

Final Evaluation On Improving Youth Reproductive Health In 4 Northern Nigerian States Project-2016

Interim draft

Prepared for//

ARFH Monitoring and Evaluation Steering
Committee

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Table of Contents

Contents	Page
Acknowledgements	2
Table of contents	3
List of Tables	4
List of Figures	7
List of Acronyms	9
Executive Summary	10
Chapter One	17
Introduction	17
1.1 Background	17
1.2 Youth Reproductive Health (Y-Access) Intervention Programme	18
1.3 Conceptual Framework	20
1.4 Final Evaluation Survey	21
1.5 Evaluation Hypothesis	22
Chapter Two	23
Methodology	23
2.1 Survey Design	23
2.2 Study Settings	23
2.3 Target Population	23
2.4 Survey Sample Size	23
2.5 Sampling Procedure	24
2.6 Instrument for Data Collection	24
2.7 Ethical Considerations	25
2.8 Inception Activities	26
2.9 Fieldwork	26
2.10 Summary of Number of Instruments for Data Collection Administered by State	27
2.11 Data management	27
2.12 Limitations of survey	28
Chapter Three	29
Results	29
3.1. Section One: Adolescent /Young People Knowledge Attitude and Practice	30
3.2 Section Two: Gatekeeper	59
3.3 Section Three : Health facility check list	69
3.4 Section Four: Qualitative result of interview for policy makers	84
4.0 Achievement of Y-Access Project	89
4.1 Impact Indicators	89
4.2 Outcome Indicators	93
4.3 Output Indicators	101
4.4 Unintended Positive Outcome	109
Logframe indicators and Final evaluation Impact Summary	111
5.0 Discussion , Conclusion and Recommendations	119
References	130

List of Tables

Table	Description	Page
2.1	Actual Respondents per LGAs/States	24
2.2	Summary of Data Collected From Communities, LGAs and States	27
3.1.1	Socio-demographic characteristics of the respondents	30
3.1.2	Distribution of Respondents by Employment Status and Types of Job	32
3.1.3	Level of Education	32
3.1.4	Respondents who are Currently in School and Level	33
3.1.5	Distribution of whom respondents currently live with	33
3.1.6	Distribution of Respondents Access to mobile phones	37
3.1.7	Respondents Knowledge of Body Changes that take place in girls during	39
3.1.8	Respondents Knowledge of Body Changes that take place in boys during	40
3.1.9	Respondents Awareness of STIs	40
3.1.10	Respondents Knowledge of Features of STIs	41
3.1.11	Prevalence of STIs among Respondents and Medications sought	41
3.1.12	Knowledge of methods of prevention of HIV/AIDS	42
3.1.13	Methods of prevention of HIV/AIDS	42
3.1.14	Distribution of respondent's opinion and reasons of possibility of young people becoming pregnant	44
3.1.15	Respondents knowledge of family planning methods	45
3.1.16	Respondents perception of when Sexual Abuse occurs during sexual intercourse	46
3.1.17	Percent distribution of Sources/preferred sources of Information on RH issues among respondents.	46
3.1.18	Distribution of respondents who had ever attended FLHE schools	47
3.1.19	Percent distribution of Respondents towards Reproductive Health	48
3.1.20	Percent distribution of respondents perception towards condom use	49
3.1.21	Percent distribution of Respondents Risk perception of STIs	49
3.1.22	Sex and age at first sex	51
3.1.23	Methods of prevention of STIs	51
3.1.24	Percent distribution of pregnancy 2012-2013	52
3.1.25	Behavioural Intentions	53
3.1.26	Distribution of RHS accessed by Respondents	54
3.1.27	Amount paid per services accessed	55
3.1.28	IEC materials at SDPs	55
3.1.29	Perception of young people about service providers	56
3.1.30	Respondents opinion concerning recommendation of Y-Access facilities to others	57
3.1.31	Young people's perception of parents support for Y-Access program	58

3.2.1	Socio-demographics of gatekeepers	60
3.2.2	Common health issues affecting young people (10-24 years) by State	61
3.2.3	Respondents perception about Reproductive health issues affecting the young people in the community	62
3.2.4	How the Reproductive health issues affect young people in the community	63
3.2.5	Factors contributing to the common reproductive health issues	63
3.2.6	Suggestions on how to solve reproductive health issues affecting young people in the community	64
3.2.7	NGO that has assisted in reproductive health issues in 3 and half years before survey	64
3.2.8	Common Reproductive Health issues Respondents had Discussed with Children/ wards	65
3.2.9	Frequency of discussion of RH issues with children/ward	66
3.3.1	Background Information	69
3.3.2	Summary of range of services provided, September 2012-February, 20116	70
3.3.3	Distribution of Personnel by training received	71
3.3.4	Supervision of Facilities	72
3.3.5	Location and Minutes trekking distance to SDPs	73
3.3.6	Facility Working Hours	74
3.3.7	Facility Environment	74
3.3.8	Staff Preparedness	75
3.3.9	Services Provided	76
3.3.10	Peer Education/Counseling program	77
3.3.11	Educational Activities	78
3.3.12	Supportive Policies	80
3.3.13	Administrative Procedures	81
3.3.14	Publicity/Recruitment	81
3.3.15	Fees Paid for Services	82
3.3.16	Average cost per service offered	83
3.3.17	Cooperative Society Register	83
4.1.1	Percent distribution of respondent's opinion and on possibility of young girls becoming pregnant or young boys impregnating girls by survey status	90
4.1.2	Percent distribution of respondent's knowledge of family planning methods by survey status	91
4.1.3	Prevalence of STIs among Respondents and Medications sought	92
4.2.1	Clients Volume of Services Rendered Over the Years (2012-2013)	94

4.2.2	Distribution of Services Provided at Close of Project by States	96
4.2.3	Percent distribution of Respondents History of sex by State by Survey Status	99
4.2.4	Distribution of use of contraception among Young people by survey status	100
4.3.1	Percent distribution of Respondents knowledge of STIs by States and Survey	102
4.3.2	Percent Distribution of Respondents Attitude towards Use of Condoms by State and study Status	106
4.3.3	Young people's perception of parents support for Y-Access program	109
5.0	Final evaluation Impact Summary	111

List of Figures

Figure	Description	Page
1.0	Conceptual framework for the effect of Y-Access programme on the Sexual Behaviour of Adolescent and Young People in Benue, Jigawa, Niger and Katsina States	21
3.1.1	Percentage distribution of duration of stay in the community	31
3.1.2	Respondents currently involved in income generating activities	34
3.1.3	Percentage distribution of Respondent Present Income level compared with three and half years before survey	34
3.1.4	Distribution of Respondents who had capacity building training under Y-Access project	35
3.1.5	Respondents membership of cooperative groups	36
3.1.6	Percent distribution of Respondents awareness of ARHS	37
3.1.7	Respondents knowledge of girl's age of puberty	38
3.1.8	Respondents knowledge of boy's age of puberty	38
3.1.9	Percent distribution of respondents who had HCT	43
3.1.10	Percent distribution of Respondents perception of Masturbation	45
3.1.11	History of drug Abuse	50
3.1.12	Condom use among those who had sex	52
3.2.1	Overall Common health issues affecting young people (10-24 years)	62
3.2.2	Percentage distribution of Respondents who Discussed SRH issues with children/wards	65
3.2.3	Percent distribution of Respondents Support for young people seeking RH information	67
3.2.4	Distribution of Respondents Perception of Community Support of Young People Seeking RH Information	68
3.2.5	Distribution of Respondents perception on special locations for RH information	68
3.3.1	Distribution of Respondents youths involvement in decision making	79
4.1.1	Percent distribution of respondents 10 -24 years who were pregnant/impregnated someone by survey status	89
4.1.2	Percent distribution of respondents ever tested for HIV and obtained result by survey status	92
4.2.1	Trend of total client's volume	95
4.2.2	Distribution of SRH client's visits to target informal service delivery points disaggregated by age, sex and type of services	97
4.2.3	Percent distribution of adolescents and young people who self-reported accessing SRH Services.	98
4.2.4	Number of formal and informal service providers providing SRH services to adolescents and young people	99

4.3.1	Respondent's percentage knowledge score of body changes that occur among girls and boys at puberty by Survey Status	102
4.3.2	Respondents Knowledge Score of Features of STIs by State and Survey Status	103
4.3.3	Percent Distribution of Respondents Knowledge Score of Methods of Prevention of HIV/AIDS by states and Survey Status	104
4.3.4	Percent Distribution of Respondents attitudinal Score of towards RHS by State and study Status	105
4.3.5	Percent Distribution of Respondents attitudinal Score on Use of Condom for Prevention of HIV/AIDS by states and Survey Status	106
4.3.6	Distribution of young people reporting good knowledge and positive attitudes towards SRH by Survey Status and Project Target.	107
4.3.7	Percent distribution of duty bearer's support of RHS by State and survey Status	108

List of Acronyms

Acronym	Meaning
AIDS	Acquired Immune Deficiency Syndrome
ARFH	Association for Reproductive and Family Health
ASRH	Adolescent Sexual and Reproductive Health
AYHD	Adolescent and Youth Health and Development
SCS	Bachelor of Science
BSUTH	Benue State University Teaching Hospital
DFiD	Department for International Development
EVA	Education as a Vaccine
ES	Educational Status
FP	Family Planning
GPAF	Global Poverty Action Fund
HCT	HIV counselling and Testing
HND	Higher National Diploma
HIV	Human Immune-Deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IGA	Income-Generating Activities
JSS	Junior Secondary School
LGA	Local Government Area
NCE	National College Of Education
MSC	Masters of Science
MOH	Ministry of Health
NHREC	National Health Research Ethics Committee
OND	Ordinary National Diploma
PGD	Post Graduate Diploma
PHC	Primary Health Centre
PMV	Patent Medicine Vendors
RH	Reproductive Health
RHS	Reproductive Health Services
SDP	Service Delivery Point
STI	Sexually Transmitted Infection
SMoH	State Ministry of Health
SSS	Senior Secondary School
UNFPA	United Nations Fund
SWODEN	Society for Women Development and Empowerment of Nigeria
TOT	Training of Trainers
Y-Access	Youth Reproductive Health Intervention Programme

EXECUTIVE SUMMARY

Introduction

In Nigeria, the adolescents (10-19 years) constitutes over a fifth of the national population while young people (10-24 years) constitutes almost a third. Overall, the adolescent women from the north makes up to 42% of the total adolescence Nigerians. Available statistics indicate that Nigerian adolescents and young people's health status is marked by major reproductive health challenges with its attending short and long term consequences. Despite constituting a huge proportion of population, young people are rarely included in decision – making process in Nigeria and they also constitute the highest proportion of unemployment rate. Between 2012-2016, the Y-Access project, a Reproductive Health Improvement project for adolescent and young people aged 10 to 24 years was implemented in 4 northern states of Nigeria: Benue and Niger states in the North Central region by EVA and Jigawa and Katsina states in the North West region of Nigeria by SWODEN. Under the partnership arrangement, ARFH had the responsibility for overall coordination of the project including financial management while EVA and SWODEN were responsible for delivery of state level activities.

Key intervention activities carried out on the project include:

- i. Capacity building of health care service providers in the public, private and community based health service delivery points
- ii. Creation/improvement of referral systems between youth, community, the public and private health systems
- iii. Identification, selection and capacity building of individual and youth groups and provision of incentives to provide Sexual and Reproductive Health (SRH) information, commodities and referrals to their peers
- iv. Utilization of mobile phones to provide SRH information, and referral of out-of-school youth and married adolescent girls to facilities to access reproductive health services
- v. Creation of a voucher scheme to address financial barriers in accessing SRH services
- vi. Mobilization and education of community gatekeepers (parents/guardians, teachers, religious/community leaders) on young people's sexual and reproductive health issues and working with the existing community structure on improving the health needs of the youths

- vii. Identification and selection of established youth groups to be provided with micro credit for viable income generating activities and
- viii. Development/implementation of advocacy plan targeting policy makers at state and local government levels to make financial investment in Adolescent, Sexual Reproductive Health (ASRH).

The implementation of the project was based on behavioural change model, peer educators referral system and adolescent and young people empowerment via income generating activities and voucher scheme. Having implemented the project for three and half years ARFH contracted team of consultants from department of Epidemiology and Community Health Benue State University to evaluate the project.

Objectives: The overall objective of the final evaluation was to assess the impact of the three and half year Y-Access programme implemented by ARFH in in 4 northern states in Nigeria and to account to implementing partners the programmes achievements.

Materials and Methods: The methodology employed for the evaluation was a cross sectional descriptive study with mixed quantitative and qualitative approach. The survey was carried out in four local government areas in Benue, Niger, Jigawa and Katsina States. The fieldwork was conducted by research team which was made up of four consultants, 4 supervisors, 32 research assistants. Two research assistants worked in one LGA as an operational team. Each of them were assisted by a community guide who was a representative of Y-Access project implementing partners. Fieldwork in each state was conducted over 6 days. That of Benue commenced on 3rd June, 2016 Niger commenced on 16th June, 2016 and Katsina and Niger Commenced on 17th June, 2016. The data collection was done manually. The data collected covers the Y-Access activities from 1st September 2012 to 29th February, 2016. The field work was finally rounded up on 25th June, 2016. Instruments used were self-reported exposure health facility records of September, 2012 to February, 2016; youth and gatekeepers' questionnaire and key informant interviews conducted for policy makers. Analysis was done with Statistical Package for Social Sciences (SPSS) version 23, and Microsoft excel software. Results of quantitative data are presented in descriptive formats as tables and charts while the qualitative data's are presented in narrative formats. A review of relevant documents related to the programme was also undertaken to complement the primary data collected.

Impact and Outcome/Output measurements: The impact and outcome indicators of interest are composite aggregate of the indicators used in the conceptual framework. Emphasis was made on the proportion of adolescents who had sex in the last 12 months before survey, adolescent with self-reporting access to sexual reproductive health services, proportion and estimated number of adolescents and young people who reported using a method of contraception during the last sexual activity within the last twelve months, and proportion of states with documented policy and strategic plan for adolescent and youth health and development (AYHD). These indicators were assessed in the youth knowledge, attitude and behaviour questionnaire, gatekeeper's questionnaire and the key informant interview. The facility check list was tailored towards summary of services provided to youths in age aggregated forms, schedule of available services rendered, the skills of personals (defined as whether they are trained on RH issues or not, number of trainings received and the content of the trainings), supervision of the staff and operation of the facilities (defined as proper monthly and quarterly internal and external reports), adequate location of the SDPs (defined as not more than 30 minutes trekking distance to the nearest popular bus stop), attitude of the personnel (defined as positive if the attitude encouraged good adolescent and young people patronage of the SDPs), IEC materials (defined as enough coverage if the means of communications are maximally utilize).

Findings: The research demonstrated that Y-Access activities reached a large proportion of adolescent and young people within the communities in Benue, Niger, Jigawa and Katsina states of Nigeria with its capacity building activities/voucher scheme, leading to a widespread recognition of the project's work through the collaborating organizations. The impact of the project was improved health status of adolescent and young people in four states of northern Nigeria, contributing to the achievements of the MDGs goal 5 and 6. Significant findings in the final evaluation include:

- **Reduction in Adolescent Pregnancy Rate:** At baseline, the average prevalence of teenage pregnancy for all the states was 48.2%. At the close of the project, the overall percentage reduction of adolescent and young people pregnancy rate in the 4 northern States where Y-Access project was implemented was 38.4%, with Katsina State having the highest proportion of impact of the program (47.5%) and the least was Jigawa State High proportion (90.2%) of the interviewed adolescent and young people had never been

pregnant/ (females) or impregnated any girl (Males). In terms of the type of contraception, the respondent's choice of abstaining from sex and use of condoms predominates (78.7% and 74.7% respectively).

- **HIV Prevalence Rate:** About three in five respondents have been tested for HIV at close of the Y-Access project (64.5%) as against 24.8% at the beginning of the project. This is probably due to geographical spread and free financial access to HCT services available at the Y-Access SDPs.
- **Positive Behavioural Change:** The project recorded tremendous improvement in behaviour change among the adolescent and young people who are the main beneficiaries of the project. These changes include: delay of sexual initiation (defined as reporting initiation of sex), fewer sex partners (defined as having fewer sex partners or reduced average number of sexual partners fewer than two in last 12 months), increase in condom use (defined as reporting condom use in last sex), consistent condom use (defined as reporting using a condom every time with current sexual partner) and increased use of contraceptives (defined as reporting use modern methods of contraception during sex). Y Access project achieved the target of positive behavioural change.
- Overall, the proportion and estimated number of young people reporting good knowledge and positive attitudes towards SRH was 78.2% and 59.8% respectively. Over 70.0% of the respondents understand the major signs and symptoms of STIs; these include: pain during urination (82.7%), itching around the genitals (78.8%), foul smelling discharge from vagina/penis (79.1%) and genital ulcers (78.8%). Over two third of the respondents in all the states had good knowledge of all the methods required for prevention of STIs. About a third of all the respondents from the four states still had misconception of use of mosquito's nets as a means of preventing STIs. The knowledge score of methods of prevention of STIS (including HIV/AIDS) was good with final evaluation and baseline difference of 14.3%. At baseline majority of respondents in Benue, Niger, Jigawa and Katsina had negative attitude towards RH services (55.0%, 56.6%, 59.8% and 56.4% respectively). The difference between positive attitude towards SRH at close of the project and the baseline was 12.2% as against the baseline.

- **Self Reporting Access to Sexual and Reproductive Health (SRH) Services:** The predicted assumption of increased access and utilization to quality and comprehensive RH services by adolescent and young people in the targeted SDPs in the 16 target LGAs (Outcome indicator 1) was achieved above the target. Overall, about 73.0% of the adolescent and young people reported to have self –reported accessing RHS at either formal or informal service delivery points within the three and half years of Y-Access implementation. Overview of the services provided and the client’s volume over the years (2013-2016) shows significant impact of the project. At baseline overall total of 228,914 [206,242 (Females), 22,672 (Males); 110,752 (10-19 years), 118,162 (20-24 years); 18,572 (contraceptives); 103,900 (ANC); 21,798 (deliveries); 57,218 (HCT); 5,270 (STI testing/treatment); and 22,156] (Pregnancy testing) were recorded. Client’s utilization for all the services provided recorded tremendous increased above the baseline. At close of the Y-Access project in 2016, a total of 1,016,131 (265,779 females, 112,856 males), 89,482 (10-14 years); 790,889 (15-19 years); 630,947 (20-24 years) was reported. The difference in client volume between the baseline and the close of the project was 787,217 and the expected target was exceeded by 32.7%. Similarly, the target for 2014 and 2015 were exceeded beyond the target for those years. Overall, the annual target for all the years exceed the target. The disaggregated services by sex, age and services provided was also achieved above the annual targets.
- **Services Provided at SDPS:** All facilities offer services on sexuality, safer sex, pregnancy prevention and STI/HIV, and majority (over 90%) of the facilities offer contraception methods e.g. condoms, Injectables and oral pills while only 18% of facilities offer implants. Above two-third (69.0%) of the facilities provide both male and female condoms with 56% of the facilities having adequate supply of condoms and others contraceptives. All the facilities have testing facilities for pregnancy with 81% of facilities using Urine micro for STI testing. About 68% of facilities have formal referral system, including tracking and follow up for services not provided.
- **Peer Education Referral System:** At baseline there was no recorded activity with youth participation. Within the three and half years of implementation of the project a total of

1587 (908 [Males]; 679 [Females]; 438 [10-19 years]; 1149 [20-24 years]; 1122 [Out of School]; 465 [In-School]) were trained as PEs disaggregated by age, sex and in/out school. In terms of number of times young people were referred by trained peer educators for SRH services, the project did not achieve the target as 7,850 referrals was recorded as against the end of project target of 17,920 (56.2% below the target). Despite the short fall, peer education still play a good impact. Final survey finding shows that almost all respondents preferred themselves accessing RH information's via peer educator.

- **Income Generating Activities and Voucher Scheme:** The Y-Access project made a significant improvement. The expected close of project target was 360 (VST: 64 Males, 96 Females; 110 10-19 years, 50 20-24 years; AP: 200 Females; 120 10-19 years, 80 20-24 years). The project made a significant improvement. At close of the project 437 (VST: 98 Males, 112 Females; 100 10-19 years, 110 20-24 years. AP: 227 Females; 39 10-19 years, 188 20-24 years) (87.2%) benefited. The number of cooperative societies formed with members in each of the communities increased by 100 percent (0-20) at the closed of the project. Two hundred and thirty nine young people (156F, 83M) received the service voucher schemes in Benue State and 223 (151F, 72M) redeemed the vouchers at service delivery points for SRH services.
- **Training of RH Service Providers:** At the end of the project, the total targeted number of formal and informal service providers trained for providing SRH services to adolescents and young people disaggregated by type was achieved. A total of 917 formal and informal health providers (480 females, 437 males; formal 190 HSPs, , 374 TBAs, and 353 PMVs) were trained in adolescent and young people sexual and reproductive health service provision at SDPs within the three and half years of Y-Access project. Of those trained 79.0% had adequate and sustained knowledge on adolescent sexual reproductive health issues and youth friendly service delivery throughout the period of the Y-Access project.

- **Costed Plans and Policy Documents:** In terms of costed plans and policy documents, all the states in collaboration with the implementing partners developed their AYHD policy and almost all the formal SDPs visited in the survey had tremendous improvements in at least three out of four youth friendliness domains. The facilities had clear written document for serving young people and there was internal and external supervision and monitoring that kept the programme on track till the end.
- **Community/religious leaders, Parents/Guardians, Teachers Support for SRH Services:** It is believed that sexual and psychological development of adolescents take place under the influence of contextual and antecedent factors, the gatekeepers inclusive. The framework indicates that the Y-Access interventions affected these antecedents directly by interacting with young people or indirectly by influencing the context within which they live, as well as by enhancing established SRH programmes for the young people. In this final evaluation survey, number of gatekeepers (parents, teachers, community leaders and religious leaders) and policy makers reached with messages on Youth SRH at the end of three and half years was 872. The proportion is below the project expected target of 1400 (37.7% below target). Similarly, the proportion and numbers of gatekeepers who report willingness to support young people to access SRH information and services was 88.2%. The findings is also below the expected target of 95.0%.
- **Utilization of Funds:** In relation to the efficient utilization of funds, the audited report shows that the funds provided for the Y-Access project was maximally utilized. On the whole, the programme was successfully implemented as shown by the achievements of the indicators and their outputs (summarized in Table 4.0). Overall, this evaluation finds that the Y-Access approach to improving the adolescent and young people's health was effective and efficient in delivering the intended outputs. The successful factors that facilitated this efficiency and effectiveness include the peer educators approach, supervisory management arrangements and the M&E system of the project. Also, partnerships with other actors and the involvement of both direct (young people) and indirect beneficiaries of the project (the gatekeepers) contributed greatly to the effective running of the project. Such innovative strategies were instrumental in the

implementation of the project. Scaling up of Y-Access project to other parts of Nigeria will improve the reproductive health of other adolescent and young people in Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 Background

In Nigeria, available statistics indicate that Nigerian adolescents and young people's health status is marked by major reproductive health challenges amongst which includes: early sexual initiation, unsafe sexual activities, early child bearing, low knowledge on the use of contraceptives, unsafe abortions, high prevalence rates of sexually transmitted infections (STIs), Human immunodeficiency Virus and Acquired immunodeficiency syndrome (HIV and AIDS), maternal mortality, drug abuse, harmful traditional practices and gender based violence with its attending short and long term consequences¹⁻⁴

Nationwide, 19% of girls were married by age 15, and 43% by age 18⁵ and 9% of women aged 25-49 have given birth by age 15, and 47% have become mothers by age 20³. The proportion of marriage teenagers are higher in the northern regions being highest in the north west and north east regions where the proportion of marriage girls (15-19 years) are 73% and 50% respectively⁵. The comparative lags of the northern region behind the rest part of the country in the trend, is largely associated with education, towards delaying age of marrying.¹ The comparative lag in the northern region behind the rest of the country is largely associated with illiteracy. Females in the north west and north east are marry on an average five years or more earlier than those in southern states where women are better educated^{1,4,5}. These adolescents (10-19 years) who are engaged in early marriages constitutes over a fifth of Nigerian population while young people (10-24 years) constitutes almost a third.³ Overall, adolescent women from the north makes up to 42% of the total Nigerian adolescence aged 15-19 years.^{1,6}

Low community awareness of the importance of reproductive health –challenges and preventive measures are amongst the potential factors responsible for reproductive health problems in Nigeria. Many parents/guardians are unaware of the health risk of early marriages to their daughters and hence give them out for marriage at an early age. Other factors responsible include economic, social, cultural and health services factors^{4,5} looking at the vulnerability of young people to adverse consequences of unsafe sexual relations, promoting safe sexual behaviour among young people is essential to curbing the adverse reproductive health outcomes⁷

Nigeria is not the only country where adolescent reproductive health issues remain a challenge. Globally, there are critical challenges in achieving universal access to sexual and reproductive health (SRH) despite efforts made by cooperate organizations, international bodies as well as national bodies^{6,8} Many governments have pursued strategies to address the specific sexual and reproductive health needs of adolescents since the 1994 International Conference on Population and Development (ICPD) placed Adolescents Sexual and reproductive Health (ASRH) on the global policy agenda⁹. However, the relative large proportion of adolescents in low and middle-income countries and related high rates of HIV, unwanted pregnancy, maternal mortality and unsafe abortion indicate needs for greater improvements in service usage.^{10,11} Many adolescents in sub-Saharan African countries underuse Sexual and Reproductive Health (SRH) services^{11,12-16} due to barriers such as service costs and distance, lack of awareness about where to get comprehensive reproductive health services, embarrassment, lack of confidentiality and privacy, and negative provider attitudes among others.^{13,17-19}

Several studies document associations between ASRH interventions and adolescent service usage worldwide and in sub-Saharan Africa. Majority of these studies reported significant positive changes in adolescent knowledge and attitudes, increasing health service attendance and contraceptive usage as post intervention benefits. However, interventions varied tremendously and many were not explicitly theoretically grounded. Evaluation methods also varied and often included relatively small sample sizes and time-periods, limiting potential conclusions²⁰⁻²⁵.

1.2 Improving Youth Reproductive Health in Northern Nigeria Project (Y-Access)

Intervention

Responding to the adolescent sexual and reproduction health needs in Nigeria, particularly in the north, the Improving Youth Reproductive Health In Northern Nigeria (Y-Access) intervention project; a three and a half years capacity strengthening and reproductive health improvement project for adolescents and young people (aged 10 – 24 years) was implemented in four northern states in Nigeria (Benue, Jigawa, Niger and Katsina states). The project was conceived against the backdrop of pervasive poverty and poor reproductive health status of adolescents and young people in Nigeria. With a population of over 150 million people, Nigeria in the 2008 HDI report was ranked 154 out of 179 countries in the world. Early sexual debut, low knowledge about reproductive health issues, low contraceptive use, high birth rates

and high rate of unsafe abortions combined with low contraceptive use increases young people's vulnerabilities and risks of HIV/AIDS, other sexually transmitted infections (STI), unplanned/unwanted pregnancies and unsafe abortions.

Four local government areas (LGAs) in each of the states were involved in the project between September 2012 and February 2016. These include: Dutsin-ma, Mashi, Malumfashi, and Rimi in Katsina State; Birnin-Kudu Hadejia, Kazaure, and Gumel in Jigawa State; Gboko, Kwande, Oturkpo, and Vandeikya, in Benue State; and Mashegu, Mokwa, Rafi, and Shiroro in Niger State respectively. The project was funded by the British Government's Department for International Development (DfID) under the Global Poverty Action Fund (GPAF) and implemented by the Association for Reproductive and Family Health (ARFH) in partnership with Education as a Vaccine (EVA) and Society for Women Development and Empowerment of Nigeria (SWODEN). The project was designed to strengthen capacity for demanding, uptake and delivery of comprehensive RH services to adolescents and young people (aged 10 – 24 years) in Nigeria.

The primary beneficiaries of the intervention project were Young people (aged 10-24 years), while the secondary beneficiaries include: Health care workers (from both formal and informal sectors), community gate keepers and policy/decision makers at state and LGA levels. The project focused on:

- i. Capacity building of health care service providers in the public, private and community based health service delivery points
- ii. Creation/improvement of referral systems between youth, community, the public and private health systems
- iii. Identification, selection and capacity building of individual and youth groups and provision of incentives to provide Sexual and Reproductive Health (SRH) information, commodities and referrals to their peers
- iv. Utilization of mobile phones to provide SRH information, and referral of out-of-school youth and married adolescent girls to facilities to access reproductive health services
- v. Creation of a voucher scheme to address financial barriers in accessing SRH services
- vi. Mobilization and education of community gatekeepers (parents/guardians, teachers, religious/community leaders) on young people's sexual and reproductive health issues

and working with the existing community structure on improving the health needs of the youths

- vii. Identification and selection of established youth groups to be provided with micro credit for viable income generating activities and
- viii. Development/implementation of advocacy plan targeting policy makers at state and local government levels to make financial investment in Adolescent, Sexual Reproductive Health (ASRH).

