USAID/NIGERIA: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROJECT REVIEW AND DESIGN

DISCLAIMER
The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
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## ACRONYMS

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AHI</td>
<td>Action Health Incorporated</td>
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<td>AHIP</td>
<td>Adolescent Health and Information Projects</td>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<td>ARFH</td>
<td>Association of Reproductive and Family Health</td>
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<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
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<tr>
<td>AYDI</td>
<td>African Youths Development Initiative</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<td>DFID</td>
<td>U.K. Department for International Development</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>ELPE</td>
<td>Extended Life Planning Education</td>
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<td>EVA</td>
<td>Education as a Vaccine</td>
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<td>FCT</td>
<td>Federal Capital Territory</td>
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<td>FLHE</td>
<td>Family life and HIV education</td>
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<td>FMOE</td>
<td>Federal Ministry of Education</td>
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<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<tr>
<td>FMYD</td>
<td>Federal Ministry of Youth and Development</td>
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<tr>
<td>FOMWAN</td>
<td>Federation of Muslim Women’s Associations in Nigeria</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<tr>
<td>GH Tech</td>
<td>Global Health Technical Assistance Project</td>
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<td>GPI</td>
<td>Girls Power Initiative</td>
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<td>HARPIN</td>
<td>HIV/AIDS Reduction Program in Niger Delta</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>ICT</td>
<td>Information communication technologies</td>
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<td>IDU</td>
<td>Intravenous drug users</td>
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<td>IEC</td>
<td>Information, education, communication</td>
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<td>IV</td>
<td>Intravenous</td>
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<tr>
<td>LGA</td>
<td>Local government area</td>
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<tr>
<td>MDA</td>
<td>Ministries, departments, and agencies</td>
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<td>Ministry of Education</td>
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<tr>
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<td>Ministry of Youth and Development</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NDHS</td>
<td>Nigerian Demographic Health Survey</td>
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<td>Acronym</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>National Youth Service Corps</td>
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<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<td>PATHS</td>
<td>Partnership for Transforming Health Systems</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>PPFN</td>
<td>Planned Parenthood Federation of Nigeria</td>
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<td>RH</td>
<td>Reproductive health</td>
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<td>Society for Family Health</td>
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<td>SRH</td>
<td>Sexual reproductive health</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>SWODEN</td>
<td>Society for Women Development and Empowerment Nigeria</td>
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<tr>
<td>TA</td>
<td>Technical assistance</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<td>TSHIP</td>
<td>Targeted States High Impact Project</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<td>UTH</td>
<td>University teaching hospital</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>YEDA</td>
<td>Youth Environment and Development Association</td>
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<td>YFHS</td>
<td>Youth-friendly health services</td>
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<td>YHS</td>
<td>Youth health services</td>
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<td>YSO</td>
<td>Youth service organization</td>
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EXECUTIVE SUMMARY

The United States Agency for International Development in collaboration with the Federal Ministry of Health, the U.K. Department for International Development and United Nations Population Funds as key stakeholders in youth programming, undertook a systematic review of adolescent reproductive health issues in Nigeria. The findings and recommendations in this report present a broad approach to addressing programming gaps in ARH in Nigeria.

BACKGROUND

With over 158 million people, Nigeria is the most populous nation on the African continent; it also encompasses 250 ethnic groups and 380 languages. The country boasts a vast range of traditional, political, cultural, and religious practices that vary by geography. The population is disproportionately young—47 million Nigerians are between the ages of 10 and 24. Addressing the sexual and reproductive health (SRH) needs of young people is thus crucial to Nigeria’s economic and social well-being.

Adolescent Sexual and Reproductive Health in Nigeria

Over one-third of Nigerians are between 10 and 24 years old. Statistics about adolescent sexual and reproductive health in Nigeria vary widely, depending on geography, education and household income, and they are set within a wider cultural context of marriage, childbearing, and cultural norms about sexual intercourse and gender issues. The adolescent dilemma has been a lack of information to make informed decisions on sexuality issues. Many adolescents pick up information from friends and the media; information provided by parents or guardians is often censored due to traditional values and norms that forbid open discussion of sexuality.

The median age of first intercourse for women is 17.7 and for men is 20.6, and there is a likelihood that they will engage in multiple sexual relationships resulting in sexually transmitted infections (STIs), unwanted pregnancies and abortions. Use of family planning (FP) among Nigerian women is low: only 40% of unmarried sexually active women use a modern method (predominantly condoms) and only 37% of young women 15–24 years know a source of condoms, as compared to 68% of men the same age. The last Nigerian Demographic Health Survey shows that 23% of women 15–19 years old have begun childbearing. It is estimated that more than half of new human immunodeficiency virus (HIV) infections occur among people aged 15–24.

Less educated adolescents from poor households in rural areas are more likely to get married, begin having sex and bearing children at a younger age than those from urban areas. Urban adolescents are often from higher-income households, have more education, and marry later. However, they are more likely than rural youths to have pre-marital sex, and thus be more exposed to sexually transmitted infections (STIs) and at higher risk of unwanted pregnancy. Given these two widely varying scenarios, it is clear that Nigeria’s adolescent sexual and reproductive health needs are diverse.

Global Support Evidence for Adolescent Sexual and Reproductive Health Interventions

The body of evidence on the effectiveness of various adolescent sexual and reproductive health (ASRH) programs around the world has been growing for the past three decades. Reviews of extensive programmatic experience offer a large number of lessons that can inform ASRH programs, such as the need for a variety of interventions to address the needs of different youth subgroups, the importance of integrated reproductive health (RH)/HIV services, and the need for curriculum-based sexuality education.

OBJECTIVE AND METHODS

The objective of this assessment was to review the ASRH situation in Nigeria in light of Nigeria’s unique social, cultural, and geographic features and to make recommendations for strengthening existing programs and for future efforts to fill program gaps, all based on global best practices.

This assessment and review, coordinated by USAID, was undertaken in collaboration with three partners who have responsibility and significant programming interests in ASRH programs in Nigeria: the Federal Ministry of Health (FMOH), UNFPA, and the U.K. Department for International Development (DFID). The assessment team consisted of a core team of three expert consultants, a USAID liaison, a USAID/Nigeria RH specialist, representatives of the FMOH, DFID, and UNFPA.

This report was informed by data collected in several ways: desk review of background documents and relevant research literature; in-person interviews with stakeholders during field visits in six Nigerian states; and a stakeholders’ meeting with people representing organizations that could not be interviewed during field visits due to time constraints. Interview guidelines were drafted to address questions specific to three categories of respondents: managers of youth-serving organizations (YSOs); government agencies and donors; and youth.

FINDINGS ON CURRENT INTERVENTIONS

The findings by the team are described below and organized along three ASRH programmatic approaches.

Fostering an Enabling Environment

- The federal government has many sound policies but they are not well-implemented throughout the country.
- Capacity and structure for coordination is improving though further support is still needed.
- Awareness and support for ASRH programs is growing, but community attitudes to such services are still generally conservative.

Knowledge, Skills, Attitudes and Self-efficacy

This assessment identified five program models for the ASRH knowledge and skills of young people:

- In-school family life and HIV education (FLHE);
- Stand-alone sexual RH (SRH) information, education, communication and life skills programs;
- IEC integrated with livelihood skills;
• IEC integrated with health services; and
• Mass-media IEC.

Each model was reviewed for program examples and target groups, and strengths and challenges noted for each.

**Health-Seeking and Safer Sex Practices**

The assessment identified six models for provision of ASRH services:

• Integrated youth-friendly health services (YFHS)
• Stand-alone YFHS
• Comprehensive youth-friendly services
• School health services
• Non-adolescent-focused RH services
• Social marketing services

Each model was reviewed for program examples and target groups, and strengths and challenges noted for each.

**Program Delivery, Human Resources, and Evidence for Future Programming**

In these areas the team identified some significant trends.

**Program Delivery**

While Nigeria as a nation boasts a wide variety of models for provision of ASRH services, in most communities there are few to no comprehensive health services that cover ASRH needs. Those that do exist vary greatly in personnel, quality and coverage, etc. Rural adolescents are particularly undeserved; many health service outlets were unequipped and had staff unqualified to treat such adolescent health issues such as STIs, tuberculosis (TB), injuries, etc. Link to other health service facilities were unsystematic, collaboration is poor, and referral networks weak. There were no links to other services adolescents need, such as counseling, skills empowerment, and information networks. Finally, most ASRH programs do not cover younger adolescents, ages 10–14, and many groups of high-risk youth, such as intravenous drug users (IDU), sex workers, and adolescents living with HIV/AIDS.

**Human Resources**

One of the principal barriers to providing adequate comprehensive RH and SRH services to adolescents is the lack of trained and skilled personnel. Where there were such personnel, the trained health workers had been transferred to other units of the hospital where they often did not interact with youth. Unfortunately, there is no recognized career path or credentialing in ASRH for health professionals. Most community-based organizations (CBOs) encountered were not utilizing or were unaware of a recognized health education curriculum. Opportunities for in-service training for service providers are few and costly. “Best practices” were not widely recognized by the interviewees.

**Evidence**

The evidence base is minimal, and many organizations do not do comprehensive external baseline surveys before initiating their work; nor do they keep records about youth participating in their programs, which means that coverage data and evidence of impact are scarce. Data are especially lacking for 10–14 year-old Nigerian youths.
Programming Gaps

After field visits and analysis, the team identified the following gaps in ASRH programming in Nigeria:

- The needs of tertiary-level students are largely unmet.
- Vulnerable populations of youth—10–14-year-olds, men who have sex with men (MSM), IDU sex workers and HIV positive youth—are underserved.
- There is a lack of programs to address sexual harassment, violence, and abuse.
- There are no parent-focused programs.
- Sources of information and services required by youth are often knot linked.

Possibly Promising Programs and Models

During our visit, the team discovered a few promising programs either in the start-up phase or for which inadequate information is available that might nevertheless be worthy of future evaluation. Among them are private-for-profit collaborations like Girl Hub, the Learning-Plus program for school health, and certificate training programs in ASRH in some universities and other institutions for health workers.

RECOMMENDATIONS FOR ADDRESSING CURRENT ASRH NEEDS

Create an Enabling Environment

- At all levels, strengthen mechanisms for information coordination and resource sharing to increase the effectiveness of all programs and reduce redundancies.
- Advocate for government to allocate funding for ASRH programming through all ministries that have an interest in young people: Health, Education, Youth and Development, and Women’s Affairs.
- Support strategic partnerships.
- Work within communities to sensitize parents, religious leaders and other stakeholders and increase support for ASRH programs.

Provide Information and Skills

- Strengthen adoption of FLHE in public and private schools and non-governmental organizations (NGOs) through teacher training and provision of materials.
- Explore using mass media and new technologies to reach young people with critical ASRH messages to improve their knowledge, skills and health-seeking behavior.
- Scale up promising educational and skill-building interventions into more local government areas (LGAs) and more states to reach all groups of adolescents, especially such vulnerable youth as married adolescents, orphans and vulnerable children (OVCs) and those with special developmental needs.
- Map community youth activities and social networks to improve access to accurate information and promotion of activities that promote self-reliance and reduce risky behavior.

