SEXUAL HEALTH INFORMATION SEEKING BEHAVIOR AMONG FEMALE ADOLESCENTS IN SELECTED PUBLIC SECONDARY SCHOOL IN OWAN WEST L.G.A EDO STATE

Mary Olayiwola OLAJUMOKE
EDU1603123

FACULTY OF EDUCATION
UNIVERSITY OF BENIN
BENIN CITY

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Olajumoke Mary OLAYIWOLA
EDU1603123

A RESEARCH PROJECT SUBMITTED IN THE DEPARTMENT OF EDUCATIONAL MANAGEMENT (DEM) AND SUBMITTED TO THE FACULTY OF EDUCATION, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DEGREE OF BACHELOR IN LIBRARY AND INFORMATION SCIENCE (BLIS) OF THE UNIVERSITY OF BENIN, BENIN CITY

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DECLARATION

I, Mary Olajumoke OLAYIWOLA do hereby declare that this project titled “sexual health information seeking behavior among female adolescents in selected public secondary school in Owan West L.G.A in Edo State" is entirely my own research work. The work contained in this project has not been presented for a degree in another institution. All sources of information have been appropriately acknowledged using references and other acceptable methods.

Signed---------- Date----------

Olajumoke Mary OLAYIWOLA

CERTIFICATION

We, the undersigned, certify that this research project titled “sexual health information seeking behavior among female adolescents in selected public secondary school in owan east l.G.A". was carried out by OLAYIWOLA Mary Olajumoke with the matriculation number EDU1603123, which is adequate in content and scope in partial fulfilment of the requirements for the award of Bachelor of Library and Information Science (BLIS) Degree in the Department of Educational Management, Faculty of Education, University of Benin, Benin City.

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Dr. G. E. Ilevbare — Project Supervisor

Rev. Sr. Dr. P. Ekejiuba — Project Coordinator

Date_____ Date_____

_____

Prof. K. O. Omorogiuwa

Dean, Faculty of Education

Date_____

DEDICATION

This research is dedicated to God Almighty for his mercies, grace and strength for the completion of this research work.

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ABSTRACT

The focus of this study was to examine the information-seeking behavior of female adolescents in selected Senior Secondary Schools in the Edo State. Six objectives and six research questions were stated to guide the study. The study adopted information pickup theory by Gibson (1974) for the dependent variable (information seeking behaviour) and the theory of health belief by Rosenstock *et al.,* (1950) for the dependent variable (sexual health). A descriptive cross-sectional study design was adopted as the research design with a population of 2774 female adolescents students in the various selected secondary schools. A purposive sampling technique was employed as the sampling technique and the sample size of 150 female senior secondary pupils was used. Questionnaire was employed as the research instrument, and the questionnaire was face validated by the project supervisor. The results show that adolescents do selective search in order to satisfy an information need; adolescents mostly seek sexual health information from non-authoritative sources; most of the channels used by adolescents are not authenticated; adolescents have high level unmet information needs; information use among adolescent is adequate; and the knowledge exchange and transfer are poor among adolescents. It is hereby recommended that stakeholders and health practitioners should make provisions for more education and enlightenment on seeking information from evidence based authoritative sources.

Keywords: Sexual health, information seeking behavior, adolescents

CHAPTER ONE

INTRODUCTION

1.1 The Background of the Study

Young people make represent a population subset with lower rates of death, illness, and medical use. However, they frequently conceal or fail to properly diagnose serious health issues that they may have. These issues may be related to risky behaviors like drug and alcohol abuse, immoral sexual behavior, smoking, and mental health conditions like depression and suicidal thoughts and attempts (Wauquiez, 2006).

As they enter the adolescent years, factors like limited access to health information and services, poverty, unequal gender norms, and conservative social norms contribute to a lack of knowledge and awareness about puberty, sexuality, and basic human rights, which can have serious consequences on their health. Young people tend to find it difficult to ask for help, especially when it comes to health issues; some with the feeling that they might be misunderstood. As a result, peers and other sources are used to gather sensitive information like that of SRH, which could endanger their lives.

Concerns about privacy, embarrassment over disclosing one's health status and problems, lack of health insurance or other financial hardships, lack of knowledge of

available services, and lack of trust in medical professionals are the main obstacles to obtaining access to health information services (Paper and Ary, 2016). (Kalembo et al., 2013). As a result, whenever young people experience health issues, they frequently seek informal medical care; in other words, they do not first seek out formal medical services or consult with professionals in the field of health. They are more inclined to turn to family, friends, or other trusted confidantes for assistance instead (Morris and Rushwan, 2015).

This study aims to look into how adolescents seek out information about their sexual and reproductive health. In order to learn more about the research subjects' information seeking behavior in relation to how they locate SRH information, their identified information needs and unmet needs, and what they do with the information and knowledge they learn during the search process, the researcher will further investigate various related literatures.

Around 1.2 billion teenagers, or more than 16% of the world's population, are between the ages of 10 and 19. According to estimates, 250 million teenage girls—or nearly 1 in 6 women of reproductive age—live in developing nations (WHO, 2020). Three percent of these adolescent girls are not in a partnership or married but are sexually active, making up more than one in five of them. 15.3 million teenage girls were expected to give birth in 2015, and if current trends continue, that number might increase to 19.2 million by 2035. (WHO, 2020). Adolescent girls are more likely to

demand and utilize contraception than other age groups, although the rates currently in place are still surprisingly lower. In order to increase adolescent access to family planning information, governments and civil society will need to make political and financial commitments. These groups will also need to use the available evidence to develop policies and interventions that specifically target the most vulnerable adolescent populations, such as those who live in rural areas, are not in school, have little to no education, and/or come from the poorest households. Additionally, this will give teenagers the chance to receive accurate and sufficient knowledge about sexual and reproductive health, regardless of their educational background or geographic location.

With the World Health Assembly and the United Nations General Assembly urging nations to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and high-quality healthcare services, universal health coverage (UHC) has gained momentum in recent years. The UHC framework offers a chance for renewed focus on addressing adolescent health needs through the provision of a package of health services that includes appropriate interventions, youth-friendly services, and promotes improved information systems and services that also include data collection on adolescents. To close any knowledge gaps and address more significant socioeconomic issues that have an effect on teenage health

and wellbeing, operations might benefit greatly from the knowledge and lessons learned from this study and the larger SHR (Morris and Rashawn, 2015).

1.2 The Problem Statement

Adolescents make up one in five persons worldwide, and 85% of them reside in poor nations. The future health status of every nation depends greatly on adolescents. Future societies are being shaped by their actions, attitudes, and beliefs. Adolescence is a relatively recent idea in human history. It refers to a protracted period of transition from childhood to adulthood that is associated with a developing sexual awareness and an age-specific urge to engage in sexual experimentation. Preadolescence, which began with the onset of physical maturity and continues until the person reaches a level of intellectual functioning, ends when the person finds satisfying, constructive, and healthy relationships. Adolescence is a period of biosocial transition between childhood and adulthood. Teenagers between the ages of 13 and 18 represent a high-risk population for reproductive health issues, but research among adolescents, particularly in developing nations, are comparatively uncommon because of cultural and customary constraints. Because it is one of the biggest investments any nation can make for a healthier future generation, the health of adolescents must be valued. Poor sexual and reproductive health knowledge and misinformation among adolescents can have serious repercussions. The needs of female adolescents worldwide in terms of sexual and reproductive health (SRH) are

severely hampered. Lack of knowledge and awareness about puberty, sexuality, and fundamental human rights can have serious effects on an individual's health and welfare as well as the welfare of their offspring. This lack of knowledge and awareness is a result of inadequate access to health information and services, poverty, unequal gender norms, and conservative social norms. For instance, an unintended teen pregnancy may reduce both the adolescent's and the child's chances of living a full life. Adolescent health demands present special difficulties for the healthcare system when compared to those of children and adults. A female adolescent, for instance, could find it awkward to discuss physical changes, if at all, with a total stranger or in front of her parent. Teenagers could wish to use contraception, but a service provider might not offer it to them without parental permission or out of bigotry. A person between the ages of 10 and 19 or a particular gender may find the location or service hours to be inconvenient. Impacts on inclusive growth and shared prosperity result from these problems.