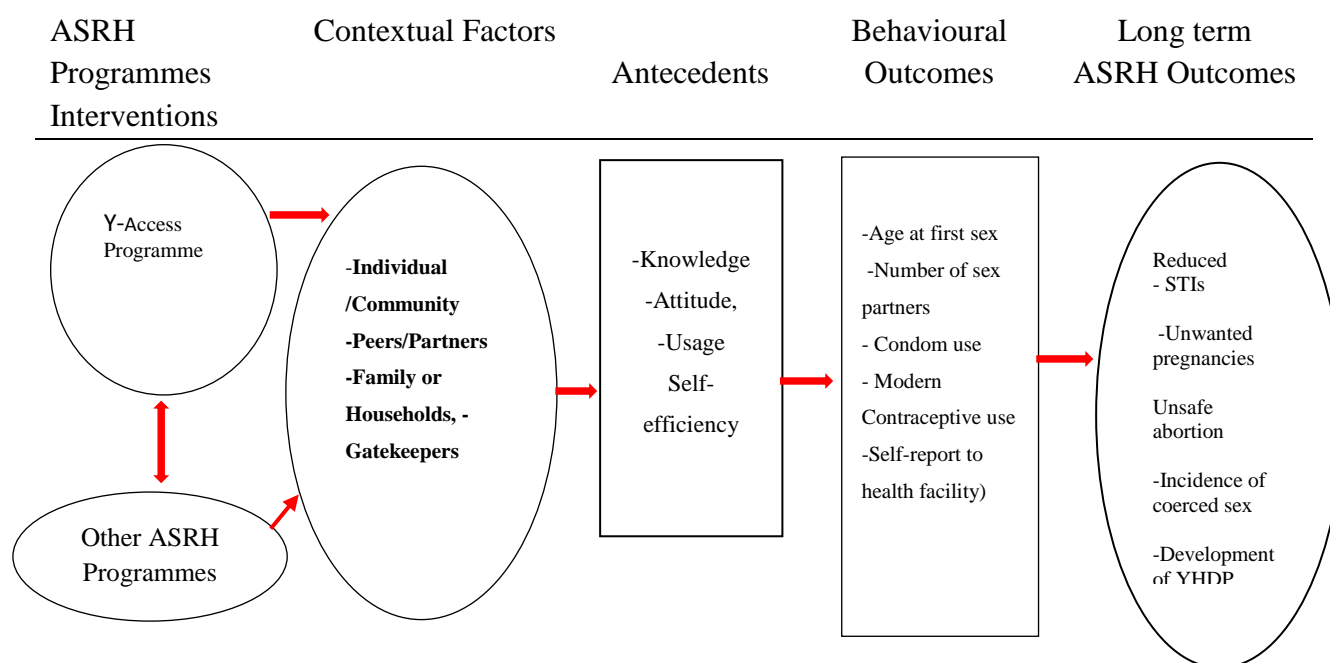
Baseline survey for the Y-Access project was conducted by ARFH in collaboration with implementing partners and the findings was combined with the results of National Demographic and Health Survey (NDHS), and antecedent reports by other stakeholders to address the health and development needs of adolescent and young peoples in Benue, Niger, Jigawa and Katsina States. The findings from the baseline survey provided the contextual evidence and justification for implementing the project activities in the various states. The baseline findings revealed that 34% to 59% of young people do not have access to money for personal needs across the project states. In addition, the knowledge of ARH issues was very low (15% - 29%) particularly in three (Jigawa, Katsina and Niger) of the project states. Consequently the target beneficiaries (adolescent and young people) were meaningfully engaged as well as key community gatekeepers in implementing project activities. There were also series of participatory open community meetings in the project states which provided space for deepened understanding of the project focus.

1.3 Conceptual Framework

The conceptual framework motivating the evaluation is based on Bandura's social learning theory²⁶ adapted at the baseline. It is believed that sexual and psychological development of adolescents take place under the influence of contextual and antecedent factors. The contextual factors (individual/community, peer groups/partners, families/households, and gatekeepers) are expected to influence SRH behaviour and its antecedents (knowledge, attitude and self-efficiency) that are presumed to act as precursors to behaviour change. The framework indicates that the Y-Access interventions affected these antecedents directly by interacting with young people or indirectly by influencing the context within which they live, as well as by enhancing established SRH programmes for the young people. The antecedents are assumed to

influence behavioural outcomes like abstinence, reduction of number of sexual partners and condom or other modern contraceptive use and health seeking behaviours. Improved behaviour is in turn expected to have a positive contribution to improved health. This model is also consistent with the health belief model²⁷ and other models of health behaviour. Figure 1 represents the summary of the model.

Figure 1: Conceptual framework for the effect of Y-Access programme on the Sexual Behaviour of Adolescent and Young People in Benue, Jigawa, Niger and Katsina States



The Y-Access was expected to provide enabling environment for positive impact on adolescent and young people's reproductive health. The overall goal is to be achieved through community mobilization and participation, provision of youth friendly reproductive health service centers, capacity building of individual and youth groups, creation of a voucher scheme to address financial barriers in accessing SRH services, school based reproductive health education and peer outreach, development/implementation of advocacy plans and policy.

1.4 Final Evaluation Survey

The overall objective was to assess the impact of the three and half year Y-Access programme implemented by ARFH, EVA and SWODEN in 4 northern states in Nigeria.

The **specific evaluation objectives** are as follows:

1. To independently verify (and supplement where necessary), grantees' record of achievement as reported through Annual Reports and defined in the project's logframe.
2. To assess the extent to which the project performed well and was good value for money, which includes considering;
 - a) How well the project met its objectives
 - b) How well the project applied value for money principles of effectiveness, economy, efficiency in relation to delivery of its outcome
 - c) What has happened because of DFID funding that wouldn't have otherwise happened; and
 - d) How well the project aligns with DFID's goals of supporting the delivery of the MDGs
3. To determine the knowledge, behavior and utilization of reproductive health services amongst adolescents and young people in target LGAs
4. To analyze the different strategies (including peer education, training of health providers, advocacy, voucher scheme, IGA etc) used for project implementation for their effectiveness.

1.5 Evaluation Hypothesis

The evaluation investigates the following hypothesis:

- a. Young people make informed decisions regarding their sexual health based on Knowledge, attitude, self-efficiency and leadership capacities developed as a result of Y-Access interventions
- b. Individual /Community, Peers/Partners, Family or Households, and policy makers in Nigeria mainstream an effective reproductive health intervention through planning, policy, and technical support from Y-Access programme.

CHAPTER TWO

METHODOLOGY

2.1 Survey Design

The survey employed a cross sectional descriptive study design with mixed quantitative and qualitative approach. The approach is aimed at providing a ‘plausible’ account of the difference that DFID’s funding has made to the impact of grantee (ARFH).

2.2 Study Settings

The survey was conducted in four local government areas (LGAs) in each of the states where the Y-Access project was implemented. These include Dutsin-ma, Mashi, Malumfashi, and Rimi in Katsina; Birnin-Kudu Hadejia, Kazaure, and Gumel in Jigawa; Gboko, Kwande, Oturkpo, and Vandeikya, in Benue; and Mashegu, Mokwa, Rafi, and Shiroro in Niger States respectively. The implementing partners of Y-Access programme in Benue State are Jigawa was EVA, while SWODEN takes the lead for Niger and Katsina states.

2.3 Target Population

The study population for the survey was drawn from the development areas of operation. These include:

- i. In- and –out-of-school young people between age 10 - 24 years
- ii. Parents, teachers, community/religious leaders
- iii. Policy makers (State Director of primary health care, Adolescent Health and Development desk officers, RH or FP coordinators at MOH).

2.4 Survey Sample Size

The formula for sample size determination provided in the baseline was used:

$$n = Z^2 pq / d^2$$

Where

n = minimum sample size for each state

z = Z score that corresponds to 95% confidence interval

p = the proportion of respondents who report the desired outcomes in the each state

d = the desired margin of error

n= approximately 400

The minimum sample size for each state was obtained with the formula on assumption of normal distribution.²⁸

2.5 Sampling Procedure

Multistage sampling technique was employed for selection of communities and the actual respondents for the survey. The key factor used to select the respondents was to come from communities/settlements where the Y-Access project was implemented.

The youth and the gatekeepers whom the quantitative data was administered to were selected based on the outlined criteria in the protocol. Four development states of operation which were selected during the baseline survey (Benue, Jigawa, Katsina and Niger) were used for the final evaluation survey. In each of the four states, four LGAs which were involved in the baseline survey were also used. The selection of the states and the respective LGAs was by convenience. Within each of the selected LGAs, five wards were selected. The selection of the communities was done by simple random sampling technique. Five communities were selected from each LGA and each was allocated with equal number of respondents. The Table 1 below is a summary of the minimum sample size of the actual respondents per LGA and State.

Table 2.1: Actual Respondents per LGAs/States

State	LGAs	Respondents	Wards/Communities					Total Per LGA
			1	2	3	4	5	
One State	LGA ₁	20 Young people	20	20	20	20	20	100
		5 Adult	5	5	5	5	5	25
	LGA ₂	20 Young people	20	20	20	20	20	100
		5 Adult	5	5	5	5	5	25
	LGA ₃	20 Young people	20	20	20	20	20	100
		5 Adult	5	5	5	5	5	25
	LGA ₄	20 Young people	20	20	20	20	20	100
		5 Adult	5	5	5	5	5	25

2.6 Instrument for Data Collection

Four instruments were used for the final evaluation survey: These are the adolescent and young people questionnaire, the gatekeepers questionnaire, the reproductive health facility check list, and key informant interviewer guide. These tools were adapted from the baseline data tools with

little modification in line with the survey research questions and hypothesis. The adolescent and young people questionnaire was used to collect information on the young people (10-24 years) who were in school or out of school. The proportions were randomly selected in the homes, markets, garages, mechanic workshops, barbing/hair dressing salons and in private/public schools. These group of respondents were asked on:

- i. Socio-demographic characteristics
- ii. Economic status/livelihood
- iii. Access to mobile phone services
- iv. Knowledge of adolescent reproductive health
- v. Attitude to reproductive health
- vi. Sexual behaviour and behavioural intentions
- vii. Experience of sexual coercion
- viii. Utilization of reproductive health services and parent support

The gatekeeper's questionnaire was administered to parents, teachers, and community and religious leaders. They were asked on:

- i. Socio-demographics
- ii. Knowledge of adolescent sexual and reproductive health issues
- iii. Support for adolescent sexual and reproductive health

The health facility check list focused on the reproductive health services provided, the schedule of available services provided, personnel and supervision, assessment of youth friendliness and co-operative society register.

The qualitative tools (Key informant interview) elicited information from policy makers and key informants at implemented health facilities and states. The key informant interview focused more on the informants' knowledge of ASRH, trainings on reproductive health, Y-Access implementation and existence of state/national youth health and development policy.

2.7 Ethical Considerations

Ethical clearance were sought from the national health research ethic committee of Nigerian federal ministry of health prior to the commencement of the survey. Oral and written informed consent was sought from each respondents before a questionnaire was administered.

2.8 Inception Activities

Thirty two research assistants were recruited and trained for data collection. The recruited research assistants were people who had never worked with any of the Y-Access implementing partners, but have basic knowledge and skills in operation research. The training for the field work take place between June 30th -31st May, 2016 for Benue and 15th -16th June, 2016 for Niger, Katsina and Jigawa State. The consultants and the supervisors had a session of Training of Trainers (TOT) at Benue State University Teaching Hospital (BSUTH) conference hall on Tuesday 30th May, 2016. The training was coordinated by the principal consultant. The supervisors were trained to conduct the training of research assistants in their respective states of assignment. The training modules consisted of interview techniques, field procedures and detailed review of variables in the tools for data collection. The instruments for data collection was later pre-tested and all the necessary corrections were made. A supervisor was assigned per state and they were deployed to their respective states of assignment to step down the training as well as to coordinate the data collection in the 4 different states. Training of the research assistants was conducted in the respective states by the supervisors/consultants a day before the commencement of data collection in that state.

2.9 Fieldwork

The fieldwork was conducted by research team which was made up of four consultants, 4 supervisors, 32 research assistants. While the consultants reside primarily in Makurdi, the research assistants reside in the local government areas of the states where the Y-Access project was implemented. Two research assistants worked in one LGA as an operational team. Each of them were assisted by a community guide who was a representative of Y-Access project implementing partners. Fieldwork in each state was conducted over 6 days. That of Benue commenced on 3rd June, 2016 Niger commenced on 16th June, 2016 and Katsina and Niger Commenced on 17th June, 2016. The data collection was done manually. The data collected covers the Y-Access actives from 1st September 2012 to 29th February, 2016. The field work was finally rounded up on 25th June, 2016.

2.10 Summary of Number of Instruments for Data Collection Administered by State

The summary of the total tools submitted by state are shown in Table 1: A total of 1600 Youth questionnaire, 400 gatekeepers' questionnaire and 16 health facility check list were completed in 80 different communities (20 in each of the four states). Fifteen (15) key informant interviews were also conducted for policy makers.

Table 2.2: Summary of Data Collected From Communities, LGAs and States

State	LGA	Community	Questionnaire/Interview				Total
			Young people	Gatekeeper	Check list	KII	
Benue State	Otukpo	5	100	25	1	1	132
	Gboko	5	100	25	1	1	132
	Kwande	5	100	25	1	1	132
	Vandekiya	5	100	25	1	-	131
Niger	Shirolu	5	100	25	1	1	132
	Mokwa	5	100	25	1	1	132
	Rafi	5	100	25	1	1	132
	Mashegu	5	100	25	1	-	131
Jigawa	Birnin-Kudu	5	100	25	1	1	132
	Gumel	5	100	25	1	1	132
	Hadeja	5	100	25	1	1	132
	Kazaure	5	100	25	1	-	131
Katsina	Dutsin-ma	5	100	25	1	2	133
	Malumfashi	5	100	25	1	1	132
	Mashii	5	100	25	1	1	132
	Rimi	5	100	25	1	1	132
Total		80	1600	400	16	14	2116

2.11 Data management

All questionnaire and the recorded interviews were returned to the department of epidemiology and community health for analysis. The information on the hard copies of the questionnaire were later transferred to Statistical Package for Social Sciences (SPSS) software and Excel Microsoft Excel software and the recorded information were transcribed and coded. Data cleaning and analysis commenced immediately.

2.12: Limitations of the Survey

The final evaluation survey goes beyond the assessment of impact of the project by incorporating the survey findings with the desk review and output of activities carried out during the intervention phase of the project. Nonetheless, the survey has some limitations; these include:

- i. **Selection Bias:** Due to security challenges in some of the project locations and its environment participation in the project activities and the utilization of the youth friendly services among the adolescent and young people may differ to some degree. Those who participated in the project may have been more likely to be predisposed to change their attitude and behaviour than non-participants and that in turn may influence the final comparison between the baseline and the final survey.
- ii. **Delayed Approval by NHREC.** Despite the early submission of research protocol and request for expedited review/approval, the national health research ethics committee did not issue the approval for commencement of the evaluation until 25th May, 2016. That in turn delayed the advocacy visit to the selected communities and the commencement of the fieldwork.
- i. **Incomplete Record:** Most of the records in health facility registers of facilities samples were incomplete. Where all the available means were sort and information was still lacking, facility copies of clients monthly summary report submitted to funding agencies were used as additional tools for complete information.
- ii. **Budget:** The fieldwork was planned on a very tight budget. The estimated research assistants were six but when the tools were pretested, the number was increased to ensure collection of valid data. Despite the measures taken, some of the research assistants still found the exercise tough in terms of duration/day allocated for the data collection. The limitation was overcome by addition of an extra day to the initial scheduled duration to ensure correct and complete data.

CHAPTER THREE

RESULTS

This chapter provides information on final evaluation findings of:

- i. the adolescent and young people's knowledge, attitude and practices of reproductive health
- ii. the gatekeepers knowledge and support for Y-access project
- iii. the service delivery points and
- iv. the interviews conducted for the policy makers

3.1. THE ADOLESCENT AND YOUNG PEOPLE'S KNOWLEDGE, ATTITUDE AND PRACTICES (KAP) OF REPRODUCTIVE HEALTH

Socio-demographic Characteristics of the Adolescent and Young People

The survey population included 1,600 respondents with Male to female ratio of 1.4:1. The predominant age group was 20-24 years (43.6%), followed by 15-19 years (42.8%), with mean age of 18.6 (± 3.5 years). Higher proportion (59.5%) of the study population were Muslims and Hausa/Fulani (57.2%). Overall, above two-third (83.2%) of the respondents are not married.

Table 3.1.1: Socio-demographic characteristics of the respondents

Variables	States				
	Benue	Niger	Jigawa	Katsina	All states
Age group (years)	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)
10-14	50(12.5)	35(8.8)	85(21.2)	48(12.0)	218(13.6)
15-19	199(49.8)	205(51.2)	152(38.0)	128(32.0)	684(42.8)
20-24	151(37.8)	160(40.0)	163(40.8)	224(56.0)	698(43.6)
Sex					
Male	250(62.5)	229(57.2)	222(55.5)	251(62.8)	952(59.5)
Female	150(37.5)	171(42.8)	178(44.5)	149(37.2)	648(40.5)
Religion					
Islam	4(1.0)	267(66.8)	380(95.0)	366(91.5)	1017(63.6)
Christianity	394(98.5)	132(33.0)	20(5.0)	33(8.2)	579(36.2)
Traditional	2(0.5)	1(0.2)	0(0.0)	1(0.2)	4(0.2)
Ethnicity					
Hausa /Fulani	0(0.0)	153(38.2)	382(95.5)	381(95.2)	916(57.2)
Tiv	297(74.2)	5(1.2)	0(0.0)	1(0.2)	303(18.9)
Nupe	0(0.0)	163(40.8)	1(0.2)	4(1.0)	168(10.5)
Idoma	101(25.2)	12(3.0)	6(1.5)	5(1.2)	124(7.8)
Gbagyi	1(0.2)	54(13.5)	9(2.2)	2(0.5)	66(4.1)
Igara	1(0.2)	11(2.8)	1(0.2)	3(0.8)	16(1.0)
Others	0(0.0)	2(0.5)	1(0.2)	4(1.0)	7(0.4)
Marital status					
Not married	363(90.8)	351(87.8)	312(78.0)	306(76.5)	1332(83.2)
Married	379.2)	49(12.2)	88(22.0)	94(23.5)	268(16.8)

How long Respondents have lived in the Community

Percentage distribution of information on how long the respondents have lived in the community are presented in figure 3.1.1. Most respondents have stayed in the communities for over four years (81.5%), followed by 3-4 years (9.2%), 2-3 years (5.0%), 1-2 years (3.4%) and the least were those that had stayed for less than a year (0.9%). This informed their inclusion for the final evaluation

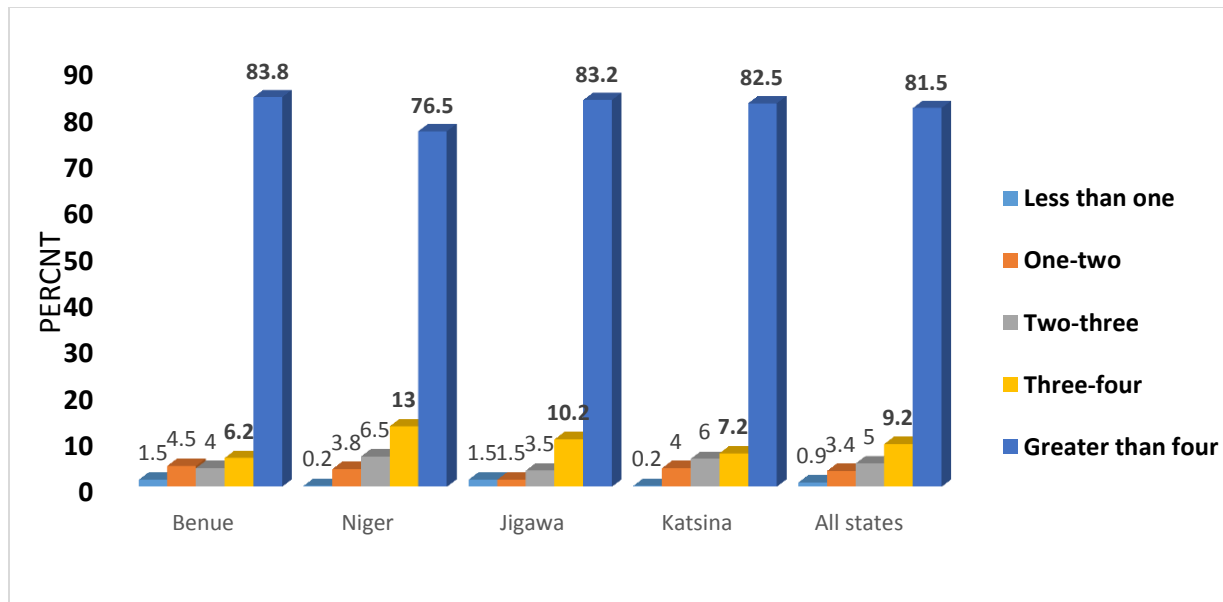


Figure 3.1.1: Percentage distribution of duration of stay in the community

Employment Status of Respondents

Table 3.1.2 shows the percent distribution of employment status of the respondents by states. Majority of the respondents in all the states are not employed. Overall, only one-fifth (20.3%) are employed amongst which artisan predominates (38.8%). In Benue majority of the respondents who are employed are engaged in farming, while in Niger and Katsina most of the respondents are civil servants (44.6% and 32.1% respectively).

Table 3.1.2: Distribution of Respondents by Employment Status and Types of Job

Employment/Type of job	States				
	Benue	Niger	Jigawa	Katsina	All states
Employed	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)	Freq. (%)
Yes	78(19.5)	65(16.2)	126(31.5)	56(14.0)	325(20.3)
No	322(80.5)	335(83.8)	274(68.5)	344(86.0)	1275(79.7)
Type of job					
Artisan	11(14.1)	25(38.5)	61(48.4)	13(23.2)	110(38.8)
Civil servants	13(16.7)	29(44.6)	21(16.7)	18(32.1)	81(.24.9)
Farming	35(44.9)	5(7.7)	17(13.5)	14(25.0)	71(21.8)
Business	16(20.5)	3(4.6)	24(19.0)	9(16.1)	5216.0)
Motorcyclist	3(3.8)	3(4.6)	3(2.4)	2(3.6)	11(3.4)

Educational Status

Table 3.1.3 presents the percentage distribution of respondents by education status shows that majority (96.5%) had ever attended school. The highest level of school attended varies across the states, but overall 45.2% had attended SSS (45.2%).

Table 3.1.3: Level of Education

Variables	States				
	Benue	Niger	Jigawa	Katsina	All States
Ever attended school	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)
Yes	398(99.5)	369(92.3)	391(97.7)	386(96.5)	1544(96.5)
No	2(0.5)	31(7.7)	9(2.3)	14(3.5)	56(3.5)
Highest educational status					
Quaranic	1(0.3)	23(6.2)	37(9.5)	35(9.1)	96(6.2)
Primary	49(12.3)	14(3.8)	69(17.6)	53(13.7)	185(12.0)
JSS	118(29.6)	43(11.7)	84(21.5)	54(14.0)	299(19.4)
SSS	204(51.3)	203(55.0)	151(38.6)	140(36.3)	698(45.2)
OND	5(1.3)	26(7.0)	27(6.9)	36(9.3)	94(6.1)
NCE	16(4.0)	51(13.8)	21(5.4)	53(13.7)	141(9.1)
BSC/HND	5(1.3)	9(2.4)	2(0.5)	10(2.6)	26(1.7)
Others	0(0.0)	0(0.0)	0(0.0)	5(1.3)	5(0.3)

Respondents Currently in School

Table 3.1.4 provide information on respondent's current history of school attendant. Above half of the respondents were in school at the time of the survey and majority of them were in SSS (35.3%)

Table 3.1.4: Respondents who are currently in School and Level

Variable	States				
	Benue	Niger	Jigawa	Katsina	All states
Currently in school	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)
Yes	232 (58.0)	228(57.0)	192(48.0)	214(53.5)	866(54.1)
No	168(42.0)	172(43.0)	208(52.0)	186(46.5)	734(45.9)
Levels					
Quaranic	0(0.0)	4(1.8)	13(6.8)	6(2.8)	23(2.7)
Primary	34(14.7)	2(0.9)	27(14.1)	22(10.3)	85(9.8)
JSS	69(29.7)	45(19.7)	48(25.0)	31(14.5)	193(22.3)
SSS	85(36.6)	104(45.6)	53(27.6)	64(29.9)	306(35.3)
OND	18(7.8)	29(12.7)	24(12.5)	39(18.2)	110(12.7)
Count	10(4.3)	39(17.1)	20(10.4)	35(16.4)	104(12.0)
BSC/HND	16(6.9)	5(2.2)	7(3.6)	17(8.0)	45(5.1)
Total	232(100.0)	228(100.0)	192(100.0)	214(100.0)	866(100.0)

Where Respondents Currently Live

Table 3.1.5 presents the distribution of respondents according to whom they currently live with. Above half of them lived with both parents, followed by those that lived with single parents. Thirteen percent, live alone, 10.8% live with relatives/care givers, 2.9% live with siblings, 2.5% with friends and 1.2% live with partners.

Table 3.1.5: Distribution of whom respondents currently live with

Live with	States				
	Benue	Niger	Jigawa	Katsina	All states
Both parents	238(59.5)	225(56.2)	202(50.5)	204(51.0)	869(54.3)
Single parent	68(17.0)	48(12.0)	74(18.5)	59(14.8)	249(15.6)
Alone	26(6.5)	62(15.5)	50(12.5)	67(16.8)	205(12.8)
Relative/Care giver	42(10.5)	45(11.2)	50(12.5)	35(8.8)	172(10.8)
Sibling	16(4.0)	5(1.2)	16(4.0)	9(2.2)	46(2.9)
Friend	3(0.8)	15(3.8)	8(2.0)	14(3.5)	40(2.5)

Partner	7(1.6)	0(0.0)	0(0.0)	12(3.0)	19(1.2)
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Economic status /livelihood

Figure 3.1.2 and 3.1.3 presents the distribution of respondent's current involvement in income generating activities and the comparism of the current economic status with previous income level. Overall 51.8% of the respondents are currently involved in income generating activities. Amongst the respondents from Benue, those involved in income generating activities constitutes 27.3%, while those in Jigawa, Katsina and Niger constitutes 61.4%, 59.1% and 58.6% respectively. Overall, 64.7% of the respondents opined that their current income level is more as compared to three and half years before the survey, 20.1% were of the opinion that their current income is lower while 15.2% felt their income level remain the same.

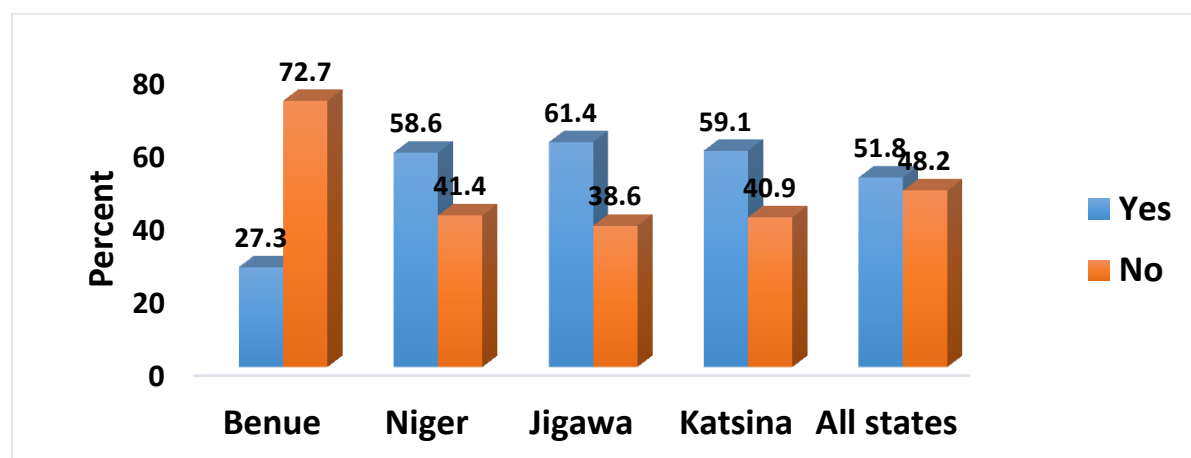


Figure 3: 1.2 Respondents currently involved in income generating activities

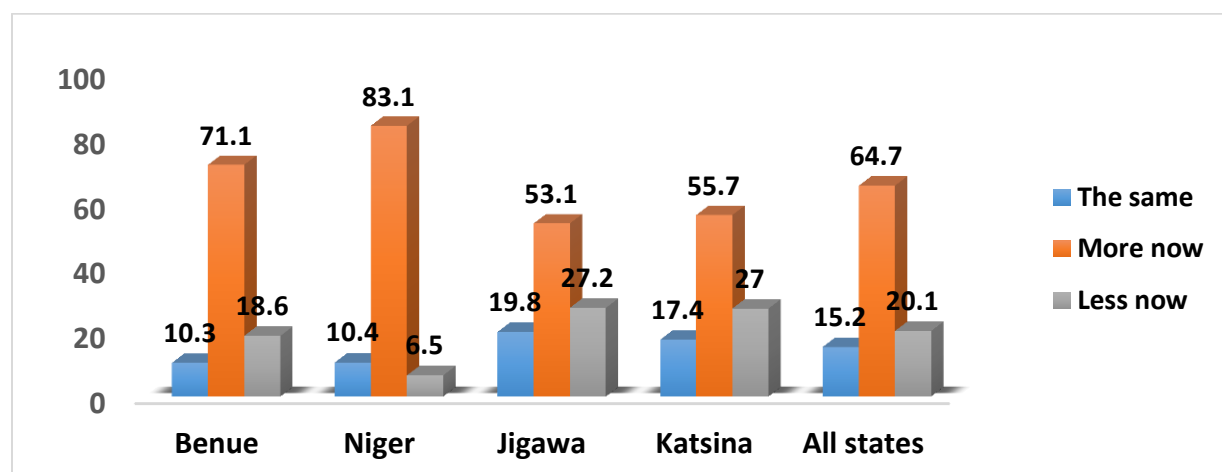


Figure 3.1.3: Percentage distribution of Respondent Present Income level compared with three and half years before survey

Capacity Training/Entrepreneur Skills Received by Respondents between 2012-2016

Figure 3.3.4 is the percent distribution of respondents (by state) who had received any form of capacity training or entrepreneur skills within the period under review. Majority of the activities were among the respondents in Jigawa and Katsina (47.4% and 39.6% respectively). Majority of the respondents in Jigawa (90.4%) and Katsina (70.3%) where capacity training on income generation and entrepreneurship were instituted stated that the skills they obtained from the training helped them in many ways to improve their life. Some of the respondents in Benue (8.2%) received service vouchers from RHS centre in the last three and half years.