Offer Sound, Integrated Services

- Integrate ASRH training for providers into a range of in-service training such as family planning (FP), immunization, HIV and AIDS.
• Support institutionalization of short-term and refresher courses and certification in ASRH specialization for health workers.
• Strengthen the ASRH component of pre-service training for all health workers.
• Create and reinforce referral linkages between primary health clinics (PHCs) and other programs within each catchment area to form networks of organizations that provide care to young people.
• Reach young married women through antenatal clinics where there is an opportunity to provide FP information and other health services.
• Build tighter linkages between other RH services, particularly HIV-related programs, and ASRH, to expand the access of young people to services.
• Recognize and address the ASRH needs of young people in universities and other tertiary institutions through specially designed interventions with heavy youth involvement.
• Recognize the RH needs of other neglected adolescent populations, especially (IDUs), MSM, sex workers, HIV positive youth, and those with special physical and mental needs.

Address Cross-cutting Issues
• Review evaluations of past and current ASRH programs in Nigeria, synthesize findings, and disseminate widely to stakeholders to inform their programming.
• Mentor and provide technical assistance (TA) to Nigerian program managers to build skills and appreciation for monitoring and evaluating ASRH interventions.
• Monitor and evaluate new programs, assessing geographic reach, cost-effectiveness and health outcomes.
• Encourage local community coordination structures to build synergy among programs and enhance community involvement.
• Create and reinforce coordination mechanisms to help NGOs and government programs support each other—which is critical for any new effort to improve adolescent health.
• Raise awareness of sexual and school violence and formulate confidential reporting mechanisms and counseling services.
• Ensure that programs reflect their social, cultural, and geographic contexts and are gender-appropriate.
• Promote youth involvement in and leadership of ASRH programs.
I. INTRODUCTION AND RATIONALE

REPRODUCTIVE HEALTH OF ADOLESCENTS IN NIGERIA

With over 158 million people, Nigeria is the most populous nation on the African continent. Nigerians belong to approximately 250 ethnic groups and speak about 380 languages. They live in six distinct geopolitical regions where there is a wide range of traditional, political, and cultural practices and religions. The North West and North East regions are predominantly Muslim, the North Central and South West regions are over a third Muslim and about two-thirds Christian, and the South Central and South East regions are mainly Christian.

The national maternal mortality rate is high, at 545 per 100,000 live births. Life expectancy at birth is about 48 years. Nigeria is a nation of young people; nearly one-third of its population is between 10 and 24 years of age.

Adolescent Reproductive and Sexual Health in Nigeria

The latest demographic and health survey provides a snapshot of certain critical indicators of the reproductive and sexual health of young people in Nigeria. In 2008:

- 23% of women 15–19 years old had given birth or were pregnant with their first child.
- The median age for first birth among women ages 25–49 was 20.4.
- Nearly half of Nigerian women were married by age 18; the median age of marriage among women aged 25–49 was 18.3.
- 20% of women were sexually active by age 15.
- The median age at first intercourse was 17.7 for women and 20.6 for men.
- More than 40% of sexually active, unmarried women were using a modern method of FP; the most common method is condoms (35%).
- 37% of young women knew a condom source, as do 68% of men aged 15–24.
- 7% of young men and women had been tested for HIV and received their results within the 12 months before the survey.

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5 National Population Council (NPC) and ICF Macro, Nigeria Demographic and Health Survey 2008 (Calverton, Maryland, USA: NPC and ICF Macro, 2009).
7 National Population Council (NPC) and ICF Macro, Nigeria Demographic and Health Survey 2008 (Calverton, Maryland, USA: NPC and ICF Macro, 2009).
Geography, Education, Income, and Cultural Sexual Norms

The statistics vary widely, however, depending on geography, education, and household income, and the wider cultural context of marriage, childbearing, and cultural sexual norms. Teenage childbearing varies from 45% in the North West to 8% in the South East. Fifty-five percent of women with no education are likely to have had a child before age 20 but only 3% of those with secondary or higher education. Among those in the poorest households, 46% had a child before 20, compared to 5% in the wealthiest. Women in urban areas have their first births on average nearly three years later (mean age 22.3) than women in rural areas (mean age 19.5). The average age of marriage among women in urban areas is 21.1 and in rural areas 16.9. The average age of marriage among women in the South East is substantially higher at 22.8 years than the average age of 15.2 in the North West.

Average Ages at First Intercourse Follow the Same Trends

- The median age for women in urban areas is 19.2 and in urban areas 16.5.
- The median age for women in the South East is 20.4 years and in the North West 15.4.

Notably, women with more than secondary education were nearly six years older at first intercourse than less educated women.

Fertility Rates and Use of Family Planning

In general, fertility rates are high in Nigeria, with an overall rate of 5.7 children. Use of modern FP methods is low: 10% of married women use a modern method and 5% a traditional method. The method most commonly used method by married women is injectables. More than 40% of sexually active, unmarried women are using a modern FP method; most commonly condoms (35%). These numbers indicate an increase in use of modern methods from earlier NDHS findings, but still this is fewer than half of young women who are sexually active; large numbers of women are thus at risk of unwanted pregnancy and other health problems associated with having children too early.

At least two studies have documented that Nigerian sexually active adolescents shy away from modern contraceptive methods because they fear infertility and other side effects and therefore risk an unwanted pregnancy. The shame of a pregnancy outside of marriage leads many young women to seek abortion, but abortion is currently illegal in Nigeria except when the life of the mother is at stake, so most abortions are clandestine and often performed by unsafe providers. Currently, induced abortions are estimated to account for 20,000 of the 50,000 annual maternal deaths in Nigeria. Because abortion-related morbidity often leads to infertility, sexually active young women in Nigeria need to be educated about the dangers of unsafe abortion and given accurate information so that they can make informed decisions about the use of contraception.

Gender Issues

Other findings from the 2008 NDHS on the status of women in Nigeria provide useful background to the health of young women:

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9 Otide et al., 2001—see previous query.
- 70% of women 15–49 were employed, though 17% receive no payment for their work.
- Only about half reported participating in decisions about their own health care and in making daily purchases.
- About 40% of women and 30% of men believed that a man is in some circumstances justified in beating his wife.
- About half of men and women believed that a woman has the right to refuse sex with her husband for any of the following reasons: husband has an STI; husband is not faithful; and wife is tired/not in the mood.
- 28% of women in the survey had experienced violence since age 15, 15% in the 12 months before the survey, and 7% had ever experienced sexual violence. A husband or partner was the most likely perpetrator. Women living in southern zones were more likely to have experienced violence, as were women who were married to men who often drink alcohol (with these two factors correlated).

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH NEEDS

Two very different scenarios for the lives and needs of young people emerge from these findings. Clearly, many young Nigerian women and men are sexually active, in part due to young ages at marriage. Young marriage is generally, though not exclusively, related to religion, geography, education, and economic factors. Girls who marry before 16 are more likely to be Muslim, from the North, with little or no education, and be from families with fewer resources. Poverty and reduced parental access to education are push factors for early marriage, motivating parents to marry off daughters early so they are less of an economic burden to them. Early childbearing follows from early marriage, both from the cultural ideal to prove fertility and from religious beliefs.

A study by the Population Council in Northern Nigeria found that girls do not make most of the important decisions in their own lives, including when and whom they marry.\textsuperscript{10} Once married, they have even less decision-making power, with husbands making most decisions. Girls described being isolated and under the control of their husbands and co-wives, which diminishes their access to information and services. Because of their special vulnerabilities, specialized programs targeted to married girls are likely to be more effective than programs for generalized audiences. These could include tailored outreach or mobilization mechanisms, such as home visits or group formation. The relative acceptability of maternal health care may make this a nonthreatening entry point for reaching married girls. Using maternal health as an entry point, other intervention subjects can be introduced, such as HIV/AIDS, FP, and eventually gender issues and violence.

Among the consequences of early childbearing are greater maternal morbidity and mortality. Compared with women in their twenties, adolescents aged 15–19 are two times more likely to die during childbirth, and those 14 years and younger are five times more likely.\textsuperscript{11} While it would be difficult to influence a cultural norm to delay first births among those who marry early, birth spacing can be promoted to protect the mother’s health. An even more effective approach might be to promote school retention as a way of delaying marriage—something which also meets with cultural resistance in the North.


In less poor southern regions where girls are more likely to attend secondary school, they are more likely to marry and give birth later than their northern counterparts. However, they may be more likely to engage in sex before marriage, putting them at risk of unwanted, possibly even dangerous, pregnancies as well as STIs, including HIV. They need accurate RH information, life skills related to sexual negotiation, counseling, condoms and contraceptive services as well as testing for and treatment of STIs.

Other high-risk groups of young people, such as IDUs, MSM, and sex workers (whose risk is most related to STIs and HIV), are not specifically covered by the DHS and not fully explored under this review.

**Global Evidence for ASRH Interventions**

Evidence on the effectiveness of various ASRH programs elsewhere has been growing for the past three decades. A number of papers\(^\text{12}\) have been written to try to synthesize what is known about what types of interventions work and what types do not. However, not all the evidence comes from scientific research. Some best practices arise from extended program experience, especially when studies would be too costly or research designs to test hypotheses would not be feasible (e.g., the effects of youth participation in program design). From the reviews and syntheses we find many lessons that can inform current ASRH programs:

- Young people are not a monolithic group. They have varying needs for information and services, and one type of intervention will not address all needs. Nor can one type of intervention address the unique needs of any single young person.\(^\text{13}\) For example, some programs are better at reaching one sex than the other.\(^\text{14}\)
- As with any type of endeavor, to sustain healthy behaviors, prevent risky ones, or promote use of services, it is necessary to deliver multiple messages through multiple modalities are needed. There is no “magic bullet” approach.\(^\text{15}\)
- Youth at-risk need access to integrated RH/HIV services.\(^\text{16}\)
- Programs should be designed to move from the current project mentality of scattered, one-time efforts into a more sustainable and comprehensive framework using multiple interventions.\(^\text{17}\)
- Improving outcomes for young people is not just about bigger and better projects, faithfully adopted, but rather about taking an ecological approach to working with schools and communities. Such an approach recognizes the complexity of change and the importance of interactions between individuals and environments rather than simply promoting changes in

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\(^\text{14}\) Ball & Moore, op. cit., n. 11.


\(^\text{16}\) YouthNet, op. cit.