This study, titled Sexual health Information seeking behavior of Adolescent in Selected Public Schools in Owan West L.G.A. Edo State, focused on female adolescent sexual health (ASRH) information seeking behavior and aimed to gain a deeper understanding of the adolescent information seeking behavior on sexual and reproductive health. In recent years, it has been noted in Nigeria that a sizeable percentage of female teenagers between the ages of 15 and 19 engage in sexual

activity (Sedgh et al., 2009).This has become more concerning in light of the unprotected sexual activities they engage in as a result of inaccurate information and a lack of understanding about SRH affairs, which primarily result from a lack of understanding of reproductive health and sexuality education and have unquestionably exposed them to problems with reproductive health. Despite several suggestions, few parents in the South-West area of Nigeria impart sexuality education to their children; instead, they obligate their children to attend school, which does not currently include sexuality education or reproductive health in its curricula (Cortez et al., 2015). Teenagers therefore turn to a range of non-formal sources, such as peers, pornography, and publications, for information and care for their sexual and reproductive health. The unguided teenagers typically test the knowledge out and are frequently exposed to STIs and unexpected pregnancy, among other things, as a result. Reproductive tract infections (RTIs) and sexually transmitted infections (STIs) are serious health problems for teenagers in Nigeria (Esiet et al., 2016), which are made worse by multiple sex relationships and have effects on HIV/AIDS, acute and recurrent pelvic inflammatory diseases (PID), chronic pelvic pain, ectopic pregnancies, and infertility (Dooley et al., 2016).In addition, it was discovered (Osakinle, 2016) that unwanted pregnancy has been a significant factor in Nigerian females dropping out of school (Okonta, 2007), restricting their access to education, possibilities for employment, and career options. Despite awareness initiatives, it

doesn't seem like there has been a significant increase in the use of contraception. Without sufficient information, it might be challenging for adolescents to meet their need for reproductive health. The use of various media effectively and sensibly to improve communication support for health projects is crucial for empowering adolescents to lead pleasant sexual and reproductive lives.

1.3 Objective of the study

The overall objective of this study is to investigate the sexual health information seeking behavior of female adolescents in selected public secondary schools in South-West Nigeria. Specific objectives are as follows

1. To identify the sexual health information needs of female adolescents in high schools;
2. To investigate the information sources used by these female adolescents in high schools for seeking information on sexual health issues;
3. To find out the information systems/channels used by these female adolescents in high schools for seeking information on sexual health related issues;
4. To examine the unmet information needs of female adolescents in high schools on sexual health;
5. To analyze the information use behavior (information use) by female adolescents in high schools for sexual health issues;

6. To explore the process of knowledge transfer and exchange (knowledge acquired from ISP) by female adolescents in high schools on sexual health issues.

1.4 Research Questions

1. What are the sexual health information needs of female adolescents in high schools?

2. What are the information sources used by these female adolescents in high schools for seeking information on sexual health issues?

3. What are the information systems/channels used by these female adolescents in high schools for seeking information on sexual health related issues?

4. What are the unmet information needs of female adolescents in high schools on sexual health?

5. What is the information use behavior by female adolescents in high schools for sexual health issues?

6. What is the process of knowledge transfer by female adolescents in high schools on sexual health issues?

1.5 The Significance of the Study

The results of this study will be helpful to the Nigerian government and society at large, given the importance of appropriate information seeking behavior in science and technology as a method of building a strong nation. The safety of their health, particularly their sexual and reproductive health, is a vital performance indicator in their lives since female adolescents are a powerful force for a prosperous

future for any country. Our young adults now have widespread access to web 2.0 technologies and social media tools, and these tools are becoming a part of their daily lives. They use these sources for a variety of purposes, including finding information on sexual and reproductive health issues, this study puts enough emphasis on how to seek out information in a way that will guarantee that the material accessed is pertinent and helpful to their sexual and reproductive health.

Therefore, individuals and organizations that implement the suggested strategy generated from the study's findings will be better able to instruct and educate female adolescent students. Administrators and policy makers will receive guidance on what should be stressed by school coordinators, religious leaders, parents/guardians, and other caretakers tasked with looking after these adolescents in the school curriculum and home informal training setting to improve on the adolescents towards achieving healthy sexual and reproductive lives.

The prevalence of rape and other forms of female sexual abuse, female genital infections, sexually transmitted diseases (STIs), and unintended pregnancies, as well as other issues like the high rate of school dropouts, complications from multiple sex relationships that may lead to HIV/AIDS, acute and recurrent pelvic inflammatory diseases (PID), chronic pelvic pain, ectopic pregnancies and infertility, crime, and high rates of maternal deaths, will all be significantly

Due to the increased awareness and effective use of contraceptives needed to enjoy safety and pleasure in sexual and reproductive health relations, health institutions and organizations will profit financially and in other ways. The study will aid the researcher in identifying significant gaps in the educational and training procedures for sexual health that many researchers have not been able to investigate. Thus, a novel theory and method for understanding appropriate information seeking behavior may be developed.

1.5. Scope of the Study

The focus of this study is on examining the information-seeking behavior of female adolescents in a few senior secondary schools in the Edo State municipality of Owan West. The factors being taken into account are information needs, information use, information systems/channels, information sources, unmet information needs, and knowledge transfer. The three secondary schools that have been chosen are Holy Trinity Grammar School Sabongidda-Ora, Avbiosi Secondary School, and Uhunmora Secondary School, all of which are located in the Owan West L.G.A. of the Edo State.

OPERATIONAL DEFINITION OF TERMS

Abortion: The deliberate termination of a pregnancy, usually before the embryo or fetus is capable of independent life. In medical contexts, this procedure is called an induced abortion and is distinguished from a spontaneous abortion (miscarriage) or stillbirth.

Adolescents: These are persons aged between 10 and 19 years. This shall be the working definition in the Policy.

Adolescent-Friendly Services: These are Sexual and Reproductive Health services delivered in ways that are responsive to specific needs, vulnerabilities and desires of adolescents. These services should be offered in a nonjudgmental and confidential way that fully respects human dignity.

Age Appropriate: This is suitability of information and services for people of a particular age, and in the case of the Policy, particularly in relation to adolescent development.

Age Appropriate Comprehensive Sexuality Education (AACSE): This is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic and non-judgmental information. Sexuality education provides opportunities to explore ones own values and attitudes as well as build decision-making communication and risk reduction skills about many aspects of sexuality.

Child: This is an individual who has not attained the age of 18 years.

Child Abuse: Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the childs health, development or dignity. Within this broad definition, five sub-types can be distinguished physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation.3

Child Marriage: This is a situation where marriage, cohabitation or any arrangement is made for such marriage or cohabitation with someone below the age of 18 years.

Female Genital Mutilation (FGM): Comprises all procedures involving partial or total removal of the female genitalia or any other injury to the female genital organs or any harmful procedure to the female genitalia, for nonmedical reasons and includes clitoridectomy, excision and infibulations but does not include a sexual reassignment or a medical procedure that has a genuine therapeutic purpose.

