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ADOLESCENT FERTILITY AND SEXUAL HEALTH IN NIGERIA

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WORLD BANK GROUP
Health, Nutrition & Population

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Health, Nutrition and Population (HNP) Discussion Paper

Adolescent Fertility and Sexual and Reproductive Health in Nigeria: *Determinants and Implications*

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Abstract: This study examines the determinants of adolescent sexual behavior and fertility in Nigeria, with a special focus on knowledge, attitudes and behaviors of adolescents aged 10-19 years old in Karu Local Government Authority (LGA), a peri-urban area near the capital city of Abuja. Using the last three waves of Demographic and Health Surveys (2003, 2008, 2013), focus group discussions, stakeholder interviews, and a specialized survey of 643 girls and boys aged 10-19 years old in Karu LGA, the study narrows in on key challenges to and opportunities for improving adolescent sexual and reproductive health outcomes.

The national median age at sexual debut for adolescent girls and boys is between 15 and 16 years of age. This is closely emulated in Karu LGA with a median age of 14.8 years for girls and 15.3 years for boys. While data on pregnancies was limited in the Karu sample, DHS data show that for girls, sexual debut is closely associated with marriage or cohabitation, which in turn is a strong predictor of adolescent fertility. Poverty is another strong predictor, with the odds of becoming pregnant being twice as high for adolescents in the lower wealth quintiles compared to their counterparts in the richest quintile in the country. While adolescents' knowledge of contraception has increased from under 10 percent to over 30 percent, use of health services among adolescents for SRH (and contraception) is limited due to factors such as fear of stigma, embarrassment, and poor access to services, something also emphasized in focus group discussions.

Challenges for improving adolescent SRH outcomes relate to: (i) the paucity of data, especially on the 10-14 year olds; (ii) availability and access to youth-friendly services and the Family Life and HIV Education (FLHE); (iii) reaching out-of-school adolescents with SRH information; and (iv) addressing ambiguities and gaps in Federal law and customs on age at marriage, and generating support for the legal age at marriage of at least 18 years old. Addressing these barriers at the State and sub-regional levels is going to be critical in improving adolescent well-being.

Keywords: Adolescents, girls, boys, sexual and reproductive health (SRH), knowledge, attitudes, sexual debut, marriage, fertility, pregnancy, contraception, use of services, sexually transmitted infections (STIs), HIV/AIDS.

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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PREFACE

Adolescents around the world face tremendous challenges to meeting their sexual and reproductive health (SRH) needs. Inadequate access to health information and services, poverty, inequitable 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 implications on their health and welfare as well as that of their off-spring. For example, an unwanted teenage pregnancy can not only limit the life chances of the adolescent, but also those of her child. In comparison to children and adults, adolescent health needs pose unique challenges to the health care system. For instance, an adolescent may feel uncomfortable talking about body changes, if at all, to a complete stranger, or in front of her/his parent. Adolescents may want to use contraception, but a service provider may not provide these without parental consent; or because of personal bias. The hours of service provision or location may not be user-friendly for someone between the ages of 10-19 years, or of a particular gender. These issues have implications for inclusive growth and shared prosperity.

This study was conducted as part of the Economic and Sector Work (ESW) on adolescent sexual and reproductive health (ASRH) titled "*Paving the Path to Improved Adolescent Sexual and Reproductive Health*", and aimed to gain a deeper understanding of the adolescent sexual behavior and fertility and its policy implications. The scope of the study was developed and conducted in collaboration with the country health team, and was designed as a knowledge and learning exercise looking at this very specific population of adolescents and/or youth between the ages of 10 and 19 years (with two distinct brackets of 10-14 and 15-19), to understand the challenges adolescents face, how these are being addressed, what gaps exists, and how can these be filled.

In recent years, universal health coverage (UHC) has gained momentum, with the World Health Assembly and the United Nations General Assembly calling on countries to "urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services." The UHC framework provides an opportunity for renewed attention to meeting the health needs of adolescents through a package of health services that includes appropriate interventions, provision of youth-friendly services and promotes improved information systems that also include data collection on adolescents. There is strong potential for applying the knowledge and lessons learnt from this study and the broader ESW into operations, building on this knowledge to fill existing gaps and address broader socio-economic issues that affect adolescent health and well-being.

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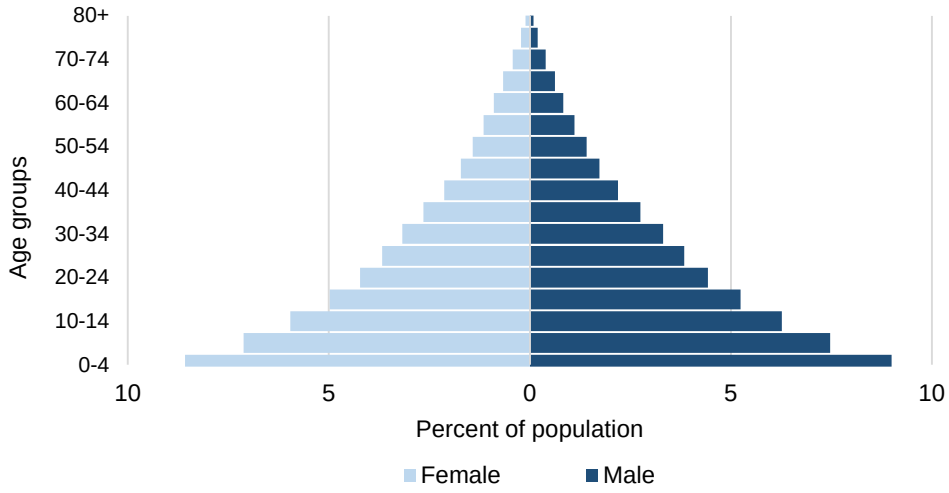
I. OVERVIEW

1. INTRODUCTION

1. **Nigeria is the most populous country in sub-Saharan Africa with a population of over 178 million. It also has a very young population.** The majority of the population (63.3 percent) is below the age of 25 years, and 22.5 percent of the country's population between the ages of 10-19 years. Figure 1 shows the current age structure of the country.

Figure 1. Nigeria: Age Structure (2014)



Source: World Development Indicators

2. **Nigeria is a lower middle income country with a GDP (nominal) per capita of US$ 3,148- in 2014, but with regional disparities**. Poverty has been relatively high with just under half the population (46 percent) living below the national poverty line. In 2010, 68 percent of the population subsisted on less than US $1.25 (PPP) per day. Recent data based on a partial reassessment of poverty suggest that poverty is much lower however, at 33.1 percent below the national poverty line in 2012/13, but due to population growth, the absolute number of people living in poverty remained unchanged at 58 million between 2010/11 and 2012/13 (World Bank 2014).

3. **Economic and social disparities separate the South and the North of the country.**[1] Poverty estimates highlight the huge gaps within Nigeria – with only 16 percent of the population living in poverty in the South West compared to 50 percent in the North East. Data also show that while poverty has been declining in the Southern areas and North Central, it has in fact increased in the North East and remains stagnant in the North West (World Bank 2014). This divide between the South and the North is much deeper and complex, with ethnic and religious differences contributing to pre-existing social fracture. The majority of the population in the Northern regions is Muslim and in the Southern areas it is Christian. The North East and West suffer from volatility

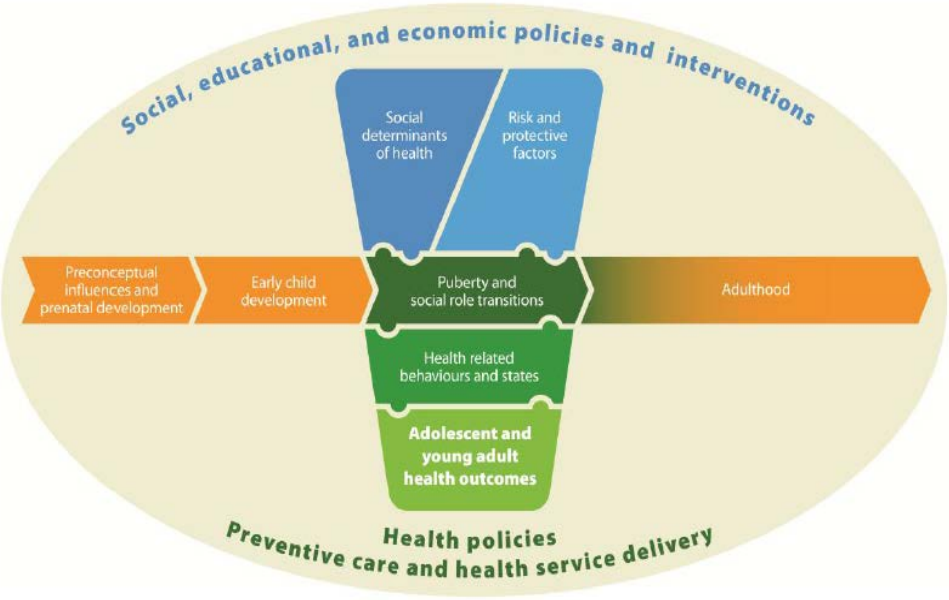
[1] Nigeria is divided into 6 main regions: South-South, South East South West, North Central (where Abuja, the capital city is located), North West and North East

created by religious extremism in recent years, and finds its roots in inequity and political instability (LeVan 2013, Danjibo 2009). Beyond this, with over 10 distinct ethnic groups, sectarian tensions and violence also scar the country (for example, Wee 2006; Nnonyelu 2013; Ogunlesi 2015).

4. **While secondary school enrolment is 54 percent, many adolescents, especially girls, drop out of school early**. Evidence indicates that 45 percent of girls and 31 percent of boys drop out at the secondary level (UNICEF 2013; Population Council 2010). This is associated with multiple factors such as poverty, absence of support systems, poor opportunities, and early marriage, especially for girls (Group 2010; Izugbara 2015; Ogunlesi et al. 2013; Viner et al. 2012). Consequently, adolescents who drop out of school are more prone to risky behaviors, including risky sexual behavior, violence, and drug use (Ajaja 2012; Gasper 2011).

5. **As Figure 2 highlights, along with health policies and service delivery, socio-economic and environmental factors affect adolescent health and development** (Sawyer et al 2012; Patton and Sawyer 2014; Viner et al. 2012). Adolescence is a time of transition. During this critical and vulnerable time of biological, physical, psychological change, youth face new challenges – initiating sexual activity, entering the age of risk-taking, entering into unions and making decisions on family formation that affect future health and opportunities (WDR 2007, WDR 2012). Key investments in health (including sexual and reproductive health), education, and economic opportunities for this cohort are important to ensure that they have the best possible life chances to fully develop their human capital potential.

Figure 2: Conceptual Framework for Adolescent Health



Source: Patton and Sawyer 2014.

6. **The Government of Nigeria has long recognized the importance of investing in its youth, including its health.** Investing in the human capital of its youth, including their health, is important for boosting Nigeria's long-term prosperity. This includes a focus on adolescent sexual and reproductive health (ASRH), as evidenced through government policies and programs. Key among these are National Reproductive Health Policy and Strategy (2001), National Policy on Health and Development of Adolescents and Young People in Nigeria (2007), and the Family Life and HIV Education (FLHE) Program.

7. **This study examines determinants of adolescent sexual behavior and fertility in Nigeria**, with a narrower focus on knowledge, attitudes and behaviors of adolescents aged 10-19 years old in Karu Local Government Authority (LGA), a peri-urban area near the capital city of Abuja. It is part of a larger study on the country that examines the determinants of ASRH, barriers to, and opportunities for addressing ASRH and aims to achieve a better understanding of the current status of ASRH outcomes and main issues in the country.

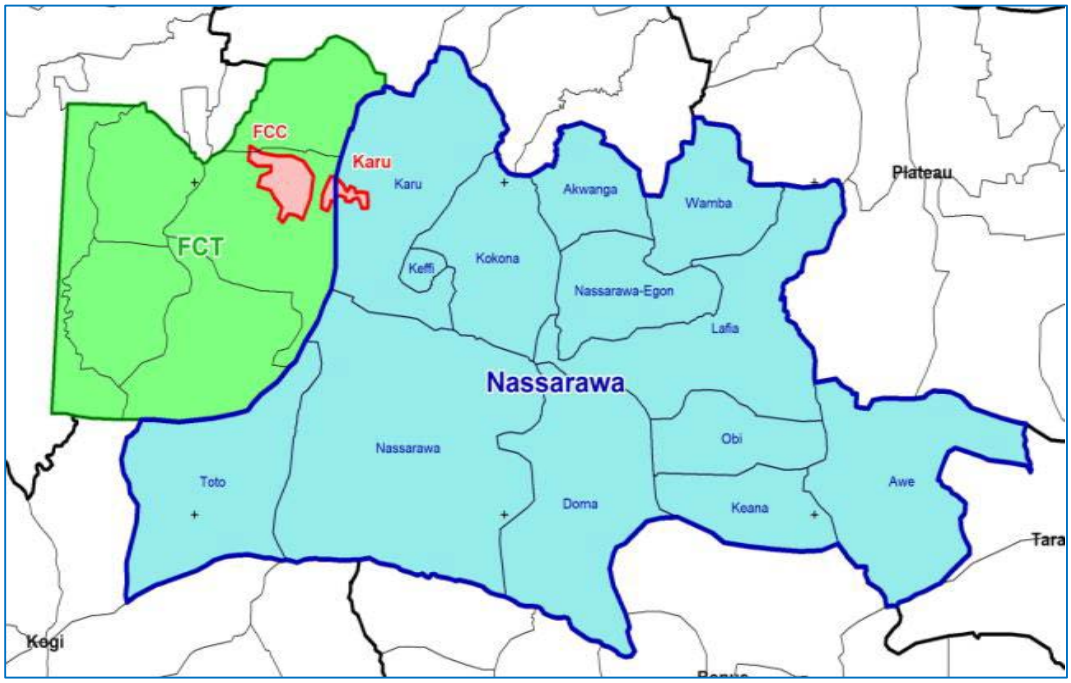
8. This study is divided into 4 parts and six sections. Part 1 provides the context of the study, the study methods, an overview of adolescent sexual and reproductive health in Nigeria in comparison to its neighbors, and the emerging themes of a literature review. Part 2 presents the main findings of the study. Part 3 highlights key policies and programs related to adolescent sexual and reproductive health in Nigeria. Part 4 presents conclusions and recommendations based on the findings of the paper.

2. STUDY METHODS

9. **This study employs mixed methods to examine ASRH outcomes in Nigeria.** It uses data from the last three Demographic and Health Surveys (2003, 2008, and 2013) to map out major trends in the country focusing on adolescent girls and conduct multivariate analysis to identify key determinants of adolescent contraceptive use and pregnancies. The study further examines knowledge, attitudes, and perceptions about SRH and SRH services among adolescent girls and boys in Karu LGA using quantitative and qualitative methods. Karu is one of 13 Local Government Areas (LGA) in Nigeria's Nasarawa State and has an estimated combined population of 216,230 people (Figure 3). Twenty percent of the population is young people aged 10-19 years. It is located close to the Federal Capital Territory (FCT) of Abuja, and its urban areas constitute one of Abuja's satellite towns. Karu LGA presents a melting pot of local and internal migrant populations comprised of different religious and ethnic groups.

10. **In Karu LGA, survey data was collected on adolescents aged 10-19 years old.** A sample of 643 adolescents, both girls and boys, was used covering urban and rural areas. The survey instrument was adapted from "*Asking Young People about Sexual and Reproductive Behaviours: Illustrative Core Instruments*" by Cleland et al. (2001), and covered sexual behavior, relationships, sexual and reproductive health knowledge, sources of information, availability and accessibility of reproductive health services, and reproductive health outcomes. Data was collected between July 30, 2014 and August 20, 2014 (for details see Annexes 1 and 3).

Figure 3: Map illustrating Karu's location



Source: Health and Development Africa (Mott MacDonald)

11. **The survey was augmented with seven focus group discussions (FGD) to delve deeper into perceptions and attitudes.** FGDs were conducted with adolescents, organized by gender and age groups, parents, teachers, and health service providers to gain insights into attitudes and behaviors (Table 3). Additional information on the focus group discussion is presented in Annex 2 and Annex 4.

Table 3: Matrix of focus groups

Adolescents		Community members	Health sector
Girls	Boys		
10 – 14 year olds	10 – 14 year olds	Parents	Doctors, Nurses, Patent medicine providers
15 – 19 year olds	15 – 19 year olds	Teachers	

12. The survey and FGDs in Karu LGA were especially useful in capturing the knowledge, and perceptions of the population in the 10-14 year age bracket.

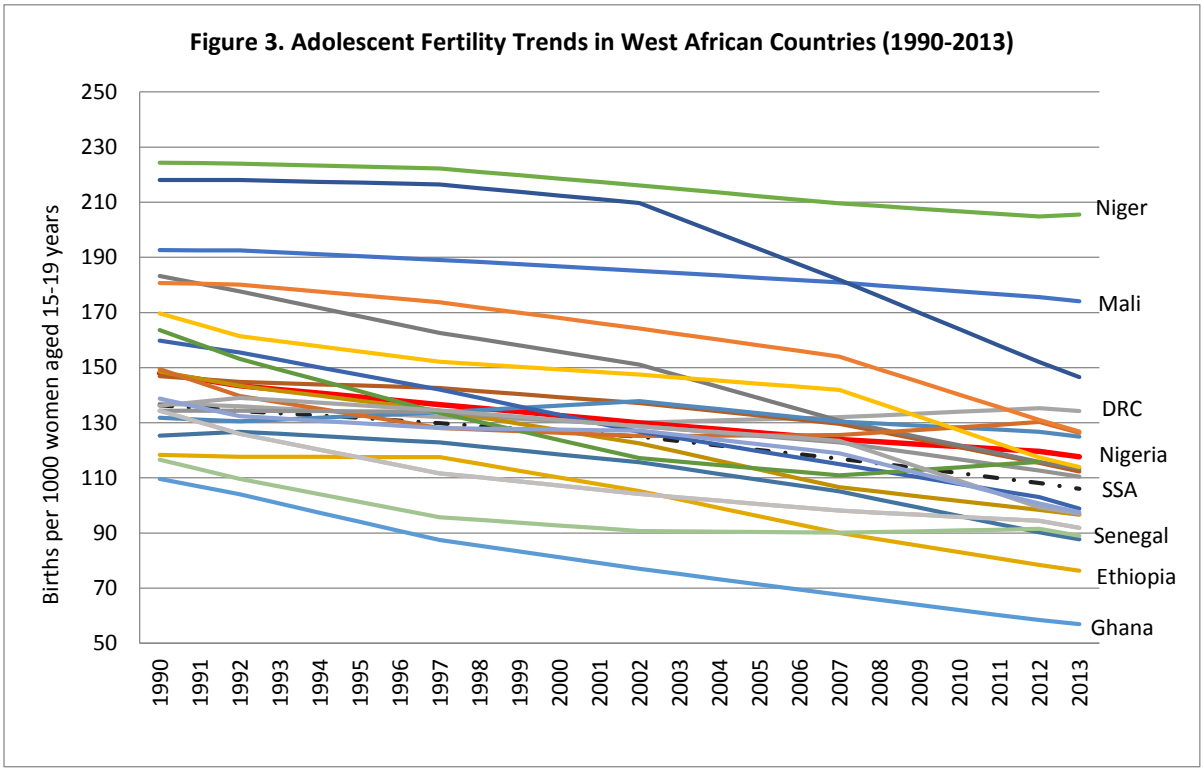
13. **The study was complemented by a comprehensive literature review and policy mapping on ASRH.** The literature review draws on peer reviewed journal articles, relevant reports and studies, and white papers covering the period 1980 to 2013 that are available in the public realm. The policy mapping is likewise based on a review of documents, websites, and stakeholder interviews and discussions held during February 2014 with representatives of the government, partner organizations, and civil society.

2. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN NIGERIA

14. **At 576 maternal deaths per 100,000 live births, Nigeria accounts for roughly 14 percent of the global burden of maternal mortality** (DHS 2013/WHO 2014). Global evidence shows that young girls bear a high burden of maternal mortality and morbidity. Data on sexual and reproductive health (SRH) outcomes in Nigeria highlight the importance of focusing on adolescents - just over 30 percent of deaths among female adolescents aged 15-19 years old are related to pregnancy and child birth (DHS 2013).

15. **Nigeria's adolescent fertility remains higher than the regional average.** The national adolescent fertility rate in Nigeria was 118 births per 1,000 women aged 15–19 years in 2013 compared to 106 births for the region. The rate of decline in Nigeria's adolescent fertility is lower than the regional average. This is associated with higher adolescent fertility in the North Western States of Nigeria, where it is as high as 171 births per 1000 women aged 15-19 years. Only a handful of countries in Sub-Saharan Africa have higher adolescent fertility (Figure 3).

Figure 3. Adolescent Fertility Trends in West African Countries (1990-2013)



Source: World Development Indicators

16. **Early sexual debut and marriage are closely associated with high adolescent fertility.** Although the age at marriage among 20–49 year old women is about 18 years, the average age at sexual debut is roughly 15 years of age among adolescent girls in Nigeria. Data show that among 15-19 year olds, 22.9 percent are already mothers or are pregnant with their first child (DHS 2003, 2008, 2013), with little change over time.

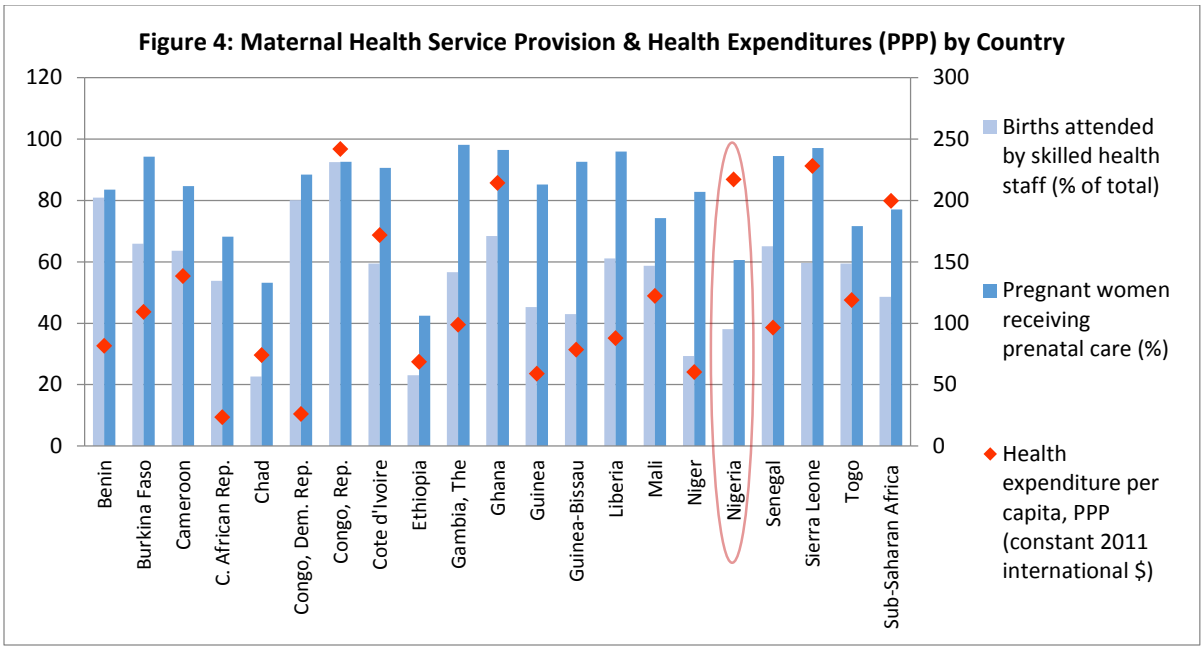
17. **These problems are compounded among the poor**. While reductions in early childbearing have taken place among the rich, it still remains high among the poor – almost 60 percent of the poorest 20–24 years old women have had a child before reaching 18, compared to only 10 percent of their richer counterparts. The differences are especially stark in urban areas. In 2008, 23 percent of poor urban adolescent females were pregnant or mothers compared to 4 percent of their richer counterparts.

