

Perception of Adolescents on the Attitudes of Providers on Their Access and Use of Reproductive Health Services in Delta State, Nigeria

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Abstract

This paper examines the perception of adolescents on the attitudes of providers on their access and use of reproductive health services (ARHS) in Delta State, Nigeria, with a view of assessing the impact of providers' attitude on the use of adolescents' reproductive health services in Delta State. The study adopted a survey design to collect primary data using questionnaires and focus group discussions (FGDs) from adolescents in a sample of schools. A sample size of 1500 respondents was taken from 12 schools in six Local Government Areas in three Senatorial Districts in Delta State, Nigeria. The locations of the schools were such that six each were in rural and urban communities respectively. The result from the study was that unfriendly attitudes of providers which keep adolescents waiting, inadequate duration of consultations, judgmental attitudes of some providers, lack of satisfactory services provision and lack of confidentiality will put off adolescents from accessing and using adolescents' reproductive health services irrespective of their sex, age, class, religion, residence, ethnic group, parents' education or income levels. The paper concludes that medical personnel take all these issues very seriously when dealing with adolescents to enhance access and use adolescents' reproductive health services in Delta State and indeed Nigeria.

Keywords

Providers Attitudes, Adolescents, Reproductive Health, Delta State, Nigeria

1. Introduction

Adolescents' Reproductive Health Services (ARHS) is concerned with the constellation of methods, techniques and services that contribute to reproductive

and sexual health and wellbeing by preventing and solving reproductive health problems of adolescents. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases [1]. Adolescence represents a unique transition during which teenagers take on new responsibilities of taking care of themselves and seeking health care. This population may not be socialized into the health care system and may have incorrect beliefs that influence their view of reproductive health. Many of the avoidable problems in reproductive health (RH), such as unwanted pregnancy, abortion and its complications, sexually transmitted infections (STIs) including the acquired immunodeficiency syndrome (AIDS) take place during this stage of the lifespan. These challenges are as a result of many factors among which are the lack of access and utilization of services by adolescents; hence there have been concerns about adolescents' reproductive health [2]. One of the major issues in adolescents' lack of access and use of reproductive health services is providers' attitude. Different aspects of providers attitude affect adolescents' uptake and usage of reproductive health services such as: how much the clients are kept waiting when they visit providers, the satisfaction with providers services; how much time they spend in rendering services to their clients, the level of confidentiality the providers observe when working with clients, how effective a physician is in his work, the assessment whether their clients are judge by them, and whether adolescents treatment required parental notification [3] [4] [5] [6]. Hence, it is the goal of the paper to examine the perception of adolescents on the attitudes of providers on their access and use of reproductive health services in Delta State, Nigeria with a view of assessing the impact of providers' attitudes on their access and use of ARHS in Delta State by seeking the perception adolescents who use or may use such reproductive health services.

Background to the Study

Adolescent age is a period when the influence of peers and the social environment is strong and contributes significantly to the attitudes and sexual behavior of young people [2] [7]. Adolescence is the most difficult stage in life; where youth try new things including sexual activities [8]. All over the world, adolescents are seen as vulnerable group due to the nature of this stage of growth in the life cycle [9] [10] [11] [12]. Adolescence is a time of major transition between childhood and adulthood. It is a period when significant physical, psychological, and behavioral changes occur and when young people develop many of the habits, behaviors, and relationships they will carry into their adult lives [13]. Globally, this is a period that has unique potentials for new sexual ideas, experiences and opportunities that affect the behavior of youth. The period of adolescence is plagued by vulnerabilities to biological and socio-cultural problems, lack of adequate health information and services, inadequate life building skills and lack of access and utilization of reproductive health services [11].

A Plethora of attitudinal issues are related to attempts by adolescents to either

access or use reproductive health services. The effectiveness of physicians had been adduced as a reason why adolescents may or may not seek health care. Adolescents, who believed physicians were more effective, were more likely to intend to seek care. Additionally, need factors such as whether adolescent seeking treatment are being judged by health professionals to have significant health needs are least likely to use health care [3] [4]. According to research with youth, the most important barrier to care relates to provider attitudes that contraceptive services are inappropriate for young people [5]. Providers with this attitude frequently fail to take seriously youth's need for services and may even try to dissuade young people from having sexual relations. Providers' attitudes often reflect the tremendous difficulty that societies and cultures have in accepting the sexuality of adolescents and in viewing sexuality as a natural and positive part of the full development of every person. Such hostile attitudes may result in young people's giving up—not on having sexual intercourse—but on using contraception [6] [14]. An aspect of provider attitude is the waiting time and duration of services in most health Centers which keep patients for hours without being attended to. This has led to many patients especially adolescents from coming to such health facilities and using the services in them [6] [12] [14] [15].

