



**Nigerian Urban Reproductive  
Health Initiative**

**Literature/Desk Review of Existing Data and Policies on Youth  
& Adolescent Sexual and Reproductive Health and Rights in  
Nigeria, with Special focus on Kaduna, Lagos and Oyo states**

**To**

**Johns Hopkins Public Health in Nigeria Initiative (JHPHINI) /  
The Nigerian Urban and Reproductive Health Initiative  
(NURHI Project)**

**By**

**Foyinsola Oyebola**

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## TABLE OF CONTENTS

List of Acronyms .....	5
Section One	
1.0 INTRODUCTION .....	7
• Context of the Study .....	7
• Rationale for the Study .....	10
• Background/Objective .....	11
• Methodology .....	11
• Target Population .....	21
• Definition of Terms .....	22
Section Two	
2.0 CONCEPTUAL & THEORETICAL FRAMEWORK .....	26
2.1 Diagrammatic representation of conceptual framework .....	27
2.2 Factors Influencing Adolescent/Youth SRH & Rights in Nigeria	27
2.2.1 Adolescence .....	28
2.2.2 Family .....	30
2.2.3 Culture .....	32
2.2.4 Religion .....	34
2.2.5 Peer Pressure .....	37
2.2.6 Technology .....	38
2.2.7 Mass Media .....	41
2.2.8 Economy/Poverty .....	41
2.2.9 Government & Policy .....	42
2.3 Theoretical Framework .....	48
Section Three	
3.0 EMPIRICAL FINDINGS .....	52
3.1 Sexual/Reproductive Health Knowledge, Attitude & Behaviour of Adolescents & Youth .....	53
3.1.1 Understanding human sexuality .....	53
3.1.2 Sources of Sexuality Information .....	54
3.1.3 Sexual Initiation & Current Sexual Activity .....	56

3.1.4	Knowledge & Attitude towards Rights .....	61
3.2	Availability & Access to SRH Information & Services .....	63
3.2.1	Family Life Education/Sex Education .....	63
3.2.2	Youth – friendly SRH Services Family Life Education & Counseling Sexual/Reproductive Health Practices .....	64
3.2.3	Youth & Adolescent Health Seeking Behaviour .....	67
3.3	Health Outcomes of A&Y Risky Sexual Behaviour .....	68
3.3.1	Unwanted Pregnancy & Early Motherhood .....	68
3.3.2	Abortion .....	70
3.3.3	Sexually Transmitted Infections & HIV/AIDS .....	71
4.0	Sexual & Reproductive Rights .....	73
5.0	SRH & Rights Policy Environment in Nigeria .....	73
<b>Section Four</b>		
6.0	Best Practices .....	79
7.0	Discussion .....	85
7.1.1	Summary of key findings .....	86
7.1.1	Knowledge of Human Sexuality/Reproductive Health & Rights .....	86
7.1.2	Sources of SRH Information .....	87
7.1.3	Sexual Initiation & Current Sexual Behaviour .....	88
7.2	Availability & Access to SAR Information and Services .....	90
7.2.1	Family Life Education & Counseling Services .....	90
7.2.2	Service Utilization by Youth & Adolescents .....	90
7.2.3	Family Planning/Child Spacing & Contraceptive use .....	91
7.2.4	Unwanted Pregnancy and early Motherhood & Abortion .....	92
7.2.5	Sexually Transmitted Infection & HIV/AIDS .....	92
7.2.6	Sexual & Reproductive Rights.....	93
7.2.7	Sexual & Reproductive Rights Policy Environment in Nigeria .....	94
7.3	Challenges/Barriers to Youth & Adolescent SRH & Rights .....	94
7.4	Key Learning Questions .....	98
7.5	Conclusion & Recommendation .....	99

Section Five

Bibliography .....102

Appendices 116

(i) Score card on performance of Kaduna, Lagos & Oyo FLHE program .....125

(ii) List of Youth – Focused NGOs/CSOs in Kaduna, Lagos & Oyo States .....126

<b>LIST OF ACRONYMS</b>		
<b>S/N</b>	<b>Acronyms</b>	<b>Meaning</b>
1	AAAA	Addis Ababa Action Agenda
2	AFCS	Adolescent Friendly Contraceptive Services
3	AHI	Action Health Incorporated
4	AIDS	Acquired Immune Deficiency Syndrome
5	ASRH	Adolescent Sexual Reproductive Health
6	ASRH&R	Adolescent /Youth Sexual Reproductive Health & Rights
7	BBS	Behavioural Surveillance Survey
8	CDI	Community Directed Intervention
9	CSO	Civil Society Organizations
10	FAHPAC	Family Health and Population Action Committee
11	FMOE	Federal Ministry of Education
12	FMOH	Federal Ministry of Health
13	FP	Family Planning/Child Spacing
14	HBM	Health Belief Model
15	HIV	Human Immunodeficiency Virus
16	IBBSS	Integrated Biological & Behavioural Surveillance Survey
17	ICPD	International Conference for Population & Development
18	IPPF	International Planned Parenthood Federation
19	IWHC	International Women Health Coalition
20	KABP	Knowledge Attitude Behavior & Practice
21	LEEDS	Local Economic Empowerment and Development Strategy
22	LGA	Local Government Authority
23	LMIC	Low and Middle Income countries
24	MCH/FP	Maternal & Child Health / Family Planning
25	MDG	Millennium Development Goals
26	MTEF	Medium Term Expenditure Framework
27	MTSS	Medium Term Sector Strategies

S/N	Acronyms	Meaning
28	NBS	National Behavioural Survey
29	NDHS	Nigerian Demographic Health Survey
30	NEEDS	National Economic Empowerment and Development Strategy
31	NIDI	Netherlands Interdisciplinary Demographic Institute
32	NPC	National Population Commission
33	NURHI	Nigerian Urban Reproductive Health Initiative
34	SDG	Sustainable Development Goals
35	SEEDS	State Economic Empowerment and Development Strategy
36	SOME	State Ministry of Education
37	SRH	Sexual Reproductive Health
38	SRH&R	Sexual Reproductive Health & Rights
39	STI	Sexually Transmitted Infections
40	TOR	Terms of Reference
41	UN	United Nations
42	UNFPA	United Nations Population Fund
43	USAID	United States Agency for International Development
44	USD	United States Dollars
45	WHO	World Health Organization



## **Section One            INTRODUCTION**

### **The context of the study**

The sexual and reproductive health of adolescent and youth is a pressing concern, especially because the world has a larger population of young people now than ever before (Chandra – Mouli et al, 2015; Woog, et al, 2015). Nigeria’s population is estimated to be 183.5 million with an annual growth rate of 3.2% (NDHS, 2013; IBBSS, 2014). About one third (36.5 million) of Nigeria's total population are youth between the ages of 10 and 24 and it is estimated that by 2025, the number of Nigerian youth will exceed 57 million (FMOH 2011; NDHS 2013; Santhya & Jejeebhoy, 2015; NBS, 2015; Envuladu et al, 2017).

Young people constitute a significant group in terms of demographic parameters and a unique population in terms of characteristics due to their developmental processes (AHI, 2010; FMOH, 2011). In particular, the adolescence phase is a time of opportunity and risk, during which attitudes, values and behaviours that form a young person's future begin to develop and take shape, in addition, nearly 35% of the global disease burden have their roots in adolescence (Aji et al, 2016; Abiodun et al, 2016) The World Health Organization estimates that 70% of premature deaths among adults are largely due to behaviours initiated during adolescence, unfortunately, Sexual Reproductive Health information, services and support needed for adolescents to make informed decisions are lacking in many developing countries including Nigeria (Aji et al, 2013).

Therefore, sexual and reproductive health of adolescents and youth in Nigeria continues to be a major cause for concern for both government and public health practitioners (Nwoji, 2011; Omo-Aghoja, 2013) For instance, age of sexual debut is generally low, yet there is dearth of knowledge on sexuality among adolescents, parents and teachers (AHI, 2010). Nigeria has the highest rates of adolescent fertility in sub-Saharan Africa and over 900 000 births to adolescents occur annually and 150 out of every 1000 women who give birth in Nigeria are 19 years old or under (FMOH, 2011; NDHS, 2013; Abiodun et al, 2016). Globally, unintended births among unmarried adolescent girls are a major contributor to maternal and childhood mortality, the vicious cycle of ill-health, poverty, and truncated educational opportunities (Izugbara, 2015, NURHI TOR, 2017). Mortality and morbidity from HIV infections and AIDS also compound the poor state of adolescents and youth reproductive health, another aftermath of early age of sexual debut and increased rate of pre-marital sex (Adeyemi, 2007; FMOH, 2011; Aji et al, 2013; Omo-Aghoja 2013; Amoo et al, 2017).

Omo-Agjoja (2013) reported that that women lack access to SRH & Rights due to gender inequality compounded by cultural norms and practice which prevent women from being self-reliant. According to Rafael, et al, (2015), greater clarity and stronger enforcement of the Child Rights Act (2003) will support adolescent well-being by encouraging girl-child education while discouraging early marriages, which are strongly linked to early pregnancies. However, Since the 1994 ICPD in Cairo when the scope of SRH was expanded to include Adolescent SRH and Rights (FMOH, 2011, Omo-Aghoja, 2013), efforts have been made by both private and public sectors to address these issues,

unfortunately, the health indices of youth and adolescents are still poor (Nwoji, 2011; Ugwu, 2014).

In a bid to respond effectively to the health and developmental challenges of young people, the Federal Government, through the Federal Ministry of Health (FMOH) developed a National Adolescent Health Policy in 1995 which was revised in 2007 to reflect the current realities. This development aims to facilitate the rapid translation of the policy into actions thereby confirming the commitment of the Nigerian government to develop the younger generations. In the context of an ever-growing population of adolescents and young people, investments supporting their transition toward leading healthy sexual and reproductive lives are critical not only for the well-being of young people themselves, but also for their families and communities and the country at large (AHI, 2010; Woog et al, 2015).

Because the reproductive health needs of adolescents and other youth remain poorly understood and under-served in many parts of the world (Abiodun et al, 2016), there is a need to better understand and harness the context of adolescents and youth SRH & rights in Nigeria in the design and implementation of realistic programme interventions to improve their health outcomes (NURHI TOR, 2017). Therefore, this desk research was undertaken to review data on historical developments, understand the present, in order to anticipate and prepare for the future. Findings should be for the consumption of a wider stakeholder because according to Ugwu (2012), AHI (2010), sexual and reproductive health is a multidimensional, multisectoral issue, hence it requires the attention of every stakeholder especially as it concerns adolescents and youth.

Future success requires increased political will and engagement of young people in the formulation and implementation of policies and programmes, along with increased investments to deliver at scale comprehensive sexuality education, SRH services that are approachable and non- judgmental, safe spaces programmes, especially for vulnerable girls, and programmes that engage families and communities (Santhya & Jejeebhoy, 2015).

### **Rationale for the current study**

The Nigerian Urban and Reproductive Health Initiative (NURHI) had earlier carried out a project among women aged 24-35 years to check the potential for increased demand for contraceptive use and found indicative response (NURHI, TOR, 2017).

In view of the fact there is inadequate information and access to sexual and reproductive health information and services, young people are continually vulnerable to risky behaviors and negative health outcomes (Aji et al, 2013; NURHI TOR, 2017), a second level of project implementation is being planned, focusing on youth and adolescents aged **15-24** in Nigeria and Kaduna, Lagos and Oyo States in particular. To this end, a review of available data and reports on sexual and reproductive health and rights of adolescents and youth in Nigeria is to be carried out in order to provide needed input for effective programme design and implementation.

## **Background/Objectives of the study**

The overarching aims of the desk/literature review are to:

- Provide relevant information and data on SRH & Rights that will contribute to programme design and implementation in the three focal states (Kaduna, Lagos & Oyo).
- Recommend appropriate implementable intervention and strategies that will maximally deliver improved health outcomes in the three focus states.

## **Methodology**

The articles used for this literature review covered a period of 2005 to 2017, and in all, 126 articles were retrieved following extensive literature searches; of these, 109 were adapted for this article. Others were excluded either because they were extremely old publications, the full texts of the articles were not retrievable or unavailable. Most of the papers adapted for this review article were well-conducted qualitative and quantitative surveys and epidemiological studies, clinical studies, case studies cross-sectional studies and conference papers, relevant research study reports, clinical studies, publications and fact sheets on various aspects of adolescent and youth sexual and reproductive health and rights. The articles were retrieved following extensive literature searches using the following search engines or databases: Google Scholar, PubMed, Semantic Scholar and Popline Elsevier and EBSCO host Academic SEARCH Complete. The search included a combination of MeSH Terms including —Adolescent Sexual and Reproductive Health, Youth Sexual and Reproductive Health, Adolescent and Youth SRH Knowledge Attitude Behaviour and Practice in Nigeria with special focus on Kaduna, Lagos and Oyo States ,

Factors influencing Adolescent and Youth Sexual and Reproductive Health in Nigeria, Reproductive and sexual rights of Adolescent and Youth in Nigeria, Prevalence of Teenage Pregnancy, Abortion and HIV/AIDS among Adolescent /Youth in Nigeria, Contraceptive/Family planning Knowledge and Behaviour. Keyword searches were supplemented with free-text and Google searches for those articles not assigned MeSH Terms. Literature on the subject was also researched using manual library searches from relevant cited textbooks and articles in journals. Majority of existing data was sourced using hard copies of the 2013 NDHS and some journals.

