FACTORS ASSOCIATED WITH THE UTILIZATION OF YOUTH-FRIENDLY SERVICES BY OUT-OF-SCHOOL YOUTHS IN IBADAN METROPOLIS, NIGERIA

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Abstract

The need to improve out-of-school youths' reproductive health challenges is being increasingly recognized throughout the world. Youths with reproductive health challenges do not seek appropriate services. Earlier studies in Oyo State focused on utilising youth-friendly clinics for secondary school students but not among out-of-school youths. This study was therefore designed to determine the factors associated with assessing Youth-Friendly Clinic (YFC) services utilisation by out-of-school youth in Ibadan Metropolis, Nigeria. The study was descriptive and cross-sectional in design. A four-stage random sampling technique was adapted to select LGAs, wards, communities and 521 consenting respondents. A semi-structured interviewer-administered questionnaire was used to elicit information on respondents' socio-demographic characteristics, knowledge of YFC and utilisation. Knowledge of YFC utilisation was measured on a 14-point scale; scores of 5, >5-10 and >10 were categorised as good and poor, respectively. A Focus Group Discussion guide was used for qualitative data collection. The quantitative data were analysed using descriptive statistics, Chi-square and linear logistic regression tests at p=0.05. Qualitative data were analysed thematically. Respondents' mean age was 20.6±2.8 years; 52.6% were males, and 39.9% lived with their parents. Less than a quarter, 20.0% and 10.2%, were currently learning tailoring and patent medicine vendors training, respectively. The majority (88.0%) of the respondents heard about YFC for the first time, 92.9% had poor knowledge of YFCs, only 91.9% had ever used or visited YFC, and 47.1% had ever used/visited YFCs more than one month before the study. Most (72.2%) respondents preferred having youths as service providers in YFC, and 54.5% pointed out that female service providers understand females better. A few of those who used YFC (19.5%), (14.4%), and (11.0%) suggested more efficient staff, that staff should be more patient-friendly, and that they should create awareness on media, respectively. Among respondents that never used YFC, the three major barriers reported were less awareness of the public about YFC (27.3%), lack of adequate drugs (19.2%) and distance (18.2%). About one-fifth (20.4%) expected YFC to provide free medicines and (19.8%) free treatment. Respondents' age ≥20 was significantly associated with knowledge of YFC. Living with their parents' father, mother and peers was significantly associated with utilising YFC. Respondents who heard about YFC were more likely to utilise YFC than those with low awareness and poor knowledge (OR:0.024;95%CI=0.006-0.0014). The FGD discussants felt YFC is important in addressing the health problems of apprentices and unanimously agreed that lack of awareness and poor knowledge were the major barriers to utilisation. Knowledge of out-of-school youths in the Ibadan metropolis on utilising YFC was poor. Awareness creation through Information Education and Communications materials would help increase knowledge and patronage of YFC.

Keywords: Factors, Assessment, Youth-friendly- Services, Utilisation, Out-of-school.

Introduction

Globally, out-of-school youths represent a vulnerable demographic with limited access to essential health and social services. This population, estimated at 260 million by the United Nations Educational, Scientific, and Cultural Organization (UNESCO), 2022), faces unique challenges, including unemployment, poverty, exposure to risky behaviours, and poor health outcomes. The lack of access to youth-friendly services (YFS) significantly contributes to increased mortality and morbidity rates among this group. For instance, the World Health Organization (WHO, 2020) reports that preventable causes, such as sexually transmitted infections (STIs), substance abuse, and mental health disorders, are leading contributors to the global disease burden among young people aged 10–24 years. Moreover, the stigma surrounding reproductive health and insufficient youth-centred policies exacerbate these issues, leaving many without the support they need.

On the African continent, the challenges are magnified by socioeconomic and cultural factors. Africa is home to the youngest population in the world, with over 60% of its population under the age of 25 (United Nations Economic Commission for Africa [UNECA], 2019). Despite this demographic advantage, the continent struggles with high rates of youth unemployment, school dropout, and early childbearing. According to the African Union (AU, 2020), over 10 million girls aged 15–19 give birth annually in sub-Saharan Africa, many of whom lack access to reproductive health services. This reality underscores the urgent need for YFS to address the health, social, and economic needs of out-of-school youths. However, challenges such as poor

infrastructure, inadequate funding, and traditional norms continue to hinder access and utilization. For instance, Ninsiima et al. (2021) identified that social stigma and provider bias deter many young people from seeking sexual and reproductive health services in African countries.

In Nigeria, the youth population is one of the largest in Africa, with about 60% of the population aged below 25 years (National Population Commission [NPC], 2022). Despite this demographic potential, Nigerian youths face significant health challenges. Out-of-school youths, in particular, are disproportionately affected by poor health outcomes due to limited access to YFS. According to the Nigerian Demographic and Health Survey (NDHS), 2018), Nigeria has one of the highest adolescent fertility rates globally, with 106 births per 1,000 girls aged 15–19. The country also faces high rates of HIV/AIDS among young people, with out-of-school youths being among the most affected (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2020). The mortality and morbidity associated with these challenges are worsened by poor service delivery, inadequate awareness, and the stigma attached to seeking care (Suleiman et al., 2024).

Focusing on Ibadan, a major urban centre in southwestern Nigeria, the situation remains dire. Ibadan has a large population of out-of-school youths who often live in underserved communities. These youths face significant barriers to accessing YFS, including poor availability of services, high levels of unemployment, and societal stigma. Studies have shown that out-of-school youths in urban centres like Ibadan are at a higher risk of engaging in risky sexual behaviours, substance abuse, and other activities that increase their vulnerability to health issues (Ajayi et al., 2019). Additionally, the morbidity and mortality rates associated with these challenges remain high. For example, a study conducted in Ibadan reported that adolescent girls aged 15–19 accounted for a significant proportion of maternal deaths due to unsafe abortions and lack of access to reproductive health services (Odetola, 2021).

The utilization of YFS in Ibadan is further hampered by systemic issues such as poor funding of health facilities, lack of trained personnel, and insufficient youth engagement in the design and delivery of services. Cultural and religious factors also play a significant role in shaping attitudes toward YFS. Many young people, especially out-of-school youths, are deterred by societal norms that discourage open discussions about sexual and reproductive health (Adesina et al., 2020). These challenges highlight the need for targeted interventions to improve the accessibility and acceptability of YFS among out-of-school youths in Ibadan.