Gross Enrolment Ratio (GER): Total enrolment in a specific level of education, regardless of age, expressed as percentage of the eligible official school age population corresponding to the same level of education in a given school year.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Life Skills Education: This is a structured program of needs and outcomes based participatory learning that aims to increase positive and adaptive behavior by

assisting individuals to develop and practice psycho-social skills that minimize risk factors and maximize protective factors. Life skills education programs are theory and evidence based, learner-focused, delivered by competent facilitators and are appropriately evaluated to ensure continuous improvement of documented results.

Marginalized and Vulnerable Adolescents: These are adolescents at high risk of lacking adequate care and protection. For the purpose of the Policy, the term includes orphans and street children as well as adolescents with disabilities; adolescents living with HIV and AIDS; adolescents living informal settlements; adolescents in the labor market; adolescents who are sexually exploited; adolescents living below poverty line and children affected by disaster, civil unrest or war as well as those living as refugees.

Non-State Actors: A non-state actor is as an entity that is not part of any state or a public institution. Non-state actors range from grassroots community organizations to non-governmental organizations, philanthropic foundations and academic institutions.

Net Enrolment Rate (NER): Refers to enrolment of the official age group for a given level of education expressed as a percentage of the corresponding population.

Orphan: A child below 18 years of age whose mother (maternal orphans) or father (paternal orphans) or both (double orphans) are dead.

Persons with Disability: Any person with physical, sensory, mental, psychological or any other impairment, condition or illness that has, or is perceived by significant

sectors of the community to have a substantial or long term effect on their ability to carry out ordinary day-to-day activities.

Post-Abortion Care: Is the physical (medical), social and psychological care and support given to a person after an abortion.

Reproductive Health: This is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.

Sexual, Reproductive Health and Rights: The exercise of control over ones sexual and reproductive health linked to human rights and includes the right to:

Reproductive health as a component of overall health, throughout life cycle, for both men and women;

Reproductive health decision-making, including voluntary choice in marriage, family formation, determination of the number, timing and spacing of ones children, right to access information and means needed to exercise voluntary choice; Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and Sexual and reproductive health security, including freedom from sexual violence and coercion, and the right to privacy.

Sexual Health: A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual Offence: This includes defilement, rape, incest, sodomy, bestiality and any other offence prescribed in the Sexual Offences Act (2006).

Sexuality: It is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

State Actors: These include government ministries, departments and agencies.

Trafficking in Persons: This is the recruitment, transportation, transfer, harboring or receipt of persons by means of threat, use of force or other forms of coercion, abduction, fraud, deception, abuse of power or a position of vulnerability, giving or receiving of payments or benefits to achieve the consent of a person having control

over another person, for the purpose of exploitation and any other offense prescribed in the Counter Trafficking in Persons Act (2010).

Unsafe Abortion: A procedure for terminating pregnancy performed by persons lacking the necessary skills or in an environment that is not in conformity with minimal medical standards or both.

CHAPTER TWO

LITERATURE REVIEW

This chapter reviewed literatures that are related to sexual health information seeking behavior of adolescents in selected secondary schools in Owan West L.G.A. in Edo State. This review is presented under the following sub-headings: Theoretical Frameworks, Conceptual Frameworks, Review of Empirical framework, Summary of Literature Reviewed.

2.1 Theoretical Framework

The study adopted information pickup theory by Gibson (1974) for the dependent variable (information seeking behaviour) and the theory of health belief by Rosenstock et al., (1950) for the dependent variable (sexual health).

2.1.1 Information Pickup Theory by Gibson (1974)

Gibson proposed the information pickup theory in 1974. According to the notion of information pickup, perception is solely dependent on the information present in the stimulus array as opposed to sensations that are impacted by cognition. Gibson proposes that the environment consists of affordances (such terrain, water, vegetation, etc.) which provide the clues necessary for perception. Additionally, the ambient array contains invariants that affect perception, including shadows, texture, color, convergence, symmetry, and layout. According to Gibson, perception is a direct

consequence of the properties of the environment and does not involve any form of sensory processing. Information pickup theory therefore stresses that perception requires an active organism. The process of perception is dependent on how an organism interacts with its surroundings. Every perception is based on the position and activities of the body (proprioception). The way the environment responds to our motions is how we become aware of it. The information pickup hypothesis has been most thoroughly established for the visual system, but it is meant to be a generic theory of perception.

The Principles of the information pickup theory are:

i. To facilitate perception, realistic environmental settings should be used in instructional materials.

ii. Since perception is an active process, the individual should have an unconstrained learning environment.

iii. Instruction should emphasis the stimulus characteristics that provide perceptual cues.

The hypothesis applies to this study in that patronage of the library is influenced by the environment's conduciveness. That is, the surroundings have all the amenities needed to draw people into the library, including aesthetics, sufficient carrels and chairs, fans, air conditioners, etc.

The theoretical foundation for this investigation was the Health Belief model.

2.1.2 Health Belief Model (Rosenstock et al., 1950).

The health belief model (HBM) is a psychological framework for understanding and predicting health-related behavior, notably the use of health services. One of the most well-known and frequently applied theories in the study of health behavior is the health belief model, which was created in the 1950s by social psychologists at the U.S. Public Health Service.

This approach sheds light on the motivations behind people's decisions about the use of healthcare services. The use of healthcare services is driven by healthcare-seeking behavior, which is impacted by the following variables described by the Health Belief Model:

Perceived Severity of Health Problem

the severity of a health issue. In the early stages of an obstetric or gynecological issue, the patient tries to determine how serious it might be (Golooba Mutebi and Tollman, 2007). The biggest and most significant predictor or determinant of whether the patient will seek care or use a health care service, according to Danso Appiah, Stolk, Bosompem, Otchere, Looman, Habbema, and de Vlas' (2010) study, is perceived severity. Howell, Smith, and Roman (2008) discovered that when symptoms get worse over time, many individuals seek medical attention. Some women put off seeking professional assistance for gynecological or obstetric issues until they become

grave and life-threatening (Mohaleni, 2013). Others follow the treatment plan and adhere to it when symptoms are present, but stop doing so as soon as the symptoms subside. For instance, this is observed in some pregnant women who avoid routine antenatal care unless they experience serious pregnancy difficulties. Sometimes after receiving initial care, especially when symptoms are minor or nonexistent, medical examinations are skipped, endangering the goal of using healthcare services (Nshi, 2017). This continues even after delivery since some women choose to skip postpartum check-ups when there are no obvious symptoms of illness.

Perceived Benefit of a healthcare service

The conviction that a specific healthcare service will be successful in lowering the risk of illness or disease. The belief that a health measure will lessen the threat will also determine whether or not the perception of a threat results in altered health behaviors (Mohaleni, 2013). This factor has two sub-components as well. Whether the person believes a specific healthcare service will be effective in treating the disorder in question and whether the cost of the treatment taken outweighs its advantages (Tayor, 1995, cited in Mohaleni, 2013). The perceived benefit factor emphasizes that usage is significantly influenced by patients' happiness with their therapy (Rahman, Islam, Islam, Sadhya and Latif, 2011).

According to Corno (2011), people's preferences for a certain form of care often change as a result of prior health results. Furthermore, according to Corno, people who have received formal or informal medical treatment and have been successfully treated are more likely to use that system again in the future than people who have not recovered (Corno, 2011).

Since education gives women the freedom to challenge unhealthy cultural restraints and beliefs as well as weigh the benefits of obtaining healthcare when faced with obstetrics and gynecological difficulties, empowered women are more likely to exercise their autonomy over matters that affect their health (Mohaleni, 2013).