Data on SRH & Rights with regards to knowledge, attitude, behaviour and practice as well as availability and access to sexual and reproductive health information and services were reviewed and analysed .Also data on how youth and adolescence are perceived and contextualized in Nigeria was reviewed with the aim of knowing how crucial they are towards the implementation efforts aimed at improving health outcomes. Table below shows the original studies:

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Abiodun et al, 2016	Qualitative	Access RH knowledge & science utilization among in-school rural adolescents	Ikene LGA, Ogun State	714 in-school rural adolescent	15.62 years	X	X		
Abubarkar, Isa Suleiman, 2011	Qualitative	To collect data for planning appropriate SRH interventions	Kombosto LGA, Kano State, NW, Nigeria	226 in and out-of school adolescents	15.8 years		X	X	
Adegbenro et al, 2006	Quantitative	Assess the effect of training programme on teachers' knowledge of and attitude towards reproductive health education/ sexuality education	Osun State	84 Teachers in Ife			X		
Adeokun et al, 2009	Exploratory & cross sectional	To explore the reproductive health knowledge, sexual behaviour and sexuality education needs of adolescents in Northern Nigeria	North Eastern Nigeria	989 in-school Adolescents	17 years		X	X	

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Akande, F.F, 2010	Qualitative Study	To investigate the magnitude and patterns of sexual coercion experienced by female adolescents	South Western, Nigeria	in and out-of school 475 girls	14 years			X	
Akinfaderin-Agara et al, 2012	Qualitative Study	To assess their access to mobile phones, as well as the barriers and limitations to the use of their phones in seeking RH information & services	Cross River, Akwa Ibom, Gombe and Taraba States, Nigeria	726 young female	19.92 years	X	X		
Amoo et al, 2017	Qualitative	To assess the effects of adolescents' exposure to sexual contents through social media in Nigeria	Lagos, Nigeria	305 Adolescents	14.5 years	X		X	
Chiazor et al, 2017	Qualitative & Quantitative	This study sought to measure the perception of teenagers with regards to teenage pregnancy	Ikorodu & Alimosho LGAs, Lagos State, Nigeria	200 teenagers	16 years			X	X

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Folayan et al, 2014	Cross sectional Quantitative Study	To identify differences in sexual behaviour, sexual practices and forced sexual initiation based on sex and HIV status of adolescents in Nigeria	12 states in Nigeria	1574 Adolescents	14.5 years	X			X
Isa, Abubarkar, 2011	Qualitative	To determine the knowledge of reproductive health and its relationship with contraceptive use among the respondents	Tertiary Educational Institutions in Niger State, North Central, Nigeria	588 students	25.5 years			X	
Isiugo - Abanihe, 2012	Household survey	Examines the age of sexual debut and patterns of sexual behaviour in Badeku & Olunloyo in Oyo State and Ugep in Cross River State	Oyo and Cross River State	450 households with 1050 respondents males & females	37 years			X	X

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Jatau, A.A , 2012	Quantitative survey	To determine the incidence and the attendant health & social problems associated with pregnancies among adolescent girls in Zango Kataf LGA	Population based study in Zango Kataf LGA, Kaduna State	281 pregnant and single parent adolescent girls in Zango Kataf LGA	13.59 years				X
Morhason-Bello et al, 2008	Cross sectional Quantitative Study	To determine the prevalence and pattern of sexual activity of adolescents	Ibadan, Oyo State, SW Nigeria	716 secondary school adolescents	15.62 years	X			
Nnorom Bammeke, 2008	Quantitative	Extent of Adolescents' Knowledge of Sexual and Reproductive Health & Rights in Nigeria	Lagos State	1300 in-school adolescents in Mainland LGA	14.5 years	X			
Nwagwu, 2007	Qualitative	To understand how in-school and out-of-school adolescent girls in use online resources to meet their reproductive health information needs	Owerri, South East Nigeria	1145 Girls	16 years	X	X		

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Odimegu & Somefun, 2017	Quantitative Pooled MDHs 2003, 8, 13	Access RH knowledge & science utilization among in-school rural adolescents	Nigeria	7951	19.5 years	X		X	
Okonkwo P. I, Fatusi, A. O., 3Ilika A. L., 2005	Qualitative	To assess the perception of Nigerian female undergraduate about sexual behaviours of their peers and the type of influence their peers tend to exert on them.	Anambra State, SE Nigeria	588 female undergraduates	19.5 years	X	X		
Omigbodun & Omigbodun, 2004	Qualitative	To elicit the reproductive health concerns of girls at a Christian summer camp with a view to making recommendations on how to improve the content and process of future sessions	Kaduna State	75 girls	14 years	X			

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Oye-Adeniran et al, 2005	Qualitative/c ommunity based Study	To examine further the sources of contraceptive distribution centres	Nigeria	2001	32 years		X		
Oye-Adeniran, 2006	Cross Sectional Descriptive study	To explore the possible reasons for contraceptive - use despite high awareness	4 health zones in Nigeria, Oyo, Anambra, Kaduna & Bauchi	323 homes	32 years				
Oyediran et al, 2002	Quantitative survey	To examine the reproductive health knowledge of Nigerian in-school adolescents, with special reference to pregnancy occurrence at first coitus.	In-school adolescents in four secondary schools in Ibadan, SW Nigeria	828 students	17 years	X		X	
Rafael et al, 2015	Qualitative and Quantitative	The study employs mixed methods to examine ASRH outcomes in Nigeria.	Karu LGA, FCT Abuja	FGD with Adolescents Teachers and Health workers	14.5 years	X	X		

Author (Year)	Type of Study	Aim of Study	Study setting/ Location	Sample Size	Mean/ median age of participants	Major influencing factors (determinants)	Access to SRH information and services	Impact (intermediate determinant)	Health outcomes among adolescents/ youths
Salami et al, 2014	Descriptive/ cross sectional survey	To elicit intergenerational views on the influence of unmet social needs on teenage pregnant	Ogbomoso, Oyo State Nigeria	175 girls	16.5 years	X	X		X
Shonde, 2006	Investigative survey	Explores the importance of impacting sexuality education on adolescent in selected secondary school	Odeda LGA, Abeokuta Ogun State Nigeria	152 students ( 3 private & 3 public schools)	17.5 years	X		X	
Takemi, 2008	Qualitative & Quantitative	To identify the challenges of Adolescents Sexuality and Reproductive Health in Nigeria	Tertiary Educational Institutions in Nigeria	2510 students		X			
Ubajaka et al, 2010 ( peer pressure); sexual debut	Cross sectional descriptive survey	assess the sexual behaviour and practices among secondary school adolescents in Anambra State	Anambra State, SE Nigeria	384 in-school adolescents	14.5 years	X			X

<b>Author (Year)</b>	<b>Type of Study</b>	<b>Aim of Study</b>	<b>Study setting/ Location</b>	<b>Sample Size</b>	<b>Mean/ median age of participants</b>	<b>Major influencing factors (determinants)</b>	<b>Access to SRH information and services</b>	<b>Impact (intermediate determinant)</b>	<b>Health outcomes among adolescents/ youths</b>
Ugwu NH, 2012	Qualitative & Quantitative	To examine the knowledge and use of contraceptive methods among youth	Abuja Metropolis	500 youth	20 years		X	X	
Abdul Wahid, Umma.& Umaru, Yinusa., 2013	Qualitative	Investigates the awareness & knowledge of STD's	Kaduna State	500 SS II students. 250 boys, 250 girls					

## Target population

This literature review, and of course the next level of NURHI project implementation, focuses on youth and adolescents within the 15-24 cohort. The gender breakdown of this sub-group which accounts for about one-third of the national population with some variation across the states is presented below:

### National Total

Age cohort	Male	Female	Total
15-19	8.6%	9.0%	17.6%
20-24	6.7%	7.8%	14.5%
<b>Total</b>	<b>15.3%</b>	<b>16.8%</b>	<b>32.1%</b>

### Break down in the 3 States

Age Cohort	Kaduna	Lagos	Oyo
15-19 (Male)	5.4%	4.2%	4.0%
15-19 (Female)	5.9%	3.9%	3.6%
20-24 (Male)	5.3%	5.3%	3.0%
20-24 (Female)	6.1%	4.0%	3.4%
<b>Total</b>	<b>22.7%</b>	<b>17.4%</b>	<b>14.0%</b>

Source: United Nations Population Fund (2017). Adolescent and Youth Dashboard in Nigeria

## **Definition of Terms**

For better understanding, consistency and clarity of the terms used in this review, the operational meanings are given below:

***Adolescent:*** An adolescent is a young person between ages 10 and 19 years; early adolescent is between ages 10 and 14 while late adolescents are those between 15 and 19 years.

***Adolescence:*** World Health Organisation identifies adolescence as the period of human growth and development that occurs post-childhood and before adulthood (WHO, 2006, Abiodun et al, 2016)

***Adolescence*** is a transitional stage of physical and psychological development that generally occurs during the period from puberty to legal adulthood (age of majority, globally put at 18 years). Adolescence is a progression from appearance of sexual characteristics to sexual and reproductive maturity; development of adult mental processes and adult identity and a period of transition from total socioeconomic dependence to relative independence (Aji et al, 2013)

**Youth:** Simply put, the United Nations describes youth as composed of individuals aged 15 – 24 years (FMOH, 2011; Ugwu, 2013). The National Youth Policy defines Youth as a Nigerian citizen between the ages of 18 and 35 years. (NBS, 2012).

**Young people:** are persons aged 10 – 24 years (Aji et al, 2013).

In a 1998 joint statement, the World health Organisation, the United Nations Children’s Fund, and the United Nations Population Fund agreed on the following categorizations of young people:

<b>Category</b>	<b>Age bracket</b>
Adolescents	10-19
Youth	15-24
Young people	10-24

Evidence from available literature indicates that various terms are used to categorize youth and young people, hence some authors use the terms adolescents, youth and young persons interchangeably. However, for the purpose of this study, youth – a phase that overlaps with late adolescent (ages 15 – 24) will be adopted often because it encompasses the target group for the proposed NURHI 2 intervention.

**Sexual Health:** According to Edward & Coleman (2004) Sexual health is the ability of women and men to enjoy and express their sexuality and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. In order to be sexually healthy, one must be able to have informed, enjoyable and safe sex, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health experiences enhance life quality and pleasure, personal relationships and communication, and the expression of one’s identity.

**Reproductive Health:** The UN Conference on Population and Development held in Cairo, 1994 defined reproductive health as: ... *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so* (Nwagwu, 2007: Page 2)

**Components of SRH:** According to FMOH (2011) and Omo-Agjoja (2013) the scope of SRH was defined in the ICPD program of action to include the under-listed; however the scope of this literature review will not cover the whole range:

- Safe motherhood and child survival,
- Family planning information and services,
- Prevention and management of infertility and sexual dysfunction in both men and women,
- Prevention and management of the complications of abortion.
- Prevention and management of reproductive tract infections, especially STIs including HIV/acquired immunodeficiency syndrome (AIDS),
- Adolescent reproductive health, responsible and safe sex throughout life and gender equality.
- Elimination of harmful practices, such as female circumcision, childhood marriage and domestic violence against women as well as management of non-infectious conditions of the reproductive track system (genital tract fistula,

malignancies, complications of female genital mutilation [FGM] and menopause) and men's SRH, in particular andropause,

- Provision of safe abortion services where the law permits

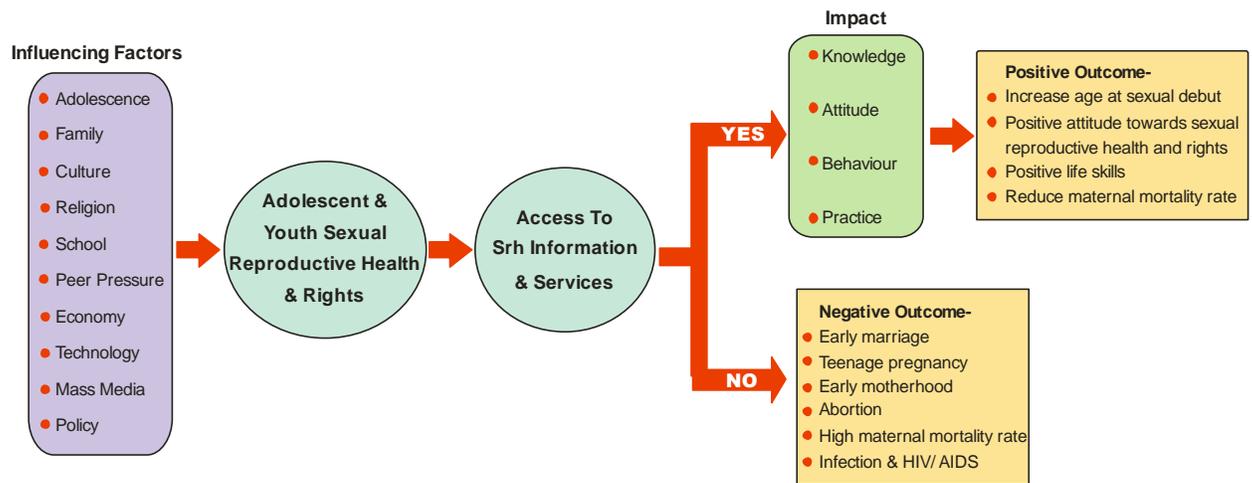
***Reproductive Rights:*** Reproductive rights implies that people are able to have a satisfying and safe life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Therefore, men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning, safe pregnancy & childbirth, and best chance of having healthy infant (Advocate for Youth ; Omo-Agojah,2013; Santhya and Jejeebhoy, (2015).

## **Section Two            CONCEPTUAL/THEORETICAL FRAMEWORK**

Sexual and reproductive health is influenced by a combination of socio-cultural, economic, political, technological and environmental factors Nwoji, (2011), Odimegwu and Somefun, (2017). Consequently, achieving desired outcome by way of improved knowledge and attitude; healthier behavior and practices among youth and adolescents will depend on a good understanding of these causal factors. In addition, examining how these factors are carefully managed and controlled in the design and implementation of any intervention programme will enhance a successful outcome. Various strategies have been employed to reach young people with information and services in the past 2 decades to achieve positive sexual and reproductive health, attitude and practices but their health indices are still poor (Morris & Rushwan, 2015) therefore a review of the contextual factors influencing adolescent & Youth SRH& Rights will provide fresh insights into the problem and approaches for achieving optimum health outcome (Blum et al, 2013).

In reviewing available data and reports, therefore, we would be guided by a conceptual approach that begins with the influencing factors and how they affect or determine SRH & Rights knowledge, attitude, behavior and practices; outcome in terms of behaviour change; challenges and strategies for achieving improved health outcomes. Using the existing evidence base, this paper presents a working conceptual framework to guide future research as well as programmatic and policy efforts for this critical population.

## 2.1 Conceptual Framework



*Diagram 1: Conceptual Framework for the Sexual & Reproductive Health & Rights of Nigerian Youth and Adolescents*

## 2.2 Factors Influencing SRH & Rights

This section discusses the contextual factors influencing the Sexual and reproductive health and rights of the youth and adolescents as illustrated in diagram 1 above. This framework suggests that A/YSRH& Rights could be influenced positively or negatively by some factors listed as shown in the figure above. The positive influence is reinforced if adolescents have access to SRH information and services leading to enhanced knowledge, Attitude, Behaviour, Practice (**Impact**) and sustained impact leads to positive outcomes such as increased age at sexual debut, positive life skills and reduced maternal mortality and morbidity rates etc. On the contrary, failure to access SRH information and services will predispose adolescents to negative outcomes such as early marriage, teenage pregnancy, abortion etc. as expatiated below.

### **2.2.1 Adolescence**

A comprehensive definition of adolescence by Evbuoma, (2013: page 101) attempts to unravel the critical elements of the adolescence phase –it says and I quote “Adolescence as a season of life interesting to observe or experience, is characterized by and synonymous to puberty; beginning at the end of childhood, and spanning the entire teenage years. At puberty, adolescence maturation indices falsely project adolescents as fully matured, ready to participate in rights accorded adults, including sexual rights. On the contrary, adolescence is better viewed as a growth period of the human sexual organs, and human sexuality, among others; in preparation toward adulthood, rather than a developmental stage in lifespan when teenagers' body should be cheaply sexually explored and exploited, before sexual rights are accorded its victim”. WHO describes adolescence as a period of life with specific health and developmental needs and rights, a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles. Nwagwu (2007) describes adolescence as a critical period of human development often characterized by confusion, mixed interpretation and understanding of adult behaviour and environment, excitement and a desire for experimentation, especially with drugs, alcohol and sex; and of all challenges, those associated with sexual maturation are the most distinctive and most problematic. Therefore, the turbulent nature of adolescent phase may predispose the individual to serious health consequences if not well understood and properly managed by all stakeholders. Chiazor, et al, (2017) in their paper on the dilemma of teenage pregnancy touched of the relationship between the adolescent rebellious attitudes and teenage

pregnancy, the authors alluded to the fact that some young people get pregnant to show their parents that they are independent.

Nwoji (2011) posits that one of the factors that influence the SRH behaviour of adolescent is the individual characteristics of young people with regards to their knowledge, attitudes, beliefs, values, motivations and experiences. The individual characteristics are often driven primarily by the adolescence phase and secondarily by parental, peer and other societal influence. Chandra-Mouli et al, 2015 reported that adolescents and young people lacked understanding of sexuality, reproduction, and sexual and reproductive health; because they were not getting the information and education they needed at home, at school, or elsewhere in their communities.