Cultural barriers refer to restrictive norms and stigma around adolescent and youth sexuality, inequitable or harmful gender norms, and discrimination and judgment by communities, families, partners, and providers (Geary, Gómez-Olivé, Kahn, Tollman & Norris, 2014).

Four studies were identified exploring the impact of religious and traditional beliefs on access to YFSRHS (Ajike, 2016; Akinyi, 2014; Lawton, 2017; Self et al., 2018; Nmadu, 2017). Sociocultural factors were greatly associated with some services, mainly FP, voluntary counselling and testing, and counselling services. It was established that some cultures and parents in a community cross-sectional study done in Kenya and Ethiopia prohibited the youth from utilising.

YFRHS as this was brought out when descriptive, chi-square and odds statistics all showed significant relationships (Ajike, 2016; Akinyi, 2014). Some participants in a study done in Malawi indicated that parents expressed negative opinions of youth using FP and that parents could prevent youth from accessing FP services. They also said youth below age 18 are not old enough to be sexually active. Therefore, the youth did not need FP and should focus on completing their education and not engage in sexual activities (Self et al. 2018).

However, the factors associated with the utilization of YFS by out-of-school youths are multifaceted, encompassing global, continental, national, and local dimensions. Addressing the high mortality and morbidity rates among this vulnerable group requires concerted efforts to overcome challenges such as stigma, inadequate funding, and poor service delivery. The case of Ibadan provides a critical lens through which to examine these issues and identify strategies to improve YFS utilization, thereby enhancing the health and well-being of out-of-school youths in Nigeria and beyond.

Statement of the Problem

Out-of-school youths are particularly vulnerable to various health risks, including unintended pregnancies, sexually transmitted infections (STIs), substance abuse, and mental health challenges (United Nations Population Fund [UNFPA], 2020). Studies have shown that several factors influence their willingness and ability to access YFS, including lack of awareness, cultural and religious beliefs, stigma, financial constraints, and distance to healthcare facilities (Bankole et al., 2017). Additionally, structural barriers such as poor service delivery, unfriendly attitudes of healthcare providers, and concerns about confidentiality contribute to the underutilization of these services (Tylee et al., 2018). The non-utilization of YFS among this group has significant implications, including an increased rate of unsafe abortions, a higher prevalence of STIs, and limited access to counselling and preventive care (Görgen, Yansané, Marx, & Millimouno, 2019).

In Nigeria, adolescents often lack adequate knowledge about their reproductive systems, leaving them vulnerable to risky behaviours with potentially severe consequences, including long-term sexual and reproductive health issues or even death (Thepthien & Celyn, 2022; Cortez et al., 2016). Economic and peer pressures further exacerbate this problem, pushing

adolescents into premature and unsafe sexual activities. Cultural and religious barriers also contribute by limiting access to vital reproductive health information and services.

Studies show alarming trends in adolescent sexual behaviour. Adebiyi and Azuzu (2009) reported high percentages of out-of-school youths engaging in sexual activities, with many having multiple sexual partners. Similarly, research by Dare et al. (2001) and Amu et al. (2020) documented widespread early sexual debut among Nigerian adolescents, with the Nigerian National Demographic Health Survey (NDHS, 2008) reporting that 16% of young women and 6% of young men experienced sexual debut before age 15. Early sexual initiation is significantly influenced by marital status and education levels, with lower levels of education associated with earlier sexual activity.

The reproductive health challenges Nigerian youth face are similar to those of youths in many other African countries. Youths are faced with many reproductive health challenges, including early and unintended pregnancy and childbirth, HIV/STIs, abortion, marriage for young girls, and harmful traditional practices such as genital cutting and malnutrition among others (Alukagberie et al., 2023; Mathewos & Mekuria, 2018; Nofiu et al., 2021; Suleiman et al., 2024). Reproductive health challenges among Nigerian youth are mirrored across Africa, including early pregnancies, STIs, unsafe abortions, child marriages, and harmful traditional practices (Alukagberie et al., 2023). Given the significance of YFS in promoting youth health and well-being, it is crucial to investigate the factors associated with the utilization of these services by out-of-school youths in the Ibadan Metropolis. Understanding these factors will provide evidence-based insights for policymakers, healthcare providers, and stakeholders to enhance the accessibility and effectiveness of YFS, ultimately improving the health and well-being of young people.

Broad Objective

The broad objective of the study is to assess the Factors Associated with the Utilization of Youth-Friendly Services (YFC) by out-of-school Youths in Ibadan Metropolis, Nigeria.

Specific Objectives

The specific objectives are to:

1. Assess respondents' level of knowledge of Youth-friendly Clinics.
2. Determine respondents' level of utilisation of youth-friendly health services.

Research Questions

The study provides answers to the following research questions.

1. What is the knowledge of Youth-friendly Services among out-of-school youth in Ibadan North Local Government Area?
2. What is the respondents' level of utilisation of youth-friendly health services?

Research Hypotheses

1. There is no significant association between respondents' age and knowledge of youth-friendly clinic services.
2. There is no significant association between the sex of respondents and knowledge of the youth-friendly clinic services.
3. There is no significant association between respondents' sources of information and youth-friendly clinic services.

Methodology

The study employed a descriptive cross-sectional survey to assess factors influencing out-of-school youths' utilization of youth-friendly services in Ibadan Metropolis. Conducted in three selected LGAs with functional youth-friendly clinics, the study targeted out-of-school youths aged 15–25 engaged in various vocations or skill acquisition programs. Using multistage sampling, participants were purposively and randomly selected from specific wards and communities. Data collection involved mixed methods, including focus group discussions (FGDs) and interviewer-administered questionnaires designed to capture socio-demographic data, workplace information, knowledge of youth-friendly services, and barriers to their utilization. Instruments underwent rigorous pretesting for validity and reliability 0.94, with translations into Yoruba to ensure accessibility. The sample size was calculated using the Kish (1967) formula. The formula is a widely accepted method for determining sample size in survey research.

$n = z^2pqd^2$;Where n = sample size d =Degree of accuracy 5%

z = Confidence level, 1.96 p = Assumed level of utilisation, 50%

q = (1 – p) = 1.0.50 = 0.50 $n = (1.96)\ 2 \times 0.50 \times 0.50 / (0.05)^2$ =384.96.

The sample size = 384.96. To cater to non-response, 30% of the calculated sample size was added to give a minimum sample of 501.