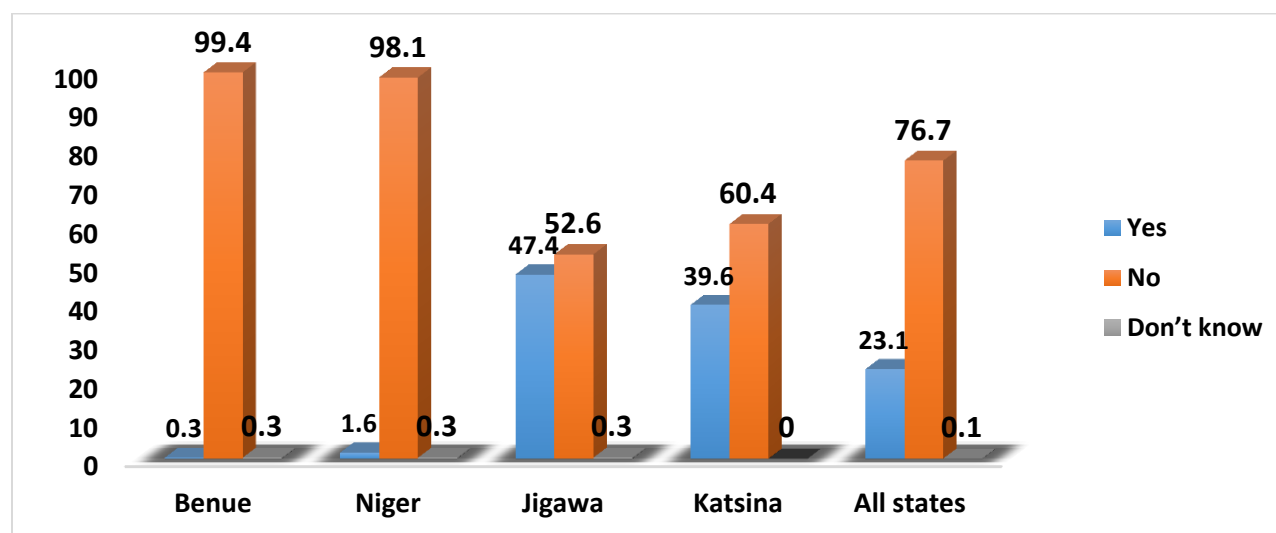


Figure 3.1.4: Distribution of Respondents who had capacity building training under Y-Access project

Membership of corporative group

Figure 3.1.5 shows that majority of respondents who belong to cooperative in Benue and Niger where income generating activities was not implemented did not partake in cooperative group membership activities (91.1% and 97.5% respectively). However, in the community where the IGA was implemented (Jigawa and Katsina states), high proportion of the respondents agreed to have been members of cooperative groups (45.2% and 42.1% respectively) are less than one third (28.8%) and 61.1% of them had never received loan from the cooperatives.

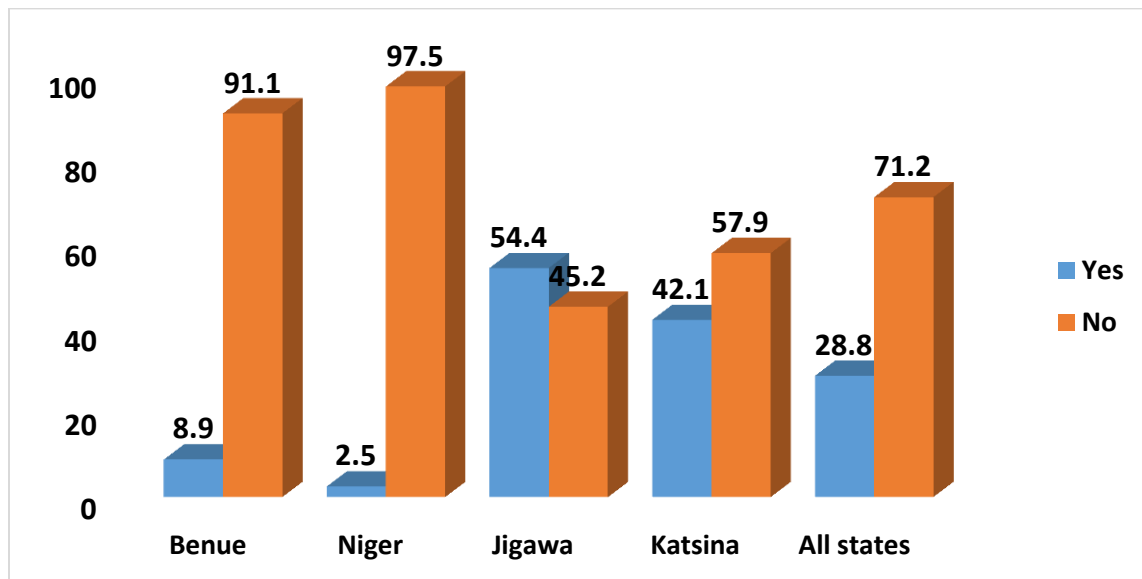


Figure 3.1.5: Respondents membership of cooperative groups

Access to Communication Facilities

Table 3.1.6 presents information on access to mobile phone according to respondents by states. Above half of the respondents in all the states owned a personal mobile phone. Overall 70.9% owned mobile phones but only 30.4% received RHS messages in the past three and half years. Amongst those who had ever received message, the least number of times they had ever received the SMS messages was four times and maximum was eight times with average frequency of four times. More than two-third (73.6%) of the respondents do not discuss RH issues on phone.

Table 3.1.6: Distribution of Respondents Access to mobile phones

Mobile Phones	States				
Personal ownership	Benue	Niger	Jigawa	Katsina	All states
Yes	249(62.2)	294(73.5)	277(69.2)	314(78.5)	1134(70.9)
No	151(37.8)	106(26.5)	123(30.8)	86(21.5)	466(29.1)
Received SMS					
Yes	77(19.2)	125(31.2)	138(34.5)	152(38.0)	492(30.8)
No	323(80.8)	275(68.8)	262(65.5)	248(62.0)	1108(69.2)
Discussed RH issues on phone					
Yes	58(14.5)	111(27.8)	114(28.5)	140(35.0)	423(26.4)
No	342(85.5)	289(72.2)	286(71.5)	260(65.0)	1177(73.6)

Ever Heard of ARH

Figure 3.1.6 presents respondents who have ever heard of ARHS. Overall, 85.1% have ever heard and 14.9% have never heard. Those who have ever heard in Benue (93.5%) were comparatively higher than the respondents in Niger, Jigawa and Katsina states (86.1%, 74.4% and 85.1% respectively).

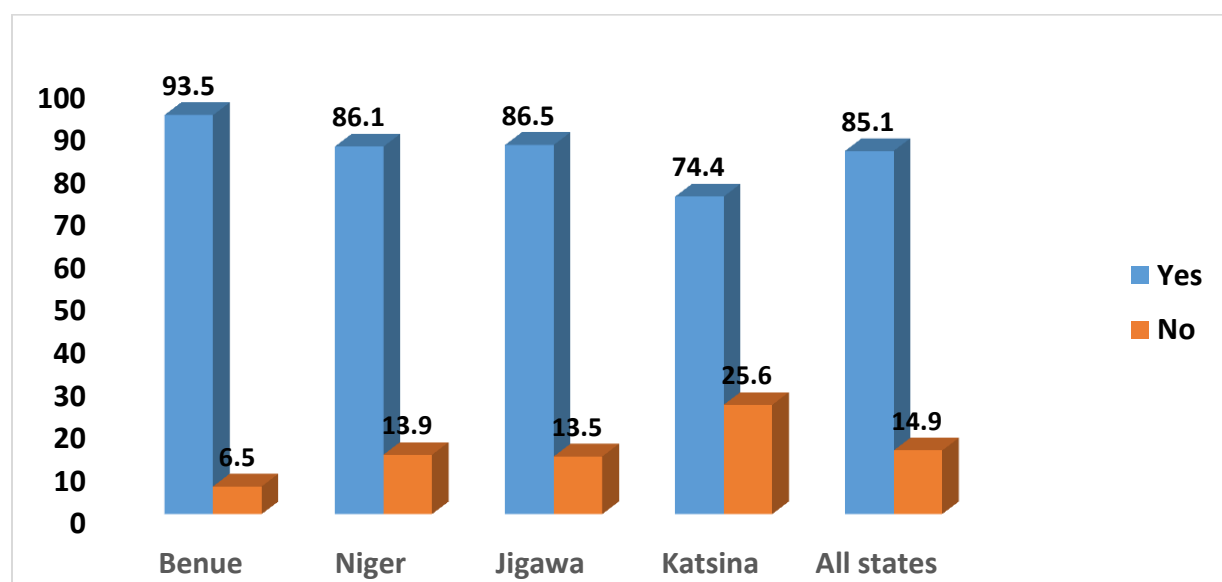


Figure 3.1.6: Percent distribution of Respondents awareness of ARHS

Knowledge of Age at Puberty

Respondent's knowledge of when puberty occurs in girls and boys is presented in figures 3.1.7 and 3.1.8. Seventy eight percent of the respondents stated that puberty occur in girls in less than

15 years and for boys. The mean age of puberty for girls is 13.0 years (± 2.0 years), while that of boys is 15.1 years (± 3.2 year).

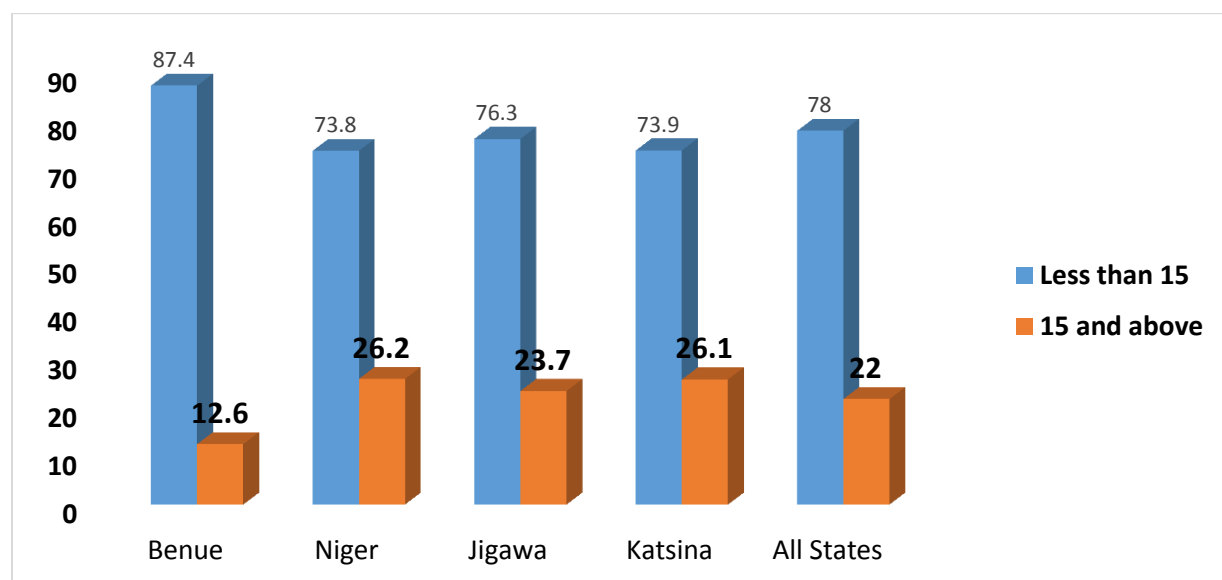


Figure 3.1.7: Respondents knowledge of girl's age of puberty

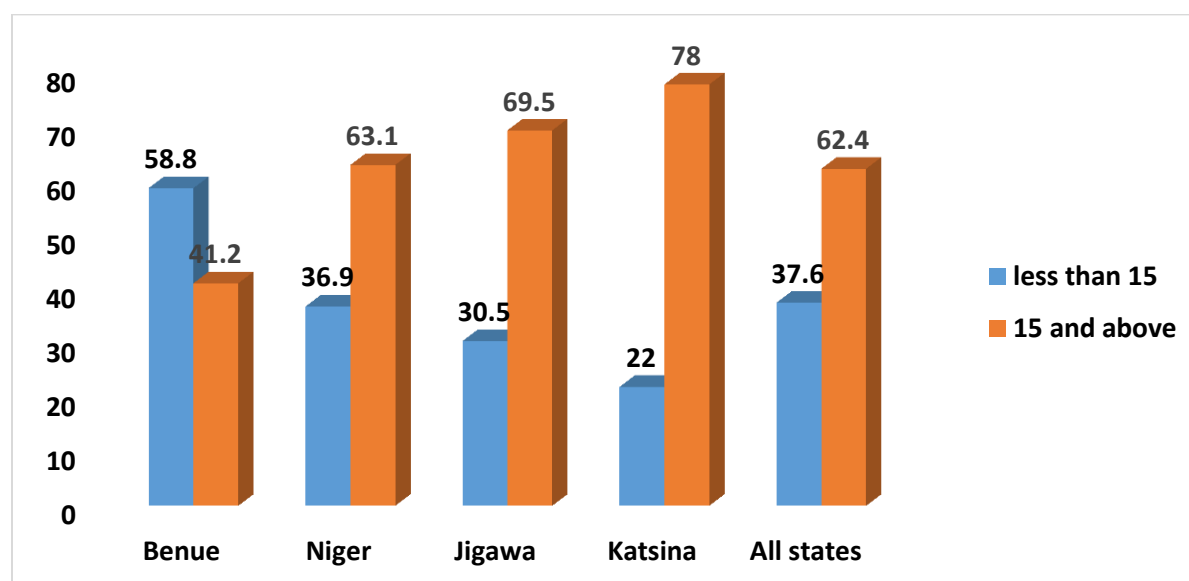


Figure 3.1.8: Respondents knowledge of boy's age of puberty

Body Changes During puberty

Respondent's knowledge of body changes that occur among girls during puberty in Table 3.1.7 shows that high proportion ($\geq 90.0\%$) of the respondents know the body changes that occurs to d girls at puberty.

Table 3.1.7: Respondents knowledge of body changes that take place in girls during puberty

Variable	Benue	Niger	Jigawa	Katsina	All States
Development of breast					
Agree	396(99.0)	387(96.8)	368(97.6)	370(93.9)	1521(96.8)
Disagree	2(0.5)	2(0.5)	4(1.1)	22(5.6)	30(1.9)
Don't Know	2(0.5)	11(2.8)	5(1.3)	2(0.5)	20(1.3)
Onset of Menstruation					
Agree	390(97.5)	379(95.2)	359(95.5)	360(91.4)	1488(94.9)
Disagree	7(1.8)	8(2.0)	4(1.1)	25(6.3)	44(2.8)
Don't Know	3(0.8)	11(2.8)	13(3.5)	9(2.3)	36(2.3)
Pubic Hair					
Agree	394(98.5)	381(95.7)	355(94.2)	356(90.4)	1486(94.7)
Disagree	4(1.0)	8(2.0)	5(1.3)	27(6.9)	44(2.8)
Don't Know	2(0.5)	9(2.3)	17(4.5)	11(2.8)	39(2.5)
Widened hips					
Agree	384(96.0)	363(91.2)	340(90.7)	333(84.5)	1420(90.6)
Don't Know	10(2.5)	22(5.5)	30(8.0)	20(5.1)	82(5.2)
Disagree	6(1.5)	13(3.3)	5(1.3)	41(10.4)	65(4.1)
Acne (Pimples)					
Agree	381(95.2)	368(92.5)	336(89.1)	338(86.0)	1423(90.8)
Don't Know	9(2.2)	21(5.3)	30(8.0)	25(6.4)	85(5.4)
Disagree	10(2.5)	9(2.3)	11(2.9)	30(7.6)	60(3.8)

Table 3.1.8 presents respondent's knowledge of body changes that occur among boys during puberty. Above 90.0% of the respondents know the body changes that occurs to boys and girls at puberty.

Table 3.1.8: Respondents Knowledge of Body Changes that take place in boys during puberty

Variable	Benue	Niger	Jigawa	Katsina	All States
Deepening of voice					
Agree	393(98.5)	395(98.5)	342(91.0)	344(91.2)	1474(94.9)
Don't Know	3(0.8)	4(1.0)	31(8.2)	5(1.3)	43(2.8)
Disagree	3(0.8)	2(0.5)	3(0.8)	28(7.4)	36(2.3)
Penile Enlargement					
Agree	380(95.5)	389(97.2)	290(77.1)	340(90.2)	1399(90.2)
Disagree	6(1.5)	6(1.5)	52(13.8)	28(7.4)	92(5.9)
Don't Know	12(3.0)	5(1.2)	34(9.0)	9(2.4)	60(3.9)
Pubic Hair					
Agree	390(98.0)	383(95.8)	344(91.2)	349(92.6)	1466(94.5)
Don't Know	7(1.8)	8(2.0)	26(6.9)	6(1.6)	47(3.0)
Disagree	1(0.3)	9(2.2)	7(1.9)	22(5.8)	39(2.5)
Broadening of Chest					
Agree	384(96.2)	317(79.4)	156(55.3)	219(58.2)	1076(73.9)
Don't Know	9(2.3)	54(13.5)	72(25.5)	125(33.2)	260(17.9)
Disagree	6(1.5)	28(7.0)	54(19.1)	32(8.5)	120(8.2)
Acne (Pimples)					
Agree	379(95.0)	364(91.0)	331(88.0)	323(85.7)	1397(90.0)
Don't Know	9(2.3)	15(3.8)	13(3.5)	37(9.8)	74(4.8)
Disagree	11(2.8)	21(5.2)	32(8.5)	17(4.5)	81(5.2)

Knowledge of STIs

Many of the respondents (89.6%) have ever heard of STIs but the overall awareness about syphilis (55.1%), gonorrhea (64.2%) was comparably lower than awareness for HIV/AIDS (93.4%).

Table 3.1.9: Respondents Awareness of STIs

Variable	Benue	Niger	Jigawa	Katsina	All States
Ever heard of any sexually transmitted infection STIs					
Yes	378(94.5)	384(95.8)	340(85.2)	331(82.8)	1433(89.6)
No	22(5.5)	17(4.2)	59(14.8)	69(17.2)	167(10.4)
Ever Heard of Syphilis					
No	229(57.2)	252(62.8)	224(56.1)	176(44.0)	881(55.1)
Yes	171(42.8)	149(37.2)	175(43.9)	224(56.0)	719(44.9)
Ever Heard of Gonorrhea					
Yes	292(73.0)	230(57.4)	246(61.7)	259(64.8)	1027(64.2)
No	108(27.0)	171(42.6)	153(38.3)	141(35.2)	573(35.8)
Ever Heard of HIV/AIDS					
Yes	395(98.8)	380(94.8)	367(92.0)	352(88.0)	1494(93.4)
No	5(1.2)	21(5.2)	32(8.0)	48(12.0)	106(6.6)

Knowledge of Features of STIs

Table 3.1.10 presents the percent distribution of respondent's knowledge of signs and symptoms of STIs. Overall, over 70.0% of the respondents understand the major signs and symptoms of STIs. These includes: pain during urination (82.7%), itching around the genitals (78.8%), foul smelling discharge from vagina/penis (79.1%) and genital ulcers (78.8%).

Table 3.1.10: Respondents Knowledge of Features of STIs

Variable	Benue	Niger	Jigawa	Katsina	All States
Foul smelling discharge from penis/vagina					
Yes	316(79.0)	368(91.8)	294(73.7)	287(71.8)	1265(79.1)
Don't Know	71(17.8)	28(7.0)	91(22.8)	87(21.8)	277(17.3)
No	13(3.2)	5(1.2)	14(3.5)	26(6.5)	58(3.6)
Pain during urination					
Yes	364(91.0)	362(90.3)	300(75.2)	297(74.2)	1323(82.7)
Don't Know	30(7.5)	32(8.0)	93(23.3)	71(17.8)	226(14.1)
No	6(1.5)	7(1.7)	6(1.5)	32(8.0)	51(3.2)
Ulcers/Sores around the penis/vagina					
Yes	321(80.2)	316(78.8)	253(63.4)	266(66.5)	1156(72.2)
Don't Know	73(18.2)	72(18.0)	127(31.8)	107(26.8)	379(23.7)
No	6(1.5)	13(3.2)	19(4.8)	27(6.8)	65(4.1)
Itching around the penis/vagina					
Yes	341(85.2)	345(86.0)	277(69.4)	297(74.2)	1260(78.8)
Don't Know	48(12.0)	48(12.0)	103(25.8)	80(20.0)	279(17.4)
No	11(2.8)	8(2.0)	19(4.8)	23(5.8)	61(3.8)

Prevalence of STIs

Table 3.1.11 presents the respondents who had ever experienced symptoms of STIs and medication sourced for. The prevalence of STIs was 20.5%. Among the respondents who had STIs in the past, the commonest health facility service point visited was primary health care centre (70.6%), followed by patent medicine vendors (17.2%), and TBA (5.1%). About seven percent did not sought for any medication.

Table 3.1.11: Prevalence of STIs among Respondents and Medications sought

Variable	Benue	Niger	Jigawa	Katsina	All States
Ever experienced any STI					
No	297(74.2)	258(64.3)	304(76.2)	269(67.2)	1128(70.5)
Yes	103(25.8)	143(35.7)	95(23.8)	131(32.8)	472(29.5)
Medications sought for					
PHC	55(53.4)	106(74.1)	70(73.7)	102(77.9)	333(70.6)
PMV	30(29.10)	24(16.8)	14(14.7)	13(9.9)	81(17.2)
Did nothing	13(12.6)	5(3.5)	5(5.3)	11(8.4)	34(7.2)
TBA	5(4.9)	8(5.6)	6(6.3)	5(3.8)	24(5.1)

Knowledge of methods of prevention of STIs

The respondent's knowledge of prevention of STIs and HIV/AIDS according to selected methods is presented Tables 3.1.12 and 3.1.13. For all STIs, abstaining from sex was highest (65.5%), followed by use of condoms (42.3%) and finally faithfulness to sexual partners (4.9%). On HIV/AIDS majority of the respondents agree with abstaining from sex (93.2%), use of condom (91.8%), not sharing of sharp subjects (91.2%) and avoiding transfusion of unscreened blood (86.8%). Misconception on use of mosquito's nets as method of prevention of HIV among the respondent's was 55.0%

Table 3.1.12: Knowledge of methods of prevention of HIV/AIDS

Methods	Benue	Niger	Jigawa	Katsina	All States
Abstinence	172(43.0)	372(92.8)	269(67.4)	235(58.8)	1048(65.5)
Faithfulness	19(4.8)	43(10.7)	48(12.0)	129(32.2)	239(14.9)
Use of Condoms	284(71.0)	71(17.7)	173(43.4)	149(37.2)	677(42.3)

Table 3.1.13: Methods of prevention of HIV/AIDS

Methods	Benue	Niger	Jigawa	Katsina	All States
Abstinence					
Agree	362(90.5)	397(99.0)	379(95.0)	354(88.5)	1492(93.2)
Don't Know	11(2.8)	4(1.0)	16(4.0)	34(8.5)	65(4.1)
Disagree	27(6.8)	0(0.0)	4(1.0)	12(3.0)	43(2.7)
Use of Condom					
Agree	386(96.5)	384(95.8)	362(90.7)	337(84.2)	1469(91.8)
Disagree	4(1.0)	2(0.5)	7(1.8)	16(4.0)	29
Don't Know	10(2.5)	15(3.7)	30(7.5)	47(11.8)	102
Not sharing of sharp objects					
Agree	382(95.5)	383(95.5)	348(87.2)	346(86.5)	1459(91.2)
Don't Know	8(2.0)	12(3.0)	36(9.0)	36(9.0)	92(5.8)
Disagree	10(2.5)	6(1.5)	15(3.8)	18(4.5)	49(3.1)
Use of Mosquitoes Net					
Disagree	232(58.0)	246(61.3)	213(53.4)	189(47.2)	880(55.0)
Agree	140(35.0)	95(23.7)	100(25.1)	158(39.5)	493(30.8)
Don't Know	28(7.0)	60(15.0)	86(21.6)	53(13.2)	227(14.2)
Rejecting the transfusion of unscreened blood					
Agree	381(95.2)	317(79.1)	345(86.5)	345(86.2)	1388(86.8)
Disagree	9(2.2)	17(4.2)	10(2.5)	10(2.5)	46(2.8)
Don't Know	10(2.5)	67(16.7)	44(11.0)	45(11.2)	166(10.4)

HIV Screening

Figure 3.1.9 presents young people ever been tested for HIV and Obtained Results. About three in five respondents have been tested for HIV (60.1%) and received results compared with 40% who are yet to be tested.

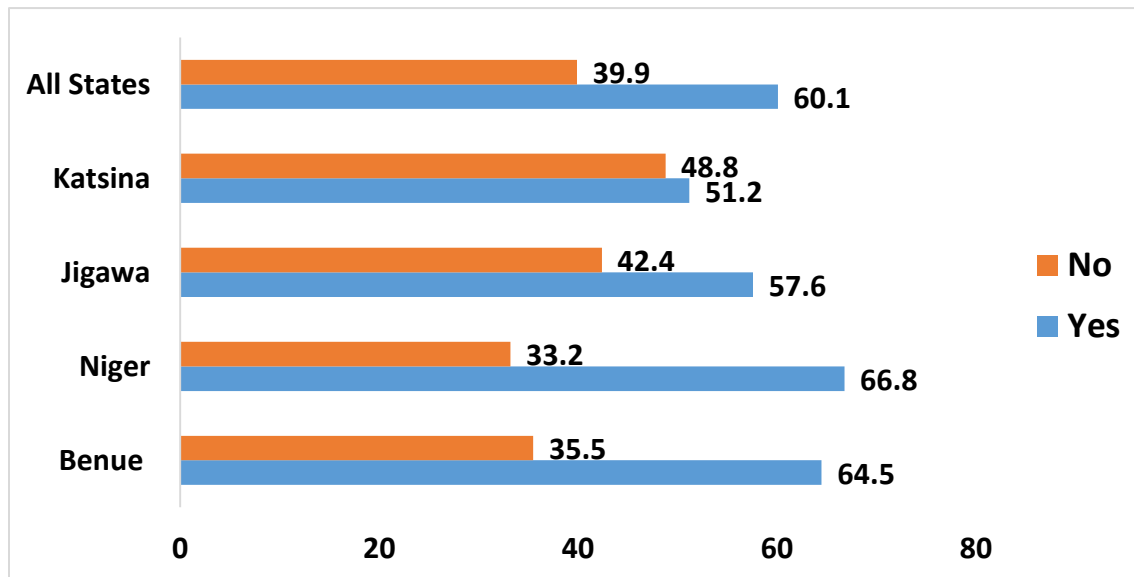


Figure 3.1.9: Percent distribution of respondents who had HCT

Opinion on Possibility to become Pregnant

Approximately 88.0% of young people think it is possible for a young girl to be pregnant the first time she engages in sex with almost all of them (98.0%) with the notion that she is old enough to get pregnant. Of those that think she is will not get pregnant the first time, about 80% think it is because the girl is not yet matured. A similar proportion (87.0%) of respondents feel that a young boy can impregnate a girl the very first time he engages in intercourse with all of them of the belief that the boy is old enough. Of those who think the boy cannot impregnate a girl, they either think the boy is not mature enough or because it is his first time, with the former being the major reason (90.0%).

Table 3.1.14: Distribution of respondent's opinion and reasons of possibility of young people becoming pregnant

Variable	Benue	Niger	Jigawa	Katsina	All States
Is it possible for a girl aged 10-24 to get pregnant the first time she has sex					
Yes	299(74.8)	387(96.5)	350(87.7)	364(91.0)	1400(87.5)
No	101(25.2)	14(3.5)	49(12.3)	36(9.0)	200(12.5)
If yes, why do you think so					
Old Enough to be Pregnant	282(94.3)	387(100.0)	343(98.0)	363(99.7)	1375(98.2)
If she is on her period	17(5.7)	0(0.0)	3(0.9)	1(0.3)	21(1.5)
Because it's her first time	0(0.0)	0(0.0)	4(1.1)	0(0.0)	4(0.3)
If no, explain					
Not yet old enough	68(67.3)	12(85.7)	43(87.8)	35(97.2)	158(79.0)
Because it's her first time	33(32.7)	2(14.3)	6(12.2)	1(2.8)	42(21.0)
Is it possible for a boy aged 10-24 to impregnate a girl the first time he has sex					
Yes	329(82.2)	376(93.8)	340(85.2)	351(87.8)	1396(87.2)
No	71(17.8)	25(6.2)	59(14.8)	49(12.2)	204(12.8)
If yes, why do you think so					
Old enough to impregnate a girl	329(100.0)	376(100.0)	340(100.0)	351(100.0)	1396(100.0)
If no, explain					
Not Yet old Enough	55(77.5)	23(92.0)	54(91.5)	49(100.0)	181(88.7)
Because it's his first time	16(22.5)	2(8.0)	5(8.5)	0(0.0)	23(11.3)

Ways of Preventing Unwanted Pregnancy

Table 3.1.15 shows the knowledge of the youths on family planning methods. Over 90% of the young people know what to do to avoid pregnancy with abstinence, use of condoms, oral pills and Injectables being the major methods with 79%, 75%, 52% and 52% respectively. However, some respondents still believed in the effectiveness of Andrews liver salt (15.4%) and potash (11.2%) in prevention of pregnancy. Many respondents believed that abstinence and condoms are effective in the prevention of teenage pregnancy.