\(^\text{17}\) Senderowitz, op. cit.
either individuals or environments. The intervention goal of ecological approaches is community development—increasing the resources of the community of concern.18

- Young people need the support of adults, and interventions should promote that. Young people should be fully involved in the design and implementation of interventions, though their capacity to do this needs reinforcement from training and support. Youth-adult partnerships help build alliances that enhance youth programs.19

- The most evidence for a specific intervention model is found for curriculum-based sexuality education, a model that the WHO has rated as a “go.”20 The characteristics of effective curricula have been identified to guide design and implementation of sexuality education.21

- There is evidence that many types of interventions can be effective, but effectiveness is usually conditional on certain social contexts. Addressing social and gender norms in program design and messaging facilitates changes in risky behaviors.22

- Several programs have been successful at one site or in one evaluation, but not in another, indicating that curriculum and programming are not the sole elements of a successful intervention. Implementation methods, staffing and tailoring programs to meet the needs of the population being served are all-important considerations.23

- Programs that have impacts on knowledge, beliefs, attitudes, and intentions do not necessarily have an impact on behavior.24

- Programs that fail to teach condom use do not appear to affect condom use.25

- A review of studies of primary care services identified six categories of youth-friendly services, but found little evidence of their effectiveness because of inadequate assessment,26 though the authors conclude that services designed to meet the needs of young people are important and further study is needed to demonstrate effectiveness. One study on comprehensive youth centers that provide RH found that the effect of recreational activities on health outcomes was not clear-cut; nor were they likely to serve a large portion of the adolescent population, especially in rural areas. It suggested that while these centers did reach boys, their participation was primarily recreational.27

- When adolescents in Kenya and Zimbabwe were asked what characterized a youth-friendly clinic, they gave priority to confidentiality, short waiting time, low cost and friendly staff. Least important were youth-only service, youth involvement, and young staff. This suggests that they do not necessarily prioritize stand-alone youth services, such as youth centers, or

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18 Butler et al., op. cit.
19 YouthNet, op. cit.
21 Kirby et al., 2006
22 Ball & Moore, op. cit.
23 Ibid.
24 Ibid.
25 Ibid.
necessarily arrangements particular to youth, such as youth involvement. Most clinical services, therefore, could make their services more attractive to youth.\(^{28}\)

- At-risk youth are reachable. Many of the most successful FH interventions directly targeted minority youth from low-income areas.\(^{29}\)

- The Africa Youth Alliance implemented a model of ASRH interventions that were comprehensive and integrated and had the support of government structures to coordinate program components through sharing workplans, networking, and collaboration among implementing partners at all levels through a variety of channels and with youth participation. This model was implemented in Botswana, Ghana, Tanzania and Uganda. An evaluation of this model by John Snow, Inc., in 2006 found it had positive effects on sexual knowledge, attitudes and behaviors related to sexual and reproductive health.\(^{30}\)

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\(^{29}\) Ball & Moore, op. cit.

\(^{30}\) Daniels, op. cit.
II. METHODS

This assessment and review, coordinated by USAID, was undertaken in collaboration with three partners who also have significant programming and interest in ASRH programs in Nigeria: the Federal Ministry of Health (FMOH), the United Nations Population Fund (UNFPA), and the U.K. Department for International Development (DFID).

THE TEAM

The assessment team consisted of a core team of three expert consultants contracted through the Global Health Technical Assistance Project (GH TECH): Cynthia Waszak Geary, PhD (Team Leader); Leni Silverstein, PhD; and Adesegun Fatusi, MD, MPH. This team brought together many years of experience related to ASRH and complementary disciplines. A USAID liaison and representatives of the FMOH, DFID, and UNFPA joined the core team for field visits and the stakeholders meeting and have contributed to this report.

To visit as wide a geographic area as possible, two teams were constituted to visit state ministries, departments, and agencies (MDAs) and youth serving agencies and to hold discussions with youth themselves. Team A visited Lagos, Ebonyi, and Calabar. Team B visited the Federal Capital Territory (FCT), Kano and Bauchi.

<table>
<thead>
<tr>
<th>Team A</th>
<th>Team B</th>
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<tr>
<td>Leni Silverstein, GH Tech</td>
<td>Cynthia Waszak Geary, GH TECH-</td>
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<tr>
<td>Adesegun Fatusi, GH Tech</td>
<td>Team Leader</td>
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<tr>
<td>David Ajagun, FMOH</td>
<td>Folake Olayinka, USAID</td>
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<tr>
<td>Joy Onuegbu, FMOH</td>
<td>Abraham Sunday, FMOH</td>
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<tr>
<td>Godwin Asuquo, UNFPA</td>
<td>Aisha Abubakar, DFID/PRINN-MNCH</td>
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<td>Abubakar Izge, DFID /PATHS 2</td>
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</table>

DATA COLLECTION

The findings presented in this report were informed by data collected by desk review of background documents and relevant research literature; in-person interviews with stakeholders during field visits in six states; and a stakeholders’ meeting in Abuja.

The USAID mission (via GH Tech) provided many documents to the team for review before the in-country assessment began. Other documents were provided during the field visits to individual organizations. Finally, a number of information sources, especially papers from peer-reviewed journals, were already known to team members or identified through literature review.
**Instruments**

Team members drafted data collection instruments before going to the field to guide the interview process. Three sets of guidelines addressed questions specific to three categories of respondents: managers of youth-servicing organizations (YSOs); government agencies and donors; and youth. (See Appendix D, Interview Guides.)

This report is a synthesis and analysis of interviews, meeting discussions and written documentation by the core team, with advice and review from the full field teams.
III. CURRENT INTERVENTIONS AND PROGRAMMATIC RESULTS

It is widely known that there is no one program model that will significantly improve the health and well-being of young people. The task requires multiple interventions directed to different aspects of adolescent health. The following describes several program models being implemented in Nigeria and analyzes their strengths and challenges, and possible solutions for these challenges.

In her review of the evidence on ASRH programs, Senderowitz organizes her work around three approaches to ASRH that prove useful for categorizing what is necessary to improve ASRH. All the approaches are necessary; none is sufficient alone to meet the ASRH needs of young people. They are:

- Fostering an enabling environment;
- Improving knowledge, skills, and attitudes and promoting self-efficacy; and
- Improving health-seeking and safer-sex practices

This report uses these categories to organize the findings; they are followed by reflections on issues that cut across the approaches.

AN ENABLING ENVIRONMENT

The federal government has many sound policies, but they are not well-implemented throughout the country.

The national policy environment is currently very favorable to providing ASRH services, given such policies as Health and Development of Adolescent and Young People in Nigeria (FMOH); National Youth Policy (Federal Ministry of Youth and Development, FMYD); and National Policy on School Health (Federal Ministry of Education, FMOE). While federal written policy is favorable, implementation in the states is uneven. The FMOH is willing to provide technical assistance (TA), monitor ASRH programs, and provide supportive assistance to them at the state levels, but they do not have the authority to require states to implement suggested services. Support for health activities is programmed by state and local governments.

A number of projects are working with state governments to build capacity and provide TA on drafting state strategies to address government priorities, including adolescent health. For example:

- USAID/Nigeria is supporting the Targeted States High-Impact Project (TSHIP) to establish durable bonds between community institutions and the healthcare delivery system in every ward of Bauchi and Sokoto, with increased use of integrated maternal and newborn and child health services. Bauchi and Sokoto will then have better health systems and management, and offer many higher-quality health services, such as for FP and antenatal care (ANC). The first objective of TSHIP is to build the capacity of state and local governments to deliver services. It has an ASRH focal person to ensure that issues specific to young people are covered.

31 Senderowitz, op. cit.
UNFPA has been the lead agency facilitating the drafting of The Action Plan for Advancing Young People's Health and Development in Nigeria. A three-day National Consultative Forum of stakeholders (mostly policymakers) from national, state, and local governments was convened May 31–June 2, 2010, by the FMOH and the FMYD with technical and financial support from UNFPA. The Action Plan is a guide for governing bodies at all levels and in numerous sectors to identify ways in which they can contribute to the health of young people over the next three years and make a commitment to doing so.

DFID’s Partnership for Transforming Health Systems (PATHS)/2 project is working in Enugu, Kaduna, Kano, Lagos and Jigawa and supporting work at the Federal level to reinforce state services in ways that will ultimately affect the services adolescents use: improving services in PHC facilities; emphasizing preventive rather than curative health care; working to retain staff in rural areas; and promoting better flow of commodities and better government planning and management to ensure that money is allocated for high-priority health needs.

DFID’s Partnership for Reviving Routine Immunization in Northern Nigeria/Maternal, Newborn and Child Health Initiative (PRINN/MCH) focuses on state governments in Jigawa, Katsina, Yobe and Zamfara. It does not deliver health care directly but supports the work of others, often tackling issues of governance and financial management that affect the health care system.

The World Bank also has plans to build up state health systems; though it does not have programming specific to young people, it recognizes that many of their programs will serve young people and feel it can contribute in that way.

WHO is supporting states to draw up plans of action for RH services. WHO also supports capacity building and is looking at drafting a revised ARH training manual.

UNICEF is working with the federal and state MOEs to push states to implement policies and with the MOYD to ensure that programs are implemented in communities. It is also working with the National Youth Service Corps.

Capacity and Structure for Coordination

In nearly every interview and meeting, the issue of coordination between agencies and organizations within and across governance levels came up. Currently there is a federal Adolescent Health and Development Working Group comprised of representatives of all stakeholders, state desk officers, NGOs, FBOs, civil society organizations, young people and line ministries. This body meets twice a year to discuss emerging issues in adolescent health and development and chart the way forward to improving adolescent health in Nigeria.

The FMOH has requested each state to assign a focal person for ASRH to facilitate coordination between programs. Though this has not happened in every state, there was a focal person in all but one of the states the assessment team, indicating that there is movement toward that goal.

Within each state, there are structures, such as coordinating committees and working groups, for sharing information across government and non-government programs. Though political and budgetary issues have affected the workings of these structures, the need for coordination to create synergy between programs and avoid duplication of efforts is recognized. There remains a need for allocating resources to support meetings and communications for coordinating bodies.

The assessment team was not made aware of coordinating bodies at the local government area (LGA) or ward level, but such bodies would strengthen implementation where it is actually occurring and benefit all youth programs. Currently state desk officers are charged with setting up coordination in the LGAs but only one state, Niger, has attempted to do so.
Certain groups are becoming more aware of and supporting ASRH programs, but community attitudes to them are still generally conservative.

There has been a noticeably positive shift in community attitudes toward ASRH services, especially in areas that are traditionally more conservative. However, donors and policymakers working at the federal level are not yet fully aware of this. For example, at the beginning of the assessment the team was told that Family Life and HIV Education (FLHE) curricula could not be widely implemented because of negative community attitudes. Apparently FLHE had been highly controversial several years ago, but by 2010 the curriculum had been approved by almost all states and was being implemented in a number of secondary schools in the states the team visited. What is currently slowing implementation is a lack of resources rather than community or state government opposition.

A number of ASRH youth programs in Nigeria are involving communities in a general way either at the beginning or throughout. Usually community engagement and mobilization interact rather than operating separately. For example, the mass communication project KuSauara! initially met with opposition to its musical road shows, but discussions with community members helped determine how they could best continue. Other programs, such as Nigeria Youth AIDS Program in Lagos found common ground with community leaders to address the needs of young people; the community helped the program design initial noncontroversial messages, which the programs were then able to augment with messages about FP and voluntary counseling and testing.

Despite the positive changes, more needs to be done to garner community support for other types of services. It was widely recognized by assessment informants that religious leaders are important at the community level. One program in Northern Nigeria implemented by the Federation of Muslim Women’s Associations in Nigeria (FOMWAN) trained Muslim leaders on the health benefits of delayed pregnancies for young married women—“healthy timing and spacing of pregnancy” (HTSP). They then became sources of information for their followers during Friday sermons and one-on-one counseling. Many respondents to a community survey were able to recall hearing about HTSP from religious leaders and reported favorable attitudes toward spacing. (This program was not visited, but an evaluation report was recently released.)

Parents also are an important target group. Traditionally, parents do not discuss sex and reproduction with their children, but giving parents relevant information would possibly improve communication, or at least motivate parents to encourage their children to use the services available. Few programs target parents, but the team found much interest in this kind of intervention.