According to Woog et al, (2015) adolescence is a period of emerging sexual desires, behaviors and relationships. These are a normal part of development and, when supported by healthy decision making and access to information and services, can form the basis of lifelong sexual health and overall well-being. However, due to a host of biological, social and economic factors, adolescents can be at high risk of adverse sexual and reproductive health outcomes, including unintended pregnancy, unsafe abortion, HIV and other STIs. It is therefore important that adolescents and other stakeholder have a holistic view of the adolescence phase for a meaningful SRH intervention programmes. The content of family life education must take into account the need to prepare adolescents for this transition period.

### **2.2.2 Family/Community**

Family is a group consisting of two parents and their children living together as a unit of the society. Family is either nuclear – made up of just the father, mother and the children, or extended which in addition to the nuclear family, includes uncles, aunties, cousins and grandparents. The extended family system is most prevalent in Nigeria and according to Shonde (2006), adolescent development takes place within the context of the nuclear or extended family and the health and development of youth and adolescent depend on the quality of family relationships and societal expectations.

Ideally, parents are the earliest socialization agents in the children's lives, therefore the family as a unit of care can mitigate adolescent problems (Nwoji, (2011), hence family cohesion is conceptualized to include the degree of commitment, help and support that family members provide. Parents could have either negative or positive influence on the sexual activity of their children because, on one hand, children of good parents have good home training and would grow up to be youth who abstain until marriage, while on the other hand, children (especially females) of bad parents stand a higher chance of being pushed consciously or unconsciously by their mothers into early sexual initiation (Aji et al, 2013).

Many studies have associated poor family background or parental guidance to risky sexual behaviour (Advocate for Youth, AHI, 2010; FMOH, 2011, Nwoji, 2011). Chiazor, et al, (2017) reported that negative community influence such as social disorganization, fewer

economic resources could predispose teenagers to engage in sex at an early age and this often result in pregnancy.

Some of the parental barriers might be due to family instability arising from death of any of the parents, divorce, or separation and these can have a lasting effect on adolescent behavior and development (Aji et al, 2013; Chiazor, et al, (2017) .Low family cohesion is associated with adolescent sexual risky behavior while high family cohesion is associated with effective parenting, that is nurturing and supportive, with clear and consistent discipline (Nwoji, 2011).

Slap et al (2003) observed that the family structure (polygamous or monogamous) could influence sexual behaviour, this is based on the findings from a study which showed that Sexual activity was more common among students from polygamous families (42% of students) than monogamous families and the assumption is that children from polygamous lack adequate attention and family cohesion. Evidence from available literature show that even though young persons prefer to receive sexuality information from their parents and or teachers, unfortunately, many parents feel ill-equipped to help prepare their children for the experience of adulthood which they themselves never had (FMOH, 2011; AHI, 2010; Advocate for Youth; Nwagwu (2007)

The youth and adolescents require safe and supportive families, safe and supportive schools and positive and supportive peers, unfortunately, the environment, includes parent–child relationships and relationships between adolescents and their teachers or other potential

adult mentors, falls short of meeting adolescents' needs and protecting their rights (Aji et al, 2015). Nwoji (2011) emphasized the need for parents to exert positive influence through modeling and recommended parental monitoring and effective communication with the adolescent children to prevent association with deviant peers, a primary pathway leading to the onset and escalation of high-risk behavior in adolescence.

### **2.2.3 Culture**

Culture is a way of life of a people, which can determine their development over time (Ojua & Ndom, 2013). Positive cultural practices such as the extended family system; adequate care for new mothers for 40 days after delivery; prolonged breastfeeding; virginity at marriage and respect for elders promote the wellbeing of members of the society (Asu et al, 2007; Morris & Rushwan, 2015). Harmful cultural practices are those customs that are known to have bad effects on people's health and obstruct the goals of equality, political and social rights. Nigeria as a country is made up of people from different ethnic groups and cultural practices with over 250 ethnic groups with different cultural practices (Asu et al, 2013; Odimegwu and Somefun, 2017)

The complexity around SRH & Rights in Nigeria stems from the diversity and complexity of each cultural group. Every ethnic group has a predefined culture which dictates people's behaviour and attitude towards their sexuality, sexual practice, behaviour and attitude. Understanding the basics of culture will explain why there are barriers to sexual and reproductive health of adolescents and youth in Nigeria and assist in developing culturally –sensitive interventions to address them. Evidence from literature confirms that majority

of the barriers to sexual and reproductive health of adolescents and youth are deeply rooted in culture (AHI, 2004; Advocate for Youth, no date; Omo-Aghoja, 2013; Morris & Rushwan, 2015).

Some of the most common traditional practices that infringe on the reproductive rights of Nigerian men, women and young persons, particularly the rights of the girl-child includes, female genital cutting, forced early marriage, traumatic puberty initiation rites, labour and delivery practices, gender based violence, wife inheritance and widowhood rites (Fadeyi & Oduwole; 2016)

Child marriage is a common practice in Nigeria, which deprives the girl of education thereby resulting in poor economic status, low self-esteem, poor decision making skills, and teenage pregnancy (Omo-Aghoja, 2013; Odimegwu & Somefun; 2017; Sinai et al, 2017). Evidence from Advocate For Youth Factsheet revealed that the traditional Nigerian masculinity or male dominance is still very prevalent and it encourages men, young and old, to dominate relationships with women. Hence, men may be less likely to accept a woman's request to use a condom or her desire to abstain from sexual engagement entirely, thereby increasing sexual and reproductive health risks for both partners. In addition, Advocate for Youth fact sheet reported that young woman's difficulty in negotiating condom use is further exacerbated in cross-generational relationships, which are fairly common in parts of Nigeria. Many cultures in Nigeria have preference for the male child and accord him certain privileges often to the exclusion of the female counterpart. This leaves the female with little or no education and at a low socio-economic stratum with sex

as the only bargaining tool (Aji et al, 2013). The patriarchal ideology discussed earlier influences sexual behavior such that young people with traditional gender role attitudes appear to be poorer contraceptive users than those with less traditional attitudes (Nwoji, 2011).

There are widespread gender inequality due to discriminatory culture, norms and practices in Nigeria which leads to denial of access for young persons to sex education or contraceptives, rights to inheritance which prevent women from being self-reliant. (Omo-Agjoja, 2013), Evidence from available literature show that despite urbanization, many of today's adolescent girls are better educated, healthier, more aware of their rights and better equipped to advocate on their own behalf than the previous generations, however, many still face threats to their health and rights and unmet health needs especially youth residing in rural areas (Takemi, 2000; Advocate for Youth; AHI, 2010; Santhya & Jejeebhoy, 2015).

#### **2.2.4 Religion**

According to Fadeyi & Oduwole (2016), NURHI2 (2016) religion is one of the most important social institutions with universal effects on various aspects of people's lives, attitudes and behaviours, and the universal influence of religion in people's lives is derived from its social functions. There are two major religions in Nigeria – Christianity and Islam and Nigerians are very religious: they believe strongly in their faith (Adamu, 2011)

Some of the functions of religion for individuals and groups include enabling people to cope with and face various problems of life such as health and ill health, participate actively in the society by upholding and legitimizing the social norms and values, including

morality (Fadeyi & Oduwole; 2016) There are positive aspects of religion with regards to SRH, for instance, the core of Christian Injunction about sexuality is chastity (Fadeyi & Oduwole (2016), this injunction encourages abstinence for the youth and faithfulness in marriage. This restraining factor towards sex was identified by some adolescent respondents as one of the major factors for abstaining from pre-marital sex; the youth acknowledge the fact that their religion forbids pre- and extramarital sex (Nwoji, 2011; Aji et al, 2013); this is a welcome development which should be encouraged.

Unfortunately, there are still pockets of religious barriers that undermine progress towards achieving universal access to SRH information and services. Some of the common religious barriers may be due to lack of knowledge of SRH or religious fundamentalism:

According to Sinai et al, (2017) in Northern part of Nigeria, there is the strong belief in the religious injunctions to procreate with the belief that children constitute flow of gifts from divine providence which must not be refused; in addition, polygamy and wife competition for inheritance and preference also influence SRH behaviour and practice.

Early marriage is still very common in the Northern part of the country which is predominantly Muslim. From the Islamic perspective early marriage is seen as a very good means of preventing promiscuity and sex outside marriage. Hence, once a girl attains the age of puberty a girl within the context of Islam, she is ready to have children. Early marriage and childbearing predisposes the teenager to complications such as VVF, anemia in pregnancy (Fadeyi & Oduwole, 2016). Most times, early marriage is compounded by age differences between partners (Morris & Rushwan, 2015).

According to Fadeyi and Oduwole (2016), Christian theology affirms that sexuality is part of the creation and that it is fundamental to the human experience and Christian identity. Therefore, Family planning is not totally acceptable to the Christian community because of their understanding and interpretation of the biblical injunctions which states in Genesis 1vs 28 “be fruitful, and multiply and replenish the earth and subdue it and have dominion over the fish, of the sea, the fowl of the air and over the living things”. Catholics forbid modern contraceptives because they are considered injurious and hindrance to human procreation as enshrined biblically. (Fadeyi &Oduwole, 2016; NURHI, 2016), Islamic Perspective is that family planning should be replaced with child spacing, using methods, acceptable in Islam (NURHI, 2006; Adamu, 2011).

With respect to Abortion and reproductive rights, evangelical Christians and Catholics have promoted a pro-life value and totally been opposed to the pro-choice and their institutional agenda of sexual rights that include abortion (Fadeyi &Oduwole, 2016; NURHI Project, 2016)

Islam Promotes gender equity not equality, it talks about equity and justice between the man and woman. Both sexes are provided with specific rights, privileges as well as responsibilities. Women can be educated, trained, gainfully employed, acquire and maintain property, as well as equity in inheritance (Fadeyi & Oduwole, 2016).

However, the Federal Republic of Nigeria, in response to obvious Reproductive Health problems and in consonance with the international standards, developed and adopted a National Policy on Reproductive Health based on the 1994 International Conference on population and development Program of action. The conference marked a critical paradigm shift from the concept of maternal and child health and family planning to Reproductive Health (Morris & Rushwan (2015). Advocacy on increasing knowledge of SRH & rights and reducing religious bias and barriers to by development agencies are being heightened through the active involvement and participation of relevant stakeholder thereby complementing the effort of the Nigerian government to support the National Policy on Reproductive Health. Stakeholder engagements and crucial conversations are ongoing to appraise the religious barriers and create awareness to reduce misconceptions around SRH & Rights (FMOH, 2011, NURHI, 2016; Fadeyi & Oduwole, 2016).

### **2.2.5 Peer pressure**

Social-psychological theories of health behavior suggest that adolescents' sexual behaviors are influenced by the sexual attitudes and behaviors of their friends (Sieving, et al, 2006). Peer pressure has been explained as a strong feeling that propels individual do the same things as other people of their age for association and recognition. Evidence form available literature shows that peer pressure has been a major social influence on adolescents' and young person's decision making process and another important causative factor which can both positively and negatively influence sexual and reproductive behavior and health of young people (Nwoji, 2011; Okonkwo et al, 2005; Sieving et al, 2006).

Adolescence is marked by the establishment of close, intimate relationships with same and opposite sex peers. It is during this developmental period that teens start relying more on friends for advice and companionship as they slowly individuate from parents. Almost all teens would cite their friendships with peers as one of the priorities in their lives (Nwoji, 2011). According to (Aji et al, 2013) Male adolescents more often than females identify peer pressure as one of the reasons for having sex. Perception of sexual behaviour of peers and the nature of the pressure that peers exert support pre-marital sex, however it is believed that peers would also respect and support the decision of those that choose to practice sexual abstinence (Okonkwo et al, 2005). In a study by (Sieving et al, 2006) to establish friends' influence on adolescents' first sexual intercourse, using the theory of triadic influence, findings suggest that the timing of adolescents' first intercourse is determined, in part, by the norms for sexual behavior and the perceived values of youth friendship groups. However the role of peers as a source of positive information has been documented in earlier study which showed positive sexual behavior changes among adolescents following a peer intervention program.

### **2.2.6 Technology**

Evidence from literature show that little is yet known about the effects of technology, such as the use of internet on sexual socialization and development, but there is reason to believe that there may be differences in the effects of new versus traditional media (Collins et al, 2012; Olusesan et al, 2014).

Olusesan et al (2014) reported that very few studies in Nigeria have examined the sexual content of the Internet in relation to the sexual behavior of the young people as compared with developing countries such as United States of America.

However, Nwoji (2011) alluded to the fact that there has been an increase in the wave of sexual and reproductive behavior since the advent of modern communication technology in Nigeria. (Nwoji, 2011). A publication for Centre for Disease Control and Prevention on ‘Adolescents, Technology and Reducing risks for HIV, STI and pregnancy by Mesnick et al (2013) noted that digital technology, including the internet, mobile phones and gaming increasingly influence the lives of adolescents. These technologies allow youths to engage in age-old behaviours such as chatting, flirting, and dating in novel ways. They also provide youths with anonymous avenues for seeking health information in general and sexual health in particular.

The excessive use of the Internet has recently attracted the attention of scholars and research evidence suggests a relationship between exposures to sexual content in the media (Nwoji, 2011). Given the popularity of the Internet amongst adolescents and youth in

Nigeria, some researchers have investigated the relationship between young adults' involvement with online sexual content (including online chats, meeting partners, and looking for romantic and sexual relationships) and the development of their sexuality. For example Nwagwu (2007) examined the role of Internet for health information seeking purposes amongst adolescent girls in Owerri, Nigeria and found that the out-of-school youth reported that internet is one of their most used sources of information.

Most authors have reported the positive and negative implications of technology on SRH (Nwoji (2011); Collins et al, (2012); Olusesan et al, (2014), however, Collins et al, (2012) opine that both the usefulness of new media in addressing issues of sexual health and their potential role in placing youth at risk depend critically on the extent with which such media are in use.

According to Nwoji (2011), Olusesan et al (2014) new mass media programs can reach a large number of young people of all ages and programs using electronic media can be strategic in reaching out-of-school and rural adolescents. Evidence from MTN Nigeria website indicated that youth 14 – 24 years constitute 21.2% of the total subscriber base of 48 million. Whilst technology might serve a positive purpose in reaching out to the youth, the limitation is the financial resource involved while the impact on sexual behavior may be inconsistent, hence this can be an area for further research.

### **2.2.7 Mass Media**

Mass media (including music, television) are an important part of the adolescent's community (Nwoji, 2011). Evidence from study in the United States on the influence of mass media on adolescent sexual health by Collins et al, (2012) show that most theories of media effects emphasized the much of the research linking media and sex has focused on television because television viewing makes up the largest chunk of adolescents' media use, accounting for 4.5 hours of media time out of nearly 11 total hours spent with media daily.

Exposure to television has been found in quantitative studies as a key correlate to onset of early sex; while locally produced movies as well as foreign films have been identified, particularly in Lagos, as a key catalyst for engagement in first sex (Aji et al, 2013). In view of the technological advancement, further research is required to identify how media strategies can be employed for positive outcome.