Table 3.1.15: Respondents knowledge of family planning methods

Variable	Benue	Niger	Jigawa	Katsina	All States
Know what to do to avoid unwanted pregnancy					
Yes	369(92.2)	385(96.0)	371(93.0)	346(86.5)	1471(91.9)
No	31(7.8)	16(4.0)	28(7.0)	54(13.5)	129(8.1)
Methods of Preventing Unwanted Pregnancy:					
Abstain from sex	239(59.8)	374(93.3)	323(81.0)	323(80.9)	1259(78.7)
Use of Condom	300(75.0)	301(75.1)	305(76.4)	292(73.0)	1198(74.9)
Use of Oral Pills	229(57.2)	155(38.7)	226(56.6)	216(54.0)	826(51.6)
Injectables	157(39.2)	180(44.9)	233(58.4)	255(63.8)	825(51.6)
Use of Andrews Liver Salts	27(6.8)	43(10.7)	89(22.3)	87(21.8)	246(15.4)
Use of Potash mixed with gin	8(2.0)	60(15.0)	54(13.5)	57(14.2)	179(11.2)
Wash after sex	10(2.5)	35(8.7)	34(8.5)	42(10.5)	121(7.6)
Best Method of Preventing Teenage Pregnancy					
Abstaining from sex until marriage	213(53.2)	376(93.8)	335(84.0)	246(61.5)	1170(73.1)
Use of Condom	187(46.8)	25(6.2)	64(16.0)	154(38.5)	430(26.9)

Masturbation

Percent distribution of respondents who reported about knowledge of masturbation in figure 3.1.10 shows that 56.1% were of the opinion that masturbation cause serious health problems.

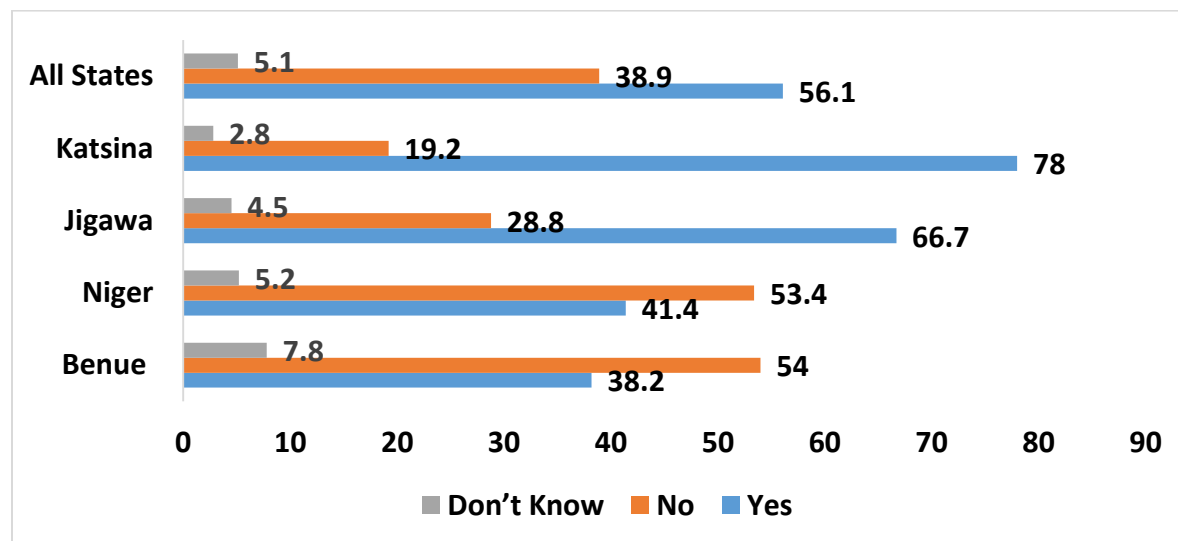


Figure 3.1.10: Percent distribution of Respondents perception of Masturbation

Sexual Abuse

Table 3.1.16 presents the respondents perception of when sexual abuse occurs during sexual intercourse. Just below two thirds of the respondents (61.1%) know that the sexual abuse doesn't occur only when there is penetration of the penis into the vagina.

Table 3.1.16: Respondents perception of when Sexual Abuse occurs during sexual intercourse

Only when there is penetration of the penis into the vagina	Benue	Niger	Jigawa	Katsina	All States
No	277(69.2)	287(71.6)	184(46.1)	229(57.2)	977(61.1)
Yes	101(25.2)	106(26.4)	208(52.1)	162(40.5)	577(36.1)
Don't Know	22(5.5)	8(2.0)	7(1.8)	9(2.2)	46(2.9)

Sources of Information on RH

In the past three and half years before the survey, almost all the respondents preferred accessing RH information's via peer educators

Table 3.1.17: Percent distribution of Sources/preferred sources of Information on RH issues among respondents.

SOURCE OF INFORMATION	Puberty		Drug Abuse		Sexual Abuse		STI		Teenage Pregnancy	
	Source	Preferred	Source	Preferred	Source	Preferred	Source	Preferred	Source	Preferred
RHS Centre	40.0		34.9		34.6		37.4		35.9	
School Teacher	59.0		58.2		54.0		51.1		51.3	
Mother	42.9		40.0		37.1		35.3		41.3	
Father	33.1		40.1		31.7		29.8		31.8	
Siblings	29.7		31.1		26.6		26.3		28.8	
Other family members, school, mate/friends	43.8		41.5		39.4		36.8		38.1	
Health Worker	37.3		41.9		38.4		41.1		38.1	
Radio/Television	40.1		43.8		41.6		40.1		38.6	
Poster or Handbill	42.0		46.0		41.0		41.1		38.3	
Phone	22.8		24.8		25.4		24.4		24.7	
Chemist Shop/Pharmacy	23.9		26.8		22.0		23.6		22.4	
TBA	21.3		22.4		21.1		21.6		23.3	
Peer Educator	72.2	**	73.1	**	69.9	**	73.6	**	72.0	**

Key: ** Preferred source of Information on RH issues among respondents.

Family life and HIV education

Over sixty percent of young people have attended a class in secondary school sometimes called Family Life and HIV Education (FLHE), where issues of puberty, boy-girl relationships, sexual abuse, pregnancy and drug abuse are discussed. More than two-third (79.0%) of the respondents who had ever attended the FLHE consider it very useful.

Table 3.1.18: Distribution of respondents who had ever attended FLHE schools

Variable	Benue	Niger	Jigawa	Katsina	All States
Ever attended a class in school on Family Life and HIV Education (FLHE)					
Yes	246(61.5)	238(59.4)	321(80.5)	227(56.8)	1032(64.5)
No	154(38.5)	163(40.6)	78(19.5)	173(43.2)	568(35.5)
Was Class Useful					
Very Useful	186(75.6)	226(95.0)	212(66.0)	191(84.1)	815(79.0)
Useful	60(24.4)	9(3.8)	104(32.4)	35(15.4)	208(20.2)
Not Useful	0(0.0)	3(1.3)	5(1.6)	1(0.4)	9(0.9)

Attitude to Reproductive Health

Table presents the percent distribution of Respondents towards Reproductive Health. Majority of the respondents are of the opinion that abstinence is the best way to prevent STIs. Regarding use of contraceptives, 68.1% opined that young people between 10-15 years should use, while above two-third opined that those between 16-19(75.5%), 20-24(78.9%) should use respectively. More than half (57.6%) disagrees with a boy/girl forcing the sexual partner for sexual intercourse, and 70.5% disagree with the idea of hitting a boyfriend or girlfriend

Table 3.1.19: Percent distribution of Respondents attitude towards Reproductive Health

Attitude	Benue	Niger	Jigawa	Katsina	All States
Abstinence is the best way to prevent teenage pregnancy and STIs					
Agree	91.5	97.7	93.4	95.5	94.5
Disagree	5.8	1.5	3.6	0.8	2.9
Don't know	2.8	0.8	3.0	3.8	2.6
Young people between ages 10 - 15 who are sexually active should use contraception					
Agree	69.7	76.2	66.9	59.8	68.1
Disagree	23.3	17.8	26.8	24.0	23.0
Don't know	7.0	6.0	6.3	16.2	8.9
Young people between ages 16 - 19 who are sexually active should use contraception					
Agree	83.0	78.2	74.9	65.9	75.5
Disagree	10.5	16.0	19.0	19.3	16.2
Don't know	6.5	5.5	6.1	14.8	8.2
Young people between ages 20-24 who are sexually active should use contraception					
Agree	87.5	86.2	72.2	69.4	78.9
Disagree	6.8	9.8	21.0	17.7	13.8
Don't know	5.8	4.0	6.8	12.9	7.4
A boy/girl has to force a girl/boy to have sex if he/she loves her/him					
Agree	15.0	36.8	38.8	54.2	36.2
Disagree	80.7	57.4	50.6	41.5	57.6
Don't know	4.3	5.8	10.6	4.2	6.2
It is sometimes justifiable for a boy to hit his girlfriend					
Agree	12.8	18.0	36.7	27.2	23.6
Disagree	83.2	77.2	54.2	67.3	70.5
Don't know	4.0	4.8	9.1	5.6	5.9
It's OK for a Boy/Girl to have sex with more than one person at a time if they love them					
Agree	6.5	12.6	30.0	27.6	19.1
Disagree	88.0	78.9	47.6	64.2	69.7
Don't know	5.5	8.5	22.4	8.3	11.2
When a man gives gifts to a girl he has the right to ask for sexual intercourse					
Agree	14.5	13.3	41.5	19.0	22.0
Disagree	79.2	81.7	36.7	72.9	67.7
Don't know	6.3	5.0	21.8	8.0	10.2

Table 3.1.20: Percent distribution of Respondents towards Use of condoms and abstinence

More than half (53.0%) of the respondents believed that it is unfair to deny boyfriend or girlfriend sexual intercourse, 50.4% consider buying of condoms embarrassing, 43.0% consider use of condom a displeasure.

Table 3.1.20: Percent distribution of Respondents perception towards condom use

Variable	Benue	Niger	Jigawa	Katsina	All States
If you have a boyfriend/girlfriend, it is unfair to keep saying NO to sexual intercourse					
Agree	23.3	32.1	38.2	40.2	33.4
Disagree	64.9	60.2	38.5	48.5	53.0
Don't know	11.8	7.8	23.3	11.3	13.5
It is too embarrassing for me to buy condoms/contraceptives					
Agree	29.3	27.9	48.0	62.7	42.0
Disagree	63.9	66.6	40.2	30.8	50.4
Don't know	6.8	5.5	11.9	6.5	7.7
If a girl suggest use of condom, it would mean she didn't trust him and vice versa					
Agree	33.9	29.6	54.2	49.4	41.7
Disagree	57.0	63.9	29.4	39.3	47.5
Don't know	9.0	6.5	16.5	11.3	10.8
Condoms reduce sexual pleasure					
Agree	39.5	38.8	49.7	43.9	43.0
Disagree	34.0	41.1	23.0	20.3	29.6
Don't know	26.4	20.1	27.3	35.8	27.4
It is impossible to abstain if you are already having sex					
Agree	33.8	30.8	47.5	39.9	38.0
Disagree	51.4	52.1	28.8	23.4	38.9
Don't know	14.8	17.0	23.7	36.7	23.1

A higher proportion (45.0%) of the respondents disagree that they are not at risk of contracting STIs including HIV/AIDS and slightly above half (51.1%) disagree that it is only those who are sexually promiscuous that sands the risk of contracting STI.

Table 3.1.21: Percent distribution of Respondents Risk perception of STIs

Variable	Benue	Niger	Jigawa	Katsina	All States
Only sexually promiscuous persons can get STIs					
Agree	19.5	36.1	44.2	35.5	33.8
Disagree	70.9	57.9	31.7	43.7	51.1
Don't know	9.5	6.0	24.1	20.8	15.1
I am not at risk for contracting HIV or STI					
Agree	34.0	43.1	32.7	48.6	39.6
Disagree	58.9	46.4	40.4	34.3	45.0
Don't know	7.1	10.5	26.9	17.1	15.4

Drug Abuse

A higher proportion of the respondents who take alcohol are from Benue (23.4%) while Katsina has higher proportion of the respondent's that smokes cigarette (11.2%). Overall, less than a tenth of the respondents smoke cigarette (7.4%) and or takes alcohol (8.9%).

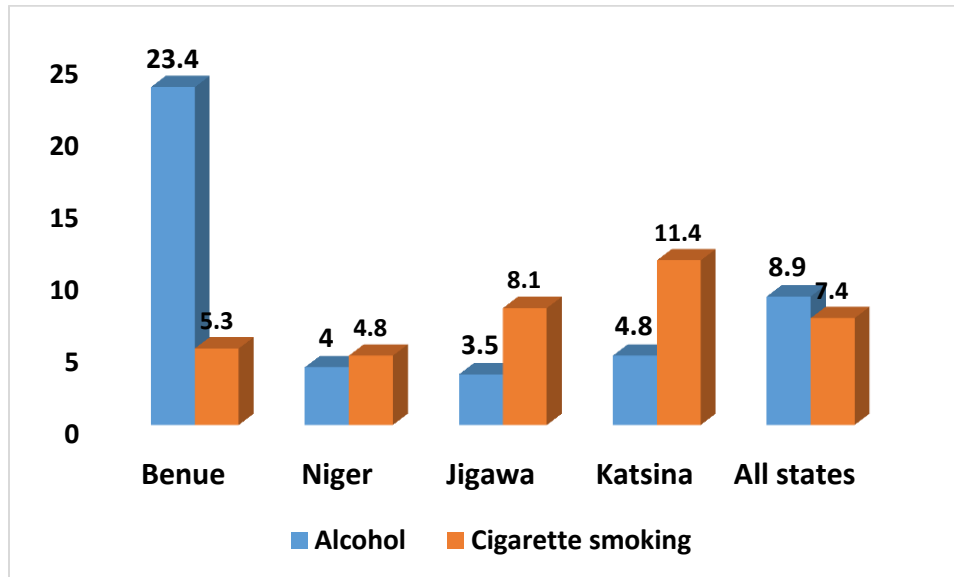


Figure 3.1.11: History of Drug Abuse

History of Sex

Table 3.1.22 provides an overview adolescent and young people's history of sex. Higher proportion (71.9%) of the respondents have never had sex. Among those that had sex, respondents from Benue constitutes the highest (51.3%) and majority (83.6%) of those who had sex had it when there were between 15-20 years old, with mean age of 17 (\pm 2.6) years. Overall, the persons the respondents had sex with were young persons in secondary school (12.3%), spouses (6.4%), young persons out of school (4.3%), university students (2.9%), adults in residential areas (2.3%), relatives/family members/family friends (1.5%) and teachers (0.3%). Sexual intercourse among the respondent's in the last 12 months before the survey reduced by 3.1% against the overall life time history of experience of sexual intercourse.

Table 3.1.22: Sex and age at first sex

Sex/Age	Benue	Niger	Jigawa	Katsina	All states
Ever had sex					
Yes	205(51.3)	104(26.0)	57(14.3)	84(21.0)	450((28.1)
No	195(48.7)	296(74.0)	343((85.7)	316(79.0)	1150(71.9)
Age at first sex (years)					
9-14	29(14.1)	9(8.7)	5(8.8)	11(13.1)	54(12.0)
15-22	167(81.5)	92(88.5)	50(87.7)	68(81.0)	377(83.6)
≥21	9(4.4)	3(2.9)	2(3.5)	5(6.0)	19(4.2)
Sex in last 12 months					
Yes	174(43.5)	90(22.5)	63(15.8)	73(18.2)	400(25.0)
No	226(56.5)	310(77.5)	337(84.2)	327(81.8)	1200(75.0)

Use of Contraception

Table 3.1.23 presents the percent distribution of respondents who used different methods of contraception to prevent pregnancy and or STIs. Of 412 respondents, 59.2% used a method of contraception and 40.8% did not use any method.

Table 3.1.23: Methods of Contraception

Contraception used	Benue	Niger	Jigawa	Katsina	All states
Yes	134(71.7)	61(67.0)	31(51.7)	18(24.3)	244(59.2)
No	53(26.3)	30(33.0)	29(48.3)	56(75.7)	168(40.8)
Methods					
Condoms	124(93.2)	47(87.0)	25(80.6)	10(66.7)	206(88.4)
Oral contraceptive	5(3.8)	4(7.4)	2(6.5)	2(13.3)	13(5.6)
Injectables	1(0.8)	1(1.9)	3(9.7)	2(13.3)	7(3.0)
Withdrawal	3(2.3)	0(0.0)	1(3.2)	1(6.7)	5(2.1)
Safe period	0(0.0)	2(3.7)	0(0.0)	0(0.0)	2(0.9)
Frequency of condom use					

Use of Condom in Last Sex

Figure 3.1.12 shows that majority (60.2%) of those who use condom during sexual intercourse used it always, 24.3% use it sometimes and 15.5% use condom most of the time. Highest proportion of the respondents get condoms from chemist/pharmacy (53.0%), followed by PHC (19.0%), peer educators, (18.8%) and the least was TBAs (8.1%). The average amount paid for condom is fifty naira only.

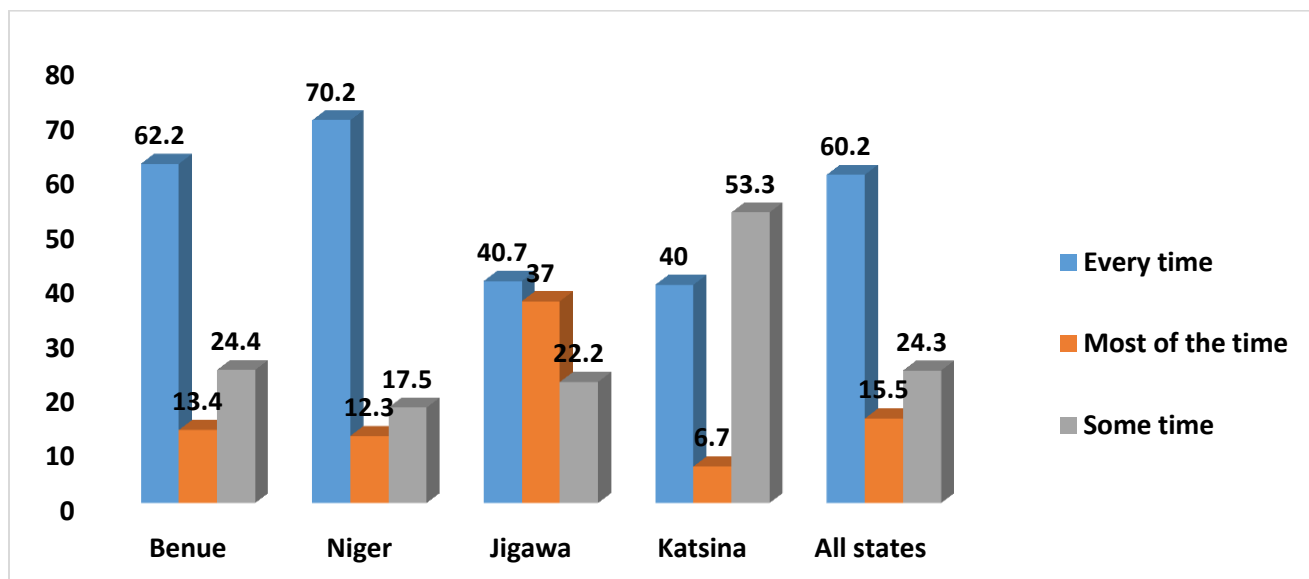


Figure 3.1.12: Condom use among those who had sex

History of Pregnancy

Percent distribution of history of female who had been pregnant or males who had impregnated a female from 2012-2016 shows 9.8%. Overall, the respondents between 20-24 years constitutes the highest proportion (17.2%), and the least were respondents 10-14 years (0.9%).

Table 3.1.24: Percent distribution of pregnancy 2012-2013

Age (years)	Pregnancy or impregnate someone	Benue	Niger	Jigawa	Katsina	All states
10-24						
	Yes	37(9.2)	31(7.8)	39(9.8)	50(12.5)	157(9.8)
	No	363(90.8)	369(92.2)	361(90.2)	350(87.5)	1443(90.2)
10-14	Yes	1(2.0)	0(0.0)	0(0.0)	1(2.1)	2(0.9)
	No	49(98.0)	35(100.0)	85(100.0)	47(97.0)	216(99.1)
	Total	50(100.0)	35(100.0)	85(100.0)	48(100.0)	218(100.0)
15-19	Yes	7(3.5)	9(4.4)	9(5.9)	10(7.8)	35(5.1)
	NO	192(96.5)	196(95.6)	143(94.1)	118(92.2)	649(94.9)
	Total	199(100.0)	205(100.0)	152(100.0)	128(100.0)	684(100.0)
20-24	Yes	29(19.2)	22(13.8)	30(18.4)	39(17.4)	120(17.2)
	No	122(80.8)	138(86.2)	133(81.6)	185(82.6)	578(82.8)
	Total	151(100.0)	160(100.0)	163(100.0)	224(100.0)	698(100.0)

Behavioural Intentions

Table 3.1.25 presents the behavioural intentions of young people in the future. More than three fourth of the respondents are unlikely to take alcohol (79.0%) or smoke cigarettes (82.9%) while over half (60.6%) of respondents are unlikely to have sex with more than one partner or use any form of contraception in the next two months. Slightly above one fifth (23.2%) of the respondents are likely to talk to their guardians about sexual health issues, and above one-thirds (39.6%) are likely to visit any PHC to access RH services in the next two months.

Table 3.1.25: Behavioural Intentions

Variable	Benue	Niger	Jigawa	Katsina	All States
You will drink alcohol in the next two months					
Unlikely	315(78.8)	342(85.3)	242(60.7)	365(91.2)	1264(79.0)
Unsure	15(3.8)	46(11.5)	141(35.3)	26(6.5)	228(14.2)
Likely	70(17.5)	13(3.2)	16(4.0)	9(2.2)	108(6.8)
You will smoke cigarettes the next two months					
Unlikely	379(94.8)	345(86.0)	234(58.6)	358(89.5)	1316(82.2)
Unsure	10(2.5)	44(11.0)	140(35.1)	13(3.2)	207(12.9)
Likely	11(2.8)	12(3.0)	25(6.3)	29(7.2)	77(4.8)
You will have sex in the next two months					
Unlikely	227(56.8)	263(65.6)	163(40.0)	317(79.2)	970(60.6)
Likely	132(33.0)	59(14.7)	77(19.3)	61(15.2)	329(20.6)
Unsure	41(10.2)	79(19.7)	159(39.8)	22(5.5)	301(18.8)
You will use contraception when next you have sex					
Unlikely	234(58.5)	152(37.9)	139(34.8)	336(84.0)	861(53.8)
Likely	141(35.2)	203(50.6)	71(17.8)	49(12.2)	464(29.0)
Unsure	25(6.2)	46(11.5)	189(47.4)	15(3.8)	275(17.2)
You will have sex with more than one person in the next two months					
Unlikely	336(84.0)	310(77.3)	187(46.9)	359(89.8)	1192(74.5)
Unsure	19(4.8)	67(16.7)	189(47.4)	24(6.0)	299(18.7)
Likely	45(11.2)	24(6.0)	23(5.8)	17(4.2)	109(6.8)
You will talk to your parents or guardians about sexual health issues in the next two months					
Unlikely	202(50.5)	227(56.6)	147(36.8)	252(63.0)	828(51.8)
Unsure	25(6.2)	124(30.9)	187(46.9)	65(16.2)	401(25.1)
Likely	173(43.2)	50(12.5)	65(16.3)	83(20.8)	371(23.2)
You will visit the PHC to access RH services in the next two months					
Unlikely	165(41.2)	144(35.9)	165(41.4)	164(41.0)	638(39.9)
Likely	204(51.0)	119(29.7)	127(31.8)	183(45.8)	633(39.6)
Unsure	31(7.8)	138(34.4)	107(26.8)	53(13.2)	329(20.6)

Access, Utilization of Reproductive Health Services

The table 3.1.26 below shows the access and utilization of reproductive health services and parental support. About 73.0% of the respondents had visited a facility that offers reproductive health services in the past three and half years. Those who had never visited a SDP constitutes less than one-third (27.0%) Four out of five of them accessed a government facility or a primary health care centre with pharmacies and chemists coming a distant second at 10%. About 55% of young people accessed HIV Testing, Counseling and Contraception services at the facilities visited while about 10% of respondents accessed more than one service at the facility.

Table 3.1.26: Distribution of RHS accessed by Respondents

Variable	Benue	Niger	Jigawa	Katsina	All States
Visited health Facility for RHS in the past 3 ½ years					
Yes	310(77.5)	291(72.6)	256(64.2)	311(77.8)	1168(73.0)
No	90(22.5)	110(27.4)	143(35.8)	89(22.2)	432(27.0)
where the service were accessed					
PHC/GH	69(76.7)	102(92.7)	117(81.8)	71(79.8)	359(83.1)
Chemist/Pharmacy	18(20.0)	6(5.5)	11(7.7)	10(11.2)	45(10.4)
TBA	0(0.0)	2(1.8)	10(7.0)	1(1.1)	13(3.0)
Herbal Medicine Home	2(2.2)	0(0.0)	3(2.1)	5(5.6)	10(2.3)
Others	1(1.1)	0(0.0)	2(1.4)	2(2.2)	5(1.2)
Type of Services Offered					
HIV Test	33(36.7)	36(32.7)	34(23.8)	6(6.7)	109(25.2)
Counseling	12(13.3)	8(7.3)	31(21.7)	22(24.7)	73(16.9)
Contraception	11(12.2)	9(8.2)	25(17.5)	16(18.0)	61(14.1)
Accessed more than one service	3(3.3)	19(17.3)	16(11.2)	7(7.9)	45(10.4)
Condoms	14(15.6)	8(7.3)	9(6.3)	4(4.5)	35(8.1)
Pregnancy Test	2(2.2)	11(10.0)	8(5.6)	13(14.6)	34(7.9)
Minor Ailments	3(3.3)	13(11.8)	8(5.6)	8(9.0)	32(7.4)
STIs treatment	11(12.2)	4(3.6)	9(6.3)	6(6.7)	30(6.9)
Child Immunization	0(0.0)	0(0.0)	0(0.0)	6(6.7)	6(1.4)
Antenatal	0(0.0)	2(1.8)	2(1.4)	1(1.1)	5(1.2)
Miscarriage	1(1.1)	0(0.0)	1(0.7)	0(0.0)	2(0.5)

Fees Paid for Services

Close to 90% of the contraceptive services were provided free of charge with less than 1% paying N50 and above for the service. The price for those that paid for other services was usually less than N5000 (more than 90%) with 65% of them paying less than N1000

Table 3.1.27: Amount Paid Per Services Accessed

Amount (₦)		Benue	Niger	Jigawa	Katsina	All States
Contraceptive Services						
Free		47(87.0)	93(89.4)	113(85.6)	75(98.7)	328(89.6)
21-30		4(7.4)	6(5.8)	12(9.1)	1(1.3)	23(6.3)
41-50		3(5.6)	5(4.8)	4(3.0)	0(0.0)	12(3.3)
50 an above		0(0.0)	0(0.0)	3(2.3)	0(0.0)	3(0.8)
Other services						
< 1000		18(51.4)	5(100.0)	15(83.3)	3(60.0)	41(65.1)
1000 – 5000		15(42.9)	0(0.0)	2(11.1)	1(20.0)	18(28.6)
> 5000		2(5.7)	0(0.0)	1(5.6)	1(20.0)	4(6.3)

IEC Materials at SDP

Four out of every five youths were given educational materials to take home and 97% of the respondents felt they could discuss their concerns with the service providers.

Table 3.1.28: IEC materials at SDPs

IEC	Benue	Niger	Jigawa	Katsina	All States
Saw any posters about young peoples' health in the facility					
Yes	83(92.2)	107(97.3)	141(98.6)	84(94.4)	415(96.1)
No	7(7.8)	3(2.7)	2(1.4)	5(5.6)	17(3.9)
Given Educational materials to take home					
Yes	42(46.7)	105(95.5)	128(89.5)	70(78.7)	345(79.9)
No	48(53.3)	5(4.5)	15(10.5)	19(21.3)	87(20.1)

Perception of Young People about Service Providers

More often than not, service providers spoke respectfully with their clients (97.7%) and 95% of the respondents like the services that they were offered. The common reasons given for the love for the services were that the services were youth friendly (73%), the staffs were knowledgeable about the services offered (10%) and the facility was accessible (7%). For those who did not like the services offered, most of them felt that the services were not youth friendly(86.4%) or were not accessible (9.1%).

