USAID/NIGERIA: REVIEW AND DESIGN OF AN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAM

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USAID/NIGERIA: REVIEW AND DESIGN OF AN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROJECT

DISCLAIMER
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# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHI</td>
<td>Action Health Incorporated</td>
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<td>AHIP</td>
<td>Adolescent Health and Information Projects</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<td>ARFH</td>
<td>Association of Reproductive and Family Health</td>
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<td>ARH</td>
<td>Adolescent reproductive health</td>
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<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
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<td>AYDI</td>
<td>African Youths Development Initiative</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>ELPE</td>
<td>Extended Life Planning Education</td>
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<td>EVA</td>
<td>Education Against AIDS</td>
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<td>FCT</td>
<td>Federal Capital Territory</td>
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<td>FLHE</td>
<td>Family Life &amp; HIV Education</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<td>FOMWAN</td>
<td>Federation of Muslim Women's Associations in Nigeria</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GH Tech</td>
<td>Global Health Technical Assistance Project</td>
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<td>GPI</td>
<td>Girls Power Initiative</td>
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<tr>
<td>HARPIN</td>
<td>HIV/AIDS Reduction Program in Niger Delta</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICT</td>
<td>Information Communication Technologies</td>
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<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>LGA</td>
<td>Local government area</td>
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<td>MDA</td>
<td>Ministry, Department and Agency</td>
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<td>MOE</td>
<td>Ministry of Education</td>
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<td>MOYD</td>
<td>Ministry of Youth and Development</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NYSC</td>
<td>National Youth Service Corps</td>
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<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<td>PATHS</td>
<td>Partnership for Transforming Health Systems</td>
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<td>PHC</td>
<td>Primary Health Clinic</td>
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<td>PPFN</td>
<td>Planned Parenthood Federation of Nigeria</td>
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<td>RH</td>
<td>Reproductive health</td>
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<td>SFH</td>
<td>Society for Family Health</td>
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<td>SWODEN</td>
<td>Society for Women Development and Empowerment Nigeria</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>TShip</td>
<td>Targeted States High Impact Project</td>
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<td>UCH</td>
<td>University College Hospital</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<td>UTH</td>
<td>University teaching hospital</td>
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<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YEDA</td>
<td>Youth Environment and Development Association</td>
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<td>YFHS</td>
<td>Youth-friendly health services</td>
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<td>YHS</td>
<td>Youth health services</td>
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<td>YSO</td>
<td>Youth service organization</td>
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EXECUTIVE SUMMARY

BACKGROUND

Nigerian context
Nigeria is the most populous nation in the sub Saharan region with 250 ethnic groups and 380 languages. The country boasts a vast range of traditional political institutions, cultural practices and religions that vary by geography. Nigeria has a predominately young population with 47 million between the ages of 10-24 years. Addressing the sexual and reproductive health needs of young people is crucial to economic and social wellbeing.

Adolescent sexual and reproductive health in Nigeria
Nigeria has a very large adolescent population, with over one third of the nation being between 10-24 years old. The median age of first intercourse for young women and men is 17.7 and 20.6, respectively. Use of family planning among Nigerian women is low, with 40% of unmarried sexually active women using a modern method (predominantly condoms) and only 37% of young women 15-24 years of age knowing one source of condoms (as compared to 68% of men the same age). The last NDHS(2008) shows that 23% of women 15-19 years have begun child bearing.

Statistics about adolescent sexual and reproductive health in Nigeria vary widely depending on geography, education and household income, and they are set within a wider cultural context of marriage, childbearing and cultural norms about sexual intercourse and gender issues. Adolescents in rural areas from poor households with less education are more likely to get married at a younger age and begin having sex and bearing children at a younger age than those from urban areas. Urban adolescents are often from higher income households, achieve higher levels of education and marry later. However, they are more likely to have pre-marital sex than rural youths, thus leading to higher exposure to STIs and a higher risk of unwanted pregnancy. Given these two widely varying scenarios, it is clear that Nigeria’s adolescent sexual and reproductive health needs are diverse.

Global evidence base for ASRH interventions
The body of evidence on the effectiveness of various ASRH programs around the world has been growing over the past three decades. Reviews of extensive programmatic experience offer a large number of lessons that can inform ASRH programs. These include the need for varying types of interventions to address needs of different youth subgroups, the importance of integrated RH/HIV services, and the need for curriculum-based sexuality education.

OBJECTIVE AND METHODS

The objective of this assessment was to review the adolescent sexual and reproductive health (ASRH) situation in Nigeria in light of Nigeria’s unique social, cultural and geographic context and to make recommendations for future programming to strengthen existing programs and fill program gaps, all set within the framework of global best practices.

This assessment and review, coordinated by USAID, was undertaken in collaboration with three other partners who also have responsibility and significant programming interest in ASRH programs in Nigeria – the Federal Ministry of Health (FMOH), UNFPA and DFID. The assessment team included a core team of three expert consultants, a USAID liaison, an
This report was informed by data collected by several means: desk review of background documents and research literature related to the assignment; face-to-face interviews with key stakeholders conducted during field visits in six states and a stakeholders’ meeting with people representing organizations who could not be included in the field visits due to time constraints. Interview guidelines were developed to address questions specific to three categories of respondents: managers of youth-serving organizations (YSOs); government agencies/donors; and youth.

