**NIU Journal of Humanities** Copyright©2025
Nexus International University ISSN: *3007-1704;* 10(4): 187-194

# Assessing Adolescents' Perception of Sources and Barriers to Sexual Reproductive Health Information and Services in Metropolitan Lagos, Nigeria

M. BABATUNDE LAWAL
Lagos University of Education, Oto/Ijanikin, Lagos, Nigeria

LATEEFAT ADEOLA OBANI
Lagos State College of Health Technology, Yaba, Lagos, Nigeria

LATIFAT APEKE SAKA
Lagos University of Education, Oto/Ijanikin, Lagos, Nigeria

**Abstract.** This study examines adolescents' perceptions of sexual and reproductive health (SRH) information and services in Metropolitan Lagos, Nigeria, addressing gaps in access influenced by cultural, educational, and systemic barriers. A survey of 228 adolescents (83.8% female; 82% aged 18–19 years) revealed significant challenges: 38.2% reported no maternal communication on SRH, and over 50% cited insufficient school-based SRH education. Privacy concerns, fear of judgment, financial constraints, and healthcare provider stigma emerged as critical barriers, with 54.8% highlighting confidentiality fears. Gender analysis showed no significant differences in perceptions of SRH sources or barriers, though females demonstrated greater awareness of available services. Post-secondary educated adolescents perceived higher systemic barriers than their secondary-educated peers. The study underscores the impact of cultural taboos, inadequate parental engagement, and poorly implemented SRH curricula. Recommendations include integrating comprehensive SRH education into school programs, establishing youth-friendly health services prioritizing confidentiality and affordability, leveraging media for awareness campaigns, and enhancing parental communication. Community outreach and technology-based interventions are proposed to bridge gaps for out-of-school adolescents. Addressing these barriers is vital to improving SRH outcomes, reducing unintended pregnancies, and empowering adolescents to make informed health decisions, necessitating collaborative efforts among policymakers, educators, healthcare providers, and families.

**Keywords:** Adolescents, Perception, Barriers, Sexual reproductive health, Nigeria

## 1. Introduction

Adolescence is a transitional period of physical, emotional and social development described by Mukherjee (2016) as the period in life when an individual is no longer a child, but not yet an adult. It is a period in which an individual undergoes enormous physical and psychological changes. It is a transitional phase of growth and development between childhood and adulthood. The World Health Organization WHO (2020) defines an adolescent as anyone between ages 10 and 19. This period marks the beginning of puberty and sexual maturation.

It is an established fact that adolescents, particularly in Nigeria, comprise a large proportion of the country's population. This is confirmed by Statista (2021), where the percentage of male and female adolescents was given as 23.1%. This stage of their development is a delicate stage that, if not properly managed, can lead them into the development and exhibition of untoward deviant behaviours.

Aderibigbe, et.al. (2011) also observed that it is a stage that they are faced with challenges, especially that of restricted access to sexual and reproductive health information and services due to developmental changes. Any attempt to

mismanage them could have severe implications for the socio-economic development of any nation. This is when girls are found getting involved in adolescent pregnancy, and boys go into drug addiction and other social vices.

MSI Reproductive Choices (2020) describes sexual re-productive health and services as essential to overall health and well-being. They are key in ensuring that everyone can enjoy fulfilling and safe sexual experiences, devoid of coercion, discrimination, or health hazards. It is all about an individual's right to maintain good health and autonomy. It includes proper education and healthcare, allowing one to choose their se-xual partners freely. Not just that, it also implements ways to prevent sexually transmitted diseases and unintended pre-gnancies.

Accessing sexual and reproductive health services means that people get to exercise their right to such care. This can span various forms, ranging from medical care for matters like treating a sexually transmitted disease or even support in exercising reproductive autonomy, like getting contraception or abortion care. Adolescents' access to information on sexual reproductive health and services is very important to their social development. The ability to access information about sexual health and reproduction plays a significant part in shaping the educational journey and life opportunities for teenagers. With the knowledge and tools to prevent unexpected pregnancies, they can smoothly continue their education, chase their dream careers, and gain more command over their future.
Mbachu, Agu, & Onwujekwe (2020) reported that adolescents in Nigeria and West Africa often face difficulties when trying to access accurate and comprehensive information regarding sexual reproductive health (SRH) and services. This limited access can result in misconceptions, experiencing negative health outcomes, and engaging in risky behaviour.