Whatever programs are adopted, documentation and evaluation of activities to shift community norms in a positive direction would be an important contribution to the evidence base for ASRH programs.

**KNOWLEDGE, SKILLS, ATTITUDES AND SELF-EFFICACY**

The team identified the following five program models for improving the ASRH knowledge and skills of young people (see also Table 1).

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33 Curricula developed for parents by YouthNet taught from a religious perspective, both Christian and Muslim, could be adapted for use in Nigeria. They can be downloaded from www.fhi.org.
In-school Family Life and HIV Education

The FLHE program is nationally approved and is being implemented in a number of the public schools visited in each state where the review was carried out. The curriculum is graded for age and educational level, and ASRH issues are integrated into certain subjects that virtually all students take. The program thus has the capacity to reach virtually all in-school Nigerian adolescents if well implemented. Coverage to date, however, is moderate due to challenges with training teachers and inadequate curriculum availability.

Program Examples

In 2003 the Lagos State MOE began with Action Health Incorporated (AHI) to draft a plan for phased implementation of the FLHE curriculum in its public junior secondary schools. It was introduced in less than a third of the schools in 2004 but as of 2007 all junior secondary schools (over 300) teach the multiyear curriculum at all levels. The electronic version was introduced in 2007 and is being implemented in 19 state junior secondary schools. A recent report offers lessons on planning and scale up from this experience.34

The Expanded Life Planning Education (ELPE) Project in Oyo State was an initiative of the Association for Reproductive and Family Health (ARFH) that later evolved into the FLHE; it is an example of a program with useful lessons. Initially funded by DFID, it linked school-based FLHE interventions with primary health services.

The current partnership between the National Youth Service Corps (NYSC) and UNICEF has great potential to promote adoption of FLHE throughout Nigeria. The initiative builds the capacity of youth to train and work with secondary school peer educators as part of their one-year compulsory national service.

The USAID-funded HIV/AIDS Reduction Program in Niger Delta (HARPIN), which is being implemented by Pro-Health International in Calabar, provides an example in which an NGO promotes ASRH information in schools by working with community members and training peer educators. The initiative results in formation of adolescent-led clubs that continuously promote ASRH issues in schools.

The USAID-supported Northern Education Initiative project in Bauchi and Sokoto states promotes the use of FLHE in the schools it supports. One means of support for FLHE is through teacher training.

Target Groups

In-school adolescents, particularly in public secondary schools.

Strengths

- The FLHE curriculum has been approved by the National Council on Education, the highest policy-making body in the educational sector. Its membership consists of the Federal Minister of Education and all state commissioners of education.
- There is evidence from all the states visited that there is broad buy-in to the FLHE program by stakeholders in the state educational sector. They expressed considerable interest in the continuity and success of the program.

• Making the FLHE curriculum available electronically has increased the potential for making it more widely available—limited availability of the curriculum has been a major impediment to increasing coverage of the program.
An evaluation by Philliber Research Associates of FLHE implementation in Lagos State found that students who had been exposed to the curriculum for three years had greater RH knowledge and more gender-equitable attitudes, were either less likely to pressure someone or be pressured to have sex, may have been less likely to be sexually active.  

Challenges
• Effective FLHE implementation requires considerable resources, particularly for training teachers. Effective monitoring and supervision are also critical to success.
• The program does not reach out-of-school adolescents.

Stand-alone ASRH IEC/Life Skills Programs
Among programs in this category are some NGO-operated programs that have no health-related services but are limited to educational interventions. Their core focus is building the knowledge and skills of young people.

Program Examples
An example is the program being implemented by Girls Power Initiative (GPI) in Calabar. The GPI program has age-graded classes for early, middle, and older adolescent life stages. GPI also provides some vocational skills training, though that is not central to their program. Another example is NAYAP in Lagos.

Target Groups
Young people of various ages both in and out of school.

Strength
Dedication to young people.

Challenge
As many young people at some point need health-related services, not just information and life skills, stand-alone IEC/life-skills programs need a robust referral network to ensure that the needs of the young people it targets are comprehensively met.

IEC Integrated with Livelihood Skills
These types of services provide ASRH information alongside vocational training or livelihood skills.

Program Examples
The programs visited in Bauchi and Kano that are being implemented by the Adolescent Health Information Project (AHIP) and FOMWAN, are examples. Most participants in both programs are young women. Other examples seen in the field were programs of the Youth Environment Development Association (YEDA) and the Adolescent and Youth Development Initiative (AYDI), both based in Kano, which build skills in income-generating activities. YEDA is also involved in conditional cash transfers and AYDI in micro-credit schemes. Both have a large number of male youth participants.

35 Ibid.
**Target Groups**
These are often older adolescents and young adults; females are targeted more than men. The AHIP and FOMWAN programs are strategically directed to married adolescent females.

**Strengths**
- These programs address economic and livelihood issues, which are major developmental challenges for young people in Nigeria, as well as dealing with of ASRH information and skills.
- They are responsive to the needs of special groups, such as married adolescent girls.

**Challenges**
They are cost-intensive. Resources are needed not only for training but also for “post-graduation” support, especially work equipment, to achieve the desired outcomes for the beneficiaries.

**IEC Integrated with Health Services**
These programs involve both IEC and service delivery. They are often implemented as part of youth-friendly health services or closely strongly linked to such initiatives.

**Program Examples**
Organizations with such programs include AHI in Lagos, ARFH in Ibadan, and Planned Parenthood Federation of Nigeria (PPFN) in Calabar.

**Target Groups**
While the services target all adolescents, older adolescents and males are likely to use the services more.

**Strength**
Because they are linked to delivery of health services, they have potential for increasing utilization and facilitating the access of many young people to adolescent-targeted services.

**Challenge**
Because this type of service incorporates several health services units and involves a variety of staff, including health professionals, start-up can be quite costly.

**Mass Media/ICT**
Programs in this category include entertaining-educative programs on television and radio. Though many of these target broader reproductive age groups, they have rich adolescent-related contents particularly relating to HIV and sexual behavior. Many enter-educative programs have a large adolescent following. Because use of such communication technologies as phones is also growing, particularly among urban-based adolescents, behavior change messages are now being disseminated through phones.

**Program Examples**
Society for Family Health (SFH) is currently implementing a behavior-change-related mass media program. It also had a nation-wide “Zip Up” adolescent-focused sexual abstinence multimedia campaign some years back. One World is cooperating on a computer-based FLHE program with Education as a Vaccine (EVA) and a number of other indigenous NGOs. The Ku Saurara! program in Northern Nigeria, which has media-based and community-dialogue components, is a promising version of this model.
**Target Groups**
Young people of all ages; the technology available would determine what would reach certain groups best.

**Strengths**
- Mass media programs can reach a large number of young people of all ages.
- Programs using electronic media can be strategic in reaching out-of-school and rural adolescents. Computer and telephone programs can be useful for urban young people and can promote learning through enjoyable activities.

**Challenges**
- While these types of programs have rich potential for improving information and attitudes, their impact on skills and behavior may be very variable and limited.
- Their cost is high.
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<tr>
<th>Model</th>
<th>Examples</th>
<th>Target Groups</th>
<th>Strengths</th>
<th>Challenges</th>
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<td>In-school FLHE</td>
<td>State public schools ELPE, Oyo State; NYSC/UNICEF collaboration; HARPIN</td>
<td>In school (and age group)</td>
<td>10–14; 15–19; 20–24</td>
<td>Nationally approved curriculum</td>
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<td></td>
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<td>Out of school (and age group)</td>
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<td>Strong state buy-in</td>
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<td>Resources</td>
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<tr>
<td>Stand-alone SRH IEC/ life skills program</td>
<td>GPI</td>
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<td>10–14; 15–19; 20–24</td>
<td>Focused solely on the needs of adolescents</td>
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<td>Cost-intensive</td>
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<td>Needs strong service back-up</td>
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<tr>
<td>IEC integrated with livelihood skills</td>
<td>AHIP; FOMWAN; YEDA; SWODEN; AYDI</td>
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<td>Mostly girls, older and married</td>
<td>Addresses economic issues</td>
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<td>Resource-intensive</td>
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<tr>
<td>IEC integrated with health services</td>
<td>AHI; PPFN; ARFH</td>
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<td>15–19; 20–24</td>
<td>Increased demand</td>
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<td>10–14; 15–19; 20–24</td>
<td>Easier access</td>
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<td>High start-up cost</td>
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<td>Mass media/ ICT</td>
<td>Ku Saurara; EVA; GPI; SFH</td>
<td></td>
<td>10–14; 15–19; 20–24</td>
<td>Focus on norms</td>
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<td>Broader reach</td>
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<td>Greater potential rural</td>
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<td>and out of school youth</td>
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<td>Can be costly</td>
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HEALTH-SEEKING AND SAFER SEX PRACTICES: SERVICES

The assessment identified six models of ASRH-related service provision in Nigeria (see also Table 2).

Integrated Youth-Friendly Health Services

Services in this category are adolescent (or youth-friendly) health clinics nested within a multi-department or poly-clinic hospital facility that has services targeting different population groups. Many of the facilities were initiated or are supported by international development organizations. The USAID-funded COMPASS project (2004–2009) worked in several locations to support youth-friendly health centers linked with community mobilization activities by youth and community leaders. While they are fairly well equipped, the youth-friendly services visited had few patrons and there was high attrition or transfer of trained health workers.

Program Examples
The Karu PHC in the FCT, Youth Friendly Clinics in Ebonyi State Teaching Hospital, Gwagwarwa Hospital Kano, and the Specialist Hospital, Bauchi are some examples.

Target Groups
All adolescent groups are targeted, but younger adolescents (ages 10–14) use such services rarely, and girls may be using them less than boys.

Strength
As a one-stop service center for young people, they can provide easy access to several services that meet the needs of adolescents.

Challenges
- They need considerable resources to set up.
- There is high staff turnover, especially in government-owned facilities where adolescent health services are not viewed as specialized services. Because many health facilities have a general policy of periodic rotation of staff among nonspecialized units, staff trained in adolescent health services are likely to be transferred to other units after only a short time.

Stand-alone Youth Friendly Health Services

Stand-alone YFHS have no services or units for any other population group or health challenge other than adolescents. They are usually run by NGOs.

Program Examples
There is a youth-friendly clinic in Calabar run by the PPFN.

Target Groups
Young people of all ages are targeted, but the services are used mostly by older males.

Strength
Services are specifically for adolescents in environments where young people can feel comfortable.

Challenges
- They are usually costly to set up and ultimately are not cost-effective: young people are generally healthy and the proportion that may need health services from a static facility may be low.
- The risk of stigmatization is fairly high because they may be labeled as “centers where young people are taught about condoms, sex, and abortions.”
Comprehensive Youth-friendly Services

These adolescent-focused services have facilities addressing developmental issues in addition to health services such as libraries, recreational facilities and skill development units.

Program Examples
Youth centers operated by ARFH and AHI.

Target Groups
All age groups younger than 24 years old.

Strengths
- They provide critical links between health issues and other adolescent development needs, such as personal and educational development.
- The variety of services available may make them attract to virtually all age groups and both sexes of young people.
- They are also likely to have the support of parents and significant others than many other forms of YFHS.

