

# Knowledge Brief

*Health, Nutrition and Population Global Practice*

## ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN NIGER

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### KEY MESSAGES:

- Poverty affects adolescents in various ways: limited school enrollment, family work, violence, disempowerment and gender inequalities.
- The median age for first marriage is 15.7 years for women and 24.2 years for men and sexual debut correlates with age of marriage for girls at 15.9 years.
- Education and place of residence have significant impact on whether or not a girl has sex before age 18.
- The median age for childbearing is 18.5 years among young women. But a quarter of them already had their first child at the age of 16. Early childbearing is more frequent among the poor and the rural.
- There is limited use of Sexual and Reproductive Health services including Family Planning (FP) (7 percent) among adolescents.
- There is strong cultural opposition toward use of FP, especially for unmarried girls and at early stage of marriage.

### INTRODUCTION

Today's adolescents and youth face substantial physical, social and economic barriers to meeting their Sexual and Reproductive Health (SRH) potential. Implicit to meeting these needs are human rights; gender equity and equality; and the provision of healthcare. In fact, despite international support for adolescent and youth SRH and rights (for example, the 1994 International Conference on Population in Development), young people consistently face high levels of unmet need for contraception, unplanned pregnancies, unsafe abortions, sexually transmitted infections (STIs), and maternal mortality and morbidity. For example, at the global level, adolescent females 10 to 14 years of age are twice as likely to die in childbirth as adult women, and half of all new HIV infections occur in young people between 15 and 24 years of age (Pathfinder International, 2011).

SRH is a right for everyone, including young people. In fact, adolescents and youth are better able to protect themselves against STIs, unplanned pregnancies, and take advantage of educational and other opportunities when they have access to private and confidential SRH

services. Meeting their SRH needs and rights are therefore important to their health, development, and future opportunities.

In Africa, Niger presents worrying characteristics for youth SRH. Niger has the highest fertility rate in the region and the world, as well as lowest age for marriage and childbearing. Early marriage and childbearing have been identified as key contributors to high fertility and maternal mortality in the region (PRB 2011). In Niger, adolescent fertility is high affecting not only young women and their children's health but also their long-term education and employment prospects (WHO 2011, World Bank 2001).

To understand how countries are addressing adolescent sexual and reproductive health and rights (SRHR), the World Bank conducted a quantitative and qualitative study in several countries with a high adolescent's SRH burden including Niger. The specific objectives of the study were to: (i) Investigate adolescent's socio-economic profile; (ii) Analyse adolescent's sexual and reproductive health status and its determinants from a demand and supply-side perspective; (iii) Assess effectiveness of existing adolescent friendly initiatives and programs; and (iv) Recommend a set of policy options to improve access and

use of services for adolescents in Niger. This Knowledge brief provides a brief background on adolescent SRH in Niger and summarizes the results of this study

Figure 1: Trends in total fertility rate in Niger and the sub-region (1990-2013)

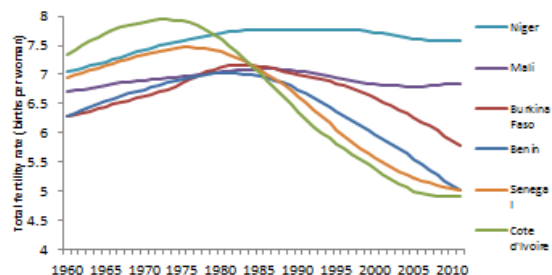
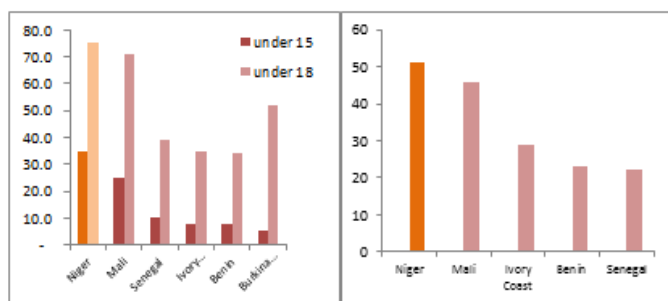