Results

Table 1: Socio-demographic characteristics of respondents (N=521)

Variable	Options	Frequency	%
Sex	Male	274	52.6
	Female	247	47.4
Age in years	(Mean age = 20.6±2.8)		
	<20	176	33.8
	≥20	345	66.2
Marital status	Single	484	92.9
	Cohabiting	12	2.3
	Married	25	4.8
Religion	Christianity	238	45.7
	Islam	273	52.4
	Traditional	10	1.9
Total income per month	<₦20,000	435	83.5
	₦ 20,000-₦ 49,000	78	15.0
	> ₦ 50,000	8	1.5
Ethnic group	Yoruba	497	95.4
	Hausa	9	1.7
	Igbo	15	2.9
Enrolment in school	Currently enrol	110	21.1
	Not currently enrol	411	78.9
Level of education currently enrol into (n=110)	JSS	10	9.1
	SSS	56	50.9
	Higher institution	44	40.0
Living with	Alone	44	8.4
	Father alone	70	13.4
	Mother alone	86	16.5
	Father and mother	208	39.9
	Grandparent	19	3.6
	Friend	61	11.7
	Husband	8	1.5
	Sister	24	4.6
	Wife and children	1	0.2

The above table revealed the distribution of respondents according to social demographic characteristics. The respondents' age was 20.6±2.8 years, ranging between 15 and 25 years, and more than half (52.6%) were male. Those who were 20 and above were 66.2%. Most (92.9%) of respondents were single. More than half of the respondents (52.4%) were Muslims, and 95.4% were of the Yoruba ethnic extraction. The top educational qualification of respondents was secondary education (72.6%) (Figure 1). Among these respondents, 78.9% were not currently enrolled in school, while 50.9% of 110 respondents who were currently in school were in senior secondary school at the time of data collection. Respondents who earned <₦20,000 monthly were the majority (83.5%), and 39.9% of the respondents were living with their father and mother. Respondents who were tailoring apprentices (20.0%) top the list of respondents undergoing apprentice training, followed by those who were learning patent medicine vendors (PMV/chemist) (Figure 2). The highest from the list of respondents' parents' educational qualifications was a secondary school (48.0% and 45.0%) of both father and mother, respectively (Figure 3).