Challenges
The cost of establishing the services is high.

School Health Services

Services found within school facilities are intended to provide some health services to school-based populations. Many secondary schools offer such services, though they provide mostly emergency services and contact parents or guardians. While the health services in many private secondary schools have professional health staff, such as nurses, in many public schools the service are managed by a health-oriented teacher, such as a teacher of health sciences or biology, and provide only basic first aid where drugs are available. Many school health services have very little focus on ASRH issues. There was little evidence that school services were linked to the nearby PHC facility or other community services that youth may need.

Program Examples
School health services were found in many public secondary schools. In some cases, as in Bauchi, a health professional from the youth-friendly facility at the State Specialist Hospital conducts regular outreach to nearby public schools.

Target Groups
Primarily in-school adolescents.

Strengths
- A variety of health services can be easily established within the existing school structure. Also, existing school health services can be strengthened and their horizon broadened to provide accurate ASRH information and counseling.
- Government policies and guidelines support their establishment and promotion. The FMOE, for example, has recently issued school health policies and implementation guidelines with the support of UNICEF, and the FMOH has worked on health-promoting issues in pilot schools with the support of the WHO.
- School health services may be able to reach a large number of young people who need such services, and can be cost-effective because they operate within schools.
Challenge
Effective school health services work best when there is a close partnership between the health and educational sectors, but sometimes the sectors have competing priorities.

Non-adolescent-focused Reproductive Health Services
These RH services are for the general population, but have a large adolescent clientele. Integrating ASRH issues into existing reproductive services, including ANC, FP, treatment for STIs and HIV-related services, would offer an opportunity to reach some categories of young people.

Program Examples
A striking example is the use of ANC facilities in northern Nigeria; more than a half of all ANC clients in Kano and Bauchi States were adolescent girls. However, they were given no adolescent-focused care other than the general care provided to all pregnant women.

Target Groups
Out-of-school adolescents and special populations such as pregnant girls and young people living with HIV.

Strengths
- Most of these RH services already have a structure and staff for service delivery. Integrating adolescent focal issues and approaches into them would require few additional resources.
- The services also already have adolescent clients who can be reached with better adolescent-related information and services. Utilization can be fairly high, which can contribute to cost-effectiveness.

Challenges
- Constraints of staff availability, service delivery structure and client load may make it harder to give adolescent-focused care within these settings.

Social Marketing Services
Social marketing can make certain RH services, particularly commodities such as condoms and emergency contraception and other types of contraceptives easily available to young people, expanding their access to these services. Since most young people would rather not go to regular health facilities for RH commodities and related services also makes social marketing an appealing alternative.

Program Examples
Though not specifically focused on youth, SFH reaches many of them through social marketing campaigns that promote condom messages and the sale of condoms.

Target groups
Primarily sexually active youth who need to prevent STIs and unwanted pregnancies.

Strengths
- Young people have easy access to services, and there is high potential for anonymity in obtaining services.

Challenges:
- Contraceptive products are usually limited to condoms and pills; other types of contraceptives require clinic visits.
- Access to and utilization of services has been disproportionately urban.
<table>
<thead>
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<th>Model</th>
<th>Examples</th>
<th>In school (age groups)</th>
<th>Out of school (age groups)</th>
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<td>YFHS, Ebonyi Teaching hospitals</td>
<td>15–19; 20–24</td>
<td>15–19; 20–24</td>
<td>One-stop shop –access to a variety of services</td>
<td>Needs large investment</td>
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<td>Stand-alone YFHS</td>
<td>PPFN</td>
<td>10–14; 15–19; 20–24</td>
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<td>Dedicated to adolescents</td>
<td>High cost</td>
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<td>Risk of stigmatization</td>
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<tr>
<td>Comprehensive youth-friendly services</td>
<td>AHI, ARFH</td>
<td>10–14; 15–19</td>
<td>10–14; 15–19</td>
<td>Links health and other development needs</td>
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<td>Better access and higher utilization</td>
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<tr>
<td>School health services</td>
<td>School (esp. public)</td>
<td>10–14; 15–19</td>
<td>10–14; 15–19</td>
<td>Existing structure can be used for more developmental purposes</td>
<td>Requires partnerships with MoH and MoE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May be cost-effective</td>
<td></td>
</tr>
<tr>
<td>Non-adolescent-focused RH services</td>
<td>Public-sector PHC services</td>
<td>10–14; 15–19; 20–24</td>
<td>15–19; 20–24</td>
<td>Existing structure and staff</td>
<td>Little attention to adolescent-specific needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Already have adolescent clients</td>
<td></td>
</tr>
<tr>
<td>Social marketing services</td>
<td>SFH</td>
<td>15–19; 20–24</td>
<td>15–19; 20–24</td>
<td>Easy access to services</td>
<td>Limited products</td>
</tr>
</tbody>
</table>
TRENDS IN PROGRAM DELIVERY AND HUMAN RESOURCES AND EVIDENCE FOR FUTURE PROGRAMMING

Because the field visits covered a wide spectrum of Nigeria’s diverse regional and cultural terrain, the two teams distinguished a number of common issues. Independent of the involvement of the state, LGA, community or cultural group, and civil society, it was possible to identify some significant trends, which were categorized under the general themes of program delivery, human resources and evidence for future programming.

While there are many models, none has very high coverage and some groups do not seem to be covered at all.

Nigeria has a wide variety of models for programs for youth seeking ASRH services (see Table 2). The different service models described suggest that there have been numerous local attempts to find ways to address the needs of a relatively healthy but nevertheless significant proportion of the population who have a variety of health needs. Although the menu of options appears robust, in most communities there are few to no comprehensive health services that cover ASRH needs, and what does exist varies greatly in terms of service delivery, availability of trained personnel and coverage. Paradoxically, perhaps, although few, the YFHSs that were visited (e.g., PPFN, Calabar) were underutilized and costly to set up and maintain. This raised questions about the extent to which context-specific cultural constraints and fear of stigma were inhibiting the desire of young people to access these services.

Moreover, rural adolescents are particularly underserved. Although many communities still lack basic and dependable electricity, most are linked (though tenuously) to urban areas and national mass media through radio and television (battery or generator-fueled), newspapers, and magazines and increasingly they are gaining access to cell phones. Responses to interview questions indicated that most young people shared information with their peers and may know something about YFHS. Without access to income, however, most rural youth cannot seek ASRH services, which are mainly in urban centers.

Because many YFHS were unequipped and had insufficient qualified staff to treat such extensive adolescent health issues as malaria, STIs, TB, and injuries, the team wondered about the extent of their referral services. Thus, when the different types of service providers were interviewed, they were asked for details about how they approached nonadolescent health problems. The team learned that most had poor and unsystematic linkages, and there was little collaboration with and referral to other health service providers (e.g., ProHealth). Many referrals were based on collegial arrangements, implying a limit to the number of cases each provider would accept. Anecdotal evidence also indicates that most adolescents neglected to follow up on referrals, although it was not possible to explore the reasons why.

Few of the assessment team visits, particularly in the south, were to specific programs addressing at-risk youth. Most programs dealing with ASRH, for example, did not cover 10–14-year-olds, IDUs, sex workers, or HIV positive youth.

Training for ASRH could be improved in several ways.

In almost all the services and programs visited, one of the principal barriers to providing adequate comprehensive SRH services to adolescents was the dearth of trained and skilled service delivery personnel. There are many facets of this omission (see below) that need to be addressed in any future program, but fundamental to the spectrum of issues is the lack of a recognized career path or credentialing in ASRH for health professionals. Thus, many are lured away from local CBOs or transferred from health provider posts. While all professionals (particularly those who are health providers) carry their knowledge with them and should
therefore be able to convey an ASRH perspective wherever they go, this situation leads to knowledge sharing that is at best unsystematic. However, University College Hospital in Ibadan and University Teaching Hospital in Ife have an ASRH training curriculum for health workers that could be adopted nationwide for university-trained health professionals. Additional in-service ASRH training could also be integrated into the many training opportunities provided through programming in areas like HIV, TB and MCH, requiring only an additional day or two to help providers recognize the unique needs of the adolescents they see.

Although acceptance of a nationwide FLHE curriculum for in-school youth is a major achievement, most CBOs (AHI and GPI were exceptions) were unaware of or not utilizing a recognized curriculum. Also, many of those interviewed had no recollection of in-service training, and many noted that such opportunities are few, largely non-institutionalized, and non-systematic. Once a member of a CBO was given in-service training, the organization could gain from this exposure by creating formal “step-down” mechanisms for information-sharing. However, no one the team spoke to in the informal health sector mentioned refresher courses or systematic exposure to and contact with new ideas and best practice information; the approach has been hit or miss. Only few people interviewed were able to describe how they use best practices in designing and implementing programs.

More data on programs are needed.

Wherever the team traveled, North or South, and independent of the type or sophistication of the organization or service assessed, there was the challenge of obtaining hard data about coverage, costs and monitoring and evaluation. Most organizations had not conducted any kind of baseline survey before their work began; nor had many maintained even rudimentary records to track information related to the young people they worked with (e.g., age, sex, nature of problem, issues discussed, etc.) outside of a clinic setting. Thus, coverage data and evidence of effectiveness were scarce. Most groups had never been trained in creating such systems and had little idea of how to measure the impact of their services. Even GPI, one of the premier youth-serving education NGOs in the country, had never conducted a follow-up study on its graduates to try to evaluate the long-term (10 years+) effect of its program. Although the assessment tried to obtain evaluations from all the programs we visited, most organizations said that while they had conducted internal evaluations in the past, the team received few such reports. With the lack of information, it was also impossible to determine whether any program was cost-effective and could be scaled up.

In general, too, very little is known about the ASRH issues of young people aged 10–14, other than that a subsector of this age group, predominantly in the North, is female and married. Some youth in the North, particularly young boys, have been enrolled in madrasas/Islamiyyas, and FOMWAN has been working to get culturally appropriate, modified ASRH content into their curricula and during their annual youth camps. Every faith-based school is supposed to teach a version of the national FLHE curriculum, but the extent and effectiveness of its implementation is something else that could not be ascertained.

PROGRAM GAPS

Drawing from the results of the broad-based field visits and subsequent analysis, the team identified several programming gaps. For instance, very few programs comprehensively address the ASRH issues of very young adolescents and what does exist has not been scientifically evaluated for impact and effectiveness.
Needs of University Students Unmet

Nigeria has 27 federal universities, 36 state universities and 41 private universities, but the visit the team made to a university program in Ebonyi served to underscore the fact that young university students are poorly covered. Although the University Teaching Hospital had allocated specific health providers and a separate building for health care for students, it lacked medical equipment, trained adolescent health care providers, and supporting IEC materials; nor was the facility involved in risk reduction interventions. UNICEF had donated a pool and other gaming tables that attracted numerous youths (mostly males) looking for a place to congregate, especially given the dearth of recreational activities, but none of them appeared to be seeking health care. However, the Campus Health and Rights Initiative at the University of Ife is designed to address this significant but underserved sector of the youth population.

