et al, (2014), also suggests that sensitizing young people on the importance of youth centre through fun-activities, radio, posters, music entertainment, religious platforms, booklets, magazines, etc can improve utilization of services. Use of one or more of these information media could be very helpful as the weakness of one could be counter-balanced by the strengths of others.

Training and re-training exercises should be made available to service providers to upgrade the knowledge and skills relating to quality service provision. The effectiveness of training in enhancing people's capacity to solve public health related problems has been demonstrated in several studies, such as Oshiname and Briegar (1992), which effectively demonstrated the use of training to make Patent Medicine Vendors safer contacts with their clientele.

Royal College of Nursing and Public Health England, (2015). recommends good

foundation training, annual updates and support for health care support workers in order to ensure that their level of knowledge and skills are appropriate, care delivery competent and their attitude to immunization positive so they can best support and assist registered healthcare professionals to safely and effectively deliver vaccination programmes. Department of Health, 2012, in her implementation framework indicated that national mental health strategy suggests that local public health services "commission or provide evidence-based mental health training for non-mental health professionals" to enable them meet the growing demand from front-line workers. Health trainers have been effective in reducing health inequalities by engaging with people in the most deprived communities. Local advocates, peer educators, parenting support volunteers and people in paid lay worker roles make a valuable contribution to public health. Shircore, 2013. The skills and attributes that a lay worker brings are different to, not less than, those of professional experts (South, White, Brannoy and Kinsella , 2013).

Public Health England also recognizes in it's framework on public mental health leadership and workforce development that public health specialists/practitioners, work with people in different ways and levels such as: individuals, other individuals that have more regular contact with individuals and families (such as health visitors and social workers). Including groups communities, organizations, leaders and elected members as a foundation for building workforce capacity and capability, as well as having an effective interventions for promoting mental health (Public Health England, 2015).

Staff in halls of residence including hall wardens, supervisors and porters and hall executives should be trained and well informed about the YFC location, knowledge of what is done in the centre and its characteristics. This becomes necessary as these categories of people interact intimately with students on a daily or regular basis. They can help promote the adoption of YFC/services at least among accommodated students.

Channels for feedback such as suggestion box, feedback telephone contact, social media (facebook page, whats app group, twitter, etc) should be created for students who visit the centre. These will help in addressing misconceptions or concerns that the students might have about the centre as they can anonymously drop their comments, disapproval or concerns and suggestions in the suggestion box. These channels can help upgrade and rebrand the centre regularly to meet up with students' demands as well as keeping them abreast of upcoming events and programmes of the centre.

Young people are concerned about conduciveness and attractiveness of centres. According to WHO (2002) and Biddlecom et al, (2007), nice furnishings and decorations encourage youths to utilize services. Godia et al, 2014, similarly noted in their study that young people suggests that neat, attractive and well organized facility can improve uptake of sexual and reproductive health services. Recreational services was reported by respondents in this study to facilitate the utilization of the YFC. This makes it paramount for the University authority and YFC management to put in more efforts into beautification of the centre and also to provide gardens for out-door relaxation and recreation.

Advocacy is another strategy that can be used to influence the pattern of utilization of the YFC. The limited access to the centre which often prevents some students from using the YFC needs to be addressed using appropriate strategies such as advocacy and the creation of links between the YFC, University authority, Student Union Body, Community based Organisations, halls of residence, etc. Advocacy interventions should target the University authorities such as Students' Affairs Division. There is a need to incorporate the YFC into the curriculum and activities of the students where necessary and help promote the centre and its services to the students and the entire University community. Advocacy should be made to the Students' Union body since it is the highest of the student's executive body and from this office the students can easily be reached at all levels. Various Faculties, Departments, their executives and the various class representatives should be reached

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with advocacy messages on the YFC. Advocacy should also target Community-based Organizations in the University including Faith-based Organizations on campus such as Chapel of Resurrection, Seat of Mercy, National Fellowship of Evangelical Students (NIFES), Nasrul Lahi-il Fathi Society (NASFAT), etc. Faith based leaders are held in high esteem by their members and can be used to influence their congregations to patronize the YFC. Advocacy campaigns can be built around global events on the global calendar, such as St Valentine's Day on the 14th of February, World AIDs Day which comes up on every December 1st every year.