Another aspect of providers' attitude which may either encourage or discourage adolescents from accessing and using adolescents' reproductive health services is how much their providers are confidential about their treatments. A host of studies have identified confidentiality as key to adolescent use or non-use of ARHS [12] [16] [17] [18] [19]. Hock-Long *et al.* [19] in their study identified confidentiality of consent for care and service environment as two types of structural factors which affect access to sexual and reproductive health services. Ralpa & Brindis [15] believed confidentiality protections are particularly important for reproductive and other sensitive healthcare, as adolescents are likely to forgo needed care in the absence of these protections. Giving tips on how to achieve confidentiality, they opined that adolescents needed to have time alone with their providers, but this has not been the case with most physicians. The consequences are that, adolescents have refused to use the services of such health facilities. Kanthiti [10] review of factors necessary for effective adolescent reproductive health services in Africa, Asia and Latin America revealed that confidentiality and privacy were the most important pull factors. For example, out of the five studies in Africa, four of them (80%) indicated that confidentiality and privacy were important to adolescents since, they would feel comfortable to discuss their problems when there is confidentiality and privacy with their providers, according to the study, sadly, some physicians have not taken issue of confidentiality seriously, thereby leading to low patronage by adolescents of their services.

A common fear that adolescents often have is that of parental notification through providers' communications or that service provider will tell their parents that they came to the clinic for reproductive health care. Young people would feel confident that their important and sensitive concerns will not be re-

vealed to other people or their parents will continue to come for the services otherwise, in the event they feel their parents or love ones will be told about their RH situation, they may not use such providers due to lack of privacy and confidentiality [8] [20] [21] [22]. Fear of disclosure inhibits the sexually active adolescents especially female from seeking contraception and other reproductive health services [23]. As a result, adolescents do not use family planning or reproductive health services. Guttmacher Institute [24] also found parental control to be significant in the usage or non-usage of adolescent reproductive health. This came up because when youths visited the health facilities, they were asked for parental approval and this worked against some adolescents taking up the services. Berkat & Murtaza [25] and Kamau [9] recommended that parents and communities need to be persuaded to support adolescents' reproductive health initiatives if the chances of access and use of such services are to be improved.

2. Methods

2.1. Reconnaissance Survey and Delimitation of the Studied Area

Reconnaissance visits were paid to the surveyed Local Government Areas (LGAs). The LGAs were: Burutu and Bomadi-Delta South Senatorial District, Ughelli North and Udu-Delta Central Senatorial District and Ika South and Ukwuani-Delta North Senatorial District). These were followed by contacts setting, acquisition of necessary clearance and authorization from the Ministry of Basic Education, Delta State, which is the body responsible for Secondary Education. Another aim of the contacts setting was to make appointments for data collection.

2.2. Research Design and Population

The survey design was adopted for this study due its nature. The data needed were primary data using questionnaires, in-depth interviews and focus group discussions (FGDs). Adolescents in schools were the focus of this study. This was in recognition of the fact that adolescents spend most of their time in schools and undergo adolescence development and transition during their school life. It is also in schools that adolescents have close interaction with their peers who may influence their sexual health behavior. The schools are thus critical in shaping reproductive and sexual behavior of adolescents, and in providing reproductive health information and services that can help them meet their reproductive and other health concerns [9]. The study populations were adolescents in public secondary schools in Delta State. The total population of students in these schools was 218,562 [26]. The reason for the selection of students in secondary schools as participants for this study is based on the fact that the students are likely to have the age range of 10 - 20 as defined as adolescents for the purpose of this study.

2.3. Data Collection: Quantitative Data

In this study, combinations of sampling techniques were used at different stages.

