Nigerian Urban Reproductive Health Initiative

NURHI 2 Youth and Adolescent Program Study Tour

1 – 2 November, 2017

Over the years in Nigeria, the health care of youths and adolescents was included in the various health interventions under paediatric health, psychiatry, internal medicine and gynecology, but none of these focused exclusively on youths and adolescents. However, as a result of the rapidly expanding adolescent population and a progressive understanding and recognition of adolescent physical, emotional and intellectual growth – there has been a rapid response to address the growing needs of this group of young persons. It is of concern, therefore, that youths and adolescents do not have access to high-quality sexual and reproductive health care programs that meet their needs and empower them especially access to high-quality and use of modern family planning contraceptives. They are deprieved of information, discriminated against and stigmatized.

During the implementation of activities in NURHI Phase I, the project did not focus on adolescents and youth. This was because the percentage of adolescents and youth who were sexually active and did not desire to be pregnant was too low to provide a meaningful increase in CPR and priority at that time was on proving the CPR in Nigeria with strategic interventions aimed at women aged 24-35 and older. However, social behavioural change materials, and service delivery materials testing often included younger women to be sure they were acceptable to them, but the target group was the core child bearing years.

From the endline research conducted on NURHI activities in Phase I, results showed some level of impart on youth and adolescent health in NURHI implementation cities. Based on these evidence, a youth and adolescent program is intended and this is being incorporated into the NURHI 2 basket of models to be tested.

A study tour of CSOs and NGOs that are involved in youth and adolescent program especially as it relates to family planning was planned and during the tour, the team visited several

organisations and institutions focused on providing adolescent health services. The sites visited were chosen because they represent different institutional structures and service delivery locations, types, and models. These visits provided examples of health services being delivered specifically to adolescents, and they helped the team gain insight into various services, settings, financing arrangements, partnerships, approaches to coordination of care, and care models used in Lagos State to meet the health service needs of youths and adolescents. A description of each site and what was learned from these visits is presented below:

Study Tour Objective

- Learn best practices in youth and adolescents Sexual and Reproductive Health Right/Family Planning programming in Lagos
- Know more about why many young persons are still unable to access and use modern contraceptives
- Learn more from CSOs/NGOs that have made great progress in increasing access to and use of contraceptives by adolescents; and
- Learn more about new opportunities that exist for improving adolescent health

Leading/Guiding questions during the study tour

1. What are the best ways/means of talking to young people about sexual and reproductive health or family planning?
2. Who are the key influencers affecting young people's access to contraceptives?
3. From where do young people get information on sexual and reproductive health and services?
4. What are the gaps in current SRHR/FP service delivery to young people?
5. How can we get more young people to utilize SRHR/family planning services?

The NURHI Team Participants;

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1. Adolescent 360 Youth Friendly Centre: The centre is managed by Society for Family Health at Alimisho, Lagos State. The centre is most referred to as 9Js Girsls space. A360 is a four-year (January 2016 – December 2019) project with purpose to break down barriers to young persons access and use of contraception while increasing voluntary use of modern contraceptive among adolescent girls aged 15–19 years. The project is being implemented in two LGAs - Alimosho and Agege. A360 has a total of eight Youth Friendly facilities these two

LGAs with the Flagship centre located at Alimosho L.G.A and the others 7 integrated into the PHC facilities in those LGAs. The target is to reach 60% of LGAs in all their 10 project states.

The team visited the FlagShip Centre in Alimosho LGA branded ***9JA GIRLS*** and is strictly for girls aged 15 - 19. A 1 year formative/discovery period was implemented on the prototype (June 2016 – July 2017) to test the model and full implementation only started in September 2017. During the discovery year priority skills and best timing for access/utilization were identified as key to running the centre. The centre operates from Monday through Friday (Monday, Wednesday and Friday being their Skills Days; While Tuesday and Thursdays being for One-On-One Counselling and Spice Talks). The girls were divided into two group – ages 15 – 17 and 18 – 19 where sessions on mentorship were carried as a strategy to address sexual and reproductive health issues and also to discuss life issues.