Advocacy can be made more effective by using locally generated data from systematically conducted studies. The use of research findings for advocacy has been revealed to be promising in raising awareness and contributing to the shaping of reforms and policies (Ellsberg, Liljestrand and Winkvist, 1997 and Bliss 2013). The use of research findings when combined with the provisions of international agreements such as the Human Rights Convention, International Conference on Population and Development (ICPD), Developing National Standard for Adolescent Friendly Health Services can further strengthen the impact of advocacy (WHO 2012).

Partnership with relevant sectors, agencies and Non-Governmental Organizations (NGOs) can be used to address the problem of knowledge and utilization of the YFC among undergraduates. According to UNICEF (2011), the mass media have been contributors to massive awareness campaign activities, and provide opinion leaders and sometimes household heads with information and knowledge on appropriate practices that trickle down to individuals within the family and facilitate the adoption of positive behaviours. The YFC can also partner with the University radio station (the Diamond FM) to disseminate information on the YFC.

Partnership involves pooling of resources from different parties together to address common concerns (Association of Chartered Certified Accountants, 2015). Partners in a partnership should be charged with the responsibilities of funding, providing drugs and supplies including contraceptives, educational materials, games, computers,

decorations, to the centre. The University could collaborate with relevant government orgatizations such as Ministry of Health and Ministry of Youth Development and non-governmental organizations to create more awareness and organize behavioural change interventions that can sensitize and educate students and University policy-makers on the importance of the YFC. In addition, partnership can be formed with students' associations within the University with a view to creating awareness, knowledge and utilization of the YFC. Reaching out to clubs, organizations and teams on campus is a unique way of reaching high-risk target groups of students (American College of Health Association, 2008 ; Leventhal and Meijs, 2010). Some students associations/groups in the University may serve as useful channels for reaching out to students on the YFC; these groups may include the Students Union Government, Uniibadan Health Organization and HIV/AIDs Prevention Promotion Youth Club (HAPPY CLUB), Gender Mainstreaming and Religious Organisations. These groups may equally provide unique opportunities for recruiting volunteers for the centre.

5.8 Conclusion

The research explored the level of knowledge, perceptions and pattern of utilization of the YFC in U.I. Majority of undergraduates have heard of the YFC in U.I. More males than females had heard of the YFC with no significant difference. Friends were the major sources of information on the centre. Overall, respondents level of knowledge relating to the services provided at the YFC was poor. In addition, many respondents perceived the YFC to be located in a place where it cannot be easily accessed by students, a situation which adversely effect its use. The YFC was poorly utilized by the study population. However, it was noted that not all those who had ever visited the centre used the services available at the centre.

The research has provided valuable information on the factors that could facilitate utilization of the centre. It has also thrown some insight into the perceived resource-related factors that could militate against utilization of the YFC, such as location of

centre too far away from where students reside, lack of drugs and supplies, making clients wait in places where people who know them can meet them, centre not opened at convenient times and also some perceived awareness and psycho-social related factors which includes;

The undergraduates have stated their perceptions as well as described factors that could influence utilization of the YFC and services offered at the centre. Such information will be useful in ensuring that the YFC is re-positioned by both the YFC staff and authorities of the University of Ibadan.

5.9 Recommendations

The recommendations arising from this study are as follows:

1. The study has revealed general lack of knowledge of the YFC, there is need therefore, for active sensitization of the undergraduates through youth forums such as seminars, rallies and through interventions and any other gathering that creates an opportunity for information about the YFC to be shared among them, this intervention has potential for increasing utilization of the services.

2. There is need to train undergraduate peer educators to compliment the youth friendly service providers in informing and educating their peers about the centre.

3. The YFC should carry out outreach services in halls of residence, Departments and recreational centres on specific days.

4. The YFC should provide means of easy access to YFC by creating a bus stop at the YFC area and also liaising with the campus shuttle drivers to ply the route.