Figure 2: Share of married women under 15 and 18 (left); and share of women who gave birth before 18 (right), in Niger and the sub-region



## SOCIO-ECONOMIC PROFILE OF ADOLESCENTS IN NIGER

The Republic of Niger is a landlocked sub-Saharan African country, where more than half of the population lives below the poverty line. Niger has the highest fertility rate in the region and the world, estimated at 7.6 children per woman in 2012 (8.1 in rural areas). At current rates, the population will double in the next 15 years. While half of the population is under 15 years of age, adolescents represent nearly a quarter of the population.

Poverty affects adolescents in various ways. They mostly live in rural areas (80 percent). Access to education is limited. Only 4 percent of women 15-19 years of age and 7 percent of men of the same age have completed primary school. The vast majority of adolescents work. Some 74 percent of young boys (12-14 years old) and over 80 percent of young girls (same age) declare working in the family's business or on family land. Cultural and social norms tend to disempower adolescents. In Niger, even though a child is seen as a blessing for the family, and he/she is considered to be worthy of investment to prepare for the future, a vast hierarchical structure is in place to ensure that young people obey their elders, thus restricting their ability to express themselves and make decisions within their family and community. Violence against

adolescents is frequent and largely sexual. A 2011 UNFPA /OXFAM study showed that 30 percent of the surveyed adolescents aged 15-18 were victims of sexual violence.

Women in Niger are disadvantaged from a young age. More than 90 percent of female's experience genital cutting and arranged marriage is common. After marriage, women go to live with their husband's family, where men have legally recognized authority over them and where mothers-in law have strong intra-familial influence. The female face of poverty also highlights issues of gender inequality. In Niger, this inequality is reflected in per capita consumption which is 45 percent lower in households headed by women (2008), access to credit (17.5 percent of demand met as against 27.4 percent for men in 2008), and employment opportunities (27.4 percent access for 51.1 percent of the workforce). The low level of women's participation in decision-making at the family, community, administrative and economic levels is a major socio-economic constraint.

## ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN NIGER

The median age for first marriage is 15.7 for women and 24.2 for men. About 61 percent of females aged 15 to 19 are already married compared to 2.6 percent of men of the same age group. Early marriage for girls is socially valued. Sexual debut correlates with age of marriage for girls (15.9). Young women become sexually active much earlier than men, since according to 24.5 percent (73.9 percent) of those aged 15 to 24, they had their first sexual encounter before the age of 15 (18), compared to only 1.1 percent (10.9 percent) for men of the same age group. A girl's education and place of residence have significant impact on whether or not she has sex before age 18. In particular, each additional year of education reduces the likelihood of sex before age 18 by 4.5 percent, and rural residence can increase the likelihood by 18 percent.

Early marriage and childbearing greatly affect maternal and child health. Maternal mortality accounts for 35 percent of all deaths occurring among women aged 15 to 19. Births to women aged 15-19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother. There is also evidence that elective abortion presents a high risk of mortality for the young mother.

The median age for childbearing is 18.5 among young women. But a quarter of them already have had their first child at the age of 16. Early child bearing is more frequent among the poor and in rural areas. Almost 70 percent of the poorest women 20-24 years old have had a child before age 18, compared to 41 percent of their richer counterparts. Similarly, while more than 80 percent of the rural women in the same age group already had a child, half of the urban women did not.

Even though female adolescents lack awareness of their reproductive cycle and fertile period, their knowledge of modern family planning methods is surprisingly good and has improved over time. In 2012, an estimated 73 percent of female adolescents had fair knowledge of contraception methods. Furthermore, knowledge appears to be accumulating with age. More than 80 percent of women above 18 years old are aware of modern family planning methods. Qualitative information reveals however that youth may lack precise knowledge about the exact role, utility and prescription of contraception.