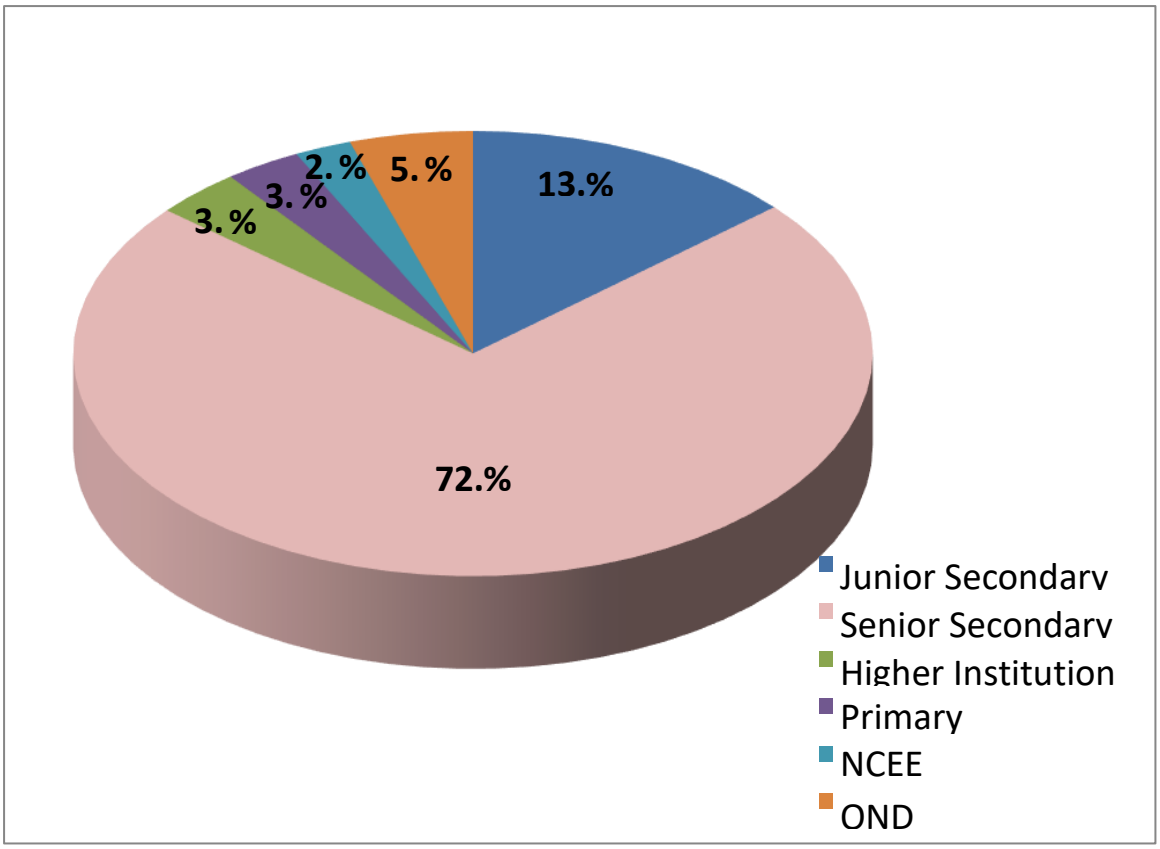

Figure 1: Respondents' Level of Education

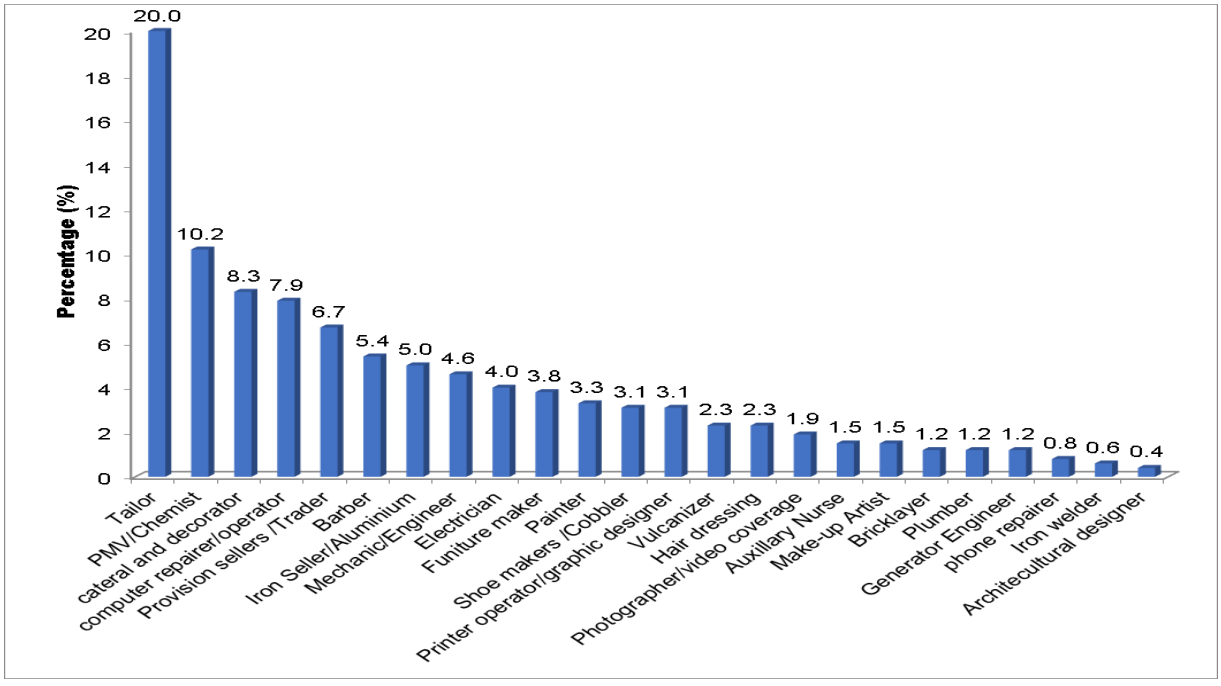

Figure 2: Respondents undergoing training

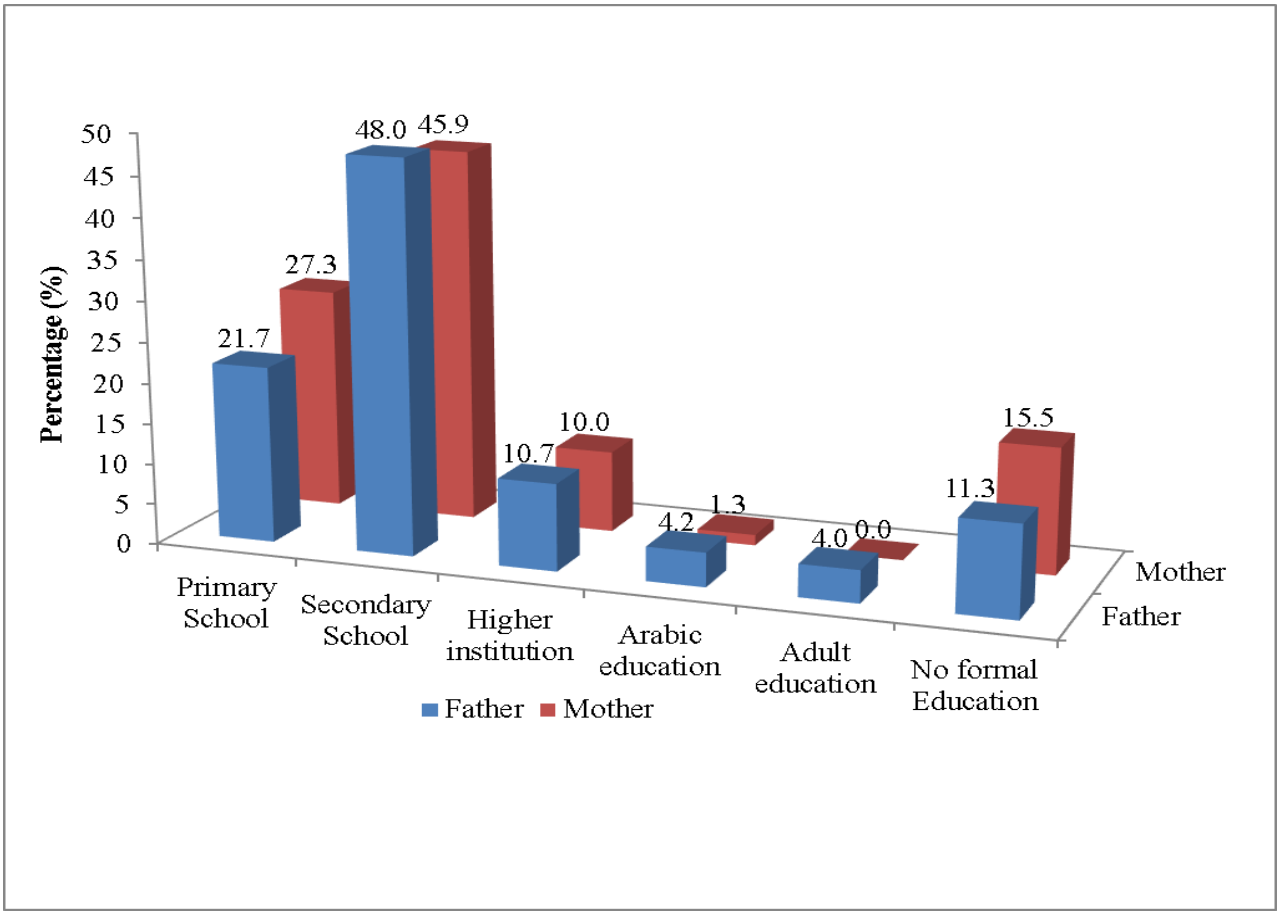

Figure 3: Respondents' parents' level of education

Table 2: Respondents' knowledge of Youth-Friendly clinic (N=521)