5. The YFC should offer services to students beyond 4.00p.m, with a view to addressing needs of some students who may not be able to access the facility on or before 4 p.m. when the facilities closes.

6. Advocacy strategy should be used to influence key policy and decision makers in the institution to formulate guidelines aimed at promoting the adoption of the services by undergraduates.

5.10 Suggestions for further study

It is suggested that further studies be carried out, to throw more light on some aspects of the YFC which were not covered in this study. These include studies relating to the following:

1. A study among undergraduate students in the U.I. who reside off-campus in order to compare data and proffer effective solutions that could be more generalizable.

2. The determinants of non-patronage of the YFC among students who had ever heard about the centre.

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APPENDIX I

QUESTIONNAIRE

Dear respondent,

My name is *Okosun O. Precious* a postgraduate student of Population and Reproductive Health Education, Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan. I am carrying out a study relating to the "**Pattern of Utilization of the campus-based Youth-Friendly Centre among undergraduate students of the University of Ibadan, Nigeria**". The pieces of information needed are strictly for academic purposes; they will also be useful for making the Centre more youth-friendly. So be free to express your views based on what you really know and do. Information collected from shall be kept confidential. For your information participation in this study is voluntary.

Kindly show by ticking (√) any of the following boxes provided to indicate that your participation in this study is voluntary.

I will participate and will sign ☐ I will participate but will not sign ☐

Signature.....

Thank you for your cooperation.

Section A: Socio-demographic Characteristics

Instruction: In this section tick (√) the option that corresponds to your answer or complete the spaces provided.

1. Course of study.....

2. Level of study: (a) 100 ☐ (b) 200 ☐ (c) 300 ☐ (d) 400 ☐ (e) 500 ☐ (f) 600 ☐

3. Hall of residence:

(a) Obafemi Awolowo Hall ☐
(b) Queen Elizabeth hall ☐
(c) Alexander Brown ☐
(d) Independence hall ☐
(e) Nnamdi Azikiwe ☐
(f) Queen Idia hall ☐
(g) Mellanby hall ☐
(h) Kuti hall ☐
(i) Tedder hall ☐
(j) Sultan Bello hall ☐

4. Religion: (a) Christian ☐ (b) Islam ☐ c) Traditional ☐
(d) Others, specify.....

5. Sex: (a) Male ☐ (b) Female ☐

6. Age (as at last Birthday; in years): .....

7. Marital status .....

Section B: Awareness and Knowledge relating to the Youth Friendly Centre (YFC).

Instruction: Complete the spaces provided or tick (√) the option that corresponds to your answer.

Please feel free and be very honest while answering the questions. Be assured that all your answers will be kept confidential. Thank you.

8. Have you ever heard of the University of Ibadan Youth Friendly Centre? (a) Yes
(b) No ☐

If "NO", STOP the INTERVIEW. Thank you for participating in the study thus far.

9. What are your sources of information about the Youth Friendly Centre of this University? Tick (√) all the sources from which you have heard about it.

(a)Television ☐ (b) Internet providers ☐ (c) Radio ☐ (d) Fliers/posters ☐ (e) Service ☐ (f) Lectures ☐ (g) Friends ☐ (h) Sign Board ☐ (i) Campaigns ☐

(j) Orientation programme for new students ☐

(k) Others (specify).....

10. Where is the Youth Friendly Centre located in U.I.?

.....

.....

.....

11. Mention four services offered by the Youth Friendly Centre

(a).....

(b).....

(c).....

(d).....

Instruction: Table 1 contains a list of statements relating to a Youth Friendly Centre. For each, tick (√) whether it is True or False. If you are not sure, tick (√) "Don't know".

Table I

		Tick (√)		
S/No.	Statements about the Youth Friendly Centre (YFC) of the University of Ibadan.	True	False	Don't Know
12.1	The Youth Friendly Centre does not provide free HIV Counseling and Testing (HCT).			
12.2	The Youth Friendly Centre provides counseling services to young people on relationships.			