Table 1: Nigeria - Reproductive Health Overview

Reproductive Health Indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births)	576
Births attended by skilled health personnel (percent)	38.1
Contraceptive Prevalence Rate (percent)	15.1
Adolescent Fertility Rate (births per 1,000 women ages 15–19) 2013	118
Antenatal care with health personnel (percent)	60.6
Unmet need for family planning (percent)	16.1
Median age at first marriage (women aged 20-49 years) 2013	18.3
Median age at first birth (women aged 20-49 years) 2013	23.5
Teenage pregnancies (percent of women 15-19 who are mothers or are pregnant with their first child)	22.5

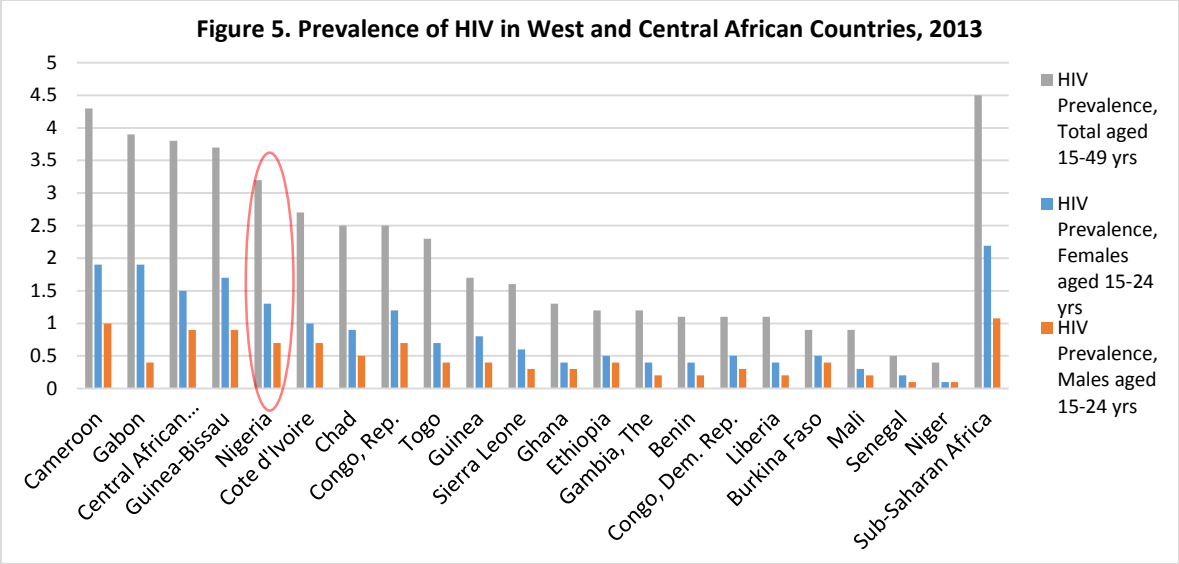
Source: World Development Indicators (latest available year); DHS 2013

18. **Uneven access to and use of maternal health services is one of the main obstacles to improving maternal health outcomes.** Despite high levels of health expenditure per capita, Nigeria has one of the lowest rates of ANC and skilled birth attendance among West and Central African countries, surpassing only Niger, Chad, and Ethiopia (Figure 4). While nationally, use of ante-natal care (ANC) is relatively high at 60 percent, only 38 percent of births in the country are attended by skilled health personnel (Table 1). Part of this low utilization is related to the significant differences across Nigeria's regions in access to and use of services. In the Southern regions, over 70 percent of pregnant women receive ANC and skilled birth attendance compared to only 24.7 percent receiving ANC and 9 percent receiving skilled attendance at birth in the North East (Adamu 2011). This is also likely indicative of income inequalities with the rich disproportionately using maternal health services (Kruk et al 2008; Anwar et al. 2008).



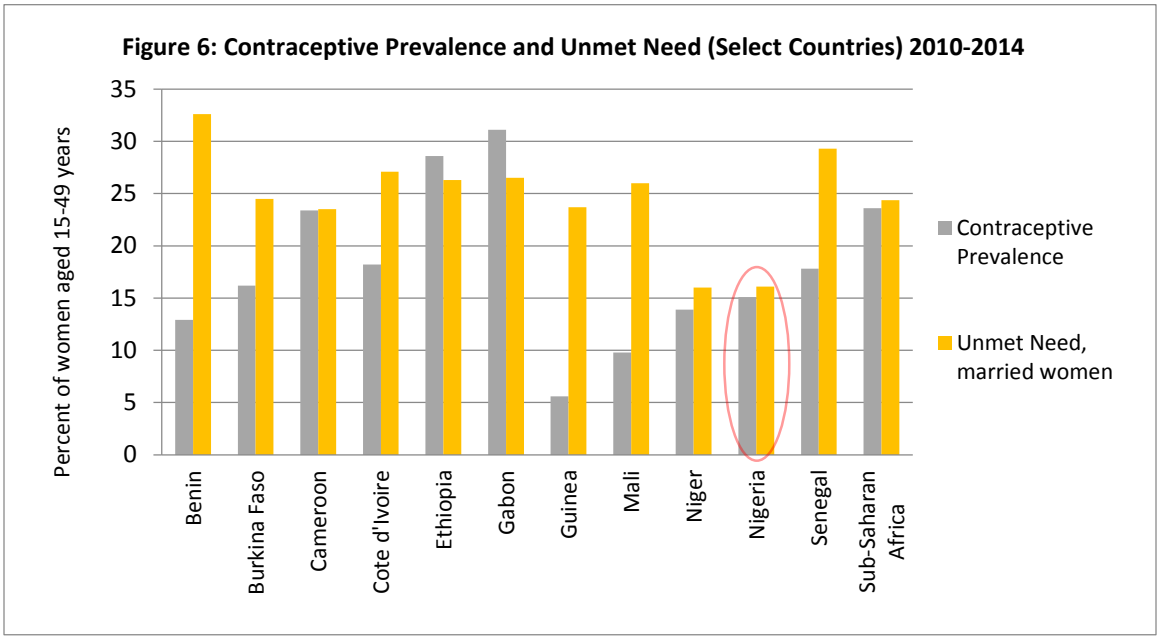
Source: World Development Indicators

19. **It is estimated that 2.6 million people in Nigeria are infected with HIV and a large knowledge-behavior gap exists, especially among adolescents.** Although at 3.1 percent, the prevalence rate of HIV in the population aged 15–49 years is much lower than that of South Africa (13 percent) and the regional average for Sub-Saharan Africa (Figure 5), it is still a serious concern due to the country's large population. It is also more prevalent among young women than men. HIV prevalence among women 15-24 years old is estimated at 1.3 percent compared to 0.7 percent for men of similar age (UNAIDS 2013). Of concern is a large knowledge-behavior gap regarding condom use for HIV prevention. While about 50 percent of young women are aware that using a condom in every intercourse prevents HIV, only 7 percent of them report having used a condom at their last intercourse.



Source: World Development Indicators

20. **At 15 percent, the contraceptive prevalence rate in Nigeria is also among the lowest among neighboring countries. It also has one of the lowest levels of unmet need for contraception** (Figure 6). Low contraception prevalence contributes to the high fertility rate, which has remained steady at 5.7 births per woman for the past decade. Poor knowledge and misinformation about modern contraception contribute to the rate of use and demand (Ankomah et al. 2013).

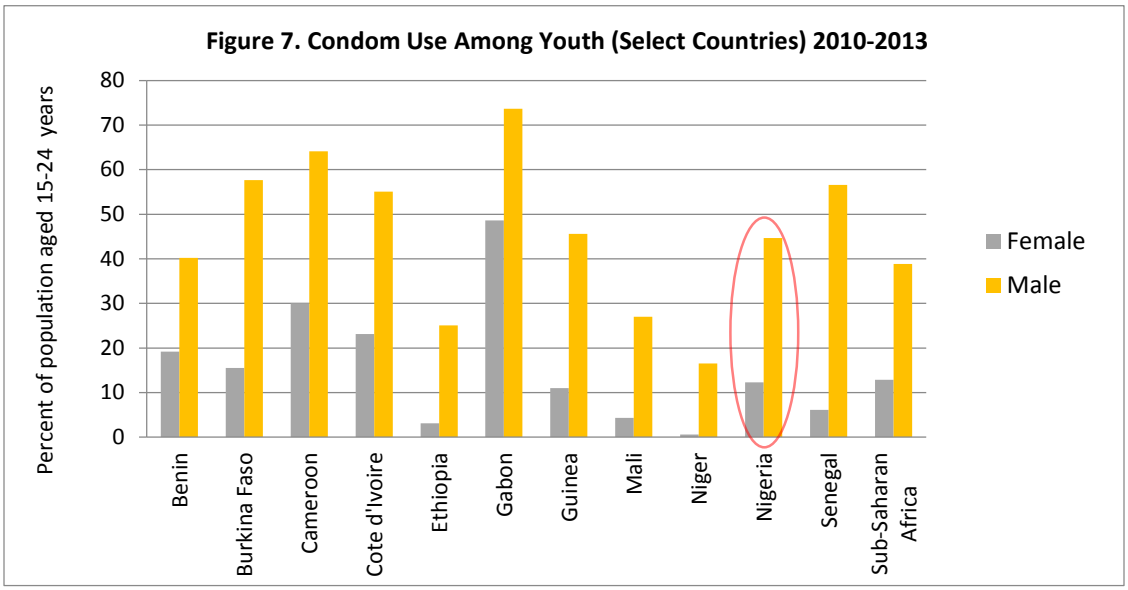


Source: World Development Indicators

21. **Over the past decade there has been an increase in contraceptive knowledge – but it is likely driven by an increase in focus on HIV/AIDS and familiarity with condoms**. Several

studies suggest that knowledge about HIV/AIDS is higher than other SRH issues (Boriri et al. 2008; Oladepo and Fayemi 2011; Sangowawa and Adebiyi 2013). However, results are somewhat mixed on the depth of knowledge and on how to protect oneself against HIV/AIDS. Wagbatsoma and Okojie (2006) for example, find that while awareness about HIV/AIDS is high (99 percent), few know about the causes (15 percent, n=852). Region and other socio-economic characteristics may be playing a role. Ikechebelu et al (2008) sampled 148 young female street hawkers in two urban settlements in Anambra State, and found that 54 percent were aware of the risk of contracting HIV/AIDS from unprotected sex. In another study of urban slum dwellers around Ibadan, the authors also found that most young people had heard of HIV/AIDS (Adedemji et al. 2007). Results from a larger scale study in Ibadan (n=786) show that at 80 percent, knowledge about condoms as protective against HIV/AIDS is high (Adedimeji et al. 2008).

22. **Among adolescents, access to contraception and the stigma attached to its use are some of the main barriers.** Female adolescents and young women are less likely than males to initiate discussion or demand use of contraception. Concerns about infertility, death, being seen as promiscuous, or upsetting their partners prevent young women from using or demanding use of modern contraceptives (Ankomah et al. 2013; Amoran 2012; Adedemeji et al. 2007). As Figure 5 highlights, there is a stark gap between condom use among sexually active female and male youth in Nigeria - 12.3 percent females compared to 44.7 percent males use condoms. This difference is in keeping with the pattern of use among neighboring countries and the Sub-Saharan African region.



Source: World Development Indicators

3. MAIN THEMES EMERGING FROM THE LITERATURE REVIEW

23. A review of literature focusing on adolescents highlights the key challenges in improving their sexual and reproductive health outcomes. These are briefly discussed here.

24. **The age at sexual debut is early and sexual activity among adolescents is common.** Studies that focus on the 10-19 year old in-school group report a median age of 14 to 16 years for both boys and girls (Murray et al. 2006; Wagbatsoma & Okojie et al. 2006; Fatusi & Blum 2008; Olugbenga-Bello et al. 2009; Owoaje & Uchendu 2009). Studies suggest levels of sexual activity ranging from 20 to 35 percent of the sampled population (Asubiaro and Fatusi 2014; Asekun-Olarinmoye et al. 2011; Eke and Alabi-Isam 2011; Oyediran et al. 2011; Fatusi and Blum 2008; Wagbatsoma et al. 2006). There is variation in outcomes depending on the region and the socio-economic characteristics associated with those regions. For example, in Niger State (in the North West) nearly 80 percent of girls (n=896) have had their sexual debut by age 16, with 14 percent having experienced first sex between ages 9 and 12 (Sunmola et al. 2002). Another study of 1246 adolescents in secondary schools in Jos which is located in the North Central region, found that the median age at sexual debut was 14 years, and more rural than urban students were sexually active. Another study covering two Southern LGAs – Ugep in Cross River State, and Badeku and Olunloyo in Oyo State – found that more than 1 in 5 adolescents had had sex before age 16 years (Isiugo-Abanihe et al. 2012). Focus group discussions and in-depth interviews as part of the study also reveal that young people felt that the age of sexual debut had decreased and both girls and boys were initiating sex sooner and were more likely to have multiple partners. Asubiaro and Fatusi (2014) also state similar results in their study of 1249 in-school students, ages 10-19 years, in Lagos State (Southern Nigeria), with the average age at first sex being around 14 years for boys and 15 years for girls.

25. **Poor economic conditions create opportunities for sexual exploitation of the financially vulnerable.** Young girls from low income groups, for example, may exchange sexual favors for goods and services or money putting them at higher risk for not only pregnancies, but also sexually transmitted diseases (Amoran 2012, Ochiogu et al. 2010, Ilika et al. 2006). For example, one recent study in the Southern State of Anambra found that financial need and peer pressure are among leading reasons for pre-marital sex and unwanted pregnancies (Ochiogu et al. 2010). The authors surveyed 1,234 secondary school students and 46 teachers on sexual and reproductive health education and teen pregnancies. They found that 27 percent of the teachers and 44 percent of the students listing financial need as the main reason for pre-marital sexual encounters. Other reasons cited by teachers included marital promise or peer pressure to get married (25 percent), lack of religious commitment, and family instability (17 percent), ignorance (9 percent), and sexual abuse or rape (7 percent). Responses from the students on the other hand suggested a more even breakdown among these other reasons for a teen pregnancy: According to students in the sample, marital promise or peer pressure to get married (17 percent), ignorance (16 percent), sexual abuse/rape (11 percent), and others including lack of religious commitment, and family instability (12 percent) were the other main reasons (Ochiogu et al. 2010).

26. **In the more conservative North, early sexual debut is also linked to early marriages** (Asad 2009; Amoran 2012; Melvin and Uzoma 2012). Adebowale et al. (2008), using DHS data, confirm that the age at marriage in the North and among Muslims is higher than in the South and among Christians. The study finds that the average age at marriage for Muslims was 16 years compared to 20 years for Christians. While there was a relatively small gap in number of Muslim and Christian girls were being married between the ages of 15-19 years (46 percent vs 39.5

percent), there were significantly more marriages among Muslim girls under age 15 years (39.5 percent) compared to Christian girls (11.9 percent).

27. **Out of school youth tend to be more sexually active** (Nichols et al 1986; Makinwa-Adebusoye 1992; Sangowawa et al. 2013). Sangowawa et al. (2013) found that 70% of out of school girls (n=146), aged 15-24 years were sexually active in Ilero, a semi-rural town in South western Oyo State in Nigeria. Owoaje and Uchendu (2009) report that nearly 80 percent of youth (n=818) in their study of two LGAs in Ibadan were sexually active –with 83 percent male and 71 percent females reporting sexual activity. Another study, which draws on the 2003 DHS found that 25 percent of the young never-married male respondents aged 15-19 years and 62 percent of their older peers aged 20-24 years had ever had sex (Oyediran et al. 2011).

28. **Age at marriage for women has been increasing, but very slowly.** Under the Child Rights Act of 2003, the legal age for marriage in Nigeria is 18 years. However, under parallel systems – customary and Islamic – that also operate in the country, marriage can take place at earlier ages. Due to this, there is limited enforcement of the law, and most women still get married in their teenage years. 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.

29. **Early age at sexual debut and early marriage expose girls to a higher risk of early pregnancy.** This is linked to poverty, early marriage, or other vulnerable situations such as being from broken homes or living on the streets (Olley 2006; Okoro and Obozokhai 2006; Owoaje and Uchendu 2009). Girls who are out of school, or have had little or no education are also more likely to experience a teen pregnancy (Sunmola et al. 2002; Okonofua 1994; Obono et al. 2010).

30. **A high proportion of teen pregnancies appear to be unwanted,** especially in the case of unmarried teenagers. A study in Sagumu LGA (Ogun State) in Nigeria surveyed 225 pregnant girls aged 14-40 years. Study finds that 22.9 percent of the pregnancies were of teenagers and among them over 48.2 percent were unwanted, compared to 13.6 percent unwanted pregnancies in the older age group (Amoran 2012).

31. **Unwanted pregnancies also lead to high rates of unsafe abortions.** While nationally representative data is unavailable, studies suggest high prevalence of unsafe abortions among adolescents. In one study, for example, 30 percent of girls in the sample (n=450) admitted that they had been pregnant in the past, and all pregnancies were terminated (Owolabi et al 2005). Okereke (2010) reports a 20 percent abortion rate among pregnant teens in Owerri (n=540 of which 30 percent became pregnant), with over a third of these being recurrent abortions. In Ilorin, all pregnant girls reported terminating the pregnancy (28 percent of n=521) – (Aderibigbe et al. 2011). Earlier studies also point to a high incidence of abortion among teens, suggesting little change in behaviors over time with roughly between 20-25 percent pregnant girls reporting an abortion (Brabin et al.

1995; Odujinrin et al. 1991), earlier study at a hospital in Benin City found that adolescents accounted for 60.8 percent of all induced abortions (Omu et al. 1981). Studies also report familiar reasons for inducing abortion including fear of violence and stigma, having to drop out of school and reduced life opportunities (Otoid et al. 2001; Oye-Adeniran 2004).

32. **Early and unwanted pregnancies reduce girls' opportunities and put girls at risk of abuse and stigma.** For instance, Ilika and Igwebe (2006) find that 97 percent of the girls in their sample (n=136) had experience violence, with 57 percent having suffered from physical violence at having become pregnant. Okereke (2010) finds that among pregnant teens who aborted a pregnancy, fear of parental disapproval and humiliation (45.4%) was the leading concern, followed by lack of established paternity of the fetus (25.3 percent), pregnancy hindering the prospects of a future marriage (13.8 percent); and expulsion from school (12.5 percent). Another very small qualitative study on adolescent mothers in Ile-Ife (Osun State, n=30) provides insights into the quality of life of teenage mothers (Box 1). The study found that most of the girls felt stigmatized – having to drop out of school, and losing support from family and friends(Melvin and Uzoma 2012).

33. **Education, especially secondary education for girls, can be a protective factor against early marriage and pregnancy.** Education brings with it the promise of a better life through employment opportunities for both men and women; and it affords the opportunity for marrying some equally or more highly educated and with greater economic prospects. Recent evidence from Nigeria also shows that women with higher education are more likely to marry later in life than those without an education – the average age at marriage for women with no education is 15.7 years compared to 23.6 years for those with secondary or higher levels of education (Adebowale et al. 2012). Similar results have also been found in earlier studies as well (Isiugo-Abanihe 1994; Orubuloye 1998; Agha 2009). Some studies also find that religiosity is a protective factor against pre-marital sex among students (Asubiaro and Fatusi 2014; Oladepo and Fayemi 2011; Abdulkarim et al. 2003). Agha (2009) also finds that living in a conservative environment affects behavior too. His study finds that in the conservative Muslim North, there is also less incidence of pre-marital sex among the Christian population.

Box 1: Not much changes in the cradle of human creation

Ile-Ife is an ancient town in the South-western State of Osun in Nigeria. In the Yoruba tradition, it is a holy city and the cradle of all human life. Several small scale studies provide an insight into the life at Ile-Ife, including sexual and reproductive health. While these are very small, qualitative studies, together they highlight the slow pace of change in the past two decades. While this box focuses on Ile-Ife, the broad lessons also hold for Nigeria overall.

A 1989 small scale study (n=48) in Ile-Ife of pregnant adolescents reported that all pregnancies were unplanned, regardless of marital status. The study found that the majority of the girls (60 percent) did not have access to contraceptive information (Alade 1989). Another, more recent study of adolescent mothers (n=30) found similar outcomes – with at least half the pregnancies being unplanned and unwanted (Melvin and Uzoma 2012). Both studies indicate that majority of the girls did not return or plan to return to school after the birth of their babies and most relied on their mothers for support. The Melvin and Uzoma (2012) study also found that most of the girls felt stigmatized – having to drop out of school, and losing support from family and friends. Many of the girls felt that they did not have either finances or know-how to care for the baby, especially in the case of an illness, and there weren't enough resources for them, even when they had family support.

On the other side of the story are boys. A 1993 study of in-school boys aged 15-19 in the city revealed that over 79 percent were sexually active and had multiple partners. Use of condoms was also low since many believed that is was only useful for preventing pregnancies (Jinadu and Odesanmi 1993). The Alade (1989)

study also found that contraceptive knowledge among adolescents was low. A more recent study, on the eve of the introduction of Family Life Health Education also highlighted that most students, teachers, and parents, (n=1000) at least in this city, held positive attitudes towards sex education (Orji et al 2003).

More recently, a larger study in the area (n=392) found that health services were not always available to adolescents. The study, which focuses on in-school girls and boys, found that even when health services may be available through the school, the quality of service provision is an issue with inadequate staffing, unavailability of drugs, and/or unfriendly staff in at least half of the reported student encounters with health services (Loto et al. 2004).

While this handful of studies cannot be used to generalize over the whole country or even a particular region, they highlight some of the common issues faced by adolescents in Nigeria in relation to sexual and reproductive health.

34. **Poor knowledge and misinformation about sexual and reproductive health and contraception keeps its use at low levels.** Adolescents may not always be accurately informed. While knowledge of HIV/AIDS, fertility, and contraception in general has increased, misconceptions persist (Nwaorgu et al. 2008, 2009; Amoran 2012). For example, Nwaorgu et al (2008) find that 51 percent of junior secondary students in Enugu State (n=412) did not know that girls can get pregnant at first sexual intercourse, and 33 percent thought that washing the vagina after sex would prevent a pregnancy. Makinwa-Adebusoye (1992) found that sexually active adolescents (n=5599) were more knowledgeable about SRH than those who were not active; and about 60 percent of girls and 57 percent of boys were aware of any contraceptive methods. Oladosu (1992-93) also finds similar results (n=1678) using 1990 DHS data. Amazigo et al. (1997) found that only 36 percent of the students had correct information about pregnancy, and that girls were more knowledgeable than boys (n=2460). In his study, Amoran (2012) finds that nearly all (99.2 percent) respondents reported using a condom during risky sexual intercourse, 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 correctly use a condom.

35. **Parent-child communication is one of the main sources of reproductive health related information in Nigeria, however incomplete that information may be** (Oladepo and Brieger 1996; Nwalo and Anasi 2012; Iliyasu et al 2012). Asekun-Olarinmoye et al. (2011) find that 85 percent of the adolescent respondents in their sample of 342 in-school adolescents, aged 10-19 in an LGA in Osun State had first received SRH education from their parents, and that the majority focused on abstinence with about half discussing other methods such as condoms, and pills. The Nwalo and Anasi (2012) study of female senior secondary school students (n=1800) in Lagos city found that “the most accessible sources of reproductive health information mentioned by the students were parents, textbooks, television, siblings, radio, friends, school teachers, music and songs” – in that order. Other studies such as Ijatuyi (2005), Mabawonku (1998) and Bammeke and Nnorom (2006) provide further evidence of the importance of parents as the first source of information.