Vulnerable Adolescent Populations Underserved

Few ASRH programs specifically address the needs of vulnerable adolescents such as MSM, drug users, sex workers (including the “Aristo[crat]” university-based escort services in the South), and adolescents living with HIV and AIDS. However, it was learned in informal conversation that many HIV and AIDS programs do consider adolescents in their service provision goals, but without a focus on their special needs.

Lack of Programs to Address Sexual Harassment, Abuse and Violence

Most troubling, perhaps, was the lack of programs for what was deemed ‘neglected’ or sensitive issues. Repeatedly, youth informants spoke of sexual abuse (inter- and intra-familial) and sexual, physical, and psychosocial school-based violence (including sexual harassment), often perpetrated by authority figures such as teachers but also originating with “cults,” as Nigerian youth gangs are called. There are no mechanisms for either reporting or punishing unwelcome or inappropriate sexually aggressive behavior. Also, young female youth in Kano were concerned about unwanted pregnancies and the high rate of divorce, which perpetuates the cycle of poverty.

Absence of Parent-focused Programs

Most adolescents interviewed, particularly in the South, stated that their peers had replaced their parents as the most influential people in their lives. Many remarked on the generational gap that separates them from their parents; others noted that their parents were uneducated and grew up in the country; they were completely unable to understand the challenges currently confronting their children. Others noted that parents and family members were either ignorant about “the facts of life” or felt uncomfortable at best and were unequipped or unwilling to discuss sexual matters with them. Given the dramatic changes that Nigeria has undergone in the last 30 years, it is understandable that most parents are “out of sync” with their adolescent children. There are no parent-focused programs that could foster communication between caregivers and children.

Need to Link Programs to Broader Issues of Development and Poverty

The underlying and overwhelming factors of poverty, inequality of wealth and privilege, corruption, rapid social change, and the disruption of traditional extended family patterns and changing gender roles shape the daily lives of all Nigerians. Most programs to address gaps in sectors like education and health cannot be considered separate from the context of the country’s development needs and generalized poverty. Thus, while this report may seem to have adopted a compartmentalized approach to the ASRH services, the team recognizes other factors significantly contribute to the situation outlined here. Any RH observations
and critical analysis are incomplete without linking these issues to broader questions of development and poverty.

**Possibly Promising Program Models**

The team found a few promising programs, some in their start-up phase, for which the information is inadequate. However, in the future they might be worthy of evaluation.

**Private-for-profit Collaboration**

Nike, in collaboration with DFID, is now designing a program called Girl Hub in Nigeria, Rwanda, and Ethiopia, starting with a “scoping” exercise to determine the best ways to empower very young (ages 12–14) girls to help them reach their full potential. The program model cites four main goals: (1) to play a challenge role with program partners to address issues of girls at every level; (2) to inspire girls; (3) to give girls greater voice and leadership in decision-making and programming; and (4) to get out the messages that will change attitudes and girls’ opportunities.36

The intervention will be implemented in three states in Nigeria: Kano, Jigawa, and Kaduna. The implementers are looking for long-term social and economic effects. In the nearer term they are focusing on girls’ enrollment in and completion of schooling and raising the ages for marriage and first pregnancy. The project is just being designed from the ground up. No details of the program design were available at the time the Nike/DFID team were interviewed.

**Learning-Plus Program for School Health**

This program, promoted and supported by UNICEF, aims to promote schools as centers not only for learning, but also for promoting development of young people generally and the delivery of social services to school-based children. It also promotes community involvement in schools.

**Certificate Training Programs in Universities and Other Institutions**

Few training programs in the ASRH Program include the certificate courses being run by the Population and Reproductive Health Program and the Institute of Public Health, Obafemi Awolowo University, Ile-Ife. The training program has partnered with the FMOH Adolescent Health Unit and the Faculty of Public Health of the West African College of Physicians in organizing short courses for various groups of health workers. The University of Ibadan has a master’s course in adolescent and child health. Any pre-service education curricula should also be implemented in programs for nurses, primary health care workers and other mid-level health providers, who are often the first-line responders to adolescent health needs, especially in the North, where there are fewer providers.

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IV. RECOMMENDATIONS FOR ADDRESSING CURRENT ASRH NEEDS IN NIGERIA

These recommendations, organized according to the results framework, were informed by discussions during this review and by documents reviewed, and each reflects input from multiple sources. They can be taken up by a variety of stakeholders in ASRH programming.

CREATE AN ENABLING ENVIRONMENT

- At all levels strengthen coordination of information and resource sharing to make all programs more effective and reduce program redundancy.
- Advocate for government to allocate funding for ASRH programming through all ministries that have an interest in young people: Health, Education, Youth and Development, and Women’s Affairs.
- Support strategic partnerships.
- Work within communities to sensitize parents, religious leaders, and other stakeholders to increase support for ASRH programs.
- Promote youth-friendly policies especially in States and LGAs.

PROVIDE INFORMATION AND SKILLS

- Build up the implementation of FLHE in public and private schools and NGOs by training teachers and providing materials. Give adolescents real access to information, counseling, and services, either within or outside schools and clinics.
- Explore the use of youth social networks, mass media, and new technologies to reach young people with information to enable them and adults to make choices that improve ASRH. Use multiple channels to reach youth where they are.
- Scale up promising educational and skill-building interventions into more LGAs and States to reach all groups of adolescents, especially more vulnerable youth, such as married adolescents, OVCs and those with special developmental needs.
- Strengthen intergenerational communication with parents and other influencers of youth in their communities, such as peers, older youth, traditional medicine practitioners, shop keepers or market vendors and informal or formal employers.
- Build up the ability of youth, especially those out of school, to adopt self-efficacy attitudes and livelihood skills.

OFFER STRONG, INTEGRATED SERVICES

- Integrate ASRH training for providers into a range of in-service training on such topics as FP, immunization and prevention of mother-to-child transmission of HIV and AIDS.
- Support institutionalization of short-term and refresher courses and certification in ASRH specialization for health workers.
- Deepen the ASRH component of pre-service training for all health workers.
- Create and reinforce referral linkages between PHCs and other programs within each catchment area to form networks of organizations providing services to young people.
• Reach young married women through antenatal clinics where there is an opportunity to provide FP information as well as other health services.
• Build tighter linkages between ASRH and more general RH services, particularly those for OVC and the HIV-infected, to expand the access of young people to relevant services.
• Recognize and address ASRH needs in universities and other tertiary institutions through specially-designed interventions with heavy youth involvement.
• Recognize the RH needs of other neglected adolescent populations such as OVC, IV drug users, MSM, sex workers, HIV-positive youth, and those with special physical and mental needs.
• Explore the use of innovative venues for reaching young people with information and services, such as barbers, wedding and naming ceremonies and dilalai (women who sell wares door-to-door).
• Expand the current Islamiyya schools intervention to bring SRH information to married adolescents.
• Collaborate with the education sector to increase access to basic education and ensure that adolescents stay in school.

ADDRESS CROSS-CUTTING ISSUES

• Review documents evaluating past and current ASRH programs in Nigeria, synthesize findings and disseminate them widely to stakeholders to inform future programming.
• Conduct more operational research and build the evidence base for effective ASRH interventions in Nigeria.
• Mentor and provide technical assistance to Nigerian program managers to build their skills and their appreciation for monitoring and evaluating ASRH interventions.
• Monitor and evaluate new programs, assessing, e.g., geographic reach, cost-effectiveness and health outcomes.
• Encourage local community coordination structures to build synergy among programs and enhance community involvement.
• Develop and reinforce coordination mechanisms to help NGOs and government programs support each other, which will be critical to any new effort to improve adolescent health.
• Raise awareness of sexual and school violence and put in place confidential reporting mechanisms and counseling services.
• Ensure that programs reflect social, cultural and geographic contexts and are gender-appropriate.
• Promote youth involvement in and leadership of ASRH programs.
APPENDIX A. SCOPE OF WORK

Global Health Technical Assistance Project
GH Tech
Contract No. GHS-I-00-05-00005-00

SCOPE OF WORK
(Revised: 9/28/10)

I. TITLE

Activity: Review and Design of Adolescent Sexual and Reproductive Health Program in Nigeria

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD (SCOPE START AND END DATES)

On or about October 1, 2010–on or about November 12, 2010 (the exact dates to be determined by consultant availability and preferred in-country work dates).

III. FUNDING SOURCE

USAID/Nigeria

IV. PURPOSE AND OBJECTIVES

To review the Adolescent Sexual and Reproductive Health situation in Nigeria and develop a concept paper on a program design on approaches to improving access to evidence-based high-impact ARH services for USAID consideration.

V. BACKGROUND

Nigeria, like other countries in sub-Saharan Africa (SSA), has continued to experience increased adolescent sexual health problems and its attendant consequences. Over one-third of the population are youths between the ages of 10 and 29 years (NPC, 2006), many of whom have experienced sexual intercourse before 17 years and are most likely to engage in multiple sexual relationships, with attendant risk of sexually transmitted infection, unwanted pregnancy and abortion, and low use of contraceptives. 23% of 15–19-year-olds have begun child bearing and often have the least access to antenatal services. This is further exacerbated by the changing socioeconomic structure, cultural values, and increased modernisation. The adolescent dilemma has been attributed to lack of information to make informed decisions on sexuality issues. According to the 2006 census, nearly 1 in 3 adolescents did not have any formal education, while 16% of are married. In the older category of ages 20–24 over 30% are married. Many adolescents receive information from friends and media, while information provided by parents or guardian is often censored due to traditional values and norms which forbid open discussion of sexuality issues.

*Generally many adolescents have knowledge of contraception but low use; the 2008 NDHS report revealed 98% knowledge of contraceptive with less than 20% utilization. Common methods among youth are condoms and pills, which are mostly obtained from chemists or private medical vendors.
VI. SCOPE OF WORK
The consultant team will:

- Take into consideration current and past ARH programs, methods, and approaches mix; geographical spread; and public and private sector activities, ongoing or planned.
- Look closely at in-school and out-of-school programs that empower adolescents with life skills.
- In line with the Global Health Initiative, look at opportunities for girl-centered approaches that ensure delay in initiation of pregnancy as well as improved access to accurate information, access to youth-friendly services and information in more locations, and demonstrated need as appropriate.
- Identify opportunities for collaboration with other partners and sectors (such as education) for synergy and wider coverage of this part of the population.
- Considering the strong linkages with the education sector, the team will be expected to interact closely with the Mission education team and other key partners, such as UNFPA and DFID. Opportunities for collaboration should be fully explored.
- A key area of focus will be the postponement of marriage and pregnancy and how to address these effectively. In particular, draw out best practices from Nigeria and other countries that take into consideration cultural and religious sensitivities where they exist.
- [Assess] communication between adolescents and parents and the extended family. Interactions and influence of peers, teachers, and influential national and local personalities could also be covered within this assignment.

VII. METHODOLOGY
The team will consider the following approaches to accomplish their work:

**Literature and documents review:** Prior to arrival, the team will be expected to review existing data on ARH; survey the literature; and prepare a synthesis of effective approaches in other countries, resulting in a matrix outlining best practices and what have been evaluated to be effective approaches in related settings, e.g., in largely Muslim populations, early marriage situations, etc.