Variable	Freq.	%
Ever heard of a Youth-Friendly Clinic?		
Yes	125	24.0
No	396	76.0
Total	521	100.0
Services expected to be provided in YFC		
Counsel the youth on sexual and reproductive health matters/family planning.	103	34.9
Free treatment/ check-up	50	16.9
Education on childbearing	31	10.5
Free drugs	22	7.5
Enlightening the youth on the consequences of drug abuse	18	6.1
To encourage the youth to donate blood	15	5.1
provision of quality health workers	14	4.7
To provide referral service to the hospital	14	4.7
Provision of indoor game and recreational facilities within the clinic	12	4.1
To provide internet and health movies on HIV/AIDS for the youth in the centre	10	3.4
Educate the youth and advice on carrier in early age	6	2.0
Total[+]	295	100.0
Knowledge about any Youth-Friendly Clinic/Centre (YFC)		
Yes	37	7.1
No	484	92.9
Total	521	100.0
Names of the YFC mentioned (n=37)		
YFC, Yemetu	9	24.3
Apata maternity and child centre	9	24.3
UCH	2	5.4
Idi-Ogungun	2	5.4
MCH	2	5.4
Maternal and Child Health, Awotunde Olopometa	4	10.8
YFC, Moor plantation	2	5.4
Ago-Tapa PHC	4	10.8
Jericho Men's Hub Clinic	1	2.7
Mokola PHC	1	2.7
Ibadan Centre Hospital	1	2.7
Sources of information (n=37)		
Peers	19	51.4
Health workers	8	21.6
Radio	4	10.8
Parent or Guardian	4	10.8
Corper/peer education teacher	2	5.4

[+] **All totals are not equal to 521 because not applicable and have been deleted**

Less than one-quarter (24.0%) of respondents had heard about youths-friendly clinics or centres (YFC), and among mentioned services expected to be provided in YFC included counselling the youth on sexual and reproductive health matters/family planning (34.9%), free treatment/checkup (16.9%), education on childbearing (10.5%), free drugs (7.5%) and enlightening the youth on the consequences of drug abuse (6.1%). Similarly, 7.1% of respondents knew any Youth-Friendly Clinic/Centre (YFC). Among mentioned names of YFC known to the respondents were YFC, Yemetu (24.3%), Apata Maternity and Child Centre (24.3%), Maternal and Child Health, Awotunde Olopometa (10.8%) and Ago-Tapa PHC (10.8%). Above Half (51.4%) of respondents heard information about YFC through their peers, followed by those who got information from health workers (21.6%) (Table 4.2).

Table 3: Respondents' Utilisation of Youth-Friendly Centre/clinic

Variable	N	%
Ever used or visited a Youth-Friendly Clinic Service Centre (n=37)		
Yes	34	91.9
No	3	8.1
Name of the Youth-Friendly Clinic/Centre that you have ever used (n=34)		
Child and Maternity Centre, Apata	13	38.2
Adeoyo	5	14.7
UCH	4	11.8
Awotunde Maternal and Child Health Centre	2	5.9
YFC, Moor plantation	2	5.9
Idi Ogungun	2	5.9
Group Medical	2	5.9
UI	1	2.9
Ibadan centre	1	2.9
Jerich Men's Hub Clinic	1	2.9
Mokola PHC	1	2.9
Name of the Youth-Friendly Clinic Service Centre that you used last before this interview (n=30)		
child and maternity centre, Apata	13	43.3
Adeoyo	4	13.3
UCH	4	13.3
YFC, Moor plantation	2	6.7
Idi Ogungun	2	6.7
Group Medical	2	6.7
Awotunde Maternal and Child Health Centre	1	3.3
UI	1	3.3
Jerich Men's Hub Clinic	1	3.3
Last time visitation to the YFC clinic (n=34)		
within the last month	1	2.9
more than one month ago	16	47.1
5 years and above	16	47.1
4 years ago	1	2.9
Owner of the YFC (n=34)		
Government	29	85.3
Private	5	14.7
Experience when visited YFC service centre (n=31)		
Satisfied	23	74.2
Educative	3	9.7
Not satisfied	5	16.1

The table above shows the respondents' utilisation of YFC. Of the 37 respondents who knew YFC in their area, 91.9% of respondents had ever used or visited a YFC Service Centre. Among mentioned names of YFC visited included Child and Maternity Centre in Apata (38.2%), Adeoyo (14.7%) and YFC in the University of Ibadan (11.8%). In the same vein, the name of the Youth-Friendly Clinic Service Centre recently used or visited by respondents included Child and Maternity Centre in Apata (43.3%), Adeoyo (13.3%) and UCH (13.3%). Many (47.1%) of respondents reported that the last time they visited the YFC was more than one month ago, and those who had visited the location for about five years and above were 47.1%, respectively (Table 4.6). Respondents' reasons for visitation to YFC included treatment (34.1%), HIV education (26.8%) and visitation's sake (12.2%). Available types of services in the YFC visited by respondents included counselling (29.5%), medical advice and treatment (22.9%) and free drugs (28.8%) (Figure 4). Out of 37 respondents who admitted receiving all the required

services, most (74.2%) declared their satisfaction with the services received. Most respondents (85.3%) reported that the YFC locations patronized were government-owned.