Perceived Barriers to Utilization Of A Healthcare Service

Perceived barriers are a perception of the barriers to using healthcare services (Mohaleni, 2013). These were listed by Golooba-Mutebi and Tollman (2007) as being the following: distance, confidentiality, a lack of available medications, a high cost of care, ignorance, and poverty. Some of these obstacles function as MHSU determinants. When these obstacles are reduced, MHSU is improved, and vice versa (Prosser, 2007).

According to the health belief model (HBM), the use of healthcare services is determined by the patient's cognitive perception (Mohaleni, 2013). People's health attitudes affect whether they self-treat or seek medical attention, as well

as the kind of provider they choose to see (Rahman et al., 2011). According to Spark-du Preez et al. (2005)'s study, it is vital to consider these aspects while determining whether or not to use a formal maternal healthcare service because beliefs are influenced by one's background, religion, and social circle. In their study, Plummer, Mshana, Wamoyi, Shigongo, Hayes, Ross, and Wight (2006) discovered that therapies were pluralistic and opportunistic, frequently starting with home cures before moving on to traditional healers and medical institutions.

However, traditional maternal healthcare services were preferred to health facilities because of the subjects perceptions of the cause, nature and severity of the illness, as well as the perceived benefits of accessibility, trust, familiarity, and considerate payment plans and perceived barriers of high cost, bureaucratic processes and mean attitudes of healthcare providers (Plummer et al., 200). Additionally, traditional healers were thought to effectively treat bewitchment and charge less for their services (perceived effectiveness), which was crucial because some maternal health issues (such as bleedings and fibroids) were thought to be caused by bewitchment in the face of a lack of financial means to pay for medical care (Mohaleni, 2013). As a result, women may avoid using allopathic maternal healthcare services because they feel they cannot treat health issues caused by witchcraft, they cannot afford the

high cost of care in allopathic centers, and sometimes the men in their lives decide where they should receive care or treatment because married women in most cultures lack the freedom to make their own decisions (a perceived barrier).Due to the fact that HBM extensively reflects how female teenagers seek out information on sexual health, it is extremely pertinent to the current study.

2.2 Conceptual framework

The concept of sexual health information-seeking behavior of adolescence

Adolescents are interested in learning more about a variety of health-related subjects, including exercise and food, sexual health, and alcohol and drug abuse. They comprise one of the most active online user communities, particularly (though not entirely) due to campaigns to encourage students to use technology in the classroom. They do not only get their information on the internet; they also get it from a variety of other places, such as their friends' and parents' social networks, radio, television, magazines, newspapers, and religious institutions, among others. Over time, a vast network of sources is used to compile information on health and medications (e.g. OKeefe, Hartwig et al., 1998; Rogers et al., 1999; Gray, Cantrill, and Noyce, 2002).You can actively seek for information or passively take it in. Gore and Madhavan (1993) classified health information sources into professional, lay, and

impersonal (not involving a two-way exchange) categories (Elliott-Binns, 1973, 1986). sources of health information that teens typically use sources from one's own life, like family, friends, and health experts Adolescents' daily life heavily rely on sources of lay personal information. Parents are important sources of knowledge for teenagers, according to studies of general health information sources (Ackard and Neumark-Sztainer, 2001). As teenagers get older, peers become more significant (e.g., Thornburg, 1981), and they are frequently mentioned as well (e.g. Gould and Mazzeo, 1982). In certain studies, there are gender differences in the likelihood that male and female adolescents will consult their parents for advice on sexual health: Thornburg (1981), for instance, reported that adolescents were more likely to consult their mothers whereas adolescents would choose peers.

On the other hand, it is well recognized that adolescents find it challenging to establish therapeutic alliances with qualified medical personnel and to obtain healthcare (e.g. Klein et al., 1999; Jacobson et al., 2001). However, sources of information about a variety of illnesses frequently credit physicians and nurses as experts (e.g. Ackard and Neumark-Sztainer, 2001). Young people with long-term diseases may select different sources for various types of information, according to a study on this population (Beresford and Sloper,

2003). They might ask medical experts for information about medicine, but ask friends or someone who has the same problem for psycho-social advice. Unpersonal sources, such as literature and the media Mass media and health reference material derived from lay sources are examples of impersonal lay information sources. The one-way information flow from the producer to the recipient and the resulting absence of feedback between them are characteristics of traditional mass media (Thompson, 1992). The mainstream media was crucial in shaping teenage illicit drug information sources, according to numerous research (e.g. Sheppard, 1980; Mirzaee, et al., 1991). Television was most frequently indicated as a source in a recent research of smoking information sources among US African American students (Kurtz et al., 2001). However, according to the authors, students who mentioned lay personal contacts performed better than average in terms of knowledge, attitude, and preventive action. Regarding adolescents' use and opinions of professional health books and leaflets, there is little prior study available. Access to these materials, in contrast to mass media, is frequently limited to medical offices and other health-related establishments like pharmacies.

2.3 Empirical framework

Sexual activity among adolescents is prevalent, and the age at which it begins is young. According to studies, both boys and girls in the 10 to 19 year old in-school group have median ages between 14 and 16 years old (Murray et al., 2006; Wagbatsoma and Okojie et al,. 2006; Fatusi and Blum 2008; Olugbenga-Bello et al., 2009; Owoaje and Uchendu 2009). Studies show that 20 to 35 percent of the studied population engages in various forms of sexual activity (Asubiaro and Fatusi 2014; Asekun et al., 2011). Depending on the geography and the socioeconomic traits associated with particular regions, there are differences in the results.For instance, in Niger State (in the North West), n=896 girls had their first sexual experience by the age of 16, and 14% had it between the ages of 9 and 12. (Sunmola et al., 2002). Another study of 1246 teenagers enrolled in secondary schools in Jos, a city in the North Central region, discovered that the median age at first sexual activity was 14 years old and that more students in rural areas than in urban ones engaged in sexual activity. More than 1 in 5 adolescents had their first sexual experience before the age of 16, according to a study conducted in two Southern LGAs: Ugep in Cross River State and Badeku and Olunloyo in Oyo State (Isiugo-Abanihe et al. 2012). Young people believed that the age of sexual debut had reduced, that both girls and boys were beginning sex sooner, and that they were more likely to have several sex partners, according to focus group

discussions and in-depth interviews conducted as part of the study. In their research of 1249 in-school adolescents in Lagos State (Southern Nigeria), ages 10 to 19, Asubiaro and Fatusi (2014) report comparable findings, with the average age for first sex being roughly 14 years for boys and 15 years for girls.

Early marriage is also connected to early sexual debut in the more traditional North (Asad 2009; Amoran 2012; Melvin and Uzoma 2012). Using DHS data, Adebowale et al. (2008) confirm that Christians and Muslims marry at a younger age in the North than they do in the South. According to the report, Christians married at an average age of 20, whilst Muslims married at an average age of 16. While the number of Muslim and Christian girls being married between the ages of 15 and 19 years was only slightly different (46 percent vs. 39.5 percent), there were significantly more Muslim girls getting married under the age of 15 (39.5 percent) than Christian girls (11.9 percent). Sadly, but accurately, Nigeria accounts for around 14% of the global burden of maternal mortality, with an estimated 576 maternal deaths per 100,000 live births worldwide (DHS 2013/WHO 2014). This extensive research demonstrates that young girls are disproportionately affected by maternal death and morbidity. The relevance of focusing on teenagers is demonstrated

by the data on sexual and reproductive health (SRH) outcomes in Nigeria, since slightly over 30% of mortality among female adolescents between the ages of 15 and 19 are related to pregnancy and childbirth (DHS 2013). Nigeria continues to have a higher adolescent fertility rate than its regional peers. In 2013, Nigeria had a national adolescent fertility rate of 118 births per 1,000 women aged 1519 years, which was higher than the region's rate of 106 births (DHS, 2013). The impoverished are particularly affected by these issues. While early childbirth has decreased among the wealthy, it has not decreased among the poor; over 60% of the poorest women in 2024 had children before turning 18, compared to only 10% of their wealthier counterparts. In metropolitan regions, the differences are particularly pronounced. In 2008, 4 percent of their more affluent counterparts were moms or pregnant, compared to 23 percent of poor urban adolescent females.