FINDINGS – HOW CURRENT INTERVENTIONS ARE ADDRESSING PROGRAMMATIC RESULTS

The team had the following findings, organized around three programmatic approaches to ASRH interventions:

Fostering an enabling environment
We found that:
- Many strong policies are in place at the federal level, but implementation throughout the country is weak.
- Capacity and structure for coordination is improving, though still in need of external support.
- Awareness and support from certain groups for ASRH programs is growing, but community attitudes are still generally conservative with regard to ASRH services.

Knowledge, skills, attitudes and self-efficacy
Five program models aimed at improving the ASRH knowledge and skills of young people were identified during this assessment. These include: in-school FLHE, stand-alone SRH IEC/life skills program, IEC integrated with livelihood skills, IEC integrated with health services, and mass-media/ICT. Each of these models was reviewed for program examples and target groups, and strengths and challenges were noted for each.

Health seeking and safer sex practices
Six models for provision of ASRH services were identified during this assessment. These include: integrated youth-friendly health Services (YFHS), stand-alone YFHS, comprehensive youth-friendly service, school health services, non-adolescent focused RH services, and social marketing services. Each of these service models was reviewed for program examples and target groups, and strengths and challenges were noted for each.

Trends in program delivery, human resources and evidence for future programming
The team also identified some significant trends in the areas of program delivery, human resources and evidence for future programming.

Program delivery
While Nigeria as a nation boasts a wide variety of models for provision of ASRH services, there are few to no comprehensive health services that cover ASRH needs in most communities. What does exist varies greatly in personnel, coverage, etc. Meanwhile, rural-
based adolescents are particularly undeserved, and many health service outlets were unequipped and had staff who were unqualified to treat extensive adolescent health issues such as malaria, TB, injuries, etc. Linkages to other health service facilities were unsystematic with poor collaboration and weak referral networks. Finally, many groups of high-risk youth such as 10-14 year olds, drug users, sex workers and adolescents living with HIV/AIDS were not included in most programs dealing with ASRH.

**Human resources**

One of the principal barriers to providing adequate comprehensive reproductive and sexual health services to adolescents was the lack of trained and skilled service delivery personnel. The underlying issue is that this is no recognized “career path” or credentialing in ASRH for health professionals. Most CBOs encountered were unaware of or not utilizing a recognized health education curriculum. Opportunities for in-service training for service providers are few and costly. “Use of best practices” is not a concept interviewees were familiar with.

**Evidence**

The evidence base is weak and many organizations do not have comprehensive external baseline surveys before initiating their work, nor do they maintain record-keeping systems about the youth participating in their programs, which means that coverage data and evidence of impact are not available. Data are especially lacking for the 10-14 year old sub-sector of Nigerian youths.

**Programming gaps**

Based on field visits and analysis, the team identified the following gaps in ASRH programming in Nigeria:

- The needs of university students are largely unmet.
- Vulnerable populations of youth such as MSM, drug users, sex workers and adolescents living with HIV/AIDS are underserved.
- There is a lack of programs to address sexual harassment, violence and abuse.
- There is an absence of parent-focused programs.

**Unexamined, possibly promising emerging programs/models**

During our visit, the team discovered a few promising programs that are either in the start-up phase or for which inadequate information is available, however, they may be worthy of future evaluation. These include private-for-profit collaboration such as Girl Hub, Learning-Plus program for school health, and certificate training programs in selected universities and other institutions for health workers to train in ASRH.

**RECOMMENDATIONS FOR ADDRESSING CURRENT ASRH NEEDS IN NIGERIA**

Create an enabling environment

- Strengthen coordination mechanisms (at all levels) for information and resource sharing to increase the effectiveness of all programs and reduce program redundancy.
- Advocate for government to allocate funding for ASRH programming through all
ministries who have an interest in young people – health, education, youth and
development and women’s affairs.
• Support strategic partnerships.
• Work at the community level to sensitize parents, religious leaders and other key
stakeholders to increase support for ASRH programs.

Provide information and skills
• Strengthen the implementation of FLHE in public and private schools and NGOs
through teacher training and provision of materials.
• Explore the use of mass media and new technologies to reach young people with
critical ASRH messages to improve knowledge, skills, and health seeking behavior.
• Scale up promising educational and skill-building interventions into more LGAs and
more states to reach all groups of adolescents, including more vulnerable youth such
as married adolescents, OVCs and those with special developmental needs.
• Map youth activities and social networks to improve access to accurate information
and promotion of activities that address self-reliance and reduce risk behaviors in the
communities.

Offer strong, integrated services
• Integrate ASRH training for providers into a range of ongoing in-service training
such as FP, Immunization, HIV and AIDS.
• Support institutionalization of short-term and refresher courses, as well as
certification in ASRH specialization for health workers.
• Strengthen the ASRH component of pre-service training for all groups of health
workers.
• Create/strengthen referral linkages between PHCs and other programs within each
catchment area to form networks of organizations providing care to young people
within a catchment area.
• Reach young married women through antenatal clinics where there is an opportunity
to provide family planning information and other health services.
• Build stronger linkages between other existing reproductive health services and
ASRH, particularly between HIV-related programs and ASRH, to expand the access
of young people to relevant services.
• Recognize and address ASRH needs of young people in universities and other
tertiary institutions through specifically-designed interventions with high levels of
youth involvement
• Recognize the RH needs of other neglected adolescent populations including: IV
drug users, MSM, sex workers, HIV-positive youth, and those with special physical
and mental needs.