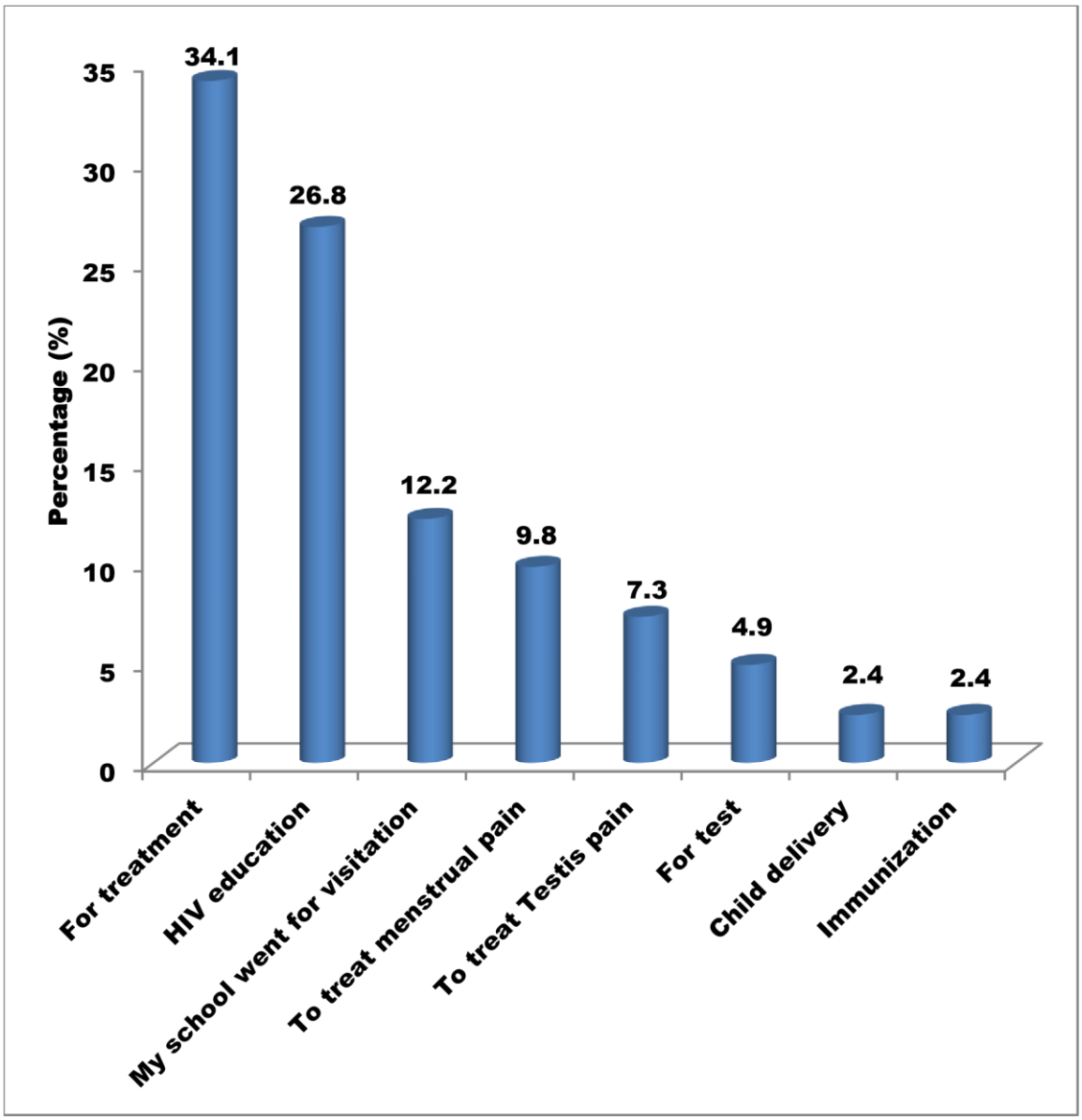

Figure 4 above shows that 34. 1% of the respondents go for treatment, 26.8% of the respondents go for HIV education, 12.2% of the respondents believed that their school went for visitation only, 9.8% of the respondents went to treat their menstrual pain, 7.3% of the respondents went to test testis pain, 4.9% of the respondents went for test and 2.4% of the respondents went for child delivery while 2.4% of the respondents went for immunization.

Figure 4.4: Respondents' reasons for visiting YFC (n=41)+

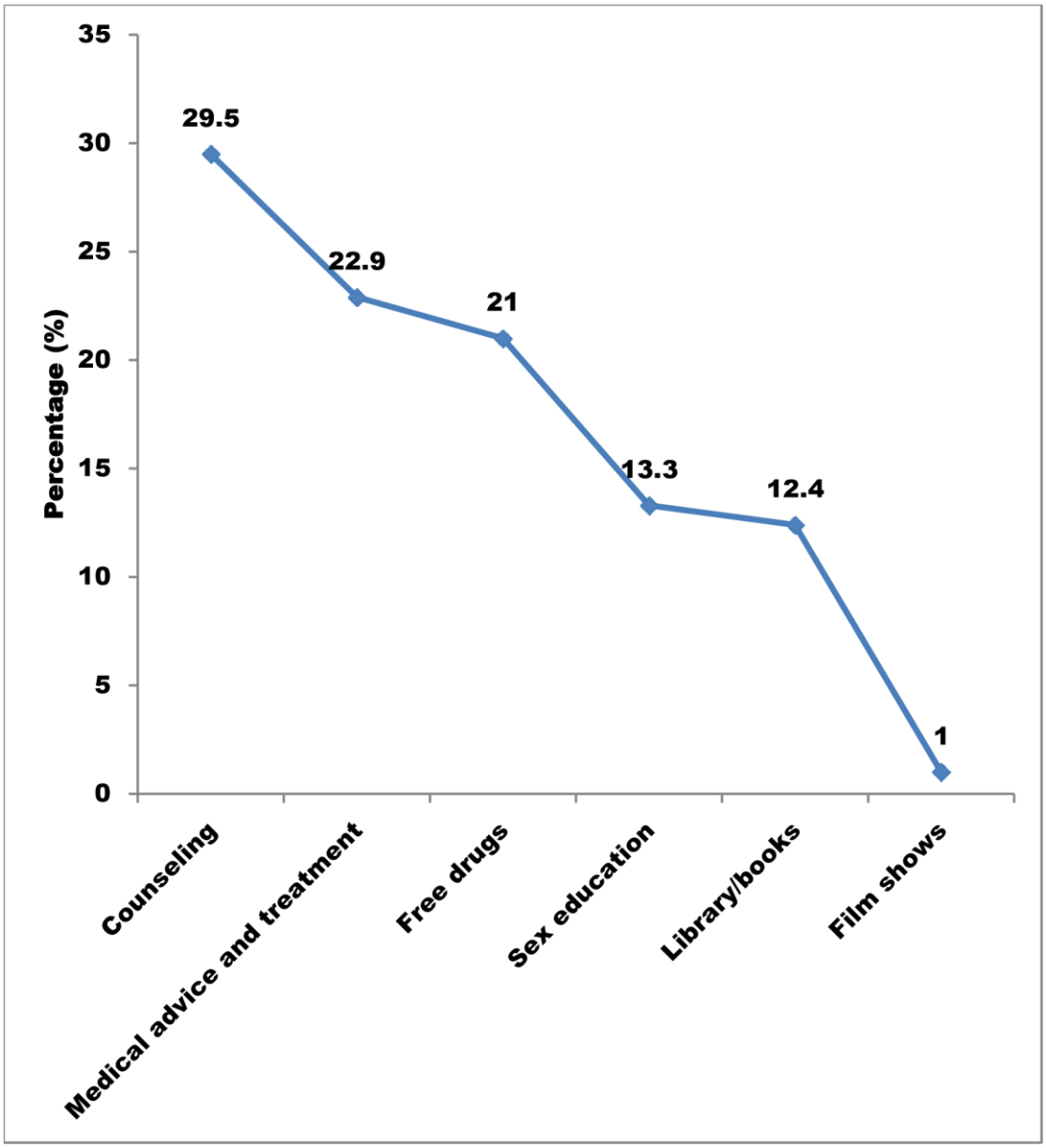

Figure 5: Available services in YFC visited (n=105)+

Findings from the Focus Group Discussions

Findings from the Focus Group Discussion revealed the utilisation of a Youth-Friendly Centre/clinic**.** The following quotes reflect some of their comment. One discussant took time to explain the factors that support the Utilisation of a Youth-Friendly Centre/clinic among the youth. He declared:

> *"I like the one in Ikolaba Ibadan because the place is quiet, and they have counselling units, treatment units, a library, a book shop and internet service for the youths. The staff are very friendly and always call you on the phone when you are sick. I am a member as of three years ago when I was still in school, but I have no time now to patronize the clinics. The workers are very competent, and the centres were structured so you can go straight to the units you have business with.*"

A discussant from the same group added that,

> *"I will be very glad if they can establish a Youth-Friendly service in our community. Most of the youths are not aware and do not like to go to the hospital for medical advice or treatment because they are not aware of the Youth-Friendly*

service and some Local Government Areas do not have the service but if this friendly service could be established, it will ginger individual youth to patronize."

