



Original Article

Availability, Accessibility, and Utilization of Youth-Friendly Reproductive Health Services in Public Health Facilities in the Federal Capital Territory, Abuja, Nigeria: A Cross-Sectional Study

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Abstract

Introduction: Adolescents and young people represent a significant proportion of Nigeria's population and remain central to the country's future health and development. However, they continue to face multiple sexual and reproductive health (SRH) challenges, including early pregnancy, unsafe abortions, and sexually transmitted infections (STIs), often due to inadequate access to youth-responsive health services. Youth-friendly reproductive health services (YFRHS) are essential to improving adolescents' sexual and reproductive health outcomes in Nigeria. This study assessed the availability, accessibility, and utilization of YFRHS in public health facilities across the Federal Capital Territory (FCT), Abuja, and examined the influence of socio-demographic characteristics on service uptake.

Methods: A descriptive cross-sectional design was adopted. Using a multistage sampling technique, data were collected from 423 respondents aged 15–25 years across 24 public health facilities selected from 12 wards within six Area Councils (Abaji, Bwari, Gwagwalada, Kuje, Kwali, and AMAC). A structured, interviewer-administered questionnaire was used, and data were analyzed using descriptive and inferential statistics, including chi-square tests and binary logistic regression at a significance level of $\alpha=0.05$.

Results: Findings indicated moderate availability (51.3%), moderate accessibility (52.5%), and moderate utilization (56.0%) of YFRHS. However, socio-cultural barriers such as fear of community judgment, limited parental support, and religious or cultural opposition continue to hinder equitable access and use. Statistical analysis showed that sex was significantly associated with accessibility ($\chi^2=5.525$, $df=1$, $P=0.019$), with females more likely than males to report access. For utilization, employment status emerged as a significant predictor ($OR=1.995$, $P=0.001$), while living arrangement showed a marginal association ($OR=1.620$, $P=0.091$). No socio-demographic variable showed a significant relationship with availability ($P>0.05$).

Conclusion: YFRHS in the FCT demonstrate moderate availability, accessibility, and utilization, with uptake strongly influenced by economic independence and supportive living conditions. This study recommends strengthening health facility readiness, enhancing youth empowerment programs, and implementing community sensitization campaigns through collaborative efforts among government agencies, civil society organizations, and development partners to promote equitable and sustainable adolescent health outcomes.

Keywords: Reproductive health, Adolescent, Health services, Health facilities, Accessibility

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Introduction

Today's generation of young people is the largest in history. Nearly half of the world's population is under the age of 25, and this period is characterized by significant physical, emotional, and social changes during which individuals begin to explore their sexual and reproductive identities.^{1,2} Youth-friendly reproductive health services (YFRHS) are designed to meet the unique needs of young people, providing them with the knowledge and tools necessary for informed decisions about their sexual and reproductive health.³

Globally, the World Health Organization (WHO)

has emphasized the need for YFRHS to address rising concerns of sexually transmitted infections (STIs), unintended pregnancies, and unsafe abortions among adolescents.^{4,5} In Nigeria, HIV prevalence ranges from 14-17% among adolescents, and STI prevalence ranges from 29% to 48.8%.^{6,7,8} With youth aged 15-24 comprising approximately 19% of Nigeria's population, ensuring adequate access to quality SRH services is an urgent national priority.⁹

Adolescents frequently forego SRH services due to stigma, embarrassment, confidentiality concerns, parental consent requirements, cost, distance, and negative



provider attitudes.^{10,11,12} Despite the Federal Ministry of Health's National Guidelines for Adolescent and Youth-Friendly Health Services (AYFHS), implementation across public health facilities remains inconsistent.¹³ In the Federal Capital Territory (FCT), which encompasses both urban and peri-urban populations across six Area Councils, there is limited empirical evidence on YFRHS in government facilities.^{14,15} This study therefore assessed the availability, accessibility, and utilization of YFRHS in selected FCT public health facilities, and examined socio-demographic influences on service uptake.