Table 3.1.29: Perception of young people about service providers

Variables	Benue	Niger	Jigawa	Katsina	All States
Felt Comfortable discussing your concerns with the service providers					
Yes	81(90.0)	110(100.0)	141(98.6)	85(95.5)	417(96.5)
No	9(10.0)	0(0.0)	29(1.4)	4(4.5)	15(3.5)
Service providers spoke to you respectfully and privately					
Yes	85(94.4)	110(100.0)	141(98.6)	86(96.6)	422(97.7)
No	5(5.6)	0(0.0)	29(1.4)	3(3.4)	10(2.3)
Liked the services offered					
Yes	86(95.6)	105(95.5)	137(95.8)	82(92.1)	410(94.9)
No	4(4.4)	5(4.5)	6(4.2)	7(7.9)	22(5.1)
Why did you like the services					
Youth friendly	68(79.1)	60(57.1)	108(78.8)	63(76.8)	299(72.9)
Knowledgeable staff	5(5.8)	22(21.0)	7(5.1)	7(8.5)	41(10.0)
Accessible	11(12.8)	8(7.6)	6(4.4)	3(3.7)	28(6.8)
Privacy	2(2.3)	13(12.4)	5(3.6)	5(6.1)	25(6.1)
Others	0(0.0)	2(1.9)	11(8.0)	4(4.9)	17(4.1)
Why did you not like the place					
Not Youth friendly	4(100.0)	5(100.0)	4(66.7)	6(85.7)	19(86.4)
Not Accessible	0(0.0)	0(0.0)	1(16.7)	1(14.3)	2(9.1)
No Knowledgeable staff	0(0.0)	0(0.0)	1(16.7)	0(0.0)	1(4.5)

Recommendation of Y-Access Facilities to other Young People

A large number of the respondents (96.3%) will recommend to their friends to attend SRH services offered by y-access supported facilities with 80.1% of them giving a strong recommendation. For the few who will not recommend y-access-supported facilities to a friend, most of them felt that the services lack youth friendliness (52.9%) or privacy (35.3%)

Table 3.1.30: Respondents opinion concerning recommendation of Y-Access facilities to others

Variables	Benue	Niger	Jigawa	Katsina	All States
Would you recommend a friend to go for SRH services in facilities supported by ARFH					
Strongly Recommend	59(65.6)	101(91.8)	111(77.6)	75(84.3)	346(80.1)
Recommend	26(28.9)	9(8.2)	28(19.6)	7(7.9)	70(16.2)
Not Recommend	1(1.1)	0(0.0)	3(2.1)	4(4.5)	8(1.9)
Don't know	3(3.3)	0(0.0)	0(0.0)	2(2.2)	5(1.2)
No Response	1(1.1)	0(0.0)	1(0.7)	1(1.1)	3(0.7)
Why would you not recommend a friend for SRH services in facilities supported by ARFH					
Not Youth friendly	0(0.0)	3(100.0)	2(40.0)	4(57.1)	9(52.9)
No Privacy	2(100.0)	0(0.0)	2(40.0)	2(28.6)	6(35.3)
Not Accessible	0(0.0)	0(0.0)	0(0.0)	1(14.3)	1(5.9)
No Knowledgeable staff	0(0.0)	0(0.0)	1(20.0)	0(0.0)	1(5.9)

Perception of Parents Support for Y-Access Programme

About four out of every five respondents opined that their parents and the elders/ in the community support the adolescent and young people's use of RH services. Over half of the respondents were of the pinion that parents of adolescent and young people in their communities discuss RH issues with their children; with about two thirds discussing STIs, drug abuse and teenage pregnancy. Most parents/guardians shied away from discussing sexual abuse, puberty and abortion with their children.

Table 3.1.31: Young people's perception of parents support for Y-Access program

Variables	Benue	Niger	Jigawa	Katsina	All States
Parents/elders in the community support ARH in the past 3 ½ years					
Yes	323(80.8)	345(86.0)	320(80.2)	313(78.2)	1301(81.3)
No	77(19.2)	56(14.0)	79(19.8)	87(21.8)	299(18.7)
Do your parents support your use of RH services					
Yes	318(79.5)	313(78.1)	313(78.4)	332(83.0)	1276(79.8)
No	82(20.5)	88(21.9)	86(21.6)	68(17.0)	324(20.2)
Parents ever discussed sex related matters with you					
No	191(47.8)	207(51.6)	196(49.1)	269(67.2)	863(53.9)
Yes	209(52.2)	194(48.4)	203(50.9)	131(32.8)	737(46.1)
If yes, list the RH issues					
STIs	43(30.1)	106(53.3)	50(23.8)	41(29.7)	240(31.5)
Drug Abuse	15(7.0)	30(15.1)	78(37.1)	28(20.3)	151(19.8)
Teenage Pregnancy	32(15.0)	34(17.1)	27(12.9)	10(7.2)	103(13.5)
Contraception	49(22.9)	13(6.5)	8(3.8)	9(6.5)	79(10.4)
Abstinence	46(21.5)	3(1.5)	5(2.4)	5(3.6)	59(7.8)
Sexual Abuse	9(4.2)	1(0.5)	32(15.2)	13(9.4)	55(7.2)
Puberty	10(4.7)	11(5.5)	10(4.8)	14(10.1)	45(5.9)
Abortion	10(4.7)	1(0.5)	0(0.0)	18(13.0)	29(3.8)

3.2: GATEKEEPER

Contextual Factors for Adolescent and Young People's Reproductive Health

In the conceptual framework of the final evaluation, the gatekeepers forms the contextual factors (individual/community, peer groups/partners, families/households, and gatekeepers) which are presumed to have significant influence on the SRH behaviour of the adolescent and young people (the antecedents). The Y-Access programme is expected to have positive influence on the gatekeepers thereby producing an enabling environment that will enhance the young people's utilization of the established youth friendly centers. The gatekeepers are also assumed to influence behavioural outcomes like abstinence, reduction of number of sexual partners, use of condom/other modern contraception and health seeking behaviours. Improved young people's behaviour will in turn lead to improved health. This section represents socio-demographic characteristics of the gatekeepers, knowledge features of the gatekeepers, perception of SRH issues of young people in their communities and their level of support to youth access to SRH information and services.

Socio-demographic Information

Table 3.2.1 shows the socio-demographic characteristics of the gatekeepers of the communities evaluated. It shows that 73.2% of respondents were male while just over a quarter of the respondents (26.8%) of the respondents were female with Benue having the highest proportion of females (39%). About 20% of the gatekeepers have an NCE. Those without any form of education whatsoever were 3.2% while only 2.2% had a postgraduate degree. The percentage of those that only have a Senior Secondary School Certificate and those with a Bachelor's Degree/HND were almost equal (18% and 17% respectively). Over a third of the gatekeepers are civil servants being followed closely by farmers (31%).

Table 3.2.1: Socio-demographics of Gatekeepers

	Benue (n=100)	Niger (n=100)	Jigawa (n=100)	Katsina (n=100)	All(n=400)
Sex					
Male	61(61.0)	71(71.0)	83(83.0)	78(78.0)	293(73.2)
Female	39(39.0)	29(29.0)	17(17.0)	22(22.0)	107(26.8)
Education					
No education	4(4.0)	9(9.0)	0(0.0)	0(0.0)	13(3.2)
Quaranic	1(1.0)	21(21.0)	30(30.0)	15(15.0)	67(16.6)
Primary	9(9.0)	11(11.0)	9(9.0)	7(7.0)	36(9.0)
JSS	3(3.0)	1(1.0)	6(6.0)	1(1.0)	11(2.8)
SSS	16(16.0)	19(19.0)	14(14.0)	21(21.0)	70(17.5)
OND	16(16.0)	5(5.0)	9(9.0)	14(14.0)	44(11.0)
NCE	27(27.0)	17(17.0)	19(19.0)	18(18.0)	81(20.2)
BSC/HND	23(23.0)	16(16.0)	12(12.0)	18(18.0)	69(17.2)
MSC/PGD	1(1.0)	1(1.0)	1(1.0)	6(6.0)	9(2.2)
Occupation					
Civil Servant	34(34.0)	32(32.0)	34(34.0)	39(39.0)	139(34.8)
Farmer	35(35.0)	36(36.0)	21(21.0)	30(30.0)	122(30.5)
Trader	13(13.0)	7(7.0)	30(30.0)	21(21.0)	71(17.8)
Clergy	10(10.0)	15(15.0)	4(4.0)	6(6.0)	35(8.8)
Traditional Ruler	8(8.0)	10(10.0)	1(1.0)	4(4.0)	23(5.8)
Student	0(0.0)	0(0.0)	1(1.0)	0(0.0)	1(0.3)
Housewife	0(0.0)	0(0.0)	1(1.0)	0(0.0)	1(0.3)

Common Health Issues Affecting Young People

Table 3.2.2 shows the common health issues affecting young people (10 – 24 years) according to the respondents. Just over a quarter of the respondents (26%) feel the most common problem affecting young people is malaria with Niger State having the highest of about 44%. Drug abuse follows closely at 23%. Drug abuse is a major concern in Jigawa and Katsina while teenage pregnancy and HIV infection raise more concerns in Benue and Jigawa states. Other significant problems are teenage pregnancy and Drug Abuse which are 15.5% and 11.5% respectively. The overall picture of the common health issues is presented in Figure 3.2.1.

Table 3.2.2: Common health issues affecting young people (10-24 years) by State as reported by the community gatekeepers

Common health issues	Benue	Niger	Jigawa	Katsina	All States
Abortion	6(6.0)	1(1.0)	2(2.0)	6(6.0)	15(3.8)
Teenage Pregnancy	24(24.0)	10(10.0)	23(23.0)	5(5.0)	62(15.5)
Drug Abuse	15(15.0)	7(7.0)	42(42.0)	28(28.0)	92(23.0)
HIV	15(15.0)	12(12.0)	11(11.0)	8(8.0)	46(11.5)
STIs	17(17.0)	9(9.0)	11(11.0)	6(6.0)	43(10.8)
Malaria	11(11.0)	44(44.0)	11(11.0)	37(37.0)	103(25.8)
Diarrhoea	2(2.0)	1(1.0)	0(0.0)	5(5.0)	8(2.0)
Diabetics	3(3.0)	4(4.0)	0(0.0)	1(1.0)	8(2.0)
Typhoid	3(3.0)	11(11.0)	0(0.0)	4(4.0)	18(4.5)
Others	4(4.0)	1(1.0)	0(0.0)	0(0.0)	5(1.2)

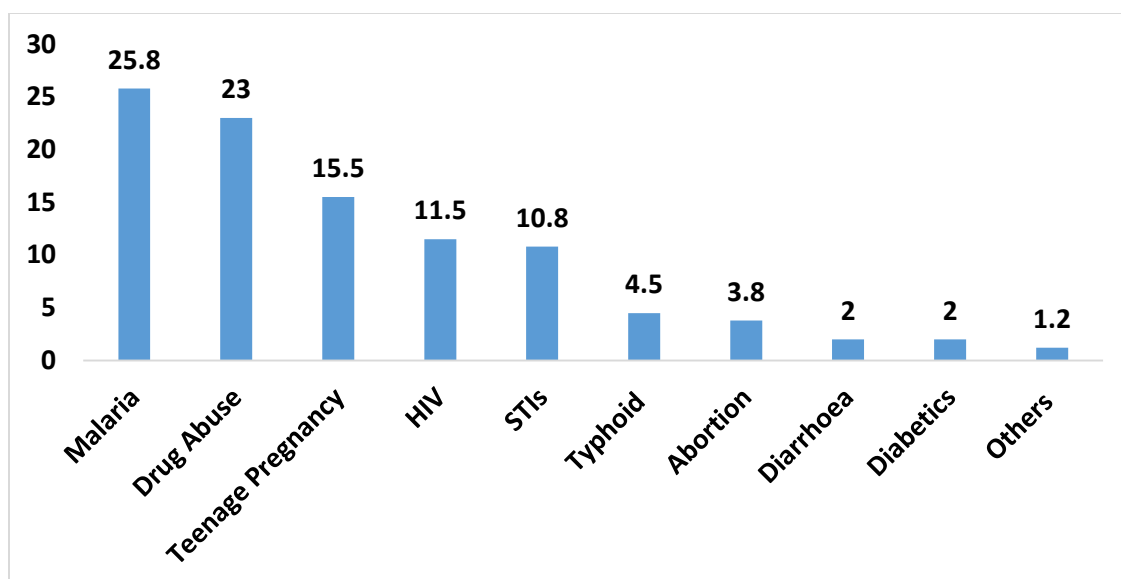


Figure 3.2.1: Overall Common health issues affecting young people (10-24 years)

Others= fibroid, rape, mental illness

Reproductive Health Issues Affecting Young People

Table 3.2.3 shows the perception about reproductive health issues affecting young people in the different communities. Most respondents were almost unanimous about drug abuse being a major reproductive health issue (93.5%) with Teenage Pregnancy and HIV/AIDS came in second and third respectively with 65.2% and 60.8% respectively. STIs came in last with just over half of the respondents (52.5%) believing it is a major health issue in young adults.

Table 3.2.3: Respondents perception about Reproductive health issues affecting the young people in the community

Reproductive Health issues	Benue	Niger	Jigawa	Katsina	All states
HIV/AIDS	78(78.0)	60(60.0)	50(50.0)	55(55.0)	243(60.8)
STIs	72(72.0)	48(48.0)	36(36.0)	54(54.0)	210(52.5)
Teenage pregnancy	84(84.0)	69(69.0)	48(48.0)	60(60.0)	261(65.2)
Sexual abuse	59(59.0)	44(44.0)	73(73.0)	53(53.0)	229(57.2)
Drug abuse	93(93.0)	92(92.0)	99(99.0)	90(90.0)	374(93.5)

How the RH Issues affect Young People

The table below shows about half of the respondents feel the most important effect of reproductive health issues is crime (50.0%). The general belief among respondents is that reproductive health issues do not lead to child marriages or infertility in couples (10% each).

Table 3.2.4: How the Reproductive health issues affect young people in the community

Reproductive Health issues	Benue	Niger	Jigawa	Katsina	All states
Crime (eg. Drug abuse)	39(39.0)	74(74.0)	44(44.0)	42(42.0)	199(49.8)
School drop out	39(39.0)	68(68.0)	11(11.0)	33(33.0)	151(37.8)
Death	22(22.0)	20(20.0)	21(21.0)	6(6.0)	75(18.8)
Poverty/under development	13(13.0)	2(2.0)	15(15.0)	23(23.0)	53(13.2)
Child marriage	10(10.0)	11(11.0)	4(4.0)	16(16.0)	41(10.2)
Infertility	13(13.0)	20(20.0)	4(4.0)	2(2.0)	39(9.8)

Contributing Factors Responsible for RH Issues in the Communities

Table 3.2.5 shows that most people believe that poverty and unemployment contribute to the common reproductive health problems (51.0% and 40.0% respectively) while 14.0% think ignorance contributes to the common reproductive health issues

Table 3.2.5: Factors contributing to the common reproductive health issues

Reproductive Health issues	Benue	Niger	Jigawa	Katsina	All states
Poverty	42(42.0)	61(61.0)	26(26.0)	76(76.0)	205(51.2)
Unemployment	25(25.0)	23(23.0)	47(47.0)	53(53.0)	158(39.6)
Lack of Parental Control/Care	25(25.0)	44(44.0)	42(42.0)	7(7.0)	118(29.5)
Peer influence	37(37.0)	20(20.0)	25(25.0)	12(2.0)	100(25.0)
Illiteracy	22(22.0)	10(10.0)	27(27.0)	30(30.0)	89(22.2)
Ignorance/lack of awareness	22(22.0)	13(13.0)	11(11.0)	12(12.0)	58(14.5)

Ways of Combating RH Issues

Table 3.2.6 shows the different suggestions that the respondents felt will solve the reproductive health issues of their communities. Counselling and awareness campaigns were the predominant recommendations (48.0% and 34.0% respectively) while the provision of contraception was the least 0.8%

Table 3.2.6: Suggestions on how to solve reproductive health issues affecting young people in the community

Variable	Benue	Niger	Jigawa	Katsina	All states
Counselling	66(66.0)	42(42.0)	47(47.0)	35(35.0)	190(47.5)
Awareness Campaign	16(16.0)	49(49.0)	35(35.0)	36(36.0)	136(34.0)
Employment	5(5.0)	2(2.0)	14(14.0)	15(15.0)	36(9.0)
Monitoring	7(7.0)	6(6.0)	1(1.0)	10(10.0)	24(6.0)
Capital punishment	4(4.0)	0(0.0)	3(3.0)	4(4.0)	11(2.8)
Provision of contraception	2(2.0)	1(1.0)	0(0.0)	0(0.0)	3(0.8)

Y-ACCESS PROJECT AND OUTCOME

The influence of different NGOs in the past three and half years in reproductive health issues were known by 83.3% of the gatekeepers in the communities. EVA and SWODEN were generally more known with 47.0% and 41.0% compared to ARFH which was a distant third at 6.0%.

Table 3.2.7: NGO that has assisted in reproductive health issues in 3 and half years before survey

NGOs	Benue	Niger	Jigawa	Katsina	All states
ARFH	8(10.0)	3(3.3)	9(9.4)	0(0.0)	20(6.0)
EVA	69(86.2)	87(96.7)	0(0.0)	0(0.0)	156(46.6)
SWODEN	0(0.)	0(0.0)	87(90.6)	50(74.6)	137(41.1)
Other	3(3.0)	0(0.0)	0(0.0)	17(25.4)	20(6.0)
Total Y-Access	77(77.0)	90(90.0)	96(96.0)	50(50.0)	333(83.3)

Discussion of SRH issues with Children/wards

Most gatekeepers reported to have been discussing sexual and reproductive health issues with their children/wards (85.1%). However, more people in Katsina State do not teach their adolescent and young people about SRH issues (25.6%) compared to the average (15.0%).

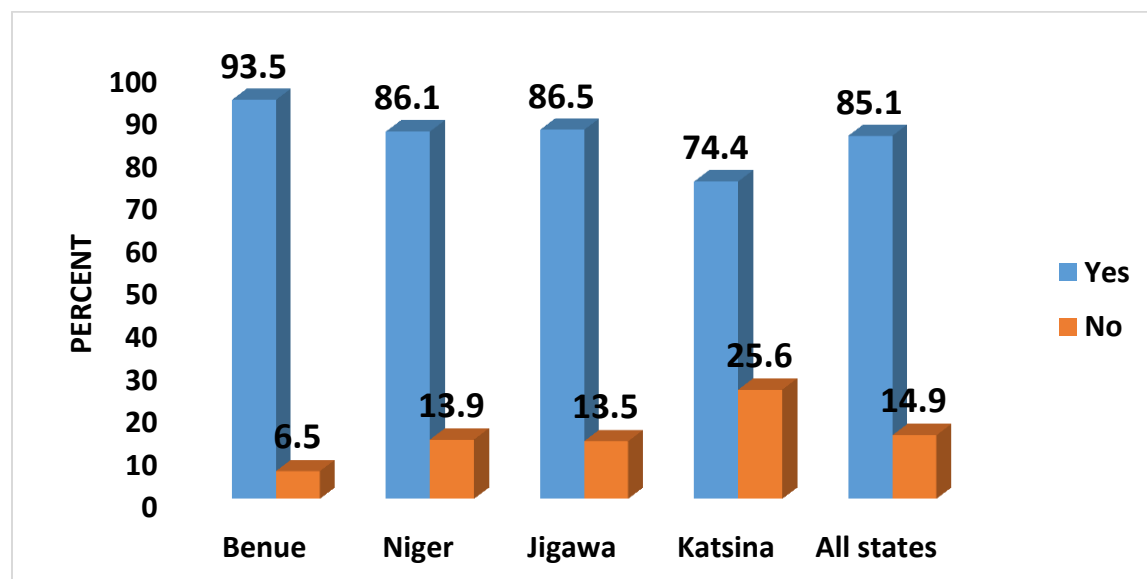


Figure 3.2.2: Percentage distribution of Respondents who Discussed SRH issues with children/wards

RH Issues Commonly Discussed

Table 3.2.8 presents the RH issues gatekeepers commonly discussed with Children/wards. Most parents or guardians discuss Drug Abuse and HIV/AIDS with their wards or children with over four fifths doing so for drug abuse and three quarters doing so for HIV/AIDS. The least discussed topic was STIs (57%).

Table 3.2.8: Common Reproductive Health issues Respondents had Discussed with Children/ wards

Health issued discussed	Benue	Niger	Jigawa	Katsina	Total
Drug abuse	85(85.0)	85(85.0)	92(92.0)	58(58.0)	320(80.0)
HIV/AIDS	89(89.0)	79(79.0)	75(75.0)	55(55.0)	298(74.5)
Teenage pregnancy	83(83.0)	78(78.0)	61(61.0)	45(45.0)	267(66.8)
Sexual abuse	70(70.0)	60(60.0)	79(79.0)	43(43.0)	252(63.0)
STIs	75(75.0)	63(63.0)	49(49.0)	39(49.0)	226(56.5)

Frequency of discussion of RH issues with Children/Wards

Table 3.2.9 shows how frequent parents/guardians discussed sexual and reproductive health issues with their children/wards. Drug Abuse was discussed every time (35%) while HIV/AIDS was discussed sometimes (32%). Sexual abuse was discussed either sometimes or not at all (29%) while STIs were most commonly never discussed (33.5%). Teenage pregnancy was either discussed most times, sometimes or never (28%, 28% and 27% respectively).

Table 3.2.9: Frequency of discussion of RH issues with children/ward

Variables	Benue	Niger	Jigawa	Katsina	All states
Puberty					
Every time	23(23.0)	5(5.0)	19(19.0)	18(18.0)	65(16.2)
Most times	25(25.0)	27(27.0)	18(18.0)	15(15.0)	85(21.2)
Sometimes	35(35.0)	39(39.0)	36(36.0)	19(19.0)	129(32.2)
Never	17(17.0)	29(29.0)	27(27.0)	48(48.0)	121(30.2)
HIV/AIDS					
Every time	30(30.0)	13(13.0)	24(24.0)	18(18.0)	85(21.2)
Most times	32(32.0)	21(21.0)	26(26.0)	17(17.0)	96(24.0)
Sometimes	30(30.0)	51(51.0)	26(26.0)	21(21.0)	128(32.0)
Never	8(8.0)	15(15.0)	24(24.0)	44(44.0)	91(22.8)
STIs					
Every time	22(22.0)	11(11.0)	14(14.0)	7(7.0)	54(13.5)
Most times	25(5.0)	21(21.0)	22(22.0)	17(17.0)	85(21.2)
Sometimes	34(34.0)	40(40.0)	30(30.0)	23(23.0)	127(31.8)
Never	19(19.0)	28(28.0)	34(34.0)	53(53.0)	134(33.5)
Teenage pregnancy					
Every time	33(33.0)	10(10.0)	19(19.0)	9(9.0)	71(17.8)
Most times	28(28.0)	39(39.0)	28(28.0)	16(16.0)	111(27.8)
Sometimes	23(23.0)	33(33.0)	34(34.0)	21(21.0)	111(27.8)
Never	16(16.0)	18(18.0)	19(19.0)	54(54.0)	107(26.8)
Sexual abuse					
Every time	29(29.0)	7(7.0)	28(28.0)	10(10.0)	74(18.5)
Most times	22(22.0)	15(15.0)	34(34.0)	21(21.0)	92(23.0)
Sometimes	29(29.0)	45(45.0)	27(27.0)	15(15.0)	116(29.0)
Never	20(20.0)	33(33.0)	11(11.0)	54(54)	118(29.0)
Drug abuse					
Every time	30(30.0)	27(27.0)	59(59.0)	27(27.0)	143(35.8)
Most times	31(31.0)	27(27.0)	17(17.0)	27(27.0)	102(25.5)
Sometimes	26(26.0)	33(33.0)	19(19.0)	5(5.0)	83(20.8)
Never	13(13.0)	13(13.0)	59(59.0)	41(41.0)	72(18.0)

Support for Young People Seeking RH Information

The vast majority of gatekeeper surveyed (90.5%) reported their willingness to support young people seeking reproductive health information. Above half (54.0) of those who accepted to support the young people on RH information will do that through counselling and advice. This is presented in Figure 3.2.3 below.

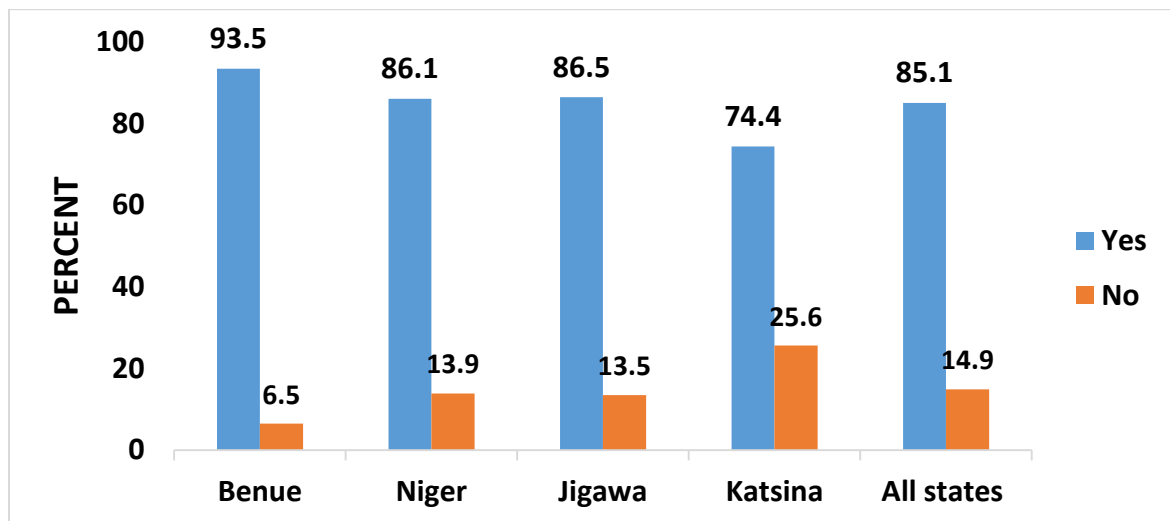


Figure 3.2.3 Percent distribution of Respondents Support for young people seeking RH information

Perception of Community Support of Young People Seeking RH Information

Majority (88.2%) of the gatekeepers within the communities where the Y-Access project was implemented reported willingness to support the adolescent and young people seeking the RH information and services. The overall target of 95.0% was not achieved.

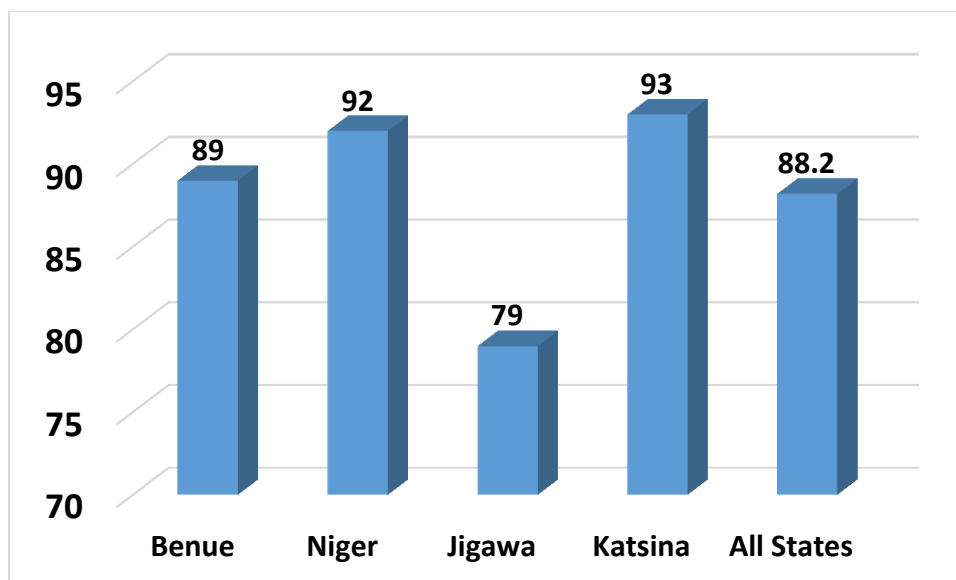


Figure 3.2.4 Distribution of Respondents Perception of Community Support of Young People Seeking RH Information

Opinion Concerning Special locations for RH Information

Majority (82.3%) of the respondents opined that there should be special locations in the community to address adolescent and young people reproductive health issues while 17.3% were not in support.

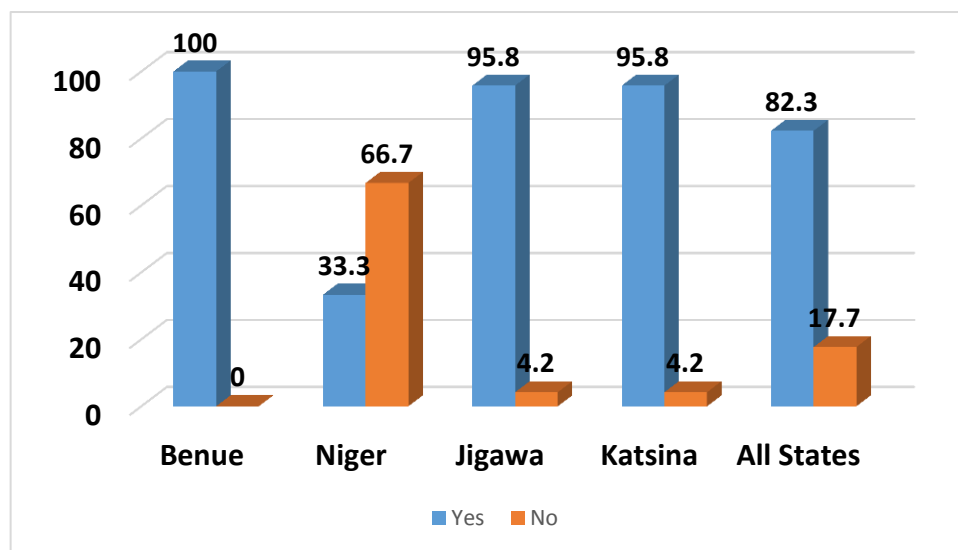


Figure 3.2.5 Distribution of Respondents Perception on Special Locations for RH Information

3.3 HEALTH FACILITIES

Background information

Sixty three percent (63.0%) of the health facilities are located in rural settings, while 37.0% are in urban setting. Predominant proportion (94.0%) of the facilities were public health facility with Niger, the only state with a private facility (25.0%). The facilities were predominantly primary care constituting about 87.5%. About 68.8% of the facilities had a functional laboratory while 31.2% did not, while there was no laboratory facility in Niger state.