They also observed that cultural and societal barriers have impeded adolescents' access to information about sexuality and reproductive health. Traditional norms and cultural beliefs have often created obstacles, treating topics related to sex and contraception as taboo. Consequently, adolescents find seeking information or discussing their concerns challenging openly.

Factors such social stigma, negative attitudes from healthcare providers and limited access to relevant information have been identified by Klu et.al. (2023) as barriers to sexual reproductive health service utilisation among adolescents. They reported that “adolescents whohad discussed sexual matters with their fathers, used contraceptives, or experienced sexual coercion were less likely to access informationon contraception, sexually transmitted diseases and teenage pregnancy.

Other barriers that are capable of affecting adolescents’ perceptionto SRH information and services have been identified by Wahyuniassih et.al. (2024) to include rigid social norms in the society which restrict access to SRH information and services, cultural and religious practices that do not encourage intergeneration dialogue about sex and SRH.

Furthermore, Mbachu, Agu, & Onwujekwe (2020) opined that not all schools in Nigeria and West Africa have SRH education, and those who do are not always the greatest. A lot of them lack coverage and a strong curriculum, and when teachers attempt to provide age-appropriate information or even accurate information, they may not be able to because they were not properly trained, to begin with.

In addition to these, they adolescents are known, especially in developing countries, Nigeria inclusive, to have limited access to youth-friendly services, negative experiences with healthcare providers who are at times judgemental in their relationship with the youth. Poor-parent-child communication is not left out in this list.

Odo, Samuel, Nwagu, et al. (2018), also, observed that getting the advice and care the adolescents need is difficult, and the services available to them do not seem to have been confidential, judgement-free and built for their specific needs. Many healthcare facilities also lack proper infrastructure and staff, which is required to provide sexual and reproduction services.

Adolescents were also reported to fear being judged by others, like peers or family members, when it comes to getting help or seeking out care. Even healthcare providers themselves can add to the stress by discriminating against them. As a result, it is no surprise that they avoid getting help entirely. The implication of the foregoing is that

these barriers are capable of significantly limiting adolescents' access to essential SRH information and services. This unfortunately can have a range of consequential effects that impede their health, well-being and even future opportunities.

This view is supported by Metha and Seeley (2020) in one of their studies on Sexual and Reproductive Health and Adolescent Pregnancy, where they found that the inability of adolescents to access contraception when needed was responsible for unintended pregnancy among adolescents. They concluded that the higher the denial level of access and information on sexual and reproductive health services, the higher the risk for that adolescent going through such an experience.

Research in adolescent sexual and reproductive can be limited in scope, scale, methodologic rigour, and explanatory power, with resultant limitations for generalizability, reproducibility, and dissemination. Despite this, it is important to establish that the findings of this study will still have its own merits. The tendency for the intended subjects to want to keep a lot of information private could however be a factor that can constrain the quality of information to be shared, due probably to the cultural setting to which they belong.

### 1.1 Research Questions

The study seeks to answer the following research questions:

- What is the adolescents' perception of sexual reproductive health information and services in Metropolitan Lagos?
- Will there be any significant difference between male and female adolescents' perception of sources, barriers and access to sexual reproductive health information and services in Metropolitan Lagos?
- Will there be any significant difference in adolescents' perception of sources, barriers and access of sexual reproductive health information and services in Metropolitan Lagos by educational level?

## 2. Research Methodology

This study used a cross-sectional design to investigate how adolescents in Metropolitan Lagos, Nigeria, perceive sexual and reproductive health (SRH) resources. Researchers surveyed 228 participants, with most identifying as female (84%) and aged 18–19 (82%). The sample included both in-school and out-of-school youth, intentionally selected to reflect diverse educational backgrounds: 89% had post-secondary training (e.g., university or vocational programs), while 11% had completed only secondary school. The design prioritised real-world applicability, blending quantitative data with open-ended feedback to address cultural, educational, and institutional factors affecting SRH access.