Address crosscutting issues
• Review evaluation documents of past and ongoing ASRH programs in Nigeria,
synthesize findings, and disseminate widely to stakeholders to inform programming
agenda.
• Mentor and provide technical assistance to Nigerian program managers to build skills and appreciation for monitoring and evaluating of ASRH interventions.

• Monitor and evaluate ongoing new programs, including assessment of geographic reach, cost-effectiveness and health outcomes.

• Encourage community coordination structures at local level to build synergy among programs and enhance community involvement.

• Develop/strengthen coordination mechanisms to help NGOs and government programs support each other -- a critical task for any new effort to improve adolescent health.

• Raise awareness of sexual and school violence and develop confidential reporting mechanisms and counseling services.

• Ensure that programs reflect social, cultural and geographic contexts, as well as gender appropriateness.

• Promote youth involvement and leadership of ASRH programs.
I. INTRODUCTION AND RATIONALE

REPRODUCTIVE HEALTH OF ADOLESCENTS IN NIGERIA

Nigerian context
Nigeria is the most populous nation on the African continent with over 158 million people (Population Reference Bureau, 2010). Nigerians belong to approximately 250 ethnic groups and speak about 380 languages. They live in six distinct geopolitical regions and have a wide range of traditional political institutions, cultural practices and religions. The North West and North East regions are predominantly Muslim, the North Central and South West regions are over a third Muslim and about two-thirds Christian. The South Central and South East regions are mainly Christian.

The national maternal mortality ratio is high, at 1100 per 100,000 live births. Life expectancy at birth in Nigeria is about 48 years. Nigeria is a nation of young people; nearly one-third of its population is between 10 and 24 years of age (Population Reference Bureau, 2010).

Adolescent reproductive and sexual health in Nigeria
The latest demographic and health survey (NPC & ICF Macro, 2009) in Nigeria provides a snapshot of certain critical indicators of the reproductive and sexual health of young people in Nigeria. In 2008:

• 23% of young women 15-19 years old had given birth or were pregnant with their first child
• The median age for first birth among women ages 25-49 was 20.4
• Nearly half of women in Nigeria were married by age 18, with the median age of marriage among women 25-49 being 18.3
• 20% of women were sexually active by age 15
• The median age at first intercourse was 17.7 years for women and 20.6 years for men
• More than 40% of sexually active, unmarried women are using a modern method of family planning; the most common method used is condoms (35%)
• 37% of young women know a condom source compared to 68% of young men (ages 15-24)
• 7% of young men and women had been tested for HIV and received their results within the 12 months prior to the survey

Geography, education, income and cultural sexual norms
These statistics vary widely, however, depending on geography, education and household income, and they are set within a wider cultural context of marriage, childbearing and cultural sexual norms. Teenage childbearing varies from 45% in the North West zone to 8% in the South East zone. Fifty-five percent of women with no education are likely to have had a child before age 20 compared to 3% of those with secondary or higher education. Among those in the poorest households, 46% had a child before age 20, compared to 5% in the wealthiest. Women in urban areas have their first births an average of nearly three years later (mean age of 22.3) compared to women in rural areas (mean age of 19.5 years). The average age of marriage among women in urban areas is 21.1 compared to the average age of 16.9 in rural areas. The average age of marriage among women in the South East zone is substantially higher at 22.8 years than the average age among women in the North West zone – 15.2 years.
Average ages at first intercourse follow these same trends:

- The median age for women in urban areas is 19.2 compared to 16.5 in rural areas.
- The median age for women in the South East zone is 20.4 years compared to 15.4 in the North West zone.

Notably, women with more than secondary education were nearly six years older at first sex than their less educated counterparts.

**Fertility rates and use of family planning**

In general, fertility rates are high in Nigeria, with an overall TFR of 5.7 children. Concomitantly, use of modern methods of family planning is low. Ten percent of married women use a modern method and 5% use some form of traditional method. The most commonly used method among married women is injectables. More than 40% of sexually active, unmarried women are using a modern method of family planning; the most common method used is condoms (35%). These numbers indicate an increase in use of modern methods from earlier NDHS. Still, this is less than half of young women who are sexually active, leaving large numbers of women at risk of unwanted pregnancy.

At least two studies have documented that Nigerian sexually active adolescents shy away from modern contraceptive methods due to a fear of infertility and other side effects. Because of this they risk an unwanted pregnancy (Koster, 2010; Otide, Oronsaye & Okonofua, 2001). The shame of a pregnancy outside of marriage leads many young women to seek abortion, and with abortion currently illegal in Nigeria except when the life of the mother is at stake, most of these abortions are clandestine, often with unsafe providers. Currently, induced abortions are estimated to account for 20,000 of the 50,000 annual maternal deaths in Nigeria (Otide, et al., 2001). Because abortion-related morbidity often leads to infertility, sexually active young women in Nigeria need information about the dangers of unsafe abortion and accurate information about contraception so that they can make informed decisions about the use of contraception.

