NURHI 2

Nigerian Urban Reproductive Health Initiative

LIFE PLANNING FOR ADOLESCENTS AND YOUTH STRATEGY

2018-2020

Contents

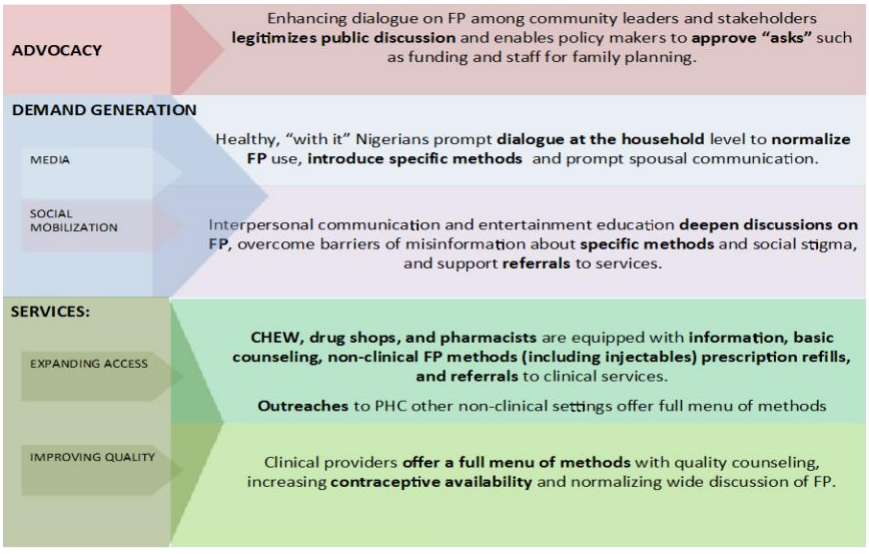
Executive Summary

The Nigerian Urban Reproductive Health Initiative (NURHI 2) is designed to increase contraceptive use in Kaduna, Lagos and Oyo States. It is an extension of the successful NURHI Project phase 1 (2009-14), and will run from 2015-2020. NURHI 2 is building on successful models and concepts implemented during a Phase 1 (2009-2014 in six Nigerian cities. NURHI 2 is driven by a strategic combination of service delivery, communication, and advocacy inputs aimed at increasing demand for, and supply of family planning, ultimately leading to long- term sustainability.

NURHI 2 Vision:

A Nigeria where supply and demand barriers to contraceptive use are eliminated and family planning becomes a social norm.

In 2017, Gates foundation requested NURHI 2 team to do a report on NURHI's impact on adolescents and youth during the projects implementation between (2009-2015).In response an approval was given for the team to working on a concept note detailing the projects plan to incorporate an intentional focus on adolescents and youth (age 15-24) in the NURHI 2 methodology. Life Planning for Adolescents and Youth (LPAY) is an add-on current to the NURHI 2 activities being implemented in Kaduna and Lagos through BMGF and in Oyo through TJ Mather funding.



The LPAY integrates a deliberate and innovative focus on adolescents and youth (aged 15-24) in its strategic approach responding to their needs and increase demand for Reproductive Health information and services among that segment of the population. This component will address current challenges facing young people's access to family planning, proactively considering the impact of interventions on young people and tailor

them to have a deeper impact and wider spread among youth in Kaduna, Lagos and Oyo. These interventions are designed to be scale-able to other states under TCI Nigeria hub.

This document represents the holistic NURHI 2 approach in meeting the unique Life Planning needs of young people through the interlocking and mutually dependent approaches of advocacy, demand generation and service delivery. They include:

Supportive Environment: Within the context of ensuring a supportive environment for meaningful participation of Adolescents and Youth in their health and well-being and thereby ensuring that their needs and views are fully considered in all Life Planning issues, efforts will be made to achieve improved political commitment of government through policy actions, policy reforms and implementation, sustainable funding, leadership and popular support, media support and increased buy-in by relevant stakeholders.

Improving Quality of Services: In order to ensure that adolescents and youth receive competent and high-quality services that meet context specific needs, are based on evidence without medical and personal providers' biases regarding use of all available contraceptives, NURHI 2 will focus on fostering an in-clinic environment that facilitates FP; training providers in counseling and contraceptive provision; and developing and disseminating the tools that enhance quality service delivery.

Expanding Access to Services: NURHI 2 Adolescents and Youth component will work to remove barriers to access by young people and proactively ensure that young people are able to obtain available services. This means expanding in-reach and out-reach services for young people for effective service delivery. Expanding in-reach and out-reach services for contraceptive methods will focus on the 18 to 24-year-olds while ensuring that care-givers and stakeholders provides appropriate information about the RH needs and challenges to 15 to 17-year-olds.

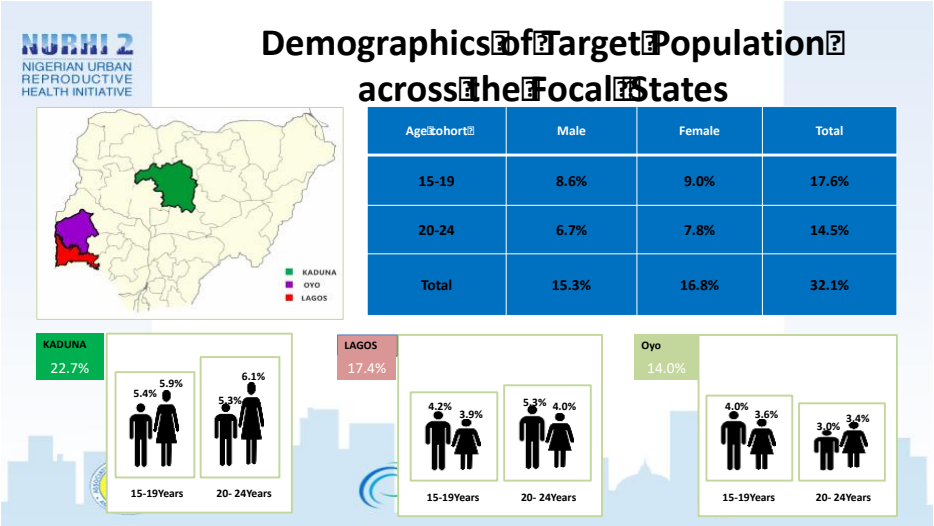
Demand Generation: In order to increase the demand for Life Planning among young people, NURHI 2 Adolescents and Youth Demand Generation approach will use communication to increase adequate and accurate knowledge of contraceptive use, promote sexual responsibility and life planning among young people and trigger discussions about LPAY at both the household and community levels. NURHI 2 will do this through an integrated communication strategy that uses social mobilization, media campaigns, and entertainment education.

Introduction

NURHI 2 Life Planning for Adolescents and Youth Component

The period of transition from childhood to adulthood requires special attention and protection. Significant changes and milestones are recorded during this period and the struggles for self-identification and recognition are sometimes drastic. Adolescents and Young people go through different maturity stages and this could affect their emotional, physical and mental abilities. It is during this period also that their knowledge and rights to health, productivity and life are developed. It is therefore important that for these rights to be fulfilled, focused investments and opportunities are created for these group of persons by families, government and stakeholders. Under the NURHI 2 Project, the Adolescent and Youth component will intentionally focus on young people (age 15-24) in its methodology to increase demand for reproductive health knowledge and services among the Adolescents and Youth in Kaduna, Lagos and Oyo.