The girls spaces are girls only clinic where girls take vocational skills classes, learn about secual and reproductive health, have private counselling with providers and receive health services. The space offers adolescent girls a variety of classes to learn skills for life, love and health. These classes teach vocational skills for life and discuss topics related to love, relationships and health.

The centre has a trained and experienced service providers and counsellors committed to providing girl-centred, non-judmental healthcare. It has a Quality Improvement Officer who conducts supportive supervision and carries out Spot-Checks on a weekly basis on the service providers. She also supervises the One-On-One counselling sessions by obtaining consent from the counselee. This is in adherence with confidentiality. Each of the 9Ja Girls centre has four trained female mobilizers who are tasked with sensitization of girls within the coverage and referral to the facility. The entry message for the centre is vocational skills while SRH services become add-on. Low use of contraceptive among girls aged 15-17 is lower because of the requirement of consent forms.

One additional strategy that the centre is using to get the buy in of the community is the mothers' session. Mothers' in the community are sensitized by the Health Educators and Women Leaders within their communities about reproductive health of their children. They are formed into a cluster of twenty (20) mothers per session, with two sessions held in a month.

Some of the Challenges encountered by A360 centres are:

1. Getting parental consent for girls aged 17 and below
2. Bureaucratic nature of governance in Lagos – Delays by Ministry of Health and the PHC Board.
3. The sensitive nature of FP among young persons does not allow for specific activies on FP directed at young persons.

The NURHI 2 team held a Focus Group Discussion with some of the girls at the centre and it was very interactive. Interacting with the girls, they attest to the fact that they have learnt new

things about their health and vocational skills. They attested to the fact that the safe space is really safe and will like more girls to benefit from the program

2. <u>Youth Empowerment and Development Initiative (YEDI)</u>

YEDI was founded in 2011 to pilot Grassroot Soccer (GRS) model to demonstrate life skills to both in and out-of-school adolescent aged 13-19. They basically use football terminologies and the Grassroot soccer curriculum as a tool to engage young people so as to achieve behavioural changes in youths and adolescents. YEDI's focus includes: Malaria Education, Sexual & Reproductive Health, HIV Prevention, Adolescent Health and Skills Training.They have about 200 volunteers, coaches, Master trainers and counsellors. Young persons must go through the 10-12 practices in the GRS curriculum.

YEDI programs includes; basic skills designed for age 10-13, Advanced skills designed for age 13-16, Skillz girls designed for girls aged 13-19, Skillz guys designed for boys age 13-19, Skillz holiday camp and Community outreaches.

The YEDI strategy is used to reach their desired audience through school outreaches, community mobilization, partnering with other CSOs working with their kind of audience and also leveraging on existing structures. Based on the availability of the coaches they decide the schools to go and based on community mapping they decide the community to go.

YEDI had a unique model of reaching young people via football metaphors. They have Master Trainers, Coaches, Counsellors and Volunteers trained for a period of two years. It is not largely focused on the girl child but has a program for girls focusing on Sexuality Education tagged SKILLZ GIRLS with a fantastic curriculum – SKILLZ GIRL DIARY. The organisation does collaborative work with other institutions and organisations. It also manages the Youth Friendly Centres in Lagos and work closely with Child Life Line. They conduct holiday camps for young people.

On follow up and progress evaluation, the participants of the Skillz girl program on identifying their need and interest to take up FP services are referred to partners with service providers and are supported to the point where they feel they are taken care of. They do have an advisory committee meetings where coaches' refresher development is done and coaches give feedbacks on their participants. Over the years, they have had participants who signed up as volunteers and coaches.

Some of the challenges highlighted by the Initiative are:

1. Excessive government protocols,
2. Individual differences and community members demanding for incentives during community outreaches.
3. Number of sessions targeted at each girl are too few. There should be at least a session for each module in the curriculum to ensure intensity and produce a lasting impact.