12.3	Youth Friendly Centre is set up for recreational purposes only.			
12.4	YFC provides a forum for young people to socialize with one another.			
12.5	The Youth Friendly Centre provides free condoms to students.			
12.6	Students can visit the Youth Friendly Centre without booking an appointment.			
12.7	A formal letter of introduction from the Dean of students or from the Head of one's Department is needed before one can use the services provided by the Youth Friendly Centre of U.I.			
12.8	The Youth Friendly Centre provides information on HIV/AIDs to students.			
12.9	The Youth Friendly Centre provides counseling services to students on choice of career.			
12.10	An identity card is needed before one can use the services at the U.I. Youth Friendly Centre.			

Section C: Perceptions relating to the Youth Friendly Centre (YFC) in U. I.

Instruction: Table 2 contains a list of statements or opinions. For each tick (√) whether you agree with it, have no opinion of your own or whether you disagree with it.

Table 2

S/No	Perceptions relating to the Youth Friendly Centre (YFC)	Tick (√)		
		Agree	Undecided / Have No Opinion	Disagree
13.1	The location of the YFC is too hidden.			

13.2	The YFC is located in a place that cannot be easily accessed by many of the students.			
13.3	The YFC is located in a place where other people will see those who use it; no confidentiality.			
13.4	Youth Friendly Centre offers services that many students do not like.			
13.5	The YFC is set up for only students who experience sexual assaults.			
13.6	The environment of the Youth Friendly Centre is not conducive.			
13.7	The YFC is operated in a manner that does not make students who have problems to feel free to share experiences.			
13.8	YFC is only good as a recreational centre.			
13.9	It is safe to discuss issues of rape with a service provider at the centre.			
13.10	Services provided at the Youth Friendly Centre are affordable.			
13.11	The hours of operation of the Youth Friendly Centre are not convenient.			
13.13	The services provided at the Youth Friendly Centre are not confidential; one's secret can easily leak or be disclosed to other students.			
13.14	The Youth Friendly Centre is only for students who want to know their HIV status.			
13.15	Fear of stigmatization prevents many students from using the centre.			

Section D: Pattern of Utilization of the Youth Friendly Centre.

14a. Have you ever visited the Youth Friendly Centre of the University of Ibadan?

(a) Yes ☐ (b) No ☐

14b. If Yes to question 19a above, have you ever benefitted from any of the services of the centre?

(a) Yes ☐ (b) No ☐

13.6	The environment of the Youth Friendly Centre is not conducive.			
13.7	The YFC is operated in a manner that does not make students who have problems to feel free to share experiences.			
13.8	YFC is only good as a recreational centre.			
13.9	It is safe to discuss issues of rape with a service Provider at the centre.			
13.10	Services provided at the Youth Friendly Centre are affordable.			
13.11	The hours of operation of the Youth Friendly Centre are not convenient.			
13.12	The services provided at the Youth Friendly Centre are not confidential, one's secret can easily leak or be disclosed to other students.			
13.14	The Youth Friendly Centre is only for students who need to know their HIV status.			
13.15	Fear of stigmatization prevents many students from using the centre.			

Section D: Pattern of Utilization of the Youth Friendly Centre.

14a. Have you ever visited the Youth Friendly Centre of the University of Ibadan?
(a) Yes ☐ (b) No ☐

14b. If Yes to question 19a above, have you ever benefited from any of the services of the centre?
(a) Yes ☐ (b) No ☐

Table 3 is for those who have benefited from the services provided at the Youth Friendly Centre only. If never benefited go to Q 16. The table contains a list of services; for each service tick (√) "Yes" if you have ever used it at the centre and "No" if you have never used the service at the centre.

Table 3 is for those who have benefitted from the services provided at the Youth Friendly Centre only. If never benefitted go to Q 16. The table contains a list of services, for each service tick (√) "Yes" if you have ever used it at the centre and "No" if you have never used the service at the centre.