Demographics of Adolescents and Youth in NURHI 2 intervention states



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

The adolescents and youth strategy builds on current local and global best practices in youth programming and research findings, highlighting the evidence and recommendations from the following:

- The Measurement, Learning, and Evaluation (MLE) project which outlined the impact on adolescents and youth;
- Literature Review of Existing Data and Policies on Adolescents and Youth Sexual and Reproductive Health and Rights in Nigeria;
- Findings from Adolescents and Youth Net Mapping of key stakeholders and Study Tour to youth led/focused organizations in NURHI 2 intervention states.
- Result of Latent Class Analysis of Ideational Characteristics of Young People in Kaduna and Lagos States.

The strategy was developed during a five-day Human Centered Design -informed workshop with representatives from the CCP portfolio (NURHI 2, TCI, CCPN and PPFP), young persons and youth led/focused organization/networks in the NURHI 2 intervention states, Federal ministries of Health, Education Women Affairs & Social Development, Youth and Sport and NYSC.

Adolescents and Youth Sexual and Reproductive Health/ Life Planning Context in Nigeria

The largest generation of young people in history are in/about to enter their reproductive years. In Sub- Saharan Africa, and South Central and West Asia, more than 60 percent of adolescents who want to avoid pregnancy, are not using any method of [1]contraception. This growing gap has enormous implication for reaping demographic dividends and achieving sustainable development. Investments made towards addressing the reproductive health needs of the youth have been insufficient and do not allow young people achieve their maximum potentials.

Teenage or Adolescent Pregnancy among girls aged 15-19 years constitutes a considerable health risk resulting in high maternal deaths and morbidities. The social consequences of teenage pregnancy are immense and often result in curtailing educational opportunities for such girls. Evidence from NDHS 2003, 2008 and 2013 indicates that Adolescents birth rate is over 120 live births per 1000 women aged 15 – 24 years. In Nigeria about one in every five young women aged 20-24 years already debuted sex by 15 years and 23 percent already had a birth or was reported pregnant based on the 2013 NDHS. The NDHS 2013 health indicators further reveal that access to essential sexual and reproductive health services is poor; modern contraceptive use was 3 percent as against national average of 9.8 percent, while unmet need was 16 percent compared to national average of 18 percent.

In Nigeria, there are 41 million adolescents aged 10–19 years – 22.5 percent of the country's total population. Just over half of adolescents live in rural areas; 50.4 percent of adolescent girls and 50.6 percent of adolescent boys. By age 19, the mean number of years of schooling attended by adolescent girls is 8.0, while for adolescent boys it is 9.2. The average age at which Nigerian adolescent girls have their first baby is 16.7, while the average age at which adolescent boys first become fathers is 17.8. Analysis of data from the NDHS shows that over 4.7 million Nigerians aged 15–19 are currently sexually active – they are either unmarried and have had sex in the last three months or they are in a union (i.e. married or living together). On the average, among adolescents who had sex before age 20, girls first have sexual intercourse at age 15.9 years and boys at 17.0 years. Among unmarried adolescents, 21.0 percent of adolescent girls report ever having sex and 11.9 percent are currently sexually active; among adolescent boys, 15.5 percent report ever having sex, while 9.1 percent are currently sexually active. Among all Nigerian adolescents, 28.8 percent of adolescent girls and 1.1 percent of adolescent boys are in a union. Among these adolescents, the mean age of the first union is 15.6 years for adolescent girls and 17.7 for adolescent boys.

The sexual and reproductive health of adolescents 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 behaviors that form a young person's future begin to develop and take shape, in addition, nearly 35 percent of the global disease burdens have their roots in adolescence (Aji et al, 2016; Abiodun et al, 2016).The World Health Organization estimates that 70 percent of premature deaths among adults are largely due to behaviors 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, the 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 SRHR 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 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 program interventions to improve their health outcomes.

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 space programs, especially for vulnerable girls, and programs that engage families and communities (Santhya & Jejeebhoy, 2015).

Ideation theory

The ideational variables assessed have been found to be critical for contraceptive intention, adoption and continued use. Continuation of the radio and television series is strongly recommended. Formative research should help to determine which radio and television formats are most appealing to various categories of young people being targeted. Programs should explore how best to package life-stage appropriate media messages and materials to maximize reach and impact among youth. The lack of effectiveness of facility-based interventions on ideational outcomes for youth in the south is probably due to the smaller proportion of married youth in the south compared to the north. There is a need for making services more youth-friendly, including increasing the number of trained providers that are sensitive to the needs of unmarried youth, especially in southern Nigeria where improving the quality and youth-friendliness of services at tertiary education institutions could be considered.

Ideational factors among Young persons

	%	Across states
Personal Advocacy	22.47	Lowest in Lagos
Discussed FP in the last 6 months with spouse/partner	34.33	Lowest in Lagos, highest in Kaduna
Close friends/relatives using contraceptives	10.77	Highest in Lagos, followed by Oyo
Discussed no. of children with spouse in last 6 months	36.95	Highest in Lagos followed by Kaduna
Require permission to use FP from anyone	61.46	Highest in Oyo, Kaduna and Lagos
Community will call you bad name if you use FP	16.42	Kaduna followed by Lagos
Could convince spouse/partner to use	50.12	Lagos, Kaduna and Oyo
Peers of the same rank you think uses FP	11.46	Kaduna, Oyo and Lagos

Socio-demographic characteristics of Ideational classes

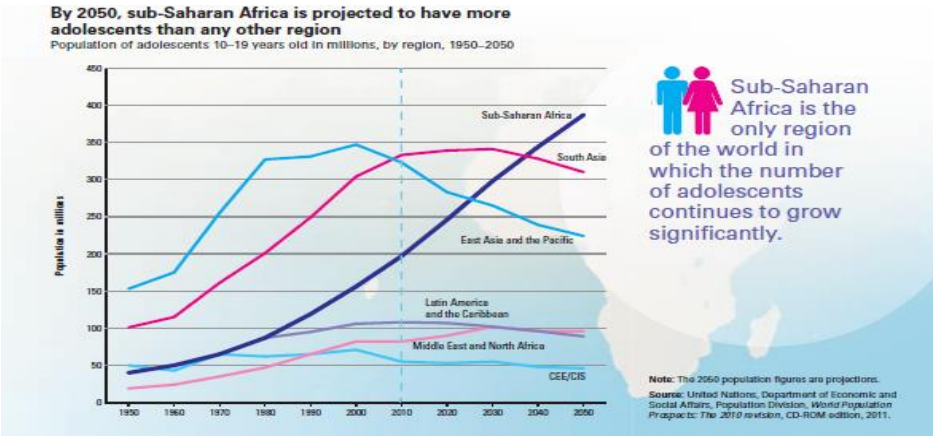
Characteristics	Class 1	Class 2	Class 3
Percent aged < 20 years	16.3	33.3	33.6
Percent with post-secondary education	23.7	17.3	15.9
Percent Muslim	55.0	47.3	54.3
Percent married or cohabiting	59.4	42.7	44.4
Percent with at least one child	61.9	41.3	39.2
Per urban residents	49.4	46.7	52.6
Percent of regular TV viewers	72.3	70.0	64.4
Percent of regular radio listeners	59.8	42.2	43.2

Class 1: Moderately knowledgeable, empowered and engaged; Class 2: Ignorant, empowered and disengaged; Class 3: Ignorant, disempowered and disengaged

Source: Omnibus survey data conducted in September 2017

Introduction to Adolescents and Youth Overarching Strategy.

The growth of young people as a demographic group in a rapidly changing world is outpacing the capacity of families, societies, and governments (and their respective institutions) to respond to their needs. Currently, many young people are not able to fulfil their rights to the highest attainable levels of physical and mental health and well-being. Health systems mostly distinguish children and adults, while adolescents and young people often fall into a policy-gap, where their specific needs and the unique barriers they face are overlooked.