Table 3.3.1: Background Information

Variable	States				
	Benue	Niger	Jigawa	Katsina	All states
Location					
Rural	4(100.0)	4(100.0)	0(0.0)	2(50.0)	10(62.5)
Urban	0(0.0)	0(0.0)	4(100.0)	2(50.0)	6(37.5)
Type of Facility					
Public	4(100.0)	33(75.0)	4(100.0)	4(100.0)	15(93.8)
Private	0(0.0)	1(25.0)	0(0.0)	0(0.0)	1(6.2)
Level of Facility					
Primary	4(100.0)	4(100.0)	33(75.0)	33(75.0)	14(87.5)
Secondary	0(0.0)	0(0.0)	1(25.0)	1(25.0)	2(12.5)
Nature of Facility					
Health Centre	4(100.0)	4(100.0)	2(50.0)	2(50.0)	12(75.0)
Hospital	0(0.0)	0(0.0)	1(25.0)	1(25.0)	2(12.5)
Dispensary	0(0.0)	0(0.0)	1(25.0)	1(25.0)	2(12.5)
Total No. of Rooms in Facility					
Number (Average)	10 (2.5)	35 (8.75)	47 (11.75)	86 (21.5)	178(11.125)
Waiting Rooms Availability at Facility					
Yes	33(75.0)	33(75.0)	4(100.0)	4(100.0)	14(87.5)
No	1(25.0)	1(25.0)	0(0.0)	0(0.0)	2 (12.5)
Consulting Rooms Availability at Facility					
Yes	33(75.0)	4(100.0)	4(100.0)	4(100.0)	15(93.8)
No	1(25.0)	0(0.0)	0(0.0)	0(0.0)	1(6.2)
Laboratory Availability at Facility					
Yes	4(100.0)	0(0.0)	3(75.0)	4(100.0)	11 (68.8)
No	0(0.0)	4(100.0)	1(25.0)	0(0.0)	5 (31.2)

Clients Volume and Range of Services Provided

A total of 1,067,340 [(265,779 females, 112,856 males), 89,482 10-14 years; 790,889 15-19 years; 630,947 20-24 years] clients were seen in all the service delivery points within the period reviewed.

Table 3.3.2: Summary of range of services provided, September 2012-February, 2016

Services Provided	Total No. of Clients Served		No. of Young Clients Served					
			(10-14) Years		(15-19) Years		(20-24) Years	
	F	M	F	M	F	M	F	M
Counseling								
Dual Protection	27366	49263	3009	15340	4013	16053	3995	17826
Other Contraceptive Methods	14020	12550	2083	2925	3507	39331	55134	46429
HIV and AIDS	31348	39017	13403	20674	68660	69917	62330	33406
Nutrition	2364	18101	604	3981	1335	1919	650	11951
Sexual Abuse/Violence	5267	16034	1978	1921	14726	23513	1899	9747
Drug Abuse	16529	23263	5091	4108	10675	50617	7135	10520
Testing								
STIs	5759	6530	2105	1873	31155	38050	35858	5211
HCT(HIV Test only Please)	14951	37543	3809	7189	30409	25138	41616	16605
Pregnancy	43688	0	31993	0	42031	0	20992	0
Treatment								
STIs	23646	28654	3120	5399	31771	31528	20672	19497
Post-abortion Care	25514	0	5840	0	19765	0	20164	0
Sexual Abuse or Violence	726	98	1177	28	23587	15	1145	53
Other Services								
Dual Protection	20462	26167	1611	9916	14536	20916	11770	2673
Other Methods of Contraception	10542	8559	1721	4272	46647	34980	4580	42101
Antenatal Care	52083	0	17067	0	39519	0	51199	0
Postnatal Care	45593	0	7848	0	28735	0	28840	0
Delivery	51704	0	10397	0	24241	0	46949	0
Total	801,561	265,779	112,856	77,626	435,312	355,577	414,928	216,019

Personnel

Three quarters of the personnel's at the health facilities were males while one quarter were females. The personnel's that had at least one training are about 44% of which 31% of them have above four trainings with 18% never being trained. Most trainings were done by EVA, ARFH and SWODEN with each of them having about a third of the personnel in the facilities

Table 3.3.3: Distribution of Personnel by training received

Variable	Benue	Niger	Jigawa	Katsina	Total
Sex of Personnel					
Male	2(50.0)	3(75.0)	4(100.0)	3(75.0)	12(75.0)
Female	2(50.0)	1(25.0)	0(0.0)	1(25.0)	4(25.0)
Number of RH trainings received					
At least one Training	1(25.0)	2(50.0)	2(50.0)	2(50.0)	7(43.8)
4 Trainings and above	2(50.0)	0(0.0)	2(50.0)	1(25.0)	5(31.2)
None	1(25.0)	1(25.0)	0(0.0)	1(25.0)	3(18.8)
2 – 3 Trainings	0(0.0)	1(25.0)	0(0.0)	0(0.0)	1(6.2)
Training Agency					
EVA	4(100.0)	1(25.0)	1(25.0)	0(0.0)	6(37.5)
ARFH	0(0.0)	3(75.0)	2(50.0)	0(0.0)	5(31.2)
SWODEN	0(0.0)	0(0.0)	0(0.0)	3(75.0)	3(18.8)
Y-Access	0(0.0)	0(0.0)	1(25.0)	1(25.0)	2(12.5)
Average Adolescent served weekly					
Average Nos.(Avg)	86(21.5)	105(26.25)	138(34.5)	187(46.75)	516(32.25)

Supervision

About 63% of the internal supervision were done on a monthly basis. About 81.2% of the facilities have system for feedback internally while only 43.8% of the facilities have system for feedback externally

Table 3.3.4: Supervision of Facilities

Variable	States				
	Benue	Niger	Jigawa	Katsina	All States
Type of Supervisory mechanism					
Both	2(50.0)	3(75.0)	1(25.0)	4(100.0)	10(62.5)
Internal	2(50.0)	0(0.0)	3(75.0)	0(0.0)	5(31.2)
Never	0(0.0)	1(25.0)	0(0.0)	0(0.0)	1(6.1)
How often does supervision occurs internally					
Monthly	3(75.0)	3(75.0)	3(75.0)	3(75.0)	12(75.0)
Quarterly	1(25.0)	0(0.0)	1(25.0)	1(25.0)	3(18.8)
Never	0(0.0)	1(25.0)	0(0.0)	0(0.0)	1(6.2)
How often dos supervision occurs externally					
Quarterly	2(50.0)	3(75.0)	1(25.0)	3(75.0)	9(56.2)
NA	2(50.0)	1(25.0)	3(75.0)	0(0.0)	6(37.5)
Monthly	0(0.0)	0(0.0)	0(0.0)	1(25.0)	1(6.2)
System for feedback internally					
Yes	3(75.0)	4(100.0)	4(100.0)	2(50.0)	13(81.2)
No	1(25.0)	0(0.0)	0(100.0)	2(50.0)	3(18.8)
System for feedback externally					
No	2(50.0)	2(50.0)	3(75.0)	2(50.0)	9(56.2)
Yes	2(50.0)	2(50.0)	1(25.0)	2(50.0)	7(43.8)
System for Progress Check Internally					
Yes	3(75.0)	3(75.0)	4(100.0)	3(75.0)	13(81.2)
No	1(25.0)	1(25.0)	0(0.0)	1(25.0)	3(18.8)
System for Progress Check Internally					
Yes	2(50.0)	1(25.0)	2(50.0)	3(75.0)	8(50.0)
No	2(50.0)	3(75.0)	2(50.0)	1(25.0)	8(50.0)

Location of service delivery points (SDP)

Niger State has the longest average time duration to access a health facility and where adolescents spend free time of 110minutes, with lowest being Jigawa State with 39minutes and 25minutes respectively. The highest average distance from schools to health facility is 15minutes in Benue State

Table 3.3.5: Location and Minutes trekking distance to SDPs

Variable	States				
	Benue	Niger	Jigawa	Katsina	All States
How Far is the facility from public transport					
Average distance in minutes. No.(Avg)	45(11.25)	110(27.5)	39(9.75)	90(22.5)	284(17.75)
How Far is the facility from place where adolescents spend their free time					
Average distance in minutes. No. (Avg)	45(11.25)	110(27.5)	25(6.25)	133(33.25)	313(19.56)
How Far is the facility from schools in the area					
Average distance in minutes	15(3.75)	75(18.75)	28(7.0)	90(22.5)	208(13)

Facility Working Hours

Half (50.0%) of the facilities have separate hours for the adolescents while the other half (50.0%) combine both adolescents and other people seeking health care together. About 63% of the facilities have a sign listing services and clinic hours while the remaining do not. Half (50.0%) of the facilities have evenings as the convenient time for adolescents to seek services while about 43% of facilities have mornings as the convenient time.

Table 3.3.6: Facility Working Hours

Variable	Benue	Niger	Jigawa	Katsina	Total
What time is the clinic scheduled to open and close					
Average working hours per day	78(19.5)	40(10.0)	84(21.0)	62(15.5)	264(16.5)
The facility have separate hours for adolescents					
Yes	1(25.0)	2(50.0)	2(50.0)	3(75.0)	8(50.0)
No	3(75.0)	2(50.0)	2(50.0)	1(25.0)	8(50.0)
Is there a sign listing services and clinic working hours					
Yes	0(0.0)	3(75.0)	3(75.0)	4(100.0)	10(62.5)
No	4(100.0)	1(25.0)	1(25.0)	0(0.0)	6(37.5)
What times are convenient for adolescents to seek services					
Evening	2(50.0)	3(75.0)	1(25.0)	2(50.0)	8(50.0)
Morning	1(25.0)	1(25.0)	3(75.0)	2(50.0)	7(43.8)
Afternoon	1(25.0)	0(0.0)	0(0.0)	0(0.0)	1(6.2)

Characteristics of Facility

More than two-third (69.0%) of the facilities have a comfortable setting for adolescents while over 50% of the facilities have separate space, waiting room, and provide both auditory and visual confidentiality for their clients.

Table 3.3.7: Facility Environment

Variable	Benue	Niger	Jigawa	Katsina	Total
The facility provide a comfortable setting for adolescent clients					
Yes	1(25.0)	2(50.0)	4(100.0)	4(100.0)	11(68.8)
No	3(75.0)	2(50.0)	0(0.0)	0(0.0)	5(31.2)
The Facility have separate space to provide services for adolescent clients					
Yes	0(0.0)	2(50.0)	3(75.0)	4(100.0)	9(56.2)
No	4(100.0)	2(50.0)	1(25.0)	0(0.0)	7(43.8)
The facility have separate waiting room for adolescent clients					
No	4(100.0)	4(100.0)	1(25.0)	0(0.0)	9(56.2)
Yes	0(0.0)	0(0.0)	3(75.0)	4(100.0)	7(43.8)
Facility have counseling area that provides both visual and auditory privacy					
Yes	2(50.0)	1(25.0)	4(100.0)	2(50.0)	9(56.2)
No	2(50.0)	3(75.0)	0(0.0)	2(50.0)	7(43.8)
Facility have an examination room that provides both visual and auditory privacy					
Yes	1(25.0)	1(25.0)	3(75.0)	3(75.0)	8(50.0)
No	3(75.0)	3(75.0)	1(25.0)	1(25.0)	8(50.0)
Both young men and women are welcomed and served either for their own need or as partners					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)

Staff preparedness for RH services

All facilities(100%) trained service providers to serve and show respect to adolescents clients in Reproductive Health with over 90% of them using job aids in their daily work, while over 81% of facilities have other staff members with at least an orientation about adolescents clients.

Table 3.3.8: Staff Preparedness

Variable	Benue	Niger	Jigawa	Katsina	Total
Service Providers are trained to serve young persons' as clients in RH					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Staff members receive at least an orientation about young adolescent clients					
Yes	4(100.0)	4(100.0)	3(75.0)	2(50.0)	13(81.2)
No	0(0.0)	0(0.0)	1(25.0)	2(50.0)	3(18.8)
Service providers show respect for the adolescents clients during counseling					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Are there job aids available to help service providers in their daily work					
Yes	4(100.0)	3(75.0)	4(100.0)	4(100.0)	15(93.8)
No	0(0.0)	1(25.0)	0(0.0)	0(0.0)	1(6.2)

Services Provided at SDPS

All facilities offer services on sexuality, safer sex, pregnancy prevention and STI/HIV, and majority (over 90.0%) of the facilities offer contraception methods e.g. condoms, Injectables and oral pills while only 18.0% of facilities offer implants. Above two-third (69.0%) of the facilities provide both male and female condoms with 56% of the facilities having adequate supply of condoms and others contraceptives. All the facilities have testing facilities for pregnancy with 81.0% of facilities using Urine micro for STI testing. About 68% of facilities have formal referral system, including tracking and follow up for services not provided

Table 3.3.9: Services Provided

Variable	Benue	Niger	Jigawa	Katsina	Total
Counseling on sexuality, safer sex, pregnancy prevention and STI and HIV provided					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Contraceptive methods are offered					
Condoms (Including Dual Protection)	3(75.0)	4(100.0)	4(100.0)	4(100.0)	15(93.75)
Injectables	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Oral Pills	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Implants	3(75.0)	0(0.0)	0(0.0)	0(0.0)	3(18.75)
Condoms are provided to both male and female					
Yes	2(50.0)	4(100.0)	3(75.0)	2(50.0)	11(68.8)
No	2(50.0)	0(0.0)	1(25.0)	2(50.0)	5(31.2)
Are supply of condoms and other contraceptives sufficient?					
Yes	1(25.0)	3(75.0)	2(50.0)	3(75.0)	9(56.2)
No	3(75.0)	1(25.0)	2(50.0)	1(25.0)	7(43.8)
Is there sufficient equipment for the provision of RH services					
Yes	1(25.0)	1(25.0)	4(100.0)	3(75.0)	9(56.2)
No	3(75.0)	3(75.0)	0(0.0)	1(25.0)	7(43.8)
Is Pregnancy testing offered					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Is STI testing Available					
Yes	4(100.0)	4(100.0)	1(25.0)	4(100.0)	13(81.2)
No	0(0.0)	0(0.0)	3(75.0)	0(0.0)	3(18.8)
Types of STI Testing offered					
Urine Micro	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Syphilis	2(6.2)	1(6.2)	1(6.2)	1(6.2)	4(25.0)
VDRL	1(6.2)	0(0.0)	0(0.0)	1(6.2)	2(12.4)
Do Young people request for services other than the ones offered					
No	3(75.0)	4(100.0)	2(50.0)	2(50.0)	11 (68.8)
Yes	1(25.0)	0(0.0)	2(50.0)	2(50.0)	5 (31.2)
Are referrals made for services not provided at the clinic					
Yes	3(75.0)	1(25.0)	3(75.0)	2(50.0)	9(56.2)
No	1(25.0)	3(75.0)	1(25.0)	2(50.0)	7(43.8)
Is there a formal referral system, including tracking and follow-ups					
Yes	3(75.0)	2(50.0)	3(75.0)	3(75.0)	11(68.8)
No	1(25.0)	2(50.0)	1(25.0)	1(25.0)	5(31.2)

Peer Education/Counseling program

About 94% of the facilities are aware of on-going peer education in the facilities with over 80% of them having a cordial relationship with the Peer Educators.

Table 3.3.10: Peer Education/Counseling programme

Variable	Benue	Niger	Jigawa	Katsina	Total
Aware of any on-going peer education program in the community					
Yes	4(100.0)	4(100.0)	4(100.0)	3(75.0)	15(93.8)
No	0(0.0)	0(0.0)	0(0.0)	1(25.0)	1(6.2)
Have a working relationship with the peer educators/counselors					
Yes	4(100.0)	3(75.0)	4(100.0)	3(75.0)	14(87.5)
No	0(0.0)	1(25.0)	0(0.0)	1(25.0)	2(12.5)
Describe the relationship with peer educators/counselors					
Cordial	3(75.0)	4(100.0)	3(75.0)	3(75.0)	13(81.2)
Not Applicable	0(0.0)	0(0.0)	1(25.0)	1(25.0)	2(12.5)
Not very Cordial	1(25.0)	0(0.0)	0(0.0)	0(0.0)	1(6.2)

Educational Activities

The table below shows the educational activities carried out at the different facilities. About 56% of the facilities visited did not have educational materials and did not have posters or brochures that described patient's rights compared to 44% that had materials on ground and posters that described the rights of clients. All the facilities displayed educational posters with only 75% of the facilities with materials for the clients to take away. Materials for IEC were not available in one quarter of the facilities assessed.

Table 3.3.11: Educational Activities

Variable	Benue	Niger	Jigawa	Katsina	Total
Educational materials available on-site					
Yes	2(50.0)	1(25.0)	3(75.0)	3(75.0)	9(43.8)
No	2(50.0)	3(75.0)	1(25.0)	1(25.0)	7(56.2)
Are there educational posters displayed					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Are there posters or brochures that describe the clients rights					
Yes	0(0.0)	4(100.0)	3(75.0)	2(50.0)	9(43.8)
No	4(100.0)	0(0.0)	1(25.0)	2(50.0)	7(56.2)
Are there print materials available for clients to take away					
Yes	2(50.0)	4(100)	3(75.0)	3(75.0)	12(75.0)
No	2(50.0)	0(0.0)	1(25.0)	1(25.0)	4(25.0)
What languages are IEC materials available					
English & Hausa	1(25.0)	3(75.0)	4(100.0)	4(100.0)	12(75.0)
English Only	3(75.0)	1(25.0)	0(0.0)	0(0.0)	4(25.0)
Are group discussions held					
Yes	1(25.0)	3(75.0)	3(75.0)	1(25.0)	8(50.0)
No	3(75.0)	1(25.0)	1(25.0)	3(75.0)	8(50.0)
Are there ways clients can access information or counseling off-site					
No	4(100.0)	2(50.0)	2(50.0)	3(75.0)	11(68.8)
Yes	0(0.0)	2(50.0)	2(50.0)	1(25.0)	5(31.2)

Youth Involvement in Project Activities

Of the total 12 project activities (Health service providers' trainings; TBAs/PMVs trainings; IEC development and adaptation workshop; Baseline Survey, Youth led assessment of health facilities; PE educators training; PET training; Stakeholder's consultative workshop; AHD Plan development workshop; Youth Advocacy training; Advocacy meeting with traditional and religious leaders; Youth led activities-film shows, quiz competitions, dramas) the youths in the communities where Y_access project was implemented participated fully. But regarding youth involvement in decision making about how programs are delivered highest proportion was recorded Niger and Jigawa (75.0% each), followed by Katsina (50.0%) and Benue (25.0%).

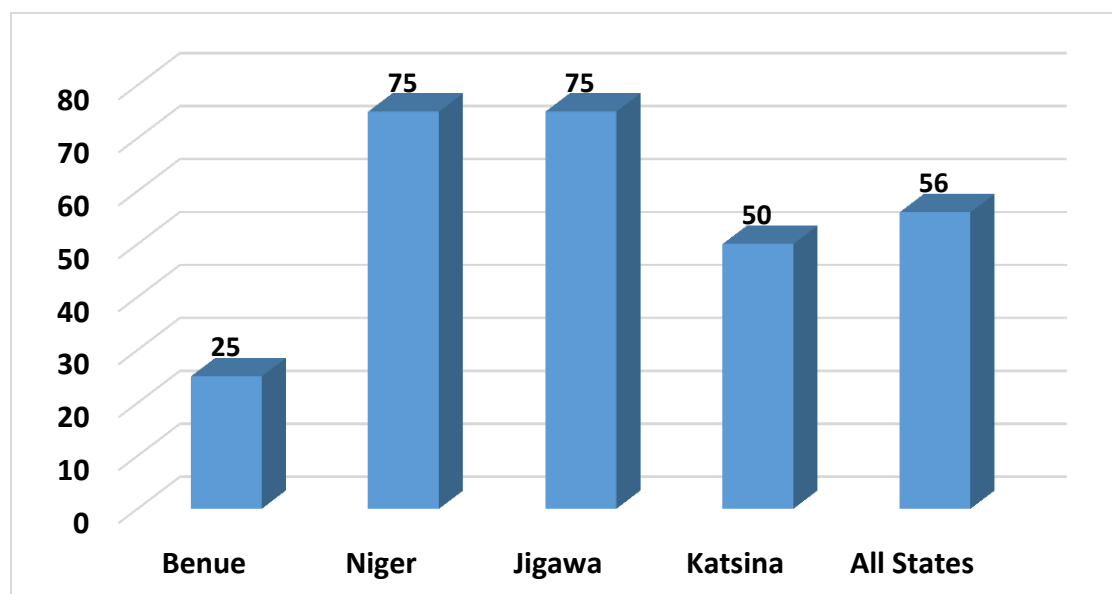


Figure 3.3.1 Distribution of respondents youths involvement in decision making

Supportive Policies

Table 3.3.12 presents the supportive policies reported by respondents. Overall, half (50.0%) of the reported that a clear written guidelines for serving young people exist in all SDPs in the communities where the Y Access project was implemented. Three-fourth (75.0%) reported that a written guideline exists for client confidentiality. Other written guidelines reported by respondents to exist in the SDPs are contraceptive methods that adolescent cannot receive (62.5%), procedures that parental/spousal consent is required (62.5%), ensuring confidentiality in all RHS (87.5%), and non-barriers to youth friendly services (81.2%).

Table 3.3.12: Supportive Policies

Variable	Benue	Niger	Jigawa	Katsina	Total
Do clear written guidelines for serving young people exist					
Yes	2(50.0)	1(25.0)	3(75.0)	2(50.0)	8(50.0)
No	2(50.0)	3(75.0)	1(25.0)	2(50.0)	8(50.0)
Do written procedures exist for protecting client confidentiality					
Yes	2(50.0)	3(75.0)	4(100.0)	3(75.0)	12(75.0)
No	2(50.0)	1(25.0)	0(0.0)	1(25.0)	4(25.0)
Are records stored so that confidentiality is assured					
Yes	4(100.0)	4(100.0)	3(75.0)	3(75.0)	14(87.5)
No	0(0.0)	0(0.0)	1(25.0)	1(25.0)	2(12.5)
Are there any contraceptive methods that adolescent cannot receive					
No	1(25.0)	3(75.0)	3(75.0)	3(75.0)	10(62.5)
Yes	3(75.0)	1(25.0)	1(25.0)	1(25.0)	6(37.5)
Is parental or spousal consent required					
Yes (When Client is Married)	2(50.0)	3(75.0)	2(50.0)	3(75.0)	10(62.5)
No	2(50.0)	1(25.0)	2(50.0)	1(25.0)	6(37.5)
Is there a minimum age requirement for young people to receive services					
No	1(25.0)	4(100.0)	3(75.0)	1(25.0)	9(56.2)
Yes	3(75.0)	0(0.0)	1(25.0)	3(75.0)	7(43.8)
Are young clients served without regard to their marital status					
No	1(25.0)	2(50.0)	3(75.0)	3(75.0)	9(56.2)
Yes	3(75.0)	2(50.0)	1(25.0)	1(25.0)	7(43.8)
Are pelvic exams routinely required					
No	3(75.0)	4(100.0)	2(50.0)	2(50.0)	11(68.8)
Yes	1(25.0)	0(0.0)	2(50.0)	2(50.0)	5(31.2)
Do policies or procedures exist that pose barriers to youth friendly services					
No	3(75.0)	3(75.0)	4(100.0)	3(75.0)	13(81.2)
Yes	1(25.0)	1(25.0)	0(0.0)	1(25.0)	3(18.8)

Administrative Procedure

The table below gives an insight into the administrative procedures that occur at the different facilities. Nine out of ten facilities ensure the registration is private and can attend to clients without an appointment. Sixty three per cent of the facilities expedite appointments of young clients

Table 3.3.13: Administrative Procedures

Variable	Benue	Niger	Jigawa	Katsina	Total
Registration process private so that other waiting clients cannot overhear the conversation					
Yes	3(75.0)	4(100.0)	4(100.0)	4(100.0)	15(93.8)
No	1(25.0)	0(0.0)	0(0.0)	0(0.0)	1(6.2)
Can young clients be seen without appointment					
Yes	4(100.0)	3(75.0)	4(100.0)	4(100.0)	15(93.8)
No	0(0.0)	1(25.0)	0(0.0)	0(0.0)	1(6.2)
If appointments are required, can they be expedited for young clients					
Yes	3(75.0)	4(100.0)	1(25.0)	2(50.0)	10(62.5)
No	1(25.0)	0(0.0)	3(75.0)	2(50.0)	6(37.5)
How long would a young client wait to see a provider					
Average time in minutes. No. (Avg)	85(21.25)	55(13.75)	155(38.75)	110(27.5)	405(25.31)
Average time allowed for client provider interaction					
Average time in minutes. No. (Avg)	75(18.75)	65(16.25)	105(26.25)	93(23.25)	338(21.13)

Publicity/Recruitment

Table 3.3.14 shows that 87.5% of the facilities do publicity with particular emphasis on confidentiality with 68.8% of the facilities with staff that do outreaches to the communities where the facility is located.

Table 3.3.14: Publicity/Recruitment

Variable	Benue	Niger	Jigawa	Katsina	Total
Does publicity about the clinic identify services offered and stress confidentiality					
Yes	2(50.0)	4(100.0)	4(100.0)	4(100.0)	14(87.5)
No	2(50.0)	0(0.0)	0(0.0)	0(0.0)	2(12.5)
Are there staff or volunteer who do outreach activities					
Yes	3(75.0)	4(100.0)	2(50.0)	2(50.0)	11(68.8)
No	1(25.0)	0(0.0)	2(50.0)	2(50.0)	5(31.2)

Charges paid per services

Table 3.3.15 shows that young people pay for the services in less than one third of the facilities. In the facilities where fess are paid, less than one fifth (12.2%) of them pay the same amount as adults and about 50% of them think the service is affordable by the young people in the area.

Table 3.3.15: Fees Paid for Services

Variable	Benue	Niger	Jigawa	Katsina	Total
Do young people pay for services					
No	3(75.0)	4(100.0)	4(100.0)	2(50.0)	13(81.3)
Yes	1(25.0)	0(0.0)	0(0.0)	2(50.0)	3(18.7)
Do young people pay the same rate for services as adults					
No	2(50.0)	0(0.0)	4(100.0)	2(50.0)	8(50.00)
NA	1(25.0)	4(100.0)	0(0.0)	1(25.0)	6(37.5)
Yes	1(25.0)	0(0.0)	0(0.0)	1(25.0)	2(12.5)
Are these fees affordable by young people in the catchment area					
Yes	2(50.0)	2(50.0)	2(50.0)	2(50.0)	8(50.0)
No	2(50.0)	0(0.0)	2(50.0)	1(25.0)	5(31.2)
NA	0(0.0)	2(50.0)	0(0.0)	1(25.0)	3(18.8)

Almost all the facilities in the states sampled charged a fee for the hospital card. However most of the other services provided were free in all the other facilities except Benue where almost every other thing was paid for, except counseling.

Table 3.3.16: Average cost per service offered

Variable	Benue	Niger	Jigawa	Katsina	Total
Hospital Card	450(112.5)	80(20.0)	110(27.5)	160(40.0)	800(50.0)
Counseling					
Contraception	Free	Free	Free	Free	Free
HIV and AIDS	Free	Free	Free	Free	Free
Nutrition	Free	Free	Free	Free	Free
Sexual Abuse/Violence	Free	Free	Free	Free	Free
Drug Abuse	Free	Free	Free	Free	Free
Testing					
STIs	850(212.5)	Free	Free	450(112.5)	1300(185.7)
HCT	500(250.0)	Free	Free	Free	Free
Pregnancy	700(175.0)	Free	430(107.5)	190(47.5)	1320(110.0)
Treatment					
STIs	4150(1037.5)	Free	Free	Free	Free
Post-abortion care	7000(1750)	Free	Free	Free	Free
Sexual Abuse or violence	5000(1250)	Free	Free	Free	Free
Others					
Contraception	Free	Free	Free	Free	Free
Antenatal Care	4250(1062)	Free	Free	Free	Free
Postnatal Care	2000(1000)	Free	Free	Free	Free
Delivery	9000(2250)	Free	Free	Free	Free

Cooperative Society

Jigawa State is notable to have formed cooperatives (2) within the members and have given about 120 members of the cooperatives loans.

Table 3.3.17: Cooperative Society Register

Variable	Benue	Niger	Jigawa	Katsina	Total
Number of cooperative society formed with members	Nil	Nil	2	Nil	2
Number of cooperative societies that gave loan to members	Nil	Nil	2	Nil	2
Number of Beneficiaries	Nil	Nil	120	Nil	120

3.4: QUALITATIVE RESULT FOR POLICY MAKERS

Several relevant stakeholders are needed in planning/development of policy documents, because of their contributions which are used in providing frameworks for improved coordination of programmes which will in turn be used for effective utilization of commodities that are pertinent to achieving the goal of the project. The purpose of the qualitative component of this survey was to assess the development plan available at the health facilities since the implementation of the Y-Access project in 2012. The interview questions focused on the socio-demographics, knowledge of adolescent sexual and reproductive health, trainings on reproductive health and adolescent and Youth health development policy. Within these major domain, there were questions on the key informant's designation, duration of stay in current designation, knowledge on ASRH issues, trainings attended, national Adolescent and Youth Health Development (NAYHD) policy, and state documented plan for implementation of NAYHD policy, availability of the policy at health facilities, contents of the policy, development process and implementation of the plan.