Table 3

S/No.	Services used in the Youth Friendly Centre	Ever used it or benefitted from it Tick (√)	
		Yes	No
15.1	Counseling on Relationships		
15.2	Counseling on choice of a career		
15.3	Counseling on Drug use/ abuse		
15.4	HIV Counseling and Testing (HCT)		
15.5	Obtain free condoms		
15.6	Follow up Counseling on HIV/AIDs		
15.7	Counseling on rape cases		
15.8	Counseling on sexual harassment		
15.9	Health talk relating to HIV/AIDs		
15.10	Obtain information on sexually transmitted infections (STIs)		
15.11	Used the centre's reading room for study		
15.12	Internet services		
15.13	Recreational activities e.g. games		

16. What encourages you to use the Youth Friendly Centre of the University of Ibadan?

.....

.....

.....

17. Have you ever encouraged someone to use the Youth Friendly Centre? (a) Yes ☐

(b) No ☐

Section B: Factors which Facilitate the Utilization of the Youth Friendly Centre

Instructions: Please indicate your answer by ticking (√) the appropriate box/space provided. Thank you.

18. In your own opinion which of the following factors encourages students to utilize the Youth Friendly Centre in UI?

Table 4

S/No	Factors	Yes	No
18.1	Awareness creation about the centre		
18.2	Publicity of the services provided at the centre		
18.3	Location of the centre in a place where it can be easily accessed by clients.		
18.4	Short time of waiting before being attended to by a service provider.		
18.5	Provision of free services		
18.6	Convenient operating hours		
18.7	The services provided to students at the centre are confidential i.e. not disclosed to other people in the centre.		
18.8	Presence of fellow young people who attend to one's needs		
18.9	Availability of contraceptive prescriptions and pills right in the centre		
18.10	Being able to obtain free condoms right in the centre		
18.11	It is difficult for people to know what one goes there to do because there are many services provided there.		
18.12	Provision of recreational activities for students who visit the centre.		

19. In your own opinion what is the best way of encouraging young people to be using the Youth Friendly Centre?

.....

.....

.....

Section F: Perceived factors which militate against the Utilization of the UI Youth Friendly Centre?

20. Which of these factors in the table below do you think are responsible for people not using the Youth Friendly Centre? Please indicate your response by ticking (√) in the appropriate spaces provided in Table 10 below.

Table 5

S./No.	Factors responsible for poor/lack of usage	Tick (√)	
		Yes	No
20.1	Lack of awareness about the centre		
20.2	Lack of knowledge of what is done at the centre		
20.3	Long time of waiting to be attended to at the centre		
20.4	Unfriendly attitude of service providers to students		
20.5	Making students wait in places where people who know them can see them		
20.6	Judgmental attitude of service providers		
20.7	Lack of confidentiality of services provided		
20.8	Lack of drugs/ supplies		
20.9	Procedures that do not make the centre user-friendly		
20.10	Ridiculing the students who visit the centre		
20.11	Students are asked embarrassing questions by service providers		
20.12	Lack of skilled service providers		
20.13	Lack of contraceptive services		
20.14	Location of centre is too far away from where students reside		
20.15	The Centre not opened at convenient times		
20.16	Fear that friends might know why one visits the centre		
20.17	Lack of referral service for students to alternative places where they can get necessary help		
20.18	Other specify.....		

21. In your own opinion, what would your friends likely think about your visiting the Youth Friendly Centre?.....

.....

.....

Questions 24-26 are for only those who have ever used the U.I. Youth Friendly Centre.

22. Are you satisfied with the services provided at the centre? (a) Yes ☐ (b) No ☐

23. If your answer to question "28" above is "No" why are you not satisfied?

.....

.....

.....

24. What are your suggestions for improving the services provided at the Centre?.....

.....

.....

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, IBADAN, NIGERIA.
Director: Prof. A. Ogunniyi, [illegible]
Tel: 08023038583, 08038094173
E-mail: aogunniyi@comui.edu.ng

UI/UCH EC Registration Number: NHREC/05/01/2008a

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Pattern of Utilization of the Campus-Based Youth Friendly Centre among Undergraduates Students of the University of Ibadan, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/14/0036

Name of Principal Investigator: Olawoore O. Precious

Address of Principal Investigator: Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan

Date of receipt of valid application: 11/02/2014

Date of meeting when final determination on ethical approval was made: 24/03/2014

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the UI/UCH Ethics Committee.