Utilization of SRH services including FP is limited among adolescents. Overall, some 16.4 percent of women aged 15 to 19 did not receive any ante-natal care during their pregnancy. Although female adolescents aged 15 to 19 visit antenatal care clinics, they do not deliver in formal health facilities. Indeed, 63.4 percent deliver somewhere other than a health center, without health care professionals, often at home. Place of residence is the variable that most affects where female adolescents give birth. In urban areas, only 18.2 percent of female adolescents aged 15 to 19 gave birth most recently outside of a health facility, without medical assistance, compared to 68 percent in rural areas. Even when young women under the age of 19 are aware of modern family planning methods (see section 2.2), they rarely use it. Some 93 percent of women aged 15-19, who are currently married, do not use any form of contraception.

The main obstacles to accessing sexual and reproductive health services for women aged 15 to 19 have to do with financial and geographical barriers. Money is cited in the majority of cases (52.3 percent), while distance and transport constitute the two other main barriers (for 38.7 percent and 38.3 percent of the surveyed female adolescents respectively). It is worth noting that in over 20 percent of the cases young women needed approval from parents, husbands/partner or other relatives to seek healthcare. Adolescents are reluctant to use formal care services. Location, purpose, utility are generally ignored among adolescents. Self-medication and traditional medicine are the first care seeking behaviors when needs emerge among unmarried adolescents. Low quality sexual and reproductive health services are also a major obstacle from the supply-side, as well as lack of adolescent-friendly approaches within public facilities. A Gender and Health Survey conducted in 2013 showed that the behavior of health workers toward adolescents constituted a barrier to accessing SRH services. Additionally, adolescents cited strong cultural and social opposition in Niger as reasons for not using FP services. Overall, nearly half of the women surveyed in the 15 to 19 age group (42.6 percent) cited "opposition" as the main reason for not-using modern contraception methods (DHS 2006). Opposition tends to pertain to both social and religious values against FP and misperceptions of FP commodities for medical reasons.

However, the opposition of the women and their husbands was the main reason for their non-use of services (28.9 percent), while the perception of negative effects on health did not seem to dominate their opposition (8.9 percent). Utilization of modern FP services is misperceived and generally not understood by male spouses, especially during the early stage of marriage.

## NATIONAL POLICIES AND PROGRAMS ON ASRH

Adolescent-friendly policies have been increasingly mainstreamed in national strategies for poverty reduction, health, education and jobs. For example, the 2011 National Strategy for Economic and Social Development aims by 2024 to "ensure that the youth are contribute to the country's sustainable development." Four main pillars of the strategy directly refer to adolescents and their role in economic progress: (i) control of the demographic pressure through increased use of family planning services; (ii) integration of the youth in economic life through inclusive growth, better involvement in decision-making and professional skills development; (iii) improvement of SR health for the youth through free provision and community-based distribution of FP commodities; and (iv) reduction of gender-based inequalities, with a particular focus on education and jobs. However, much remains to be done to enhance national ability to effectively mainstreaming adolescent SRH issues across programs. A review of the implementation of the strategy shows little progress toward adolescent-specific outputs.

The emerging sexual and reproductive health agenda has relatively favored the inclusion of youth issues in the policy formulation process in Niger. The adoption of the Reproductive Health law in 2006 marked a milestone in acknowledging sexual and reproductive health rights, especially for young women, as a top priority for government action. It particularly recognized right to access adequate care and prevention services for pregnant (and in childbearing age) women. The Family Planning Action Plan (2012-2020) also made room for adolescent specific issues. A specific National Plan for Adolescent Sexual and Reproductive Health was adopted in 2011 in Niger. Niger was one of the pioneer countries for introducing such strategic guidance for the sector in the sub- region. The Action Plans relies on four strategic pillars: (1) improve access to information responsive to needs; (2) improve adolescents and youth access to, and use of health services; (3) promote an environment supportive of adolescent and youth health; and (4) improve management of operations targeting adolescents.