### **2.2.8 Economic/Poverty factor**

The influence of economic factors like poverty and unemployment on sexual and reproductive behavior is pervasive. As noted in a USAID publication of 2009, very high rates of unemployment and poverty exist among young people aged 15-24; hence poverty and reproductive health are intricately related. Poverty is associated with high risk behaviours such as unsafe sex in exchange for monetary incentives. These behaviours put young women at risk of unintended pregnancy and sexually transmitted infections such as HIV, which in turn affect their reproductive health. According to Aji et al (2013)

adolescents with low parental income were more sexually active than those who reported high or medium parental income, which is consistent with arguments and reports that economic hardship encourages girls to become sexually active at an early age for economic reasons. The perceived or real rewards, both financial and material, are also major enticements to engage in early sex (Aji et al, 2013)

Studies have documented the association between socio-economic status and sexual behavior which shows that economic deprivation considerably affects ability to negotiate or adopt protective behavior, especially among young women whose sexual partners are often older, richer and more powerful men with whom they may be unable to negotiate safe sex for fear of losing the economic benefits from such relationships (Nwoji, 2011).

### **2.2.9 Government & Policy factor**

According to Nwoji (2011), government can directly or indirectly contributed to the sexual and reproductive behaviour problem among young people through its actions or in-action.

In a study by Santhya and Jejeebhoy (2015) on ‘Sexual & Reproductive Health & Rights of adolescent girls revealed that while governments have reaffirmed many commitments and policy development, however, programme implementation fall short of realizing these commitments.

According to Nwoji (2011) Policies on Adolescents Sexual and Reproductive Health (ASRH) in Nigeria have shown an increasing commitment to the health and development

of young people. However, this commitment has been selective and has not fully addressed adolescent ASRH needs. For example, the Federal Government's decision to allow the Child Rights Act implementation to be left to the discretion of individual states as to whether or not such marriage acts should be passed into law has not helped in promoting optimal sexual and reproductive health among adolescents (Nwoji, 2011). The future success of ASRH & Rights depends on increased political will and engagement of young people in the formulation and implementation of policies and programmes (Santhya &Jejeebhoy, 2015).

### **2.2.10 FROM MDGs to SDGs**

This section discusses the Millennium Development Goals (2002 to 2015) and new the Sustainable Development Goals in relation to ASRH & Rights policy environment. This discussion will provide public health practitioners with insights on the why of SDGs, implications for ASRH and the score card for Nigeria to date.

According to Sachs (2012) the Millennium Development Goals (MDGs) marked a historic and effective method of global mobilization to achieve a set of important social priorities worldwide

The MDGs were introduced and agreed on at the united nation millennium summit in September 2000 with nearly 190 countries, including Nigeria as signatories to the agreement, the eight MDGs were: poverty and hunger; Achieve Universal Basic Education;

Promote Gender equality; Reduce Child Mortality; Improve maternal health; Combat AIDS, Malaria and Other Diseases; Ensure environmental sustainability; Develop a Global Partnership for Development (Igbuzor, 2006; Sachs, 2012; Olabode, 2014)

Alongside the goals a series of 18 targets were also drawn up to give the international community a number of tangible improvement to aim for within a fixed period of time, and also make it easier for

Countries to progress according to the timelines (Olabode et al, 2014) the intention is that almost all of these targets will be achieved by 2015.

### **Nigeria's commitment to the MDGs:**

- According to Olabode et al, (2014), resource commitments were made by the Government of Nigeria to achieve the MDGs. For instance in 2003; a poverty reduction strategy was approved which gave birth to the National Economic Empowerment and Development Strategy (NEEDS), based partly on the Millennium Development Goals (MDGs) and was cascaded to states as SEEDs and LGAs as LEEDs.
- Medium Term sector Strategies (MTSS) were developed to guide the preparation and implementation of the Medium Term Expenditure Framework (MTEF), with 57 percent of total capital spending earmarked for the MDGs related sectors.
- A presidential committee on the MDGs was set up in 2005, with membership comprising of the Federal and State governments, the Legislature,

Civil Society organisations and the Private sector and development. Despite the effort discussed above, Nigeria did not meet the MDGs

A review of conference paper by Igbuzor (2006) highlighted the status of the MDGs implementation in Nigeria, the modest achievement and challenges. The author discussed three major limitations which are – the lack of accurate, reliable, credible and believable statistics; implementation is development assistance - focused, finally that the report did not indicate the policies and practices that need to change to attain the goals. He then concluded that despite the modest efforts, Nigeria may not likely to meet the Millennium Development Goals and that strong political will and sustained efforts are required.

### **Why SDGs?**

At the global level, the MDGs was assessed at the end line of 2015 and findings showed that Developing countries made substantial progress towards achievement of the MDGs, although the progress is highly variable across goals, countries, and regions. However, there were probable shortfalls in achieving the MDGs. Despite the shortfall, policy makers and civil society recognize some progress made in the areas of poverty eradication, hunger, and disease. In addition, policy makers' belief that because the world is already undergoing dangerous climate change and other serious environmental challenges, the need to address worldwide environmental objectives alongside the poverty-reduction objectives. Sachs, (2012). Therefore, the world's governments agreed to adopt a new round of global goals to follow the 15 year MDG period. UN Secretary-General Ban Ki-Moon's high-level global sustainability panel, appointed in the Lead-up to the Rio+20 summit in June, 2012,

issued a report recommending that the world should adopt a set of Sustainable Development Goals (SDGs).

The idea of the SDGs has quickly gained ground because of the growing urgency of sustainable development for the entire world, and sustainable development embraces the triple bottom line approach to human wellbeing. Almost all the world's societies acknowledge that they aim for a combination of *economic development*, *environmental sustainability*, and *social inclusion*. The SDGs comprise of 17 goals with timeline of 2015 to 2030.

### **SDG & SRH & Rights**

According to IPPF (2011) the 2030 agenda includes many achievements in relation to gender equality and women's and girls' empowerment, and sexual and reproductive health and reproductive rights which go beyond the commitments of the MDGs. The 2030 Agenda and sexual and reproductive health and right include:

- **SDG 3** on health and **SDG 5** on gender equality and women's and girls' empowerment include targets relating to sexual and reproductive health and reproductive rights
- Target 3.7, under goal 3 of the agenda, calls for universal access to sexual and reproductive health-care services, including for family planning, information, education, and the integration of reproductive health into national strategies and programmes.

- Target 5.6, under goal 5, calls for universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action and the outcome documents of their review conferences.

In addition, the 2030 Agenda requires all countries to take measures to end discrimination and eliminate violence against women and girls as well as harmful practices, such as child, early and forced marriage and female genital mutilation. It also sets out targets calling for a significant reduction of maternal mortality, an end to preventable deaths of newborns and children under five years of age, an end to the AIDS epidemic, as well as universal health coverage, among other objectives.

***Financing the 2030 Agenda*** - One of the questions that come up frequently in the context of the 2030 Agenda is how the ambitious goals and targets will be funded?

In response to the above question, reference was made to the Addis Ababa Action Agenda (AAAA), agreed in July 2015, which provides the foundation for implementing the global sustainable development agenda, although the AAAA also covers broader issues such as debt and trade.

The AAAA does not refer specifically to funding for SRHR, but does call for increased health financing, especially for women and children “the vulnerable groups”.

The publication recommends that SRHR services need to be a priority for both international and domestic budgets, and governments will need to ensure that they are closing the funding gap through effective resource mobilization.

## **NIGERIA'S SCORE CARD WITH REGARDS TO MDGs**

Nigeria was a signatory to the Abuja Declaration pledge made by the member states of the African Union for a target of allocating at least 15% of their annual budget to improve the health sector, unfortunately, ten years down the road, Nigeria is one of the 20 countries making insufficient progress (WHO, 2011)

### **2.3. THEORETICAL FRAMEWORK**

Available literature show that there are limited direct theories explaining the factors influencing the SRH behaviour, attitude and practice of youth and Adolescent. However, psychologists are adapting early theories of health behaviour for this purpose. Gibson et al (2012) in his paper on Social-Psychological Theories and Adolescent Health Risk Behavior expressed the concerns of parents, the press, and other psychologists: who are curious to know why young people decide to do things that they know can harm their health.

According to Gibson et al, (2012), health psychologists and researchers in the public health domain have been exploring this question for many years. But it has only been within the last two decades that significant numbers of social psychologists have become convinced

that their theories and methods may provide a better understanding of what is a very important, but also a very complex behavior.

In view of the above and for a better understanding of why adolescents and youth engage in risky behaviours and to provide answers to future research questions, this study applies the psychosocial theory of **Health Belief Model (HBM) and perceived vulnerability**. The theory is based on the principle that individuals need a good understanding of the risk associated with their actions (risky behaviour) and the degree of vulnerability, which is an attempt to explain and predict health behaviours by focusing on the attitudes and belief of individuals. It is relevant to the study of SRH behaviour and adoption of services because according to Chandra-Mouli et al, (2015), the standard approaches to improving adolescent health have focused on health promotion, prevention, and treatment of problem behaviors, therefore understanding the deep-seated issues around behaviour will assist in developing appropriate prevention strategies.

Based on the work of Gibson et al, 2012, pages 171 – 174, there are three categories of risk:

- **Perceived risk** implies that individuals are more likely to try to stop an unhealthy behavior such as smoking, unprotected sex or start a healthy one such as dieting if they believe the associated risk of either action or inaction is significant. In the Health Belief Model, risk could be general in terms of perceived seriousness or could be personal based on how susceptible the individual is to the risk - that is

the direct effect on the individual. For instance, a youth want to know if he/she is susceptible to HIV infection.

- **Comparative risk** implies that the youth compares the degree of his/or her own risk with peers, for instance, young smokers may realize their risk for lung cancer is elevated, but still believe that their risk is lower than that of others with the same smoking habits and history. These carefree attitudes tend to reinforce sustained risky behaviour
- **Social comparison and risk** prevalence implies that adolescents and adults are, of course, less likely to change health behaviors if they are not concerned about the consequences. Concern may reflect perceived danger, but it can also reflect perceived prevalence. Rare illnesses usually elicit more concern than common illnesses, and even serious ailments will produce less anxiety if it is thought that many others share the illness or vulnerability to it -- the question of how serious is the health condition and is it life-threatening?

Therefore, in order to change behaviour, benefits must outweigh costs – that is the perceived risk and belief in effectiveness of proposed intervention. The assumption therefore is that young people may change risky sexual behaviour if they understand the severity of perceived risk.

Therefore, in designing feasible SRH & Rights intervention for youth and adolescent in Nigeria, consideration should be given to the implication perceived risks, comparison risks and social comparison and risk prevalence factors.. With these assumptions, the content of

SRH information programmes must be very robust and reflect cause-effect relationship of risky behaviours. Youth and adolescents must understand that there are individual differences and must not compare themselves with other peers.

## Section Three

### 3.0 EMPIRICAL FINDINGS

#### Introduction

This section presents empirical findings on previous studies focusing on the various dimensions of Sexual and Reproductive Health and Rights (SRHR) of youth and adolescents in Nigeria, with special focus on Kaduna, Lagos and Oyo States. Attempt was made to enrich the literature review with region specific studies, articles and papers on the contextual factors associated with the Sexual and Reproductive Health and Rights of Youth and Adolescent in Nigeria. The sub-sections will examine the *(i) Sexual/Reproductive Health knowledge, attitude and behaviour of Youth and Adolescents* in relation to - Knowledge of Human Sexuality, Sources of SRH information, Sexual initiation and Current Sexual Behaviour, Knowledge & Attitudes towards SRH Rights; *(ii) Availability and Access to SRH Information & Services* with regards to Family Life Education & Counseling services, Family Planning/Child Spacing & Contraceptive Use; *(iii) Health Outcomes of Adolescent & Youth Risky Behaviour* in terms of Unwanted Pregnancy & Early Motherhood, Abortion, Sexually Transmitted Infections & HIV/AIDS; *(iv) SRH & Rights Policy Environment in Nigeria* and *(v) Best Practices*.

### **3.1 Sexual/Reproductive Health Knowledge, Attitude and Behaviour of Youth & Adolescents:**

#### **3.1.1 Knowledge of Human Sexuality:**

Evidence from past studies show the need to increase private and public sector intervention to reverse the deplorable health indices (FMOH, 2011; Ugwu, 2012; Abiodun et al, 2016) and the starting point is a good knowledge of adolescent sexuality and associated factors. A comprehensive review of the sexual and reproductive health and rights of adolescent girls in low-income and middle-income countries (LMIC) conducted by Santhya and Jejeebhoy (2015) showed that adolescent girls and boys all over the world are generally uninformed or misinformed about their bodies, sexuality and health promoting behaviours. In his own study, Ugwu (2012) also noted that youth lack reproductive health information on the consequences of risky sexual behavior. Corroborating this, Rafael et al (2015) reported that less than 2% of boys and 6.6% of girls aged 15-19years in Karu Local Government Area of Abuja were able to consistently identify when a female is most likely to get pregnant during the ovulation cycle. Religious factor tends to contribute to this low level of knowledge as study by Sinai et al (2017) showed that religious and Muslim scholars in Borno State were very ignorant of Reproductive health knowledge but their attitude became positive after educating them on basic ASRH concepts. Further evidence of lack of knowledge was reported in a study by Oyediran et al (2002) where they found that majority of sexually active adolescents were not aware of the consequences of their actions at first coitus. The African traditional stance on discussion of sexuality with adolescents/youth has not helped the situation, the study by Nnorom and Bammeke (2008)

carried out in Lagos revealed that not only are adolescents poorly informed, most of them were reluctant to discuss sexuality – a corollary of the silence and secrecy associated with sexual matters in Africa.

### **3.1.2 Sources of SRH Information:**

Source of sexual information is a predictor of ASRH knowledge because it confirms whether or not the adolescents have been informed, the quality and quantity of information received. Aji et al (2015) reported that adolescents generally would prefer to receive constant sexual information from their parents and teachers. However, the authors found that parents are not living up to this expectation because of inhibition to discuss sex-related issues as they believe that such discussion would lure the youth to sexual activities. Findings from the 2005 National HIV/AIDS and Reproductive Health Survey showed that only 39% of adults have discussed sexual issues with their male children/wards over 12 years of age and 51% had discussed such with their female children/wards in the one year preceding the survey (FMOH, 2011)

A School-based study of 714 eligible Nigerian adolescents conducted by Abiodun et al (2016) showed that Schools were the main sources of information (29.7%). Study on demand for Women's Health & services in Northern Nigeria by Sinai et al (2017) showed that women in Kaduna State preferred to talk to their husbands about family planning (because the husbands own them), followed by their mothers, mother – in – law and friends. In addition, women want their mother in law to mediate on their behalf for approval to use contraception.

Nwagwu (2007) examined the role of Internet for health information seeking purposes amongst in-school and out-of-school adolescent girls in Owerri, Nigeria, in order to understand how the two sets of girls use online resources to meet their reproductive health information needs. Findings showed that more than 73% of the girls reported having ever used the Internet; more than 74% and 68% of them being in-school and out-of-school respectively. Results also showed that while parents (66.22%) and teachers (56.15%) are the two sources most used by the in-school girls, friends (63.18%) and the Internet (55.19%) were reported by the out-of-school youth as their two most used sources of information.

Bankole & Singh (2010) noted that most men probably learn about sex from their friends and on the street, rather than from parents or at school except in countries where the majority of teenage men are still in school where sex education has been part of the school curriculum. In related findings of a formative research by Sinai et al, 2017, contraceptive conversation never happened because of bulk-passing. Shittu et al (2007) studied the negative health outcomes related to sexual behavior in adolescents who face unique and challenging economic, health and education problems in our society among public school students in the Oworonshoki region of Lagos, Nigeria, the study showed that 61.5% had sex education from misinformed friends/peers. Morhason-Bello et al (2008) conducted a cross sectional survey among 716 senior secondary school adolescents in Ibadan, Oyo State to understand their sexual behaviour, findings showed that about half of the respondents learn about sex from their friends while others through their parents and media. Ajike & Mbegbu (2016) examined the knowledge of youths on available adolescent/youth friendly

services (A/YFRHS) in Ikeja, Lagos State, Nigeria. Findings showed Friends/peers (45.7%) were the best source of information on adolescent and youth friendly reproductive health services. The most popular services known were family planning (81.6%), voluntary counseling and testing (73.8%), and sexually transmitted diseases (67.3%).