Massive under-investment in adolescent health is partially responsible for young people's high vulnerability. Central to the AY Strategy is investment in young people in ways that best help them make that transition to a healthy, capacitated adulthood. This means that adolescents and young people need the information, the means, the opportunity and the autonomy to protect their own health and make sound decisions.

Critically, many lifelong habits are formed during adolescence and these shape future health, social and economic outcomes in important ways. Supporting young people to make a healthy transition to adulthood is a sound health investment.

Adolescence, as a stage of physiological and other transitional changes from childhood to adulthood, creates a lot of vulnerability. Unfortunately, these changes are not understood by the adolescents, thereby challenging and exposing them beyond their capacity, including sexual activity and abuse. Lacking confidence to discuss with parents, guardians, caregivers, and responsible and knowledgeable adults predisposes them to more vulnerabilities, which further challenges their ability to emerge as responsible adults.

Evidence from sentinel survey and NDHS 2013 shows that Nigerian youth are becoming sexually active. For the nation to achieve demographic dividends, it is essential to help the young people who are already sexually active to plan their lives. They need information to prepare them and equip them and skills to equip them to face the challenges of the stage to be able to achieve their dreams and avoid negative impacts of unplanned pregnancies, Sexually Transmitted Infections (STIs) and other social effects including dropping out of school and its future consequences. Nonetheless, sexually active young people need holistic counselling to avoid risky sexual behaviors and make informed choices.

Ensuring that every adolescent has the appropriate knowledge, skills, and opportunities to fulfil their right to a healthy, productive life is essential for achieving improved health, social justice, equity and other development goals. To this end, Nigeria's young population must be considered a great asset, and government and necessary stakeholders must consciously respond to their needs to enable them to contribute meaningfully to national development.

NURHI 2 Youth Audience

The adolescents and youth age group is very dynamic and diverse. This diversity is determined by several factors such as demographics, socio-economic status, educational exposure, and even the age bracket they fall within. Taking into consideration this diversity and the provisions within the National RH policy (2017), two distinct groups of youth have been identified to facilitate program implementation for the NURHI 2 Youth and Adolescent program.

This population group falls into the following category:

1. Unmarried Adolescents and Youth
2. Married Adolescents and Youth who are
    - 15 to 17-year olds
    - 18 to 24-year olds

The 15 to 17-year-olds are still considered as minors, who are still under parental care, and require parental consent. In cases where they may be married, they are considered to be under their husband's care. This group of adolescents does not seek care at the health facility except they are very ill and need additional care.

The health facility is usually not their first point of contact for healthcare, not because they do not like the place, but rather because they do not feel a connection to the place. They usually access healthcare in the company of a parent, older sibling, older guardian, older friend or group of friends in the same age bracket. The 15 to 17-year-olds seek reproductive health information from friends, peers, trusted adults and safe spaces. They also access information from books, social media and other online platforms. But due to their short attention span, they are more attracted to literature with colorful graphics and short prose. The provisions in the National RH policy is limited for this age group to only appropriate FP counselling.

On the other hand, 18 to 24-year-olds are legally recognized as adults, and they commonly dress, behave and appear older. They are independent in their thinking and decision making. It is during this period that many youths become newly employed. Majority still live with their parents or guardians but they want to assert their independence. These young adults are very social and open to try new things, making them prone to social vices and thus exposed to high-risk behaviors. It is not unusual to have one or two of them who have experienced an unplanned pregnancy. 80.7 percent of females have their first sexual intercourse at 20 to 24 years, of which 65.2percent are likely to be married (FMOH, 2011). It is not uncommon to have a married youth in this age bracket going to school in her husband's house. They usually walk into a health facility alone to seek health care services on their own, and are not averse to reading/using SBC educational material that was developed for the general adult audience. This group also has regular access to the internet and are actively involved with social media. The National RH policy covers this group for all contraceptive methods.

Unmarried Adolescents and Youth: Studies have shown that there is a proportion of this group willing to abstain. For the abstaining AY, it is necessary to re-enforce their information base and relevant skills to continue to abstain until they decide to become sexually active based on informed decision, recognizing their ability to take responsibility for their actions. For the sexually active AY on the other hand, they need information and relevant skills that will enable them to either chose to engage in secondary abstinence or adopt safer sexual behaviors including adopting FP services.

Married Adolescents and Youth: They may have some needs and challenges based on their locations. This group is sexually active, living with partners and/or other significant family members who may influence the kind of information accessible to them as well as their fertility based decisions. They also are exposed to their peers who may be married or unmarried. Therefore, they may also need information and skills to guide them into making informed Life Planning and fertility decisions.

Layering on Advocacy, Demand Generation and Service Delivery Approaches

NURHI 2 will layer on and build on the success of the past seven years to focus its interventions on removing the barriers that prevent the adolescents and youth population group from accessing Life Planning information and services and Family Planning services in Nigeria, and in particular in the three NURHI 2 project of Kaduna, Lagos and Oyo. The tested approaches and lessons from NURHI, the endline survey results from NURHI, and the analysis from the recent MLE Researches will enable NURHI 2 to move quickly into implementing a successful program for young persons to access modern family planning services, as may be required.

It is expected that successful implementation of the program strategies in these three states will also set the stage for catalyzing change in non-NURHI 2 states in two ways: first, that young persons are able to abstain from sex until when they are married and that young persons, no matter their age, religion or social status who need access to family planning services (counseling or contraceptives) especially modern contraceptive will be able to access them freely.

The MLE youth paper recommended that NURHI 2 should build on existing successful programs and to adapt those to be more appropriate and intentional for youth. That means that the basic structure of NURHI 2– an interdependent mix of advocacy, service delivery, and demand generation – will be maintained. Also, given the success of NURHI in impacting adolescents and youth already, the strategy will be integrated into the overall NURHI 2 program, rather than having a stand-alone vertical youth component. The NURHI 2 Adolescent and Youth strategy therefore, represents a holistic approach to advocacy, demand generation and service delivery. The components are interlocking and mutually dependent.

Outcome: Positive shift in family planning social norms at the structural, service, and community levels that drives increases in CPR in Kaduna, Lagos, and Oyo state

Supportive Environment Adolescent and Youth Approach.

The Federal Government of Nigeria is a signatory to international conventions that protect the right and wellbeing of adolescents and other young persons. Consequently, Nigeria adopted the child right act (2003), FLHE (2000) and National policy and strategy for the health and development of adolescent and other young people (2007). Unfortunately, all these policies and laws have not been fully operationalized due to lack of strong political will and funding by government at the national, state and local government levels. The result is that there are more rhetorics than sustainable deliberate and conscious effort to implement and execute the national strategic framework that addresses the needs of the young persons. Consequently, the key beneficiaries of these policies are left out in the scheme of things and all national development aspirations.

Other militating factors are lack of parental support/disapproval by significant gate keepers such as parents, religious/community leaders, teachers, peers etc. Self-imposed restrictions and lack of confidence on the part of the adolescents/young people. Even though they recognize developmental changes in their bodies, they mostly do not fully understand it, particularly those in the lower socio-economic quintile. Their inability to get parental support due to the lack of Life Planning knowledge and skills leaves them feeling isolated and insecure and ending up seeking information from sources that may increase their vulnerabilities.

The media may serve as a barrier where they provide negative/poor sensitization. The media often fails to do sufficient investigative analysis and stories that can be beneficial, to inform, create awareness and sensitize young people to adopt behaviors that will promote their sexual and reproductive health. Ideally, the media is supposed to be a source of information on issues including LPAY, however, most have failed to represent the interest of the young people to ensure accountability and policy actions on the part of the government.

The focus of the advocacy component is to achieve a supportive environment for meaningful participation of AY in their health and well-being and thereby ensuring that their needs and views are fully considered in all LPAY and related concerns. This support should be evident by improved political commitment of govt. through policy actions and sustainable funding and policy reforms and implementation, leadership and popular support, media support and increased buying by stakeholders.