In the first stage, the cluster sampling technique was used in selecting the Local Government Areas (LGAs) and the schools in the LGAs where this research was carried out. The use of cluster sampling was due to concentration of youth in the selected LGAs and schools with similar attributes [27]. Before the selection of LGAs, Delta State was demarcated into three parts based on existing senatorial districts. Two LGAs were selected from each senatorial district; making a total number of six LGAs. In each LGA, two secondary schools were selected purposively which included a school in an urban area and one school from a rural location; bringing the total schools where the study was carried out to 12 from a pool of 452 secondary schools [26]. The sample size was 1500 students and this was equally drawn from the twelve schools with each having 125 respondents respectively. The selection of 125 students from each class was based on the fact that equal sample of students were drawn from each class for equal representation of students in each school. The sample size of 1500 was drawn using the Rule of Thumb which states that; for large populations (over 150,000), small sampling ratios (1 percent) are possible and sample of about 1500 can be very accurate [28]. In the second stage, the stratified sampling technique was used in order to ensure equal opportunity of participation of students (males and females). The study used systematic random sampling to select respondents from each school—125 secondary students comprising 63 male and 62 females, since the population of males was higher in most classes.

The questions for the study were drawn from existing studies on access and use of ARHS by adolescents in Nigeria. The questionnaire comprised of two sections. Part “A” is made up socio-demographic and economic characteristics of respondents such as: sex, class, age, religion, ethnicity, residual location and their parents’ level of education and income. In order to find perceptions of adolescents to attitudes of providers and how they affect their access and use of ARHS, the study relied on part “B” of the questionnaire where respondents were interrogated on their comfort level to waiting time for ARHS providers before receiving services; satisfaction with the duration of the services they eventually received after waiting; overall satisfaction with the ARHS they have received from providers; willingness to use ARHS in the presence of a third party and view on the unfriendly attitudes of medical person. The questionnaires consisted of simple questions requiring “Yes” or “No” answers on hand and a likert scale questions ranging from strongly agreed to strongly disagree. The questionnaire was first pilot-tested in one secondary school and appropriately revised by authors before coming out with the final questionnaire that was used for this study.

2.4. Data Collection: Qualitative Data

Six focus group discussions (FGDs)-three for males and three for females were held in the three senatorial districts with 12 students each (6 males and 6 females) from each senatorial district to complement data from survey. In all, two FGDs were held per Senatorial District with one for males and the other for females. In all the 12 schools where the study was conducted, the best students in

either integrated science or biology in classes were selected to take part in the FGDs depending on whether they were senior or junior schools. The selection of either biology or integrated science was due to their subject of reproductive health. In the school, a balloting was first introduced to select either a male student or a female best student, since six schools were allotted male slots while some got female slots. This allowed for equal participation of equal number of male as well as female FGDs—36 persons each who took part in three FGDs. Three focus group discussions for males were conducted by the two authors who had versed experiences in the use of this tool for data collection over time. The other three focus group discussions were conducted by female research officers of Centre for Population and Environmental Development with excellent knowledge of FGDs. In both male and female focus group discussion sessions, one of the persons involved took care of the tape recorder and note taking while the other was responsible for facilitating the discussions. A focus group discussion guide was used to itemize questions on: barriers to effective access and use of ARHS by adolescents; significance of prompt ARHS to access and use of RH by adolescents; effects of long waiting time at ARHS clinics; confidentiality and access/use of ARHS by adolescents and medical personnel attitudes that are unfriendly and ARHS provision to adolescents. All, the questions were also pilot-tested to avoid ambiguities. The FGDs were held in six of the schools where the study took place in a serene environment devoid of noise. Each session was held for an average of 58 minutes.

2.5. Data Analysis

The Statistical Products and Service Solutions (SPSS) by IBM, version 21 was used for data analysis in this study—analyzing 1465 filled questionnaires—with 35 questionnaires declared invalid of 1500 administered in this study. Thus, the analysis was based on 1465 questionnaires. First, the analysis involved the use of descriptive statistics such as frequency tables, percentages to elucidate respondents' demographic characteristics. Cross tabulation was used to analyze adolescents' perception of providers' attitude using variables such as waiting time, duration of services, satisfaction with services and the relationship between demographic/economic characteristics and attitude. N6 NUD*IST software was used to analyze qualitative data after transcription and coded by themes relevant to the study.

2.6. Ethical Considerations

As a study that dealt with minors and in line with the Centre for Population and Environmental Development standards, some ethical guidelines were followed. Necessary authorizations and clearance before commencement of the study was obtained from relevance authorities. Although parental or guardian consent was required in the course of undertaking this research with minors, this was not necessary because the target of this study was the in-school adolescents. The researchers considered the Ministry of Basic Education as well as the school au-

thorities as the guardians. In Nigeria, once, the students were in school, the school authorities take over the role of guardians and decide on what is best for their students within government approved boundaries. The approval of this study by CPED's ethics committee was also predicated on this belief of students' ownership by the school authority once in schools premises. However, Informal and verbal consents were obtained from the adolescents before the commencement of the survey and interviews [9]. The researchers also informed the target group in detail about the study purpose and were made to be aware that participation was voluntary, and that they will be free to decline or end the participation or interviews at any time if they have compelling reasons to do so. The target groups were also informed that the survey will be confidential and that the FGDs would be held with confidentiality, and that it would not be used for any other purpose other than for academic purposes. The FGDs took place in situations that enhanced confidentiality and which was comfortable for the researcher and adolescents [9] [29] [30]. This enhanced participant's sensitivity and cooperation [31].