(WHO, 2014).

One of the major barriers to enhancing maternal health outcomes is unequal access to and utilization of maternal health services. Nigeria ranks just behind Niger, Chad, and Ethiopia among West and Central African nations in terms of skilled birth attendance and ANC rates, while having high health expenditure per capita. Only 38% of births in the nation are attended by trained medical workers, despite the fact that the usage of antenatal care

(ANC) is quite high at 60% nationwide. The large regional variations in service accessibility and use in Nigeria are partly responsible for this poor utilization. Compared to the North East, where only 24.7% and 9% of births are attended by qualified professionals, over 70% of pregnant women in the Southern regions receive ANC and competent birth attendance (Adamu, 2011).This is consistent with the claims made by Kruk et al. (2008) and Anwar et al. (2008) that there is probably evidence of income disparities, with the wealthy using maternal health services more frequently than the poor.

In Nigeria, there are reportedly more than 2.6 million HIV-positive individuals, and there is a sizable knowledge-behavior gap, particularly among adolescents (WHO, 2017). Despite South Africa's prevalence rate of HIV among those aged 15 to 49 being substantially higher at 13 percent and the regional average for Sub-Saharan Africa being much lower at 3.1 percent, it is still a serious worry given the size of the country. Young ladies experience it more frequently than males do. HIV prevalence in women aged 15 to 24 is predicted to be 1.3% compared to 0.7% in men of the same age (UNAIDS, 2013). There is a significant knowledge-behavior gap about condom use for HIV protection among male and female adolescents in Nigeria, which is cause for concern. Only 7% of young women report using a condom during their most recent encounter, despite around 50% of them

being aware that doing so protects HIV. Nigeria has one of the lowest rates of contraceptive prevalence among its neighbors, at 15%. Additionally, it has one of the lowest rates of unmet contraceptive need. The high fertility rate, which has been stable at 5.7 births per woman for the previous ten years, is a result of low contraception use. The rate of use and demand for modern contraception is influenced by a lack of awareness and false information about it (Ankomah et al. 2013).

Contraceptive awareness has grown over the previous ten years, but this development is probably a result of increased attention on HIV/AIDS and condom use. According to several research, understanding of HIV/AIDS is greater than that of other SRH issues (Boriri et al. 2008; Oladepo and Fayemi 2011; Sangowawa and Adebiyi 2013). The information on how much is known and how to protect oneself from HIV/AIDS is, however, rather inconsistent. Wagbatsoma and Okojie (2006), for instance, found that while there is a high level of awareness of HIV/AIDS (99 percent), few people are aware of the reasons (15 percent, n=852). Possible contributing factors include regional and other socioeconomic traits. In two urban communities in Anambra State, South Eastern Nigeria, Ikechebelu et al. (2008) selected 148 young female street vendors and discovered that 54% were aware of the risk of obtaining HIV/AIDS from unprotected sex.Researchers also found that the

majority of young people had heard of HIV/AIDS in another study of urban slum residents in the Ibadan area (Adedemji et al., 2007). Results from a bigger study in Ibadan (n=786) reveal that at 80%, awareness of condoms as an HIV/AIDS preventative is high (Adedimeji et al., 2008)

One of the biggest obstacles for teens is access to contraception and the stigma associated with its usage. Young women and female teenagers are less likely than boys to bring up the topic of contraception or insist that it be used. Young women are discouraged from utilizing or insisting upon the usage of contemporary contraceptives due to worries of infertility, death, being perceived as promiscuous, or upsetting their spouses (Ankomah et al. 2013; Amoran 2012; Adedemeji et al. 2007). In Nigeria, there is a significant difference between the usage of condoms by sexually active male and female youth: 44.7% of men and 12.3% of females, respectively. This distinction is consistent with how neighboring nations in the Sub-Saharan African region use the term (Ankomah et al. 2013; Amoran 2012; Adedemeji et al. 2007).

Financially vulnerable people can be sexually exploited in times of bad economic hardship. Young women from lower socioeconomic status groups, for instance, may trade sexual favors for commodities, services, or money, putting them at greater risk for both pregnancy and sexually transmitted

diseases (Amoran 2012, Ochiogu et al. 2010, Ilika et al. 2006). For instance, a recent study in the Southern State of Anambra discovered that peer pressure and financial need are among the main causes of premarital sex and unintended pregnancies (Ochiogu et al. 2010). In order to gather information about teen pregnancies and sexual and reproductive health education, the authors polled 46 teachers and 1,234 secondary school students. They discovered that 44 percent of students and 27 percent of professors cited financial need as the primary driver of premarital sex. Other explanations given by educators were a promise to marry or peer pressure to do so (25 percent), a lack of religious fervor and unstable families (17 percent), ignorance (9 percent), and sexual assault or rape (9 percent) (7 percent). However, the responses from the students revealed that these additional causes for a teen pregnancy were distributed more evenly: The majority of the reasons given by students in the survey included lack of religious commitment (12%), family instability (17%), ignorance (16%), ignorance of sexual assault/rape (11%) and marital promise or peer pressure to get married (17%). (Ochiogu et al. 2010).

Youth who don't attend school tend to be more sexually active, as shown by (Nichols et al 1986; Makinwa and Adebusoye, 1992; Sangowawa et al. 2013). According to Sangowawa et al. (2013), in Ilero, a semi-rural town in

South Western Oyo State of Nigeria, 70% of girls who were not in school (n=146), aged 15 to 24, engaged in sexual activity. In their study of two LGAs in Ibadan, Owoaje and Uchendu (2009) found that 818 youths, or approximately 80 percent of all youths, reported engaging in sexual activity, with 83 percent of men and 71 percent of women. Although very slowly, the average age of women getting married has been rising. Nigerian law stipulates that a person must be 18 years old before they can get married. Although marriage can occur at younger ages under alternative systems that are also practiced in the nation, the customary and Islamic systems. Because of this, the legislation is not consistently enforced, and most women continue to be married when they are still in their teens. Adebowale et al. (2012) analyze the data on age at marriage from DHS 2008, confirming that majority of the women married between ages 15-19 years (43.1 percent) and about 27 percent married between ages 10-14 years. Using DHS data, Adebolwale et al. (2012) show that in rural areas the incidence of early marriages with 31.7 percent of girls being married between the ages of 10 and 14, and another 45.5 percent between the ages of 15-19. Although in urban areas, the incidence of early marriage is lower, there are still a considerable proportion of young girls being married in their teenage years, with 15.9 percent being married between the age of 10-14 years and another 38.2 percent between ages 15-19 years.

Adebowale et al. (2012) evaluate the age at marriage data from the DHS 2008, indicating that the majority of women (43.1%) married between the ages of 15 and 19 years, and roughly 27% married between the ages of 10 and 14. Adebolwale et al. (2012) demonstrate the prevalence of early marriages in rural areas using DHS data, showing that 31.7 percent of girls get married between the ages of 10 and 14 and another 45.5 percent between the ages of 15 and 19. Although the prevalence of early marriage is reduced in urban areas, a sizeable percentage of young girls are still getting married in their teenage years, with 15.9% getting married between the ages of 10 and 14 and another 38.2% getting married between the ages of 15 and 19.