**Gender issues**

Other findings from the 2008 NDHS on the status of women in Nigeria provide useful background to the health of young women. Seventy percent of women ages 15-49 were employed, though 17% receive no payment for their work. Only about half of women reported participating in decisions about their own health care and in making daily purchases. About 40% of women and 30% of men believed that a man is justified for beating his wife under certain circumstances. About half of men and women believed that a woman has the right to refuse sex with her husband for all three of the following reasons: husband has an STI; husband is not faithful and wife is tired/not in the mood. With regard to gender-based violence, 28% of women in the survey had experienced violence since age 15; 15% in the 12 months prior to the survey and 7 percent had ever experienced sexual violence. A husband or partner was the most likely perpetrator of violence. Women living in southern zones were more likely to have experienced violence as were women who were married to men who often drink alcohol (with these two factors correlated with one another).

**DIVERSE ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH NEEDS**

Two very different scenarios for the lives and needs of young people emerge from these findings. From these statistics we see that many young Nigerian women and men are sexually active, in part due to young ages at marriage. Young marriage is generally, though not exclusively, related to religion, geography, education and economic factors. Girls who marry before the age of 16 are more likely to be Muslim, from the North, have little or no education and be from
families with fewer resources. Poverty and parents’ reduced access to education are push factors for early marriage – motivating parents to marry their daughters early so they are less of an economic burden to them. Early childbearing results from early marriage – both from the cultural ideal to prove fertility and from religious beliefs that childbearing is the will of God. A study by the Population Council in Northern Nigeria found that girls do not make most of the important decisions in their own lives, including when and whom they marry (Erulkar & Bello, 2007). Once married, they have even less decision making power, with most husbands making most decisions. Girls in the study described being isolated and under the control of their husbands and co-wives, which diminishes their access to information and services. Because of their special vulnerabilities, specialized programs for married girls are likely to be more effective than programs for generalized audiences. These could include tailored outreach or mobilization mechanisms, such as home visits or group formation. The relative acceptability of maternal health care may make this a non-threatening entry point for reaching married girls. Using maternal health as an entry point, other subjects can be introduced, such as HIV/AIDS and family planning, and eventually gender issues and violence.

The consequences of early childbearing include greater maternal morbidity and mortality. Compared with women in their twenties, adolescents ages 15 to 19 are two times more likely to die during childbirth, and those ages 14 years and younger are five times more likely (UNICEF, 2000). While it would be difficult to influence a cultural norm to delay first births among those who marry early, birth spacing can be promoted to protect the mother’s health. Perhaps an even more effective approach would be the promotion of school retention as a way of delaying marriage – which also meets with cultural resistance in the North.

In less poor Southern regions where girls are more likely to attend secondary school, they are more likely to marry and give birth later than their Northern counterparts. However, they may be more likely to engage in sex prior to marriage, putting them at risk of unwanted, possibly even dangerous pregnancies, as well as STIs, including HIV infection. Their needs include accurate RH information, life skills related to sexual negotiation, counseling, condoms and contraceptive services and testing and treatment of STIs.

Other risk groups of young people including injection drug users, MSM and sex workers (whose risk is most related to STIs and HIV) are not specifically covered by the DHS, and little is known about their prevalence to date.

Global Evidence Base for ASRH Interventions

The body of evidence on the effectiveness of various ASRH programs around the world has been growing over the past three decades. A number of review papers and documents (Kirby, 2006; Senderowitz, 2000, Victoria Ball & Moore, 2008) have been written that have tried to synthesize what is known about what works and what does not work among various types of interventions. However, not all the evidence comes via scientific research. Some best practices arise from extended program experience – especially when research studies would be too costly, or research designs to test relevant hypotheses would not be feasible (i.e., the effects of youth participation in program design.) From these reviews and syntheses we find many lessons from program experience that inform current ARSH programs:

- Young people are not a monolithic group with varying needs for information and services, and one type of intervention is not going to address these different needs, nor can one type of intervention address the unique needs of any one young person (Daniels, 2007). For example, some programs are better at reaching one sex than the other (Victoria Ball & Moore, 2008).
• As with any type of endeavor, to maintain health behaviors, prevent risky ones or promote use of needed services, multiple messages delivered through multiple modalities are needed. There is no “magic bullet” approach. (Butler, Bond, Drew, et al., 2005; YouthNet, 2006)

• Youth at risk need access to integrated RH/HIV services (YouthNet, 2006).

• Programs should be conceptualized and designed to move from the current “project mentality” of scattered, one-time efforts into a more sustainable and comprehensive program framework using multiple interventions. (Senderowitz, 2000).

• Improving outcomes for young people is not just about bigger and better projects, faithfully adopted, but rather about taking an ecological approach to working with schools and communities. Such an approach recognizes the complexity of change and the importance of interactions between individuals and environments rather than simply changes in either individuals or environments. The intervention goal of ecological approaches is community development, increasing the resources of the community of concern. (Butler, Bond, Drew, et al., 2005).

• Young people need the support of adults in their lives, and interventions should promote that. Young people should be fully involved in the design and implementation of interventions, though their capacity to do this needs strengthening through training and support. Youth-adult partnerships help build alliances that strengthen youth programs (YouthNet, 2006).