3. Results and Discussions

The socio-demographic and economic characteristics of the respondents are presented in **Table 1**. From the table, it is evidence that the study comprised of 51.3% of male and 48.3% female of which 49.7% of them were in Junior Secondary Schools and 50.3% of them who were from Senior Secondary Schools. The respondents were made up of 37.5% who fell between the ages of 15 - 17 years, 36.2% whose ages were 12 - 14 years, 21.5% of them were from ages 9 - 11 years. In terms of religion denominations, the respondents were from protestant, Pentecostal and catholic worships with 42%, 40.6% and 15.4% respectively. By the ethnic origin of the respondents, almost equal percentages were found in Ijaw, Urhobo and Igbo with 28.5%, 28.3% and 28.1%. Regarding the educational level of respondents' parents, 32.9% of them completed secondary school, 32% of them completed primary school, and 25.8% had no schooling while 9.3% of them attended one form of tertiary education or the others. Evidence from the table also showed that 34.8% of the respondents do not know the income level of their parents, 28.7% of the parents earned N10,000 or less, 14% of parents were found to be in the income bracket of N11,000 - N20,000, 12.2% of parents earned N21,000 - N30,000, 6.2% of the parents also earned N41,000 and above and 4% of the respondents' parents earned N31,000 - N40,000. The participants in the FGDs included 72 adolescents in school, made up of 36 males and 36 females with ages ranging from 11 to 18 years. The participants were also made up of 36 adolescents each from junior (Integrated science Students) and senior (Biology Students) secondary schools respectively.

3.1. Waiting Time in Adolescents Clinic and the Comfort Level of Service Users in the Studied Area

Respondents in this study were asked whether they were comfortable with the

Table 1. Socio-demographic and economic characteristics of the sampled population (1465).

Variable	No	%
Sex		
Male	752	51.3
Female	713	48.7
Classes of Students		
Junior Sec. Students	731	49.7
Senior Sec. Students	734	50.3
Age (Year)		
9 - 11	315	21.5
12 - 14	530	36.2
15 - 17	550	37.5
18 - 20	70	4.8
Religion		
Catholic	226	15.4
Protestant	616	42.1
Pentecostal	595	40.6
Others	28	1.9
Ethnicity		
Igbo	411	28.1
Isoko	118	8.6
Ijaw	418	28.5
Urhobo	430	28.3
Itsekiri	19	1.3
Others	69	5.2
Parents' Highest Level of Education		
No schooling	377	25.8
Completed Primary School	469	32.0
Completed Secondary School	483	32.9
Tertiary education and equivalents	136	9.3
Parents' Income		
10,000 or less	421	28.7
11,000 - 20,000	205	14.0
21,000 - 30,000	179	12.2
31,000 - 40,000	59	4.0
41,000 and above	91	6.2
I don't know	510	34.8
Residence		
Rural	726	49.6
Urban	739	50.4

waiting time in medical places they went to seek for ARHS more recently. **Figure 1** shows that an average of 66.8% was not comfortable with the waiting time in the studied area. The highest proportion of respondents who were not comfortable with the waiting time was in Bomadi LGA with 88.8%. Others were 69.4% in Ukwuani, 67.6% in Ika South LGA, 67.3% in Burutu LGA, 62.8% in Udu LGA and 54.6% in Ughelli North-thus establishing that respondents in the study area were not happy with waiting time before seeing a provider and with the attitude of health workers who keep them waiting when they visit the health centers. Therefore, adolescents who were not comfortable with the waiting time might have issue with the accessing and using the reproductive health services in the health facilities they visited especially if they perceive their situation not to be so severe and forgo the use of such services [32] [33] [34]. According to Adelman *et al.* [32], once adolescents perceived themselves as healthy, they may forgo the services they are supposed to access and utilize if any barrier like waiting time is placed before them as the excerpt below reveals from a female FGD participant in Delta Central:

“Waiting for a long time in health centre because of coming late of doctor, I believed is a big challenge to get treatment. I for one do not like it. I am sure most persons do not also like it like me. If we keep experiencing this, it will make us not to use the clinic. This one is a big problem”.