36. **Several studies also confirm the central role peers play as a source of sexual and reproductive health information**. Onyeonoro et al. (2011) find that the most common first sources of information on sex were peers (76.3 percent) followed by the media (69.0 percent) among girls, ages 10-18, in the Osisioma LGA in south western Nigeria (n=304). Rani, Figueroa and Ainsle (2003), Mohammadi et al (2006) and Odusanya and Bankole (2006) report similar findings. Adeokun et al. (2009) find that students in co-ed schools are better informed than those not in co-

ed schools, and that peers are a main source of information in their study of 4 North-Eastern Nigerian states - Bauchi, Borno, Gombe and Yobe. Okanlawon. Asuzu (2011) also find a positive effect of peer education on SRH knowledge. The authors conducted a quasi-experimental study with 519 participants, and a 6 month intervention in 2 LGAs in Oyo State. The findings highlight the potential of peer education in improving access to accurate information about SRH. Van der Maas and Otte (2009) find similar outcomes in their study in a north eastern rural part of Ebonyi State – those who received peer education have better knowledge and lesser misconceptions compared to those who did not receive it.

37. **Evidence seems to suggest that knowledge about HIV/AIDS is higher than other SRH issues** (Boriri et al. 2008; Oladepo and Fayemi 2011; Sangowawa and Adebiyi 2013). This is reasonable since HIV prevention has been a major focus of the federal government and efforts to prevent spread of HIV/AIDS have been ongoing for over a decade. However, the results are somewhat mixed on the depth of knowledge and on how to protect oneself against HIV/AIDS. Wagbatsoma and Okojie (2006) found that while awareness about HIV/AIDS was high (99 percent), few knew about the causes (15 percent). Region and other socio-economic characteristics may be playing a role. For example, results from a larger scale study in Ibadan (n=786) show that knowledge about condoms as protective against HIV/AIDS was high at 80 percent of the sample (Adedimeji et al. 2008). In another study of urban slum dwellers around Ibabdan, the authors also found that most young people had heard of HIV/AIDS (Adedemji et al. 2007). Ikechebelu et al (2008) sampled 148 young female street hawkers in two urban settlements in Anambra State, and found that 54 percent were aware of the risk of contracting HIV/AIDS from unprotected sex.

38. **Beyond knowledge, adolescent use of services is a key issue in Nigeria.** Several studies highlight the low usage of contraceptives among adolescents and youth (Okonofua et al. 2004; Olaseha et al. 2004; Bassey et al 2005; Adedimeji et al. 2007). Okpani and Okpani (2000) report a 30 percent use of contraceptives among adolescent girls (ages 14-21) in Port Harcourt. Sunmola et al (2002) report similar numbers (35 percent) in their study of young people (ages 11-25) in Niger State. Other studies report even lower levels. In Calabar, only 6 percent adolescents (n=888) between the ages of 13 and 18 years reported using contraception (Etuk et al. 2004). Oye-Adeniran et al. (2005) found an 11 percent rate of contraceptive use among adolescents in 4 health zones in Oyo, Anambra, Kaduna, and Bauchi States. On the other hand, at 62 percent, Adebowale et al. (2013) report a higher use of condoms among males 15 to 24 years old using 2008 DHS data, but they also point out that men over 20 were twice as likely to use a condom compared to younger men.

39. **Even when services are available, adolescents may not use them.** Okekere (2010), for instance, finds that in his sample of 836 adolescents in Owerri city (Imo State), 73.4 percent confirmed the availability of reproductive health center(s) within their residential neighborhood, but only 21.5 percent were willing to purchase the contraceptives offered at these centers. He suggests that this is a function of poor communication and cost of services among a population that is generally illiterate and poor. Suleiman (2011) examines access to maternal and child health services for young mothers using DHS 2008 data. He finds that adolescent women were less likely than older women to receive ante-natal, post-natal care and skilled birth attendance. Data reveal that the majority (85 percent) of women under age 20 years in the Northern regions and 56 percent in the South delivered at home. Overall, about 25 percent of women under age 20 used skilled

attendants at birth in the country, and about 32 percent received post-natal care within 42 days of birth (Rai et al. 2012). Owolabi et al (2005) on the other hand found that girls were more confident than boys that they could seek contraceptives and contraceptive advice from a health facility, shop or a friend. Adekunle et al. (2000) report how biases among health workers also contribute to the poor access to family planning services. In their survey of 735 health workers, the authors find that those who approved of family planning were 12 times more likely to approve of adolescent contraception than those who were not in favor of it and this is linked to their treatment of adolescents – while 59 percent of the health workers reported seeing an adolescent seeking SRH care, only 31 percent had prescribed contraceptives.

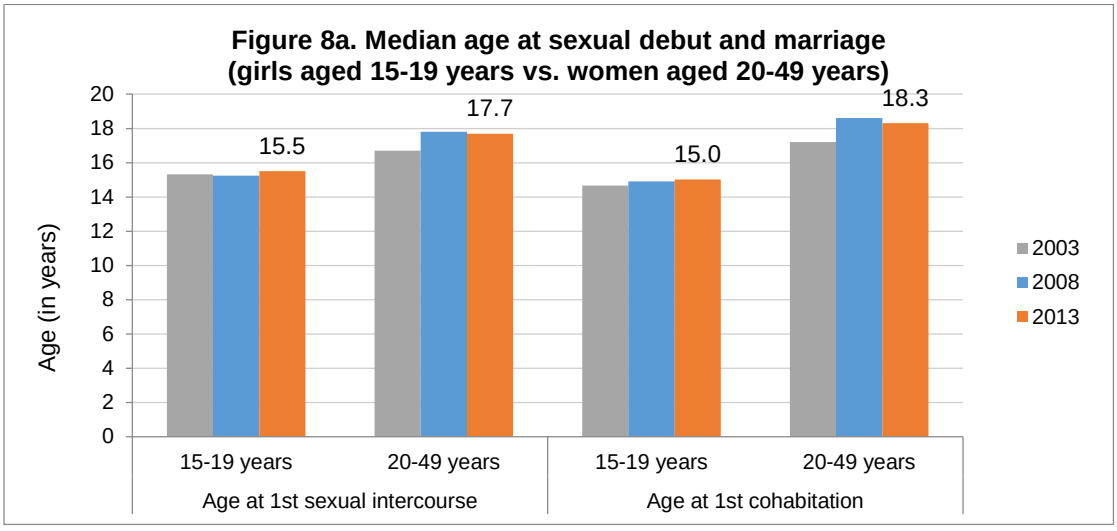
40. **Low usage is linked to several issues including convenience of access to services and fear of stigma.** Slum dwellers in Ibadan (n=1042) mention shyness, concern about self-image and stigma, as well as perceived lack of trust by a partner as the reason why they do not bring up use of condoms for example (Adedimeji et al. 2007). Another study of teen mothers highlights the preference for emergency contraception over condoms because this was easier to access compared to condoms, which they would also have to negotiate a price for. In other words, buying emergency contraception is more discreet and there is less danger of being discovered by parents (Ilika and Igwegbe 2006). Temin et al (1999), in a series of focus groups in Benin City found that traditional healers are the most popular source of healthcare among adolescents with symptoms of sexually transmitted infections (STIs) followed by patent medicine dealers, private doctors and hospitals. Oye-Adeniran et al. (2005) also find that most respondents (19.7 percent) turned to chemists or patent medicine shops for contraceptive needs, but their decision also depends on the type of contraceptives they choose to use. For example, those who used injectables were more likely to go to family planning clinics while those preferring intra-uterine devices (IUDs) were turning to clinics. However this needs to be further explored as few studies look in depth into why and how these choices are made.

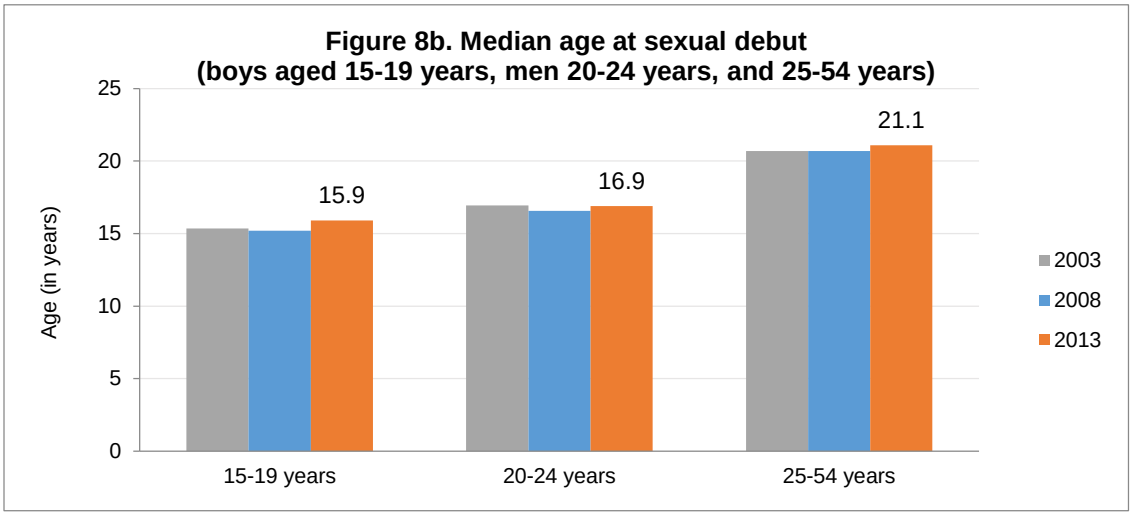
II. STUDY FINDINGS

41. The following section focuses on the results of the study itself. It presents the nationally representative findings from an analysis of DHS data for 2003, 2008, and 2013, and the results of the knowledge, attitudes, and perspectives survey in Karu LGA.

1. AGE AT SEXUAL DEBUT AND MARRIAGE

42. **As the literature indicates, early sexual debut is a concern in Nigeria, especially among girls.** While the median age at sexual debut for women aged 20-49 years in Nigeria is about 17.7 years, among adolescent girls (age 15 -19 years), it is lower, with a median age of 15.1 years. Data also suggest that co-habitation or marriage happens around the same time as the first experience with intercourse for the 15-19 years age group (Figure 8a). On the other hand, the median age at first sexual intercourse for boys aged 15-19 years, is slightly higher at 16 years (Figure 8b). As of 2013, only 4.2 percent reported being sexually active by age 15 and 22.2 percent by age 18 (DHS 2003, 2008, 2013).





Source: DHS 2003, 2008, 2013.

43. **The age at sexual debut also shows some variation across regions.** In rural areas, for example the reported age at first intercourse is 16.7, compared to 19.3 for urban areas. Similarly, in the North East and North West regions, the median age at first sex is 15.7 and 15.4 years respectively, compared to 16.7 years in the South West (DHS 2013). Interestingly, the tendency for early sexual debut is reversed for men. It is higher in the Northern areas compared to the South - the median age at sexual debut is 21 years and 24 years for the North East and North West respectively, whereas it is around 19-20 years of age in the Southern areas. This is likely related to the sexual and reproductive behaviors in the North and South. Whereas in the South first sexual encounters may be more likely to be outside of marriage, in the North, greater religious conservatism may be confining sexual encounters to marital relationships, in which case it is likely than men will be older than the women since they are expected to be gainfully employed by the time they are married.

44. **In Karu LGA about 25 percent of adolescents sampled were sexually active**, with the median age at 14.8 (SD=1.8) years for girls and 15.3 (SD=1.6) years for boys aged 10-19 years (Figure 9). It is 15 years for both girls and boys in the 15-19 age group. Karu LGA is located in the North Central region, and the survey suggests a slightly younger age at sexual debut than reported for the region - according to DHS 2013, the median age at sexual debut for girls aged 15-19 years was 16.5 years, and that for boys was about 16.6 years. However, this difference may be due to sample characteristics. The results are however aligned with the overall DHS results.

Figure 1: Age at first sexual encounter

45. **There were proportionately more females than males who had initiated sex in the 10-19 age group** (23 percent compared to 19 percent), although this was not statistically significant. These numbers are driven by the behaviors of adolescents in older age groups. In the 15-19 years age group, 40 percent of girls and 35 percent of were sexually active. In the 10-14 years age group, only 7 percent of girls and 4 percent of boys were sexually active. A very small proportion of the sample (1 percent), were married. However, most participants had had only one partner. About a third of the study participants had been in a heterosexual relationship.

46. **Focus groups conducted in Karu LGA suggest that while adolescents indicate a preference to wait before initiating sex, it may not be the case.** Adolescents thought that they should be allowed to date by the time they are 16 years of age, and majority of boys and girls in the focus groups though one should be at least 18 years old before having sex. However, focus group responses from health care providers suggest that very young adolescents were accessing SRH services because they needed them, supporting the evidence suggesting low ages at sexual debut and pregnancy. As one participant stated,

> *"A lot of them do come (to the health care centers), because in this center we have a case of less than 15 years, she's already a mother; so, many of them will come, and when you run a pregnancy test it will be positive…*" - Health Care Provider.

Another participant highlights the motivations of adolescents,

> *"Some date because of marriage but some because of sex."* - Adolescent female (15-19 years).

47. **Focus groups also highlight the close relationship between marriage and sexual debut for girls.** Marriage in Nigeria is viewed with high regard. Adolescent participants stated that when they date, they are "expecting marriage", and that sex should be preserved for "the time they get married". Parents in focus groups emphasized that sex is only allowed within a marriage and should be discouraged otherwise. Fathers were more agreeable to girls marrying early than mothers in focus groups for the sake of financial stability.

> *"A girl can get married at the age of 19 years and above, no problem but if a girl is not in school and she doesn't want to learn any trade…at the age of 17 and above she can get married."* – Parent (Father).

> *"I will not like it [early marriage] because the girl will still be in school. Even if she wants to marry it should be about 20 – 22 years. Afterwards the girl can still continue if her husband agrees…but 15 – 16 years [is] no good."* – Parent (Mother).

> *"A girl as from 16 years above can marry but a man from 18 years … a girl is more likely to marry early but the man has to be ready because he would be the one to take care of the girl."* – Parent (Father).

> *"Some parent use to force their child to marry a man that they did not love. Some parent want their child to marry a rich man but the woman will not like the man, that is why some parents use to like money even though, like a man brings a girl a man that is poor, the parents will not*

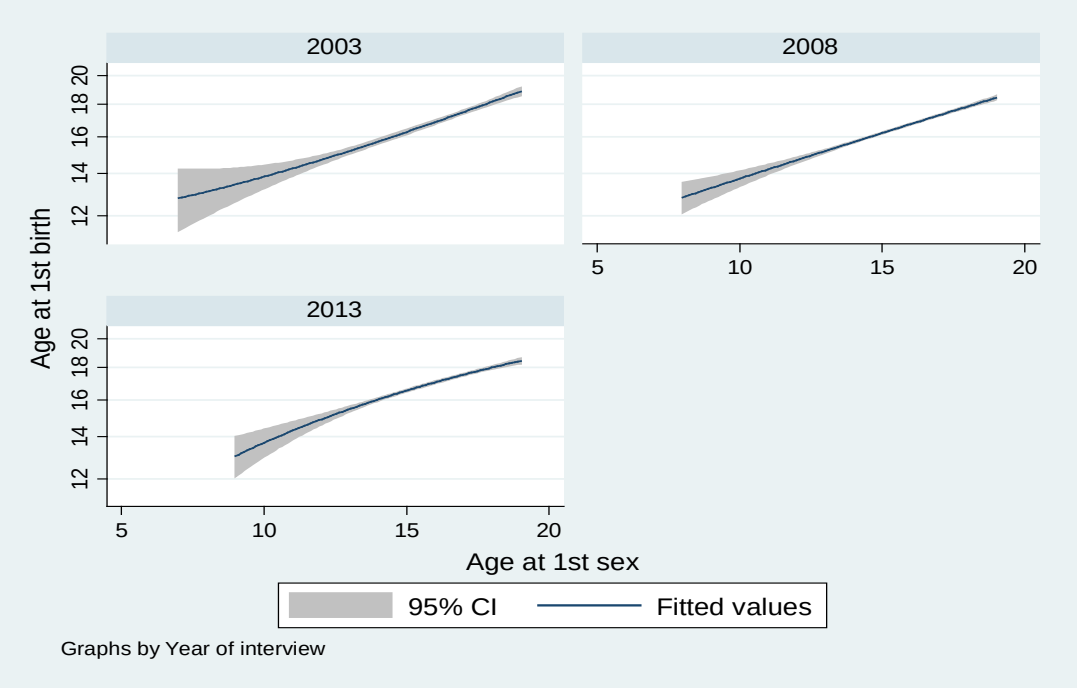
agree that let them marry that man. They only want their child to marry a rich man." - Adolescent female, (10-14 years).

48. **These discussions shed light on expectations of parents and their role in early marriages among girls.** One of the themes that emerged from the parents' feedback is that men take care of the family financially while the women are responsible for bearing and taking care of children, and that marriages are meant for procreation. They shared that girls should be married at a much younger age than boys "because if they get older say up to 40 years they are likely not to get any man to marry them again" and that "girls can be married as young as 16 years but boys have to consider their economic circumstances before marriage as they have to take care of their families". This highlights some of the deep set traditions and beliefs that contribute to the vulnerability of female adolescents in being married early and often to older men.

2. FERTILITY AND PREGNANCY

49. **The adolescent fertility rate in Nigeria is 118 live births per 1,000 women aged 15-19 years.** Nearly 1 in 5 girls in Nigeria between the ages of 15 and 19 years has either given birth, or is pregnant, and as figure 10 highlights this is strongly correlated with sexual debut (r^2=0.61) and has been for the past decade (DHS 2003, 2008, 2013).

Figure 10: Relationship between age at sexual debut and age at birth



50. Data from DHS also reveal that among women whose first pregnancy was in their adolescence, the median age for the pregnancy was between 16.2 and 16.7 years of age (DHS 2013). There is little variation across age cohorts and across the DHS surveys, suggesting that for groups of adolescents that are at high risk of pregnancy little has changed (DHS 2008, DHS 2013). This is in keeping with the findings in literature, and alluded to in the Karu focus groups that certain

populations (such as those with little or no education or from low income households) are more vulnerable to early pregnancies.

51. **In addition to age at sexual debut, adolescent pregnancies are also strongly linked to early marriage.** Multivariate regression analysis of adolescent pregnancies using DHS data shows that being in a union is one of the strongest predictors of pregnancies among adolescent girls (Table 5). Knowledge of contraception and use of contraception are also linked to pregnancy (OR=2.2, SE=0.19; and OR=3.5, SE=0.41 respectively) which may be indicative of use of contraception by sexually active females. As expected, secondary education significantly reduces the odds of adolescent pregnancies (OR=0.67, SE=0.09), while the odds increase by poverty - the odds for becoming pregnant as an adolescent in the poorest household are over 2 times higher than for the richest households. While religion or ethnicity by itself does not appear to be significant, the odds of becoming pregnant in adolescence are significantly higher for Ijaw girls, and may reflect particular social attitudes among this population.

Table 5. Determinants of Adolescent Pregnancies

Variables	Odds Ratio	Std. Err.	P>|t|	[95% Conf. Interval]	
Region	(Reference Category: South West)				
North Central	1.046	0.219	0.829	0.694	1.578
North East	0.833	0.191	0.425	0.532	1.305
North West	0.704	0.160	0.122	0.451	1.099
South East	1.243	0.415	0.514	0.646	2.394
South South	1.248	0.282	0.328	0.801	1.944
Education	(Reference Category: No Education)				
Primary	1.175	0.133	0.153	0.942	1.466
Secondary	**0.671**	**0.085**	**0.002**	**0.524**	**0.860**
Higher	0.386	0.147	0.013	0.183	0.816
Knowledge of contraceptives	**2.237**	**0.190**	**0.000**	**1.894**	**2.641**
Ever use of contraceptives	**3.462**	**0.406**	**0.000**	**2.752**	**4.356**
In a union	**97.85**	**11.88**	**0.000**	**77.11**	**124.15**
Religion	(Reference Category: Others)				
Christianity	1.606	0.650	0.242	0.727	3.550
Islam	0.920	0.365	0.834	0.423	2.003
Traditionalist	1.014	0.429	0.973	0.443	2.325
Wealth Index	(Reference Category: Richest)				
Poorest	**2.334**	**0.359**	**0.000**	**1.725**	**3.156**
Poor	**2.150**	**0.310**	**0.000**	**1.621**	**2.852**
Middle	**2.141**	**0.291**	**0.000**	**1.641**	**2.795**
Richer	**1.660**	**0.219**	**0.000**	**1.281**	**2.152**
Ethnicity	(Reference Category: Others)				
Hausa	0.877	0.135	0.396	0.648	1.187
Igbo	0.585	0.178	0.079	0.321	1.063
Yoruba	0.899	0.184	0.603	0.601	1.344

Ijaw	**1.793**	**0.360**	**0.004**	**1.209**	**2.659**
Fulani	0.790	0.148	0.209	0.547	1.141
Ibibio	1.812	0.437	0.014	1.128	2.909
Kanuri	0.647	0.176	0.110	0.379	1.104
Tiv	0.401	0.150	0.015	0.192	0.836
_cons	0.012	0.005	0.000	0.005	0.029

Source: DHS 2003, 2008, 2013
Notes: (a) The dependent variable is defined as all adolescents who have given birth, are currently pregnant, or have terminated a pregnancy; (b) logistic regression based on pooled data controlled for survey design, year, and sub-population of women aged 15-19 (n=16245)

52. **Data on pregnancies in Karu LGA was limited**, and therefore did not lend itself to multivariate analysis. There were only 17 live births in the 3 years preceding the survey. However, bi-variate analysis indicates that pregnancy was associated with the age of the girl, her marital status, her education level and where she lived (Table 6). Fifty five percent (55 percent) of sexually active girls who lived in tribal settlements reported that they had been pregnant at least once in the past five years. This compared to 20 percent in farming areas and 30 percent in informal urban centers. It is likely that settlement type is a proxy capturing a number of factors such as cultural, religion and system variables.

Table 6: Factors associated with pregnancy among the female survey participants

Factors	Pregnant (n, %)	p-value
Socio-Demographic		
Age Category (years)		
10-14	1 (4.6)	**<0.001**
15-19	32 (45.7)	
Marital Status		
Single	27 (32.1)	**0.016**
Married	6 (75.0)	
Highest Education attained		
None	5 (71.4)	
Primary	8 (21.1)	**0.014**
Secondary	20 (43.5)	
School Enrolment		
At School	17 (65.4)	0.279
Out of School	9 (34.62)	
Settlement Type		
Urban formal	0	
Urban Informal	9 (30.)	0.008
Tribal Settlement	22(55)	
Farming	1 (20)	
Knowledge Questions		
Condoms knowledge		
No	4 (19.1)	0.067
Yes	29 (40.9)	
There is treatment for HIV		
False	3 (20.0)	
True	22 (37.9)	0.426
Don't know	4 (33.3)	
HIV mis-conception: Mosquitos transmit HIV		
False	22 (43.1)	
True	3 (12.5)	**0.027**
Don't know	4 (44.4)	

Stigma: HIV transmitted by sharing food		
False	21 (35.0)	
True	7 (38.9)	0.948
Don't know	2 (33.3)	
HIV testing: There is a Simple Test for HIV		
False	0	
True	22 (32.8)	0.105
Don't know	8 (53.3)	
Pass time activities		
Hang Out		
No	20 (36.4)	0.904
Yes	13 (35.1)	
Consume Alcohol		
No	28 (35.0)	
Yes	5 (41.7)	0.653

53. **As expected, older girls (ages 15-19 years) were more likely to have been pregnant compared to younger girls (ages 10-14 years)** - 46 percent compared to 4.6 percent, respectively. While the numbers are small, 71 percent of adolescent girls who had never been to school had been pregnant in the past 5 years. Yet the numbers are too small to draw any conclusions.