Key Outputs:

1. Changes in Life Planning Adolescent and Youth-focused policies and policy implementation tracked and documented

2. Level of funding (budgeted and actual spent) for LPAY services in State and LGA budgets documented
3. Religious/community leaders, parents, teachers, policy makers and other stakeholders trained in LPAY
4. Adolescents and Youth and Youth-led and focused Organizations trained on Voice and Accountability to drive LPAY agenda.
5. Media trained to advocate and report on LPAY issues

Intermediate Outcome: <u>1.1 Increased support by key stakeholders for FP at the State and LGA levels.</u>

NURHI 2 will enhance dialogues and public discussions to remove the barriers from the national, state, Local Government Area (LGA), and community leaders and stakeholders that prevent the adolescents and youth from accessing FP information and services, and enable engaged policy makers to support policy actions such as funding and staffing for equitable LPAY/family planning services.

Working from a Human Centered Design perspective, implementation of the advocacy strategies will deliberately revolve around building synergies with existing NURHI 2 structures that have been proven to work in order to achieve sustainable results, particularly at the policy decision-making and leadership support levels. Deliberate efforts will be made to ensure that the youth take their necessary place in leading all programming decisions and activities. Their capacities will be built to improve their knowledge and skills and as well be enabled to identify and attract resources. Community networks and partnerships will be built with youth-led and youth-focused organizations to enhance discussions and consensus building among stakeholders.

Furthermore, the primary roles of the Advocacy Core Groups and the Interfaith Forums will be expanded in content to also include discussions and dialogues on the unique needs of the adolescent and youth, recognizing the peculiarities and local nuances, to achieve the necessary support for the well-being of the target group. NURHI 2 will build capacity and partnerships and alliances with youth-focused and youth-led organizations to expand the LPAY agenda, particularly at the community level. They are recognized as useful resources for sustainable LPAY programming and implementation.

Adolescents and youth are unique in their demographics and socio-economic characteristics, repositioning them to understand the physical, physiological, emotional and other changes in their bodies will create appropriate platform for increasing their representational roles and giving them a voice in decision affecting their personal growth and development. In addition, increase opportunities will be created for youth-led/focused CSOs and community based groups to strengthen their roles and provide increase leadership particularly for community dialogue, youth engagement and social mobilization.

- Build their capacity to understand human sexuality, the implications of the biological/emotional changes, LPAY and implications of the risky sexual behaviours
- Build partnerships among youth-focused and youth-led projects to enhance discussion

- Build the skills of CSOs, youth focused FBOs and youth leaders in SMART advocacy, budget tracking and leadership skills.
- Mainstream LPAY information and services in existing safe spaces and meet context specific needs, evidence based, and implemented, monitored and evaluated in partnership with YP.
- Build capacity of CSOs and youth led/focused organizations on the effective use of the media

Output 1.1.2: Level of funding (budgeted and actual spent) for LPAY services in State and LGA budgets documented

The Government of Nigeria through the FMOH developed the National Strategic Framework and plan for health and development of adolescent and young people in Nigeria (NSF revised 2011), which unfortunately was not implemented due to lack of funding. Currently, the absence of budget line and epileptic budgeting and expenditures in other ministries are bottlenecks to successful LPAY programing. Therefore, sustained advocacy to government at all levels is required to support AY focused programmes.

Activities:

- Advocacy through engagement of all relevant government parastatals with information on the status of A/Y in Nigeria
- Mobilize key government agencies to ensure allocation of funds to support the provision of LPAY information and services.
- Promote dialogue with government to ensure that the NSF on LPAY is operationalized; there is realistic work plan and funding to achieve the plan.
- Build multi-sectoral capacity on LPAY and budgeting.
- Continuous monitoring of budgetary allocations and expenditures on AYLPAY and if possible generate score cards among states and LGAs.

Output 1.1.3 Changes in LPAY policy and policy implementation tracked and documented

All existing policies will be reviewed and updated to make them relevant to emerging realities of the AYLPAY. State and LGA buy-in will be sought, as well as involvement of stakeholders in the programming and implementation to achieve the needs of the A/Y while responding to the FP2020 as well as the SDGs. Increased discussion and information on healthy sexual, maternal health including PPFP behaviors. User-driven strategy and programming approaches will be used in all interventions and to achieve improved accountability.

Activities:

- Formative research to identify the most effective approaches to meeting the needs of LPAY
- Review and dissemination of key policies to promote LPAY and delivery of information and services.
- Mainstreaming of AY friendly content into existing LPAY dialogues, information and services at all levels.

- Continuous dialogue and advocacy with stakeholders, decision makers and policy makers using appropriate tools and materials to achieve sustainable policy actions that will be favourable to target population.
- Continuous review of LPAY situations and regular dissemination of information and findings to guide policy response.

Output 1.1 3: Religious/Community leaders, Parents, Teachers, policy makers and other stakeholders trained in LPAY

Adolescents and Youth operate within a society thereby interacting with relevant stakeholders such as parents, teachers, community/religious leaders, media hence ensuring that critical stakeholders understand the issues as well as the interventions. LPAY is crucial in ensuring that young people can fulfil their potential and achieve high level of health and wellbeing. Leveraging on the successful NURHI advocacy models, the project will undertake the following activities:

Activities:

- Build alliance and capacity of the leadership including parents, teachers, community/religious leaders and media to gain their support for LPAY issues.
- Engage all critical stakeholders in the implementation of culturally sensitive and user-friendly LPAY information and services for buy-in and support.
- Galvanize religious and community leaders' support.
- Promote dialogue with community and religious leaders on the needs of adolescents and youth.
- Promote parent-child, and child-teacher LPAY communication
- Create and build the capacity of champions to be in the fore front of AYLPAY advocacy and dialogue within the community, as well as serving as the community voices.
- Adapt the existing appropriate and culturally sensitive materials to support dialogue with leaders, recognizing local nuances.

Output 1.1.4: Media trained to advocate and report on LPAY issues

The media is an important gate-keeper because of the capacity to reach out and inform the general public on a large scale and they also represent the voice of the people in drawing attention to issues that affect the well-being of the people. Most importantly, they act as check and balances on governance and related matters thereby ensuring accountability. However, in view of the sensitivities around LPAY issues, empowering the media to get the right messages across to avoid backlash is critical.

The activities include:

- Capacity building on LPAY information and messaging for the media.
- Build the capacity of the media to advocate for the LPAY thereby promoting, understanding of the issues to stimulate political and policy responses.
- Create opportunities for the media to engage AY-led discussion forums
- Increase media coverage on LPAY issues

- Build capacity of relevant media organizations to enhance the dissemination of accurate/culturally sensitive Life Planning messages and facilitate meaningful dialogue/discussions on LPAY issues.
- Promote dialogue on LPAY through multiple channels.