3.2. Adolescents' Satisfaction with Adolescents Reproductive Health Services Received from Providers

The ultimate goal of every reproductive health service received is to be satisfied, as defined by certain parameters. In adolescents' reproductive health, satisfaction is defined by meeting the reproductive health of the adolescents in question. It is from this perspective that the respondents were asked of their satisfaction with the ARHS they have received from providers. **Table 2** summarizes the answers to the questions by respondents based on the number of respondents that have used reproductive health services as at the time of the study (1035). In the six surveyed LGAs, a greater proportion of the respondents (61.8%) were not satisfied with the reproductive health services they received the last time they went for ARHS. There were some variations from one LGA to the others. The highest

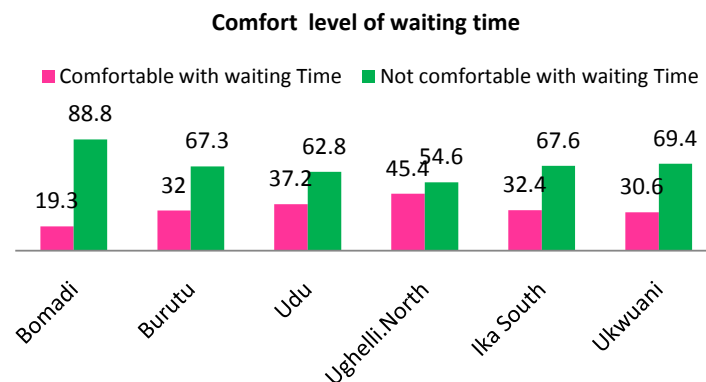


Figure 1. Waiting time and comfort level of ARHS seekers (LGAs).

Table 2. Satisfaction with providers adolescents reproductive health services in the studied LGAs.

LGAs	Satisfaction with ARHS				Total	
	Satisfaction with ARHS		Do not Satisfy with ARHS			
	N	%	N	%	N	%
Bomadi	40	24.8	121	75.1	161	100
Burutu	54	36.7	93	63.2	147	100
Udu	72	40.0	108	60.0	180	100
Ughelli. North	97	52.4	88	47.6	185	100
Ika South	70	39.1	109	60.9	179	100
Ukwuani	62	33.9	121	66.1	183	100
Total	395	38.2	640	61.8	1035	100

proportion of respondents (75.1%) who were not satisfied with the services provided was in Bomadi LGA. This was followed by Ukwuani (66.1%), Burutu LGA with 63.2%, Ika South and Udu LGA with 60.9% and 60% respectively. It was only in Ughelli North LGA that the lowest proportion of 47.6% was recorded. This may be due to the individual experiences when they visited the healthcare facilities in their LGAs. That most respondents were dissatisfied with the services is an indication of the challenges which may restrict access and use of such services occasioned by the length of time they spent in the locations where they received services which might be connected to attitudes of the providers. This finding agrees with those of Brown and Guthrie [6] and Coyne-Beasley *et al.* [33] who in their separate studies observed that lack of use of adolescents' reproductive health services was connected with their dissatisfactions with the services provided by the medical personnel as the extract from the male Focus Group Discussion in one of the schools show:

“Why should I go back to get treatment from a doctor or a nurse who could not treat me well. Most of the persons attending to us are very judgmental. I have not been satisfied with the services of most of the medical persons because of this attitude. I have to look for alternatives each time I meet these kinds of personnel”.

3.3. Adolescents' Satisfaction with Duration of ARHS Services

Table 3 shows that the clients were not satisfied with the time the medical personnel spent with them. In the six surveyed LGAs, over 62% of the respondents (1035 who used ARHS) were of the opinion that they were not satisfied with the time the medical personnel spent with them. In the individual LGAs, Bomadi LGA recorded the highest proportion (75.2%) of respondents who were dissatisfied with the time the medical personnel spent with them. Bomadi LGA was followed by Burutu and Ukwuani LGAs with 66.9% and 66.1% respectively. Other LGAs in this category were Udu and Ika South with 62.2% and 62% respectively

Table 3. Satisfaction with medical personnel duration of services in the studied LGAs.