This approval dates from 24/04/2014 to 23/04/2015. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. No changes are permitted in the research without prior approval by the UI/UCH EC except in circumstances outlined in the Code. The UI/UCH EC reserves the right to conduct compliance visit to your research site without previous notification.

Professor A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: uiuchirc@yahoo.com

• Drug and Cancer Research Unit • Environmental Sciences & Toxicology • Genetics & Cancer Research • Molecular Entomology • Malaria Research • Pharmaceutical Research • [illegible] • Neurodegeneration Unit • Palliative Care • HIV/AIDS

DEPARTMENT OF HEALTH PROMOTION AND EDUCATION

College of Medicine, University of Ibadan, Nigeria
Tel: 08108955615 | E-mail: [illegible] | [illegible]

Professor O. Oladepo
Head

O. Oladepo
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O.E. Oyewole
M.A. Titiloye
I.O. Dipeolu
Adeyimika T. Desmennu
Mojisola M. Oluwasanu
Yetunde O. John-Akinola

Our Ref: HPE/SF/

15th March, 2011

TO WHOM IT MAY CONCERN

Re: OKOSUN, Okponoma Precious
Matric No: 167337

This is to certify that the bearer Okosun Okponoma Precious is an MPH (Population and Reproductive Health Education) student in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan.

The student is to [illegible] "[illegible] of the Cannabis Based Youth [illegible] Centre among Undergraduates of the University of Ibadan".

Kindly accord her all necessary assistance she may require.

Thank you.

Professor O. Oladepo

HEAD
DEPARTMENT OF HEALTH PROMOTION & EDUCATION
COLLEGE OF MEDICINE
UNIVERSITY OF IBADAN
IBADAN [illegible]

APPENDIX Iv

Consent form for Survey Respondents

Name of Principal Investigator: OKOSUN Okainemen Precious

Department of Health Promotion and Education,

Faculty of Public Health,

University of Ibadan,

Ibadan,Oyo State.

IRB Research Approval Number: .....

This approval will elapse on: ...../...../.....

Title of Research Project:Pattern of Utilization of the campus-based Youth-friendly Centre among Undergraduates of the University of Ibadan, Nigeria.

Greetings: My name is ..... and I am a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan. I am involved in the study which focuses on the "Pattern of Utilization of the Campus-based Youth-friendly Centre among Undergraduates of the University of Ibadan, Nigeria".The study is designed to learn from you about what you know about the youth friendly centre, your perceptions about the centre, pattern of use and the factors which influence the utilization of the centre among the undergraduates of the university.

Purpose of the research: The results of the study will be useful for policy formulation and adoption of evidence-based strategies aimed at maximizing the utilization of the centre.

Procedures:

You are hereby invited to take part in this research by participating in an interview in order to find answers to some of these questions. You will be asked some questions relating to aspects of your life. Some other questions will relate to some of your experiences as a student here on campus, while others will focus on your awareness and knowledge relating to the services provided at the youth friendly centre of the University of Ibadan. In addition there are questions aimed at learning from you about your pattern of use of the services at the centre and your perceptions of the services provided.

An interviewer administered semi-structure questionnaire will be used for documenting your responses. The questionnaire will not contain your name, matriculation number or any other identifier so whatever you put down can be as anonymous as possible. It is important for the research that you answer all the questions but if you do not wish to answer any of the questions, you may move to the next question. All information collected from you will not be shared with any other person. The interview is expected to last for about 30 minutes.

Risks and Discomforts:

The interview may take some of your time. There is also a slight risk that you may feel uncomfortable talking about some of the topics. However, you may refuse to answer any questions if you feel the question(s) makes you feel uncomfortable

Benefits:

There may be no direct benefit to you; however the information obtained from this study be useful in making recommendations aimed at improving the services provided at the youth friendly centre.

Incentives: You will not be provided any incentive to take part in the research.

Confidentiality:

The information that we collect from you during the conduct of this study will be kept confidential. This implies that only the investigator (Okosun Okainemen Precious) will have access to the copy of the questionnaire you have completed.