Objectives

The general objective was to assess YFRHS in selected public health facilities in the FCT. The specific objectives were:

1. To determine the availability of YFRHS in selected public health facilities.
2. To examine the accessibility of these services from the perspective of young people.
3. To evaluate the level of utilization of YFRHS among youth.
4. To identify the socio-demographic factors associated with the availability, accessibility, and utilization of YFRHS.

Methods

Study Area and Design

The study was conducted in the Federal Capital Territory (FCT), Nigeria, encompassing six Area Councils: Abuja Municipal (AMAC), Bwari, Gwagwalada, Kuje, Kwali, and Abaji. A descriptive cross-sectional study design was adopted to capture a snapshot of YFRHS across this diverse geographic setting.

Sample Size and Sampling Technique

The study population comprised adolescents and young adults aged 15-25 years accessing SRH services in public health facilities. Sample size was determined using $n = Z^2pq/d^2$ ($Z = 1.96$, $P = 0.43$, $d = 0.05$), yielding 384; adding 10% for non-response produced a final sample of 423. A four-stage multistage sampling technique was used: Stage 1 - all six Area Councils included for geographic equity; Stage 2 - two wards randomly selected per council (12 wards total); Stage 3 - two facilities randomly selected per ward (24 facilities total); Stage 4 - systematic random sampling for youth respondents and purposive sampling for healthcare providers at each facility.

Data Collection and Analysis

A structured, pre-tested, interviewer-administered questionnaire comprising six sections covered: (A) socio-demographics; (B) YFRHS availability; (C) accessibility; (D) utilization; (E) barriers; and (F) strategies for improvement. The questionnaire was pre-tested among 30 youth in a non-participating facility in the FCT to assess clarity, flow, and comprehension; ambiguous questions

were revised based on feedback. Likert-scale items were rated 1-5 (Strongly Disagree to Strongly Agree); a mean score of 3.0 or above was considered a positive response, as a score of 3 represents the "Neutral" midpoint on the scale, and values at or above this point indicate a shift towards agreement. Data were analyzed using SPSS v25.0. Descriptive statistics summarized variables; chi-square tests examined socio-demographic associations ($\alpha = 0.05$); and binary logistic regression identified significant predictors of accessibility and utilization.

Ethical Considerations

Ethical approval was obtained from the Bingham University Research Ethics Committee. Informed consent was secured from all participants prior to data collection. Parental or guardian consent was obtained for participants below 18 years of age. Confidentiality and anonymity were assured throughout the study.

Results

Socio-demographic Characteristics of Participants

Table 1 presents the socio-demographic profile of the 423 respondents. The majority were female (51.8%). Using WHO standard age groupings, most respondents fell in the 20–24 years category (59.1%), with the remaining 40.9% aged 15–19 years. Most were single (50.6%), while 11.1% fell under "Others" (comprising those who were cohabiting or engaged). In terms of education, 27.4% had tertiary and 25.1% secondary qualifications. Nearly half were students (48.2%), with 29.6% self-employed. Regarding living arrangement, 45.2% lived with parents and 38.3% with guardians. Participants were well distributed across all six Area Councils, with the highest proportion from Kuje (18.4%) and Abaji (18.2%).

Availability of YFRHS

Table 2 shows that 51.3% of respondents reported their nearest public health facility provides YFRHS. Among specific services available, menstrual hygiene was most frequently reported (20.5%), followed by STI testing/treatment (20.4%), HIV counselling/testing (20.3%), antenatal/postnatal care (20.1%), and family planning (18.7%). Table 3 presents the Likert mean analysis for availability. All seven items scored at or above the decision threshold of 3.0 (range: 3.0-3.3), confirming respondents' general recognition of YFRHS attributes including trained staff (3.1), a welcoming environment (3.2), well-equipped facilities (3.3), and availability of health education materials (3.1).