LGAs	Satisfaction with Medical Personnel duration of Services				Total	
	Satisfy with duration of Services		Not Satisfy with duration of Services		N	%
	N	%	N	%		
Bomadi	40	24.8	121	75.2	161	100
Burutu	50	34.0	97	66.9	147	100
Udu	68	37.8	112	62.2	180	100
Ughelli.North	96	51.9	89	48.1	185	100
Ika South	68	38.0	111	62.0	179	100
Ukwuani	62	33.9	121	66.1	183	100
Total	384	37.1	651	62.9	1035	100

and Ughelli North LGA with 48.1%. A close observation of the respondents' discomfort with waiting time, their dissatisfaction with the services they received and dissatisfaction with providers' duration of services in this study corroborate earlier studies results that equally showed adolescents dissatisfaction with services they received due to providers attitudes [12] [14] [15]. The statement from a female FGD equally revealed the dissatisfaction with duration of services as reported:

“Most medical providers are full of themselves. You can imagine my own experience. After waiting for over 2 hours, he only took 5 minutes to talk to me and calling in the next person without doing proper examination on me. This is what happens all the time you visit for consultations”.

3.4. Providers Attitudes and Confidentiality of Adolescents' Service

One of the issues relating to providers' attitudes is confidentiality of services which may be observed or not depending on the providers. In this study, respondents (All 1465 participants) were asked if they would be willing to use ARHS in the presence of a third party by allowing them to be in their rooms of services. **Table 4** indicates that a vast proportion of the respondents disagreed with the statement that they would be willing to be attended to in the presence of other persons. Though some proportion of respondents in the studied area (15.9%) revealed that they will not mind to be attended to in the presence of others, 84.1% of respondents in the six LGAs were of the opinion that they will be concerned. This was an overwhelming decision in all the six LGAs, thus revealing the importance of confidentiality in the health seeking behaviors of teenagers. Thus any services provided without confidentiality most likely will not be used by adolescents in Delta State. Hence this study agrees with what Milstein [35]; Ralpa & Brindis [15] and Isiugo-Abanihe [36] who in their separate studies found out that lack of confidentiality will hinder the ability to disclose

Table 4. Respondents tolerance for a third party during services in the studied LGAs.

LGAs	ARHS Seekers and tolerance for a third Party during services								Total	
	Strongly Agreed		Agreed		Disagreed		Strongly Disagreed		N	%
	N	%	N	%	N	%	N	%		
Bomadi	27	11.1	18	7.4	174	71.3	25	10.2	244	100
Burutu	14	5.8	18	7.4	174	71.6	37	15.2	243	100
Udu	17	7.0	20	8.3	165	68.2	40	16.5	242	100
Ughelli North	20	8.2	22	9.0	164	67.2	38	15.6	244	100
Ika South	23	9.3	15	6.1	159	64.6	49	19.9	246	100
Ukwuani	23	9.3	16	6.5	170	69.1	37	15.0	246	100
Total	124	8.5	109	7.4	1006	68.7	226	15.4	1465	100

sensitive reproductive health information. According to them in their studies, in order to ensure adolescents' willingness to access health services, disclose sensitive health information, and return for necessary follow-up care, there must be confidentiality of ARHS. Therefore, providers who undermined the place of confidentiality in the provision of ARHS to Adolescents might make them not forgo not having sex but in the use of ARHS services as the statement from a male FGD revealed:

“Each time I go out to consult a medical person, this should be my personal affair with the medical personnel. He should be the one to keep my secret. However, most times, this had not been the case. If my health situation is exposed to anybody including my parents, I will not be using such health personnel because I desire some privacy in my life. Nobody is supposed to know what my health condition is, unless I volunteered to make it so”.

3.5. Importance of Medical Personnel Attitude in Access and Use of Adolescents' Reproductive Health Services in Delta State

In order to explore the place of providers' attitudes in adolescents' access and use of ARHS, a direct question relating to provider attitude was asked (to all 1465 respondents who took part in the survey), if Medical personnel unfriendly attitude will not discourage them from using adolescents' reproductive health services? **Table 5** contains the answers to the question. Across the six LGAs in the study area, 81.7% of respondents were of the opinion that providers attitudes will discourage them from using ARHS since they disagreed with the statement that unfriendly attitude of providers will not discourage them. In the LGAs, more respondents disagreed with the statement in Bomadi LGA (86%), followed by 82.6% in Ukwuani LGA, 82.2% in Udu, 81.1% in Ughelli North LGA, 79.3% in Ika South LGA and 79.1% in Burutu LGA. Thus provider attitude is significant to adolescent access and use of ARHS. The findings from this study agree

Table 5. Medical personnel attitude and the use of ARHS.