### **3.1.3 Sexual Initiation & Current Sexual Behaviour:**

Even though sexual initiation and activity do vary by region and gender, generally, young people are reaching puberty early and are engaging in sexual activity at a younger age (AHI, 2010; Morris & Rushwan, 2015).

Studies on the sexual and reproductive behavior patterns of young people in Nigeria have shown that early onset of sexual activity and early marriages are highly prevalent as evidenced by the median age at first marriage of 16.6 years (ranging from 14.6 in the Northwest to 21.3 years in the Southwest (FMOH, 2011). Following a review of surveys by NPC and ORC Macro and some direct studies in Anambra, Rivers, Delta and Ogun States respectively States on the sexual practices and behaviours of Nigerian adolescents in the last twelve years, Aji et al (2013) reported that on the average - 20% of women in Nigeria were sexually active by age 15 whilst the median age for first sexual intercourse stood at 17.7% for women and 20.6% for men; (i) in Nnewi, Anambra state 68.3% of in-school adolescents had their first sexual debut between the ages of 13 to 16 years whilst a total of 34.4 % are sexually active (ii) In Niger and Delta states respectively, findings showed that early sexual initiation is consistent with results from other studies. (iv) In Rivers State, 78.8% are sexually exposed whilst their first sexual initiation ranges between

ages 12 to 19 years (v) study on 407 secondary school students in Sagamu Ogun State showed that 64.9% had initiated sexual activity.

On perception and attitude of adolescents towards sexual abstinence in Niger state, findings showed that 73% favored being a virgin until marriage, in Ogun state 76.2% of adolescents agreed that youth should remain virgins until marriage and irrespective of their previous sexual experience, 62.7% of the respondents intended to abstain until they marry, while 30.7% were undecided and 6.6% would not abstain (Aji et al, 2013)

Uche et al (2012) examined the age of sexual debut and patterns of sexual behavior of adolescents never-married in Ugep, Cross River State, and Badeku and Olunloyo in Oyo State. Findings showed that the median age of first sex among never-married males and females were 17 years and 18 years respectively; more than one in five adolescents have had sex before age 16. Never-married males and females initiated sex earlier than ever-married, older respondents. 14% of married men keep other sexual partners besides their wives; also 12% of never-married male respondents with regular sex partners have other sexual partners. Condom use is fairly high, especially in sexual relations involving non-regular partners.

Sangowawa et al (2009) compared the sexual practices of the hearing impaired students with their non-hearing impaired counterparts in Ibadan, Oyo State. A total of 78 deaf students and 74 hearing students with mean ages of 17.1 and 15.8 years respectively participated. Findings showed that 33.3% of the deaf students and 48.6% of the hearing

students had ever had sexual intercourse. Median ages at sexual debut were 16 and 14 years for the deaf and hearing students respectively

With regards to number and type of sexual partners, findings from the study by Aji et al (2013) showed that multiple sexual partnering is very prominent. Findings showed the percentage of sexually active adolescents who have had more than one sexual partner in the target states as follows: 40% in Anambra state; 50.5% in Rivers; 54% in Niger, Cross Rivers 22% and Delta 30% respectively. It further revealed the type of sexual partners by adolescents by state, for instance, in Bida, Niger State, 56.4% of the sexually active adolescents engaged in sex with their boyfriend/girlfriend; 7.4% did with their fiancé/fiancée; 3.6% with a sugar daddy/mummy; 1.3 % had sex with any man/woman and 31.3% gave no response. In Abia State, among sexually active adolescents, the findings were different - 35.8% with classmate/playmate; 25.9% with boyfriend/girlfriend; 10% (boys) with prostitute; 9.3% with sugar daddy/mummy; 4.9% with proposed spouse; 1.2% with strangers and 12.4% with others.

Amoo et al (2017) examined the trends, determinants and health risks of adolescent fatherhood in countries where adolescent motherhood is condemned but with liberal male sexual freedom. The study showed that (i) more than one out of every five adolescents has had two or more sexual partners, (ii) the likelihood of adolescents fatherhood is inversely related to condom use but positively associated with increasing age at first cohabitation and higher number of multiple sexual partners, (iii) adolescents that have attended primary and tertiary institution, are professionals and skilled labourers were less likely to father a

child as adolescents. Similar studies of 4218 students aged 12 – 21 attending schools in Nigeria reported by Amoo et al (2017) showed that more than 34% had engaged in sexual intercourse. Study of adolescents in Karu by Rafael et al (2016) showed that 20% of adolescents in the sample were sexually active with the mean age at 14.8 years for girls and 15.3 for boys.

Morhason-Bello et al (2008) conducted a cross sectional survey among 716 senior secondary school adolescents in Ibadan, Oyo State to understand their sexual behaviour. Findings showed that majority's first sexual exposure was unplanned. The methods of sexual activity were mainly through vagina route while some had also practiced oral and anal sex. Most of those that are sexually exposed had more than one partner.

A study conducted by WHO (2013) to assess the sexual behaviour and practices among secondary school adolescents in Anambra State, Nigeria showed that 34.3% out of the 384 respondents have had their first sexual exposure and are sexually active. 65.0% were males while 35.0% were females. The mean age of initiation into sexual activity was 15.08 years. About 40.8% have multiple sexual partners, while the most common reasons for having premarital sex were peer group pressure 50.0% and monetary gains 27.5%.

On the factors influencing sexual behaviour, Amoo et al (2013) examined the effects of adolescents' exposure to sexual content through social media in Lagos metropolis and identified Facebook, Twitter, YouTube, Flickr, Instagram and LinkedIn as the major types of social media used by these adolescents, and that they are more likely to engage in sexual activity.

The reasons for pre-marital sexual activity as reported in the various reviews by Aji et al (2013) showed that in Anambra State, peer pressure recorded 50%, monetary gain 27.5%, personal satisfaction 16.7%, curiosity 4.2%, lack of home guidance from parents and relative 1.7%; in Niger State, pleasure constitutes 58% of the reasons, to test fertility 22% and to enhance sexual proficiency 7%. In Abia State, the context of sexual intercourse is worrisome because the findings revealed that 5.4% were drugged, 4.1% were raped, 7.4% coerced, 14.2% deceived, 23% of the girls did it out of curiosity and 4.1% represents biological urge.

Slap et al (2003) examined the influence of family structure (polygamous or monogamous) on sexual activity among school students in Plateau state Nigeria aged 12-21 years, Findings revealed that 34% reported ever having had sexual intercourse and 41% reported a polygamous family structure. Sexual activity was more common among students from polygamous families (42%) than monogamous families, an indication that secondary school students in Nigeria from a polygamous family structure are more likely to have engaged in sexual activity than students from a monogamous family structure.

### **3.1.4 Knowledge & Attitude towards Sexual & Reproductive Health & Rights:**

In a school-based cross-sectional study of 714 eligible young persons conducted by Abiodun et al (2016), it was found that about 50% of the respondents were knowledgeable about Sexually Transmitted Infections while 31% were knowledgeable about fertility issues. Knowledge was influenced by being male, having regular access to a telephone and the internet. Almost two thirds, (64.7%), of the respondents, had ever heard about sexual and reproductive health services while 51.0% had ever used the services. Abdulwahid and Umaru (2013) investigated the level of awareness and knowledge of STDs among secondary school students in Kaduna and findings show that students know very little about the forms of STDs, the students have moderate knowledge of the signs and symptom of various STDs, their mode of transmission, and they have poor awareness of the control measures.

Ajike and Mbegbu (2016) examined the knowledge of youths on available adolescent/youth friendly services (A/YFRHS) in Ikeja, Lagos State, Nigeria. Findings showed that most popular services known were family planning (81.6%), voluntary counseling and testing (73.8%), and sexually transmitted diseases (67.3%).

Shittu et al (2007) studied the negative health outcomes related to sexual behaviour in adolescents who face unique and challenging economic, health and education problems in our society. Data was collected from young adults attending public school in the Oworonshoki region of Lagos, Nigeria. Findings showed that 51% had no basic knowledge

about sexual behavioral practice and attitude towards STDs/AIDS (HIV). 41% of boys used condoms for preventing STI/HIV transmission and unwanted pregnancies Also, Omo-Aghoja (2013), in a study of sexual and reproductive health concepts and current status showed that the low level of knowledge of reproductive health among adolescents and limited access of young people to youth-friendly health services have been identified as underlying factors contributing to the rising trend of HIV/AIDS in Nigeria. Only 57% of young people in 2005 knew all the transmission routes for HIV (FMOH, 2011).

Similarly, Suleiman (2011) in a study on sexual behaviour and knowledge of STD among in- school and out of school adolescents in Northern Nigeria found that general knowledge of STD/HIV/AIDS is poor and inadequate but also shrouded in misconceptions and strong emotion. The mean age of the respondent was 15.8 Years with slightly more males 52.4% than female 47.6%, 6.2% of the entire students have sexual experience (8.9% of in school and 17.4% of out of school). Majority of the respondents attributed premarital sex to influence of erotic film from TV, video and cinemas, while majority of their out of school counterparts attributed it to peer group influence. Ajike and Mbegbu (2016) found that friends/peers (45.7%) were the best source of information on A/YFRHS. The most popular services known were family planning (81.6%), voluntary counseling and testing (73.8%), and sexually transmitted diseases (67.3%). The participants knew what adolescent/youth friendly services were but did not know where to get these services from because they were not aware of the available A/YFRHS facilities.

## **3.2 Availability & Access to SRH Services**

### **3.2.1 Family Life Education/Sex Education:**

Shonde (2006) investigated the importance of impacting sex education on adolescents in Odeda local government area in Abeokuta, Ogun State of Nigeria among 150 secondary school students and found that 67% of the students lacked the knowledge. The author noted that despite the importance of sex education for the adolescent, most of them do not have access to it, which calls for the integration of sex education in the school curriculum. Ajike and Mbegbu (2016) examined the knowledge of youths on available adolescent/youth friendly services (A/YFRHS) in Ikeja, Lagos State, Nigeria. Findings showed (82%) of the respondents had general knowledge about A/YFRHS, while (79.5%) of the respondents did not know of a specific A/YFRHS provided in study area.

Adegbenro et al, (2006) assessed the effect of training programme on teachers' knowledge of and attitude towards reproductive health education /sexuality education in five randomly selected rural schools in Ife-North local government area Southwest, Nigeria. The teachers were all given SRH training for one month. Their knowledge and attitude towards RHE/SE were assessed pre-and post-training programme. The results showed a significant increase in percentage of those who had good knowledge in general areas of RHE/SE at post-training assessment compared with pre-training assessment [from 14.3% to 53.6%). Also, pre-post attitudinal disposition assessments showed that there was an increase in percentage of those who were favorably disposed to the teaching of sexuality education in Schools at post-training assessment from 17.9% to 45.2%). The study suggested that sexuality education should be included and made compulsory in all training programme for all teachers in Nigeria.

Isiugo-Abanihe et al (2015) investigated the extent to which out-of-school adolescents across the six geopolitical zones and the Federal Capital Territory Abuja have been reached with sexuality education in Nigeria. Findings showed that most of the youth had been exposed to sexuality education through seminars, trainings and workshops organized by different organizations. However, states in the south were better served than those in the north. Sexually Transmitted Infections including HIV/AIDS prevention accounted for more than 40% of the content of sexuality and life skills education received by out-of-school adolescents. The programmes were reported to have impacted positively on adolescents' disposition and relationship with the opposite sex, knowledge and skill building. This recommendation was based on the findings from the study by where 84% of girls sampled from 24 North-Eastern Nigerian secondary schools Adeokun et al (2009) showed that adolescents should be given sexuality education but only 48.3% had received any.

### **3.2.2 Family planning/child spacing & contraceptive use:**

A study conducted by WHO (2013) to assess the sexual behaviour and practices among secondary school adolescents in Anambra State, Nigeria showed that Contraceptive awareness was 52.0%, while contraceptive uses at first and last sexual intercourse were 29.2% and 75.0% respectively. The most commonly used contraceptive methods were condom 90.0% and pills 8.20%. As observed by Aji et al (2013), the high level of sexual activity reported in the various studies did not translate to corresponding level of contraceptive use. For example in their analysis of studies on sexual and reproductive health of adolescents in Nigeria, the authors discovered that in Anambra and Rivers States,

64% of sexually active adolescents have never used any form of contraceptive at first sexual intercourse; in Abia State, only 12.4% of adolescents in the study used condom during their first intercourse; in Niger State, 65% did not use any family planning method because they were ignorant of contraceptive methods; in Ogun State, knowledge of contraceptives was 36.9% and 21.1% for male and female students respectively whilst contraceptive use was recorded as 10.9% for males and 6% for females.

The reasons for non-use in Ogun state included non-availability (22.3%); cost (11.8%), negative attitude towards contraception because of society's disapproval (33.2%), lack of knowledge on how to use (21.3%) In a study on the knowledge and use of contraceptives among youth in Abuja metropolis by Ugwu (2012), it was revealed that there is a wide disparity between contraceptive knowledge and practice – while knowledge of contraceptives was put at 78.8%, knowledge of sources on contraceptives is about 34.6% even for sexually active youth notwithstanding their level of education. Attahir et al (2010) investigated the knowledge, perception and practice of emergency contraception among 1, 200 female adolescent hawkers aged 15-29 in Rigasa community, a suburb of Kaduna town. Results showed that out of the 18 participants who were aware of emergency contraception; none correctly identified 72 hours as the time limit for the method's use. Antibiotics or home remedies such as dye Robin Blue mixed with Coca cola or mixed with lime or lime mixed with potash and salt water were mentioned as unlisted methods of emergency contraception by responders. Osinusi et al (2011) studied the level of contraceptive knowledge and use among adolescents in three secondary schools in Lagos. Results showed that 5% of 1155 students with knowledge of contraception are users, 85%

of sexually active respondents were non-users while condom is the most common contraceptive method used. Also, nearly 45% of respondents obtained knowledge about contraception from their parents. Olaseha et al, (2004) explored the reproductive health knowledge and use of contraceptives among 316 young mothers (17-20) in Ogbere, a suburban community in Oyo State. The results showed that 5% had lost a pregnancy due to abortion, miscarriage or still birth. 43% had fair, 34.5% poor, and 22.5% good knowledge of contraceptives; 53% did not know any of the routes for HIV transmission. A large majority (70%) had never used any contraceptives, 29% had done so. 80% of those who had ever used any contraceptive were using one at the time of the survey. The most popular contraceptives used were condoms (44.4%) and pills (16.1%).

Barriers to contraceptive use were disapproval by partner and lack of knowledge, Study by Rafael ET al (2015) on the determinants of Adolescent sexual behaviour, attitude and fertility with a narrower focus on KAB of adolescents aged 10 – 19 years old in Karu Local Government Area of Abuja showed that only 17% of boys and 5% of girls were using contraception while reasons for non-use were fear of social stigma, and issues around infidelity. Other reasons for non-use were shyness, concern about self-image, stigma, perceived lack of trust by partner; high preference for emergency contraception over condom was reported because it is discreet and less dangerous.