Another discussant supported him by saying,

"I don't think if any apprentices here in Agbowo area have heard of it not talking about going there for treatment. You know, people look at us as if we don't have a brighter future because we are under training; they taught us that school is everything. I like the hospital and the workers are vey ok. I think the Government should create more awareness about it and make it free and convenient for the apprentice because most of us are not educated."

"I don't think apprentices are aware of YFC because we are not recognized like school students. In countries like China, I even heard that phones are manufactured by apprentices and their government cares for apprentices. You are on your own if you rely on government for treatment."

Test of Hypotheses

Hypotheses One

H_{01}: There was no relationship between respondents' socio-demographic characteristics (like age, gender, marital status, education) and their knowledge of utilisation of YFC

Table 4: Relationship between the socio-demographic variables of respondents and knowledge of Youths-Friendly Clinic/Centre

Socio-demographic variable	Knowledge of YFC			Chi-square (χ^2)
	Good (n=37)	Poor (n=484)	Total (N=521)	Fisher's Exact
	Freq. (%)	Freq. (%)	Freq. (%)	Test (*f*)
Age in year				
<20	5(13.5)	171(35.3)	176(33.8)	χ^2 = 7.314
≥20	32(86.5)	313(64.7)	345(66.2)	*p* = 0.007*
Gender				
Male	21(56.8)	253(52.3)	274(52.6)	χ^2 = 0.277
Female	16(43.2)	231(47.7)	247(47.4)	*p* = 0.599
Marital status				
Single	32(86.5)	452(93.4)	484(92.9)	*f* = 3.474
Cohabiting	2(5.4)	10(2.1)	12(2.3)	*p* = 0.132
Married	3(8.1)	22(4.5)	25(4.8)	
Religion				
Christianity	19(51.4)	219(45.2)	238(45.7)	*f* = 0.483
Islam	18(48.6)	255(52.7)	273(52.4)	*p* = 0.814
Traditional	0(0.0)	10(2.1)	10(1.9)	
Education				
Primary	0(0.0)	16(3.3)	16(3.1)	*f* = 3.111
Secondary	30(81.1)	419(86.6)	449(86.2)	*p* = 0.200
Post-secondary	7(18.9)	49(10.1)	56(10.7)	

*** - Significant at 0.05; *f* - Fisher's Exact Test**

N.B: Fisher's exact test was used in all Chi-square tables below because of those variables with cell counts of less than 5. Therefore, this information applies to many socio-demographic factors and other tested variables because some cells are counted under 5.

Relationship between the socio-demographic variables of respondents and knowledge about utilisation of YFC

The relationship between socio-demographic variables and their knowledge of the utilisation of YFC is shown in Table 4. The results revealed that good knowledge of YFC services utilisation was more prevalent among older youths ≥20 (86.5%) than other ages. However, this same age bracket recorded a high percentage among those who had poor knowledge of YFC (age ≥20 (64.7%) (p=0.007). However, other tested socio-demographic characteristics like gender (p=0.599), marital status (p=0.132), Religion (p=0.814) and education (p=0.200) of respondents were not found statistically significant to knowledge about utilisation of YFC. Although good knowledge about YFC utilisation was more pronounced among males (56.8%), single respondents (86.5%), those who practised Christianity (51.4%) and respondents who had secondary education (81.1%). Based

on the result shown in Table 4, the null hypothesis, which stated that there is no significant relationship between respondents' socio-demographic characteristics like sex, level of education, marital status, education and youths' knowledge about YFC utilisation, is not therefore rejected (p>0.05) but not applicable to the age of respondents which made the hypothesis to be rejected (p<0.05).

Hypotheses Two

$H_0$2: There is no significant relationship between respondents' personality living with and knowledge of utilisation of YFC

Table 5: Respondents' personality living with and their knowledge of the Utilisation of YFC Personality living with Knowledge of YFC Chi-square (χ^2)

	Good (n=37) Freq. (%)	Good (n=37) Freq. (%)	Good (n=37) Freq. (%)	Fisher's Exact Test (f)
Alone	6(16.2)	38(7.9)	44(8.4)	f= 18.933
Father alone	4(10.8)	66(13.6)	70(13.4)	p = 0.009*
Mother alone	1(2.7)	85(17.6)	86(16.5)	
Father and mother	13(35.1)	195(40.3)	208(39.9)	
Grandparent	3(8.1)	16(3.3)	19(3.6)	
Friend	9(24.3)	52(10.7)	61(11.7)	
Husband	1(2.7)	7(1.4)	8(1.5)	
Sister	0(0.0)	24(5.0)	24(4.6)	
Wife and children	0(0.0)	1(0.2)	1(0.2)	

*** - Significant at 0.05; f - Fisher's Exact Test**

The second null hypothesis was tested, which stated that there is no significant relationship between respondents' personality living with and knowledge of utilisation of YFC service. Table 5 shows that respondents living with their parents (father and mother) (35.1%) have more exposure to utilisation of YFC (p=0.009) compared to other personalities in that category. Based on the result in Table 5, the null hypothesis, which stated that no significant relationship exists between respondents' personality living with and youths' knowledge about YFC, is therefore rejected (p<0.05).

Hypotheses Three

$H_0$3: There is no relationship between sources of information and their knowledge of the utilisation of YFC

Respondents' sources of information and their knowledge of the utilisation of YFC were cross-tabulated to determine if they influenced their knowledge of the utilisation of YFC. The level of significance was set at 0.05. Table 6 reported a significant relationship between respondents' sources of information and their knowledge of utilising YFC (p=0.000). Respondents who had information about YFC through their peers had a greater percentage (51.4%), followed by information from health workers (21.6%) compared with others in the same category. This means that respondents' sources of information have a significant role in knowledge about utilising YFC. Based on the result shown in Table 6, the null hypothesis, which stated that there is no significant relationship between respondents' sources of information and youths' knowledge about YFC, is therefore rejected (p<0.05).