3.4.1: Characteristics of the Respondents

The self-reported mean age of the discussants was 46 years (± 2.4 years). The respondents were predominantly male, from state ministry of health, medical services department, local government reproductive health representatives, programme officers, monitoring and evaluation officers and coordinators of the Y-Access implementing partners. Some of the respondents also had previous working experience with other organizations like DFID, USAID, CHAN, UNFPA, UNICEF and MSH. The least number of years spent on a particular designation before the interview as reported by the respondents was 1 year and the highest was 13 years.

3.4.2: Training On Reproductive Health Issues

Regarding training on ASRH issues, almost all the respondents had at least one training while in their current position. Majority of the training they had was conducted by ARFH, EVA or SWODEN and State ministries of health. Only one respondent among all interviewed stated that she was not opportune to attend any formal training outside her place of work, but she received RH training by her boss who attended a training and did a step down training for her. The general picture from the respondents depicts the picture that other workers in the state health

facilities and non-governmental organization have had similar training experiences in the past three and half years ago. One of the respondents said:

‘Some other staff not interviewed had trainings as well. Many have been trained on reproductive health. I am aware because as an M&E officer to the LGA, all the trainings that comes to the local government must pass through me, so I am the one to dispatch the letters to those nominated for trainings and I also have documents for who was train for what and what?’

Regarding the scope of the trainings had by respondents; several explanations were reported. These includes: STIs including HIV/ADIS, child marriage, contraception, miscarriages, antenatal care, abortion and post abortal care, condom use, drug abuse, gender violence among others.

One of the respondents said:

“In Gboko Benue state, I had a training by ARFH, the training lasted for 3 days. The content of the training was on reproductive health issues which include HIV testing, child marriage, STIs, condom use, drug and substance abuse, and gender based violence”.

Another respondent statement is paraphrased as:

“The main contents of the training were: how to encourage the youths to come out for HIV test, use of condoms, and not to shy away from the health facilities within their domain. All is tailored towards having a good access to youth friendly reproductive health facilities”

Another respondent said:

”I was trained on reproductive health issues, STIs, school drop outs, family planning, negotiations, HIV and management of abortion”

3.4.3: Self-Assessment of Knowledge on Reproductive Health

When the respondents were asked to describe their knowledge on ASRH issues before and after their current positions and trainings had on RH, they stated several responses. Almost all the respondents reported that they have better and improved knowledge on reproductive health issues because of their trainings and responsibilities in reproductive health programmes. Some even stated that the position made them to become good advocates of reproductive health issues. Some respondents stated that they were programme and field workers with vast experience in public health, but still acknowledged that the implementation of Y-Access programme improved

their knowledge in adolescent and young people reproductive health issues, while some reported that they were not just trainees but also facilitators for EVA and SWODEN.

A respondent is quoted as:

“Before I took over this present position, sexual and reproductive health issues were a no go area for me, it was like a taboo; something that shouldn’t be discussed as a topic, a shameful thing to talk about. But, when I took up the position and undergone series of trainings I have come to see that definitely Sexual and reproductive health issue is not something we should shy away from. This is because it affects us directly or indirectly. I have gained a lot of knowledge concerning reproductive health issues. So now I do not shy away from. I am now the one championing the campaign for people to support young people in assessing such services. Definitely my knowledge and perception about the whole thing has changed.

A respondent who later became an educator following the implementation of Y-Access programme and trainings she had stated that:

“I also teach in one of the health schools, so the training on RH has increased/improved my knowledge and I was able to step it down to impact that knowledge to the younger ones in the school where I am teaching”

3.4.4: National Adolescent and Youth Health Development (NAYHD) Policy

A good proportion of the respondents mentioned that they have heard of NAYHD policy, but some respondents have seen them. Some stated that the states developed the policy in collaboration with either ARFH, SWODEN or EVA.

Regarding whether the state have a documented plan to implement the policy, all the respondents who have an idea about the process the NAYHD policy had passed through were of the opinion that what they have as a document today was became operational after the Y-Access project was fully implemented. Majority of the respondents attested to the fact that the national policy was drafted by several stakeholders drawn from all parts of the nation i.e. all state adolescent health coordinators, ministry of women affairs, ministry of health, ministry of education, faith based organizations and development partners.

A respondent in Benue state said:

“Yes in this state we are working directly with EVA and we have supports from them. Prior to EVA coming to this state, we had started the implementations of some of the recommendations of adolescent and reproductive health. One of the first youth friendly center that was set up in this country as pilot by the UNFPA was done in Gboko, Benue state. At the time the Gboko youth center was set up there were two other prototypes; one in Akwa-ibom and another one in Gboko: all were set up by UNFPA and been managed by the states. Quite a lot was done in raising the awareness on the youths, the young and adolescent sexual and reproductive health. Based on that, subsequently the issue of introducing the issue in all the local governments was also started. We worked with those agencies and organizations that are working through the implementation of those programmes. Despite the collaboration, at the point I take over as the director of public health there was no clear policy that has been implemented on adolescent and youth sexual and reproductive health in the state and I think visa a vice at the federal level. I think the policy then were just in the process of development at the national level. We later had a final policy document through the effort of the state and the collaborating partners. In the north central there was an interphase of the programme in Jos in 2008, it was a five day workshop. I think at that point the most interesting thing that came was up in that workshop was that it was an interphase between the policy maker and the service providers and also the youths, the young and the adolescents and the people that were directly involved in the policy. Several things were look at; these include: the issues of knowledge of reproductive health, the use of reproductive health commodities and some reproductive health issues that has negative effects on reproductive health of the youths. That was the main time that all these were been done.

The policy document which was sighted in in the course of interview with the respondent is the action plan for advancing health and development of adolescent and young people in Benue state which according to the respondent was developed by the state ministry of health in collaboration with EVA, UNFPA and ARFH. Almost all the respondents from other states said that the document is available, some even have personal copies outside the health facility copy.

Concerning the availability of NAYHD policy document at health facilities: Many of the policy makers were aware of the policy but it is not all the facilities that have copies of the document. The policy makers and implementer who do not work directly in the filed do not have copies of

the policy and some are not even aware of the policy. However, they welcome the development of making the document available to all.

The content of the policy emphasized by the respondents were areas of risky sexual behaviour by the adolescent and the young people, establishment of youth friendly centers where they will have access to adequate knowledge, positive peer relationships, screening for RH infections, access to condoms etc. Other contents stated by the respondents were the role of gatekeepers. Gatekeepers was defined by most of the respondents as religious leaders, community leaders, teachers and parents/guardians. A respondent was quoted”

“Yes we strongly believe that they are critical stakeholders in modeling the behaviour of the youths and one of the things that came out in development of that policy was that a lot of youths were ignorant about the things they needed to do so we designed building capacities of youth leaders, that we strongly believe that they will be in the better position to help themselves. Bringing an innovations that can serve as a sort of changing the life styles of the youth. We also believe that a lot of them belong to religious organizations where they have strong affiliation and faith on. A lot of youths are the ones that goes for this night vigils, sometimes they go there and a lot of negative things happen. In the policy we have issues where we will be able to sensitize the gatekeepers on the right approach to health on sexuality.

3.4.5: Perception of the Impact of Y-Access Project

Majority of the respondents agreed that the Y-Access project has made tremendous impact on the lives of the youth in their communities.

One of the respondent’s statement (paraphrased) is:

“From my own point of view, so many people (especially youths and adolescent) are now aware of so many behaviour that can negatively affect them. They are aware of where to access youth friendly reproductive health services, and they have support from their guardians and parents. We know that most of the youth friendly programmes are provided by development partners, but do we need to leave the partners alone to be doing these? We need to buy a lot of advocacies, we work a lot in trying to have a budget line for adolescent and reproductive health. Right now there is symbolization of maternal and child health. We need to have a specific budget line for reproductive health, now that we have the strategic health plan, we can address the problem of youth and adolescent in our society.

CHAPTER FOUR

ACHIEVEMENTS OF Y-ACCESS PROJECT

This chapter examines the achievements of Y-Access project over three and half years of the implementation bearing in mind the key impact indicators and the outcome and input indicators. The baseline and final results are compared and presented as percent. Questions concerning knowledge, attitude and practice are awarded one mark for correct answers and zero mark for all wrong answers and the total aggregate scores are computed and also compared with the baselines where necessary.

4.1. IMPACT INDICATORS

The most important indicator of the final Y-Access final evaluation survey is the improved reproductive health status of adolescent and young people in the 4 northern states of Nigeria, contributing to the achievements of MDG 5 and 6. This indicator further assessed the percentage of adolescent girls (15-19 years) who have begun child bearing and the HIV prevalence rate among 15-24 years old.

Reduction in Adolescent Pregnancy Rate

Figure 4.1.1 presents the percentage of adolescents who have begun child at baseline and close of Y-Access project. Overall, the percentage reduction of adolescent and young people pregnancy rate in the 4 northern States where Y-Access project was implemented was 38.4%, with Katsina State having the highest proportion of impact of the project (47.5%) and the least was Jigawa State (12.3%).

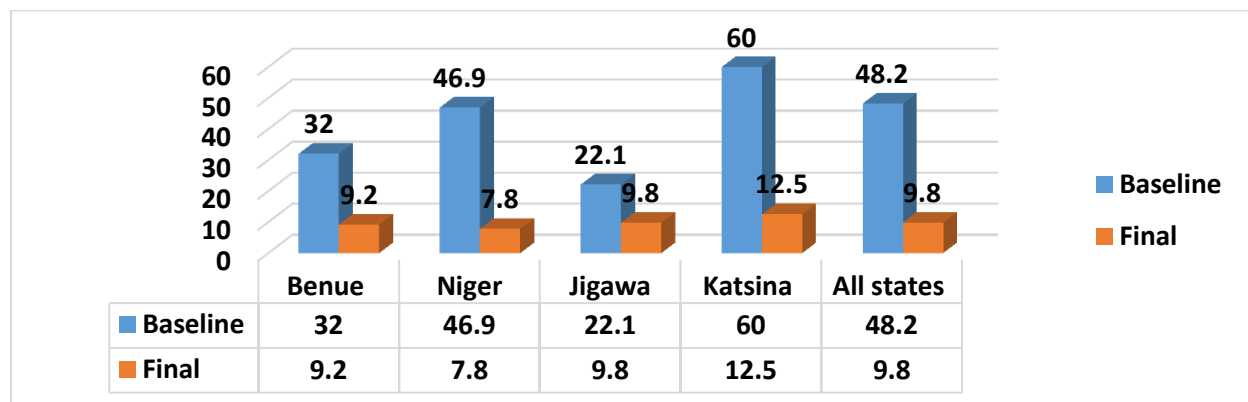


Figure 4.1:1 Percent distribution of respondents 10 -24 years who were pregnant/impregnated someone by survey status

Respondents Opinion on Possibility to Become Pregnant

At the end of the project activities approximately 88.0% of young people within the implemented project communities knew that it is possible for a young girl to be pregnant the first time she engages in sex. About eighty seven percent of them also knew that it is possible for a boy 10-24 years to impregnate a girl the first time he has sex with a woman. The percentage increase of the final result over the baseline findings was 22.0% and 20.7% for the possibility of girl to be pregnant or for boys to impregnate a girl in first sex respectively. This attribute may have contributed to the reduction in teenage pregnancy.

Table 4.1.1: Percent distribution of respondent's opinion and on possibility of young girls becoming pregnant or young boys impregnating girls by survey status

Variable	Benue	Niger	Jigawa	Katsina	All States
Is it possible for a girl aged 10-24 to get pregnant the first time she has sex					
Baseline	67.6	70.2	69.3	54.9	65.5
Final	74.8	96.5	87.7	91.0	87.5
Is it possible for a boy aged 10-24 to impregnate a girl the first time he has sex					
Baseline	71.0	65.7	68.3	60.9	66.5
Final	82.2	93.8	85.2	87.8	87.2

Ways of Preventing Unwanted Pregnancy

Table 4.1.2 shows the percent distribution of knowledge of the youths on family planning methods at baseline and final survey. Over 90.0% of the young people within the communities where the Y-Access project was implemented know the good possible options of preventing unwanted pregnancies; Jigawa and Katsina had more average percent difference (55.9% and 55.5% respectively) compared to Katsina (30.9%) and Benue (10.2%). The overall difference at the close of the project was 37.1%. In terms of the type of contraception, the respondent's choice of abstaining from sex and use of condoms predominates (78.7% and 74.7% respectively).

Table 4.1.2: Percent distribution of respondent's knowledge of family planning methods by survey status

Variable	Benue	Niger	Jigawa	Katsina	All States
Know what to do to avoid unwanted pregnancy					
Baseline	82.0	44.5	37.1	55.6	54.8
Final	92.2	96.0	93.0	86.5	91.9
Average difference	10.2	55.5	55.9	30.9	37.1
Methods of preventing unwanted pregnancy					
Abstain from sex					
Baseline	66.1	28.0	83.3	88.4	66.5
Yes	59.8	93.3	81.0	80.9	78.7
Use of Condom					
Baseline	14.9	48.1	71.2	63.8	49.5
Final	75.0	75.1	76.4	73.0	74.9
Use of Oral Pills					
Baseline	0.5	47.1	48.7	44.3	36.2
Final	57.2	38.7	56.6	54.0	51.6
Injectables					
Baseline	0.2	45.0	30.8	44.0	30.0
Final	39.2	44.9	58.4	63.8	51.6

HCT Uptake

Figure 4.1.2 present's young people ever been tested for HIV and obtained results. About three in five respondents have been tested for HIV at closed of the Y-Access project (64.5%) as against 24.8% at the beginning of the project. This is probably due to geographical spread and free financial access to HCT services available at the Y-Access SDPs.

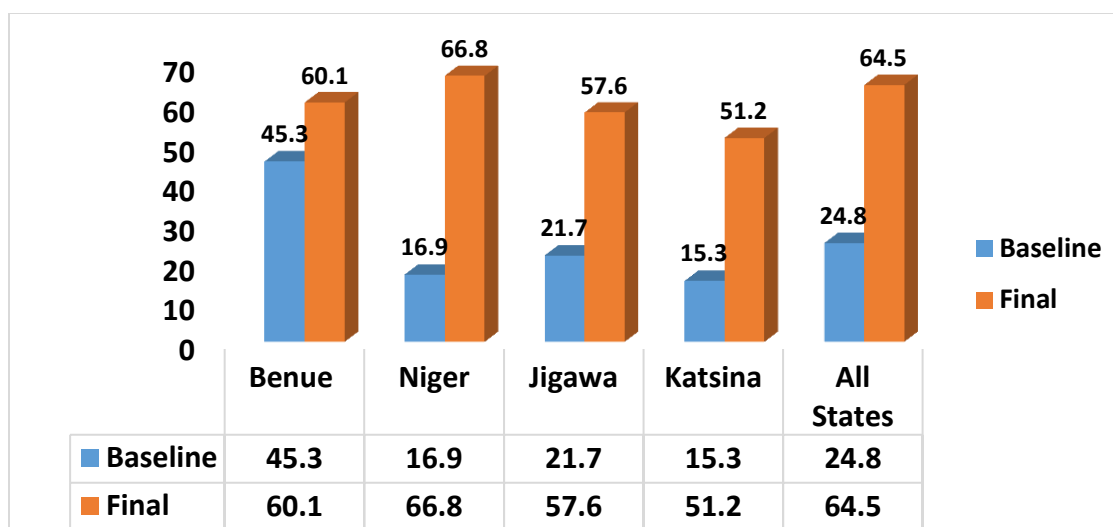


Figure 4.1.2: Percent distribution of respondents ever tested for HIV and obtained result by survey status

History of STIs

Table 4.1.3 presents the respondents who had ever experienced symptoms of STIs and medication sought for. Overall, the prevalence of STIs increased at the closed of the project by 1.8%. This is probably due to increased SPDs, increase case detection rate and improved treatment services. Use of informal health service delivery points for treatment of STIs is reduced at close of the project as compared to the baseline.

Table 4.1.3: Prevalence of STIs among Respondents and Medications sought

Variable	Benue	Niger	Jigawa	Katsina	All States
Ever experienced any STI					
Baseline	30.4	24.1	43.8	12.3	27.7
Final	25.8	35.7	23.8	32.8	29.5
Medications sought for					
PHC					
Baseline	34.9	37.5	63.4	40.0	44.0
Final	53.4	74.1	73.7	77.9	70.6
PMV					
Baseline	31.3	14.6	16.9	20.0	20.7
Final	29.1	16.8	14.7	9.9	17.2
Did nothing					
Baseline	8.7	33.1	2.8	4.0	12.5
Final	12.6	3.5	5.3	8.4	7.2
TBA					
Baseline	7.2	2.1	15.5	4.0	7.2
Final	4.9	5.6	6.3	3.8	5.1

4.2 OUTCOME INDICATORS

The outcome indicators measure the:

- i. Adolescent and young people in 16 target LGAs of northern Nigeria who have access to and make use of quality comprehensive health services
- ii. Number of SRH client's visits to target informal service delivery points disaggregated by type of service
- iii. Proportion and estimated number of adolescents and young people who self-reported accessing SRH Services
- iv. Number of formal and informal service providers providing SRH services to adolescents and young people disaggregated by type and
- v. Proportion and estimated number of adolescents and young people who reported using a method of contraception during the last sexual activity within the last twelve months
- vi. Number of states with specific Adolescent health and development strategic plans.

Access to, and Utilization of Quality Comprehensive Health Services

Table 4.2.1 provides an overview of the services provided and the client's volume over the years (2013-2016). At baseline overall total of 228,914 [206,242 (Females), 22,672 (Males); 110,752 (10-19 years), 118,162 (20-24 years); 18,572 (contraceptives); 103,900 (ANC); 21,798 (deliveries); 57,218 (HCT); 5,270 (STI testing/treatment); and 22,156] (Pregnancy testing) were recorded. Client's utilization for all the services provided recorded tremendous increased above the baseline. At close of the Y-Access project in 2016, a total of 1,016,131 (265,779 females, 112,856 males), 89,482 (10-14 years); 790,889 (15-19 years); 630,947 (20-24 years) was reported. The difference in client volume between the baseline and the close of the project was 787,217 and the expected target was exceeded by 32.7%. Similarly, the target for 2014 and 2015 were exceeded beyond the target for those years.

Table 4.2.1: Clients Volume of Services Rendered Over the Years (2012-2013)

Variable	2013	2014		2015		2016	
	Target	Target	Achieved	Target	Achieved	Target	Achieved
Sex							
Female	206,242	267,242	272, 427	443,242	534,979	686,078	731,580
Male	22,672	48,878	48,878	48,672	201,798	79,661	284,551
Age (years)							
10-19	110,752	150,413	150,413	237,952	379,869	365,638	522,257
20-24	118,162	170,892	170,892	253,962	356,908	400,101	493,874
Services							
Contraceptive	18,572	23,412	49,905	39,872	220,048	61,087	283,711
ANC	103,900	130,850	115,321	223,300	43,108	341,855	179,971
Delivery	21,798	27,064	27,064	46,798	43,539	72,348	59,767
HCT	57,218	84,584	84,584	123,018	195,890	198,968	293,284
STIs testing and treatment	5,270	17,549	17,549	11,270	87,288	18,010	133,489
Pregnancy testing	22,156	26,882	26,882	47,656	46,904	73,471	65,909
Total	228,914	300,914	321,305	491,914	736,777	765,739	1,016,131

Trend of total client's volume

Figure 4.2.1 presents the trend of the overall client volume over the three and half years Y-Access was implemented. Overall, the annual target for all the years exceed the target. The disaggregated services by sex, age and services provided was also achieved above the annual targets

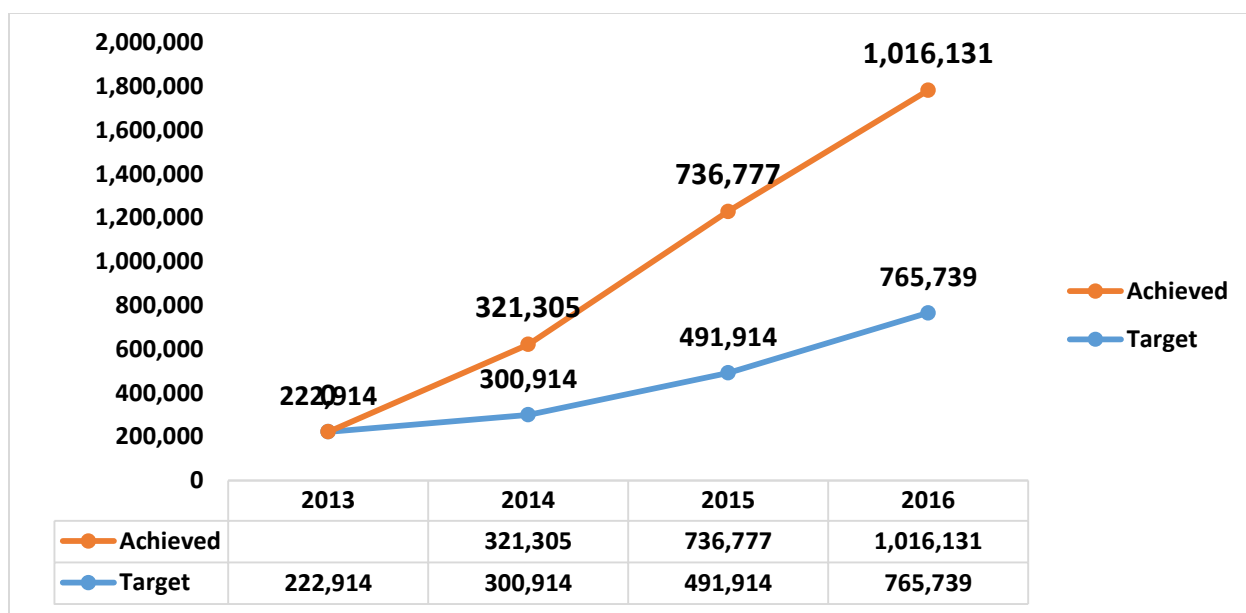


Figure 4.2.1: Trend of total client's volume

Services Provided at SDPS

Table 4.2.2 is an overview of the different types of services provided in different states. All facilities offer services on sexuality, safer sex, pregnancy prevention and STI/HIV, and majority (over 90%) of the facilities offer contraception methods e.g. condoms, Injectables and oral pills while only 18% of facilities offer implants. Above two-third (69.0%) of the facilities provide both male and female condoms with 56% of the facilities having adequate supply of condoms and others contraceptives. All the facilities have testing facilities for pregnancy with 81% of facilities using Urine micro for STI testing. About 68% of facilities have formal referral system, including tracking and follow up for services not provided.

Table 4.2.2 Distribution of Services Provided at Close of Project by States

Variable	Benue	Niger	Jigawa	Katsina	Total
Counseling on sexuality, safer sex, pregnancy prevention and STI and HIV provided					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Contraceptive methods are offered					
Condoms (Including Dual Protection)	3(75.0)	4(100.0)	4(100.0)	4(100.0)	15(93.75)
Injectables	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Oral Pills	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Implants	3(75.0)	0(0.0)	0(0.0)	0(0.0)	3(18.75)
Condoms are provided to both male and female					
Yes	2(50.0)	4(100.0)	3(75.0)	2(50.0)	11(68.8)
No	2(50.0)	0(0.0)	1(25.0)	2(50.0)	5(31.2)
Are supply of condoms and other contraceptives sufficient?					
Yes	1(25.0)	3(75.0)	2(50.0)	3(75.0)	9(56.2)
No	3(75.0)	1(25.0)	2(50.0)	1(25.0)	7(43.8)
Is there sufficient equipment for the provision of RH services					
Yes	1(25.0)	1(25.0)	4(100.0)	3(75.0)	9(56.2)
No	3(75.0)	3(75.0)	0(0.0)	1(25.0)	7(43.8)
Is Pregnancy testing offered					
Yes	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Is STI testing Available					
Yes	4(100.0)	4(100.0)	1(25.0)	4(100.0)	13(81.2)
No	0(0.0)	0(0.0)	3(75.0)	0(0.0)	3(18.8)
Types of STI Testing offered					
Urine Micro	4(100.0)	4(100.0)	4(100.0)	4(100.0)	16(100.0)
Syphilis	2(6.2)	1(6.2)	1(6.2)	1(6.2)	4(25.0)
VDRL	1(6.2)	0(0.0)	0(0.0)	1(6.2)	2(12.4)
Do Young people request for services other than the ones offered					
No	3(75.0)	4(100.0)	2(50.0)	2(50.0)	11 (68.8)
Yes	1(25.0)	0(0.0)	2(50.0)	2(50.0)	5 (31.2)
Are referrals made for services not provided at the clinic					
Yes	3(75.0)	1(25.0)	3(75.0)	2(50.0)	9(56.2)
No	1(25.0)	3(75.0)	1(25.0)	2(50.0)	7(43.8)
Is there a formal referral system, including tracking and follow-ups					
Yes	3(75.0)	2(50.0)	3(75.0)	3(75.0)	11(68.8)
No	1(25.0)	2(50.0)	1(25.0)	1(25.0)	5(31.2)

Client's Visits to Target Informal Service Delivery Points

Figure 4.2.2 presents the number of SRH client's visits to target informal service delivery points disaggregated by type of service, age and sex. Services provided were counselling/information, contraceptives, pregnancy-delivery, ante-natal care, post-natal care and post abortion care. At baseline, there was no record of SRH clients visit to informal SDPs, while at close of the project the target of 253,800 was achieved above target. The expected client's volume to all the informal SDPs were exceeded above the expected.

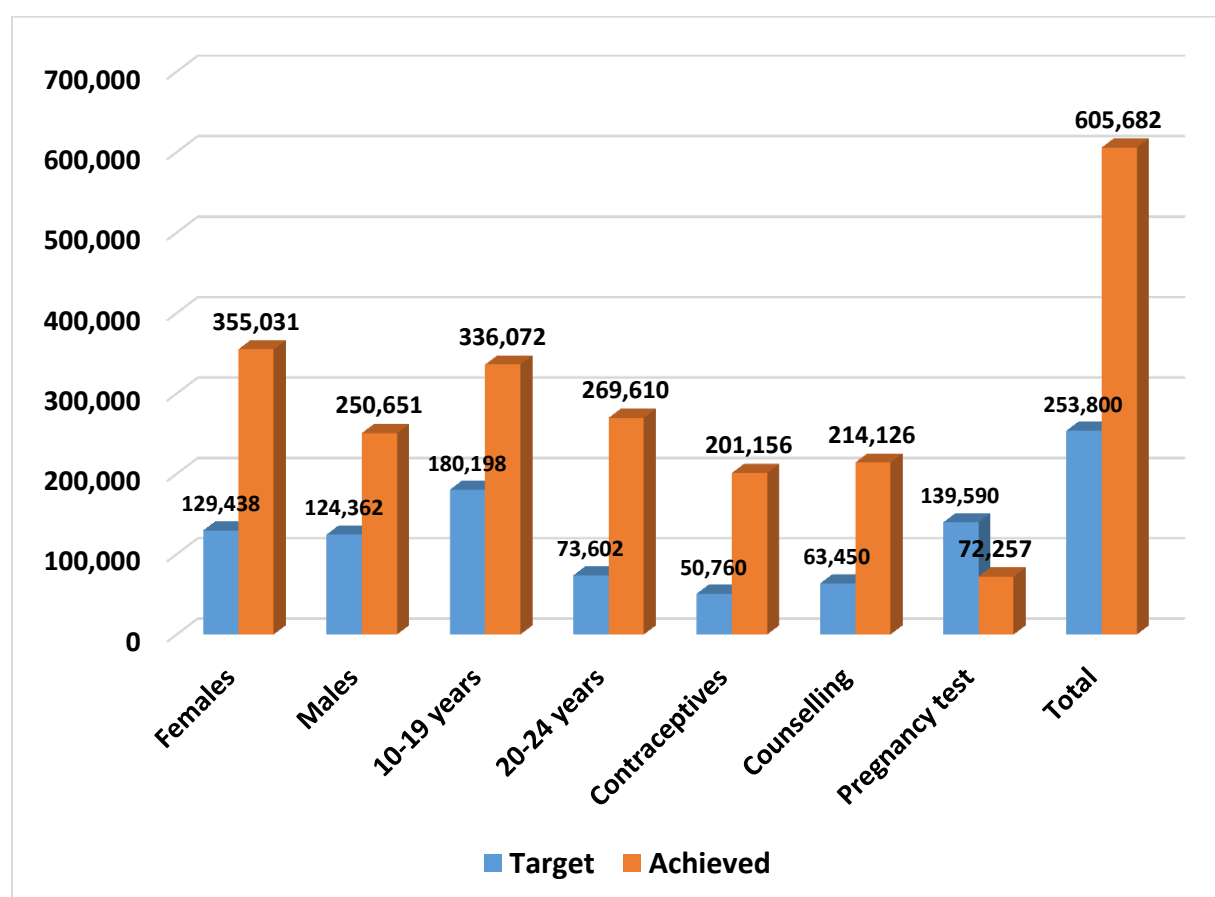


Figure 4.2.2: Distribution of SRH client's visits to target informal service delivery points disaggregated by age, sex and type of services

Self-Reported Access to SRH Services

Figure 4.2.3 presents the proportion of adolescents and young people who self-reported accessing SRH Services. The planned target of 36.0% in all the states was exceeded. Overall, at the close of the project, 77.3% of the respondents (adolescent and young people) reported to

have self –reported accessing RHS at either formal or informal service delivery points within the three and half years of Y-Access implementation.