Oye – Adeniran et al (2006) conducted a community-based study among women of reproductive age (15-49 years) in Nigeria to explore the possible reasons for contraceptive non-use despite reported high awareness. Findings showed that Contraceptive prevalence

among sexually active respondents was 14.8% for all methods, 10.1% for modern methods and only 0.8% for emergency contraceptives. The most frequently stated reasons for non-use of contraceptives among those who had never used any contraceptives but who did not want more children were: "did not think about it", "against religious belief" and "fear of side effects." Prior counseling significantly improved the continuation rate of contraception. It was also found that older, married and more educated women tended to use contraceptives more.

### **3.2.3 Service utilization by youth & adolescent:**

Study by Abiodun et al (2016) showed that service utilization remains low largely due to lack of awareness. Omo-Aghoja (2013); Aparna et al (2017) identified paucity of youth-friendly services, affordability and denial of access for young people to sex education and SRH services as some of the factors that militate against health seeking behaviour. The findings from the study of adolescents in Abuja by Ugwu (2012) showed that only 10% had visited a health facility or doctor for SRH services and 15% of those that visited were girls aged 15 – 19 seeking contraception, abortion, pregnancy and STI-related services. Reasons for non-use are embarrassment and fear of stigmatization; hence study subjects prefer to go to private hospitals, traditional healers or chemists for SRH services. Similar study in Owerri reported by Rafael et al (2016) showed that 73.4% of adolescents sampled confirmed availability of RH center within their neighborhoods but only 21.5% were willing to purchase contraceptives from these centers. Sinai et al (2017) showed that only 27% of women with live births attended at least one ante natal consultation, 30% sought advice from friend, TBA while the rest did not receive or seek pregnancy-related advice.

The authors further revealed that respondents to in-depth interview in Kaduna State said delivery at home and alone is as safe as in the hospital.

### **3.3 Health Outcomes of Adolescents & Youth Risky Behaviour**

#### **3.3.1 Unwanted pregnancy & early motherhood:**

Evidence from literature show that there are several negative consequences of risky sexual behaviour by adolescents and youth. Unintended pregnancies remain a substantial global public health issue despite considerable advances in contraceptive methods (Joshi et al, 2015). Adolescent fertility rate in Nigeria is put at 122 births per 1000 women aged 15 – 19 years (Rafael et al, 2016). Report on extensive literature reviewed by Sinai et al (2017) alluded to the fact that early marriage remains a common practice in Northern Nigeria and the median age is 15 with many girls marrying when they were 12 years old or younger.

In Rivers State, 27% of the sexually active girls claimed to have been pregnant at least once. In Abia State, 4.9% of the sexually active girls admitted to have been pregnant, while 2.5% of their male counterparts admitted getting a girl pregnant. Pregnant adolescent girls who do not succeed in procuring an abortion go on to have a delivery and are exposed to the risks associated with teenage pregnancy, labour and childbirth (Aji et al, 2013). Omo-Agjoja (2013) noted that unintended and unwanted pregnancy is a result of an unmet contraceptive need; consequently, the response to this in most instances is to seek an abortion which is accompanied by serious complications. Salami et al(2014) showed that unmet social need of the teenager have much implication on the reproductive health of teenage girls and by extension can lead girls into unwanted pregnancy.

Jatau (2012) investigated the incidence and the attendant health and social problems associated with pregnancies among adolescent girls in Zango Kataf LGA of Kaduna State. Data collected from 281 pregnant and single parent adolescent girls revealed that the incidence of pregnancies out of wedlock was high among both ages 11 – 14, 15 – 18 and 19+ adolescent girls. The incidence of pregnancies out of wedlock was high among both Christian and Muslim adolescent girls, but tends to be higher among Muslim adolescent girls. The attendant health problems associated with pregnancies among adolescent girls were bleeding, maternal death and prolonged labour. Financial problems, school dropout, unplanned marriage and unemployment were the attendant social problems associated with pregnancies among adolescent girls.

Izugbara (2015) investigated the socio-demographic risk factors for unintended pregnancy among unmarried adolescent Nigerian girls. Findings showed that non-pregnant adolescents had older household heads; such households were wealthy, and parents of such households had higher educational standing. Female-headed households were less likely to experience unwanted adolescent pregnancy compared to those of the reference group category. There is a significant relationship between age and sex of household head and risk of unintended adolescent pregnancy among unmarried adolescent girls. Adolescent girls from households headed by young adults are more likely to experience adolescent pregnancy compared to adolescent girls from households headed by older adults

Lamina (2015) studied the prevalence of unwanted pregnancy in urban and rural settlements in South-western Nigeria. Findings showed that the prevalence of unintended pregnancy was 35.9% while that of induced abortion was 33.5%. The study concluded that unwanted pregnancy constitutes a problem, even at the community level and that the high contraceptive awareness should normally translated to an increased use so as to bridge the large gap of unmet need.

### **3.3.2 Abortion**

Unsafe Abortion is one of the main causes of maternal mortality especially in countries in which abortion is restricted (Faundes & Iqbal, 2015). In Nigeria, the law restricts abortion, thus, most abortions are done illegally under septic conditions. In Rivers State, 24.8% of sexually active girls have had at least one abortion, out of which 7.3% had had more than three. Maternal mortality is also high. The authors observed that pregnant women aged less than 15 years were 4-8 times more likely to die during pregnancy and childbirth than pregnant women aged more than 19 years. In Nigeria, abortion complications are responsible for 72% of all deaths among teenagers aged less than 19 years.

Adesiyun et al (2006) conducted a retrospective study of patients aged 13 -46 in Kaduna that had pelvic abscess as a complication of unsafe abortion. Results showed that 24.3% of them were teenagers. The abortionist providers were mainly untrained personnel. Contraceptive prevalence rate was low, 5.4% and maternal death of 18.9% were recorded. The authors concluded that unsafe abortion and its attendant complication is still a problem in Nigeria, and high quality post abortion care will help a long way in saving the lives of

women. Shittu et al (2007) studied the negative health outcomes related to sexual behaviour in adolescents who face unique and challenging economic, health and education problems in our society. Data was collected from 60% of student's population of young adults attending public school in the Oworonshoki region of Lagos, Nigeria. Findings showed that one out of every five sexually active teenagers had experienced forced sex, especially among the circumcised girls who were more sexually active than the uncircumcised girls. 60% of girls between ages of 12 and 18 years had more than one unsafe abortion with severe vaginal bleeding as the chief complication. However, 65% of the girls did abortion for fear of leaving school and financial hardship as the reasons.

### **3.3.3 Sexually Transmitted Infection & HIV/AIDS:**

Globally, an estimated 38.6 million people were living with HIV in 2005, an estimated 4.1 million became newly infected with HIV, and estimated 2.8 million lost their lives to AIDS (Adeyemi, 2007). In Nigeria, the HIV prevalence in the general population is estimated at 3.4% (FMOH, 2013).

According to Omo-Agjoja (2013) in a study of sexual and reproductive health concepts and current status, the low level of knowledge of reproductive health among adolescents and limited access of young people to youth-friendly health services have been identified as underlying factors contributing to the rising trend of HIV/AIDS in Nigeria. Aji et al (2013) also found that most of the adolescents seen in STD clinics had previous history of vaginal intercourse; In Cross River State, 13.1% of the sexually active female adolescents have had genital tract infection; in Abia State, 19.3% boys and 9.5% girls claimed they had

been infected with gonorrhoea and syphilis while data from Niger State show that 15.4% of sexually active adolescents had contacted STDs. Adeyemi (2007) conducted a situation analysis of people living with HIV/AIDS in Lagos where it was found that 11% of those infected with HIV were less than 20 years of age, while 66% of female and 44% of male respondents were in age group 21-40 years. According to the 2013 National Demographic and Health Survey, only a few females (2%) and male (4%) adolescents had HIV counseling and testing in the previous 12 months (Abiodun et al, 2016). The 2005 national HIV zero-prevalence survey conducted at sentinel ante-natal care clinics reported a rate of 3.6% and 4.7% for young people aged 15-19 years and 20-24 years respectively (FMOH, 2011). Abdulwahid & Umaru (2001) investigated the level of awareness of forms, symptoms, mode of transmission and control of STD among adolescents in Kaduna state and found that students know very little about the forms of STDs, the students have moderate knowledge of the signs and symptom of various STDs, their mode of transmission, and they have poor awareness of the control measures toward STDs.

#### **4.0 SEXUAL & REPRODUCTIVE RIGHTS**

Respect for women's sexual and reproductive rights is still a long worn battle in Nigeria. In an extensive review of articles by Omo-Agjoja (2013) to assess the concepts and current status of SRH Rights in Nigeria from 1985 to 2013, findings confirmed that women lack SRHR due to gender inequality compounded by cultural norms and practice which prevent women from being self-reliant. Akande( 2010) showed that that girls have experienced sexual coercion such as verbal threats, unwanted touch, deceived into sex or forced sex.

Other forms of sexual coercion such as verbal pressure, threats or unwanted holding of hands unwanted hugging or kissing as well as forced sexual activities.

The author sadly observed that in some developing countries including Nigeria, people cannot be sure of their Sexual and reproductive rights because they are not yet domesticated and not contained in the Nigerian legal system, which creates major problems, such as a high level of unwanted pregnancies, maternal mortality and human immunodeficiency virus (HIV) infection among others.

In a comparative review by Santhya & Jejeebhoy (2015), of the evidence on sexual and reproductive health and rights (SRHR) of adolescent girls in low-income and middle-income countries (LMIC), findings indicated that many countries are yet to make significant progress in delaying marriage and childbearing, reducing unintended childbearing, narrowing gender disparities that put girls at risk of poor SRH outcomes, expanding health awareness or enabling access to SRH services.

In a paper by Morris and Rushwan (2015) on the global challenges of ASRH, the authors alluded to the fact that ASRH & Rights are domesticated in various legal instruments at the global level. Morris and Rushwan (2015) identified the relevant global tenets as follows:

- In 2002, the UN General Assembly special session on children recognized the need to develop and implement health practices and programmes for adolescents that promote their physical and mental health.

- In 2003, the committee of the convention on the Rights of the child issued a general commitment recognizing the special health and development needs and rights of adolescents and young people;
- Other supportive instruments are the Convention on the Elimination of all forms of Discrimination Against Women – CEDAW.

Available literature reported that there are delays in domesticating the tenets that support SRHR. According to (Morris & Rushwan, 2015, Nwoji, 2011), Nigeria is still faced with issues around inheritance rights by women; denial of access for young people to sexuality education; denial of SRHR of sexual minorities and people with HIV and most importantly, government apathy to allocate sufficient resources to fund education and services that promote SRHR.

The infringement of women SRHR has led to so many consequences, for instance, Omo-Aghoja (2013) alluded to the fact that women face the highest risk of HIV infection through heterosexual sex; not all women who become mothers planned to do so – 10% of births to all women aged 15 – 24 years in the previous 3 years to the study were not planned and Nigeria continues to have the highest sets of abortion ratio globally with a reported average of 35 per 1000 women of reproductive age and over 610,000 abortions annually. Santhya & Jejeebhoy (2015) identified barriers such as lack of knowledge of services tailored to girls' specific needs and situations and a supportive environment as factors affecting girls' sexual and reproductive health and rights. The legal age for marriage in Nigeria is 18 years (Rafael et al, 2015) but this has been difficult to enforce because of series of socio-cultural barriers.

Publication by ENGENDERHEALTH, posited that mainstreaming adolescent – friendly contraceptive services elements into existing services globally requires: ensuring legal rights, policies, and guidelines that respect, protect, and fulfill adolescents’ human rights. The participating countries in 1994 ICPD in Cairo conference adopted “sexual and reproductive rights as human rights, and affirmed them as an incontrovertible integral and inseparable part of universal human rights., which was buttressed by Kofi Annan – a former Secretary General of UN, who aptly summed it up this way: “The Millennium Development Goals, (MDGs), now SUSTAINABLE DEVELOPMENT GOALS (SDGs) particularly the eradication of poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed (Omo-Agjoja, 2013).

## **5.0 SRH & RIGHTS POLICY ENVIRONMENT IN NIGERIA**

Following strong advocacy for the domestication of the tenets of SRHR, Nigeria was one of the first nations in sub-Sahara Africa to make adaptive policy statement in 1998; Nigeria adopted the regional RH strategy and endorsed all the components of SRH as entrenched in the ICPD platform of action except the provision of safe abortion which is against the law (Morris & Rushwan (2015).

Nigeria equally signed onto the MDGs with its array of RH components while some states in the north have commenced domestication of the concept of SRH through their HIV/AIDS & FLE (FLEH) programme (Morris & Rushwan, 2015; FMOH, 2011).

In Nigeria, there has been a growing recognition of the need to respond effectively to the health and developmental challenges of young people, hence, the Federal Government, through the Federal Ministry of Health (FMOH) developed a National Adolescent Health Policy in 1995 which was revised in 2007 to reflect the current realities and aid the rapid translation of the policy into actions in line with the commitment of the Nigeria government and people to develop the younger generations. However, evidence in literature show that translating the framework into actionable programmes and backing it up with appropriate funding has been very slow (Nwoji, 2011; Ugwu, 2012).

To confirm the efforts made so far to respond to the SRH challenges of adolescents and youth in Nigeria, Udegbe et al (2015) enumerated the evolution of school-based sexuality and family life education in Nigeria<sup>14</sup> as follows:

- The first major step started in 1988, Nigeria adopted the Population Policy to address the consequences of uncontrolled population growth and the development of educational activities meant to translate policy into action;
- The implementation of the Population and Family Life Education Programme (Pop/FLE) by NERDC in the mid-1980s and the pioneering behavioural change programmes of the MacArthur Foundation whose Fund for Leadership Development (FLD) and Institutional Grant programmes starting in early 1990s, supported the initiation of sexuality education;
- Participation of Nigeria's Federal Ministry of Education (FMOE) and the National Education Research and Development Council (NERDC) in the design of UNESCO principles on managing population education programme in Africa;

- The 1994 International Conference on Population Development (ICPD) which, for the first time, highlighted the need to focus on reproductive health and individual sexual health behaviour, and thus catalyzed the teaching and learning of sexual health and legitimized HIV/AIDS-based school initiatives;
- The scourge of HIV/AIDS pandemic, wherein 60% of reported cases were among youths within the age bracket of 15-24 years, hence, The Family Life and HIV Education Curriculum by the 49th National Council on Education with the primary goal of providing awareness, preventing and reducing the spread of new HIV infections and the prevalence by at least 25% in 2010, was pioneered in Lagos State (AHI, 2010). The FLHE curriculum has since been adopted in 35 states across the country (Udegbe et al, 2015).