Girls are more likely to become pregnant young if they marry young and have their first sexual experience at a young age. This is connected to poverty, early marriage, or other risk factors including coming from a broken home or living on the streets (Olley 2006; Okoro and Obozokhai 2006; Owoaje and Uchendu 2009). Teen pregnancies are also more common among girls who are not in school or who have had little or no schooling (Sunmola et al. 2002; Okonofua 1994; Obono et al. 2010). As a result, there is a need for effective information transmission among all adolescent classes at all literacy levels, including the illiterate.

Particularly in the case of adolescent girls who are not married, it appears that a large percentage of teen pregnancies are unwanted. In Sagumu LGA (Ogun State), Nigeria, 225 pregnant girls between the ages of 14 and 40 participated in a study. According to the study, 13.6 percent of pregnancies in the elder age group were unintended, compared to 22.9% of pregnancies among teenagers, who had over 48.2% of those pregnancies (Amoran 2012).

High rates of unsafe abortions are also a result of unintended pregnancies. Studies indicate a significant rate of unsafe abortions among adolescents, despite the absence of statistics that are nationally representative. For instance, in one study, 30% of the girls in the sample (n=450) admitted to having previously been pregnant; however, all pregnancies were aborted (Owolabi et al. 2005). In Owerri, pregnant teens had a 20% abortion rate (n=540, of which 30% became pregnant), with more than a third of them having recurring abortions, according to Okereke (2010). All Ilorin pregnant women reported aborting their pregnancies (28 percent of 521 total) (Aderibigbe et al. 2011). According to earlier studies, a high percentage of pregnant teens report having abortions, indicating little change in behavior over time (Brabin et al. 1995; Odujinrin et al. 1991). Another earlier study at a hospital in Benin City discovered that adolescents were responsible for 60.8% of all induced abortions (Omu et al. 1981). Studies also note common justifications for

abortion, such as the need to drop out of school and fewer chances in life, as well as the fear of violence and shame (Otoid et al. 2001; Oye-Adeniran 2004).

Pregnancy at an early age limits a girl's options and increases her vulnerability to abuse and social stigma. Ilika and Igwebe (2006), for instance, found that 136 girls in their sample (n=97) had experienced violence, with 57 percent having been physically harmed at the time of becoming pregnant. According to Okereke (2010), among pregnant teenagers who aborted their pregnancies, fear of parental rejection and humiliation (45.4%) was the main worry. This was followed by concerns about the undetermined paternity of the fetus (25.3%), the pregnancy's potential negative effects on future marriage (13.8%), and expulsion from school (45.4%). (12.5 percent). Insights into the quality of life of teenage moms are provided by a second, very small qualitative study on adolescent mothers in Ile-Ife (Osun State, n=30). According to the survey, the majority of the girls felt stigmatized about dropping out of school and about losing support from their families and friends (Melvin and Uzoma 2012).

Early pregnancy and early marriage can be prevented through education, especially secondary school for girls. Education offers the possibility of a better life through work options for both sexes, as well as the chance to marry someone who is more educated and has better economic prospects. Recent

data from Nigeria also demonstrates that educated women are more likely to marry later in life than uneducated women. Women with no formal education typically marry at a younger age—15.7 versus 23.6 years—than those with secondary or higher education (Adebowale et al. 2012).

In past research, comparable outcomes were also observed (IsiugoAbanihe 1994; Orubuloye 1998; Agha 2009). Additionally, according to several research, students' religiosity protects them from having premarital sex (Asubiaro and Fatusi 2014; Oladepo and Fayemi 2011; Abdulkarim et al. 2003). Living in a conservative atmosphere, according to Agha (2009), also has an impact on conduct. His research reveals that pre-marital sex is less common among Christians in the orthodox Muslim North.

Low rates of contraceptive use are due to a lack of understanding and false information regarding sexual, reproductive, and sexual health. Sometimes, adolescents may not receive accurate information. Despite advances in understanding, there are still many myths about HIV/AIDS, fertility, and contraception in general (Nwaorgu et al. 2008, 2009; Amoran 2012). In Enugu State, for instance, 51 percent of junior secondary students (n=412) did not know that girls can become pregnant after their first sexual encounter, and 33 percent believed that cleansing the vagina after sex would prevent pregnancy. Makinwa-Adebusoye (1992) discovered that adolescents

who were sexually active (n=5599) knew more about SRH than those who were not, and that roughly 60% of girls and 57 percent of males were aware of some form of contraception. Oladosu (1992-93), utilizing DHS data from 1990, finds comparable results (n=1678). Only 36% of students (n=2460) in the study by Amazigo et al. (1997) had accurate knowledge of pregnancy. Girls had more knowledge than boys. Amoran (2012) found in his study that nearly all (99.2%) respondents reported using a condom during risky sexual encounters, but many did not know how to use it properly – 41.1 percent of the teenage pregnant women and 28.6 percent of the older pregnant women did not know how to properly use a condom.

In spite of the incompleteness of the information, parent-child communication is one of the primary sources of reproductive health information in Nigeria (Oladepo and Brieger 1996; Nwalo and Anasi 2012; Iliyasu et al 2012). According to Asekun-Olarinmoye et al. (2011), the majority of adolescent respondents in their sample of 342 in-school adolescents aged 1019 in an LGA in Osun State had first received SRH education from their parents, with about half discussing other methods like condoms and pills. The majority of the respondents focused on abstinence, with the remainder discussing other methods like condoms and pills. Parents, textbooks, television, siblings, radio, friends, school teachers, music, and

songs were cited as the most accessible sources of information about reproductive health by the students in the Nwalo and Anasi (2012) study of female senior secondary school students (n=1800) in Lagos metropolis. It is further supported by several research, like Ijatuyi (2005), Mabawonku (1998), and Bammeke and Nnorom (2006), that parents are the best people to get information from.

Numerous studies also support the importance of peers as a source of knowledge on sexual and reproductive health. According to Onyeonoro et al. (2011), females between the ages of 10 and 18 in the Osisioma LGA in southwest Nigeria (n=304) most frequently got their first information about sex from their peers (76.3 percent), then from the media (69.0 percent). Similar findings are reported by Rani, Figueroa, and Ainsle (2003), Mohammadi et al. (2006), and Odusanya and Bankole (2006). In their study of four North-Eastern Nigerian states, Bauchi, Borno, Gombe, and Yobe, Adeokun et al. (2009) found that students in co-ed schools are more knowledgeable than those who are not in co-ed schools and that peers are a major source of information. Okanlawon and Asuzu (2011) also found that peer education has a beneficial impact on SRH knowledge. In 2 LGAs in Oyo State, the authors carried out a quasi-experimental study with 519 participants and a 6-month intervention. The results show how peer education can increase

access to reliable information regarding SRH. According to Van der Maas and Otte's (2009) research in a rural area of north-eastern Ebonyi State, people who got peer education had higher knowledge and fewer misconceptions than those who did not.

Evidence would seem to indicate that understanding of HIV/AIDS is greater than that of other SRH concerns (Boriri et al. 2008; Oladepo and Fayemi 2011; Sangowawa and Adebiyi 2013). This makes sense given that the federal government has made HIV prevention a top priority and that there have been ongoing attempts to stop the spread of HIV/AIDS for more than ten years. However, the findings regarding the breadth of knowledge and strategies for HIV/AIDS prevention are rather contradictory. Wagbatsoma and Okojie (2006) discovered that although there was widespread knowledge of HIV/AIDS (99%), few people were aware of its causes (15 percent). Region and other socioeconomic factors might be important.