Right to refuse or withdraw:

Participation in this study is voluntary. Refusing to participate in the study does not attract any penalty whatsoever. You may also wish to stop participating in the interview at any time that you wish and there will be no negative consequences for doing so. You will however be happy at the end of the study that you have contributed something that can be used to develop further the services provided at the youth friendly centre.

Who to contact:

If you have any questions you may ask now or later. If you wish to ask questions later, you may contact any of the following persons:

OKOSUN Okainemen Precious
Department of Health Promotion and Education,
Faculty of Public Health,
University of Ibadan, Ibadan,
Oyo State.
Telephone : 0706-638-3595
Email: preshj2009@yahoo.com

Dr. F.O. Oshiname
(Supervisor)
Department of Health Promotion and Education,
Faculty of Public Health,
University of Ibadan,
Ibadan,
0803-500-1060
foshinamc@yahoo.com

The Consent

I have been invited to take part in the research project on the "Pattern of Utilization of the Campus-based Youth-friendly Centre among undergraduates of the University of Ibadan, Nigeria". I have read the information relating to the study. In addition I have had the opportunity to ask questions about it and any question(s) I have asked have been satisfactorily answered. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without any penalties.

Name of Participant

Date and Signature of Participant

(Not names, please)

....(dd/mm/yy)

Name of Researcher/ Moderator

Date and Signature of Researcher/Moderator

.....

.....(dd/mm/yy)

APPENDIX v

SCORING OF YOUTH FRIENDLY SERVICES KNOWLEDGE SCALE

QUESTION	VARIABLES	MAXIMUM SCORE (points)
10	Where is the Youth Friendly Centre located in U.I.?	
	Accurate description* (1)	1
	Inaccurate description (0)	
	Don't know (0)	
11	Mention FOUR services offered by the Youth Friendly Centre	4
	HIV counselling and testing (HCT)*	
	Provision of free condoms*	
	Reading services*	
	General Counselling *	
	Health talks relating to HIV/AIDs*	
	Education on sex related matters*	
	Recreation services*	
	Internetservices*	
	Registration for health services*	
	Catering service/snack sales	
	Weight measurement*	
	Eye test/screening	
	Blood / genotype test	
	Urine test	
	Social networking	
	Pregnancy test*	
	HIV Post exposure prophylaxis*	
	Don't know	
12	Statements about the Youth Friendly Centre (YFC) of the University of Ibadan.	
12.1	The Youth Friendly Centre does not provide free HIV Counseling and Testing (HCT).	
	True (0)	1
	False* (1)	

	Don't know (0)	
	The Youth Friendly Centre provides counselling services to young people on relationships.	
	True* (1)	1
	False (0)	
	Don't know (0)	
	Youth Friendly Centre is set up for recreational purposes only.	
	True (0)	
	False* (1)	1
	Don't know (0)	
	YFC provides a forum for young people to socialize with one another.	
	True* (1)	1
	False (0)	
	Don't know (0)	
	The Youth Friendly Centre provides free condoms to students.	
	True* (1)	1
	False (0)	
	Don't know (0)	
	Students can visit the Youth Friendly Centre without booking an appointment.	
	True* (1)	1
	False (0)	
	Don't know (0)	
	A formal letter of introduction from the Dean of students or from the Head of one's Department is needed before one can use the services provided by the Youth Friendly Centre of U.I	
	True (0)	
	False* (1)	1
	Don't know (0)	
	The Youth Friendly Centre provides information on HIV/AIDs to students.	
	True* (1)	1
	False (0)	

	Don't know (0)	
	The Youth Friendly Centre provides counselling services to students on choice of career.	
	True* (1)	1
	False (0)	
	Don't know (0)	
	An identity card is needed before one can use the services at the U.I. Youth Friendly Centre.	
	True (0)	
	False* (1)	1
	Don't know (0)	
	Total YFS knowledge score	12 points scale

*Correct option

Categorization of Youth Friendly Service knowledge score		Code
Poor	≤7	1
Fair	> 7-10	2
Good	> 10	3