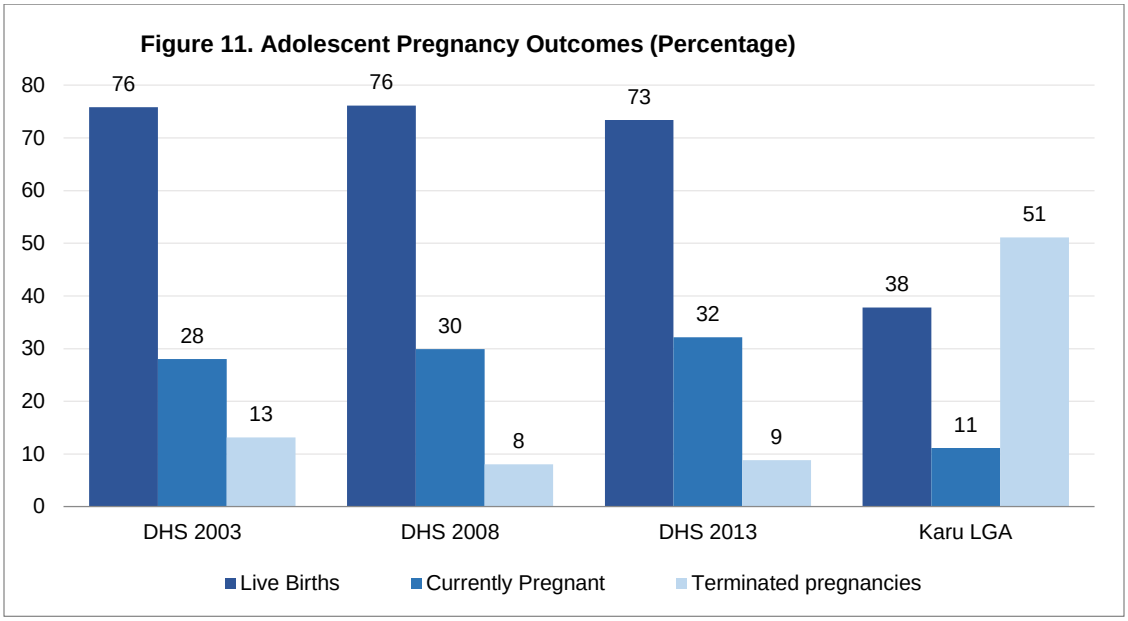
Pregnancy outcomes

54. **Not all pregnancies end in a live birth, especially if they are to very young adolescents.** Figure 11 presents the pregnancy outcomes to adolescents in the three waves of the DHS (2003, 2008, 2013) and Karu LGA. While national data shows that over 70 percent of births to adolescents aged 15-19 years have had live births, there were 8 -13 percent who aborted their pregnancies. On the other hand, the data from Karu LGA suggests a much higher level of abortions. This is likely driven by the small sample size. However, data also reveal that those with most of the abortions were girls with a junior secondary, primary or no education, and mostly among single girls. While data is lacking, the timing of these pregnancies is likely a factor in the high levels of abortions – very early and unwanted, and associated with girls who may have either dropped out of school or never went to school (Analysis of Karu LGA Survey Data 2014).

55. **Unwanted pregnancies also contribute to high rates of unsafe abortions.** While the latest nationally representative data puts abortion rates among adolescents at 9 percent (DHS 2013), as the literature highlights, studies suggest much higher prevalence of unsafe abortions among adolescents, ranging from 20 to 30 percent (Owolabi et al 2005; Okereke 2010; Aderibigbe et al. 2011).

56. **The dangers of early pregnancy are well documented in literature** (World Bank 2010). Loto et al (2004) compared 104 adolescents (under age 20) with 208 mothers aged 23 to 29 years. The study showed that teenagers experienced significantly higher obstetric complication rates compared to their older counterparts, including anemia in pregnancy, preterm delivery, low birth weight and neonatal admission. Ebeigbe and Gharoro (2007) estimated that the maternal mortality ratio for teenagers was 1835 per 100,000 births – more than double the national maternal mortality ratio. The study also found a high rate of caesarian sections among teenagers even though there were no significant difference in complications between these pregnancies and those of older

women. Another study that examined the prevalence rate of under-5 deaths found that 52 percent, the under-5 mortality was significantly more pronounced among younger mothers (under age 20 years) compared to women aged 20-35 years (33 percent) Occurrence of under-5 deaths was also significantly more frequent among women from rural residence, with less education, in those who delivered at home, those who never gave birth with a medical doctor's assistance, among women who never completed vaccination for their children, in those who never attended antenatal clinic and those whose main source of drinking water was well water (Ayotunde et al. 2009).



Source: DHS 2003, 2008, 2013; World Bank 2014. Karu LGA Survey

3. KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH

57. **While there has been an increase in knowledge about sexual and reproductive health and contraception in Nigeria, among adolescents it is still very low.** Knowledge about contraception has increased from under 10 percent to over 40 percent among adolescents aged 15-19 years over the past decade. However, over half the adolescent population still lacks proper knowledge, with more awareness among boys than girls (Figure.12). However, when asked about reproductive health itself, the level of knowledge is much less - less than 2 percent of boys and 6.6 percent of girls, aged 15-19 were able to correctly identify when a female is most likely to get pregnant during the ovulatory cycle (DHS 2013).

58. **Data from Karu LGA highlight the limited levels of SRH knowledge, especially among younger adolescents.** While majority of the respondents (81.6 percent) had heard about HIV/AIDS, only 23 percent knew of any other sexually transmitted infection (STI) for example. Among those who knew of other STIs, only 14 percent were able to identify some of the signs of STIs correctly, and older adolescents were more likely to be better informed that younger ones. In the 15-19 years old age group, there was near universal awareness about HIV/AIDS, with 93 percent of girls and 91 percent of boys stating that they knew about the disease. On the other hand,

76 percent of girls and 68 percent of boys in the 10-14 years old age group knew about HIV/AIDS. Two thirds of the respondents knew that one could easily be tested for HIV, and a similar proportion knew that there was treatment for HIV/AIDs. This is consistent with the emerging evidence in literature that SRH awareness tends to be in the context of the disease.

Knowledge of Contraception

59. **Aligned with the DHS findings, roughly 45 percent of the surveyed adolescents in Karu LGA were aware of contraception**. This is driven by the level of contraceptive knowledge among older adolescents, aged 15-19 years who know at least one or more methods of modern contraception (Figure 13).[2] However, younger adolescents show lower levels of knowledge, especially girls - among the 10-14 year old age group 48 percent of boys and 58 percent of girls had no knowledge of contraceptives.

Figure 12. Nigeria: Contraceptive knowledge, all adolescents (15-19 years)

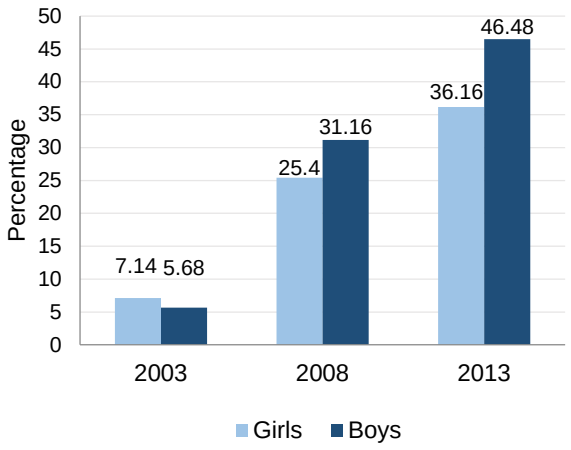
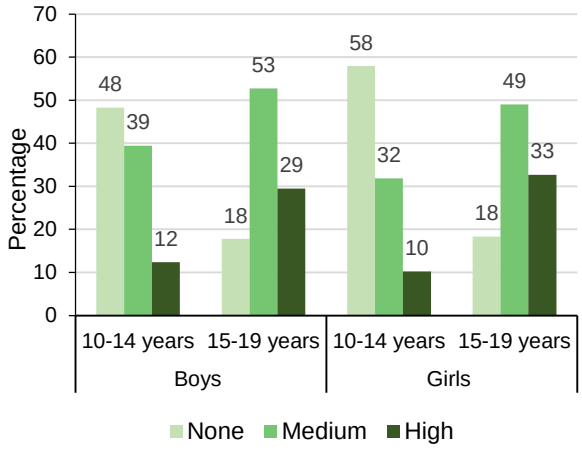


Figure 13. Karu LGA: Contraceptive knowledge among all adolescents (10-19 years)



Source: DHS 2003, 2008, 2013 *Source: World Bank 2014. Karu LGA survey*
Note: DHS data: (a) weighted proportions; (b) all respondents aged 15-19 years.

Determinants of Knowledge of Contraception

60. **Multivariate analysis using DHS data confirms the strong relationship between socio-economic characteristics and knowledge of contraception among adolescents.** The analysis uses data from three rounds of DHS focusing on the sub-population of girls aged 15-19 years. It draws on both married and unmarried adolescent girls in the sample (Table 8). The data highlight the importance of exposure to family planning messaging. Visiting a health facility or being exposed to family planning messaging through audio and visual media are significantly and positively related with knowledge of contraception among adolescents. While being visited by a family planning worker is also significant, the odds are lower compared to other avenues of

[2] The categories are based on an index of knowledge where None = 0, Medium>0 & <=0.33, High>=0.34.

exposure. This is because the exposure of women under age 19 years to family planning workers is very limited with only 2 percent (on average) having been visited by a family planning worker (DHS 2008, 2013).

61. **Education and income are also strong predictors of contraceptive knowledge.** Having a primary or secondary education raises the odds of knowledge of contraception (OR=1.8 & 3.2) compared to no education. Higher than secondary education is not significantly related, which is because the target age group is concentrated at the secondary or lower levels of education. Being poor is negatively related with knowledge when compared to richer counterparts, once again confirming what the literature suggests. By itself, religion does not seem to be a significant factor,[3] but when compared to each other, being Christian raises the odds (OR=6.06) of having contraceptive knowledge significantly compared to other religions. Similarly, region by itself is not a significant factor, but when compared to each other, the odds of knowing about contraception are about 2 times the odds of contraceptive knowledge compared to North Central (with the exception of South East). However, only the Northern regions have significant results. This needs further exploration and may be related a number of factors such as earlier age at marriage and exposure to family planning or programmatic interventions in those areas.

Table 8. Determinants of Contraceptive Knowledge among Adolescents (Ages 15-19 years)

	Odds Ratio	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Has heard of FP from at least 1 source	3.73	0.63	7.73	**0.000**	2.67	5.20
Has been visited by FP worker	0.52	0.07	-4.78	**0.000**	0.40	0.68
Has visited health facility in past 12 months	1.97	0.26	5.23	**0.000**	1.53	2.54
Region			**Ref. Cat. North Central**			
North East	2.44	0.49	4.45	**0.000**	1.65	3.61
North West	2.20	0.42	4.07	**0.000**	1.50	3.21
South East	1.05	0.50	0.1	0.922	0.41	2.65
South South	2.12	1.02	1.56	0.119	0.82	5.45
South West	1.84	0.77	1.47	0.142	0.81	4.16
Education			**Ref. Cat. No Education**			
Primary	1.82	0.22	4.85	**0.000**	1.43	2.31
Secondary	3.21	0.64	5.88	**0.000**	2.17	4.73
Higher	0.28	0.33	-1.07	0.284	0.03	2.90
Religion			**Ref. Cat. Other**			
Christian	6.06	3.31	3.3	**0.001**	2.07	17.70
Muslim	1.87	0.92	1.27	0.204	0.71	4.92

[3] Results not shown here

Traditionalist	1.85	0.96	1.19	0.233	0.67	5.10
Wealth Index			**Ref. Cat. Richest**			
Poorest	0.37	0.12	-3.04	**0.002**	0.19	0.70
Poorer	0.50	0.16	-2.13	**0.033**	0.26	0.95
Rich	0.66	0.21	-1.29	0.197	0.35	1.24
Richer	1.30	0.44	0.76	0.448	0.66	2.53
Currently Pregnant	1.37	0.14	3.17	**0.002**	1.13	1.67
Relationship Status	0.54	0.16	-2.09	0.037	0.30	0.96
Is a Parent/Has at least 1 child	1.89	0.17	7.27	**0.000**	1.59	2.25
Female is Sexually Active	1.11	0.12	0.95	0.340	0.90	1.37
Partners' Education			Ref. Cat. No Education			
Primary	1.21	0.15	1.56	0.120	0.95	1.54
Secondary	1.23	0.17	1.56	0.118	0.95	1.61
Higher	1.32	0.35	1.06	0.288	0.79	2.22
Woman is working	1.23	0.11	2.43	0.015	1.04	1.46
Ideal no. of children						
1	6.99	7.80	1.74	0.082	0.78	62.32
2	1.75	1.25	0.79	0.431	0.43	7.10
3	8.53	5.64	3.24	**0.001**	2.33	31.20
4	5.10	3.22	2.58	0.010	1.48	17.61
5	5.76	3.61	2.79	**0.005**	1.69	19.69
6	5.94	3.66	2.89	**0.004**	1.77	19.89
7	3.11	1.95	1.81	0.071	0.91	10.66
Intercept	0.07	0.07	-2.76	0.006	0.01	0.46

Source: DHS 2003, 2008, 2013; n=4541.

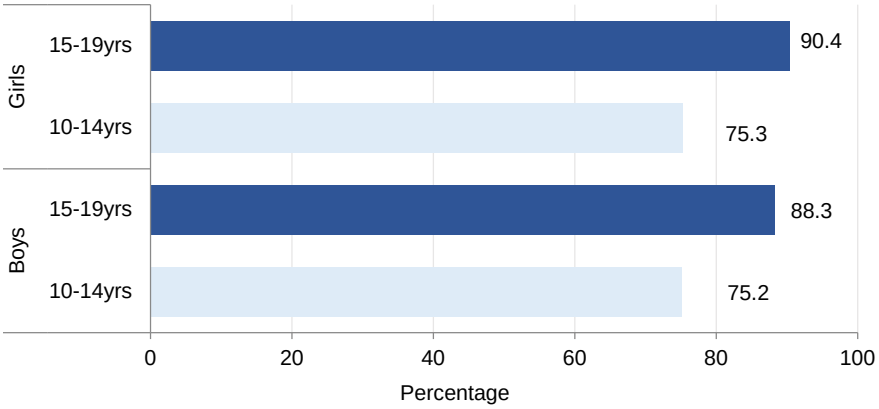
Sources of Information

62. **In keeping with the literature review, findings from the Karu LGA study reveal the role of parents and peers as source of information about sexual and reproductive health and contraception.** Nature of information and gender of the adolescent seem to drive the source, at least in Karu. Focus group discussions in Karu LGA with girls, aged 10-14 and 15-19 years, reveal mothers as an important first source of information for issues such as puberty and body changes. However, there is hesitation around more sensitive topics such as sex and contraception, motivated by the concern that parents may think the girl is either sexually active or is interested in having sex. Boys, on the other hand, consider hospitals or teachers/school as their first source of information on issues such as puberty. They also voice similar concerns as girls about what their

parents may think. Friends, peers, and other older people who the adolescents may trust such as a neighbor or a relative also come across as important sources of information.

63. **Interestingly, quantitative analysis suggests that the in-school population of adolescents look up to their teachers as the most important source of SRH information.** Nigeria introduced the Family Life and HIV Education (FLHE) program in schools in 2003 (for example, see Kirby et al. 2007), and about half of the respondents in the Karu survey indicated that they had received SRH education in school. This includes a high percentage of boys and girls in both age groups (Figure 14). Seventy-five percent of the respondents (80 percent boys and 69.6 percent girls), name their school teachers as the most important source of SRH information followed by mothers and peers. It is likely that the increased access to information students have through their schools is partly responsible for why two-thirds of respondents place teachers as a first source of information.

Figure 14. Karu LGA: In-school adolescents with school-based SRH education, by age and gender



Source: World Bank 2014. Karu LGA survey (n=365)

64. **The quality of information however may be poor.** Less than half (47 percent) of respondents believed that condoms were an effective way of preventing pregnancies. An even lower proportion believed that condoms were effective in preventing HIV infection (40 percent), and that condoms could prevent other STI infections (44 percent). Knowledge about the effectiveness of condoms were even lower among the younger adolescents, aged 10-14 year olds. Additionally, 36 percent of all interviewed adolescents believed that the same condom could be used more than once. Interestingly, and seemingly aligned with the data on contraception, boys were more knowledgeable than girls about the use and effectiveness of condoms, but they were also more likely to say that condoms could be used more than once, indicating the lack of accurate knowledge (Table 9).

Table 9. Condom Use and SRH Outcomes: Perceptions of Adolescents, Karu LGA

Statements	Positive responses (%)				
	Boys		Girls		Total
	10-14 years	15-19 years	10-14 years	15-19 years	
Condoms are an effective method of preventing pregnancy	32.35	70.55	24.84	60.78	46.97
Condoms are an effective way of protecting against HIV/AIDS	28.24	60.12	8.82	12.27	40.44
Condoms are an effective way of protecting against sexually transmitted infection	29.41	66.87	28.66	52.94	44.32
Can you use the same condom twice	22.94	56.44	16.56	47.71	35.77

Source: World Bank 2014. Karu LGA survey

4. ATTITUDES SURROUNDING SEXUAL AND REPRODUCTIVE HEALTH

65. **Perceptions and attitudes regarding sexual and reproductive health also influence behavior and consequently outcomes** (WDR 2007). Since this study included a component specifically focusing on knowledge, attitudes, and perceptions in Karu LGA, there is an opportunity to explore what adolescents in that area think about their sexual and reproductive health and norms.

66. **Evidence indicates that attitudes towards pre-marital sexual relationships are relaxing.** While 65 percent of boys and 71 percent of girls and boys surveyed in Karu LGA thought that people should remain virgins until they get married, they also did not think that there was anything wrong with unmarried boys and girls (56 percent boys, 55 percent girls) having sexual intercourse.

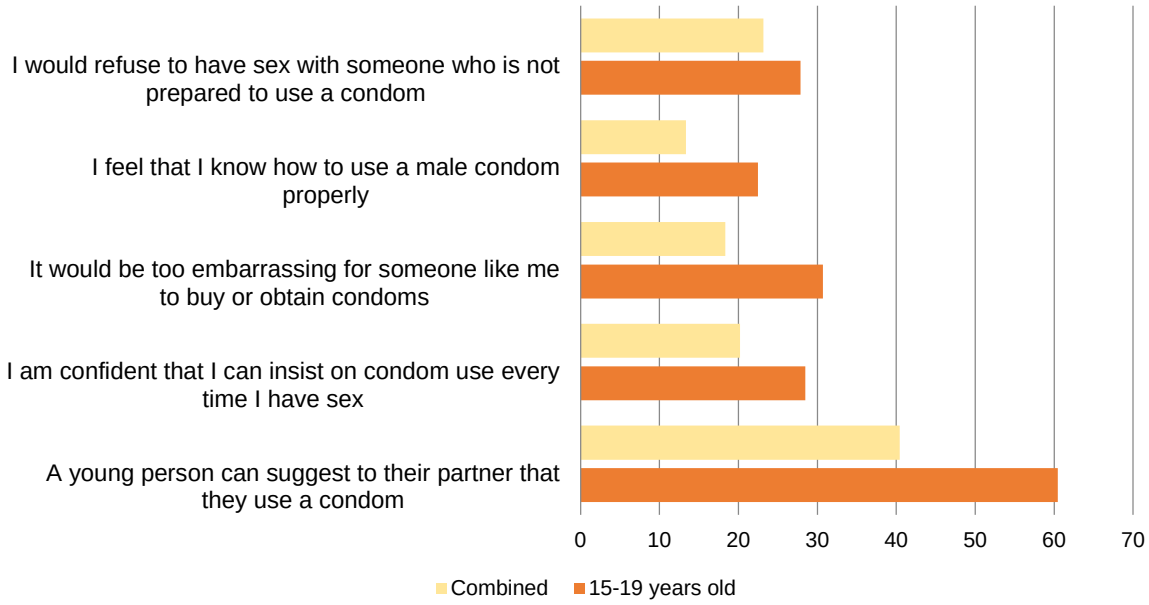
67. **Yet, the majority believed that they should have sex only after marriage, and this is reflected in their behavior.** About 75 percent (n=643) of the adolescents surveyed had never had sex. The main reasons given for not having started engaging in sexual activities included: that sex before marriage was wrong (82 percent), they were afraid of getting HIV/AIDS or another sexually transmitted infection (68 percent). However, about 20 percent of the adolescents said they had not had an opportunity to engage in sex yet.

68. **Peer pressure is a challenge**. Thirteen percent of the respondents also expressed that they had experienced some form of peer pressure, especially from friends, to engage in sexual activities. Focus group respondents also felt that there was a lot of peer pressure to date or engage in sexual activity.

> *"Some of the girls they use to accept [to date a boy] because they want to be like their friends*." - Adolescent female (15-19 years).
>
> *"[they are] pushed into doing it."* – Adolescent female (15-19 years).

69. **Relatedly, being assertive in negotiating relationships is important.** While majority of the respondents felt that a sexual partner could request using a condom, in practice few had done it themselves. A higher proportion of boys (64 percent) compared to girls (57 percent) aged 15-19 years felt that a younger person could suggest using a condom to their older sexual partner. Thirty four percent of boys and 22 percent of girls said they had the confidence to insist on using a condom every time they had sex; and 26 percent of boys and 30 percent of girls felt confident that they would not have sex with someone who was not prepared to use a condom. Figure 15 provides more insights into adolescents' assertiveness regarding condom use.

Figure 15. Adolescent assertiveness in negotiating condom use



Source: World Bank 2014. Karu LGA survey,

70. **Adolescents also expressed fear of stigma if they were assertive about contraception.** Thirty one percent (31 percent) of boys and 24 percent of girls felt that if a girl suggested using condoms to her partner, it would mean that she did not trust him. These sentiments were much stronger among the older adolescents. Almost a third of participants felt that contraception was the woman's responsibility.

71. At the community level, access to contraception may be impeded by norms, morals, attitudes and beliefs that adolescents should not be sexually active and that they therefore do not need contraception.

> *"because if there are no condoms many teenagers will not have the idea to have sex*" - Adolescent male (10-14 years)
>
> *"you have moral instruction, you will be able to hold yourself; and you will not take those things (sex and contraceptives) to be anything, because you know yourself and you stand*

on what you have learned from the Church, from the family, and to the school through moral instruction" – Educator/Teacher

72. **These attitudes are also linked to sexual violence.** When there is too much pressure to engage in a sexual relationship, or when one person forces himself or herself on the other, because one has a weaker voice, it contributes to gender-based violence. .About 15 percent of boys and 11 percent of girls believed that boys were justified in beating their girlfriend if they believed that the girlfriend had done something wrong. Moreover, 70 percent of boys and 71 percent of girls were unsure whether or not it was acceptable for a boy to force a girl to have sex. Of those who were unsure or agreed that a boy should sometimes force a girl to have sex, 10 percent of boys aged 15-19 years had forced a girl to have sex with them, while 33 percent of girls aged between 10-14 year and 16 percent girls aged between 15-19 years reported having been forced by their partner to have sex, the first time they had sexual intercourse. Focus group discussions with adolescents further underscore how there is acknowledgement and even justification (among boys) for violence:

"Some they force to have sex with you, you wouldn't like it but they will force you to do it……because he is stronger than her." – Adolescent girl (10-14 years)

"I want to tell you, it is good to beat her, because I'm already married to her and she's obliged to satisfy my sexual needs as long as she lives with me" – Adolescent male (15-19 years)

"…I will seriously beg her, but if she refuses I will force her." – Adolescent male (15-19 years).