### 2.1 Data Collection Process

A 35-question survey, checked by experts for clarity and tested beforehand, gathered insights on three areas:

- Where adolescents get SRH information (e.g., schools, families, or social media), rated on a 5-point scale from "strongly disagree" to "strongly agree."
- Challenges accessing services, such as costs, privacy issues, or stigma from healthcare workers.
- Background details like age, gender, and education level.

### 2.2 Data Analysis

The team summarised participant demographics using basic statistics (Table 1) and calculated average agreement levels for each perception statement (Table 2). To compare responses between genders and education levels, they ran T-tests on mean scores for sources, access, and barriers (Tables 3–4). A P-value below 0.05 was considered significant, and all calculations were done in SPSS version 26.

## 3. Results

**Table 1:** Respondents Demographic Information

| | Frequency | Percent |
|---|---|---|
| Gender | | |
| Male | 37 | 16.2 |
| Female | 191 | 83.8 |
| Total | 228 | 100.0 |
| Age | | |
| 15-17yrs | 28 | 12.3 |
| 18-19yrs | 187 | 82.0 |
| 19 yrs above | 13 | 5.7 |
| Total | 227 | 99.6 |
| Education | | |
| Secondary | 25 | 11.0 |
| Above secondary | 203 | 89.0 |
| Total | 228 | 100.0 |
| Marital Status | | |
| Married | 13 | 5.7 |
| Single | 215 | 94.3 |
| Total | 228 | 100.0 |

Table1 indicates that 16.2% of the respondents were male while 83.8% are females. 11.0% of the adolescents had secondary education while 89.0% hold post-secondary education qualification. Majority of the respondent 82.0% were with the age of 18-19yrs.

**Table 2:** Respondents' perception of sexual and reproductive health

| | SD | D | U | A | SA |
|---|---|---|---|---|---|
| My mother has never discussed any sexual reproductive health issue with me before | 1 (0.4) | 87 (38.2) | 41 (18.0) | 50 (21.9) | 49 (21.5) |
| I have gained very important information and knowledge about sexual reproductive health through my school | 18 (7.9) | 66 (28.9) | 28 (12.3) | 67 (29.4) | 49 (21.5) |
| I have never attended a class on sexuality education before either in my class or outside the class | 45 (19.7) | 103 (45.2) | 27 (11.8) | 29 (12.7) | 24 (10.5) |
| I have been opportuned to see a poster on how to use contraceptives and the benefits of using them | 23 (10.1) | 43 (18.9) | 24 (10.5) | 116 (50.9) | 22 (9.6) |
| I have never felt comfortable to seek information about contraceptive from any health facility | 23 (10.1) | 67 (29.4) | 64 (28.1) | 44 (19.5) | 30 (13.2) |
| Lack of privacy when seeking information on sexual reproductive health has prevented me from getting adequate and detail useful information that can help me learn | | 73 (32.0) | 37 (16.2) | 70 (30.2) | 47 (20.6) |
| Good parent-child communication can help reduce adolescents' involvement in risky sexual behaviours | 13 (5.7) | 32 (14.0) | 12 (5.3) | 75 (32.9) | 96 (42.1) |
| Religious organisations like churches and mosques should preach safer sex messages to help reduce risky sexual behaviours among adolescents | 30 (13.2) | 39 (17.1) | 19 (8.3) | 99 (43.4) | 41 (18.0) |
| The social media can be taken as a major source of sexual and reproductive health information but in most cases, they give more negative information than positive ones | 27 (11.8) | 36 (15.8) | 5 (2.2) | 67 (29.4) | 93 (40.8) |
| I have never visited a health facility or doctor of any kind to seek or receive any sexual reproductive health service on pregnancy of sexually transmitted infections | 27 (11.8) | 68 (29.8) | 8 (3.5) | 81 (35.5) | 44 (19.3) |
| The fear of lack of confidentiality can never make me seek sexual reproductive health service on contraceptives that can help me prevent pregnancy. | 27 (11.8) | 68 (29.8) | 8 (3.5) | 81 (35.5) | 44 (19.3) |
| Poor access to youth-friendly reproductive health service can be a cause of increasing rate of teenage pregnancy | 9 (3.9) | 30 (13.2) | 41 (18.0) | 101 (44.3) | 47 (20.6 |
| There is a very high level of unmet need for modern contraception and this is causing an increase in teenage pregnancy | 27 (11.8) | 68 (29.8) | 8 (3.5) | 82 (36.0) | 43 (18.9) |
| There is a relationship between low access/usage of contraceptives and incidence of teenage pregnancy among the adolescents | | 18 (7.9) | 37 (16.2) | 123 (53.9) | 50 (21.9) |
| Some sexual and reproductive health services are fairly accessible to adolescents but are with insufficient quality which incidentally cannot guarantee them safer sex | 1 (.4) | 39 (17.1) | 32 (14.0) | 96 (42.1) | 59 (25.9) |