Accessibility of YFRHS

Overall, 52.5% of respondents reported YFRHS were accessible. Table 4 shows that seven of ten Likert items scored at or above the decision threshold of 3.0. The strongest facilitators were proximity of the facility (mean = 3.5), safety at the facility (mean = 3.2), and reasonable waiting time (mean = 3.2). However, affordability of

Table 1. Socio-demographic Characteristics of Participants (N=423)

Variable	Frequency (N = 423)	Percentage (%)
Sex		
Male	204	48.2
Female	219	51.8
Age (years)		
15-19	173	40.9
20-24	250	59.1
Marital Status		
Single	214	50.6
Married	152	35.9
Divorced	10	2.4
Others (Cohabiting/Engaged)†	47	11.1
Educational Level		
Non-formal	97	22.9
Primary	104	24.6
Secondary	106	25.1
Tertiary	116	27.4
Employment Status		
Student	204	48.2
Employed	54	12.8
Unemployed	40	9.5
Self-employed	125	29.6
Living Arrangement		
With Parents	191	45.2
With Guardians	162	38.3
Living Alone	70	16.5
Area of Residence		
Abaji	77	18.2
Gwagwalada	60	14.2
Kuje	78	18.4
Bwari	69	16.3
Kwali	73	17.3
AMAC	66	15.6

Source: Field Survey, 2025. †“Others” in Marital Status includes respondents who identified as cohabiting or engaged (n=47, 11.1%). Age groups are approximated to WHO standard categories (15–19; 20–24); the 18–20 cohort was split proportionally as individual-year data were unavailable.

services (mean = 2.9), convenient service hours (mean = 2.9), and freedom from gender discrimination (mean = 2.9) fell below threshold.

Utilisation of YFRHS

A total of 56.0% of respondents reported utilizing YFRHS. Table 5 shows that eight of ten items were accepted. The highest scores were for attending health education sessions (mean = 3.5) and satisfaction with service delivery (mean = 3.4), followed by respectful provider attitudes (mean = 3.3) and use of services without fear of judgment (mean = 3.2). However, visiting the facility when having RH concerns (mean = 2.9) and recommending services to peers (mean = 2.9) fell below threshold.

Table 2. Availability of YFRHS - Frequency Distribution

Variable	Frequency (N = 423)	%
PHF Provides Youth-Friendly RH Services		
Yes	217	51.3
No	206	48.7
Specific Services Available (multiple response)		
Family Planning	208	18.7
STI Testing/Treatment	227	20.4
HIV Counselling/Testing	225	20.3
Antenatal/Postnatal Care	223	20.1
Menstrual Hygiene Services	228	20.5

Source: Field Survey, 2025

Barriers to Accessing YFRHS

Table 6 presents perceived barriers. Items at or above the decision threshold included: fear of community judgment (mean = 3.0), lack of parental/guardian support (mean = 3.0), shame or shyness (mean = 3.2), and religious or cultural beliefs discouraging service use (mean = 3.3). Structural barriers - including distance (2.9), financial constraints (2.9), lack of privacy (2.9), negative staff attitudes (2.9), limited service awareness (2.9), and language barriers (2.9) - all fell below threshold.

Inferential Statistics

Table 7 presents chi-square and logistic regression findings. No socio-demographic variable was significantly associated with availability (all $p > 0.05$). For accessibility, sex was the only significant variable (chi-sq = 5.525, $P = 0.019$), with logistic regression confirming that males were approximately 37% less likely to report access (OR = 0.631, $p = 0.019$). For utilization, employment status (chi-sq = 19.267, $P < 0.001$; OR = 1.995, $p = 0.001$) and living arrangement (chi-sq = 11.231, $P = 0.004$) were significant. Employed youth were nearly twice as likely to utilize services, while living arrangement showed a marginal but non-significant logistic association (OR = 1.620, $P = 0.091$).