73. Table 10 provides more insights into attitudes.

Table 10. Attitudes of Adolescents regarding sexual relationships

	Agree n (%)		Disagree n (%)		Not Sure n (%)	
	Boys	**Girls**	**Boys**	**Girls**	**Boys**	**Girls**
If a girl suggested using condoms to her partner, it would mean that she didn't trust him	72 (51.06)	53 (39.85)	29 (20.57)	36 (27.07)	40 (28.37)	44 (33.08)
I believe there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each other.	67 (41.61)	56 (37.33)	4 (2.48)	8 (5.33)	90 (55.90)	86 (57.33)
I think that sometimes a boy has to force a girl to have sex if he loves her	35 (21.74)	28 (18.67)	4 (2.48)	6 (4)	122 (75.78)	116 (77.33)
A boy will not respect a girl who agrees to have sex with him.	83 (52.20)	81 (54.36)	15 (9.53)	15 (10.07)	61 (38.36)	53 (35.57)
It is mainly the woman's responsibility to ensure that contraception is used regularly.	50 (31.45)	50 (34.01)	21 (13.21)	11 (7.48)	88 (55.35)	86 (58.50)
Men need sex more frequently than women do	75 (47.17)	82 (55.03)	14 (8.81)	15 (10.07)	70 (44.03)	52 (34.90)
It is sometimes justifiable for a boy to hit his girlfriend	25 (15.43)	16 (10.67)	3 (1.85)	5 (3.33)	134 (82.72)	129 (86)
I believe that girls should remain virgins until they marry	114 (70.37)	114 (76.51)	13 (8.02)	13 (8.72)	35 (21.60)	22 (14.77)

I believe that boys should remain virgins until they marry	104 (64.60)	106 (70.67)	9 (5.59)	12 (8)	48 (29.81)	32 (21.33)

Source: World Bank 2014. Karu LGA survey

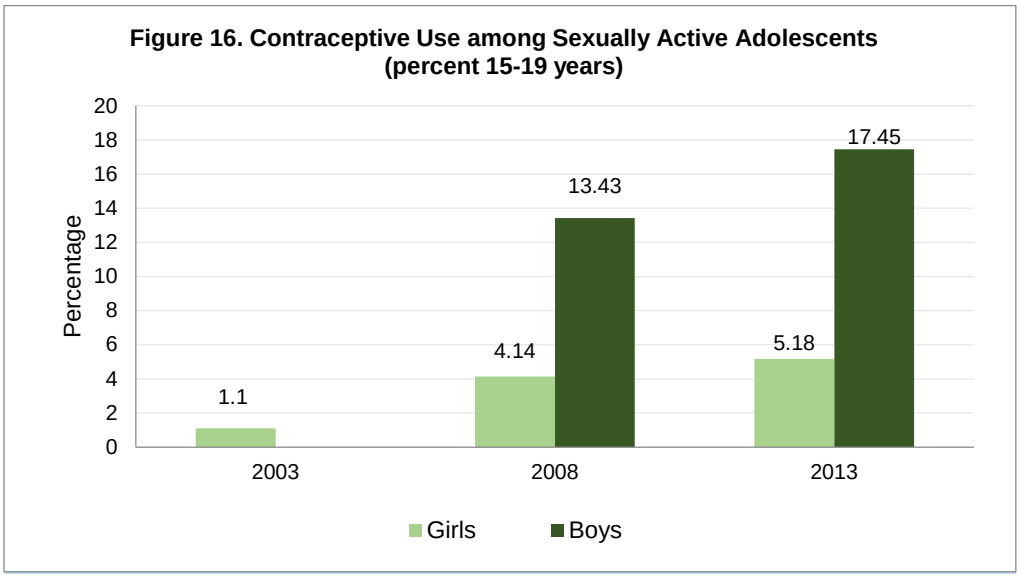
5. USE OF SERVICES AND CONTRACEPTION

74. **Availability, access, and use of reproductive health services adds to the risks associated with adolescent sexual and reproductive health outcomes, including pregnancies.** One of the major problems in addressing ASRH is that use of services remains low - partly due to social and cultural reasons, and partly due to limited access to these services. This section covers use of contraception and use of health services.

Use of Contraception among Adolescents

75. **Use of contraception among sexually active adolescents in Nigeria is very low** (Figure 16). Among sexually active adolescents, only 17 percent of boys and 5 percent of girls were using contraceptives, and roughly 65 percent expressed that they did not intend to use contraception. One of the key reasons for this is fear of social stigma. Participants in the Karu LGA study, particularly girls, indicate that they would not ask their partners to use condoms because it may be perceived as a sign of infidelity or promiscuity. Slum dwellers in Ibadan (n=1042) mention shyness, concern about self-image, stigma, and perceived lack of trust by partner as the reason why they do not bring up use of condoms for example (Adedimeji et al. 2007). One study of teen mothers highlights the preference for emergency contraception over condoms because it is more discreet and there is less danger of being discovered by parents (Ilika and Igwegbe 2006).

Figure 16. Contraceptive Use among Sexually Active Adolescents (percent 15-19 years)



Source: DHS 2003, 2008, 2013.
Note: (a) weighted proportions; (b) sexually active respondents, aged 15-19 years

Determinants of Use

76. **Multivariate analysis among women aged 15-19 years highlights the determinants of contraceptive use**. It confirms the importance of family planning messaging (OR=1.86, SD=0.38)

and visiting a health facility (OR=1.15; SD=0.066) which may also increase exposure to family planning messaging. The analysis also confirms the importance of a woman's education, specifically secondary education (OR=1.88; SD=0.55), as well as that of her partner. Interestingly religion and wealth do not seem to be significant determinants. While women who were currently pregnant were not significantly likely to use contraception, those who had at least one living child were. Additionally those who wanted medium sized families (3 or 4 children) were also significantly likely to use contraception (Table 11).

Table 11: Determinants of Contraceptive Use

Variable Name	Odds Ratio	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Ever use contraception						
Heard of family planning from at least 1 source (radio, newspaper, TV)	1.860	0.381	3.030	**0.002**	1.245	2.779
Visited a health facility in past 12 months	1.152	0.066	2.480	**0.013**	1.030	1.289
Region			**Reference Category: North Central**			
North East	0.440	0.134	-2.700	**0.007**	0.243	0.799
North West	0.321	0.097	-3.750	**0.000**	0.178	0.582
South East	2.262	0.848	2.180	**0.030**	1.084	4.720
South South	2.251	0.806	2.270	**0.024**	1.115	4.545
South West	1.779	0.603	1.700	0.089	0.915	3.457
Education			**Reference Category: No Education**			
Primary	1.274	0.342	0.900	0.367	0.752	2.159
Secondary	1.880	0.552	2.150	**0.032**	1.057	3.345
Higher	0.665	0.606	-0.450	0.654	0.112	3.968
Religion			**Reference Category: Other**			
Christian	1.775	2.074	0.490	0.623	0.179	17.553
Muslim	0.965	1.098	-0.030	0.975	0.104	8.989
Traditionalist	2.035	2.390	0.600	0.545	0.203	20.369
Wealth index			**Reference Category: Richest**			
Poorest	0.586	0.237	-1.320	0.186	0.265	1.295
Poorer	1.030	0.379	0.080	0.937	0.501	2.117
Rich	0.560	0.202	-1.600	0.109	0.276	1.137
Richer	1.453	0.453	1.200	0.231	0.788	2.677
Currently pregnant	0.786	0.175	-1.080	0.278	0.508	1.215
Is a parent/has a living child	2.802	0.555	5.200	**0.000**	1.900	4.133
Partners' Education			**Reference Category: No Education**			

Primary	1.352	0.422	0.970	0.334	0.734	2.492
Secondary	1.924	0.517	2.430	**0.015**	1.135	3.260
Higher	2.532	0.912	2.580	**0.010**	1.249	5.131
Employed	1.289	0.249	1.310	0.189	0.882	1.884
Ideal no. of children						
None	1	(empty)				
1	1	(empty)				
2	1.965	1.308	1.020	0.310	0.533	7.251
3	4.506	2.240	3.030	**0.002**	1.700	11.945
4	2.707	1.293	2.090	**0.037**	1.061	6.906
5	2.465	1.166	1.910	0.057	0.975	6.233
6	1.726	0.765	1.230	0.218	0.724	4.115
7 or more	1	(omitted)				
Intercept	0.008	0.010	-3.980	0.000	0.001	0.088

Source: DHS 2003, 2008, 2013; n=4480

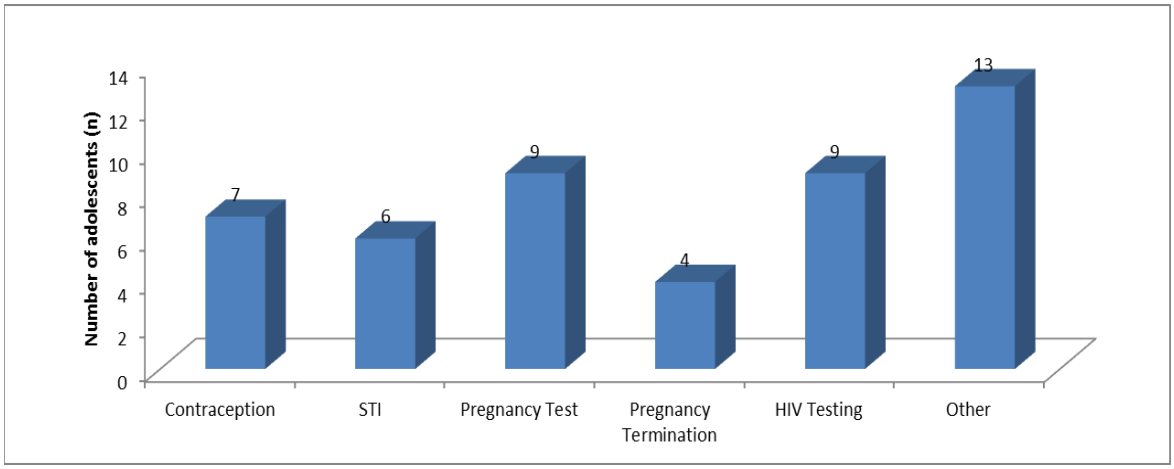
Use of Health Services

77. **Use of sexual and reproductive health service among adolescents in Karu LGA is limited, especially for unmarried girls.** Only 10 percent had visited a health facility or doctor for SRH services, with the largest proportion (15 percent) being girls aged 15-19 seeking contraception, abortions, pregnancy, or STI related services. Embarrassment and fear of stigmatization are among the main concerns adolescents express as a reason for not using public health services. Focus group discussants mention turning to private hospitals, traditional healers, patent medical vendors (PMVs), or chemists for reproductive health services, specifically contraception, and in cases of unwanted pregnancies and abortions. In the words of one parent:

> *'The services are for everybody, but for young people they are ashamed or afraid of people knowing their secret and their issues being told to their parents. That is why most of them feel they don't have the space to access such things (services)."* - Parent (Father)

78. Ten percent of all study participants (n = 51) had visited a health facility or doctor for services or information related to sexual and reproductive health. By far the largest proportion of adolescent who sought services related to contraceptives, pregnancy, abortions or STIs were girls aged 15 – 19 years (15%), Figure 8 below, while younger girls (10 – 14 years) had the least (2 percent) visits. Of those who visited a health facility, 28 (54.5 percent) had visited government facilities while 15 (29.4 percent) had used private hospitals.

Figure 17: Sexual and reproductive services sort from health facilities



79. Close to half of all 342 participants indicated that they lived far from health facilities and services. The majority of participating adolescents (n = 492, 77 percent) felt that young people needed their own dedicated youth friendly treatment clinics. Eighty five percent (85%, n = 547) believed that young people should receive services on contraception, pregnancy and sexual reproductive health and this was unanimous across gender and age. When they become sexually active, unmarried adolescent girls and young women face much greater difficulties in obtaining contraceptives than married women, due to the stigma attached to being sexually active before marriage.

Table 12: Access to SRH services among study participants

	Boys		Girls		Total
	10-14 yrs	15-19 yrs	10-14 yrs	15-19 yrs	
Have you ever visited a health facility or doctor of any kind to receive services or information on contraception, pregnancy, abortion or sexually transmitted infections?	12 (7.06)	13 (7.98)	3 (1.91)	23 (15.03)	51 (7.93)
Do you feel that the health facilities are far from where you stay?	92 (54.12)	90 (55.21)	77 (49.04)	83 (54.25)	342 (53.19)
Do you think that young people should be treated at a different clinic from adults?	139 (81.76)	120 (73.62)	120 (76.43)	113 (73.86)	492 (76.52)
Do you think that young people should receive services on contraception, pregnancy, or sexually transmitted infections at school	141 (82.94)	141 (86.50)	132 (84.08)	133 (86.93)	547 (85.07)

Source: World Bank 2014. Karu LGA survey,

III. POLICY AND PROGRAMMATIC ENVIRONMENT

80. **In 1999, Nigeria initiated a series of reforms to update its policies on health and development.** Health sector reforms were undertaken between 1999 and 2007 to improve the conditions of the health sector. A new ***National Health Policy*** was adopted in 2004 that aimed to address the weaknesses in the health system. This included strengthening the primary level health services and rolling out of an integrated maternal and child health strategy that focused on increasing access to skilled attendance at birth and family planning. The National Health Policy also emphasized the importance of investing in sexual and reproductive health, committing itself to the millennium development targets for maternal, and child health and combatting HIV/AIDS (FGON 2004, 2009).

81. **As part of reviving primary care services, a minimum package of services was developed, which incorporated maternal and child health care, including family planning**. Family planning services would be offered to "couples to educate them about family life and to encourage them to achieve their wishes with regard to: preventing unwanted pregnancies; securing desired pregnancies; spacing of pregnancies; and limiting the size of the family in the interest of the family health and socio-economic status. The methods prescribed shall be compatible with their culture and religious beliefs" (FGON 2004).

Box 2: Nigeria's Health Sector Reforms (1999-2007)

Nigeria' government initiated health sector reforms in 1999. These reforms were a starting point for revitalizing the health sector and reversing the negative health trends in country. For example, between 1990 and 2002, DPT immunizations declined considerably – going from 56 percent to 25 percent, and life expectancy barely budged from around 46 years of age. The reforms aimed to address the weaknesses in a health system that had been crippled due to inefficient investment and brain drain.

One of the main issues had been the collapse of the primary health care system due to neglect and inadequate investment. Higher level facilities absorbed about 75% annual capital investments. Despite this, there was a lack of sufficient investment in the health system (due to the devaluation of the Niara) that led to its decline. One survey of 15 tertiary health facilities, for example, found that operating equipment in all facilities was broken and in disrepair or simply unavailable. Furthermore, poor working conditions contributed to low morale, regular strikes by health care workers and a brain drain - with qualified health personnel seeking employment outside of Nigeria where quality of services and working conditions were better.

Health sector reforms were initiated with the aim of making health care accessible, equitable, and affordable as well as cost-effective and efficient. This involved improving the governance structure and management, building public-private partnerships for service delivery, and reducing the disease burden – especially from malaria, HIV/AIDS and its opportunistic diseases including non-communicable diseases.

The reforms helped to revive the primary health care system and established a National Hospital Services Commission to manage all federally funded tertiary health care facilities in the country. A national health insurance scheme was also launched, initially being rolled out in 14 states, and a National Health Bill, outlining the roles and responsibilities of the tiers of government was also enacted.

The reforms contributed to the following key outcomes:

1. *Development and implementation of the National Strategic Health Development Plan (NSHDP):* The principles underlying the development of the NSHDP were alignment, harmonization, mutual ownership and accountability in line with the Paris Declaration of AIDS Effectiveness. Developed through a participatory process, the NSHDP aimed at a single national health plan for the country, a single fiduciary framework, a single results framework and a single monitoring and evaluation framework for all levels of government. While a single national health plan/policy has been implemented, problems remain with monitoring and evaluation.

2. *Repositioning the National Primary Health Care Development Agency (NPHCDA):* One of the aims of the reforms was to rebuild primary healthcare services, increase their coverage, and provide cost-effective high impact interventions, the NPHCDA was repositioned to provide leadership for scaling up of the Minimum Health Care Package through the Ward Health System, and plays critical role in implementing policies and programs at the primary care level. The current engagement of the World Bank on results oriented services for maternal and child health are also in coordination with the NPHCDA.

3. *Health insurance*: By 2009, Community-based Health Insurance had been rolled out to 70% of people in the informal sector and other vulnerable groups for making health services more affordable for these population groups.

4. *Integrated Maternal Newborn and Child Health Strategy*: The strategy aims to reduce maternal and child mortality (MDGs 4 and 5) with interventions at the political ward level using midwifery corps scheme to ensure availability and access to critical human resources. By 2009, it had been rolled out in 14 states. An overall RH policy was also initiated in 2001 to provide a comprehensive framework for addressing RMNCH.

Source: Federal Government of Nigeria (FGON) 2009; World Development Indicators

82. **Despite reforms, challenges persist in the health sector. One of these is poor governance and accountability.** Nigeria has a three-tier health system that has been decentralized to the State and Local Government Authority (LGA) levels. While the Federal Government finances the public health sector, (and operates some of the hospitals directly), LGAs and the States do not have to report their budgets or expenditures to the Federal government. "Such patterns also characterize practices at the facility levels and are inherent in the input-based or historical budget financing systems through which facilities are currently financed" (World Bank 2012). With no monitoring, it is difficult to estimate how the funds are spent at the local and State levels perpetuating the higher risk of corruption and wastage. There is recognition that it will require both capacity building, and a change in organizational culture to achieve further gains in health service provision.

1. KEY POLICIES

83. **Within this environment, two policies have been pivotal in the direction the country has taken on ASRH.** The first is the ***National Reproductive Health Policy and Strategy (2001)***, which paved the way for Nigeria's largest SRH education program – the Family Life and HIV Education (FLHE) Program. It was also the first to provide an overarching framework for addressing SRH. The second is the ***National Policy on Health and Development of Adolescents and Young People in Nigeria (2007).*** The policy, which is currently in effect, emphasizes the importance of access to information and youth friendly services, and encompasses reproductive health, HIV/AIDS, risky behaviors, and education.

84. The following section provides an overview of the policy environment in Nigeria that has defined how ASRH is addressed in the country.

Overall Policy Environment: defining the boundaries of engagement

85. **In 2009, Nigeria unveiled its Vision for 2020 (NV20: 2020).** Nigeria to one of the most populous countries in Africa, with a very large youth population, and potential for rapid economic growth and raised productivity provided the right types of investments are made. With this in mind,

Nigeria's Vision 2020 aims for the country to become a major economy rivaling the BRICS by 2020 (FGON 2009a). This necessitates investments across all sectors of the economy, including health, as outlined in the strategy, and is the guiding framework for current policies and programs in the country.

86. ***The Transformation Agenda:*** The Transformation Agenda is based on and draws its inspiration from the NV 20:2020 and the 1st National Implementation Plan (NIP). It aims to deepen the effects and provide a sense of direction for the current administration over the 2011-2015 period. **The agenda aims to strengthen focus on key interventions across sectors, including health, to operationalize the goals of NV20: 2020** and other development plans. In health, activities are guided under the National Strategic Health Development Plan 2010-2015 (discussed below).

87. **Recognizing the importance of a healthy and productive labor force, the Agenda also focuses on job creation, especially for youth.** Unemployment data show that the highest proportion of unemployed is youth with a secondary or tertiary education. Despite economic growth, job creation has not kept pace with the speed of new **entrants** into the labor markets. Literature highlights the risks of youth unemployment with negative behaviors such as smoking, drugs, and alcoholism, which are also linked to violence. To address this gap in employment, the Transformation agenda calls for implementing a youth employment safety net support program that includes conditional cash transfer and vocational training. It also aims to align university curricula with market requirements (FGON 2011).

88. ***The National Strategic Health Development Plan 2010-2015*****:** The NSHDP was developed to mobilize resources to "**significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system".** The plan focuses on improving service delivery at all levels, enhancing good governance and accountability as well as better management, and making services affordable for the more vulnerable groups of population (pregnant women, children under 5, and the elderly). The plan also defines an essential package of services which includes RMNCH services including family planning, PMTCT, and management of HIV/AIDS, along with immunizations, and pregnancy related care (FGON 2010). While the plan does not mention adolescents as a particular population group, nor does it mention adolescent/youth friendly services, it does include monitoring of indicators related to unmet need and contraception prevalence as well as condom use for high risk sex. Given that majority of the Nigerian population is under the age of 30, and that there is a high rate of teenage pregnancies (121 births per 1000 women aged 15-19), it would be useful to also enhance youth friendly service provision as part of the service delivery package, especially in future planning. This would include for example, training modules on youth friendly/sensitive service provision as part of basic training of health service providers or investing in patient confidentiality and privacy at facilities.

89. ***National Youth Policy (2009):*** **In keeping with the focus on its young population, Nigeria has also enacted two policies focusing on youth.** Both policies broadly cover the roles, responsibilities and rights of young people. The 2009 National Youth Policy builds on the first youth policy of 2001, and promotes a holistic approach to addressing youth issues including social, economic and health concerns. The 2009 policy provides a framework 'to promote the

fundamental human rights of young men and women and protect their health, social, economic, and political well-bring to enhance their participation in overall development'. The policy lays out the protections for and responsibilities of the youth. This includes protection from violence and harmful traditional practices and calls on them to promote reproductive health and rights (FGON 2009b). In doing so, the National Youth Policy continues to create space and aligns with the National Policy on Reproductive Health for Youth and Adolescents (discussed below).

90. ***National Policy on Population and Sustainable Development (2004):*** **The population policy of Nigeria (2004) also creates space for addressing the needs of young people**. Nigeria enacted its first population policy in 1988, and the second one in 2004. The first policy emphasized the links between better maternal and child health outcomes and fertility regulation as well as economic growth. The second policy also emphasizes the link between health, population growth, and economic growth. The policy addresses maternal and child mortality as well as HIV/AIDS, and brings in the importance of the youth, stating that "Young people are the future leaders of the nation. Appropriate provisions for their growth and development shall be made in recognition of their special needs" (Lozanes 2012; www.population.gov.ng).

Reproductive health and adolescents in policy

National Reproductive Health Policy and Strategy (2001):

91. **As part of health reforms, Nigeria also adopted a national reproductive health policy which still guides the government's engagement on sexual and reproductive health in the country.** The policy was a first step in bringing attention to adolescent sexual and reproductive health issues. While other policies on maternal and child health or HIV/AIDS had been enacted previously, this was the first comprehensive policy that provided an overarching framework for addressing sexual and reproductive health. Following the principles laid out at the International Conference on Population and Development (ICPD) 1994, the policy was inclusive of women and men and promoted a cross-sectoral approach to improving sexual and reproductive health outcomes through engaging education, reducing poverty, and other social aspects such as gendered power relations. It also aimed to address gender based violence, and female genital mutilation/cutting.

92. **The policy was critical as it acknowledged the reproductive health risks of youth (ages 10-24), specifically raising concerns about the age at first intercourse, teen pregnancies, sexual abuse, and spread of HIV/AIDS.** These concerns in fact were among the justification for initiating a national reproductive health policy. The recent **National Policy on HIV/AIDS (2009)** also includes a focus on youth, highlighting them as among the most vulnerable groups.

93. **The reproductive health policy paved the way for Nigeria's largest sexual and reproductive health education program -** the Family Life and HIV Education (FLHE) Program, which began operating in 2003 (discussed later). The FLHE is nested in the education sector, and finds strong support in the National School Health Policy (2006). The policy includes family life and HIV/AIDS as key components of the school health education curricula aligning it with the objectives

of the reproductive health policy to improve access to information on reproductive health for young people.