Health System Strengthening/Service Delivery Approach

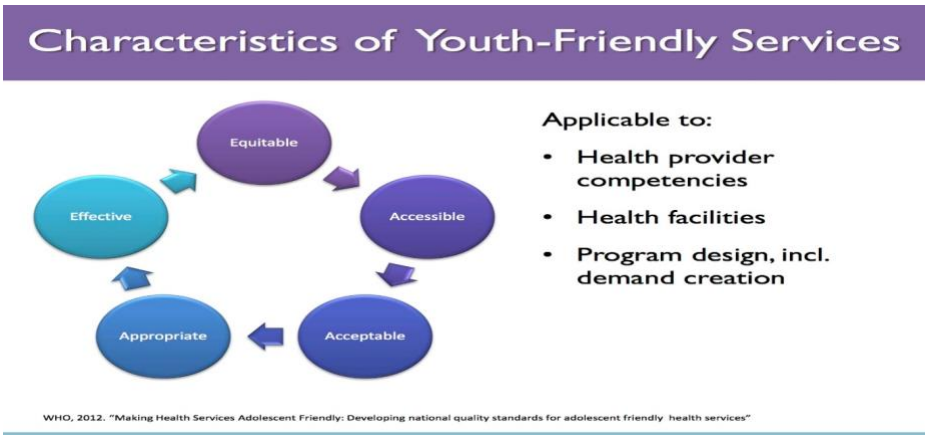
Evidence gathered from the net mapping/study tour, the strategies adopted by NURHI 2 Adolescents and Youth Service Delivery will focus on four priority areas namely:

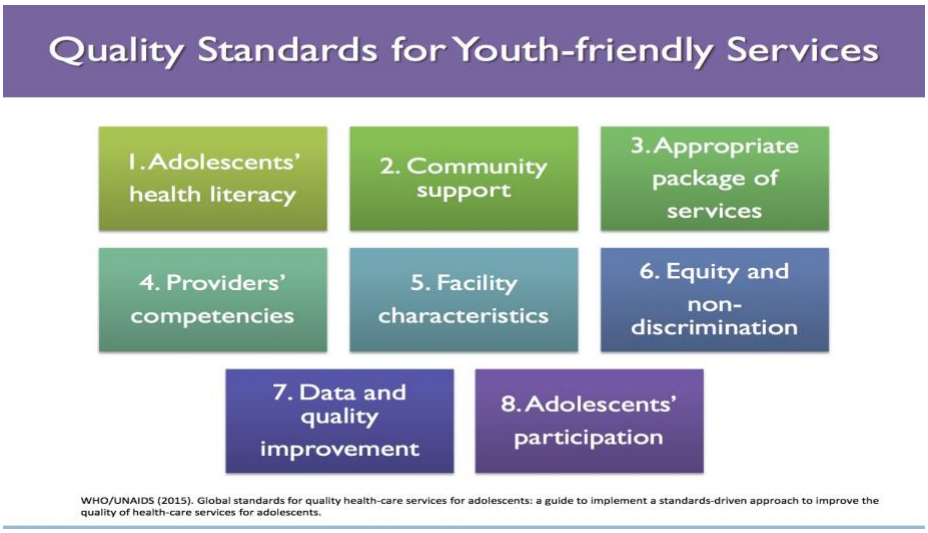
- Delay Sexual Debut
- Preventive Services
- Healthy Pregnancy and Childbearing
- Healthy Timing and Spacing of Pregnancy

These priority areas will enable NURHI 2 address the needs of adolescents and youth, within the provisions of the law for every possible RH scenario that may be faced by each age bracket. It also outlines the peculiarities of each project state and the strategy adopted, as it relates to each group ensuring effective and efficient implementation. The interventions will be cross-cutting and involve overlaps between the thematic areas because of the dynamics of the age groups involved.

At every stage of design and implementation, there will be active involvement and participation of the youth and adolescents across board to ensure the initiative and actions are based on their needs and sensitivities and also meets the quality standards of Adolescents and Youth Friendly Services. This will help build their capacity to take the lead, and facilitate in the long-term a system whereby more youths are engaged and equipped with the necessary knowledge and life skills.

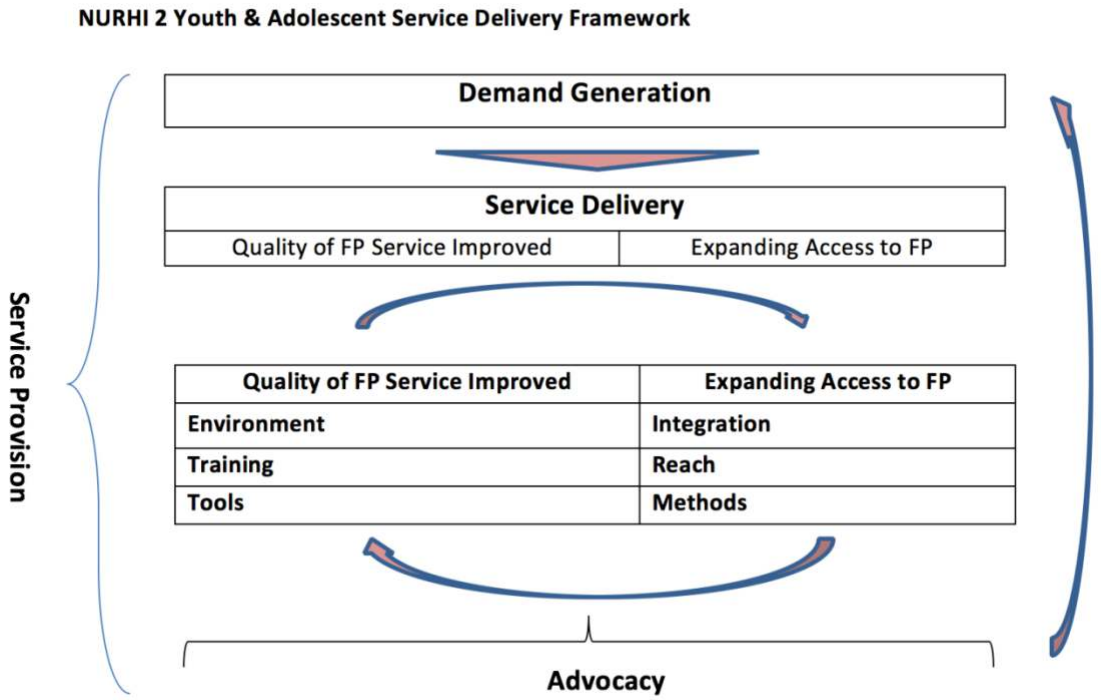
The national quality standards for provision of AYFHS in Nigeria have been developed to provide a platform for the optimal health and development of young people. These standards are consistent with existing national adolescent and youth health and development policies, and in line with the WHO's criteria for AYFHS.





Intermediate Outcome: <u>1.2 Quality of FP service provision improved at NURHI intervention sites</u>

Expanded equitable access of women to family planning services through new and existing service channels. The strategies developed for the adolescents and youth components of service delivery will feed into achieving these two intermediate outcomes and ensure successful expansion of the NURHI 2 project to cover this unique group. The framework below provides a snap shot of the interlocking processes between thematic areas. It also provides the core strategic areas that help achieve the intermediate outcomes. A detailed description of these strategies is contained below.



Environment: In ensuring quality service delivery, understanding the environment is key. Both the physical and the non-physical environment must be optimized to ensure no gap is left unaddressed. For the 15 to 17-year-olds, the health facility environment can be hostile due to the legal, moral and societal nuances and practices. Considered as minors, this age group is expected to seek and gain parental consent before having access to RH/FP services. In addition, as minors they are not expected to indulge in adult-like behavior such as partaking in sexual activity. The expectations about these group of adolescents result in service provider bias and prejudice towards adolescents seeking Life Planning information or services, lack of access to accurate information, lack of access to appropriate services, lack of support leading to unsupportive policies amongst many other challenges, and ultimately low self-esteem of adolescents.

The environment of the health facility is more accommodating to the 18 to 24-year-olds because legally they are considered as adults and the existing RH policies clearly provides for them. This means that they are able to have access to modern family planning methods. However, they are also affected by the moral and sociocultural norms which expects unmarried youth to remain celibate until marriage. This means that they also experience provider bias (in terms of approach, marital status, type of method and myths and misconceptions), lack of access to accurate information and appropriate services, and prejudice about their sexually active status.