Discussion

In the present study, our aim was to assess the availability, accessibility, and utilization of YFRHS in public health facilities across the Federal Capital Territory (FCT), Abuja, and to examine the influence of socio-demographic characteristics on service uptake. In our study, we found a moderate availability rate (51.3%), which reflects the uneven implementation of national adolescent health policies and infrastructural disparities across FCT facilities, consistent with findings in the previous studies from in Ethiopia¹⁶ and Nigeria.¹⁷ All availability indicators being above threshold confirms that where YFRHS exist, they generally meet baseline operational standards.

As reported in the results section, the strongest facilitators were proximity of the facility, safety at the facility, and reasonable waiting time. However, affordability of services, convenient service hours, and freedom from gender discrimination were below

Table 3. Availability of YFRHS - Likert Mean Analysis (N=423)

S/N	Availability of Youth-Friendly Reproductive Health Services	SD	D	N	A	SA	Mean	Decision
1	PHF closest to me provides RH services for youth	75	83	41	124	100	3.2	Accepted
2	Facility offers a wide range of services (counselling, FP, etc.)	71	84	65	111	92	3.1	Accepted
3	Staff trained to handle youth-specific RH issues	77	65	87	102	92	3.1	Accepted
4	Environment is welcoming and youth-friendly	51	90	79	126	77	3.2	Accepted
5	Service delivery is consistent and uninterrupted	65	93	90	98	77	3.0	Accepted
6	Facility is well-equipped to handle RH cases	33	80	79	150	81	3.3	Accepted
7	Health education materials are available at facility	69	80	79	99	96	3.1	Accepted

Source: Field Survey, 2025. Decision threshold: Mean $\geq$ 3.0 = Accepted; Mean $<$ 3.0 = Rejected. SD = Strongly Disagree; D = Disagree; N = Neutral; A = Agree; SA = Strongly Agree

Table 4. Accessibility of Available YFRHS - Likert Mean Analysis (N=423)

S/N	Accessibility of Available Services	SD	D	N	A	SA	Mean	Decision
1	Health facility is located near my home or school	63	48	52	118	142	3.5	Accepted
2	I can afford transportation to and from the facility	103	54	53	128	85	3.0	Accepted
3	Services are affordable or free of charge	97	73	86	73	94	2.9	Rejected
4	I can access the facility during convenient hours	85	89	89	80	80	2.9	Rejected
5	Waiting time at the facility is reasonable	71	74	84	83	111	3.2	Accepted
6	I can access services without parental consent	71	78	81	99	94	3.1	Accepted
7	Facility does not discriminate based on gender/appearance	93	84	74	84	88	2.9	Accepted
8	Information about available services is easily accessible	74	78	86	91	94	3.1	Accepted
9	I feel safe accessing services at the facility	80	45	74	136	88	3.2	Accepted
10	Staff communicates in a language I understand	48	79	83	129	84	3.2	Accepted

Source: Field Survey, 2025. Decision threshold: Mean $\geq$ 3.0 = Accepted; Mean $<$ 3.0 = Rejected

Table 5. Utilisation of YFRHS - Likert Mean Analysis (N=423)

S/N	Utilisation of Youth-Friendly Reproductive Health Services	SD	D	N	A	SA	Mean	Decision
1	I visit the facility whenever I have RH concerns	94	88	77	85	79	2.9	Rejected
2	I feel comfortable asking questions about my RH	70	95	88	90	80	3.0	Accepted
3	I have used STI testing, HIV screening, or FP services	78	87	80	86	92	3.0	Accepted
4	I trust the confidentiality of services offered	85	88	71	93	86	3.0	Accepted
5	I have recommended the facility to friends/peers	82	96	86	75	84	2.9	Rejected
6	I use the services without fear of judgment	78	64	54	147	80	3.2	Accepted
7	Information and services received were helpful and clear	79	71	91	82	100	3.1	Accepted
8	Service providers answered my questions respectfully	70	74	59	88	132	3.3	Accepted
9	I am satisfied with the way services are delivered	42	83	56	122	120	3.4	Accepted
10	I attend health talks/educational sessions at the facility	59	43	71	125	125	3.5	Accepted

Source: Field Survey, 2025. Decision threshold: Mean $\geq$ 3.0 = Accepted; Mean $<$ 3.0 = Rejected

threshold, indicating persistent barriers. These findings align with Agwuncha and Akinwaare,¹⁸ who found 70.8% high access to SRHS among Nigerian youth, and with Ndayishimiye et al.¹⁹ who reported satisfactory adolescent SRH accessibility in Rwanda. The proximity of facilities, availability of trained and approachable staff, and absence of strict parental consent requirements emerged as the primary facilitators.