| | | | | | |
|---|---|---|---|---|---|
| Poor access to sexual reproductive health services and adolescents' contact with unskilled healthcare providers can result in serious complications and possible lack of | 16 (7.0) | 36 (15.8) | 15 (6.6) | 98 (43.0) | 63 (27.6) |
| The location of health facilities affect adolescents access to sexual reproductive health services. | 22 (9.6) | 17 (7.5) | 54 (23.7) | 95 (41.7) | 40 (17.7) |
| When adolescents are denied access to sexual reproductive health services whenever they visit health facility | 6 (2.6) | 34 (14.9) | 66 (28.9) | 76 (33.3) | 46 (20.2) |
| The financial state of some adolescents negatively affect their access to sexual reproductive health services | 24 (10.5 ) | 22 (9.6) | 25 (11.0) | 66 (28.9) | 91 (39.9) |

Table 3: Test of Significance among Gender, Source, Access of and Barriers to SRH

| | Sex | N | Mean | Std. D | t | Sig. |
|---|---|---|---|---|---|---|
| Source | Male | 37 | 7.892 | 3.213 | -1.468 | .143 |
| | Female | 191 | 8.801 | 3.490 | | |
| Access | Male | 37 | 28.757 | 3.269 | -1.488 | .138s |
| | Female | 188 | 30.181 | 5.631 | | |
| Barriars | Male | 37 | 42.054 | 5.281 | .029 | .978ns |
| | Female | 190 | 42.026 | 5.749 | | |

From Table 3, that there was no significant difference between male and female adolescents' source and barriers to issues of sexual and reproductive health. However, significant difference was observed in the access of sexual and reproductive health between male and female with female have higher perception than the male.

**Table 4:** Test of Significant Difference in Education

| | Education | N | Mean | Std. D | t | sig |
|---|---|---|---|---|---|---|
| Source | Secondary | 25 | 9.800 | 4.031 | 1.766 | .079 |
| | Above secondary | 203 | 8.512 | 3.363 | | |
| Access | Secondary | 24 | 30.500 | 3.438 | .537 | .592 |
| | Above secondary | 201 | 29.881 | 5.521 | | |
| Barriars | Secondary | 25 | 40.360 | 5.353 | -1.569 | .110 |
| | Above secondary | 202 | 42.237 | 5.679 | | |

The results in Table 4 indicated that no significant difference existed in source, and access to sexual rproductive health issues according to the level of education attained by the respondents. However, there is significant difference between adolescents with secondary education and those with post-secondary education in barriers to sexual reproductive health. The post-secondary school education adolescents has higher mean score than those with secondary education.

## 4. Discussion of Findings

From the analysis of the collected and collated data for this study, highly valuable discernments into the challenges faced by adolescents with regards to their perception on the sources and barriers to sexual reproductive heatlh information and service were revealed.

Specifically, the demographic details of the respondents revealed a significant female majority (83.8%), and those aged between 18 and 19 years (82%). Majority of the respondents (89%) also had an educational background that is beyond secondary level, and were mostly single in their marital status.