Training: Training is fundamental to ensure that both clients and healthcare workers (technical and non-technical) have relevant knowledge and skills transfer concerning

about adolescents and youth and RH needs, and where to access the necessary and appropriate services. Many adolescents within the age group of 15 to 17-years are experiencing puberty and undergoing several physical and emotional changes. These adolescents also have several questions and perceptions about the transition period from childhood to adulthood – when they are vulnerable and can fall prey to manipulative adults and harmful influences. Therefore, all stakeholders including parents, guardians, teachers and religious/traditional leaders must understand the issues concerning adolescent life planning needs and sexuality education, and how to address them. All target audience need to be equipped to handle issues concerning life choices, assertiveness, self-esteem etc.

Lack of youth friendly health workers and facilities, lack of appropriate and adequate information on life planning, stock-out of FP commodities, and the myths and misconceptions surrounding FP use and uptake are the common challenges affecting the 18 to 24-year-olds life planning needs. FMOH 2006 Assessment of youth and adolescent health services showed that one-third of the staff who work in youth-friendly facilities have no special training. The training approach will be to leverage on strategic partnerships and existing platforms to include youth content and lay emphasis on its implementation. The priority audiences will include adolescents and youth as well as the relevant stakeholders involved.

Tools: Availability and use of adequate tools is necessary for effective and efficient service delivery. Tools empower clients and stakeholders to put into use the knowledge and skills they have acquired. The appropriate tools needed for 15 to 17-year-olds include life planning SBC materials, religious pamphlets, and appropriate training materials. The 18 to 24-year-olds on the other hand will need detailed information and materials on all contraceptive methods and where they can access the services.

Other instruments such as safe spaces, learning spaces and skill acquisition centers are vital tools needed to create conducive learning centers for youth and adolescents. NURHI 2 will develop and build strategic partnerships with organizations already working in these spaces to introduce and integrate the Life Planning for Adolescents and Youth component.

Intermediate Outcome 3: <u>Expanded equitable access of women to family planning services through new and existing service channels</u>.

Integration: The integration of LPAY services into other existing platforms within and outside health services is fundamental for expanding services. Adopting an integrated approach enables the youth and adolescent component to leverage on several opportunities such as:

- Integration into health talks of other clinical units
- Integration into HIV Preventive Services
- Integration into programs for youth and adolescents in the community

Integration into programs for youth and adolescents within religious organizations

- Integration into school health programs for youth and adolescents in the community
- The content and type of messaging will vary for the different age categories to reflect their peculiarities and address their needs. NURHI 2 will work with all stakeholders along the thematic areas to develop this content, keeping in focus the four priority areas outlined above.

Reach: Expanding in-reach and out-reach services for youth and adolescents is vital for effective service delivery. Although expanding in-reach and out-reach services for contraceptive methods will be focused more on the 18 to 24-year-olds, a component of this strategy will be focused on ensuring that care-givers and stakeholders for 15 to 17-year-olds have the appropriate information about the life planning needs and challenges of this age group. In addition, healthcare providers (including FP service delivery providers) will be equipped with the skills to address the Life Planning needs of young persons.

- All stakeholders (i.e. adolescents and youth and other stakeholders) also need to be aware of where to seek or refer for appropriate LPAY services including management of violence/rape, management of sexually transmitted diseases, post-abortion care, PNC/ANC etc.
- This will be achieved through alliance with youth led and centered networks, and leveraging on existing platforms. It will also involve capacity building for service providers and youth leaders.

Method Mix: As increase in awareness and information on LPAY services is provided to the 18 to 24-year-olds, there will be a corresponding increase in demand. There needs to be an appropriate increase in the ability of health workers to provide quality services for all methods to meet demand. NURHI 2 will leverage on the domestication and implementation of the task-shifting and task-sharing policy to incorporate youth friendly content into trainings for CHEWs, Nurses, Midwives and Doctors. The content will be aimed at improving their understanding about youth and adolescents, and building their communication skills. This will be achieved through IPCC trainings and SBCC interventions that improve client-provider interactions.

Intermediate Outcome: <u>1.4-Increased demand for family planning by women and men of reproductive age</u>

To effectively reach the priority audience, demand generation for adolescents and youth will use a combination of media, print materials and interpersonal communication channels. These strategies will be situated in the context of what obtains in each intervention state and modified to suit local nuances and specific characteristics of the audiences. The demand generation component will leverage on existing NURHI 2 communication channels, or create new ones as required, and build networks with youth

led, youth focused organizations to link the target audience with additional services that will empower them, such as life and skill building opportunities.

The Transmedia approach will also be adopted to popularize and reinforce positive Adolescence and youth LPAY messages across multiple media platforms, with particular emphasis on social media, radio drama serials and mobile applications. The focus of the messages will be to increase LPAY knowledge, reinforce positive sexual attitudes/behaviors among male and female adolescents and youths and debunk myths and misconceptions around contraceptive use and make life/family planning a trending topic of discussion and a norm among adolescents and youths.

Television, radio and mobile phones (particularly for social media purposes) remain the most commonly used media channels among young persons in Kaduna, Lagos and Oyo states. Findings from the net mapping exercise conducted in all 3 states revealed social media to be one of the main sources through which young people access information. The NURHI 2 Flexi Track Omnibus survey also showed that more than 60 percent of young persons (aged 15-24) access information on both radio and television.

To respond to the unique needs of the priority audience and address the identified barriers, the adolescents and youth demand generation strategy will:

- Trigger discussions about LPAY at household and community levels
- Promote sexual responsibility and life/family planning among young persons
- Correct misinformation and dispel fears around contraceptive use

Key outputs

- Increase the number of young persons who have correct knowledge about their sexual and reproductive health
- Increase the number of persons who know where to access correct Life Planning Information and services.
- Increase the number of young persons who feel confident about sharing Life Planning information
- Increase the number of young persons who feel confident accessing Life Planning information and services
- Increase number of young persons who are willing to delay sexual debut or practice secondary abstinence.
- Increase the number of persons who utilize certified Life Planning services and information

The NURHI 2 adolescents and youth program will use the following types of communication:

Output 1.4.1 TV and radio campaigns broadcast

NURHI 2 will develop and roll out a series of youth focused, fun and engaging transmedia campaigns on new media and traditional media platforms.

Activities

- Individual influencers: individuals whose personalities have garnered popularity making them influencers by default. These individual, who will be carefully selected from results of the net map (as well as additional surveys to reveal the most favored or most followed celebrity by young persons) will be engaged to promote or share LPAY messages and share transmedia spots on their social media handles.
- Influencing platforms: Pages on social media or websites that have high followership or viewership and hence have influence based on their content.
- Trending hash tags (#) online: Create hashtags that will trend on social media, following principles of social media marketing, and link to other platforms that carry our messages/spots.
- Paid adverts on social media platforms: Paid adverts increase reach on platforms such as Facebook or Instagram. NURHI 2 will explore this to further disseminate its messages.
- Online media: NURHI 2 will engage young persons through popular online platforms such as google search, google ads, Nairabet, Nairaland, Pulseng, YouTube etc. using pop up ads (Fuller life for young people) that redirect to other platforms that carry our messages/spots. Such engagements include short skits that can be used on social media and are easily shared.
- Radio/TV Spots: The NURHI project will produce multiple 60-second television and radio spots to spur change and generate demand for LPAY information and services for adolescent and youths. The end line data for NURHI 1 high exposure to the project's radio and television spots.
- IVR: Interactive Voice Response, the NURHI 2 is developing an IVR system in collaboration with Voto Incorporated where people can call-in and listen to frequently asked questions about family planning, as well as direct them to a health facility near them to access services and more information. The messaging on this platform is general information and not specifically targeting adolescents and youth.
- NURHI 2 Adolescents and Youth Component will collaborate with DKT to integrate NURHI 2's youth friendly service providers into the Digital Customer Care center, and will promote the center in its materials, as possible and appropriate.