• The greatest amount of evidence for a specific intervention model is found for curriculum-based sexuality education, and this model was rated as a “go” by WHO (2006). A set of characteristics of effective curricula have been identified to guide design and implementation of sexual education curriculum (Kirby, et al., 2006).

• There is evidence for effectiveness of many types of interventions, but this effectiveness is usually conditional upon certain social contexts. Addressing social and gender norms in program design and messaging facilitates changes in risky behaviors. (Butler, Bond, Drew, et al., 2005; YouthNet, 2006).

• Several programs are successful at one site or in one evaluation, but not in another, indicating that curriculum and programming are not the sole elements of a successful intervention. Implementation methods, staffing, and tailoring programs to meet the needs of the population being served are all-important considerations. (Victoria Ball & Moore, 2008).

• Programs that have impacts on knowledge, beliefs, attitudes, and/or intentions do not necessarily have an impact on behavior (Victoria Ball & Moore, 2008)

• Programs that fail to teach condom use skills do not appear to have an impact on condom use (Victoria Ball & Moore, 2008).

• A review of studies on youth-friendly primary-care services identified six categories of youth-friendly services. They found little evidence of the effectiveness of any of these models because of inadequate assessment (Tylec, Haller, Graham, Churchill & Sanci, 2007), though the authors conclude that services designed to meet the needs of young people are important and further study is necessary to demonstrate effectiveness. One study on comprehensive youth centers which provide RH found that the effect of recreational activities on health outcomes was not clear-cut, nor were they likely to serve a large portion of the adolescent population, especially in rural areas. The study suggested that while these centers reached boys, their participation was primarily recreational. (Erulkar, 2001).
• In a study in Kenya and Zimbabwe when adolescents were asked about characteristics of a youth friendly clinic they rated confidentiality, short waiting time, low cost and friendly staff as the most important characteristics. The least important characteristics included youth-only service, youth involvement and young staff. This indicates that young people do not necessarily prioritize stand-alone youth services such as youth centers, or necessarily need arrangements particular to youth such as youth involvement. Most existing clinical services, therefore, have the possibility of making their services more attractive to youth (Erulkar, Onoku & Phiri, 2005).

• At-risk youth are reachable. Many of the most successful reproductive health interventions specifically target minority youth from low-income areas. (Victoria Ball & Moore, 2008)

• The Africa Youth Alliance implemented a model of ASRH interventions that were comprehensive and integrated and featured the support of government structures to coordinate program components within implementation areas through sharing workplans, networking and collaboration among implementing partners at all levels through various channels and with youth participation. This model was implemented in sites in Botswana, Ghana, Tanzania and Uganda. An evaluation of this model by John Snow, Inc. in 2006 found positive effects of the model on sexual knowledge, attitudes and behaviors related to sexual and reproductive health (Daniels, 2007).
II. OBJECTIVE

The objective of this assessment was to strategically review the adolescent sexual and reproductive health (ASRH) situation in Nigeria in light of Nigeria’s unique social, cultural and geographic context and to make recommendations for future programming to strengthen existing programs and fill program gaps, all set within the framework of global best practices.

A concept paper proposing a program design for USAID/Nigeria based on the findings from this assessment process – will be written and submitted as a separate document.
III. METHODS

This assessment and review, coordinated by USAID, was undertaken in collaboration with three other partners who also have significant programming and interest in ASRH programs in Nigeria – the Federal Ministry of Health (FMOH), UNFPA and DFID.

DATA COLLECTION METHODS

The findings presented in this report were informed by data collected by several means: desk review of background documents and research literature related to the assignment; face-to-face interviews with key stakeholders conducted during field visits in six states and a stakeholders’ meeting in Abuja with people representing organizations who could not be included in the field visits due to time constraints.

The USAID mission (via the GH Tech) provided many documents for the desk review prior to the in-country assessment process. Other documents were provided to the team during the assessment during field visits to individual organizations. Finally, a number of information sources, especially papers from peer-reviewed journals, were already known to team members or identified through literature searches.

THE TEAM

The assessment team included a core team of three expert consultants to GH Tech; Cynthia Waszak Geary, PhD (team leader); Leni Silverstein, PhD and Adesegun Fatusi, MD, MPH. This core team brought together many years of experience related to ASRH as well as complementary disciplines. A USAID liaison and representatives of the Federal Ministry of Health (FMOH), DFID and UNFPA joined the core team for field visits and the stakeholders meeting and are contributing to this report.

In order to visit as wide a geographic area as possible, two teams were constituted to visit state level ministries, departments and agencies (MDAs), and youth serving agencies and to hold discussions with youth themselves. Team A visited Lagos, Ebonyi and Calabar. Team B visited the Federal Capital Territory (FCT), Kano and Bauchi. Team membership is listed below.