For instance, findings from a larger-scale study in Ibadan (n=786) reveal that 80% of the sample had a good level of understanding regarding condoms' ability to protect against HIV/AIDS (Adedimeji et al. 2008). The majority of young people have heard about HIV/AIDS, according to the authors of another study of urban slum inhabitants near Ibabdan (Adedemji et al. 2007). 54 percent of the 148 young female street vendors Ikechebelu et al. (2008)

sampled in two Anambra State urban communities were aware of the risk of obtaining HIV/AIDS via unprotected sex.

Beyond education, a major problem in Nigeria is adolescent service use. Numerous studies show that teenagers and young people rarely use contraception (Okonofua et al. 2004; Olaseha et al. 2004; Bassey et al 2005; Adedimeji et al. 2007). According to Okpani and Okpani (2000), adolescent girls (ages 14 to 21) in Port Harcourt take contraceptives at a rate of 30%. Similar percentages (35%) are reported by Sunmola et al. (2002) in their investigation of adolescents (aged 11–25) in Niger State. Even lower amounts are reported by other research. Only 6% of adolescents in Calabar between the ages of 13 and 18 reported taking contraception (n=888) (Etuk et al. 2004). According to OyeAdeniran et al. (2005), adolescents in four health zones in the states of Oyo, Anambra, Kaduna, and Bauchi used contraceptives at a rate of 11%. Adebowale et al. (2013) use 2008 DHS data to report a higher condom use rate among males aged 15 to 24 (62%) but also note that men over 20 were twice as likely to use a condom in comparison to younger men.

A sizeable portion of adolescents between the ages of 15 and 19 have been shown to be sexually active. This has grown increasingly concerning in light of the unprotected sexual behaviors in which they engage, primarily as a result of a lack of understanding of sexuality education and reproductive

health, which has undoubtedly exposed them to reproductive health issues. The majority of parents in Owerri rarely teach their kids about sexuality; instead, they require it of the school. Despite numerous recommendations, sexuality education and reproductive health are not part of the curriculum. As a result, teens turn to peer pressure, pornography, and magazines for information and care on their sexual and reproductive health. The unguided youths typically experiment with the knowledge they are given and are frequently exposed to STIs and unexpected pregnancy, among other things. Teenagers in Nigeria are at risk for serious health problems such as reproductive tract infections (RTIs) and sexually transmitted infections (STIs), which are made worse by multiple sex relationships and have implications for HIV/AIDS, acute and recurrent pelvic inflammatory diseases (PID), chronic pelvic pain, ectopic pregnancies, and infertility (2). Additionally, it has been discovered (3) that unwanted pregnancy had been a significant factor in Nigerian females dropping out of school, hence restricting their access to education, employment possibilities, and career options. Despite awareness initiatives, it doesn't seem like there has been a significant increase in the use of contraception. The author contends that contraceptives, in particular condoms and pills, are inexpensive and easily accessible on the shelves of even supply shops in Owerri and other urban centers in Nigeria, in contrast to

staged arguments about lack of access to reproductive health facilities. Instead, consumption, which has at least three dimensions, is the worrying problem. First, premarital sex is still seen as a deviant practice, and sexual practices in general, including the use of condoms by adolescents, are still seen as the domain of the married. Second, despite their availability, people who prefer the naturalness of coitus may choose not to use condoms since they conceal sexual joy. Third, inadequate contraceptive use may be a result of transactional sex, which results from gender inequality and patriarchal institutions, in order to obtain material rewards (cash, physical possessions, etc.), to build trust, or to maintain a married connection. Without sufficient information, it might be challenging for adolescents to meet their need for reproductive health. In Ethiopia, it has been recognized how crucial it is to use the various media sensibly and effectively to improve communication support for health projects. Similar to this, it has been discovered in Ghana that the use of communication channels like dialogue, the town crier, the market place, churches, schools, health officers, and radio is highly helpful in raising and maintaining awareness of the needs for health and the provision of health care. Several mass enlightenment initiatives have been launched in Nigeria by various governments to raise public knowledge of STIs, including HIV/AIDS, through the media (especially radio, television and print). The outcomes,

though, have not had a significant impact. The goal of this study is to evaluate how teenagers in South-South Nigeria seek health and their requirements for sexual and reproductive health, both satisfied and unmet. In South-South, Nigeria, the region that is the nation's economic backbone due to its oil production, there is a scarcity of data on teenagers' information requirements and seeking behavior regarding their sexual and reproductive health. This study is aimed at and concentrated on the necessity to expand the boundaries of knowledge.

2.4 Summary of reviewed literature

This study analyzed the literature on adolescents' conduct in Owan West L.G.A., in Edo State, senior secondary schools when seeking information on sexual health. The study used Rosenstock et al(1950) .'s theory of health belief and Gibson's (1974) information pickup theory for the dependent variable (information seeking behavior) (sexual health). The literature on a variety of topics, including related material, concepts, teenage information seeking behavior, and sexual health, was reviewed. According to the literature review sections, there are significant knowledge gaps regarding adolescents' information-seeking behavior about sexual and, therefore, reproductive health.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

The methods and processes the researcher will use to carry out this investigation are described in this chapter. Research design, study population, sampling strategy, research instrument, instrument validation, method of data collecting, method of instrument administration, and method of data analysis make up the structure of the procedures and methodologies.

3.1 Study Design

In order to evaluate how female teenagers in particular public secondary schools in Owan West L.G.A., Edo State, seek out sexual and reproductive information, a descriptive cross-sectional study design will be employed. As they are based on sample data, investigations that are intended to locate, characterize, explain, or report events in their actual settings are ideal for this sort of study design. The researcher agreed that the qualities and characteristics of survey research as described above are what led to the adaption of the survey design for this study.

3.2 Area of the Study

Edo is an inland state in southern Nigeria and its capital is Benin City. It is bounded in the north and east by Kogi State, in the south by Delta State, and in the west by Ondo State. The state which produces crude oil has English as its official language. The major tribal languages spoken in the state are Igarra, Edo, Etsako/Afemai, Esan, Okpamheri, and Owan. The state which has 18 local

government areas also houses a federal university, the University of Benin, and a state university, Ambrose Alli University, which are part of the study areas of this research ((Isumonah et al, 2001).

3.3 Target Population

The population will consist of 2774 female adolescents' students in the various selected secondary schools under study. The choice of the population is necessitated to ensure proper representation.

3.4 Sampling size and technique

The study's sample size was 150 female senior secondary pupils, and a multi-stage sampling technique was employed. Purposive sampling was used in the initial stage to select the secondary schools, which helped give the researcher the chance to interact with female respondents from various backgrounds. The second stage involved choosing study participants using a straightforward random procedure. The implementation of a simple random sampling technique ensures that all participants have an equal chance of success and eliminates prejudice. The respondents were chosen at random from the public secondary schools, and those who selected "yes" were given the questionnaire to complete before 150 people were chosen to participate in the study.

3.3 Eligibility criteria

3.3.1 Study inclusion criteria: Senior secondary school students ages 15 to 24 who attend the chosen public secondary schools in the L.G.A. will be included in the study.

3.3.2 Exclusion criteria: The youths who are below 15 years or above 24 years old and those who are seriously ill at time of data collection will be excluded.

3.4 Instrument of the study

The researchers structured questionnaire was used as the research instrument. Section A contains questions on socio-demographic characteristics while section B contains questions on sexual health information seeking behavior of adolescent.

3.5 Validation of the Instrument

The instrument was face validated by the researchers supervisor to ensure that it complies with the set objectives.