National Policy on Health and Development of Adolescents and Young People in Nigeria (2007):

94. **Following ICPD 1994, the government of Nigeria also developed an adolescent specific framework on reproductive health** along with a broader frameword on adolescent health and development by 2005.. In 2007, and in alignment with other key policies, the government introduced a comprehensive policy on adolescent health and development, which is currently in effect. The 2007 policy aims to "promote the optimal health and development of adolescents and other young people in Nigeria". The policy emphasizes the importance of access to information and youth friendly services, and encompasses reproductive health (including HIV/AIDS), social issues such as risky behaviors, and education. The policy also lays out a broad outline of the roles and responsibilities of the ministries of health, education, youth, and women's affairs and development. The policy supports the FLHE mandate as part of the education sector, and lays the responsibility for youth friendly health services with the Ministry of health. It also holds it responsible for advancing the youth in health and development agenda for the country.

95. **While successful implementation of the strategy requires coordination among Ministries, on the ground, this is lacking.** A case in point is the lack of coordination between the Federal Ministry of Education (FMoE) and the Federal Ministry of Women's Affairs (FMoW). While the first is responsible for implementing the FLHE, the latter is responsible for reaching out of school girls, but there appears to be a lack of communication and coordination in ensuring that the different populations are covered. Moreover, there also appears to be no formal coordinating mechanism connecting the FMoE. FMoW, and FMoH on improving access to information and services related to sexual and reproductive health (Federal Ministry of Education, Interview).

National Gender Policy (2008):

96. **The National Gender policy brings together various gender related polices in the country and focuses on five critical areas**: (i) bringing about a change in gender perceptions and stereotypes through sensitization and cultural re-orientation; (ii) promoting women's human rights, especially related to sexual and gender based violence (SGBV); (iii) promoting the empowerment of women and integrating gender within key sectors; (iv) enhancing women's political participation and engendering governance ; and (v) supporting institutional development and building strategic partnerships.

97. **In terms of reproductive health, it aims to integrate gender and human rights into national curricula.** Aligned with the National Policy on Reproductive Health for Adolescents it promotes reduction of harmful traditional practices including FGM and early child marriages and addresses gender-based violence and HIV affected women's rights.

2. PROGRAMS

98. **The Family Life and HIV Education (FLHE) program is the central piece of the government's efforts to improve ASRH outcomes in Nigeria.** Initiated in 2003, the program targets in-school adolescents, ages 10-17 years. It is implemented through the Federal and State Ministries of Education and Local Government Authorities (LGA). Under the National Response to HIV/AIDS mandate, the FMoE has adopted a two-pronged approach to HIV/AIDS: (1) the FLHE, which is being implemented countrywide and the FCT with support of Global Fund resources, and (2) co-curricular strategy, which includes peer education and mentoring. Rising from the mandate to include reproductive health education in schools, the program focuses on upper primary (junior secondary) and higher secondary school curricula in the country to improve knowledge about sexual and reproductive health and HIV/AIDS.

99. **The FLHE is built into the curricula,** and covers topics on puberty, personal skills (such as self-esteem and values), sexual health, relationships, and sexual behaviors. However, the program stops short of promoting contraception, opting to support abstinence as a means for avoiding unwanted pregnancies, or reducing the risk of HIV/AIDS.

100. **Since its implementation began in 2003, the FLHE has faced some challenges.** Although being implemented country-wide, according to recent data, it only covers 13 percent of in-school adolescents (NACA 2014). While there has been no large scale impact evaluation, evidence of the FLHE's influence has been mixed. A survey conducted in 2006 showed that only 45 percent of teachers sampled (n=1,131) had ever heard of the program (FMoE 2006); while several other studies highlight improvements in knowledge and attitudes among students due to FLHE (for example, Arnold et al. 2012; Adeniyi 2011).

101. **Teaching and providing contraceptives to adolescents remains a highly contested issue especially in many developing countries** (Arai 2003). School-based sexual and reproductive health interventions for in-school adolescents are widely recognized in Nigeria. However teachers have different perceptions and desires when it comes to getting involved in sexual and reproductive health education (RHE) (Adegbenro, Adeniyi et al. 2007; Aransiola et al. 2013). Aransiola et al. (2013) found that the majority of teachers in Nigeria were supportive of RHE or sexual education to be part of the education syllabus and were willing to teach it (Aransiola, Asa et al. 2013). However a large proportion of these teachers were uncomfortable with the inclusion of contraceptive matters in the curricula neither were they comfortable with making contraceptives directly available to adolescents in schools. They preferred teaching 'biology-focused pubertal related information' (Aransiola, Asa et al. 2013). Studies have found that teachers in Nigeria, especially in urban settings, were supportive of RHE being taught in schools but their rural counterparts were less keen of the idea. The majority of teachers in a study conducted in rural communities in south-west Nigeria for example found that teachers were unwilling to be involved in sexual education even after receiving sexual education training (Adegbenro et al. 2007).

102. **Quality of education varies,** with willingness and interest at the State level to implement the program. One of the main challenges in implementing the FLHE is the overall structure of public education. Like the public health sector, the education sector is decentralized, with implementation

in the hands of the States governments. Whereas there may be interest at the Federal level to implement the FLHE, at the states level it is the willingness and interest of the government on how well the program performs. Because of this, there are variations in the extent of FLHE integration into the curriculum and quality of implementation.

103. **There is also a standalone information system that collects data on FLHE implementation**.[4] Based on this, in Phase II, 127,401 students have been reached, and over 2500 teachers trained in 21 States. This is only within the public education system. At the State level, coordination is through the State Desk Officers, and implementation varies depending on the resources available to them. The political will at the States level is very important for quality FLHE implementation. The big gap here is the out of school youth population. While the FMoWASD addresses them, there is no mechanism for coordination. According to the FMoE the only collaboration is on addressing the needs of the orphans and the vulnerable.

104. **One of the issues initially was the lack of adequate funding. However, funding has been increasing with support from the Global Fund for HIV/AIDS, TB, and Malaria.** The FLHE has been receiving Global Fund support since 2009. FLHE is in its second phase of funding through the Global Fund. This runs from 2010- 2015, after which new funding will be sought. The Society for Family Health (SFH) is the recipient of the Global Fund Phase II funding in Nigeria. The funds support the FLHE with the FMoE as the sub-grantee of the funds. The organization has 18 locations and 12 programs country wide. In addition, SFH supports a peer education program in some schools through the FLHE (with 10 students being trained as peer educators per school). Health clubs with membership of teachers and students are also encouraged to promote long-term sustainability.

105. **Among the barriers to a comprehensive scaling-up the program are the "gate keepers" of society – a small but vocal minority that is defining the cultural boundaries of what is appropriate.** This means that messages get watered down. Vocal activism against the program has been a drawback to the potential the program holds in educating young populations comprehensively on sexual and reproductive health (SFH Interview February 2014).

106. **Another challenge is that what students learn in school may not be reinforced in their daily lives.** The reasons for this may range from discomfort in speaking about SRH with parents to receiving inaccurate or limited information at home. For example, one qualitative study of SRH communication between mothers and daughters in Northern Nigeria (n=184) found that while most mother-daughter pairs communicated about SHR (at least 69% of the sample), it revolved around puberty, marriage, stigma related to premarital sex and unwanted pregnancies as well as STIs including HIV/AIDS. Less discussed were issues around sexuality, family planning, and complications related to child bearing such as fistula (Iliyasu et al. 2012). Similar results are also expressed in other studies (Izugbara 2008, Iyaniwura 2006, Bastien et al. 2011). One way to reinforce what is being taught in schools is to connect the FLHE with service provision, for example, by linking the program to counselling services on SRH.

[4] The data system for FLHE is not linked to the EMIS or HMIS. One potential reason for this is that the data is not aggregated enough/no appropriate indicator for inclusion in the EMIS.

107. **Appropriate teacher training provides another challenge**. It needs to be continuous and mainstreamed within the national teaching curricula, which is currently not the case. Currently teachers have to be specifically trained to participate in FLHE, but this is inefficient and not sustainable. However, there is advocacy around that right now and the expectation is that this will happen.

108. **On the ground, there is also an issue with expectations.** Teachers feel that FLHE presents additional workload on top of an already full workload (Dlamini et al. 2012). Most people think that they should be paid to teach FLHE since it is donor funded. However, they need to be reminded continuously that FLHE is integrated into the curriculum which they are already paid to teach. The issue of different cultures and different attitudes was also raised as well as discomfort in addressing SRH issues.

Other Programs:

109. **In conjunction with the mandate for reaching in-school and out-of-school populations, several other programs have also been initiated.** While the FLHE reaches the in-school adolescent population, those who are out-of-school do not have access to the same type of streamlined education. There are a few efforts ongoing to reach these populations. Although information on their implementations is scarce, they are briefly discussed here.

110. **The Peer Education Plus (PEP) program is one of the programs focusing on out-of-school population.** This program is implemented by the same civil society organization that working with the government to implement FLHE – the Society for Family Health (SFH). Peer education plus is an existing model of affecting behavior change. As part of addressing HIV/AIDS, SFH is partnering with the National Agency for Control of AIDS (NACA) on Peer Education Plus focusing on HIV/AIDS and reproductive health. The program targets high risk populations, training peer educators who then work with the high risk groups.

111. **Another program that supports young women is a Mentorship program initiated by the Federal Ministry of Women's Affairs and Social Development (FMoWASD) for girls who drop out of school due to pregnancy or are single parents to teach them life skills.** The program's aim is to provide these young mothers with skills that they can use to generate an income and be financially stable. The program also provides education and information related to sexual and reproductive health. According to FMoWASD, the program is being expanded at the State level with support from the State ministries, but challenges exist such as limited financial resources, and need for advocacy with other government agencies to promote gender and women's well-being. The FMoWASD is also actively engaged on **violence against women**. This includes working on legislation, advocacy with police and the attorney general, and religious organizations. This includes support to (1) the Network of Men against VAW; (2) Restoration of girls who have experienced violence; (3) expansion of the violence prevention program (in some cases, in collaboration with the FMoE).

112. While these are promising programs, they are small in scale, and each operates independently of the other, and the FLHE. Each has a different target audience and is administered through different government agencies (NACA and FMoWASD), but broadly speaking, their objectives are to reach out to out-of-school populations with information and education.

Coordination between these programs and the FLHE at the Federal and State levels (where they operate at State level) has the potential of more pro-actively reaching the population of school drop outs, through early identification of the drop-out population, and having similar messaging on sexual and reproductive health.

IV. RECOMMENDATIONS/CONCLUSIONS

113. **Adolescents are an important age group in Nigeria. They comprise over 20 percent of the population.** Their well-being is essential to Nigeria's future, not only in terms of economic but also social development and stability. Within the realm of health, sexual and reproductive health is a key component in the determination of future outcomes. This is recognized in policy and has been put into practice, most visibly through the FLHE program. Based on the evidence presented in this study, the following recommendations are presented as points to consider in future policy and programmatic interventions on adolescent health, and in particular adolescent sexual and reproductive health:

114. **Improving the depth and quality of SRH knowledge:** Whereas knowledge regarding contraception and HIV/AIDS has increased, there are still considerable gaps in the quality of information and the depth of knowledge. Adolescents, especially the very young do not have complete information and myths persist especially about pregnancies and fertility. Depending on the topic, it is likely that girls may have more information than boys or vice versa. While there is a need to continue to expand coverage of existing programs, there is also a need to ensure that adolescents are receiving accurate information. This requires working across sectors and with key partners such as the UNFPA, and the Global Fund to find solutions.

115. **Enhancing the FLHE:** The FLHE is a promising program. Its effectiveness can be improved through better funding and coordination between the ministries of education and health and women's affairs to create links between education and access to services. The FLHE will also benefit from more comprehensive curricula and some mechanism to ensure its reinforcement outside of schools. In this regard, parent information sessions may be organized to help them learn techniques for communicating on SRH issues with their children. In addition to parents, other key stakeholders such as community leaders may benefit from information and advocacy around the program. This could happen in campaigns organized by the DoH or community workshops organized by churches, NGOs.

116. **Provision of youth friendly services (YSF):** This is important in removing some of the barriers to use. Adolescent friendly services may be available and adolescents may not have access to them due to inconvenient locations, opening hours, cost or stigma they may experience in their communities. Policy makers committed to increasing adolescents' access to and use of services should ensure that providers are trained to work with young people, respect confidentiality and offer complete, evidence-based and accurate information. The National Primary Health Care Development Agency has played a facilitating role in developing guidelines and identifying a minimum package of services at the primary level and Nigeria provides some YFS at the secondary

and primary level. These efforts need continued support, especially in rural and farming communities.

117. **Revisiting child marriage in policy and practice**: The ambiguity surrounding age at marriage also needs to be addressed. Global evidence indicates that the risk of death from giving birth is much higher for younger adolescents when their bodies are not fully developed. Children whose mothers die at birth also face higher risk of mortality before age 5. Public awareness based on these types of messages may be useful in the longer-term in reducing maternal and child mortality and morbidity in the country.

118. **Gaps in data – health metrics:** Not specific to Nigeria, but quite applicable is the limited data on all adolescents. This includes data by gender, age, and marital status. Data on boys is very scarce, DHS data is only for 20 and above in most cases, and not all the same questions are asked of boys as for girls, making comparisons difficult. Data on 10-14 years is extremely difficult to come by because it is rarely collected (due to ethical considerations). Since adolescents are an important age group, it is essential that surveys are reexamined to collect data on the 10-19 years of age population for both boys and girls. Additionally, the data do not cover unmarried populations for some of the questions. Perhaps what is needed is a separate tool on adolescents with its own set of topics including issues such as risky behaviors (smoking, drug use, alcohol consumption and others).

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ANNEX 1
KARU LGA: QUANTITATIVE STUDY DESIGN AND METHODOLOGY

Karu Local Government Area (LGA) is made up of four districts: Guruku-Kabusu, Aso, Kodape and Karu; and two development areas: Karishi and Panda. Karu has an area of 40,000 hectares and has a population of about 216,230 people, 20 percent of whom are aged 10-19 years (GoN 2006). It is located about 60 km from the Abuja city centre in Nasarawa State of Nigeria and is one of 13 LGAs in Nasarawa.

Sampling and Sample Size

Assuming an initial adolescent fertility rate of 21 percent, and that the indicator will be reported with 95 percent confidence interval, then 255 adolescents were required to be sampled to give an estimate of fertility with a precision of 5 percent. We assumed a 20 percent non-response rate and 20 percent chance of not meeting an adolescent in a household, and determined the final sample size of 638 adolescents. A stratified random method was used to choose representative samples of locations across the settlement types and characteristics. The population of adolescents in the LGA was estimated to be 20 percent and there are five settlement types hence, 20 percent of number of villages per stratum was used to randomly select the number of villages to be visited per settlement type.

In each of the 5 settlement areas, a geographical mapping exercise was carried out to create the sampling frame. The primary enumeration units were households from districts in these study areas. All households in each of these districts were then counted. Households from each selected enumeration area were selected using systematic sampling, i.e. starting from a randomly selected starting point; enumerators selected every n^{th} house or enumerated all households depending on the size of the district:

- Sampling in big selected towns used a sampling fraction of 5
- Sampling from smaller towns selected every 2^{nd} household.
- Sampling in Zhayi, Kudu and Guruku I included all households because there were very few houses in these towns.

Enumerators visited each of the selected households and randomly select one eligible adolescent using random number generator cards when households had more than one adolescent. The interviews were conducted in private and each interview took an average of 45 minutes. In situations where an adolescent was not available at the time of the visit, a letter was left at the household scheduling an appointment for the interview at a later time. Three follow-up visits were made.

Variables collected

The research instrument was adapted from an instrument developed by Cleland et al. (2001) titled "Asking young people about sexual and reproductive behaviours", Illustrative Core Instruments. The instrument covers different domains that include: sources of reproductive health information; sexual reproductive health knowledge; sexual behavior including condom use; relationships; availability and accessibility of sexual reproductive health services; and reproductive outcomes such as number of pregnancies and live births.

Data management and data analysis

Data was collected between the 30^{th} of July 2014 and 20^{th} of August 2014 using paper based face-to-face interviews with selected adolescents residing in Karu at the time of the study. After each day of data collection, all questionnaires (both new and completed) were collected from the enumerators and kept in the custody of the supervisor. At the end of fieldwork, all tools were sorted and grouped per enumerator, and prepared for data entry. Data was captured using *Epi Info* with quality control checks done using SPSS. Data was transferred and analyzed in STATA (version 12). Sampling weights for Karu were not available to be used for estimation. Baseline characteristics of respondents are presented in Table A1.1.

The field team manager under the supervision of the statistician ensured quality control of all field work including data collection/interviews. In addition, the supervisor made post-interview visits to the sampled households where enumeration had taken place. These visits helped to understand the views of parents and adolescents from the selected households regarding their understanding of the overall aim of the survey, their feelings towards the data collection processes and to check on the progress made by the enumerator(s). The supervisor purposively chose 1-3 villages per day for the visit.

Table A1.1: Baseline characteristics of 10-19 year old boys and girls in Karu (Nigeria)

	Boys (333; 51.8%)		Girls (310; 48.2%)		
	10-14 yrs.	**15-19 yrs.**	**10-14 yrs.**	**15-19 yrs.**	**Total (643)**
Sample size	170 (51.1)	163 (49.0)	157 (50.7)	153 (49.4)	
Median age	14 (12-17)		14 (12-17)		
Settlement type*					
Urban formal	18 (10.9)	30 (18.8)	30 (19.9)	25 (16.9)	103 (16.5)
Urban informal	83 (50.3)	67 (41.9)	67 (44.4)	50 (33.8)	267 (42.8)
Tribal Settlement	64(38.8)	63 (39.4)	54 (35.8)	73 (49.3)	227 (40.7)
Marital Status					
Single	170 (100)	163 (100)	156 (99.4)	145 (94.8)	634 (98.6)
Married	-	-	1 (0.6)	8 (5.2)	9 (1.4)
Religion:*					
Traditional Christian	176 (53.0)		177 (57.7)		353 (54.9)
Pentecostal	36 (10.8)		43 (14.0)		79 (12.3)
Muslim	119 (35.8)		87 (28.3)		206(32.0)
Highest Education level completed*					
None	24 (14.5)	6 (3.8)	16 (10.3)	14 (9.2)	60 (9.3)
Nursery	78 (47.0)	16 (10.1)	62 (40)	10 (6.6)	166 (25.8)
Primary	52 (31.3)	36 (22.6)	60 (38.7)	37 (24.3)	185(28.8)
Junior Secondary	12 (7.2)	65 (40.9)	16 (10.3)	57 (37.5)	150 (23.3)
Senior Secondary	-	35 (22.0)	1 (0.7)	34 (22.4)	70 (11.0)
Ability to read*					
Yes	131 (77.1)	139 (85.3)	122 (77.7)	127 (83.0)	519 (80.7)
No	39 (22.9)	24 (14.7)	35 (22.3)	26 (17)	124 (19.3)
Currently in School*					
Yes Full time	117 (93.6)	104 (72.2)	114 (89.1)	88 (72.1)	423 (65.8)
Yes Part time	5 (4)	7 (4.9)	4 (3.1)	2 (1.6)	18 (2.8)
No	3 (2.4)	33 (22.9)	10 (7.8)	32 (26.2)	78 (12.1)
Type of current institution of Education*					
Government	231 (77.8)		199 (71)		430 (74.5)
Private	66 (22.2)		81 (29)		147 (25.48)
Form of Employment					
Formal part-time	4 (2.4)	18 (11.1)	5 (3.2)	8 (5.3)	35 (5.4)
Formal full-time	0	8 (4.9)	0	2 (1.3)	10 (1.6)
Informal	19 (11.2)	30 (18.5)	11 (7.1)	18 (11.8)	78 (12.1)
Self employed	6 (3.6)	13 (8.0)	2 (1.3)	6 (4.0)	27 (4.2)
None	140 (82.8)	93 (57.4)	138 (88.5)	118 (77.6)	489 (76.1)

*-chi-square p> 0.05, testing gender differences

Study Limitations

It is important to get reliable and valid results in any study. This study was designed to capture sexual and reproductive health outcomes for adolescent boys and girls in Karu. It was also meant to map out sources of sexual and reproductive health knowledge, access and utilization of these services in the area.

The areas mapped out for the survey covered the main different settlement types found in Karu; urban formal and informal, tribal and farming areas. Although we assume that the selected sample was representative of the adolescent population in Karu, there is no independent way of verifying this assumption. We could not get local estimates of the distribution of children aged 10 – 19 stratified by age and sex, thus reported estimated are not weighted. A few adolescents especially girls refused to take part in the study. Some of the reasons given for refusal were the lack of consent from husbands and, some married adolescents who had children felt that they could no longer be considered as adolescents; they felt that they were grown up women. The fact that some individuals refused to participate in the study is likely to introduce some biases including selection bias. If those who refused to participate were systematically different from those who were interviewed, then the results cannot be generalized to all adolescents in Karu. Rates of being sexually active as well as fertility levels may be underestimated in this study because those who refused to take part in the study were likely to be married.

Karu is a satellite city of Abuja, which is likely to have different socio-economic characteristics compared to other settlements in Nigeria. Nigeria is known to have two main dominant religious groups, the Muslim population who are found predominantly in the North of the country and Christians who are likely to be found in the Southern part of the country. These two religions have different views and practices on sexual and reproductive matters. Although Karu, is said to consist of a culturally and religiously diverse group of people, it is unlikely that the results obtained in this study can be generalized to the whole of Nigeria.

ANNEX 2

KARU LGA: QUALITATIVE STUDY DESIGN AND METHODOLOGY

Karu is one of 13 local government areas in Nasarawa State and has an estimated combined population of 216,230 people, 20 percent of whom are aged 10-19 years. Of the 12 communities sampled for the quantitative survey, five were selected for the qualitative study, and included: Karu, Mararaba, Auta Gurugu, Guruku1 and Kudu (rural). The target groups for the focus group discussions included adolescents between the ages of 10-19, health care service providers, educators, and parents.

The following criteria were applied in making the selection: (1) the study had to cover both urban/rural communities; (2) the distance from Karu Local Government Secretariat; (3) the size and accessibility of community.

The FGDs covered the following topics:

- Potential reasons behind adolescent pregnancies in Karu, Nigeria.
- Factors that contribute to 'unsafe' sexual practices among adolescents.
- Receptiveness to various SRH awareness interventions and programs.
- Demand and supply side factors and constraints of SRH services that prevent or encourage adolescents to using these services.
- Opportunities and platforms that exist within health, education, and other sectors that can maximize improvements in ASRH within the Nigerian context.

Sampling and Sample Size

The research used purposive sampling to conduct focus group discussions to maximize variation and include as wide a selection of individuals as possible for a representative sample.

Adolescent Focus Groups: Adolescents were stratified into the very young adolescents (10-14 years old) and older adolescents (15-19 years old). The local chiefs identified and helped to mobilize adolescents who participated in the discussion groups. Of the 16 adolescents aged 10-14 years selected to participate in the focus groups, 10 were urban residents and 6 were rural dwellers. Of the 17 15 – 19 year old adolescents who participated in the discussions, 11 were from rural communities whilst 6 were from urban areas. There were 9 males and 7 females in the 10 to 14 years old age group and, 9 males and 8 females' participants in the 15 to 19 years old discussions. This resulted in a total of 4 FGD being conducted with adolescents.