<table>
<thead>
<tr>
<th>Team A</th>
<th>Team B</th>
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<tr>
<td>• Leni Silverstein, GH Tech consultant</td>
<td>• Cynthia Waszak Geary, Team leader</td>
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<tr>
<td>• Adesegun Fatusi, GH Tech consultant</td>
<td>• Folake Olayinka, USAID</td>
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<td>• David Ajagun, FMOH</td>
<td>• Abraham Sunday, FMOH</td>
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<td>• Joy Onuegbu, FMOH</td>
<td>• Aisha Abubakar, DFID representative</td>
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<td>• Godwin Asuquo, UNFPA</td>
<td>• Abubakar Izge, DFID representative</td>
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DATA COLLECTION INSTRUMENTS

Data collection instruments were developed by team members prior to the field visits to guide the interview process. Three sets of interview guidelines were developed to address questions specific to three categories of respondents: managers of youth-serving organizations (YSOs); government agencies/donors; and youth. (See interview guides in Appendix C.)
This report is a synthesis and analysis of interviews, meeting discussions and written documentation by the core team, with input and review from the full field teams.
IV. HOW CURRENT INTERVENTIONS ARE ADDRESSING THREE PROGRAMMATIC RESULTS

It is widely known that there is no one program model that will significantly improve the health and well-being of young people. This task requires multiple interventions that focus on different aspects of adolescent health. Presented below are descriptions of several program models being implemented in Nigeria with analyses of strengths, challenges and potential solutions for these challenges.

In Senderowitz’ review of the evidence of on ASRH programs (2000), Sederowitz organizes her work around three approaches to ASRH that continue to be a useful way of categorizing results necessary for improved ASRH. All of these are necessary, but none of them alone is sufficient to meet the ASRH needs of young people. These three approaches include:

- Fostering an enabling environment
- Improving knowledge, skills, attitudes and self-efficacy
- Improving health seeking and safer sex practices

We use these categories to organize our findings related to specific interventions and models. These are followed by reflections on issues that cut across these approaches.

FOSTERING AN ENABLING ENVIRONMENT

Many strong policies are in place at the federal level, but implementation throughout the country is weak.

The national policy environment is currently very favorable to providing ASRH services to young people. In our review we found the following relevant documents: The Health and Development of Adolescent and Young People in Nigeria (FMOH); National Youth Policy (FMYD) and National Policy on School Health (FMOE). While written policy is favorable at the federal level, implementation at the state level is uneven. The FMOH is willing to provide technical assistance, monitor and provide supportive assistance to ASRH programs at state levels, but they do not have the authority to require states to implement suggested services. Support for health activities is programmed at the state and local government.

A number of projects exist that are working with state governments to build capacity and provide technical assistance in the development of state-level strategies to address various government priorities including adolescent health. For example:

- USAID/Nigeria is supporting Targeted States High Impact Project (Tship) in Bauchi and Sokoto to establish strong and durable bonds between community institutions and the healthcare delivery system in every ward of Bauchi and Sokoto, with increased use of integrated maternal and newborn and child health services. Bauchi and Sokoto will have improved health systems and management, and higher quality service delivery for many health services including for family planning (FP) and antenatal care. Its first objective is to strengthen the capacity of state and local government to deliver services. Tship has an ASRH focal person to ensure the inclusion of issues specific to young people.

- UNFPA has been the lead agency facilitating the development of The Action Plan for Advancing Young People’s Health and Development in Nigeria. A three-day National Consultative Forum of key stakeholders (mostly policymakers) from national, state and LGA levels was held May 31 – June 2, 2010 convened by the Federal Ministry of Health and the Federal Ministry of Youth and Development was given technical and financial
support by UNFPA. The Action Plan document is a guide for governing bodies at all levels and in multiple sectors to identify ways in which they can contribute to the health of young people over the next three years and make a commitment to do so.

- DFID’s Partnership for Transforming Health Systems (PATHS)/2 project is working in Enugu, Kaduna, Kano, Lagos and Jigawa as well as supporting work at the Federal level to strengthen state services in ways that will ultimately affect services that adolescents use: improving services in PHC facilities; emphasizing preventative rather than curative health care; working to retain staff in rural areas; better flow of commodities and better government planning and management to ensure that money is allocated for high priority health needs.

- DFID’s Partnership for Reviving Routine Immunization in Northern Nigeria/Maternal, Newborn and Child Health Initiative (PRINN/MCH) focuses on state government in Jigawa, Katsina, Yobe and Zamfara. They do not deliver health care directly but support the work of others, often tackling issues of governance and financial management that affect the health care system.

- The World Bank also has plans to strengthen health systems at the state level; though it does not have programming specific to young people, they recognize that many of their programs will serve young people and feel they are contributing in that way.

- WHO is supporting states to develop a plan of action with regard to reproductive health services. WHO also supports capacity building and is looking at the development/revision of an ASRH training manual.

- UNICEF is working with the MOE at the federal and state level to push having policies implemented at the state level. They are also working with the MOYD to ensure implementation of programs at the community level. They also work with the National Youth Service Corps.

**Capacity and structure for coordination**

In nearly every interview and meeting, the issue of coordination among agencies and organizations within and across implementation levels was discussed. Currently at the national level there is an Adolescent Health and Development Working Group comprised of all stakeholders, state desk officers, NGOs, FBOs, CSOs, young people and line ministries. This body meets twice a year to discuss emerging issues in adolescent health and development and chart the way forward to improving adolescent health in Nigeria.

The Federal Ministry of Health has requested that a focal person for ASRH be assigned in each state to facilitate this coordination across programs. Though this has not happened in every state in Nigeria, there was a focal person in every state we visited except one, indicating movement towards that goal.