Table 7: Respondents' Sources of Information and their Knowledge of Utilisation of YFC Sources of Information Knowledge of YFC Chi-square (χ^2)

	Good (n=37) Freq. (%)	Good (n=37) Freq. (%)	Good (n=37) Freq. (%)	Fisher's Exact Test (f)
Radio	4(10.8)	0(0.0)	4(0.8)	f= 257.633
Peers	19(51.4)	0(0.0)	19(3.6)	p = 0.000*
Parent or Guardian	4(10.8)	0(0.0)	4(0.8)	
Health workers	8(21.6)	0(0.0)	8(1.5)	
Corper/peer education teacher	2(5.4)	0(0.0)	2(0.4)	
No knowledge	0(0.0)	484(100.0)	484(92.9)	

*** - Significant at 0.05; f - Fisher's Exact Test**

Hypotheses Four

$H_0$4: There is no relationship between respondents' usage of YFC and their knowledge of utilisation of YFC

Table 8: Respondents' Usage of YFC and their Knowledge of Utilisation of YFC

Variable Knowledge of YFC	Chi-square (χ^2) usage of YFC			
	Good (n=37) Freq. (%)	Good (n=37) Freq. (%)	Good (n=37) Freq. (%)	Fisher's Exact Test (*f*)
Usage of YFC				*f*
Yes	34(91.9)	0(0.0)	34(6.5)	=
				-
No	3(8.1)	484(100.0)	487(93.5)	*p* = 0.000*
Recent usage				
Within the last month	1(2.7)	0(0.0)	1(0.2)	*f*= 226.157
More than one month ago	16(43.2)	0(0.0)	16(3.1)	*p* = 0.000*
Five years and above	16(43.2)	0(0.0)	16(3.1)	
Four years ago	1(2.7)	0(0.0)	1(0.2)	
NR	3(8.1)	484(100.0)	487(93.5)	

*** - Significant at 0.05; *f* - Fisher's Exact Test; NR – Not applicable**

Respondents' usage of YFC and their knowledge of utilisation of YFC were used to determine if their previous utilisation influenced their knowledge of YFC. Table 8 showed a significant relationship between respondents' usage of YFC and their knowledge of utilisation of YFC (p=0.000). Knowledge about utilisation of YFC was more pronounced among respondents who had ever used YFC (91.9%) and visited the place more than one month ago (43.2%) or five years ago (43.2%), respectively, compared with others in the same category. This means that respondents' utilisation has a significant role in knowledge about the utilisation of YFC. Based on the result shown in Table 8, the null hypothesis, which stated that there is no significant relationship between respondents' usage of YFC and youths' knowledge about YFC, is therefore rejected (p<0.05).

Logistic Regression Analysis

Logistic regression analysis for knowledge about utilisation of youths-friendly clinic/centre (YFC) against various predictors. From all the predictive factors used to establish the knowledge about YFC utilisation, ever heard of YFC (OR = 0.024, p = 0.024), sources of information (OR = 0.515, p = 0.000), and currently using YFC (OR = 0.479, p = 0.000) were found to be predictive factors in that category. Respondents' sources of information were five times more predictive of knowledge about YFC utilisation than other factors (OR = 0.515, p = 0.000) (Table 9).

Table 9: Linear logistic regression analysis for knowledge about utilisation of youths friendly clinic/centre against various predictors

Variable	β	S.E.	Odds Ratio (OR)	T	Sig. p=value
Constance	0.551	0.021		26.760	
Age	-0.004	0.005	-0.007	-0.855	0.393
Personality living with	0.001	0.001	0.006	0.757	0.449
Ever heard of YFC	0.014	0.006	0.024	2.462	0.014*
Sources of information	0.113	0.004	0.515	26.011	0.000*
Currently using YFC	0.005	0.000	0.479	24.240	0.000*

S.E. = Standard Error; * = Significant at p<0.05

Table 10: Linear logistic regression analysis for knowledge about utilisation of youths friendly clinic/centre against various predictors

Variable	β	S.E.	Odds Ratio (OR)	T	Sig.p=value
Constance	0.551	0.021		26.760	
Age	-0.004	0.005	-0.007	-0.855	0.393
Personality living with	0.001	0.001	0.006	0.757	0.449
Ever heard of YFC	0.014	0.006	0.024	2.462	0.014*
Sources of information	0.113	0.004	0.515	26.011	0.000*
Currently using YFC	0.005	0.000	0.479	24.240	0.000*

S.E. = Standard Error; * = Significant at p<0.05

From all the predictive factors used to establish the knowledge about YFC utilisation, ever heard of YFC (OR = 0.024, p = 0.024), sources of information (OR = 0.515, p = 0.000), and currently using YFC (OR = 0.479, p = 0.000) were found to be predictive factors in that category. Respondents' sources of information were five times more predictive of knowledge about YFC utilisation than other factors (OR = 0.515, p = 0.000).

Conclusion

This study aimed to document the utilization of Youth-Friendly Clinics (YFC) among out-of-school youths within the Ibadan Metropolis. The findings revealed a very low level of knowledge about YFCs and a moderate level of utilization of these services. The establishment and promotion of youth-friendly clinics are critical to ensuring that adolescents have access to comprehensive healthcare services in a supportive and non-judgmental environment. These clinics address unique adolescent needs, including sexual and reproductive health education, mental health support, behavioural change, unwanted pregnancy prevention, unsafe abortion care, and substance abuse intervention.

Recommendation

1. Implement targeted awareness campaigns to educate youths about the existence and services of YFCs, emphasizing their benefits. Schools, community leaders, and peer education programs should be involved to reach a broader audience.
2. Government and stakeholders should ensure YFCs are more accessible, particularly for those aged under 20 years, who showed lower levels of awareness and usage. This can involve setting up clinics in underserved areas and providing transportation support where needed.
3. Leverage diverse platforms like social media, radio, and school programs to disseminate information about YFCs, as peers and health workers were the main sources of information in the study.
4. Include information on YFC services and sexual and reproductive health education in school curricula to improve students' knowledge and utilization, especially among secondary school students.

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