5.6 Method of Data Collection

The researcher administered the instrument with the help of research assistants. All the designated secondary schools in the area of study were visited after obtaining permission and copies of the questionnaires administered.

3.7 Method of Data Analysis

Mean and Standard deviation were used to analyze and answer the research questions.

3.8 Ethical Issues

In order to conduct this research, questionnaires were used to collect data from the respondents. This was moderated in the right way. The questionnaire was given to the respondents to fill up, with or without giving their identities, and they were assured of the anonymity and confidentiality of their answers while also being informed of the importance of these technologies to them as aspiring librarians. The purpose of the questionnaire was to collect sufficient and pertinent data from the respondents. The respondent had the option to take part in the activity or not. This research is free of plagiarism, copyright violations, and unauthorized computer usage.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter presents the statistical analysis of the data obtained from the questionnaire. The data was analysed using mean and standard deviation for the research questions and the results were presented under each research question. Therefore, this chapter is presented under the following sub-headings: results, findings of the study, and discussion of findings.

4.1 Results

The data analyses are presented as follows:

Answering of Research Questions

Descriptive statistics of absolute frequency counts and percentages were used to answer all the research questions raised.

Research Question 1

What are the sexual health information needs of female adolescents in high schools?

Table 4.1: Frequency distribution on Sexual Health Information Needs of Female Adolescents In High Nigeria

S/N	Sexual Health Information Needs Of Female Adolescents	Agree %	Disagree %	Remark
1.	I seek information on abstinence	43	64	
2.	I seek information on contraceptives	61	39	
3.	I seek information on pregnancy	32	68	
4.	I seek information on abortion	11	89	
5.	I seek information on sexual encounters	69	31	

The results in table 4.1 indicate that adolescents majorly sexual health information on contraceptives (61%) and sexual encounters (69%) while just fairly proportion seeks information on abstinence (43%). The implication of this is that the sought for information to satisfy a need is not encompassing but on specific areas.

Table 4.2: Frequency distribution on sexual health information sources among adolescents in high school

S/N	Sexual Health Information sources Of Female Adolescents	Agree	Disagree	Remark
1.	I seek information on sexual health from social media	81	19	
2.	I seek information on sexual health from friends and peers	88	12	
3.	I seek information on sexual health from family members	45	65	
4.	I seek information on sexual health religious leaders	5	95	
5.	I seek information on sexual health from print and non print media	19	81	
6	I seek information on sexual health from the internet websites	92	8	
7	I seek information on sexual health from health practitioners.	33	67	

The results in table 4.2 show the various sexual health information sources. The output of the results indicate that most adolescents the following as sources of sexual health information: internet websites (92%), peers (88%), and social media (81%). The implication of this is that most adolescents do not seek information from sources with adequate authority such as family members, print and non print media, health practitioners, and religious leaders

Table 4.3: Frequency distribution on the information channels used by female adolescents

S/N	Information systems/channels used by these female adolescents	Agree	Disagree	Remark
1.	I use OPAC to get sexual health information	03	97	
2.	I use compact disk – Read Only Memory (CD-ROMs),to get sexual health information	11	89	
3.	I use Online databases to get sexual health information	43	57	
4.	I use the internet search engines to get sexual health information	89	11	
5.	I use subject directories to get sexual health information	17	83	

6	I use web directories to get sexual health information	04	96	

The results in table 4.3 show that most adolescents do not use OPAC (97%), web directories 96%, CD-ROMs 89%, and subject directories 83%. The mostly use information channel is search engines to search for sexual health information. The implication of this is that most of the channels with authentication and authority like OPAC are not used.

Table 4.4: Frequency of unmet information needs of female adolescents

S/N	**Unmet Information Needs Of Female Adolescents**	**Agree**	**Disagree**	**Remark**
1.	How safe is safe sex?	84	16	
2.	Does use of contraceptives have adverse effects on my future?	89	11	
3.	Will I be stigmatized if I truly express my sexual rights?	98	02	
4.	Is the information I have about sex adequate enough?	76	24	

The results in table 4.4 show that there are lots of unmet information needs of female adolescents: concern on sexual rights protection (98%), effects of contraceptives (89%), how safe is sex (84%), and having enough information about sex (76%). The implication of this is that these unmet needs could be occasioned by stigma or lack of sex education.

Table 4.5: Frequency distribution on information use behavior of adolescents

S/N	Information use behavior of adolescents	Agree	Disagree	Remark
1.	I use the sexual health information I have to avoid sexual encounter	67	33	
2.	I use the sexual health information I have to avoid multiple sex partners	94	06	
3.	I use the sexual health information I have to avoid STIs	78	22	
4.	I use the sexual health information I have to avoid getting pregnant	71	39	
5.	I use the sexual health information I have to avoid sexual risky behavior	56	44	

The result in table 4.5 indicate the information use pattern. The output shows that adolescents use health information to avoid sexual encounters (67%), while 94% use sexual health information to avoid multiple sex partners, 78% to avoid STIs, 71% to avoid pregnancy, and 56% to avoid sexual risky behavior. The implication is that the information use of adolescents is adequate.

Table 4.6: Frequency distribution on knowledge transfer among adolescents

S/N	The Process Of Knowledge Transfer And Exchange	Agree	Disagree	Remark
1.	I participate in group discussions on sexual health	05	95	
2.	I participate in seminars on sexual health	11	89	
3.	I participate in workshops on sexual health	03	97	
4.	I participate in the use of folk media to share information on sexual health	04	96	
5.	I use documentation share knowledge on sexual health	07	93	

Table 4.6 shows the results for knowledge transfer among and exchange shows that most adolescents do not participate in group discussion (95%), 89% do not participate in seminars, 97% do not participate in workshop on sexual health and 93% do not use documentation. The implication of this is that there is poor knowledge exchange and transfer among adolescents.

4.2 Findings

1. Adolescents do selective search in order to satisfy an information need
2. Adolescents mostly seek sexual health information from non authoritative sources
3. Most of the channels used by adolescents are not authenticated
4. Adolescents have high level unmet information needs
5. Information use among use adolescent is adequate
6. Knowledge exchange and transfer are poor among adolescents

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 SUMMARY

This study focused on the investigating the information seeking behavior of female adolescents on sexual health related matters. The results show that adolescents do selective search in order to satisfy an information need; adolescents mostly seek sexual health information from non authoritative sources; most of the channels used by adolescents are not authenticated; adolescents have high level unmet information needs; information use among use adolescent is adequate; and knowledge exchange and transfer are poor among adolescents.

5.2 CONCLUSION

The study investigated the information seeking behavior of female adolescents on sexual health. Six objectives and six objectives were framed to guide this study. The study adopted information pickup theory by Gibson (1974) for the dependent variable (information seeking behaviour) and the theory of health belief by Rosenstock *et al., (*1950) for the dependent variable (sexual health). Descriptive survey design was adopted as the framework for the study, while a sample size of 150 female adolescents out 5233 female adolescents' population were purposively selected. The results show that adolescents do selective search in order to satisfy an information need; adolescents mostly seek sexual health information from non authoritative

sources; most of the channels used by adolescents are not authenticated; adolescents have high level unmet information needs; information use among use adolescent is adequate; and knowledge exchange and transfer are poor among adolescents. Recommendations are provided thereafter.

5.3 RECOMMENDATION

1. It is hereby recommended that stakeholders and health practitioners should make provisions for more education and enlightenment on seeking information from evidence based authoritative sources.

2. Parents are advised to keep close association with their female adolescents and provide them with the right and resourceful information relation to their sexual health.

5.4 SUGGESTIONS FOR FUTURE STUDY

1. Reproductive health information seeking behavior of young adults College students

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