Within each state there are structures such as coordinating committees and working groups for information sharing across government and non-government programs. Though there have been political and budgetary issues that affect the workings of these structures, the need for coordination to create synergy among programs and avoid duplication of efforts recognized. There continues to be a need for allocation of resources to support meetings and communication for coordinating bodies.

We were not made aware of coordinating bodies at the LGA or ward level, but this is another step that would strengthen implementation where it is actually occurring and would benefit all
youth programs. Currently state desk officers are charged with setting up coordination at the local government level but only one state, Niger, has attempted to do so.

**Awareness and support from certain groups for ASRH programs is growing, but community attitudes are still generally conservative with regard to ASRH services.**

A noticeable positive shift in community attitudes toward ASRH services has occurred, especially in areas of the country which are traditionally more conservative. However, this is not well understood by donors or policymakers working at the national level. For example, we were told at the beginning of the assessment that the Family Life and HIV Education (FLHE) curricula could not be widely implemented because of negative community attitudes. Apparently there had been much controversy several years ago, but in our visits we found that the curriculum had been approved by almost all states and was being implemented in a number of secondary schools in the states visited by the assessment team. What is now hindering wider implementation is the lack of resources rather than community or state government opposition.

We found a number of ASRH youth programs in Nigeria that involve communities in a general way either at the beginning or throughout. Usually community engagement and mobilization is not a stand-alone project, but incorporated as one component. For example, the mass communication project *KuSaana!* initially met with opposition to their musical road shows, and discussions with community members helped determine how they could best continue. Other programs, such as NYAP in Lagos found a common ground with the needs of the community leaders for addressing the needs of young people. In these cases, the community helped the program design initial non-controversial messages, which they were then able to augment with messages about family planning and VCT.

Despite the positive changes, there is more to be done to garner community support for other types of services. It was widely recognized by our informants that religious leaders are important influencers at the community level. One program in Northern Nigeria implemented by FOMWAN trained Muslim leaders on the health benefits of delayed pregnancies for young married women or “healthy timing and spacing of pregnancy” (HTSP) (Lane, et al., 2010). They then became important sources of information for their followers during Friday sermons and one-on-one counseling. Many respondents to a community survey were able to recall hearing about HTSP from religious leaders and reported favorable attitudes towards spacing. (We did not visit this program, specifically but an evaluation report was recently released.)

Parents also are an important target group. Traditionally parents do not discuss matters of sex and reproduction with their children, but providing parents with information about this topic would possibly change this or at least motivate parents to encourage their children to use available services. We found few programs targeting parents, though much interest in this kind of intervention. (Curricula developed for parents by YouthNet taught from a religious perspective – both Christian and Muslim – could be adapted for use in Nigeria. They can be downloaded from [www.fhi.org](http://www.fhi.org).)

Going forward, documentation and evaluation of activities to shift community norms in a positive direction would be an important contribution to the evidence base for ASRH programs.

**IMPROVING KNOWLEDGE, SKILLS, ATTITUDES AND SELF-EFFICACY**
We identified the following five program models aimed at improving the ASRH knowledge and skills of young people in the field. These programs are also summarized in Table 1.

**In-school Family Life & HIV Education (FLHE)**

The FLHE program is a nationally approved program, and though not nationally implemented, is being implemented in most public schools visited in each of the states where the review was carried out. The curriculum for FLHE is graded for age and educational level, and ASRH issues are integrated into selected carrier subjects that are taken by virtually all students. As such, the program has the capacity to reach virtually all in-school adolescents across the country, if well implemented. The coverage of the program, however, to date it remains moderate due to challenges with training teachers and inadequate availability of curriculum.

*Program Examples:* In 2003, the Lagos State MOE with Action Health Incorporated (AHI) began the development of a plan for a phased implementation of the FLHE curriculum in public junior secondary schools across the state. Beginning implementation in less than one third of the schools in 2004, as of 2007 all (over 300) schools junior secondary schools teach the multi-year curriculum as part of relevant subjects at all levels. The electronic version was introduced in 2007 and is being implemented in 19 Lagos State public junior secondary schools. A recent report published by AHI provides lessons on planning and scale up from their experience (AHI, 2010).

The Expanded Life Planning Education (ELPE) Project in Oyo State was an initiative of ARFH that later evolved into what is now known as the FLHE. Initially funded by DFID, it linked school-based FLHE intervention with primary health services is an example of a program with useful lessons.

The current partnership between the National Youth Service Corps (NYSC) and UNICEF has great potential to boost the implementation of FLHE across the country. The initiative builds the capacity of youth to train and work with peer educators at a secondary school level throughout the country as part of their one-year compulsory national service.

The USAID-funded HIV/AIDS Reduction Program in Niger Delta (HARPIN), which is being implemented by Pro-Health International in Calabar, provides an example whereby a non-governmental organization (NGO) can promote ASRH information in school environment through working with selected community members and training peer educators in schools. The initiative results in formation of adolescent-led school clubs that continue to promote ASRH issues within schools.

The USAID-supported NEI project in Bauchi and Sokoto states promotes the use of FLHE in the schools they are supporting. One way in which they support FLHE is through teacher training.