LGAs	Medical Personnel Attitude and the Use of ARHS								Total	
	Strongly Agreed		Agreed		Disagreed		Strongly disagreed			
	N	%	N	%	N	%	N	%	N	%
Bomadi	16	6.6	18	7.4	45	18.4	165	67.6	244	100
Burutu	15	6.2	36	14.8	48	19.8	144	59.3	243	100
Udu	16	6.6	27	11.2	47	19.4	152	62.8	242	100
Ughelli North	17	7.0	29	11.9	44	18.0	154	63.1	244	100
Ika South	17	6.9	34	13.8	55	22.4	140	56.9	246	100
Ukwuani	18	7.3	25	10.2	54	22.0	149	60.6	246	100
Total	99	6.8	169	11.5	293	20.0	904	61.7	1465	100

with previous studies that providers' attitudes will affect the rate of access and utilization of ARHS. According to the studies, providers with repulsive attitudes frequently fail to take seriously youth's need for services and may even try to dissuade young people from having sexual relations. Providers' attitudes according to the studies often reflect the tremendous difficulty that societies and cultures have in accepting the sexuality of adolescents and in viewing sexuality as a natural and positive part of the full development of every person. Such hostile attitudes from the perspectives of the studies, may result in young people's giving up-not on having sexual intercourse—but on using contraception and other ARHS [6] [12] [14] [15]. The portion of female focus group discussion supports the point:

“Negative attitudes of doctors and nurses have not worked well in our hospitals. Some of them always abuse us girls. To them we are spoilt and do not know we should be treated well to receive health care. Most us preferred not taking treatment from such doctors and nurses”.

3.6. Relationship between Some Demographic Variables and Providers Attitudes to Adolescents' Reproductive Health Services

Another issue examined relates to medical personnel unfriendly attitude and its effects on adolescents' reproductive health services looking at various demographic variables. The respondents were asked to agree or disagree with the statement “Medical personnel unfriendly attitudes will not discourage me from using adolescents' reproductive health services”. **Table 6** shows 82.3% and 81.1% of male and female respectively of respondents were of the view that unfriendly attitudes of providers will discourage them from using adolescents' reproductive health services. As for the perception of the respondents in classes, a vast proportion of them (83.7%) in junior classes were of the view that unfriendly attitudes of medical personnel will discourage them from using ARHS while it was 79.8% of senior classes who held similar view in the studied location. In term of

Table 6. Relationship between some demographic variables and providers attitude to ARHS.

Variable	Strongly Agreed (N/%)	Agreed (N/%)	Disagreed (N/%)	Strongly Disagreed (N/%)	Total (N/%)
Sex					
Male	36 (4.8)	97 (12.9)	154 (20.5)	465 (61.8)	752 (100)
Female	63 (8.8)	72 (10.1)	139 (19.5)	439 (61.6)	713 (100)
Classes of Students					
Junior Sec. Students	24 (3.4)	89 (12.9)	160 (23.0)	423 (60.7)	696 (100)
Senior Sec. Students	75 (10.0)	80 (10.2)	133 (17.0)	481 (62.8)	769 (100)
Age (Year)					
9 - 11	13 (4.1)	43 (13.7)	74 (23.5)	185 (58.7)	315 (100)
12 - 14	37 (7.0)	58 (10.9)	104 (19.6)	331 (62.5)	530 (100)
15 - 17	43 (7.8)	58 (10.6)	109 (19.9)	338 (61.7)	548 (100)
18 - 20	6 (8.3)	10 (13.9)	6 (8.3)	50 (69.4)	72 (100)
Religion					
Catholic	15 (6.6)	28 (12.4)	47 (20.8)	136 (60.2)	226 (100)
Protestant	40 (6.5)	69 (11.2)	130 (21.1)	377 (61.2)	616 (100)
Pentecostal	41 (6.9)	71 (11.9)	110 (18.5)	373 (62.7)	595 (100)
Others	3 (10.7)	1 (3.6)	6 (21.4)	18 (64.3)	28 (100)
Ethnicity					
Igbo	32 (7.8)	48 (11.7)	96 (23.4)	235 (57.2)	411 (100)
Isoko	6 (5.1)	15 (12.7)	20 (16.9)	77 (65.3)	118 (100)
Ijaw	26 (6.2)	48 (11.5)	78 (18.7)	266 (63.6)	418 (100)
Urhobo	35 (8.1)	51 (11.9)	89 (20.7)	255 (59.3)	430 (100)
Itsekiri	0 (0.0)	2 (10.5)	5 (26.3)	12 (63.2)	19 (100)
Others	6 (8.7)	8 (11.6)	23 (33.3)	32 (46.4)	69 (100)
Parents' Highest Level of Education					
No schooling	20 (5.4)	46 (12.2)	72 (19.1)	239 (63.3)	377 (100)
Completed Primary School	30 (6.4)	58 (12.4)	106 (22.6)	275 (58.6)	469 (100)
Completed Secondary School	40 (8.3)	54 (11.1)	86 (17.8)	303 (62.8)	483 (100)
Tertiary education and equivalents	8 (5.9)	11 (8.1)	30 (22.1)	87 (63.9)	136 (100)
Parents' Income					
10,000 or less	29 (6.9)	53 (12.6)	83 (19.7)	256 (60.8)	421 (100)
11,000 - 20,000	10 (4.9)	20 (9.8)	50 (24.3)	125 (61.0)	205 (100)
21,000 - 30,000	8 (4.5)	16 (8.9)	37 (20.7)	118 (65.9)	179 (100)
31,000 - 40,000	5 (8.5)	8 (13.6)	12 (20.3)	34 (57.6)	59 (100)
41,000 and above	8 (8.8)	8 (8.8)	21 (23.1)	54 (59.3)	91 (100)
Residence					
Rural	40 (5.4)	90 (12.4)	166 (22.8)	430 (59.1)	726 (100)
Urban	57 (7.7)	72 (9.7)	167 (22.6)	443 (59.9)	739 (100)