In terms of utilization of YFRHS, we identified a 56.0% of YFRHS utilization rate. Table 5 shows that eight of ten items were accepted. As we reported, visiting the facility when having RH concerns and recommending services to peers were below threshold, suggesting that despite high satisfaction, active health-seeking and peer advocacy

remain subdued. The 56.0% utilization rate substantially exceeds comparable rates documented in Ethiopia (28.9%¹⁶ and 32.8%,²⁰), and the Nigeria's Cross River State (21.5%¹⁷), likely reflecting the FCT's higher urbanization, facility proximity, and investment in trained health workers.

In our study, fear of community judgment, lack of parental/guardian support, shame or shyness, and religious or cultural beliefs discouraging service use were the barriers at or above the decision threshold, and the structural barriers all were below the threshold. These findings align with those reported by Eremutha and Gabriel²¹ and Mulaudzi et al.²², who highlighted socio-cultural stigma as a primary barrier in Nigerian and South

Table 6. Barriers to Accessing YFRHS - Likert Mean Analysis (N=423)

S/N	Barriers to Accessing Youth-Friendly Reproductive Health Services	SD	D	N	A	SA	Mean	Decision
1	Fear of community judgment prevents me from seeking services	91	72	74	88	98	3.0	Accepted
2	The facility is too far from where I live	88	80	92	77	86	2.9	Rejected
3	I do not have money for transport or services	80	85	132	32	94	2.9	Rejected
4	Parents/guardians do not support using such services	87	80	88	81	87	3.0	Accepted
5	I feel ashamed or shy to seek RH services	113	39	48	81	142	3.2	Accepted
6	Religious or cultural beliefs discourage service use	58	71	68	105	121	3.3	Accepted
7	Facility lacks privacy, making it uncomfortable for youth	84	98	78	78	85	2.9	Rejected
8	Bad experiences with rude or unprofessional staff	82	89	84	94	74	2.9	Rejected
9	I do not know which services are available for youth	82	95	88	91	67	2.9	Rejected
10	Language barriers or unclear explanations discourage me	75	94	87	91	76	2.9	Rejected

Source: Field Survey, 2025. Decision threshold: Mean $\geq$ 3.0=Accepted; Mean $<$ 3.0=Rejected

Table 7. Relationship between Socio-demographic Characteristics and YFRHS Outcomes

Variable	Availability p	Accessibility χ^2/p	Utilization χ^2/p	Significant	Logistic Regression OR (95% CI)
Sex	.397	5.525/.019*	.468	Accessibility	OR=0.631, $P=0.019$ (females 37% more likely to access)
Age	.201	2.418/.490	.503	NS	-
Marital Status	.180	5.954/.114	.127	NS	-
Religion	.956	1.532/.675	.316	NS	-
Educational Level	.476	2.464/.482	.566	NS	-
Employment Status	.950	3.137/.371	19.267/ $<.001^*$	Utilization	OR=1.995, $P=0.001$ (employed 2x more likely to utilize)
Living Arrangement	.713	2.566/.277	11.231/.004*	Utilization	OR=1.620, $P=0.091$ (marginal association)
Area of Residence	.409	4.138/.530	.244	NS	-

Source: Field Survey, 2025. * $P<0.05$ (statistically significant). NS=Not Significant. OR=Odds Ratio from binary logistic regression.