The findings obtained on the variable regarding parent-child communication on SRH showed a gap on whether mothers ever discussed sexual reproductive rights issues with them. This was evident in their response patterns (38.2% disagreed, 21.9% agreed and 21.5 strongly agreed. This revealed gap in parent-child communication is capable of reducing the respondents' knowledge about SRH, just as it can ultimately affect their attitude and skills required for handling SRH-related issues.

Furthermore, the respondents expressed a position on the amount of knowledge about SRH gained through school-based education, as over 50% of them felt that not much of SRH knowledge has been gained. This implies that school-based SRH delivery may not have contributed significantly to their increase in knowledge on this variable. However, a little over half of the respondents (50.9%) still confirmed that they had seen poster on contraceptives, which is an indication that they

have actually had some exposure to SRH information through the visual media.

On the adolescents' perception of barriers to SRH services, privacy concern was noticed to major issue. Many of the respondents seeking SRH information and services expressed an opinion that there were barriers obstructing them from accessing these services. Some of the reasons attributed to this include, the fear of wrong judgement by community members and the health workers and in charge of the provision of such services.

Closely related to this is the fear of being judged by family members or even the healthcare providers as being promiscuous. This is evident in the percentage of respondents (54.8%) who agreed with fear of judgement and betrayal of confidentiality as part of the barriers constraining adolescents' access to SRH information and services. Financial limitation was equally identified by adolescents as one factor debarring their access to SRH services. In addition, adolescents expressed concerns about policy and legal barriers as other factors hindering access to SRH information and services.

The study findings revealed that respondents' gender did not significantly influence their perceptions of the sources and barriers to sexual and reproductive health (SRH) information and services. Interestingly, however, female adolescents demonstrated a heightened awareness of available SRH resources relative to males—a trend corroborated by broader global research on gender-specific SRH experiences. For instance, a 2020 World Health Organisation (WHO) analysis underscored how gendered social norms and biological factors may amplify adolescent girls' psychological engagement with SRH topics, potentially increasing their susceptibility to adverse health outcomes compared to boys. These findings suggest that while gender may not shape perceptions of SRH accessibility in a uniform way, systemic inequities and sociocultural expectations could indirectly influence how different groups navigate and prioritize SRH resources.

## 5. Conclusion

The study highlighted some critical issues that affect access to SRH information and services in Metropolitan Lagos, Nigeria. Some of the key challenges noted included inadequate parental communication, privacy concerns, fear of wrong judgement and financial limitations.

The findings of the research indicate that cultural norms and beliefs in Nigeria significantly hinder open conversations between parents and adolescents about sexual and reproductive health. Factors such as parental discomfort, cultural taboos, and religious beliefs contribute to this communication gap, which can have detrimental effects on young people's well-being.

Although Nigeria has a national curriculum for sexual health education, its effective implementation in Lagos schools is lacking. Issues like inadequate resources, lack of commitment from some stakeholders, and opposition from certain groups impede the delivery of comprehensive sex education. Furthermore, out-of-school adolescents are often excluded from these educational efforts.

Again, the study revealed that adolescents in Lagos are often hesitant to seek sexual and reproductive health services due to fears about confidentiality and judgment from healthcare providers. This concern, coupled with potential stigma from the community and family, creates a significant barrier to accessing necessary care. Reports suggest that breaches of confidentiality have occurred, which further exacerbate these fears. The study also highlights the need for comprehensive SRH education that myths and misconceptions about modern contraception.

Concerted efforts of concerned stakeholders (government agencies, health workers, trainers, legislators) to address these barriers will be very crucial to ensuring that all adolescents are exposed to opportunities that can assist them in making informed decisions about their sexual health.

## 6. Recommendations

Overcoming the barriers that adolescents face in accessing SRH information and services is crucial to improving their sexual health outcomes and overall well-being. Arising from the findings of this research, the following recommendations:

Superintending agencies in charge of curriculum development in Nigeria should initiate the development and integration of SRH Education curriculum into the school curricula across all the levels, with a high degree of caution to avoid an

opposition from religious bodies. This is with the belief that improved knowledge about SRH can help reduce misconceptions, and risky sexual behaviours among the adolescents.