**Team planning meeting:** The evaluation team will hold an initial two-day team planning meeting (TPM) in-country. The team will start its work with a planning meeting with the team members only prior to meetings and work with USAID and others. During this meeting and in the further meetings the time will be used to clarify team roles and responsibilities, deliverables, development of tools, and approach to the assessment and refinement of the team schedule. In the meeting the team will:

- Share background, experience, and expectations of each of the team members for the assignment.
- Formulate a common understanding of the assignment, clarifying team members’ roles and responsibilities.
- Agree on the objectives and desired outcomes of the assignment.
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion.
- Revisit and finalize the evaluation timeline and strategy for achieving deliverables.
- Develop and finalize data collection methods, instruments, tools, and guidelines and obtain Mission approval before implementation.
• Develop preliminary outline of the team’s report/concept paper and assign drafting responsibilities for the final report/concept paper.

As part of this meeting, the team will meet with USAID/Nigeria to review the purpose and scope of the review and finalize the methodology, deliverables, timeline, etc. The outcome of the TPM will be a detailed workplan report for the evaluation.

Meetings with relevant organizations/groups and interviews with key stakeholders: During the in-country visit, the team will meet and interview key organizations and individuals involved in ARH and that provide funding, including the GON and FMOH at federal and state levels, private sector Nigerian organizations, development partners (DPs) including major donors involved in ARH, and others as required.

Some key organizations working in ARH:
• UNFPA
• Association for Reproductive and Family Health (ARFH)
• Adolescent Health Information Project
• Society for Family Health
• Action Aid
• Planned Parenthood Federation of America
• Urban Reproductive Health Project
• Pathfinder International
• Islamic Medical Association
• UNICEF
• Action Health Incorporated
• FOMWAN
• Christian Aid

Site visits: The consultant team will undertake in-country site visit travel to review the status of ARH needs of adolescents and young people, coordinate data-gathering as needed, synthesize evaluations from ARH evaluations in Nigeria, and engage stakeholders’ projects that have been implementing ARH to review functionality of youth-friendly service facilities, service patterns and approaches, etc. in each of the six geopolitical zones in Nigeria.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

It is envisaged that the team will be composed of two international consultants with extensive experience in SARH programming and design especially in developing countries. The addition of a national consultant with experience in ASRH will be valuable to unpacking best designs for the Nigerian context. Representatives from partners such as DFID and UNFPA may be able to participate on the team, depending on availability at the actual time of the review. They will be responsible for their own expenses. A member of the FMOH will also be included in the team. All members will have good writing, facilitating, and synthesizing skills. Members of the team will be current on the comprehensive literature and best practices in ARH programming in other countries.

Members of the Mission HPN team will also be part of the team: Folake Olayinka, Abdullahi Maiwada, Kayode Morenikeji, and a member from the Education team.
**Logistics assistant:** The team will be supported by one local logistics assistant who will provide logistical and administrative support during the team’s work in-country. The assistant will work directly with and report to the team leader. Responsibilities will include:

- Assist with local travel arrangement, hotel reservations, arranging for vehicles for appointments and for site visits;
- Assist with scheduling meetings and interviews with the various stakeholders;
- Arrange for copying and compiling reading materials;
- Serve as note-taker and participate in daily field debriefing, as appropriate; and
- Perform other tasks as identified by the team leader

An illustrative timeline and LOE schedule is presented below:

<table>
<thead>
<tr>
<th>Activity</th>
<th>International Consultant A (Days)</th>
<th>International Consultant B (Days)</th>
<th>Local Consultant (Days)</th>
<th>FMOH Member (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial discussion/ conference calls with USAID/Nigeria and team members</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Reading of background documents; literature review and synthesis of effective approaches</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Travel to Nigeria</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conduct team-building meeting including meeting with Mission staff)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Finalize data collection tool, list of key informants, site visits based on Mission’s input</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Submit data collection tools for review by USAID/Nigeria</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>USAID reviews data collection tools and provides feedback to consultant team for revision and completion</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Information and data collection, including interviews with key informants in selected sites</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Data analysis and draft of concept paper and preparation of debriefing presentation</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Debriefing meeting with USAID</td>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Activity</td>
<td>International Consultant A (Days)</td>
<td>International Consultant B (Days)</td>
<td>Local Consultant (Days)</td>
<td>FMOH Member (Days)</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Submit draft concept paper to USAID/Nigeria before team departs from Nigeria</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Depart Nigeria /travel to US</td>
<td>2</td>
<td>2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>USAID/Nigeria provides comments on draft concept paper (5 days)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Team revises draft paper and submits in final form to USAID/Nigeria (out of country)</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mission provides sign-off on the concept paper (5 days)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GH Tech edits/formats report (one month, but may not be necessary if the report is an internal document)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total # days</td>
<td>40</td>
<td>38</td>
<td>31</td>
<td>25 (tentative)</td>
</tr>
</tbody>
</table>

Note: A six-day work week is approved when team is working in country.

IX. LOGISTICS
GH Tech will make all logistical arrangements, including travel and transportation, country travel clearance, lodging, and communications.

X. DELIVERABLES AND PRODUCTS
The following deliverables will be submitted to USAID/Nigeria. The timeline for submission of deliverables will be finalized and agreed upon during the TPM.

Team planning meeting: The outcome of the TPM will be an approved work plan for the evaluation. The work plan will include, but not be limited to, a timeline for key activities, due dates for deliverables, and schedules for key informant interviews, country visits, and debriefing meetings. Also, the team will prepare a draft outline for the concept paper.

Briefing: During the first week in-country, the team will host a briefing with Mission staff, preferably during the TPM, so that USAID can clarify any questions regarding the SOW, provide the team with background information, etc.

A debriefing will be organized by USAID/Nigeria for the team leader and the team to present key highlights from the literature review and country visits to USAID/Nigeria staff using a PowerPoint presentation format. The team leader is expected to be available to lead the debriefing on the date and time agreed to by USAID/Nigeria. The team will consider USAID comments and revise the draft report accordingly, as appropriate.
A draft concept paper will be submitted by the team leader to USAID/Nigeria for review and feedback prior to departure from the country and will incorporate comments and feedback from the debriefing. The draft concept paper will address elements to strengthen ARH in Nigeria; outline the best program options, including overall costs that USAID/Nigeria/HPN will be able to meet with earmarked funds. The concept paper is expected to comprehensively examine ARH designs in areas such as background, workable strategies, activities, potential partners, program options, and potential mechanisms, as well as the costing. Once edits are concluded on this, any further internal Mission-specific editing will be done by the HPN team.

The draft concept paper will be an internal USAID/Nigeria document not for external release or publication.

XI. RELATIONSHIPS AND RESPONSIBILITIES (USAID AND CONSULTANTS)

GH Tech will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the consultant team.
- Make all logistical arrangements, including travel and transportation, country travel clearance, lodging, and communications.
- Respond to all points included in the SOW and submit the final deliverables.
- Edit and format the final report and provide the final product to USAID/Nigeria in a timely manner.

GH Tech will also manage and direct the efforts of the local logistics consultant who will report to the team leader.

USAID/Nigeria will provide overall technical leadership and direction for the team throughout the assignment and will undertake the following specific roles and responsibilities:

Prior to in-country work:

- Assist GH Tech with identification of potential local consultants and provide relevant information about the implementing partner being evaluated that could create a potential conflict of interest, or the appearance of such, with proposed consultants.
- Identify and prioritize background materials for consultants and provide them to GH Tech as early as possible prior to team work.
- Provide information as early as possible on allowable lodging and per diem rates for stakeholders who will travel/participate in activities with the evaluation team.
- Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs (i.e., number of in-country travel days required to reach each destination, and number of days allocated to interviews at each site).
- Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics.

During in-country work:

USAID/Nigeria will undertake the following while the team is in country:

- Ensure constant availability of the Mission point of contact person(s) and continue to provide technical leadership and direction for the team’s work.
XII. MISSION CONTACT PEOPLE

Sharon Epstein
Team Leader, Health/Population/Nutrition
USAID/Nigeria
sepstein@usaid.gov
Abuja cell phone 0803 665 0832
From USA: (+234) 803 665 0832

Dr. Folake Olayinka
Maternal and Child Health Program Manager
Health Population Nutrition Team
Investing in People Office
USAID
Tel 09-461-9300
Mobile 08038615988
Email folayinka@usaid.gov

XIII. COST ESTIMATE
GH Tech will provide.

XIV. REFERENCES (PROJECT DOCUMENTS)
USAID/Nigeria will provide; however, it is expected that the consultants will do a literature review of relevant documents and evaluations, identifying what has worked in similar environments, which would be part of this list.
APPENDIX B. PERSONS CONTACTED

ABUJA

Association for Reproductive and Family Health (ARFH)
Professor Oladapo A. Ladipo, President, CEO

Education as a Vaccine
Tope Fashola
Manre Chirtau
Sylvia Ekponimo
Funmi Okeowo

Youth Advocates Group (YAG)
Faith Olowokere
Medina Saliu
Aliyu Abdulrahaman
Thompson Ukah
Kikelomo Taiwo

Federal Ministry of Health
Dr. P.N. Momah, Director, Federal Ministry of Health
Dr. M.O. Alex-Okoh, Deputy Director, Family Health Division

FCT Department of Public Health
Dr. Mrs. Folashade Momah, Director Public Health
Dr. Mathew Ashikem, Deputy Director Public Health
Balaraba Sani, Child and Adolescent Health focal person
Omolara Omotayo, Child and Adolescent Assist. Focal person

Karu Primary Health Care Clinic
Mrs. Talatu Adala, CHO
Mr. Watson Sabo, CHO
Peer educators/beneficiaries

FOMWAN
Allila Hakeem Kudirat
Hamsatu Allamin
Rashida Ibrahim
Hauwa K. Ibrahim
Jemila O. Ariori
Giwa Lasak
Aisha Akanbi
PATHFINDER INTERNATIONAL
Murtala Mai, Country representative

PATHS/2
Garba Safiyanu, States Coordinator

Society for Family Health
Obi Oluigbo, Director, Programs
Emeka Chima, HIV Program Manager
Hailisa Mohammed, Assistant Manager, HIV Division
Otunomeruke Allen, Research Manager, Gates Project
Okafor Uchenna, Assistant Manager, Field Operations

UNICEF
Victoria Isiramen, Health specialist
Esther Obinya, Health specialist

UNAIDS
Esther Nnorom
Lord Donbey

USAID
Ray Kirkland, Mission Director
Sharon Epstein, Team Leader, HPN
Folake Olayinka, Focal Point, MCH Program Manager, Liaison with Assessment Team
Trevor Rittmiller, HIV/AIDS, TB
Haladu Mohammed, Basic Education Program Manager,
John Quinley, Senior Health Advisor
Abdullahi Maiwada, Senior RH program manager
Irene Philomena, OVC Senior program manager
Garba Abu, Child Survival program Manager
Sandy Ojikutu, Team Leader, Education

World Bank
Dinesh Nair, Senior Health Specialist

WHO
Taiwo Oyelade

BAUCHI

AHIP
State manager
Peer educators
ATBU Teaching Hospital
ARH focal person-Youth Friendly centre

Bauchi State Ministry of Health
Aisha Abubakar, Permanent Secretary

Bauchi State Ministry of Education
Fati Y. Bappah

Bauchi State Ministry of Social Welfare
John Maina

Bauchi State Ministry of Women’s Affairs
Ladi B. Yusuf

Bauchi State Ministry of Youth Development
Danlandi A. Ilelah

Bauchi State Primary Health Care Development Agency
Dr. Musa Dambam Mohammed, CEO
Musa Danlami