African contexts. Notably, structural barriers were not dominant in this FCT setting, distinguishing it from more rural and resource-limited environments where such factors remain the primary obstacles. This finding carries a profound programmatic implication: in the FCT's semi-urban context, socio-cultural factors have overtaken structural ones as the primary hurdle to youth SRH service access. Simply improving facility infrastructure or reducing distance is insufficient; meaningful progress requires intentional community-level interventions that address stigma, shame, and religious or cultural resistance. Programs that invest only in structural readiness without simultaneously engaging communities, religious leaders, and families will fall short of the transformative outcomes needed. This finding should directly inform the design of demand-generation and community engagement strategies within the FCT's adolescent health programs.

In the present study, no socio-demographic factor was significantly associated with availability, indicating that structural factors - facility distribution and policy implementation - rather than individual characteristics, are the primary determinants of service presence. For accessibility, sex was the only significant factor, and the males were approximately 37% less likely to report access - corroborating evidence on masculine gender norms discouraging engagement with reproductive health services. For utilization, the strong association between employment and utilization is likely explained by several intersecting mechanisms: employed youth tend to have

greater financial autonomy to cover transportation costs or service fees that may deter their unemployed peers; they may also exercise greater independence in health decision-making, unconstrained by parental or guardian oversight; and through workplace exposure, they may have broader health awareness and lower perceived stigma around seeking SRH services. These findings uniquely suggest that in the FCT context, socio-economic independence and living autonomy - rather than traditional demographic predictors such as age, education, or marital status - are the primary drivers of YFRHS utilization. This has direct implications for program design: livelihood empowerment and financial inclusion components should be integrated into adolescent SRH interventions to address the economic dimensions of service uptake.

Conclusion

Youth-friendly reproductive health services remain a critical component of adolescent health promotion in the FCT and Nigeria at large. Findings reveal that while public health facilities demonstrate moderate availability (51.3%) and relatively high accessibility (52.5%) and utilization (56.0%), significant socio-cultural and structural barriers persist. Fear of community judgment, lack of parental support, and religious or cultural opposition are the primary deterrents. The significant influence of employment status and living arrangement on YFRHS utilization underscores the role of socio-economic independence and supportive environments

in facilitating SRH service uptake, beyond traditional demographic factors. Healthcare providers generally demonstrate positive attitudes; however, challenges including inadequate youth-specific materials, privacy infrastructure limitations, and cultural resistance continue to impede optimal service delivery.

Recommendations

1. The FCT Health Department should ensure all public health facilities are adequately equipped with youth-specific reproductive health materials, trained personnel, and dedicated spaces to improve service readiness and delivery. Youth-friendly indicators should be incorporated into monitoring and evaluation frameworks to strengthen accountability and quality of service provision.
2. Policy makers and program designers should develop targeted interventions addressing the socio-economic realities influencing service utilization. Since employment status and living arrangements significantly affect access and use, reproductive health programs should integrate livelihood and empowerment components that strengthen young people's financial independence and decision-making autonomy.
3. Civil society organizations and youth networks should intensify peer education programmes, youth outreach activities (online and offline), and school health clubs to encourage proactive health-seeking behaviour. Parent and caregiver education should be prioritized to foster healthy, open parent-child communication on sexual and reproductive health.
4. Development partners including UNFPA, UNICEF, and other international organizations should continue providing technical and financial support to scale up YFRHS across all Area Councils in the FCT, prioritizing youth-led interventions, continuous capacity building for health workers, and data-driven planning.
5. Healthcare providers should receive regular refresher training, supportive supervision, and incentives to sustain youth-friendly attitudes, confidentiality, and non-judgmental service delivery.

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Competing Interests

The author declares no competing interests.

Ethical Approval

Ethical approval was obtained from the Bingham University

Teaching Hospital Health Research Ethics Committee (Approval No: NHREC/21/05/2005/01540; Date: 23rd June 2025). Informed consent was obtained from all participants prior to data collection. Parental or guardian consent was obtained for participants below 18 years of age. Confidentiality and anonymity were assured throughout the study.

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