Output 1.4.2 New radio entertainment education program developed

Statistics have shown that entertainment education is a highly useful tool for health promotion programs, it can help to increase the knowledge of young people on reproductive health, create favorable attitudes and influence behavior and cultural norms. Well-crafted stories can inspire, teach and move young people to take actions that will improve their reproductive health behaviors. Young people can become emotionally tied to strong characters in these stories. Such ties can influence values and achieve behavior change much more powerfully than direct demand for change.

NURHI 2 will produce entertainment education materials and leverage on platforms that young people frequently interact with, such as:

Television: Exposure data from NURHI 2 FlexiTrack Survey shows that about 70 percent of young people watch television. Recent interviews conducted among young people also

afforded us deeper understanding of television stations and programs that young people 15–24 years of age watch. The entertainment education content will be screened on channels such as HipTV, Africa Magic Yoruba, Africa Magic Hausa, Soundcity, Mtv Base and SuperSports. The content created will be short (30 seconds to one minute), funny, factual and feature A-list actors, we will also create a specific sound to introduce all our entertainment education content. A typical example of this is the champions league sound.
Also, we will partner with high level events that interest young people to play these videos during their main ceremony. Such events include All Africa Music Award (AFRIMA), Africa International Film Festival (AFRIFF), Headies Awards etc.

Radio: Popular radio programs and on-air personalities (OAP) are effective ways to reach and engage young people. Therefore, we will create radio dramas that are humorous, emotional and informative. These radio drama serials will be aired before a popular show on the chosen network. NURHI 2 will leverage on relationships with existing radio stations in the intervention states. We will work with OAPs to indirectly discuss the scenario of our drama on their program and encourage young people to listen and call in. Key life events and/or competitions: Young people in and out of school are highly competitive and enjoy fun-filled events that celebrate their skills and uniqueness. To this end, the program will organize the following activities to engage young people:

- Spoken words competitions/events.
- Short drama competitions.
- Music and Dance competitions.

These events will be hosted in secondary schools and on tertiary institution campuses when student's associations plan to celebrate their annual week events. Winners from these competitions will have the opportunity to make an entertainment education video with a celebrity. Studio recordings of the winning spoken word/drama/music will be produced, and the videos/audio files shared on the various social/online media platforms by the young people, using their social networks and groups to ensure that the messages trend and reach multiple audiences.

Social Networks:

Social networks present a great opportunity or platform to inform and engage in- and out-of-school young persons to take actions that will improve their reproductive health. They have friends within this network who influence them directly or indirectly and the leadership of these networks are committed to ensuring that members receive new update that can help members see them as functional and highly interested in their welfare. NURHI 2 will work with different social networks – both within schools and with formal and informal vocational training outfits, including associations that both in- and out-of-school youths belong to – to provide information to young people on reproductive health and also use this platform to provide information on locations that provide youth-friendly RH services. Some of the identified social networks include:

- Student Associations such as International Association of Students in Economic and Commercial Sciences (AIESEC), National Association of Nigerian Students (NANS), Junior Chamber International (JCI), Anti-HIV clubs, etc.
- National Youth Service Corps
- Trade Unions

- Community Youth Groups

NURHI 2 will build male and female youth champions within these networks who will go on to become voices for SR health in their states and across Nigeria. NURHI 2 will also collaborate with youth led organizations that provide leadership, coaching and mentoring opportunities for young people on life skills to link the identified social networks with opportunities that engage and empower them.

Output 1.4.3 Social mobilization routinely implemented

NURHI 2 will work with existing social mobilization structures within the communities in Kaduna, Lagos and Oyo to create general awareness, establish basic knowledge about LPAY and address ideational factors among the priority audience. The social mobilizers will be trained on youth focused messaging and activities (Neighborhood campaigns, community dialogue and key life events) to trigger life planning conversations both at the household and community levels. Volunteers from some of the identified social networks including networks of People Living with Disabilities (PLWD) will also be incorporated into social mobilization activities.

- **Job Aids*:*** Demand generation will work with the SD/HSS team of NURHI 2 to design and produce DLE videos, posters and other tools, aimed at changing the ideation of providers towards youth friendliness. These job aids will also be designed to promote providers', enabling them to recognize LPAY needs and provide services to them.

Audience Profiles

Using a Human Centered Design to further understand the unique Life Planning needs of young persons, an audience profiling was conducted with young people and other key stakeholders during the Net map exercise in Kaduna, Lagos and Oyo States. Gaps in the audience profiling were discussed and bridged during the strategy design workshop by participants.

Profiling of Priority Audience

South

Unmarried Youth (Sexually Active)

Titi Ajanlekoko is a 22 year-old-lady currently learning Make Up at Nikki O Beauty Studio, Surulere. She resides in Yaba, Lagos with her mother who sells cloth at the Yaba Market. She has a cordial relationship with her religious mother but doesn't discuss RH/FP issues. She is social media inclined,spends most of her time on Instagram, WhatsApp and Facebook. She aspires to become a highly sought-after Make-Up Artist like Tara in Lagos state. She is a music lover, very sociable and enterprising. Though economically challenged she likes shopping and always want to be trendy.

Titi is currently in a stable relationship with Bayo who lives close to her place of work. She is sexually active though not ready to get married as she wants to explore her youthful exuberance (club and partying) without being labelled. Titi had abortion during her OND, she got the drugs used from Bayo who assured her it would work. Titi loves Bayo because he takes her to cinema and buy her little things for her upkeep. Titi is very shy, she doesn't engage in naughty conversation

with her friends but listen to everything they say and check to validate online.Titi knows that she can get contraceptives from pharmacy and PMVs but she is concerned about her privacy and confidentiality. Bayo uses condom sometimes and when he doesn't he gets postinor 2 for Titi. She heavily relies on Bayo's information on contraceptive.Titi looks forward to marrying Bayo someday but heavily concerned about Bayo's many female friends and hopes there is way she can have access to something long-term than postinor 2.

Unmarried Youth (Never had sex)

Ife Ajayi is a beautiful 300-level sociology student at the University of Ibadan, Oyo state. Her parents who are church leaders are based in Oyo town. She is a committed member of the Drama group in her fellowship and also an active member of her departmental association. She is sociable, jovial and social media inclined. She is very ambitious, wants to be a financial analyst and hopes to occupy a leadership position in Nigeria someday. Out of her many suitors from fellowship, department and the university community, she like Akin who is the Bible study coordinator of another fellowship. She has to quit many relationships due to her strong convictions on abstinence till marriage though she has been kissed and hugged before. Ife has sexual feelings and under pressure from her friends to have sex but she is well informed about RH/Modern FP as she was the vice-president of anti HIV/AIDS club while in secondary school and hopes to pick up a method after marriage. Ms Ajayi is influenced by her fellowship leaders, parent, role model (Ex-Finance Minister, Dr Ngozi Okonjo -weala) and lecturers.

Unmarried Adolescent (Sexually active)

Pretty (Ewa) is a 15-year old girl student who lives in Ibadan with her parents. She loves movies, music, make-up and is a social media savvy. Ewa wants to go to a higher institution, learn a trade, own a smart phone and someday, buy a car. She is stylish and likes anything that is trending. She has a boyfriend and is sexually active but her self-esteem is low. She has inadequate and incorrect information on contraceptives but does not have access to it, hence she patronizes PMVs for contraceptives.

The opportunities available for young people like Ewa to get information is through the media especially, social media, youth- friendly centers and drop-in referral centers.Ewa desires to be more informed on the different methods available, accurate information on side effects and the benefits of family planning. She will also desire to have information about the nearest service provision centers. She will like to achieve her goals in life, avoid unplanned pregnancy and prevent STIs.