NEI
Dalhatu Darazau, OVC Program manager

RHISA
Regina Lee, PRO
Kinglsey Kamalu, Managing Director
David Ayodele, Board Member
Peer educators

Targeted States High Impact Project (TSHIP)
Marc A. Okunnu, Sr., Chief of Party
Dr. Habib M. Sadauki, Deputy Chief of Party
Juliana Nathaniel, RH Senior Advisor
Ahmed Ahmed, Senior Mobilization Advisor
Usman Rashid, Senior Policy Advisor
Hannatu Abdullahi Senior, Quality Improvement Advisor

CALABAR

Girls Power Initiative
Ndodey Bassey
Helen, Kanu
Margaret Udoh
Gloria Henry
Bassey Duke
Isu Okpa
Margaret Afandige
Emmanuel Akpan

**Cross Rivers State Ministry of Health**
Honorable Commissioner of Health
Dr. Ikpi

**ProHealth International (HIV/AIDS Reduction in Nigeria – HARPIN)**
Yinka Adekugbe, Program manager
Uduak Emmanuel Nta, Peer education advisor

**Planned Parenthood of Nigeria**
Ms. Archibong
Chief Volunteer Okon
Malafe Emmanuel
Janet Agha
Untime Friday Asanga
Cohbam Bassey
Godwin Jackson
Otu Essien Iyong
Samuel Comfort
Dennis Sunday Akpata
Polycarp A Austin

**Sam Dave Global Foundation**
Dr. Magdaline Ikpi, CEO

**EBONYI**

**Agape Foundation**
Pastor Gabriel Odom

**Eboyni State Ministry of Health**
Mrs Okpata, AHD for Ebonyi

**Ebonyi State Ministry of Youth Development**

**Ebonyi State University Teaching Hospital- Youth Friendly Centre**
Bertha Faryou

**Educational Foundations for Less Privileged Teenagers**
Mrs. Okoro Ngozi
Hon Comm and their Adolescent Health Focal persons, Ministry of Health, Min of Women’s Affairs & Social Dev, Min of Youth Dev, Min of Education and Min of Information.

Foundation for the Empowerment of Teenagers
Ngozi Okoro, Coordinator
Barrister Kelechi Okereke, Secretary
Onwe Daniel, Program Officer

NEPAD Youth Initiative
Pastor Chukwuma Onwe

Office of the First Lady
Her Excellency, Chief Josephine Elechi

Safe Motherhood Ladies Association (SMLAS)
Mrs. U. N. Uduma Ugo, Executive Director

Youth Skill Acquisition Centre,
Abakaliki Local Govt. Headquarters, Nkaliki

Women, Children’s Health and Community Dev. Initiative (WOCHAD)
Mrs. Maria U. Orji

KANO

DFID
Susan Elden
Jakesh Mahey

Gwagwarwa PHC
Magaji Wada

Girl Hub
Fatima Sada
Jumoke Adekunle

Jakara PHC
Fatima Abdullahi

KuSarara
Hadiza Babayaro

Kano State Ministry of Health
Mallama A. Kiru, Commissioner of Health
Nuhu Bamalli Maternity Hospital
Dr. Mohammed Muhktar
Matron
FP Service provider

PATHS/2
Mansour Mohammed
Nabila Ismail
Abubakar Izge, Kano State Team Leader
Samaila Baba

PRINN/MCH
Aishatu Sani Abubakar, Midwifery Advisor

AHIP
Mairo Bello
Students of skills acquisition center

AYDI
Nasir T Rangaza
Fatima Ibrahim
Amina Balarabe Adamu
Hadiza Haruna Suleiman
Halima A Suleiman
Dauda Mohammed

YEDA
Mohammed Jalal Lawal
Nurudeen Mohammed Tsauni
Lukman Ibrahim
Anas Isa Yunusa
Nasir Inuwa Fagge

LAGOS

Action Health International
'Nike & Ewen Esiet

Ford Foundation
Friday Okonofua, Program officer

Hello I’m Pregnant
T.Olalekan, Executive Director
Nigerian Youth Aid Program
Elizabeth Asuquo, Assistant program officer
Onem Amadi, Executive director
Christian Onya, Sr. Program Officer and Accounts Manager

PATHS/2
Bisi Tugbobo, Team leader
Abdul Ishowo, Program officer

Lagos State Ministry of Health
Dr. Jide Idris, Honorable Commissioner of Health
APPENDIX C. REFERENCES


APPENDIX D. INTERVIEW GUIDES

INTERVIEWS WITH PROGRAMS SERVING YOUNG PEOPLE

1. Date of interview:
2. Name of organization:
3. Name and title of person interviewed:
4. Contact information for organization and organization head:
5. Date organization began:
6. Budget (?):
7. Staff size:
8. How many sites and where:
9. Ever had an evaluation? Is a report available?
10. How many adolescents does it reach per month? Other statistics available?
11. What are the key objectives of the young people program? What is the issue it seeks to address or problem it wants to solve?
12. Describe the program: what are the activities that comprise this program and why is it designed the way it is? Was there a theoretical model/behavior theory used to design the program? Who is the target audience? (sex, specific age, in-school, out of school, married, unmarried, other)
13. Are you aware of existing national policies/plans related to ARH? Do you use any of these policies to design programs?
14. How are young people involved in the design or implementation of the program?
15. Does the program follow any particular set of best practices?
16. How is the program supported? What factors contribute to its sustainability?
17. What other groups do you work with as partners? What kind of partnership is it?
18. To what extent do you collaborate with government at the national, state, or local level in implementing your programs?
19. Are you or have you ever been part of a network?
20. To what extend is the community involved and how?
21. Do you make referrals to other services? To whom do you make referrals? Do other services make referrals to your program? Which ones? (Other linkages?)
22. To what extent do you monitor and evaluate the program? What are the indicators used to monitor program success?
23. How often does your staff get training? When was the last time any of them received training? What was the training for?
24. What are the program’s strengths?

25. What are the program’s weaknesses?

26. What are the major challenges for this program?

27. What would you say are the primary lessons learned from this program with regard to meeting the RH needs of young people?

28. If there were more resources, what else would this program do? (What is missing?)

29. What are the potential solutions to the challenges it faces?

30. What are the major challenges facing young people today?

31. Who do you think are the most influential people in the lives of young people?

32. What do you see as the emerging issues facing ARH in your region?
INTERVIEWS WITH POLICYMAKERS AND DONORS

1. Name of organization:

2. Persons interviewed and titles:

3. Contact information:

4. Current annual budget for young people programs:

5. How many adolescents are reached by young people programs per month?

6. How do you define a program as being ARH-related?

7. Is there a strategic plan for programs for young people in your state or region that guide your program planning?

8. Are you aware of existing national policies or guidelines related to ASRH? Do you think they are being effectively implemented? What are the issues/challenges regarding translating policies into programs?

9. What programs related to ARH does your organization support that reach young people?

10. How do you deliver your programs?

11. What are your goals for working with young people?

12. Do you think youth can be effectively involved in program design and implementation? How? What are the challenges?

13. What do you think are the primary ARH issues for young people in your region?

14. What are the challenges you face in working with young people programs?

15. What new and emerging issues for young people do you see on the horizon?

16. Who do you consider as your partners in your young people work? How are these partnerships constructed/implemented?

17. How well coordinated are the programs serving young people in your region? How could this be improved?

18. Where do you get financial support for your young people programs?
GROUP INTERVIEWS WITH YOUNG PEOPLE

1. Name of organization:

2. Location:

3. Number of boys:

4. Number of girls:

5. Age range:

6. Educational backgrounds/ breakdown of in-school/out of school/ employed/unemployed:

7. Other relevant characteristics: (language group; religion; ethnicity)

8. What's it like to be a young person in ________ these days?

9. What kinds of programs are available for young people in your community?

10. What other kinds of programs do young people need?

11. Where do you get information about RH? HIV/STIs? Where would you like to get information about RH/HIV/STIs? Do you ever use the Internet to get health information?

12. What kind of media do you use (TV, radio, CDs, Internet, Facebook, YouTube)? Who are your favorite musicians? TV or movie stars?

13. Who are the people who are most influential in your lives? Who give you advice and help you make decisions?

14. Do you use a cell phone? What do you use it for?

15. Have any of your friends had an unwanted pregnancy? What did they do? Who did they ask for help?

16. If you had access to money to address adolescent reproductive health needs, what kind of program would you provide?

17. Do you think that programs for young people involve young people in a substantial way? How can they involve young people more?
APPENDIX E. STAKEHOLDERS MEETING: AGENDA AND ATTENDANCE

DESIGN AND REVIEW OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMS

Stakeholders Meeting

AGENDA

26 October 2010
9am–12

9.00 Welcome and Meeting Objectives - Adesegun Fatusi
9.10 Opening Remarks - P.N. Momah, Director, Federal Ministry of Health
9.15 Addresses by:
   • Agathe Lawson, Resident Representative, UNFPA
   • Jane Miller, Senior Health Advisor, DFID
   • Sharon Epstein, Team Leader, Health, Population & Nutrition, USAID
9.35 Rationale, Objectives & Methods of ASRH Review—Cynthia Waszak Geary, Team Leader
9.45 Preliminary Findings and Discussion—Leni Silverstein
10.10 Tea Break
10.30 Introduction to Group Work—Adesegun Fatusi
10.35 Group Work
11.15 Feedback from Group Work—Adesegun Fatusi
11.50 Wrap-up and Closing—Sharon Epstein

Review Team:
   • Cynthia Waszak Geary, team leader
   • Leni Silverstein, GH Tech consultant
   • Adesegun Fatusi, GH Tech consultant
   • David Ajagun, FMOH
   • Abraham Sunday, FMOH
   • Joy Onuegbu, FMOH
   • Godwin Asuquo, UNFPA
   • Aisha Abubakar (PRRINN-MNCH), DFID representative
   • Abubakar Izge (PATHS 2), DFID representative
   • Folake Olayinka, USAID liaison
Acknowledgements:
- ARH focal points and partners in Lagos, Cross Rivers, Ebonyi, Bauchi, Kano, and the FCT

Attendance for the Design and Review of Adolescent Sexual and Reproductive Health Programs Stakeholders Meeting, held at Chelsea Hotel, Abuja on the 26th October 2010.

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<th>ORGANIZATION/ ADDRESS</th>
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<td>1</td>
<td>Aisha Abubakar</td>
<td>PRRINN-MNCH, Kano</td>
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<td>Ajagun David</td>
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<td>Dr. Folake Olayinka</td>
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<td>Dr. Nanna Chidi-Emmanuel</td>
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<td>Nobis E. E.</td>
<td>Fed. Min. of Women Affairs</td>
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<td>Dr. Damilola Toki</td>
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<td>Azubuike Ozoemenा</td>
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<td>Dr. Moji Odeku</td>
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<td>Jumai Idris Mohammed</td>
<td>SPHCDA/SMOH Minna</td>
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<td>30</td>
<td>Dr. E.W. Chidama</td>
<td>NPHCDA</td>
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http://resources.ghtechproject.net