Service Providers: Service providers were categorized into educators and health care providers. The service providers were made up of 8 educators and 8 healthcare providers. These were identified with the support of the Heads of the Departments of Education and Health and the Social Mobilization Officer of the LGA Health Department. Among the healthcare providers were a doctor, 2 nurses, 2 community health providers and 3 private medicine vendors (also called Chemists). Two of the 8 educators were primary school teachers, while the remaining 6 taught in secondary schools. They were selected based on their willingness and availability to participate in the focus group discussions. A total of 2 FGD were conducted with service providers; 1 for healthcare providers and another for educators.

Parents (Adults): One FGD was held with parents of adolescents. Of the 12 parents that participated, 7 were males and 5 were females. An equal number of participants (6) came from the rural and 6 from urban communities. The community heads were responsible for identifying rural parents that participated in the discussions, while the Social Mobilization Officer contacted parents from the urban communities. Of these parents, two were also heads of their communities.

FGDs were conducted predominantly in Pigeon or English to ensure the participation and understanding of all members of the group. All discussions were held in the same location in Karu town. The 4 FGDs for adolescents were all held on the same day, but separately. Male and female facilitators led the discussions for male and female adolescent groups respectively, while a male facilitator was used to guide the discussions with parents, educators, and healthcare providers.

Semi-structured interview guides were used to collect data for the FGDs. These instruments were developed and informed by a review of relevant literature including (Cleland et al 2001), "Asking young people about sexual and reproductive behaviors", Illustrative Core Instruments.

ANNEX 3
KARU LGA SURVEY INSTRUMENT

WORLD BANK GROUP Mott MacDonald

PAVING THE PATH TO IMPROVED ADOLESCENT SEXUAL AND REPRODCUTVE HEALTH IN NIGERIA-2014
ENGLISH VERSION

GEOGRAPHIC INFORMATION **QUESTIONNAIRE NUMBER** [ ]
THIS SECTION IS NOT TO BE ASKED OF THE RESPONDENT

A. PSU/ Small Area number					
B. Locale or settlement type	**1 = Urban formal (built up or city area) 2 = Urban informal 3 = Tribal settlement 4 = Farming**		**C. Dominant housing type in AREA**	**1 = Formal housing 2 = Mostly formal housing 3 = Mostly informal housing 4 = Squatter housing/ impoverished area 5 = Traditional housing 6 = Hostels 55= Other (Specify)**	
D. Area name			**E. Household roster number**		
F. Name of fieldworker			**G. Date of interview** *[dd/mm/yy]*		
H. Name of team leader					

A1. The respondent is in the room with no others present except for the interviewer.	**1=Yes 2=No**	
A2. I have read the individual information sheet, statement of confidentiality and informed consent form	**1=Yes 2=No**	
A3. If the participant agreed to participate, did he/she sign the consent form?	**1=Yes 2=No**	
A4. If the participant is 10-17 years old, did his/her guardian sign the parental consent/assent form?	**1=Yes 2=No**	
A5. Has the participant retained a copy of the information sheet?	**1=Yes 2=No**	

Don't know= 96

Refused= 99

Instrument adapted from Cleland et al 2001, "Asking young people about sexual and reproductive behaviours", Illustrative Core Instruments UNDP, UNFPA, WHO, World Bank - Special Programme on Research, Development and Research Training in Human Reproduction (HRP): Geneva, Switzerland.

SECTION 1: SOCIOECONOMIC AND FAMILY CHARACTERISTICS

1.1	Sex Of Respondent	Male 1 Female 2	
1.2	What day, month and year were you born?	Day ☐☐ Month ☐☐ Year ☐☐	
1.3	How old were you at your last birthday?	Years ☐☐ CROSS-CHECK WITH DATE OF BIRTH AND RECONCILE	
1.4	Can you read, for example, a newspaper?	Yes 1 No 2	
1.5	What is the highest level of formal schooling you completed? (CIRCLE HIGHEST SCHOOL LEVEL)	None 1 → 1.9 Primary Junior Secondary 2 Senior Secondary 3 Technical College 4 Commercial or Secretarial 5 University 6 Postgraduate 7 Other 8	
1.6	Are you currently attending regular formal school, college or university? Full-time or part-time?	Yes, full-time 1 → 1.9 Yes, part-time 2 → 1.9 No 3	
1.7	How old were you when you left formal school, college or university?	Age ☐☐	

1.8	Is the formal school, college or university that you attend a government, private, religious institution?	Government 1 Private 2 Religious 3	
1.9	Now I have some questions about work. Are you currently employed?	Yes, formal part-time employment 1 Yes, formal full-time employment 2 Yes, informal 3 Yes, self-employed 4 No → 5	1.11
1.10	How are you paid for the work you do?	Cash direct to me 1 Cash to someone else 2 I am not paid 3 Other 4 Specify	
1.11	What is your religion? IF RESPONSE IS 1 TO 5 SKIP TO 1.13	None 1 Traditional Christian Churches 2 Pentecostal 3 Local Traditional Religion 4 Atheist 5 Muslim 6 Other 7 Specify	

1.12	Have your or are you currently attending an Islamic or Arabic Religious School (Almajiri)?	Arabic School 1 Islamic school 2 None 3	
1.13	Now I have some questions about your family. Who lives with you in your household? Circle all applicable options	Father 1 Mother 2 Sister 3 Brother 4 Aunt 5 Uncle 6 Other 7 Specify.....	

1.14	What is your marital status? (Marital status referring to legal, traditional or common-law) [ONE RESPONSE ONLY] IF RESPONSE IS 1 TO 5 SKIP TO 1.17	Single 1 Not married or living together but in a steady sexual relationship lasting more than 3 months 2 Not married, but living with sexual partner/boyfriend/girlfriend 3 Divorced 4 Widowed 5 Married, living with husband/wife 6 Married, NOT living with husband/wife 7 Other 8 Specify……	
1.15	Are you in a polygamous marriage?	Yes 1 No → 2	1.17
1.16	How many (other) wives are in this relationship?	Number ☐☐	
1.17	Do you have children?	Yes 1 No → 2	1.19
1.18	How many?	Alive ☐☐ Dead ☐☐	
1.19	And now I have some questions about your social activities Do you like hanging out?	Yes 1 No → 2	1.21
1.20	Where do you like to hang out?	Party 1 Movies 2 Bar/lounge 3 Sit-out (fence) 4 Swimming area 5 Other 6	

		Specify.....	
1.21	Do you ever drink alcohol?	Yes 1 No → 2	1.23
1.22	On how many days in the last month have you taken alcohol?	Number of d☐☐	
1.23	Do you ever smoke cigarettes?	Yes 1 No → 2	1.25
1.24	How many have you smoked in the last 7 days?	Number of cigarett☐☐	
How many days a week do you usually do the following?			
1.25	Listen to Radio	Less than once a week 1 1 to 3 days a week 2 4 to 6 days a week 3 Every day of the week 4 Never 5	
1.26	Watch Television	Less than once a week 1 1 to 3 days a week 2 4 to 6 days a week 3 Every day of the week 4 Never 5	
1.27	Read a book/magazine	Less than once a week 1 1 to 3 days a week 2 4 to 6 days a week 3 Every day of the week 4 Never 5	
1.28	Use the internet	Less than once a week 1 1 to 3 days a week 2 4 to 6 days a week 3 Every day of the week 4 Never 5	

SECTION 2: SOURCES OF REPRODUCTIVE HEALTH INFORMATION

Young people learn about *PUBERTY* - I mean the ways in which boys' and girls' bodies change during the teenage years - from many sources. They may learn from teachers at school, parents, brothers and sisters, from friends, from doctors or they may learn from books, films and magazines.			(1) Most Important	(2) Second most important	(3) Preferred
2.1	What has been the most important source of information for you on this topic?	School teacher	01	01	01
2.2	And the second most important? CIRCLE MOST IMPORTANT IN COL 1 AND SECOND MOST IMPORTANT IN COL 2	Mother	02	02	02
2.3	From whom, or where, would you prefer to have received more information on this topic? (Any response) CIRCLE ONE ANSWER IN COL. 3	Father	03	03	03
		Brother	04	04	04
		Sister	05	05	05
		Friends	06	06	06
		Doctors/Nurse	07	07	07
		Community Health Care Worker	08	08	08
		Book/magazines	09	09	09
		Radio	10	10	10
		TV/Videos	11	11	11
		Internet	12	12	12
		Other (Specify)	13	13	13 .....
2.4	Have you ever obtained information about PUBERTY from the following social network sites?	Facebook	Yes 1 No 2		
		Twitter	Yes 1		

		Badoo BBM Other	No 2 Yes 1 No 2 Yes 1 No 2 Specify.....		
Now I want to ask you a similar question about sources of information for FAMILY PLANNING, STI, HIV/AIDS, AND HOW PREGNANCY OCCURS.			(1) Most Important	(2) Second most important	(3) Preferred
2.5	What has been the most important source of information for you on this topic?	School teacher	01	01	01
2.6	And the second most important? CIRCLE MOST IMPORTANT IN COL 1 AND SECOND MOST IMPORTANT IN COL 2	Mother	02	02	02
2.7	From whom, or where, would you prefer to have received more information on this topic? (Any response) CIRCLE ONE ANSWER IN COL. 3	Father	03	03	03
		Brother	04	04	04
		Sister	05	05	05
		Friends	06	06	06
		Doctors/Nurse	07	07	07
		Community Health Care Worker	08	08	08
		Book/magazines	09	09	09
		Radio	10	10	10
		TV/Videos	11	11	11
		Internet	12	12	12
		Other (Specify)	13	13	13 .....

2.8	Have you ever obtained information about FAMILY PLANNING, STI, HIV/AIDS, AND HOW PREGNANCY occurs from the following social network sites?	Facebook Twitter Badoo BBM Other	Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Specify.....		
Now there is a third similar question about sources of information on DATING RELATIONSHIPS - I mean how boys should treat girls and vice versa.			(1) Most Important	(2) Second most important	(3) Preferred
2.9	What has been the most important source of information for you on this topic?	School teacher	01	01	01
2.10	And the second most important? CIRCLE MOST IMPORTANT IN COL 1 AND SECOND MOST IMPORTANT IN COL 2	Mother	02	02	02
2.11	From whom, or where, would you prefer to have received more information on this topic? (Any response) CIRCLE ONE ANSWER IN COL. 3	Father	03	03	03
		Brother	04	04	04
		Sister	05	05	05
		Friends	06	06	06
		Doctors/Nurse	07	07	07
		Community Health Care Worker	08	08	08
		Book/magazines	09	09	09
		Radio	10	10	10

		TV/Videos	11	11	11
		Internet	12	12	12
		Other (Specify)	13	13	13 ....
2.12	Have you ever obtained information about DATING RELATIONSHIPS from the following social network sites?	Facebook Twitter Badoo BBM Other	Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Specify.....		
Some schools have classes on puberty, on family planning, STI, HIV/AIDS, and how pregnancy occurs and on dating relationships between boys and girls.					
2.13	Did you ever attend any school classes on any of these topics?	Yes 1 No 2 Not sure 3 Never been to school 4 →			2.15
2.14	Do you think that there should be (more) classes on these topics, fewer classes or were the number about right?	More 1 Less 2 About right 3			
Now I have some other questions on sex and reproduction. I will read you some statements. Please tell me whether you think the statement is true, or false, or whether you don't know.		True	False	Don't Know	
2.15	A woman can get pregnant the very first time that she has sexual intercourse.	1	2	96	
2.16	A woman stops growing after she has had sexual intercourse for the first time.	1	2	96	
2.17	A woman gets pregnant if a man touches her	1	2	96	
2.18	A woman is most likely to get pregnant if she has sexual intercourse half way between her periods.	1	2	96	
2.19	Masturbation causes serious damage to health.	1	2	96	

SECTION 3: CURRENT/MOST RECENT HETEROSEXUAL RELATIONSHIP

	Now I am going to ask you some questions about dating and sex. The answers you give are very important for helping to design better adolescent sexual reproductive health programmes for your community and we appreciate your help. Please feel comfortable to answer questions honestly; you will not be judged and there is no right or wrong answer. Your answers are confidential and will not be known by anyone else.		
3.1	Have you ever had a girlfriend/ boyfriend? By girlfriend/boyfriend, I mean someone to whom you were sexually or emotionally attracted and whom you 'dated' (*use local terms to specify going out together unaccompanied by other adults*)	Yes 1 No → 2	Section 4
3.2	How many girlfriend/boyfriends have you ever had?	Number ☐☐	
	Ask the following sequence of questions about CURRENT (MOST RECENT) girl / boy friend		
3.3	What is her/his INITIALS?	Initial:_____	
3.4	How old is INITIAL? *Probe for current age*	Age ☐☐	
3.5	When you started your relationship, was INITIAL single, married, divorced or separated?	Single 1 Married 2 Divorce 3 Separated 4 Widowed 5 Other.....	
3.6	When you started your relationship with INITIAL, was INITIAL a full time student, working or neither?	Full time student 1 Working 2 Neither 3	
3.7	During the time you were/have been 'dating' INITIAL did you /have you had any other partner?	Yes 1 No 2	
3.8	How would you describe your relationship with INITIAL? Was (is) it (a) a casual friendship; (b) a serious relationship but with no intention of marriage; or (c) an important relationship that might lead to marriage?	(a) Casual 1 (b) Serious 2 (c) Important/might lead to marriage 3 (d) Engaged to be married to INITIAL 4	

	(d) OR you are engaged to be married to INITIAL		
3.9	And how do you think INITIAL would describe her /his relationship to you? (a) as a casual friendship; (b) a serious relationship but with no intention of marriage; (c) an important relationship that might lead to marriage?	(a) Casual 1 (b) Serious 2 (c) Important/might lead to marriage 3 (d) Don't know 4	
3.10	Did you and INITIAL ever have sex?	Yes 1 No 2	
	QUESTION 3.10 - 3.23 ARE ONLY FOR THOSE WHO HAVE EXPERIENCED PENETRATIVE SEX		
3.11	Think back to the first time you had sex with INITIAL - I mean the first time that the penis was in the vagina. Would you say. READ OUT (a) I forced INITIAL to have intercourse against her/his will (b) I persuaded INITIAL to have intercourse (c) INITIAL persuaded me to have intercourse (d) INITIAL forced me to have intercourse (e) We were both equally willing	(a) I forced 1 (b) I persuaded 2 (c) INITIAL persuaded 3 (d) INITIAL forced 4 (e) Both willing 5	
3.12	And would you say it was planned or unexpected?	Planned 1 1 Unexpected 2 2	
3.13	On that last time you had sex with INITIAL did any of you use anything to avoid a pregnancy?	Yes 1 No 2	
3.14	What method did you use?	Condom 1 Pill 2 Injection 3 Withdrawal 4 Safe period 5 Emergency contraception 6 Other 7 Specify.....	

3.15	Did you ever discuss contraception with INITIAL? IF YES Did you discuss contraception before or after you first had intercourse?	Before first intercourse 1 After first intercourse 2 Never 3	
3.16	Apart from the last time, did you and INITIAL ever use a method to avoid pregnancy? IF YES Always or sometimes?	Always 1 Sometimes 2 Never 3	
3.17	What method did you and INITIAL mostly use? (MULTIPE RESPONSES PERMITTED)	Condom 1 Pill 2 Injection 3 Withdrawal 4 Safe period 5 Emergency contraception 6 Other 7 (Specify) 6	
3.18	Where did you or INITIAL get this method? (CIRCLE ONLY ONE)	Shop 1 1 Pharmacy 2 2 Govt.Clinic/Health Centre/Hospital 3 Private Doctor/Nurse/Clinic 4 4 Friend 5 5 Patent Medicine Trader 6 Family member 7 Other 8 (Specify)..... 6 Don't know 96 96	
3.19	Whose decision was it to use a method always/sometimes/never? Was it mainly	My decision 1	

	your decision, INITIAL'S decision or a joint decision?	1 INITIAL'S decision 2 2 Joint decision 3 3	
3.20	Were you ever concerned that you might catch HIV or another sexually transmitted infection from INITIAL? IF YES Very or somewhat?	Very concerned 1 1 → Somewhat concerned 2 2 Not concerned 3 3	GO TO SECTION 4
3.21	Were you able to do anything to reduce the risk of infection	Yes 1 → 111 No 2 2	GO TO SECTION 4
3.22	What did you do? Probe	Use condoms 1 11 Take medicines 2 2 Other 3 (Specify)	GO TO SECTION 4

SECTION 4: FIRST SEXUAL RELATIONSHIP

I am going to ask you some questions your about the sex again. The answers you give are very important for helping to design better sexual reproductive health programmes for adolescents in your community. We know that some people have had sexual intercourse and some have sexual intercourse with more than one person. Please feel comfortable to answer questions honestly; you will not be judged and there is no right or wrong answer. Your answers are confidential and will not be known by anyone else.

4.1	Have you ever had sex with anyone? (that is to say when the penis was in the vagina/anus)	Yes 1 No 2 Refused to answer 99	→ 4.3
4.2	How many sexual partners have you ever had?	Number ☐☐	
4.3	What is your main reason for not having had sex? SKIP TO SECTION 5	1=No partner available 2 = Main partner away 3 = Do not want to have sex 4 = Waiting for marriage to have sex 5 = Religious reasons 6 = Avoiding HIV or other sexually transmitted disease 7 = Avoiding pregnancy or getting someone pregnant 8 = Don't like sex 55= Other (specify) 96 = Don't know 98 = Refused to answer	
4.2	Now I have some question about the first time that you had sexual intercourse. How old were you at that time?	AGE ☐☐	
4.4	What is the INITIAL of the person?	INITIAL:_____ Don't know 96	
	In the following questions, use "that person" instead of INITIAL if name of first partner is not known How would describe your relationship to INITIAL (that person)? PROBE	Boy/girlfriend 1 Stranger/relative/other person who forced me 2 Friend with benefit 3	

4.5	How old was INITIAL?	Age ☐☐ Don't know 96	
4.6	When you had sex for the first time with INITIAL (that person), was INITIAL single, married, divorced, widowed or separated?	Single 1 Married 2 Divorce 3 Separated 4 Widowed 5 Don't know 96	
4.7	During the first time you had sex with INITIAL was INITIAL a full time student, working or neither?	Full time student 1 Working 2 Neither 3 Don't know 96	
4.8	Has the relationship ended?	Yes 1 No 2	
4.9	During the time you had sex with INITIAL did you 'date' anyone else?	Yes 1 No 2	
4.10	At that time how would you describe your relationship with INITIAL? Was (is) it (a) a casual friendship; (b) a serious relationship but with no intention of marriage; or (c) an important relationship that might lead to marriage? (d) OR you are engaged to be married to INITIAL (e) None	(a) Casual 1 (b) Serious 2 (c) Important/might lead to marriage 3 (d)Engaged to be married 4 (d) None	
4.11	Think back to the first time you had sex with INITIAL - I mean the first time that the penis was in the vagina. Would you say. (a) I forced INITIAL to have intercourse against her/his will	(a) I forced 1 (b) I persuaded 2 (c) NAME persuaded 3 (d) NAME forced 4	

	(b) I persuaded INITIAL to have intercourse (c) INITIAL persuaded me to have intercourse (d) INITIAL forced me to have intercourse (e) We were both equally willing	(e) Both willing 5	
4.12	And would you say it was planned or unexpected?	Planned 1 Unexpected 2	
4.13	Did you regret having intercourse with INITIAL on that first time?	Yes 1 No 2 If yes, WHY …… ……	
4.14	On that first time did you or NAME do anything to avoid a pregnancy?	Yes 1 No 2	
4.15	What method did you use?	Condom 1 Pill 2 Injection 3 Withdrawal 4 Safe period 5 Emergency contraception 6 Other 7 (Specify)……	
4.16	Did you ever discuss contraception with INITIAL? IF YES Did you discuss contraception before or after you first had intercourse?	Before first intercourse 1 After first intercourse 2 Never 3	
4.17	Apart from the first time, did you and NAME ever use a method to avoid	Always 1	

	pregnancy? IF YES Always or sometimes?	Sometimes 2 Never 3	
4.18	What method did you and NAME mostly use?	Condom 1 Pill 2 Injection 3 Withdrawal 4 Safe period 5 Emergency contraception 6 Other 7 (Specify)..... 6	
4.19	Where did you or INITIAL get this method? (CIRCLE ONLY ONE)	Shop 1 Pharmacy 2 Clinic/Health Centre/Hospital 3 Private Doctor/Nurse/Clinic 4 Friend 5 Patent Medicine trader 6 Family Member 8 Other..... 7 (Specify)	
4.20	Whose decision was it to use a method always/sometimes/never? Was it mainly you decision, INITIAL'S decision or a joint decision?	My decision 1 NAME decision 2 Joint decision 3	
4.21	Were you ever concerned that you might catch HIV or another sexually transmitted infection from INITIAL? IF YES Very or somewhat?	Very concerned 1 Somewhat concerned 2 Not concerned 3 →	SECTION 6

4.22	Did you do anything to reduce the risk of infection?	Yes 1 No 2	
4.23	What did you do? Probe	Use condoms 1 Take medicines 2 Other 3 (Specify).....	

SECTION 5: TYPES OF HETEROSEXUAL CONTACT

I now want to ask you about any sexual contacts that you may have experienced.

5.1	Some young people are forced to have sexual intercourse against their will by other people. Has this ever happened to you?	Yes 1 No 2 →	5.4
5.2	How many different strangers or people have forced you to have sex against your will?	No.	☐☐
5.3	Did you or the sexual partner do anything to avoid a pregnancy or STI/HIV on these occasions? IF YES Always or sometimes?	Always 1 Sometimes 2 Never 3	
5.4	Some young people/females are touched on the breast or some other part of the body when they do not want to be, by other people. Has this ever happened to you?	Yes 1 No 2	→ 5.6
5.5	Would you say this has happened often, sometimes, or rarely?	Often 1 Sometimes 2 Rarely 3	
5.6	Some young people have 'one night stands' (*use local terms*), perhaps after a party or after drinking. Has this ever happened to you?	Yes 1 No 2 →	5.9
5.7	In the past 12 months, how many 'one night stands' have you had?	No.	☐☐
5.8	Did you or the sexual partner do anything to avoid a pregnancy or STI/HIV on these occasions? IF YES Always or sometimes?	Always 1 Sometimes 2 Never 3	

5.9	Some young people pay money or gifts in exchange for sexual intercourse. Has this ever happened to you?	Yes 1 No 2 →	5.12
5.10	Some young people receive money or gifts in exchange for sexual intercourse. Has this ever happened to you?	Yes 1 No 2 →	5.12
5.11	How many women/men have you had sex with for money or gifts?	No.	☐☐
5.12	Did you or the sexual partner use anything to avoid a pregancy or STI/HIV on these occasions? IF YES Always or sometimes?	Always 1 Sometimes 2 Never 3	

THE FOLLOWING QUESTIONS ARE ONLY FOR THOSE WHO HAVE NEVER EXPERIENCED SEXUAL INTERCOURSE

People may have mixed reasons for not having intercourse. I will read out some reasons. Please tell me for each reason whether it applies to you or not.		Applies	Not applies	Not Sure	Don't Know
5.13	I don't feel ready to have sex.	1	2	3	96
5.14	I have not had the opportunity.	1	2	3	96
5.15	I think that sex before marriage is wrong	1	2	3	96
5.16	I am afraid of getting pregnant	1	2	3	96
5.17	I am afraid of getting HIV/AIDS or another sexually transmitted infection.	1	2	3	96

5.18	And now I have a question about your future plans about sexual intercourse. Which of these statement best describes your plans? READ OUT (a) I plan to wait until marriage (b) I plan to wait until I am engaged to be married (c) I plan to wait until I find someone I love (d) I plan to have sexual intercourse when an opportunity comes along	(a) Marriage 1 (b) Engagement 2 (c) Love 3 (d) Opportunity 4	
5.19	Do you feel any pressure from others to have sexual intercourse? IF YES A great deal or a little?	A great deal 1 A little 2 None 3 →	Section 6
5.20	From whom do you feel pressure? PROBE CIRCLE ALL THAT APPLY	Friends 1 Relatives 2 Work colleagues 3 Partner/special friend 4 Family 5 Other 6 (Specify).....	