Knowledge building is usually in phases and a deeper understanding results in lasting impression

4. Most of the girls were in an educational transition phase. Completed SSCE and awaiting admission.

3. <u>HACEY Health Initiative</u>: Situated in Surulere. HACEY is a development organization on improving the health and productivity of underserved population in Africa. They work with communities, government institutions, private sector, companies, civil society groups and the media to design and implement sustainable interventions aimed at creating lasting impact for their beneficiaries. HACEY uses the CARE (Capacity Building, Advocacy, Research and Education) Approach. They work in four thematic areas which include SRH/FP programs for Women & Girls, Violence Against Girls, Economic Empowerment and Multi-Stakeholders dialogue.
It's major operations includes the GIRLS SPACE. A safe space to directly engage girls, for counselling and referrals. The space is lightened by provisions of games. The Initiative has also created virtual spaces such as WhatsApp Groups. These safe spaces provide knowledge on sexual and reproductive health and leadership programs concerning their rights to make healthy and positive decisions concerning their lives and prepares them to become focused and productive adults.

They employ certain strategies for their work

- Build community structures, influencers, TBAs, Women Groups and Associations
- Produce high quality videos and use of digital methods
- Training and retraining of teachers and counsellors. They also provide anonymous question boxes for schools.

The HACEY's team do not see socio-cultural issues as barriers, rather as platforms for more with policy makers and high-level decision makers. They have conducted a lot of research and piloted several projects targeted at adolescents and young people. Some of their studies reveal that:

- NGOs often provide information, IEC and condoms without providing other FP services
- Primary Health Facilities provide basic FP commodities
- Secondary/Tertiary Health Facilities provide high range of contraceptives
- There were only nine functional facilities in Lagos who render Youth Friendly Health Services and they are grossly insufficient to meet the needs of the Youth Population (estimated at 8million) in Lagos
- The policy environment in Lagos also influence service provision. The health care providers work in consonant with existing policies and laws. This in turn affect programming for young people under age 18.

HACEY's way forward using it's experiences:
The team suggested that programs should be strategically and intentionally developed in line with the desires and demands of young people and the different platforms for communication with young people used. In addition, they reiterated the need for institutional strengthening by

partners like NURHI for identified youth focused groups that do not have the required competence for such programs.

4. **Action Health Incorporated (AHI**) situated Jibowu, Lagos State. The study tour team was taken on a tour of the facility. The organisation was well structured with diverse projects targeted at adolescents. They implement projects for both In-School and Out-of-School youths and has a fully equipped clinic with a Nurse and a Resident Doctor which run from 2 - 5pm daily. The clinic is strictly for young persons aged 10-24. For FP services clients aged 15-19 frequently utilizes non-prescriptive methods of Family Planning such as condoms and Emergency Contraceptives.

The AHI team led us to Alimosho Primary Health Centre which is one of their project site. The team met with groups of adolescents to discuss their perceptions of adolescent health issues and health service needs in their community and to gather first-hand accounts of experiences illustrating how health programs have successfully reached out to this population. The adolescents were also encouraged to suggest ways in which adolescent health services in general could better serve their needs and those of their peers.

AHI leverages on on existing structures within the project communities and also emphasizes the critical roles played by members of Technical Working Groups in States.

Observations and Comments

From the study tour in Lagos State, the following were observed:

1. Generally, individuals and groups — adolescents, their parents, other adults, and the various practitioners who deliver health services—have views about adolescent health status, behavior and perspectives on appropriate and needed adolescent health services. Understanding the perceptions and attitudes of these many stakeholders is important to the successful development of adolescent health policies and services. This will help the relevant stakeholders respond appropriately to the needs and interests of those who are served.
2. Those involved, in adolescent health (adolescent themselves, parents, health practitioners, schools) face complex and sometimes controversial issues with regard to the right to and importance of confidentiality of care.
3. Adolescents sometimes appear to be a difficult group for the public to embrace. They may also be blamed for the health conditions that result from such risky sexual conduct and other high risk behaviours and are often times the challenges of these young persons are perceived as 'someone else's problem' — a problem for which the government does not take responsibility for.
4. There is a restricted information of varying quality and significance on perceptions and attitudes regarding adolescent health and health services. These literatures when available, do not have adequate data information to back facts.
5. It is imperative that the design and delivery of adolescent health services should appeal to adolescents and be responsive to their needs and concerns. In the group discussions held with youths in understanding the health perspectives and interests of adolescents