Government agencies in charge of the nation's education system and relevant non-governmental organisations should consider the establishment and implementation of youth-friendly health services that geared towards taking care of adolescents' privacy and financial concerns in the course of sourcing for SRH services. Such youth-friendly services must consider the introduction of confidential and affordable service, flexible outreach strategies, and financial support. This will improve their access to and use of SRH services.

Media and community platforms for information dissemination on SRH and ways of promoting safer sexual practices among adolescents should be introduced, by relevant stakeholders like the faith-based organisations, non-governmental organisations, social groups and the young people themselves will go a long way to help reduce stigmatization and encourage open communication and the use of SRH services.

Parents will need to step up their communication and interaction with their adolescents through open discussions and interactions with them. Such intervention will help improve adolescents' understanding of SRH srvices early enough. It will equally build some confidence in them to feel freer and comfortable in engaging their parents on such issues.

The out-of- school adolescents must also be reached as the school-based interventions will not reach this group. Community-outreach programmes should be initiated to target this group. Mobile clinics could also be floated in partnership with interested community-based organisations. Young people could be trained to educate their peers on ways to promote healthy sexual behaviours and strategies for seeking help when needed.

The introduction of technology-based interventions can also be considered. For the provision of convenient and accessible SRH information, keeping track of their sexual behaviours and delivering of health education messages. This could be through the design of simple to use mobile apps that can provide personalised information, and the services required.

The consideration of these recommendations for implementation will significantly contribute to addressing the challenges arising from adolescents' perception of the sources and barriers to SRH information and services, and ultimately assist greatly in enhancing adolescents' health and well-being

**Ethical Practices**

Participants aged 18+ provided written consent; guardians approved for younger individuals. No names or identifiers were collected to protect privacy. The study protocol was approved by the University ethics board.

**References**

Aderibigbe, S. A.,et.al. (2011). Teenage pregnancy and prevalence of abortion among in-school adolescents in North Central, Nigeria. *Asian Social Science*. 7(1): 122-127.

Klu, D., Gyapong, M., Agordoh, P.D. *et al.* (2023). Adolescent perception of sexual and reproductive health rights and access to reproductive health information and services in Adaklu district of the Volta Region, Ghana. *BMC Health Serv Res* 23, 1456 https://doi.org/10.1186/s12913-023-10447-1

Mbachu, C., Agu, I., Onwujekwe, O. (2020). Cross-sectional survey data of adolescent sexual and reproductive health in Nigeria 2018. [data collection]. *UK Data Service.* SN: 854374, DOI: 10.5255/UKDA-SN-854374

Mehta S, Seeley J. Grand challenges in adolescent sexual and reproductive health. (2020). *Frontiers Reprod. Health*. 2:2.

Mukherjee, S.P (2016). Adolescence https://dspmuranchi.ac.in › pdf › Blog › ADOLE..

MSI Reproductive Choices (2020). Statement. 29-msi_reproductive_choice_rev

Odo, A.N., Samuel, E.S., Nwagu, E.N. *et al.* (2018). Sexual and Reproductive Health Services (SRHS) for Adolescents in Enugu State, Nigeria: A Mixed Methods Approach. *BMC Health Serv Res* 18, 92 https://doi.org/10.1186/s12913-017-2779-x

Singh, S., Sharma, S., Tandukar, B., Silwal, P., & Sharma, M. R. (2022). Knowledge and

perception regarding adolescent sexual and reproductive health services among adolescents attending a tertiary level hospital. *Journal of Nepal Paediatric Society*, *42*(1), 87–91. https://doi.org/10.3126/jnps.v42i1.42662

WHO (2020). Adolescent sexual and reproductive health and rights. *Human Reproduction Special Programme (HRP).* https://icd.who.int

Wahyuningsih, S., Widati, S., Praveena, S. M., & Azkiya, M. W. (2024). Unveiling barriers to reproductive health awareness among rural adolescents: a systematic review. *Frontiers in Reproductive Health*, 6, https://doi.org/10.3389/frph.2024.1444111