SECTION 6: PREGNANCY HISTORY

THE FOLLOWING SECTION IS TO BE ASKED TO FEMALES ONLY

Now I am going to ask you some questions about pregnancy. Please feel comfortable to answer questions honestly; you will not be judged and there is no right or wrong answer. Your answers are confidential and will not be known by anyone else.

6.1	Have you ever fallen pregnant? IF NO SKIP TO SECTION 7	Yes No	1 → 2 Section 7
6.2	How many times have you fallen pregnant?	Number	☐☐

For each time you have fallen pregnant, I would like you to give me the year it was and whether you the outcome of the pregnancy (miscarriage, abortion, still birth or live birth)

		Year	Abortion	Miscarriage	Still Birth	Live Birth	Current
6.3	a) Pregnancy 1						
	b) Pregnancy 2						
	c) Pregnancy 3						
	d) Pregnancy 4						
	e) Pregnancy 5						
	f) Pregnancy 6						
	g) Pregnancy 7						
	h) Pregnancy 8						

SECTION 7: KNOWLEDGE AND USE OF CONTRACEPTIVE METHODS

7.1	I now have some questions about contraception - I mean ways in which men and women can avoid getting pregnant. Which methods have you heard of? What others? CIRCLE CODE 1 IN COL. 2 FOR EACH METHOD MENTIONED. FOR EACH METHOD IN THE TABLE NOT ALREADY MENTIONED, READ THE DESCRIPTION IN COL.1 AND RECORD ANSWER IN COL.2 FOR EACH METHOD KNOWN ASK QUESTION IN COL.3		
	COL 1.	COL. 2.	COL. 3.
7.2	Pill Women can take a pill every day	Knowledge of Method Yes (spont.) 1 Yes (prompted) 2 No 3	Knowledge of Source "Do you know any place or person where young people could obtain this method? Yes 1 No 2
7.3	Injection Women can have an injection every 2 or every 3 months	Yes (spont.) 1 Yes (prompted) 2 No 3	"Do you know any place or person where young people could obtain this method? Yes 1 No 2
7.4	Condom A man can put a rubber device on his penis before intercourse	Yes (spont.) 1 Yes (prompted) 2 No 3	"Do you know any place or person where young people could obtain this method? Yes 1

			No 2
7.5	Emergency Contraceptive Pills A woman can take pills soon after intercourse	Yes (spont.) 1 Yes (prompted) 2 No 3	"Do you know any place or person where young people could obtain this method? Yes 1 No 2
7.6	Female Condom A women can insert a rubber device in her vagina	Yes (spont.) 1 Yes (prompted) 2 No 3	"Do you know any place or person where young people could obtain this method? Yes 1 No 2
7.7	Withdrawal A man can pull out of a woman before climax	Yes (spont.) 1 Yes (prompted) 2 No 3	
7.8	Periodic Abstinence/Rhythm A couple can avoid sex on days when pregnancy is most likely to occur.	Yes (spont.) 1 Yes (prompted) 2 No 3	

7.9	There are other methods of contraception that I have not mentioned. What other methods have you heard of? CIRCLE EACH METHOD MENTIONED.	IUD 1 Implant 2 Jelly/foam 3 Female Sterilization 4 Male Sterilization 5 Other (SPECIFY)…….. 6 None 7	
7.10	Which method do you think is most suitable for you and your partner?	Pill 1 Injection 2	

	CIRCLE ONE ANSWER	Condom 3 Emergency Pills 4 Withdrawal 5 Periodic Abstinence 6 Don't have a partner 7 Other 8 Specify…….. Don't Know 96	

SECTION 8: KNOWLEDGE OF HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS

8.1	Have you heard of HIV or AIDS (*use local terms*)?	Yes 1 No → 2	8.6
8.2	I am now going to read you some statements about HIV/AIDS. Please tell me whether you think the statement is true, or false, or whether you don't know.	True False Don't know	
8.3	It is possible to cure AIDS	1 2 3	
8.4	Is there a treatment for HIV infection & AIDS? NOTE: READ OUT DEFINITION [Treatment being something to keep people healthy for a long time & not a cure for the disease]	1 2 3	
8.5	HIV infection can be prevented by having a one uninfected sexual partner	1 2 3	
8.6	A healthy looking person can be HIV infected	1 2 3	
8.7	HIV can be transmitted by mosquito bites	1 2 3	
8.8	People can get infected by sharing food with HIV infected individuals	1 2 3	
8.9	People can take a simple test to find out whether they have HIV	1 2 3	
8.10	Apart from HIV/AIDS, there are other diseases that men and women can catch by having sexual intercourse. Have you heard of any of these diseases?	Yes 1 No → 2	SECTION 9
8.11	What are the signs and symptoms of a sexually transmitted infection in a man? PROBE CIRCLE EACH MENTIONED	Discharge from penis 1 Pain during urination 2 Ulcers/sores in genital area 3 Other 4 (Specify)..... Don't Know 96	

8.12	And what are the signs or symptoms when a woman is infected?	Vaginal discharge 1 Pain during urination 2 Ulcers/sores in genital area 3 Other 4 (Specify)..... Don't Know any signs 96	
8.13	If a friend of yours needed treatment for a sexually transmitted disease, where could he or she obtain such treatment? PROBE Any other places? CIRCLE EACH MENTIONED	Shop 1 Pharmacy 2 Govt. 3 hospital/health centre/clinic Private doctor/nurse/clinic 4 Patent Medicine Trader 5 Other 6 (SPECIFY).....	
8.14	Have you ever had a sexually transmitted infection? IF YES Once or more than once?	Once 1 More than once 2 Never → 3	SECTION 9
8.15	On the last occasion did you seek treatment?	Yes 1 No → 2	8.17
8.16	Where did you seek treatment?	Shop 1 Pharmacy 2 Govt. hospital/health centre/clinic 3 Private doctor/nurse/clinic 4 Patent Medicine Trader 5 Other 6 (Specify)	
8.17	Did your sexual partner (any of your partners) also obtain treatment?	Yes 1 No 2 Don't know 96	

SECTION 9: CONDOM KNOWLEDGE AND ATTITUDES

9.1	Have you ever heard of condoms? *Use local word for condoms.*	Yes No	1 2		
9.2	Have you ever seen a condom?	Yes No	1 2		
9.3	Have you or a partner ever used a condom?	Yes No	1 2		→ 9.5
9.4	Have you ever experienced a condom that split or broke during intercourse?	Yes No	1 2		
	People have different opinions about condoms. I will read out some opinions. For each one, I want you to tell me whether you agree or disagree, or whether you don't know	Agree	Not sure	Disagree	Don't know
9.5	Condoms are an effective method of preventing pregnancy	1	2	3	96
9.6	Condoms can be used more than once	1	2	3	96
9.7	A girl can suggest to her boyfriend that he use a condom	1	2	3	96
9.8	A boy can suggest to his girlfriend that he use a condom	1	2	3	96
9.9	Condoms are an effective way of protecting against HIV/AIDS	1	2	3	96
9.10	Condoms are suitable for casual relationships	1	2	3	96
9.11	Condoms are suitable for steady, loving relationships	1	2	3	96
9.12	It would be too embarrassing for someone like me to buy or obtain condoms	1	2	3	96
9.13	If a girl suggested using condoms to her partner, it would mean that she didn't trust him	1	2	3	96
9.14	Condoms reduce sexual pleasure	1	2	3	96
9.15	Condoms can slip off the man and disappear inside the woman's body	1	2	3	96
9.16	If unmarried couples want to have sexual intercourse before marriage, they should use condoms	1	2	3	96
9.17	Condoms are an effective way of protecting against sexually transmitted diseases	1	2	3	96

SECTION 10: SEXUALITY, GENDER AND NORMS

Young people have various views about relationships. I will read you out some views. For each one, please tell me whether you agree or disagree?

10.1	I believe there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each other.	Agree Disagree Not sure Don't know	1 2 3 96	
10.2	I think that sometimes a boy has to force a girl to have sex if he loves her.	Agree Disagree Not sure Don't know	1 2 3 96	
10.3	A boy will not respect a girl who agrees to have sex with him.	Agree Disagree Not sure Don't know	1 2 3 96	
10.4	I believe that girls should remain virgins until they marry.	Agree Disagree Not sure Don't know	1 2 3 96	
10.5	I believe that boys should remain virgins until they marry.	Agree Disagree Not sure Don't know	1 2 3 96	
10.6	It is sometimes justifiable for a boy to hit his girlfriend.	Agree Disagree Not sure Don't know	1 2 3 96	
10.7	Most of my friends who have sex with someone use condoms regularly.	Agree Disagree Not sure Don't know	1 2 3 96	
10.8	I am confident that I can insist on condom use every time I have sex.	Agree Disagree Not sure Don't know	1 2 3 96	
10.9	I would never contemplate having an abortion my self or for my partner.	Agree Disagree Not sure Don't know	1 2 3 96	
10.10	It is mainly the woman's responsibility to ensure that	Agree Disagree Not sure Don't know	1 2 3 96	

	contraception is used regularly.		
10.11	I feel that I know how to use a condom properly.	Agree 1 Disagree 2 Not sure 3 Don't know 96	
10.12	Men need sex more frequently than do women	Agree 1 Disagree 2 Not sure 3 Don't know 96	
10.13	I would refuse to have sex with someone who is not prepared to use a condom.	Agree 1 Disagree 2 Not sure 3 Don't know 96	
10.14	How many of your friends have had sexual intercourse? Would you say many, some, a few, or none?	Many 1 Some 2 A few 3 None 4 Not sure 8	

SECTION 11: USE AND PERCEPTIONS OF HEALTH SERVICES

11.1	Have you ever visited a health facility or doctor of any kind to receive services or information on contraception, pregnancy, abortion or sexually transmitted infections?	Yes 1 No 2 →	11.12
11.2	How many times have you sought services or information from a doctor or a nurse for these services in the last twelve months?	Number of times ☐☐ Did not seek care in last 12 months →	11.12
11.3	Thinking about your last visit, did you go to a government clinic, health centre or hospital or a private doctor or clinic?	Government 1 Private 2 Traditional healer 3 CHW 4 Other 5 (Specify).....	
11.4	When you last saw a doctor or a nurse, what was your reason for going?	Contraception 1 STI 2 Gynaecological exam 3 Pregnancy test 4 Pregnancy termination 5 MCH 6 Antenatal Care 7 HIV testing 8 Other 9 Specify.....	
11.5	At this facility Did you see any posters on contraception?	YES NO 1 2	
11.6	Were you given brochures on contraception?	1 2	
11.7	Did you attend a talk on contraception?	1 2	
11.8	Did you request contraceptive services during the consultation?	1 2	
11.9	Did you feel comfortable enough to ask questions?	1 2 →	11.11

11.10	Were the questions you asked during the consultation answered adequately?	1	2	
11.11	Was there enough confidentiality?	1	2	
11.12	Do you feel that the health facilities are far from where you stay?	1	2	
11.13	Do you think that young people should be treated at a different clinic from adults?	1	2	
11.14	Do you think that young people should receive services on contraception, pregnancy, or sexually transmitted infections at school?	1	2	

END

ANNEX 4
KARU LGA FOCUS GROUP DISCUSSION GUIDES

WORLD BANK GROUP

Mott MacDonald

PAVING THE PATH TO IMPROVED ADOLESCENT SEXUAL AND REPRODCUTVE HEALTH IN NIGERIA

Focus Group Discussions Guide for Adolescents

(Generic Version)

Introduction

Hello. My name is _____. We have invited you here today to speak about the sexual and reproductive health of adolescents, that is, young people between the ages of 10 and 19. Our reason for conducting this focus group is to gain a better understanding of your views and perceptions about sexual and reproductive health knowledge and behaviours of young people today. We also want to hear views about the information and services related to sexual and reproductive health available to young people today. Please note that when I say sexual and reproductive health I refer to body changes/puberty, sexual intercourse, prevention and management of sexually transmitted infections and HIV/AIDs as well as pregnancy.

Thank you all for coming and consenting to be a part of this focus group.

I will now go over a few basic rules. First, we will be recording this session so that I do not have to take notes and can pay more attention to what you are saying. Second, there are no right or wrong answers here. We want to hear from you about your views and perceptions. Please be assured that your confidentiality will be maintained. Third, since we have only __ hours for this focus group and several questions we would like to go over, if I feel that we have stayed on a question for too long, I will intervene to wrap up and move on to the next issue. I may also re-direct to other questions that come up as part of our discussion.

Please let me know if you have any questions before we start. [Answer any pertinent questions that come up].

Basic Information

1. Let's go around and introduce ourselves. Please tell me a little about yourself:
    - Name (will be kept confidential)
    - Age
    - Something unique about yourself (favourite colour/food/etc.) –For the 10-14 to get them comfortable.
    - What do you want to do when you grow up (for 10-14); where do you see yourself in the future/Adulthood?

2. Are you in school?
    - Which class/form/grade?

3. Do you work?
   Probe
   - What type of work
   - Where
   - How do you spend the money?

Puberty & SRH Knowledge

4. What are some of the important changes that girls/boys go through when they become women/men?
   Probe
   - Are you aware of these changes?
   - Please describe them
   - Are these same in case of boys/girls? (Ask to see if they know about the opposite sex)

5. A young girl/boy in your community has questions about bodily changes/puberty. She/he wants to learn more about these changes. Where do you think she/he will go/or who will she/he turn to, to learn more?
   Probe
   - Is there anyone that she/ he would avoid talking to? Why?

6. How about other things like relationships, love, marriage, the biology of sex/reproduction, pregnancy, contraception, STIs, HIV/AIDs?
   Probe
   - Whom or what do young people rely on for information?
   - Is there anyone that young people don't talk to? Don't like talking to?
   - What are the most important sources of information for young people? Whom, what, where and how?

7. Have you ever learnt about these things in school (puberty, relationships, pregnancy, HIV/AIDs and other STIs)?
   Probe

   If yes:

   - Is this useful? Would it be useful? How?
   - Do you have the opportunity to ask questions?
   - Are you comfortable asking questions?
   - How can it be made more useful for you?

   If no:

   - Do you think young people would find the introduction of classes on sexual issues useful?

- How should sex education be taught in schools?
- What methods do you think are appropriate for teaching sex education?
- Who should teach it, at what age?

8. Do young women/men of your age talk about these issues with friends?
   Probe
   If yes:
   - What do they usually talk about?
   - Does it tend to be with female/male only or both sexes?
   - With one person or in a group(s)?
   - Do you think that girls and boys talk about the same or different things? What are the similarities/differences?

   If no:
   - Why not?

Relationships

9. Is it common for a girl to have a boyfriend or boy to have a girlfriend in the community?
   Probe
   - Is this acceptable? Why or why not?
   - At what age would you say that a girl/boy may start dating?
   - Why do you think that girls and boys date? Is this encouraged / discouraged or influenced in anyway, by anyone/some events/things?
   - Does the age of the partner matter?
   - Is the occupation of the partner important?

10. What expectations are there when young people start dating?
    Probe
    - Number of partners
    - Faithfulness
    - Sex
    - Marriage
    - Are there differences between young women and men's expectations?
    - Are there differences between young people and adults expectations?

11. When do young people start having sex?
    - Is this encouraged / discouraged or influenced in anyway, by anyone or anything? *[Probe to cover following peer pressure? Family pressure? Financial pressure?]*
    - What discussions/negotiations go on before sex takes place?
    - Do young people receive or give gifts for sex? What do they give/receive? Why do you think they receive or give gifts for sex to?

12. Do husbands/boyfriend hit/ beat their wives/girlfriends when they get angry
    Probe
    - Is this a common event? If yes, can you mention the circumstances?
    - Do you think it is ok to hit a woman for this? Why or why not?
    - How about if she was out and got home late? **Probe**
    - How about if she refuses to have sex with him? **Probe**

Sources of information & health services

13. Can you list for me all the places and people young people are able to visit and talk to, in order to find out about sex, contraception, STI's?
    Probe
    - Where do young people frequently get these services from?
    - How do young people young man/ women usually find out about these services?

14. Where do young people in your community go more frequently for sexual and reproductive health services?
    Probe
    - Why?
    - Is it different for boys and girls?
    - Is it different for married and unmarried?
    - Is it different for those younger than 15 years of age?

15. Sometimes young people may need SRH services or information, but do not use them. Do you agree with this statement? **Probe**
    - Why or why not?
    - Why do you think some young people do not use these services *[Probe for privacy/confidentiality, attitudes, cost, distance, hours of operation]*.
    - How can these services be made better for you
16. How can these SRH services be better advertised

17. Can you think of 3 words which are the most important to use when advertising and promoting SRH services for you young people?

PAVING THE PATH TO IMPROVED ADOLESCENT SEXUAL AND REPRODCUTVE HEALTH IN NIGERIA

Focus Group Discussion Guide for Adults

(Generic Version)

Introduction

Hello. My name is _____. We have invited you here today to speak about the sexual and reproductive health of adolescents, that is, young people between the ages of 10 and 19. Our reason for conducting this focus group is to gain a better understanding of your views and perceptions as parents/ teachers/service providers about sexual and reproductive health knowledge and behaviours of young people today. We also want to hear views about the information and services related to sexual and reproductive health available to young people today. Please note that when I say sexual and reproductive health I refer to body changes/puberty, sexual intercourse, prevention and management of sexually transmitted infections and HIV/AIDs as well as pregnancy.

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Please let me know if you have any questions before we start. [Answer any pertinent questions that come up].

Collect basic information on SE characteristics. Note: This also helps participants to settle in and become more comfortable

Aspirations/Expectations [Adults other than health service providers]

1. What do you believe are the most important goals for adolescent boys and girls today?
   Probe
   - How best can these be achieved?

2. What are some of the biggest challenges that adolescents face as they transition from childhood to adolescence?
   Probe
   - Individual, social?
   - How about in terms of education?
   - What about sexual and reproductive health issues? [if it hasn't come up]
   - Is it different for boys and girls?

3. How about from adolescence to adulthood?
   Probe
   - Individual, social?
   - How about in terms of education, employment?
   - What about sexual and reproductive health issues? [if it hasn't come up]
   - Is it different for boys and girls?

Sexual development [Adults other than health service providers]

1. To what extent do adults discuss sexual and reproductive health with their children or other young people?
   Probe
   - Do you think adolescents feel comfortable going to their parents for information and advice on sexual and reproductive health?
   - What sorts of issues may be discussed?
   - How often do you think adolescents ask their parents for information or advice regarding sexual and reproductive health issues?

2. Has an adolescent or young person ever come to you seeking advice or information about sexual and reproductive health (puberty, relationships, sex, contraception, and pregnancy)?
   Probe
   - In what capacity (i.e. as the parent, teacher, someone they look up to, other)?
   - What sort of information or advice did they want?
   - What information did you provide? **Probe further**
     - Were you able to answer their questions?
     - Did you speak about contraception? If yes, what did you suggest?

Sources of information [All]

1. Do you think that young people are adequately informed about sexual and reproductive health, including their rights and responsibilities?
   Probe
   - Who should be responsible for this education?
   - What are the roles of parents, educators, health service providers, and community leaders?

2. How do you feel about sexual and reproductive health education being taught in schools?

   [Ask them to list what they think is in the curriculum]

   Probe
   - Are the topics covered appropriate? What issues should or should not be discussed?
   - Should it be different for boys and girls?
   - Does this education start too early or too late

3. Can you list for me all the places and people that young people are able to visit and talk to, to learn about sexual and reproductive health (puberty, sex, contraception, STIs, HIV/AIDs, and pregnancy)?
   Probe
   - Are these different for boys and girls?
   - Is it different for married and unmarried boys and girls?

- How about for boys and girls under the age of 15?
- How do boys/girls usually find out about these resources?

Sexual and health services [All]

1. What types of sexual and reproductive health services are available in your community? *[Have the respondents list all possible services. If no one mentions, probe for family planning (contraception), pregnancy testing, STI testing, ANC, PNC*]

2. Where do you think that young people can get services for sexual and reproductive health issues? [Have the respondents list all possible places]
   Probe
   - Is it different for boys and girls?
   - Is it different for married and unmarried?
   - Is it different for those younger than 15 years of age?
3. Where do you think they go more frequently for services?
   Probe
   - Why?
   - Is it different for boys and girls?
   - Is it different for married and unmarried?
   - Is it different for those younger than 15 years of age?

4. Sometimes young people may need SRH services or information, but do not use them. Do you agree with this statement?
   Probe
   - Why or why not?
   - Why do you think some young people do not use these services

Sexual Health Services [Service providers only]

1. Are health care workers comfortable in advising/ treating adolescents on sexual reproductive health issues?
   If yes
   - Why

   If no
   - Why
   - Who is best positioned to talk to adolescents and give advice? Ask for gender and age of service provider
   - Do clinics and hospitals have appropriate resources to these needs of adolescents? (resources including equipment, condoms, contraceptives, private rooms)
   - What needs to be done for health care providers to be able to attend to adolescents

2. Are service providers given training for providing services to adolescents?
   - What type of training?
   - If not, do you think it would be useful?
   - How best can they be trained? Why?
   - What information would be useful to be given in theses trainings?

3. In your community, do you have dedicated health care facilities with adolescent/youth friendly services?

If yes

- How many?
- Are they standalone clinics or they are within the normal health care facility?
- Are there enough for the adolescents?
- Do the adolescents use the services?

If not

- Do you think that services are needed in your community? Why?
- Where should they be situated? (Within a normal health facility or as standalone)

Sexual Health Services [Service providers, teachers, community leaders]

1. Where do think is the largest gap in providing SRH services to young people/adolescents?
   Probe
   a. How can this be improved?

2. What do you think are the best ways of advertising and promoting sexual health services?
   Probe
   - Can you think of 3 words which are the most important to use when advertising and promoting sexual health services for young people?

Perceptions, Norms, Attitudes [All]

1. Do you think boys and girls should date?
   - Why?
   - What do you think are the main considerations?

2. What do you think is the ideal age for marriage for a girl? And boy?
   Probe
   - Why?
   - What do you think are the main considerations?
3. Do you think that the views of young people/adolescents about relationships, marriage, sex, HIV, and/or pregnancy are different from those of the older generations?

   Probe

   - How so?
   - Why?
   - How do you feel about that?
   - Are there circumstances where sex is encouraged or discouraged?
   - Do you think young people are under pressure to engage in sex?

4. Do you think that adolescents should have access to contraception including condoms?
   - Why/why not

This study examines the determinants of adolescent sexual behavior and fertility in Nigeria, with a special focus on knowledge, attitudes and behaviors of adolescents aged 10-19 years old in Karu Local Government Authority (LGA), a peri-urban area near the capital city of Abuja. Using the last three waves of Demographic and Health Surveys (2003, 2008, 2013), focus group discussions, stakeholder interviews, and a specialized survey of 643 girls and boys aged 10-19 years old in Karu LGA, the study narrows in on key challenges to and opportunities for improving adolescent sexual and reproductive health outcomes. This includes addressing gaps in health data, especially for the 10-14 year olds; (ii) scaling up availability and access to youth-friendly services and the Family Life and HIV Education (FLHE); (iii) reaching out-of-school adolescents with SRH information; and (iv) generating greater support and enforcement, especially at the sub-regional level, of the Child Marriage Act (2003) which sets the legal age at marriage at 18 years old.

ABOUT THIS SERIES:

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author/s whose name appears on the paper. Enquiries about the series and submissions should be made directly to the Editor Martin Lutalo (mlutalo@ worldbank.org) or HNP Advisory Service (healthpop@worldbank.org, tel 202 473-2256).

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