Government interventions have mostly focused on strengthening the supply of adolescent health and wellbeing services. Interventions on the demand-side have been scarce. Efforts to increase national capacity to provide user friendly SR services for adolescents shall be

pursued. Some 48 health centers (8 for each province) are now adolescent-friendly, with staff trained on adolescent specific health issues and provision of adequate services and commodities. Specific guidelines have been developed with the support of development partners, mainly WHO and UNFPA, to define standards and norms for adolescent-friendly services, and train health personnel accordingly. Training has reached over half of the health personnel in the country. In their medical practices, provider behaviors remain, however, largely influenced by cultural and religious norms that condemn sexual intercourse before marriage for females. Government's interventions have often been implemented in silos with little coordination developed between the education, health and jobs sectors. Strategic linkages and partnerships between schools, health facilities and youth centers need to be reinforced to allow better dissemination of SR health awareness among adolescents.

Demand-generating actions have been developed at small scale and are largely under-funded. Life skills development, peer education and behavior change activities are the three main interventions under implementation on the demand-side to generate greater demand for ASRH services. While interventions aim to improve knowledge and practices towards SR services, they also tend to contribute to enhancing the empowerment of adolescents within the Nigerien society. Peer education activities have been practiced by a number of youth-oriented organizations, but scaling-up needs to be further encouraged. Such activities are generally practiced on a voluntary basis and many peer-based interventions remain on the informal side. The turnover of peer educators is high, as they move on to study or get involved in income-generating activities. Since peer educators work as unpaid volunteers, their commitment is limited. Furthermore, peer education remains largely under-supervised and would require further supervision and guidance to be effective on a larger scale. Behavior change communication programs have been implemented with relatively good results at a small scale with support from development partners. The scaling-up of those pilot activities coupled with mass media communication campaigns would help to reach a larger audience.

## MAIN RECOMMENDATIONS

- **Mainstreaming ASRH in national programs:**
  - ✓ Inclusion of youth and adolescents issues in all health policies and programs.

- ✓ Scaling-up of adolescent-friendly training to all health cadres.
- ✓ Inclusion of adolescent-related monitoring indicators in health facility supervision guidance.
- ✓ Tailored approaches to engage with traditional leaders.
- ✓ Mobilization of school teachers to actively relay information on SR and FP to the youth in the community.
- ✓ Decentralized authorities are better involved in ASRH.

- **Prioritizing demand-side interventions:**

- ✓ Scale-up financially sustainable Demand-side interventions.
- ✓ Dissemination of results to policy-makers.
- ✓ Demand-side initiatives based on best practices and tailored approaches for the Nigerien socio-cultural context.
- ✓ Community-based interventions that include community dialogue with traditional leaders.

- **Empowering the youth:**

- ✓ Adolescents' views to be integrated in the design of future adolescent-related strategies and interventions.
- ✓ Youth centers to be upgraded, better equipped and staffed throughout the territory.
- ✓ Youth to be engaged in community relays/peers identification.
- ✓ Life skills, capacity development programs are scaled-up.
- ✓ Professional training opportunities to be offered to adolescents.
- ✓ Future research and programmatic efforts need to address gender norms and consider the influence of other family members, such as mothers-in-law.

- **Designing and implementing multi-sectoral interventions:**

- ✓ Better coordinated and integrated initiatives for youth to be implemented across education, health and job sectors.
- ✓ Flagship initiatives to be developed jointly between MoH, Ministry of Youth and Labor.
- ✓ Schools and health facilities to partner for joint health education sessions, especially in rural areas.
- ✓ Community peer educators to be trained in multi-sectoral approaches.

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*This HNP Knowledge Brief highlights the key findings from a study by the World Bank titled "Addressing Adolescent Sexual and Reproductive Health in Niger: A Policy Note" (2015), prepared by a WBG team including, Barroy H., Lejean N., Wang H; and R. Cortez (World Bank's Team Lead). This study was part of the Bank's Economic Sector Work "Paving the Path to Adolescent Sexual and Reproductive Health" conducted by the Health Nutrition and Population Global Practice and financed by the World Bank-Netherlands Partnership Program (BNPP).*

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