Adolescent (Female)

Kemisola Ajayi is a Christian 17-year-old girl who just graduated from secondary school and is awaiting admission in Theatre Arts. She lives with her mother (single parent) and 2 siblings. Her mother is a clerk in a government establishment.

She is swagalicious (stylish) and wants to be a dancer like Kaffi and attends a local dance training school twice a week. She has a boyfriend and is sexually active. She usually hangs out with her boyfriend, and two other friends on Friday night for night club outing/social gathering. She looks up to her mum's older brother who is a local politician. She has a smart phone and loves make-up and she uses social media actively. She seeks attention and desperately seek peer validation. She uses contraceptives like pills from the PMVs and she gets this information from her friends. She loves X-rated literature and she only goes to the general hospital for malaria treatment alone.

Adolescent (Male)

Tunji is 16 years old male and lives with his parents. He is from a middle or low-income earning home. He has completed his secondary education, loves music, sports, social media and he is technologically savvy. He is sexually and self-

aware, is experimented with alcohol or/and drugs and has a girlfriend. He craves for fame and wants to be rich with little efforts.

NORTH

Unmarried Youth Female:

Hadiza Bwari is a 20 years old Muslim girl who was born in Kaduna, but at a certain point of her life, she relocated to Sokoto to live with her Aunt after she lost her parents to crises in the State. Her love for Kaduna and desire to start a new life brought her back to Kaduna. Hadiza, being an industrious young girl started Waina Business, which she usually hawk around the Central Market. As a young, beautiful and business oriented girl, it was easy for her to build a wide network of friends, having males as the larger category. Her daily routine of hawking also predisposed her to have more male admirals, engage in cordiality/romantic relationship with them, and these also informed her sexual activeness, but with the decision of preventing pregnancy. Her being a Petty Trader does not deprive her of listening to music, which she feels makes her relax after every eventful day. Her love for Fashion also makes her see most Hausa Female Singers as Role Models and the kind of lifestyle musical videos she sees informed her choice of decision to marry a wealthy man. She is informed about modern Family Planning because she seeks information from her friends but not ready to take any method because of infertility myth, so uses traditional FP method.

Unmarried Youth Female: Amina Dogara 21years

Well educated and religious, adequately informed and knowledgeable about LPAY are the best attributes that describe Amina, a 21 years old girl who resides in Mararaba Rido in Igabi Local Government Area of Kaduna State. Amina is one of those young girls who have well educated parents and also reference them as their sources of financial support. Her inclination to social media and love for technology expose her to adequately access relatively good information about LPAY. She does not only access LPAY information but also disseminates them to her peers. She is confident to adequately circulate whatever she learns on social media with her friends but not courageous in visiting health facilities to get more accurate information. Despite her awareness and knowledge, she chose to have a boyfriend that agreed to ''NO SEX TILL MARRIAGE''. Her expectation is to see a future where she becomes a Renowned Nursing Researcher who would spread information that can help to stop death of women and improve their access to Health Information.

Unmarried Adolescents

Larai Usman is 15 years old Muslim girl who resides in Sabon Gari, Kaduna State. She is the seventh child from an extended family of 22. She is a secondary school dropout who hawks groundnut. This puts her at risk of being sexually violated. Before Larai dropped out she wanted to become a midwife, however, after her Junior Secondary School she could not continue because her parents could not afford the fees. She aspires to go to the state school of nursing/midwifery if she ever completes her education. She enjoys watching Hausa and Indian movies, hanging out with her friends and reading Hausa novels.She has three suitors, but she prefers Bala because he bought her a smart phone. She usually gist with him at night in her Father's Zaure (Corridor) She is not sexually active because the community frowns at sex before marriage. However, she has many married friends who she often discusses sex with.Larai's role models are her female teacher in school and a community health

extension worker at the Primary Health Care Centre. Should Larai want to access FP information and services possible barriers are social stigma, provider bias, lack of information and low self-esteem.

Risk Mitigation and Sustainability Strategy

Risks Mitigation Plan

The crisis communication plan for the Adolescents and Youth component involves a thorough and detailed mapping of critical stakeholders at both the systems (structural and institutional level) and community levels (religious/ community and opinion leaders, youths, parent, teachers, etc.), which the net mapping effectively addressed. A careful consideration of the provisions within the National RH policy (2017) for young people is critical.

Highlighted below are broad risks to the successful implementation of the LPAY for the project.

Socio-cultural:

- Adolescent and Youth Sexual and Reproductive Health Programming, considered sensitive across all of Nigerian communities because of sexuality issues are regarded as highly sensitive at the household and community levels. The project is mitigating this sensitivity by renaming the project as Life Planning for Adolescents and Youth.

Policy and funding gap:

- Non-implementation of the national adolescent and youth policies.
- No law or policy exists that address provider discretion or consent from a parent or spouse to access FP services.
- Law or policy exists that supports youth access to FP services regardless of age but does not include provision of a full range of methods.
- Law or policy exists that supports access to FP services for unmarried women, but without specifying youth.
- Policy promotes abstinence-only education or discourages sexuality education.
- Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services.
- Non-availability of funding mechanisms for the implementation of LPAY at the structural level.
- Political commitment, transition and attrition, changes in government policy and actors
- The current economic realities in the country may be a key hindrance to policy consideration to address the needs of the AY.

Gaps in knowledge and experience

- Lack of experience working with youths and people living with disabilities limits progress towards outcomes.

Location/Geographies

- Context, nuances and language sensitivity to the issues.

Choice of partners and weak capacity to respond

- Key representative groups for youth and young people living with disability do not participate in project activities.
- Inadequate mapping of community stakeholders and groups.
- Public and private providers do not engage in mainstreaming activities.

- Lack of participation from private providers in social franchising.
- Youth led groups lacking capacity to effectively collaborate on policy engagement around LPAY

Target groups

Communities' unwillingness to support youth-focused services.

- Project fail to result in increased utilization of LPAY services among target groups.
- Gender norms limit adolescent and youths access to information and services.
- Cultural norms/religious perception limits opportunities for dialogues, and engagement on the issues.

Opposition

- Parents/guardians
- Religious leaders
- Community leaders – sensitive to community perception

Sustainability strategy

The project specifically addresses sustainability through the identification, mapping, and partnerships with existing local youth-focused and youth-led organizations. The project seeks to increase existing capacity through the introduction of quality accreditation mechanisms and increased competency. This strategy aims to contribute to the sustainable delivery of an expanded, more client-responsive, LPAY mainstreaming, with special consideration for spatial spread. Supply-side interventions would be complemented by demand creation interventions which, through strategic alliances will build on existing community and organizational 'assets'. In addition, successful interventions may be integrated into the challenge initiative project in new geographies. Engagement of government is within the parameters of strengthening existing policy and service provision.

Institutional sustainability: This project seeks to strengthen equitable responsive LPAY intervention and partnership across selected geographies. The project emphasizes alignment with national LPAY policies and priorities across different sectors. It also emphasizes integration to strengthen institutional linkages and mainstreaming of the LPAY activities into key existing intervention models through increased coordination, communication and strengthened community linkages, which may also serve to redress perceptions towards LPAY.

Policy sustainability: The action will consider its impact on community processes as well as LPAY outcomes. A focus on process, in particular local ownership, will reinforce sustainability of benefits. Results and output will be documented with strong focus of partnership activities and ownerships thrust. Through this, the project should lead to a greater evidence base for equitable, sensitive and integrated LPAY advocacy and service models that strengthen youth-focused and youth-led organizations. It will add valuable understanding of community based engagement strategies within the special population groups and age categories that NURHI2 interventions is focusing on.

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