Udegbe et al (2015); ISERT REPORT (2014) evaluated the implementation of FLHE to capture patterns and trends with respect to adoption and implementation at the state and zonal levels. The study revealed that there was a high level of variation in the year of adoption of FLHE by states. Approximately half of the states introduced FLHE within one year of the directive. Seven years after (2010), about three-quarters (77.8%) had started the programme. Only 50% of the states indicated that they engaged in some form of FLHE advocacy programmes as at 2012. Only 44% of the states responded to the question relating to budgetary allocation for FLHE in 2012. Although about six states provided figures (ranging from N500,000 to N12.5million) reflecting budgetary allocations for FLHE, there were indications that in many instances, the funds were estimates and usually inaccessible, not separated from a larger unit budget or were under control of other related units such as

the State Agency for Control of HIV/AIDS. **The score care for Kaduna, Lagos and Oyo States is attached as Appendix One.**

There is need for government policy action especially in the area of training of service providers, in a study by Herbert et al (2013) to understand the perceptions of, experiences with and challenges of delivering family planning services in two urban areas of Nigeria from the perspectives of family planning service providers in Ibadan and Kaduna States, Nigeria, findings showed that providers lack adequate training in family planning and expect the Nigerian government's role to take a variety of forms,

## Section Four

### 6.0 BEST PRACTICES

This section will present best practices from the local and international points of view

#### Local perspective:

- *Leverage the success story of the partnership between Lagos State Ministry of Education and Action Health Incorporated* to provide school – based family life and HIV Education using ICT (e-FLHE) has shown some positive results on the students that benefitted from the curriculum with regards to (i) increased knowledge of sexuality and RH; (ii) gender equality attitudes; (iii) negotiations skills (SAYING – NO); (iv) reduction in pressure by boys to have sex with girls). Though this is a small pilot project, it can be replicated across the country after formative research to ensure relevance and consideration for cultural realities/variations (AHI, 2010)
- *NURHI Phase 1 Model of Best Practices and Innovations* – Implementation of the first phase of NURHI project was acclaimed as successful and this is due to the adoption of innovative models such as sustained and media-based advocacy at all levels to influence policy decisions and programme funding and eliminate socio-cultural barriers; NURHI Service delivery strategy which included health systems strengthening, quality improvement and public-private partnership; user-oriented demand creation and regular monitoring and evaluation. While the target audience for the next phase of NURHI is very unique, most of the innovative ideas could be adopted taking into consideration cultural realities (NURHI Toolkit, 2015).

- ***Training of Critical Stakeholders:*** In their study of demand for women's health services in Northern Nigeria, Sinai et al (2017) found that the training of religious/political leaders has helped to drum up support in the North through the adoption of the Stage Leadership Development Model – which trained religious leaders, supported them to attend study tour in Egypt, facilitated their use of internet and mobile technologies.
- ***Strategic partnership & Engagement with existing community structures:*** Nsirim et al (2015) assessed the effect of integrating Traditional Birth Attendants on the uptake of Prevention of Mother to Child Transmission services in 25 supported Primary Health Care Facilities in Kaduna, North West Nigeria. Community dialogues technique were held with the TBAs, community leaders and women groups. These dialogues focused on modes of mother to child transmission of HIV and the need for TBAs to refer their clients to PHCs for testing. Subsequently, data on number of pregnant women who were counseled, tested and received results was collected on a monthly basis from the 25 facilities using the national HIV/AIDS tools. Prior to this integration, the average number of pregnant women that were counseled, tested and received results was 200 pregnant women across all the 25 health facilities monthly. After the integration of TBAs into the program, the number of pregnant women that were counseled, tested and received results kept increasing month after month up to an average of 1500 pregnant women per month across the 25 health facilities. The conclusion was that TBAs can play a key role in improving service uptake and utilization for pregnant women at primary health centers in the community - especially in the context of HIV/AIDS, and

therefore need to be integrated, rather than alienated, from primary healthcare service delivery.

- ***Dramatization/Participatory approach:*** Kafewo (2008) describes the use of drama and participatory methods in a girls-only secondary school in Zaria, Kaduna Nigeria, as a means of sexuality education, carried out by the Nigerian Popular Theatre Alliance and the Second Chance Organization of Nigeria. Participatory approach was used to understand the SRH challenges of the 15 adolescent girls who participated from the school. Findings showed that the topics that concerned the group of 15 girls who participated from the school included abortion, premarital sex and pregnancy, teacher–student relationships and lesbianism. Participants developed a play about teacher–student relationships and presented it to the whole school. The presentation was stopped several times in order to involve the audience in discussing the choices available to the protagonist and what they would do in her place. This allowed all the students to explore the problem, generate and assess alternative solutions and communicate their learning to others. It also started a process of change in how the school dealt with girls who were forced to drop out due to sexuality-related problems, including pregnancy. Our long-term aim is advocacy to support the introduction of sexuality education as a permanent element in the curriculum throughout the school system.

- ***Community Directed Intervention (CDI):*** According to Ajayi et al (2013), CDI is a proven strategy to address the problem of access to health interventions and has been used successfully in rural areas. In a formative study conducted in

eight urban poor communities in the Ibadan metropolis in the Oyo State Nigeria to assess resources required for implementing community directed interventions in urban poor communities in south western Nigeria, the authors found out that the feasibility of using the CDI process in delivering health interventions in urban poor communities exists and that potential resources for the strategy abound in the communities.

- ***Leveraging technology for SRH Information dissemination:*** Evidence from literature supports the need to leveraging mobile technology to reach adolescents and youth with SRH information (Nwagwu, 2007, Nwoji, 2011; Collins et al, 2012; Olusesan et al, 2014) Adolescents and Youth are technology savvy and evidence from MTN online report show that over 21% of subscribers are between ages 15 to 24. However, this may be more applicable to out of school youth who have some income to ensure sustainability.

***International Perspective:***

User-driven service strategy: International women health coalition (IWHC Fact Sheet credited to Donna et al (2015) reported that service should be based on what adolescents want and so suggested a three – pronged approach to programme implementation:

- Training and supporting health workers to provide services to adolescents in a friendly and appropriate manner; modifying health facilities to respond to the needs expressed by adolescents; and generating demand for services through information dissemination in the community, schools, and mass media.

- Linking youth-friendly clinics with community-based activities (e.g., youth clubs, street theater, etc.) and school-based components (e.g., referral systems) has demonstrated greater uptake of services and self-reported condom and contraceptive use among adolescents.
- Policy - Governments should formulate and apply laws and policies that enable and promote the delivery of adolescent sexual and reproductive health services.

***Mainstreaming Adolescent-friendly Elements into Existing Contraceptive Services:***

Fact sheet on FAMILY PLANNING HIGH IMPACT SERVICES, reported that mainstreaming adolescent-friendly elements into existing contraceptive services has been very successful. The following steps to achieving this were suggested:

- Conduct a needs assessment to identify the most effective approaches to reaching sexually active adolescents with contraceptive services. Formative research and monitoring data should be disaggregated
- Use multiple service modalities to reach a wider range of adolescents. Such approaches can include static facilities (both public and private), community-based distribution, mobile outreach services, pharmacies and drug shops, informal settings, schools, or workplace-based services
- Train providers to offer adolescent-friendly services.
- Use a whole-clinic approach to training on AFCS. This approach will help ensure adolescent-friendly care is not invested in only one provider and that adolescents do not experience resistance from support staff

- Reinforce training through supportive supervision, job aids, and mentorship to change provider attitudes and behaviors. Supportive supervision tools and provider job aids can be helpful to enforce rights-based programming
- Enforce confidentiality and ensure audio and visual privacy
- Tailor health communication to the needs and interests of adolescents. Consider where and from whom adolescents get information on sexual and reproductive health. Engage young people in developing messaging and in identifying appropriate channels for communication
- Offer a full range of contraceptive options.
- Provide no-cost or subsidized services
- Provide an enabling environment by ensuring legal rights and supportive policies related to provision of contraceptive services for adolescents
- Link service delivery improvements with activities that build support within communities. Interventions directed at influencing the sexual and reproductive health behaviors of adolescents are significantly enhanced where there are complementary interventions for parents, providers, religious leaders, and other influential adults who can foster a supportive environment in health facilities, schools, religious places of worship, and in homes
- Pay attention to gender and social norms to ensure successful investments in AFCS. Adolescent girls will access contraception in settings where gender norms have been transformed to allow girls to know about sexual and reproductive health and to feel empowered to access services

***Effective Tracking system:*** For better information tracking system, Mathai et al (2015) had recommended the use of maternal death surveillance and response system to monitor trends in maternal mortality.

***Integrated development programme*** (especially for young girls): Santhya & Jejeebhoy, (2015) conducted a recent systematic review of 23 evaluations of programmes for girls at risk of early marriage and found that programmes that combining the critical elements of safe spaces for in- and out-of-school girls, and building their ability to exercise informed life choices, information, skills and networks with community mobilization are a promising approach for delaying marriage.

## **7.0 DISCUSSIONS**

In this section, we present summary of the findings on the status of SRH and Rights among adolescent and youth highlighting the challenges/barriers and proffering possible solutions to attaining desired health outcomes, key learning questions for further attention, conclusion and recommendations

## **7.1 Summary of Findings:**

### **7.1.1 Knowledge of Human Sexuality / Reproductive Health & Rights:**

From the various studies and reports examined, show that adolescents which constitute the major chunk of the youth cohort do not know much about the biological changes that take place from puberty and the implications of those changes on SRH & Rights. For example, Rafael et al (2015) reported that less than 2% of boys and 6.6% of girls aged 15-19years in Karu Local Government Area of Abuja were able to consistently identify when a female is most likely to get pregnant during the ovulation cycle.

In addition, level of knowledge of sexual and reproductive health and rights issues is generally low among Nigerian youth and even in the three focal states (Kaduna, Lagos and Oyo). This is evidenced in the study by (Amoo 2016) which showed that 50% of the respondents were aware of sexually transmitted infections, while 31% knew about fertility, 64.7% of the respondents had ever heard about sexual and reproductive health services, 51.0% had ever used the services. A study by Shittu et al (2007) also confirmed that that 51% of the adolescent respondents had no basic knowledge about sexual behavioural practice and attitude towards STDs/ HIV and AIDS.

It was the submission of the various authors that this low level of knowledge is due to lack of comprehensive sexuality education for both in-school and out of school youth; parental barriers and resistance by teachers. This can be significantly improved through targeted education for all young people, including persons with HIV/AIDS and those of them with

disability (Sangowawa et al 2009). Indeed, it was demonstrated in some of the studies that prior information/education on SRH issues given in a coordinated manner led to remarkable improvement in knowledge and attitude, thus underscoring the crucial importance of a clear-cut plan of action to educate sexually active young people through an effective family life/sex education programme involving parents and other stakeholders to forestall exposure to risky behaviours (Oyediran et al 2002; Nnorom & Bammeké 2008). The limitation of most of the studies reviewed include the fact that there are no regional studies hence the samples are not representative, therefore reliance will be placed on the national average from NDHS (2013) for the three target states.

### **7.1.2 Sources of SRH Information:**

Parents, teachers, friends and internet are among the various sources of information on SRH knowledge and services. Findings show that while many adolescents/ youth prefer to learn about these issues from parents, the cultural factor tends to inhibit free discussion or communication especially with the male adolescent/young person. Study on demand for Women's Health & services in Northern Nigeria by Sinai et al (2017) showed that women in Kaduna State preferred to talk to their husbands about family planning (because the husbands own them), followed by their mothers, mother – in – law and friends. Morhason-Bello et al (2008) conducted a cross sectional survey among 716 senior secondary school adolescents in Ibadan, Oyo State to understand their sexual behaviour, findings showed that about half of the respondents learn about sex from their friends while others through their parents and media. Ajike & Mbegbu (2016) examined the knowledge of youths on available adolescent/youth friendly services (A/YFRHS) in Ikeja, Lagos State, Nigeria.

Findings showed Friends/peers (45.7%) were the best source of information on A/YFRHS. The most popular services known were family planning (81.6%), voluntary counseling and testing (73.8%), and sexually transmitted diseases (67.3%). The above study reports show that there are regional variations which should be taken into consideration for programme communication plan. Whilst friends/peers could be sources of wrong information, study by Ajike and Mbegbu (2016) in Lagos, reported that friends/peers were found to be important sources of SRH information and services, which may be attributed to effectiveness of FLHE programme in Lagos State. The above scenarios underscore the need for credible sources of information through sexuality education programme targeted at adolescents/youth, parents, teachers and other gate keepers. Further research should investigate extent to which parents and teachers discuss SRH issues with their children and students respectively and how to remove the barriers to parent-child communication on sex-related issues.

### **7.1.3 Sexual initiation & Current sexual behaviour:**

Nationally, Sexual debut is widely reported to range between 13 and 16 years (NDHS, 2013). However, there are regional variations due to access to education and socio-cultural factors. Finding from the National Strategic Framework of Adolescent and Youth SRH & Rights For instance shown that early onset of sexual activity and early marriages are highly prevalent as evidenced by the median age at first marriage of 16.6 years (ranging from 14.6 in the Northwest – which included Kaduna state to 21.3 years in the Southwest - which included Lagos and Oyo States (FMOH, 2011). Aji et al (2013) also reported that about 34% of the young people are sexually active while multiple sexual partnering is very

prominent across the states. This is worrisome especially when viewed against the backdrop of low level of SRH knowledge and precautionary measures among the young people. Peer pressure and monetary gains have been established to induce youth into sexual act (Nwoji, 2011) WHO (2013) found out that in Anambra State that the most common reasons for having premarital sex were 50% due to peer group pressure and 27.5% due to monetary gains 27.5%. This calls for parent-centered education on the need for them to maintain constant communication with their children so as to discourage them from being wrongly influenced by their peers. It is also important to impress on the parents to endeavour to provide for their children's basic needs.

The social media platforms (Facebook, Twitter, YouTube, Flickr, Instagram and LinkedIn among others) have also been cited as a major contributor to the increased sexual activity of the young people. While it may be practically impossible to stop the youth from using these social media gadgets, Amoo et al (2013) is of the view that it is inimical not to monitor adolescents' exposure to sexual contents and censor the scenes available on these gadgets. In a related study by Suleiman (2011), majority of the respondents attributed premarital sex to influence of erotic film from TV, video and cinemas, while majority of their out of school counterparts attributed it to peer group influence. . It also pinpoints the need to popularize sexuality education using youth-friendly approaches such as drama to stem the risk of HIV/AIDS among the group. Future research should focus on the extent to which knowledge of SRH influence sexual initiation and multiple sexual partnering.

## **7.2 AVAILABILITY & ACCESS TO SRH INFORMATION AND SERVICES**

### **7.2.1 Family life Education & Counseling Services:**

The importance of effective and regular family life education and counseling services for the young people cannot be over emphasized in view of poor of knowledge (Shonde,2006), lack of access to SRH services (Ajike & Mbegbu 2016), relatively low level of sexuality education particularly in the North (Isiugo-Abanihe et al 2015).

Evidence from some studies by Isiugo-Abanihe et al (2015) show that programmes on sex education have impacted positively on adolescents' disposition and relationship with the opposite sex, knowledge and skill building. It is therefore very important to make it part of the SRH programme in schools especially in the North where a study by Adeokun et al (2009) found that 84% of girls sampled from 24 North-Eastern Nigerian secondary schools were of the opinion that adolescents should be given sexuality education but only 48.3% had received any. To make sexuality education work, there is need for Christian and other religious groups to work with health educators to develop realistic teaching guidelines that focus on the everyday needs and concerns of the youth (Omigbodun & Omigbodun 2004)

### **7.2.2 Service Utilization by Youth & Adolescents:**

Utilization of reproductive health services has been reported to be low nationally, due to lack of awareness (Abiodun et al, 2016); inadequate youth friendly services Omo-Aghoja (2013 and denial of access to young people as part of their fundamental human rights (Aparna et al, 2017). Other factors militating against access include embarrassment and

fear of stigmatization (Ugwu, 2012). To address these challenges calls for increased awareness and proper training of service providers

### **7.2.3 Family planning/Child spacing & Contraceptive use:**

Evidence show that most young people are sexually active but do not use family planning/child spacing methods measures. For example a study in Kaduna by Attahir et al (2010) showed that respondents lack knowledge of modern emergency contraceptive method, rather they used Antibiotics or home remedies such as dye Robin Blue mixed with Coca cola or mixed with lime or lime mixed with potash and salt water. Osinusi et al (2011) found that 85% of study subjects in Lagos secondary school were non-users of contraceptives. Olaseha et al, (2004) 70% of young mothers in Ogbere, Oyo State had never used any contraceptives.