themselves, nearly all adolescents responded passionately to questions about their access to medical services, barriers to receiving care, communication about health services and the extent to which their parents or other adults or peers are involved in helping them obtain health services.

6. Disparities in adolescent views can be largely be to certain geographic and religious variables. There may also be differences in adolescent perspectives among racial and ethnic groups.
7. Health care providers (physicians, nurses, nurse practitioners) lack confidence that they have the training needed to provide the best health services to adolescents. They see them as a difficult group to handle and needs some form of training for them. Among the few that specifically care for adolescents, manyhave not received formal training in doing so. So, there still remains baisis and misconceptions about young persons health.
8. Communication between health care providers and adolescents is also important. Many parents and health care providers fail to realize that the health concerns of young persons can vary greatly by gender. Conscious effort should be made to find out about he social, emotional and physical issues of an adolescent, otherwise, they may not reve reveal important information that relates to their total well-being.
9. More advocacy need to be done in changing policies and behaviours at the governmental levels. Whether adolescents receive quality health services, preventive health services, and supportive counseling is affected by the policy environment in which the need for and cost of these services are deliberated upon.
10. There is quite some disparity among policy makers on the exact definition of the age of young persons that can receive family planning services and national policy concensus. There is also no standard of practice for and the role of government-supported health services and youth friendly centres. The quality and extent of care has been left to the mercy of the service provider inrespect of their biases.
11. Outside attitudes and misconceptions about adolescent health and health services, the issue of confidentiality and informed consent are significant to most discussion regarding the interests and rights of adolescents with respect to their health. These matters are ethically and legally complex, and a great deal is at stake in these discussions. This discussions is usually intense and has the capacity to divide key stakeholders. Some individuals have in recent times lost their practicising licenses for not seeking parental consent before administering modern contraceptives to an adolescent.
12. **Safe spaces, both physical and remotely if properly will enhance dialogue and discussions on best case practices and identifying innovative approaches to increase youth contraceptive prevalence rates.**

<u>Recommendations:</u>

1. **Youths and Adolescents should be treated with respect and their health rights recognized:** Young persons are Respectful treatment is critical as adoles- cents are mostly sensitive to rude, judgmental, or overbearing attitudes and behaviors on the part of adults. Such attitudes can cause them to react negatively to their health benefits. They should also involve adolescents in their own health management. Youth will

appreciate and respond positively to being treated with dignity.

2. **Uphold young persons confidentiality:** All personnel (clinical and non-clinical) should be trained in all facilities especially youth friendly centres about the importance of protecting adolescents' confidentiality. Making sure that they all understand how sensitive youths may be to any incident of carelessness with regard to their medical records, name, appointment, test results, and/or the reason they are seeking care.
3. **Providing different youth and adolescent health services in one place**: Integrating all youth in one place This will reduce suspicion as they do not exposewhat particular service they have gone to get. Since adolescents often have difficulty navigating complex medical systems, points of receiving services and referral appointments for them should be made easy and efforts made to nsure that they know exactly where and when to go. Give them clear directions, assurances of continuing confidentiality, and information about fees, if any. Knowledge can help lessen their anxiety so they will be more likely to keep the referral appointment.
4. **Ensure that staff are properly trained**: Health providers should be trained in the different types of methods and in a language that the youths understand. Language should focus on the mostly spoken language in that community and that which the young person understands. Language clarity is very important during discussions.
5. **Ensure availability of high quality adolescent health education** materials in all the languages that young people in the community speak and for various reading levels, including low literacy.

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