the age of respondents across all ages, 80.9% believed that unfriendly attitudes of providers of ARHS will make them not to use services—with persons between the ages of 9 - 11 (82.2%) holding this view while youth of 18 - 20 years least (77.8%) in their opinion of being discouraged by unfriendly attitudes of medical providers. The view that medical personnel unfriendly attitudes will discourage adolescents was also overwhelmingly held by religious denominations and ethnic groups since aggregate of religious bodies was 82.6% compared to 82.3% of all ethnic groups such as urhobo, Ijaw, Igbo, Itsekiri, Isoko and others who took part in the studies who agreed that unfriendly attitudes of medical personnel will discourage them from accessing and using ARHS. Respondents whose parents have different level of education and income also have a collective proportion of 82.6% and 82.5% respectively that unfriendly attitudes of medical personnel will discourage them from using ARHS while at the residential level, both rural (81.9%) and urban (82.5), it was the opinion of respondents in the studied area that the unfriendly attitudes of medical personnel will discourage them from using ARHS. Hence, it evidence from the above, that irrespective of the demographic or economic attributes used in this study, the attitudes of providers is very important in the access and use of ARHS. Therefore, the success of any program which wants to encourage adolescents' access and usage of reproductive health services, care must be taken to promote healthy and friendly attitudes of providers which make adolescents feel safe to receive the services.

The findings from this study agree with previous studies that providers' attitudes will affect the rate of access and utilization of ARHS. According to the studies, providers with repulsive attitude frequently fail to take seriously youth's need for services and may even try to dissuade young people from having sexual relations. Providers' attitudes according to the studies have to do with the cultures that do not accept sexuality of adolescents and sexuality in general as a natural and positive part of the full development of every person. Such hostile attitudes from the perspectives of the studies may result in young people's giving up-not on having sexual intercourse—but on using contraception and other ARHS [6] [12] [14] [15].

4. Conclusion

Poor or unfriendly health providers' attitudes such as keeping adolescent waiting, spending little time with them during consultations, judgmental attitude of providers and lack of confidentiality in service provision are associated with low adolescents' access and use reproductive health services in Delta State irrespective of the sex, age, class, religion, residence, ethnic group, parents' education or income levels. It is important that medical personnel take all these issues very seriously when dealing with adolescents to enhance access and use adolescents' reproductive health services in Delta State and indeed Nigeria.

5. Limitations

This study is a perception study relying heavily on what respondents think in

most instances, and partly on users' experiences. Study dealing entirely on users' experiences of ARHS would reveal greater determinant of lack of access and use as occasioned by providers' attitude. Also, data analyses did not involved gender segregations since no gender differences were noticed for both sexes of adolescents in their outlook to providers' attitude to access and use of reproductive health services. Lastly, the relationship between some demographic variables and providers attitude would have been more apparent if regression analysis was attempted here, but this was not the case with this paper, since the data are being explored for further publication with more rigorous analyses.

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