*Key target groups:* In-school adolescents, particularly those in public secondary schools

*Strengths:*

- FLHE has a nationally approved curriculum; it was approved by the National Council on Education, which is the highest policy-making body in the educational sector. Its membership includes all state commissioners for education and the Honorable Minister for Education.
- Evidence from all the states visited, including Bauchi and Kano States, indicated that there is a strong buy-in into the FLHE program by the key stakeholders in the state.
educational sector. State stakeholders indicated a strong interest in the continuity and success of the program.

- Availability of curriculum in electronic form has increased the potential for wider availability of FLHE curriculum nationally. Thus, the e-curriculum has the potential to overcome the challenge regarding the limited availability of curriculum, which has been a major impediment to increasing the coverage of the program hitherto.
- An evaluation of the implementation of FLHE in Lagos State conducted by Philliber Research Associates found that students who had been exposed to the curriculum for three years had greater RH knowledge, more gender equitable attitudes, were either less likely to pressure someone or be pressured to have sex and there was a trend toward less likelihood of being sexually active (AHI, 2010).

**Challenges:**
- Effective implementation of FLHE requires a lot of resources, particularly in forms of training for teachers. Appropriate monitoring and supervision is also critical to success.
- Out-of-school adolescents are basically excluded.

**Stand-alone ASRH IEC/life skills programs**
Programs belonging to this category include some NGO-operated programs that do not include health-related services, but rather limited to educational interventions. Thus, the core focus is building the knowledge and skills of young people.

**Program examples:** An example of the program is the one being implemented by Girls Power Initiative (GPI) in Calabar. The GPI program has age-graded classes – for those in early, middle, and older adolescent life stages. GPI also provides some vocational skills training, though that is not the core strength and focus of their program. Another example of this is NAYAP in Lagos.

**Key target groups:** Both in-school and out-of-school young people of various ages

**Strength:**
- Such programs have dedicated focus on young people

**Challenges:**
- As many young people would need health-related services at some point (and not just information and life skills), stand-alone IEC/life-skills programs need a robust referral network to ensure that the needs of its focal young people are comprehensively met.

**IEC integrated with livelihood skills**
These types of services provide ASRH information alongside vocational training or livelihood skills.

**Program examples:** The programs visited in Bauchi and Kano, which are being implemented by Adolescent Health Information Project (AHIP) and also the Federation of Muslim Women Association of Nigeria (FOMWAN), are examples of this model. Most of the participants in the programs being implemented by AHIP and FOMWAN are young women. Other examples seen on the field include Youth Environment Development Association (YEDA) and Adolescent and Youth Development Initiative (AYDI) – both of which are based in Kano and are involved in income-generating activities. YEDA is also involved in conditional cash transfer while AYDI is involved in micro-credit schemes, among others. Both of them have large male youth participants.
Key target groups: These are often older adolescents and young people, and females are more targeted than men. It is particularly a strategic program for reaching married adolescent females.

Strengths:
- These programs address economic and livelihood issues, which are major developmental challenges of young people in Nigeria, alongside the issue of ASRH information and skills.
- They are responsive to the needs of special groups such as married adolescent girls

Challenges:
- They are cost-intensive and the resources needed are not limited to that of training; they also require “post-graduation” support, especially work equipment, to achieve the desired outcome for the young people.

IEC integrated with health services
These are services that involve both IEC and service delivery. They are often implemented within the context of youth-friendly health services or strongly linked to such initiatives.

Program examples: Organizations with such programs include Action Health Incorporated (AHI), Lagos, Association for Reproductive and Family Health (ARFH), Ibadan, and Planned Parenthood Federation of Nigeria (PPFN), Calabar.

Key target groups: While the services target all adolescents, older adolescents and males are likely to use the services more.

Strengths:
- In view of their linkage with health services delivery, they have potential for increased utilization, and facilitate the access of many young people to various adolescent-targeted services

Challenges:
- Considering that this type of service incorporates several health services units and involves various kinds of staff, including health professionals, the start-up cost can be quite high.

Mass Media/ICT
Programs in this category include entertain-educative programs on electronic media such as television and radio. Many of these are not adolescent-specific, but targets broader reproductive age groups; yet, they have rich adolescent-related contents particularly relating to HIV and sexual behavior. Many of such enter-educative programs also have a large adolescent following. The use of information and communication technologies, particularly the phone, is growing particularly among urban-based adolescents. Behavior change messages are now being disseminated through phones.

Program examples: Society for Family Health has and is currently implementing behavior-change related mass media program. The organization also implemented a nation-wide “Zip Up”
adolescent-focused sexual abstinence multi-media intervention some years back. One World is implementing a computer-based FLHE program with Education against AIDS (EVA) and a number of other indigenous NGOs. The *Ku Saurara* program implemented in Northern Nigeria, which has media-based and community-dialogue components, is a promising type of this model.

**Key target groups:** Young people of all ages; available technology would determine what would reach certain group best.

**Strengths:**
- Mass media programs can reach a large population of young people of all ages.
- Electronic media-based programs can be strategic in reaching out-of-school and rural-based adolescents. Computer- and telephone-based programs can be useful for urban-based young people and can promote learning through enjoyable activities.

**Challenges:**
- While these types of programs have rich potentials to improve information and attitudes, their impact on skills and behavior may be very variable and limited.
- Cost of implementing them is high.