Historically, contraceptive usage among youth has been a major challenge and several factors have been identified in literatures which need to be addressed. Barriers such as disapproval by partner, lack of knowledge, fear of social stigma, and issues around infidelity. Shyness, concern about self-image, stigma, and perceived lack of trust by partner has been identified (Rafael ET al, 2015). Programmes should target sexually active adolescents with information and services that will help them understand the perceived risk and manage it appropriately.

#### **7.2.4 Unwanted pregnancy and early motherhood & Abortion**

High incidence of unwanted/unintended pregnancy has been reported across the country due to poor SRH knowledge, attitude and cultural practices that predispose young women to early sexual initiation. Jatau (2012) reported that teenage pregnancy tends to be more prevalent among Muslim adolescent girls. Lamina (2015) on the prevalence of unwanted pregnancy in urban and rural settlements in South-western Nigeria showed that the prevalence of unintended pregnancy was 35.9% while that of induced abortion was 33.5%. The study concluded that unwanted pregnancy constitutes a problem, even at the community level and that the high contraceptive awareness should normally translated to an increased use so as to bridge the large gap of unmet need.

#### **7.2.5 Sexually transmitted infections & HIV/AIDS:**

Findings show a rising trend in sexually transmitted infections especially HIV/AIDS across the country. In Nigeria, the HIV prevalence in the general population is estimated at 3.4% (FMOH, 2013).. With a large proportion of young people being sexually active and yet having poor knowledge and practice of safe sexuality there is fear that the trend may continue in the upward direction. In fact, low level of knowledge of reproductive health and limited access of young people to youth-friendly health services have been identified as underlying factors contributing to the rising trend of HIV/AIDS in Nigeria. Given the heavy burden the HIV/AIDS epidemic places on women, children and relatives, there is a need for more information on the socio-economic consequences of this disease. For greater impact on the youth/adolescent students, school psychologists and counselors should continuously sensitize the students and organize group guidance programme in the

secondary schools on personal health and risky behaviours. There should be a synergy between public health workers, school administrators and parents in creating awareness among students on the risk factors, symptoms and control of STIs, and voluntary HIV test before marriage

### **7.2.6 Sexual & Reproductive Rights:**

All the literature on SRH rights agreed that not much has been done to enforce youth/adolescent sexual and reproductive rights despite affirmation by the various countries. Failure to see SRH rights as part of universal human rights has not helped matters. socio-economic, religious and cultural factors tend to frustrate the operation of the fundamental rights of the child which includes the right to be informed (sexuality education) and the right to express his/her opinion (e.g. refusal to early/forced marriage)

The summary of opinions is that the rights of adolescents/youth have not been sufficiently mainstreamed into the fight against sexual and reproductive health problems threatening the young people and by extension the future development of the country. The government has been blamed for apathy to allocate sufficient resources to fund education and services that promote SRHR. However, none of the studies reviewed sought to ascertain from the young people their knowledge of SRH rights and how this has influenced their SRH attitude, behaviour and practice.

### **7.2.7 Sexual & Reproductive Health & Rights Policy Environment in Nigeria:**

The consensus is that not much has been done to give vent to promotion of SRH rights of youth/adolescents in Nigeria. Though governments have reaffirmed many commitments, policy development and programme implementation fall far short of realizing these commitments (Nwoji, 2011; Morris & Rushwan, 2015, Santhya & Jejeebhoy (2015) The conclusion is that that Future success requires increased political will and engagement of young people in the formulation and implementation of policies and programmes, along with increased investments to deliver at scale comprehensive sexuality education, health services that are approachable and non- judgmental, safe spaces programmes, especially for vulnerable girls, and programmes that engage families and communities.

The family life and health education programme is a veritable platform for teaching and promoting SRH knowledge and rights, and will be a huge success if all the cultural sensitivities are taken on board and there is strong political will to support it with adequate budgetary allocation. There is also need for government policy action especially in the area of training of service providers as study in two urban areas of Ibadan and Kaduna showed that the service providers lacked adequate training in family planning.

### **7.3 Challenges/barriers against achievement of improved health outcomes**

Analyses of findings from the various studies show that the following factors pose great challenges or barriers to achievement of improved SRH outcomes.

**Religious and cultural beliefs:** These have continued to limit communication or discussion of SRH matters with young people at home, school and places of worship. Unfortunately, as evidenced in most studies, this infringes on the sexual and reproductive rights of adolescents and youth, especially girls and women in Nigeria due to negative interpretation of the components of SRH & Rights most time due to religious fundamentalism and deep seated cultural practices. Continuous awareness and sustained advocacy to religious/opinion and community leaders will go a long way in breaking some of the religious and cultural barriers. In addition, increased school enrolment and girl child education will help improve the perception, attitude and knowledge of young people and empower them to make informed decisions.

**Knowledge gap:** There is still insufficient knowledge and in some cases complete lack of knowledge of SRH among our young people, a situation that predispose them to risky behaviour with undesirable outcomes. Many of the young people especially those in the rural areas and those out of school have not been reached with the appropriate information and services to be able to act responsibly. Existing FLHE programmes should be well coordinated and made available to both in-school and out of school adolescents and youth nationally and delivered in a culturally sensitive environment through leveraging existing structures. Unfortunately, cultural and religious beliefs tend to work compound the situation. This is an area for future comprehensive research to better understand the best approach in addressing this huge challenge.

**Peer pressure:** Getting young people informed correctly on SRH is one thing but getting them to avoid negative influence from their uninformed friends/peers could be quite difficult. So peer pressure is a barrier to achieving positive health outcome. The way out is for every one of them to receive proper education and information to avoid negative peer influence.

**Socio-economic factors:** It has been shown that SRH attitude, behaviour and practices correlate with level of education, economic/financial status and urban/rural location. Knowledge of SRH issues increases with level of education and economic/financial status. Thus, vulnerability is higher among youth/adolescents whose parents are poor and, less educated. The situation described above is also compounded with the current economic recession in Nigeria; it has increased parental pressure on young persons to support the family income through illicit activities such as prostitution, drug abuse and cybercrime – which may indirectly or directly influence their sexual behaviour. Therefore, programmes with element of economic empowerment may help in reducing this challenge.

**Stigmatization:** The fear, shame and loss of face surrounding negative sexual and reproductive health outcomes makes most youth/adolescent to prefer to keep the problem to themselves and avoid seeking health service from the right place. Many go to quacks and under cover place where complications usually result. This is why the issues of confidentiality and friendly health services that will address the concerns of young people are critical.

**Availability and location of service centres:** The issue of poor access to youth- friendly information and services has been widely reported in available literature. Most youth have limited knowledge of services centres where they can access counseling, information, treatment and testing services confidentially, and in a friendly, non-judgmental manner. Even for the few of them that know, usage is poor because of fear of stigmatization and provider bias. This remains a major challenge or barrier to the improvement of health outcomes among our young people, however, engaging young persons to understand what type of services they want and how they want the services delivered; sustained advocacy to government for health system strengthening and training of all levels of service providers and other gate keepers will go a long way in improving access to information and services.

**Absence of parent-child communication at home:** Parents are the primary teachers of their children and are in positions to counsel, enlighten and educate their children on SRH better than anyone else but due to cultural and religious inhibition, lack of time, and ignorance, this aspect of the child's development is often overlooked or passed down to the teachers. Unfortunately the teachers have their own cultural inhibitions and are often not well equipped to handle sensitive issues such as SRH & Rights.

**Lack of Political will:** One of the major challenges or barriers identified in the fight to arrest negative SRH & Rights outcomes is lack of strong commitment on the part of the government. Policy implementation has not been encouraging because fund allocation has also been poor. Sustained advocacy and stakeholder engagement is critical to gain the

support of government and make Adolescent and Youth SRH & Rights a priority in Nigeria.

## 7.4 Key Learning Questions

In the light of findings from the literature review, the following pertinent questions are worth asking

Questions	Evidence from the Review
Will contraceptive demand generation among adolescents & youth automatically lead to rise in supply?	According to Renee et al(2006); Nwoji(2011); Ugwu(2012 and Ojua et al(2017)this will depend on (i) personal reasons such as family background, religious belief, culture education, personal conviction and perceived risk; (ii) availability, accessibility, affordability of contraceptives (iii) health systems such as the clinic environment, health care provider bias, _ Herbert et al(2017) identified provider-imposed eligibility restrictions such as age, marital status etc.
Has SRH & Right Issue received the attention it deserves in Nigeria	Shonde (2006); Nwoji (2011), and Abiodun et al( 2016) agreed that SRH & Rights is receiving attention from non-governmental organisations but certainly little attention from government,
Are we winning the war on adolescent/youth SRH & Rights	Not at all, going by the trend in negative health outcomes ( Action Health, 2010; FMOH, 2011)
What are the characteristics of adolescents and youth in the 3 states and what do they want to know and how do they want it delivered	Out of school, in-school, educated, non-educated, rural/urban etc. This calls for formative research using both qualitative (FGD) and quantitative methods to get realistic data for baseline. data must also be collected from gatekeepers to set positive programme direction
What has been the major focus of SRH &Rights?	The health ministry has been driving SRH & Rights, however, multisectoral approach should be further strengthened by involving Ministries of Education, Women Affairs, Labor and productivity

What is the best way to achieve success?	By engaging all stakeholders and gatekeepers: government/political leaders, community leaders, religious leaders, teachers and parents
Have the young people been sufficiently educated/informed to be able to behave responsibly	No, there is still very low level of knowledge of SRH issues, while behaviour has not changed significantly. In addition, the youth do not appreciate the potential risk associated with their behavior ( Nrorom & Bammeke, 2006)
What platform is best to reach young people with?	This will depend on the socio-cultural milieu of each state and what the young people want and can afford/access
Where has interest/attention been focused in previous studies?	Mostly on in-school students and less on out-of-school adolescents/youth
What should be the activity focus	Massive education/enlightenment on SRH and Rights issues, leveraging on available services and community structures

## **7.5 Conclusion & Recommendations**

Based on evidence from the literature review, it can be concluded that:

- Formative research using both qualitative and quantitative data collection methodology to confirm the socio-demographic and personal characteristics of adolescents and youth; the existing peculiar barriers, attitude of various gate keepers and level of government support in the three target states. This will set the stage for appropriate programme approaches that will address the cultural sensitivities and point of entry because it can never be “one size fits all”
- Explore multisectoral/multidisciplinary approach to improving access to SRH & Rights information and services
- Involve all critical stakeholders right from the conceptualization through to implementation and evaluation for buy-in and support

- Adopt the current NURHI phase 1 model of using religious groups and community leaders/structured for advocacy, implementation and monitoring
- More state-wide SRH & Rights studies using representative samples for benchmark data
- Sustained advocacy to get government buy-in to operationalizing the tenets of the various conventions on SRH & Rights in Nigeria. This should be palpable through budgetary allocation at the three tiers of government for SRH & Rights programme implementation, training of teachers and providers at all levels
- Advocacy for increased school enrolment especially for the girl-child
- Knowledge of SRHR and services is generally low among the target population. There is therefore a compelling need for increased and sustained effort at educating, enlightening or informing the young people nationally. Failure to do this will worsen the current rising trend in negative health outcome.
- Strategic partnerships with both private and public sector agencies to leverage existing youth health and empowerment programmes to increase access to SRH information and services. For instance, partnership with private Foundations doing grassroots work
- The provision of information and services should be adapted to the different realities of adolescents' lives to ensure that the sexual and reproductive rights of all adolescents are fulfilled.
- In view of the digital age and based on the percentage of youth using mobile phones (21.16% of MTN Subscribers are youth ages 15 – 24), possibility of exploring technology in deploying SRH & Rights information and services.

## **LIMITATION OF THE STUDY**

Comprehensive and representative studies on components of adolescent and youth reproductive health and rights in Nigeria are very limited. Most of the studies have small samples and are not representative of the target population; in addition, studies focused on the three target states are also few or inaccessible, therefore, heavy reliance was placed on existing data sourced from NDHS 2013. This calls for more investment in social research.

## Section Five

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The International Women’s Health Coalition (IWHC) promotes and protects the sexual and reproductive rights and health of women and young people, particularly adolescent girls, in Africa, Asia, Latin America and the Middle East. 333 Seventh Avenue, 6th Floor, New York, NY 10001 T + 1.212.979.8500 | F +1.212.979.9009 | **IWHC.ORG** Based on Donna Denno et al., “Effective Strategies to Providing Adolescent Sexual and Reproductive Health Services and to Increasing Demand and Community Support,”

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## 9.0 Appendices

### 9.1: Appendix II showing performance of Kaduna, Lagos & Oyo States FLHE programme

Key performance indicators	Kaduna	Lagos	Oyo
Year of adoption	2011	2003	2008
% of Implementing schools reporting to SMOE	98%	89%	No data recorded
State performance on selected indicators	High	High	Nil
Schools implementing the FLHE	JSS 1-3	JSS1-3	JSS1-3
Schools supplied with materials	Average	High	No Record
Data available for recent quarter preceding the evaluation	High*	High*	Nil
State budget for FLHE in 2012	NIL	NIL	High *
Budget for training Teacher	Low	High	Low
% of schools supplied with FLHE Curriculum	NIL	NIL	NIL

*Source: INSERT REPORT (2014) Evaluating the Implementation of Sexuality AND Life Skills Education*

**9.2: Appendix II**

<b>LIST OF NON-GOVERNMENTAL ORGANISATIONS AND CIVIL SOCIETY ORGANIZATIONS WORKING ON YOUTH AND ADOLESCENT HEALTH IN KADUNA, LAGOS &amp; OYO STATES, NIGERIA</b>			
<b>S/N</b>	<b>KADUNA</b>	<b>LAGOS</b>	<b>OYO</b>
1	Global Initiative for Women and Children	Action Health Incorporated	Association for Reproductive & Family Health
2	I CARE Women and Youths Initiative	Youth Empowerment Foundation	FAHPAC
3	Mother Care	Human Development Initiative	Live Vanguarders
4	Red Cross	Society for Family Health	OYZA FOUNDATION
5	Association of orphans and Vulnerable Children NGOs in Nigeria (AONN)		LIVE BUILDERS
6	Christian Association of Nigeria (CAN)		CHESTRAD
7	Jama'tul Nasril Islam (JNI)		REST ANCHOR
8	Association of Positive Youths with HIV/AIDS in Nigeria (APYIN)		ASSOCIATION OF WOMEN IN BUSINESS
9	The Youth Challenge (TYC)		RUPEDIN
10	Movement Against Premarital Sex Among Youths (MAPSAY)		JDPC
11	Hope for the Handicapped Person Foundation (HHPF)		MISSION TO THE UN

12	Enhancing Community Action for Peace and Better Health Initiative (E-CAPH)		REACHED
13	African Network of Adolescents and Youth Development (ANAYD)		WORDOC
14	International Youth Alliance for Family Planning		RAY OF HOPE
15	AYDF		GOOD WORKERS
16	ACHI-DACA		DORCAS HOPE ALIVE
17	Women		YOFAS
18	RUWOYSI		
19	Center for Girls Education		
20	Girl Child Concerns		