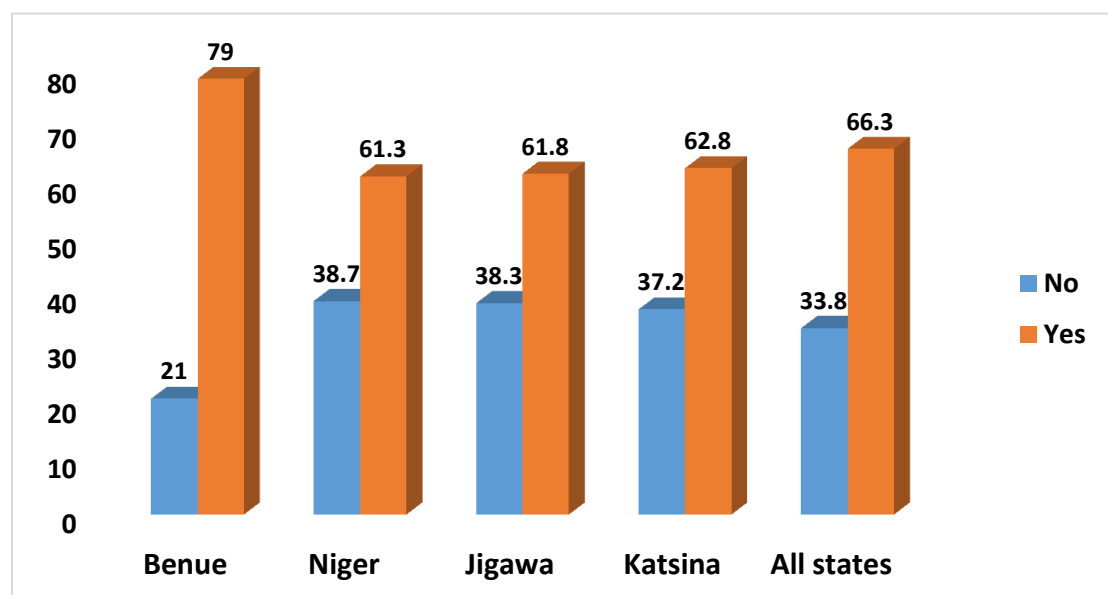


Figure 4.2.3: Percent distribution of adolescents and young people who self-reported accessing SRH Services.

Formal and Informal Service Providers Providing SRH Services to AYP

Figure 4.2.4 presents the distribution of formal and informal service providers providing SRH services to adolescents and young people disaggregated by type. The overall target was achieved. In terms of types of service providers, the informal service providers exceeded the target by 3.4%, whereas the achievement in provision of RHS by the formal health providers were short of 14.3%.

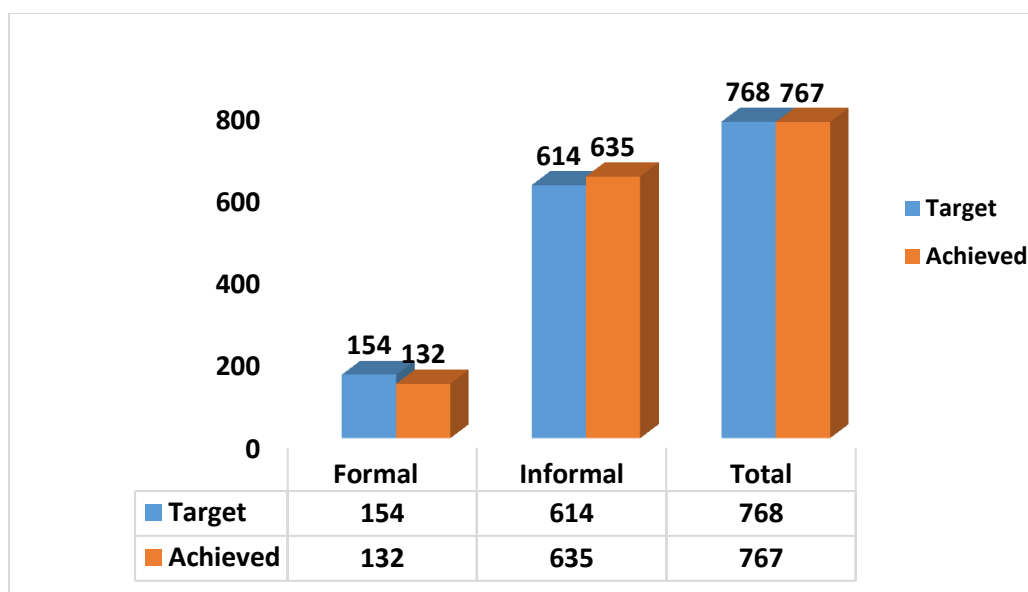


Figure 4.2.4: Number of formal and informal service providers providing SRH services to adolescents and young people

History of Sex and Use of Contraception

Tables 4.2.3 provides information on the proportion and estimated number of adolescents and young people who had sexual intercourse within the period under review. A higher proportion of the respondents had delayed sex initiation at the closed of the project survey (28.1%) as compared to the baseline survey (36.2%). The difference cut across all the states, with overall, percent decrease of 8.0%. The difference in the proportion of respondents who had sex twelve months before the baseline and final survey reduced from 79.7% to 25.0% (54.7% reduction).

Table 4.2.3: Percent distribution of Respondents History of sex by State by Survey Status

Sex/Age	Benue		Niger		Jigawa		Katsina		All states	
	Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final
Ever had sex	56.9	51.3	38.4	26.0	37.1	14.3	15.8	21.0	36.2	28.1
Age at first sex (years)										
≤14	29.6	14.1	36.3	8.7	18.6	8.8	33.3	13.1	21.1	12.0
15-22	26.5	81.5	39.0	88.5	25.6	87.7	22.2	81.0	28.3	83.6
≥21	25.2	4.4	18.5	2.9	24.4	3.5	27.8	6.0	24.0	4.2
Sex in last 12 months	84.8	43.5	71.2	22.5	84	15.8	78.8	18.2	79.7	25.0

Use of Contraception

Information on the proportion and estimated number of adolescents and young people who reported using a method of contraception during the last sexual activity within the last twelve months is presented in Table 4.2.6. The expected target was 59.2% and the final percent use of contraception among the respondents was 59.2%. Overall, there was 34.4% increase of usage of at least a method of contraceptives by respondents. Among the contraceptives used, condom predominates (88.4%), with 16.4% difference of usage between respondents at final and baseline surveys. Consistent used of condoms (respondents who always use condom during sexual intercourse) constitutes 60.2%.

Table 4.2.4: Distribution of use of contraception among Young people by survey status

Contraception used	Benue		Niger		Jigawa		Katsina				All states
	Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final	
Yes	47.4	71.7	15.8	67.0	17.9	51.7	18.2	24.3	24.8	59.2	
Methods											
Condoms	85.3	93.2	56.5	87.0	56.5	80.6	75.0	66.7	72.0	88.4	
Oral contraceptive	7.3	3.8	13.0	7.4	13.0	6.5	8.3	13.3	42.9	5.6	
Injectables	3.7	0.8	21.7	1.9	21.7	9.7	0.0	13.3	8.1	3.0	
Withdrawal	0.0	2.3	4.3	0.0	0.0	3.2	8.3	6.7	3.8	2.1	
Safe period	3.7	0.0	4.3	3.7	4.3	0.0		0.0	0.0	0.9	
Consistent condom use		62.2		70.2	4.3	40.7		40.0		60.2	

State with Specific Adolescent Health and Development Strategic Plans

In terms of costed plans and policy documents; none of the states where Y-Access project was implemented have at baseline. At close of the project, all the government of all states where the Y- Access was implemented in collaboration with the implementing partners developed their AYHD policy which have clear written guidelines for serving young people. The document was sighted in 14 (87.5%) of all the facilities visited during the final evaluation.

4.3 OUTPUT INDICATORS

These indicator's measures the:

- a) Increase in capacity of target health service outlets to deliver comprehensive youth sexual and reproductive health services
- b) Adolescents and young people in the target areas who are empowered with the knowledge and skills to access SRH information and services
- c) Young people who benefited from income generated activities and the voucher scheme used to reduced financial barriers to access SRH services and
- d) Target communities, young people, local duty bearers who have increased awareness of the importance of youth SRH and improved capacity to advocate for improved SRH at the local and state level.

The Knowledge and attitudes of adolescent and young people towards SRH and the proportion and numbers of duty bearers who report willingness to support young people to access SRH information and services are presented below. Other specific indicators necessary for the assessing the overall achievement against the project logframe outputs/indicators is included in the final logframe indicators summary.

Number of Young People Reporting Good Knowledge and Positive Attitudes towards Sexual and Reproductive Health

This indicator measures the proportion and estimated number of young people reporting good knowledge and positive attitudes towards SRH. The project target of overall good knowledge and positive attitude score of 67.0% was achieved. Figure 4.3.1 and Table 4.3.1 below provides an overview of the final achievements of this indicators over the baseline.

Knowledge of Body Changes That Occur During Puberty

The respondent's percentage knowledge score of body changes that occur among girls and boys at puberty was higher at closed of the project as compared to the baseline across all the states the Y-Access project was implemented. Overall, the percent knowledge score of respondents increased by 83.4%.

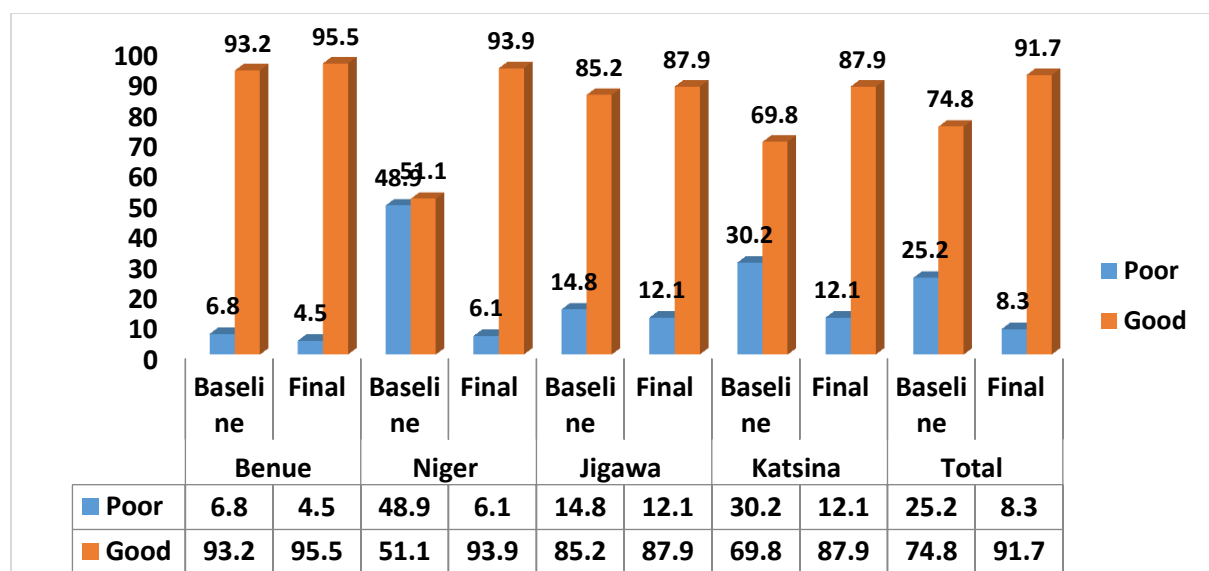


Figure 4.3.1 Respondent's percentage knowledge score of body changes that occur among girls and boys at puberty by Survey Status

Awareness of STIs

Overall, respondent's awareness of STI at baseline was 46.8% and that increased by 42.8% at closed of the Y-Access project. There is wide disparity in the respondent's level of awareness of syphilis as compared to other sexually transmitted infections across all the project implementing states both at baseline and even at closed of the project. This may imply that the project did not focus on syphilis

Table 4.3.1: Percent distribution of Respondents knowledge of STIs by States and Survey status

Variable	Benue	Niger	Jigawa	Katsina	All States
Ever heard of any sexually transmitted infection STIs					
Baseline	67.6	47.4	35.0	37.0	46.8
Final	94.5	95.8	85.2	82.8	89.6
Ever Heard of Syphilis					
Baseline	54.6	5.5	38.8	33.5	33.0
Final	42.8	37.2	43.9	56.0	44.9
Ever Heard of Gonorrhea					
Baseline	86.4	62.8	80.3	69.0	74.6
Final	73.0	57.4	61.7	64.8	64.2
Ever Heard of HIV/AIDS					
Baseline	94.0	68.0	83.0	74.0	79.8
Final	98.8	94.8	92.0	88.0	93.4

Knowledge of Features of STIs

Figure 4.3.2 presents the percent distribution of respondent's knowledge of signs and symptoms of STIs. Overall, over 70.0% of the respondents understand the major signs and symptoms of STIs. These includes: pain during urination (82.7%), itching around the genitals (78.8%), foul smelling discharge from vagina/penis (79.1%) and genital ulcers (78.8%). All the states recorded tremendous improvement except in Jigawa State which recorded a drop from 72.8% at baseline to 70.4% at the close of the project.

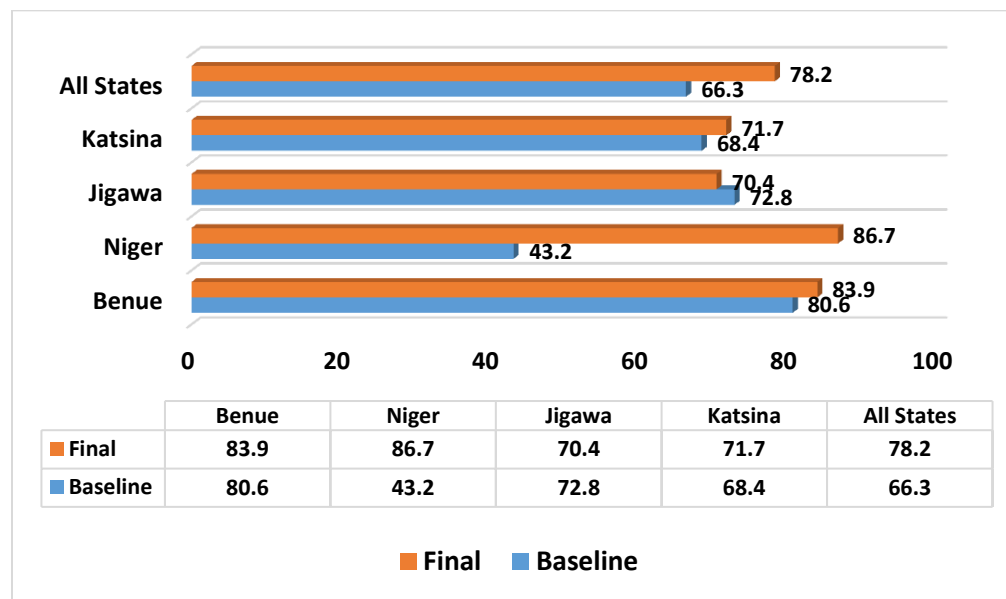


Figure 4.3.2: Respondents Knowledge Score of Features of STIs by State and Survey Status

Knowledge of Methods of Prevention of STIs

The respondent's knowledge score of methods of prevention of STIs and HIV/AIDS is presented in Figure 4.3.3. Among the variable reported, over two third of the respondents in all the states had good knowledge of abstinence, use of condoms, not sharing of sharp objects and rejecting transfusion of unscreened blood as preventive measure. Above one-fifth of all the respondents from Benue, Niger, Jigawa and Katsina (35.0%, 23.7%, 25.1% and 39.5% respectively) still had misconception of use of mosquito's nets as a means of preventing STIs. Overall, the respondent's good knowledge score increased by 55.9% and the poor knowledge score decreased by 52.9%.

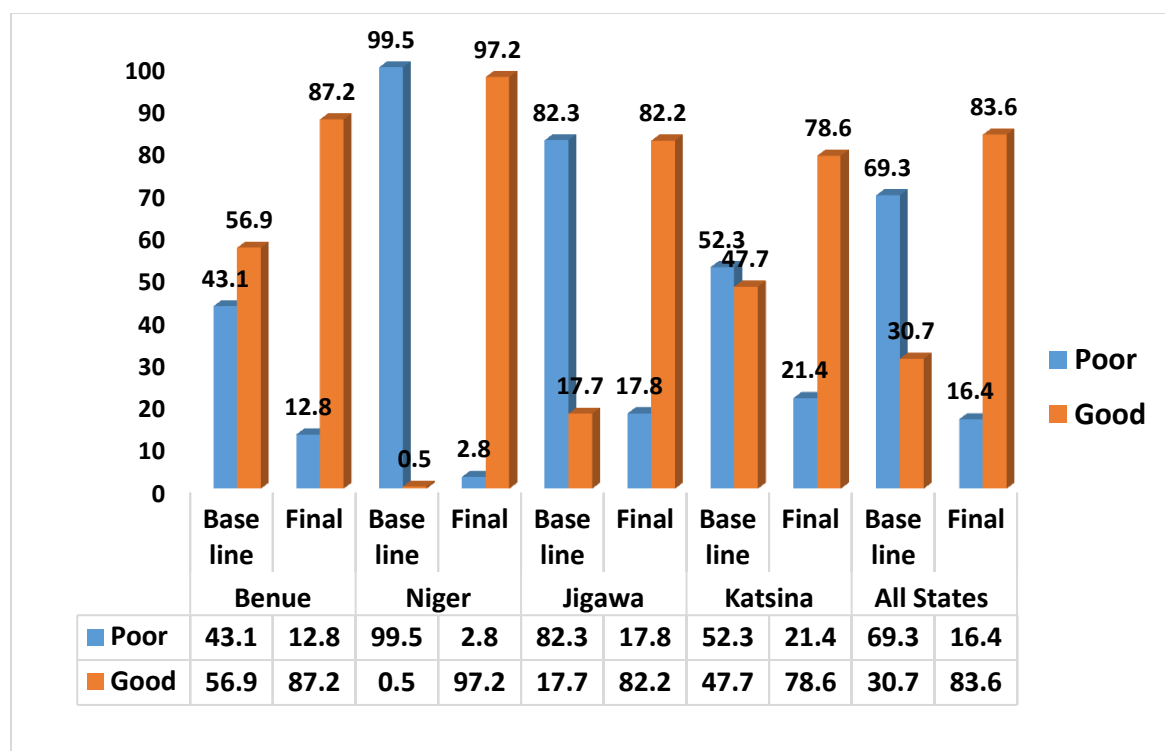


Figure 4.3.3: Percent Distribution of Respondents Knowledge Score of Methods of Prevention of HIV/AIDS by States and Survey Status

Attitude towards Reproductive Health Services

Figure 4.3.4 presents the percentage attitudinal score of respondents by states and survey status. At baseline majority of respondents in Katsina (59.8%) and Jigawa (79.2%) had negative attitude towards RHS, while respondents from Benue and Niger who had negative attitude towards RHS constitutes 44.5% and 46.3% respectively. At close of the project there was tremendous increase in positive behaviour across the states with overall difference of 56.4% as against the baseline.

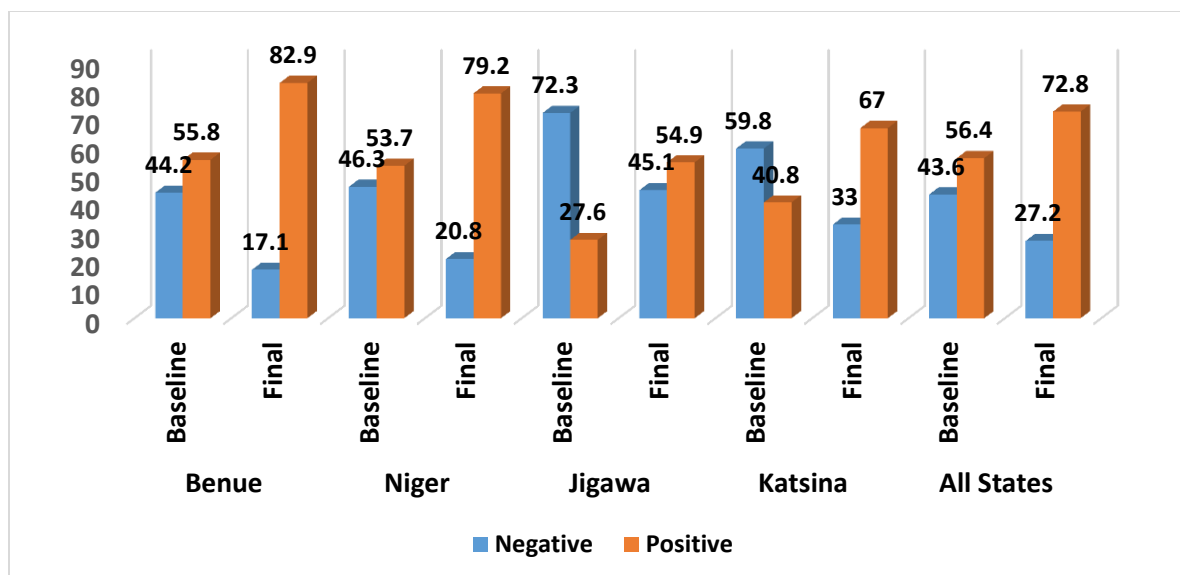


Figure 4.3.4: Percent Distribution of Respondents attitudinal Score of towards RHS by State and study Status

Perception of Respondents towards Use of Condoms

At baseline high proportion of the respondents had negative attitude towards use of condom. There was improvement in the attitude at closed of the project with 53.0% disagreeing that it is unfair to keep saying no to boyfriend/girlfriend for sexual intercourse. About fifty percent are not in support of perception that buying condom is embarrassing. Forty three still believe that condom reduces sexual pleasure, while 38.9% disagree that is impossible to abstain if you are already having sex.

Table 4.3.2: Percent Distribution of Respondents Attitude towards Use of Condoms by State and study Status

Attitude	Benue		Niger		Jigawa		Katsina		All States	
	Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final
If you have a boyfriend/girlfriend, it is unfair to keep saying NO to sexual intercourse										
Agree	29.7	23.3	33.1	32.1	19.3	38.2	27.8	40.2	27.5	33.4
Disagree	53.0	64.9	29.0	60.2	14.8	38.5	16.1	48.5	28.2	53.0
Don't know	11.9	11.8	0.7	7.8	31.0	23.3	51.1	11.3	23.7	13.5
It is too embarrassing for me to buy condoms/contraceptives										
Agree	54.5	29.3	35.0	27.9	28.3	48.0	38.6	62.7	39.1	42.0
Disagree	28.2	63.9	27.4	66.6	8.6	40.2	13.4	30.8	19.4	50.4
Don't know	11.9	6.8	37.1	5.5	30.0	11.9	43.6	6.5	30.7	7.7
If a girl suggest use of condom, it would mean she didn't trust him and vice versa										
Agree	47.0	33.9	29.8	29.6	22.1	54.2	25.2	49.4	31.0	41.7
Disagree	34.4	57.0	30.2	63.9	8.8	29.4	13.4	39.3	21.7	47.5
Don't know	13.1	9.0	39.5	6.5	36.0	16.5	56.6	11.3	36.3	10.8
Condoms reduce sexual pleasure										
Agree	38.4	39.5	38.4	38.8	14.8	49.7	28.5	43.9	27.6	43.0
Disagree	24.0	34.0	24.0	41.1	5.5	23.0	7.2	20.3	13.1	29.6
Don't know	31.9	26.4	31.9	20.1	46.4	27.3	59.5	35.8	48.1	27.4
It is impossible to abstain if you are already having sex										
Agree	42.1	33.8	30.2	30.8	17.1	47.5	20.9	39.9	27.5	38.0
Disagree	30.9	51.4	30.5	52.1	9.8	28.8	14.1	23.4	21.3	38.9
Don't know	21.3	23.3	37.6S	17.0	38.1	23.7	59.2	36.7	39.1	23.1

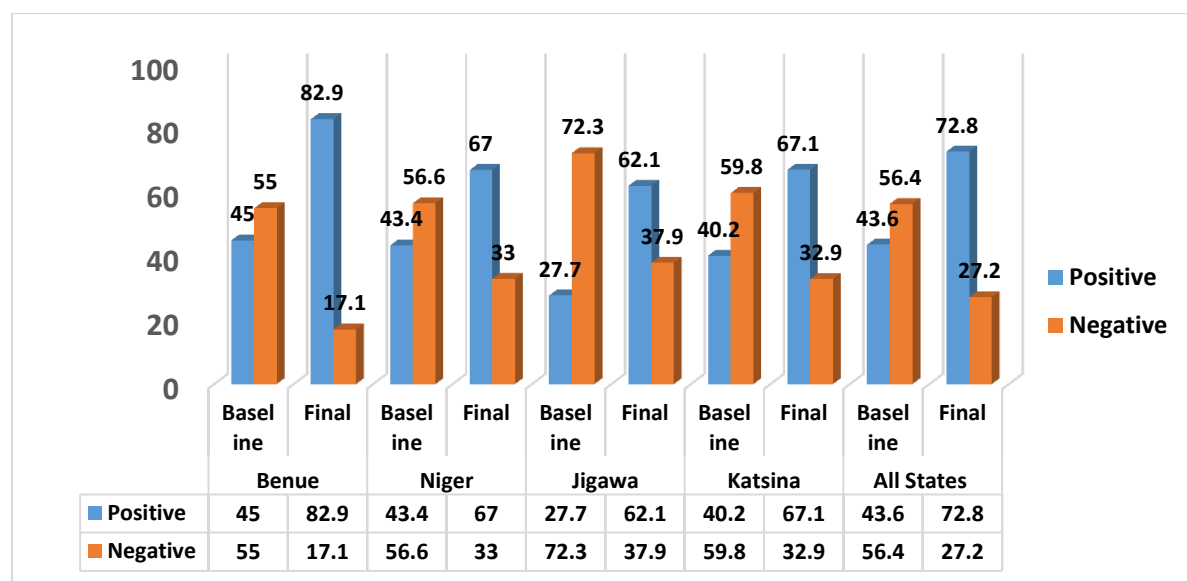


Figure 4.3.5: Percent Distribution of Respondents attitudinal Score on Use of Condom for Prevention of HIV/AIDS by states and Survey Status

Overall Knowledge and attitudinal Score

Figure 4.3.6 presents the summary of the proportion and estimated number of young people reporting good knowledge and positive attitudes towards SRH. Overall knowledge score at close of the project was 78.2% against the baseline (43.5%). The achievement was 18.2% above the estimated close of the project target (60.0%). Positive attitude towards SRH also increased from 47.6% at baseline to 59.8% at close of project, but the improvement was 7.2% short of the proposed close of project target (67.0%).

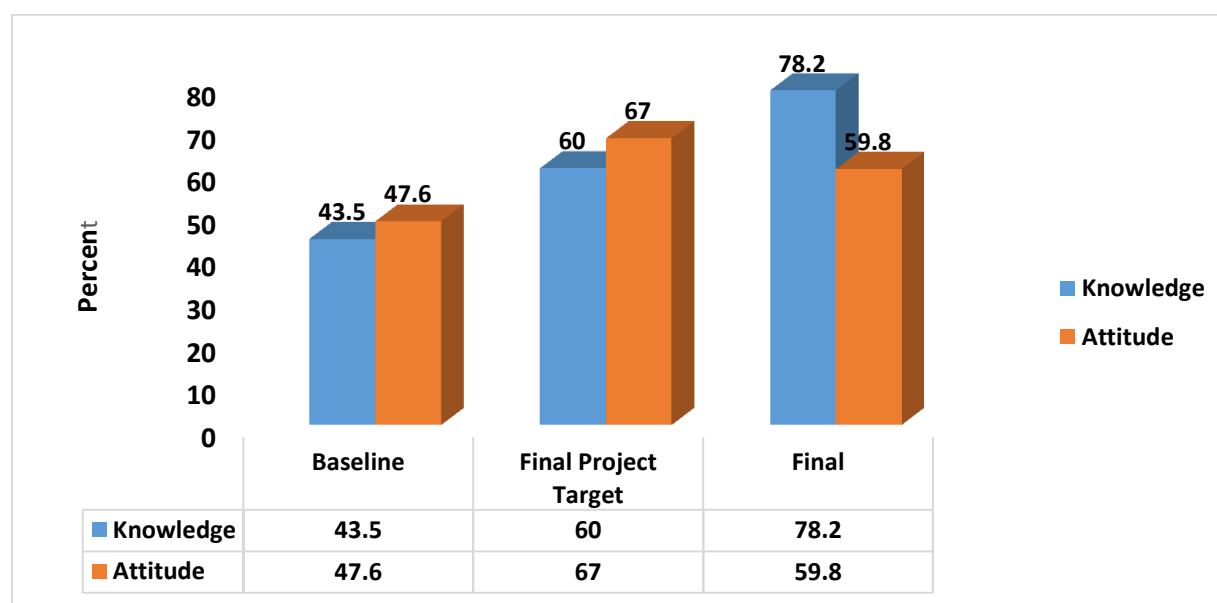


Figure 4.3.6: Percent Distribution of Respondents overall Knowledge and attitude towards SRH by Survey Status and Target

Duty Bearers willingness to Support Young People to Access SRH Information and Services

Figure 4.3.7 represents the proportion of duty bearers (parents, teachers, community leaders and religious leaders) who reported willingness to support young people to access SRH information and services. There was improvement of final assessment over the baseline but the 100% target was not achieved.

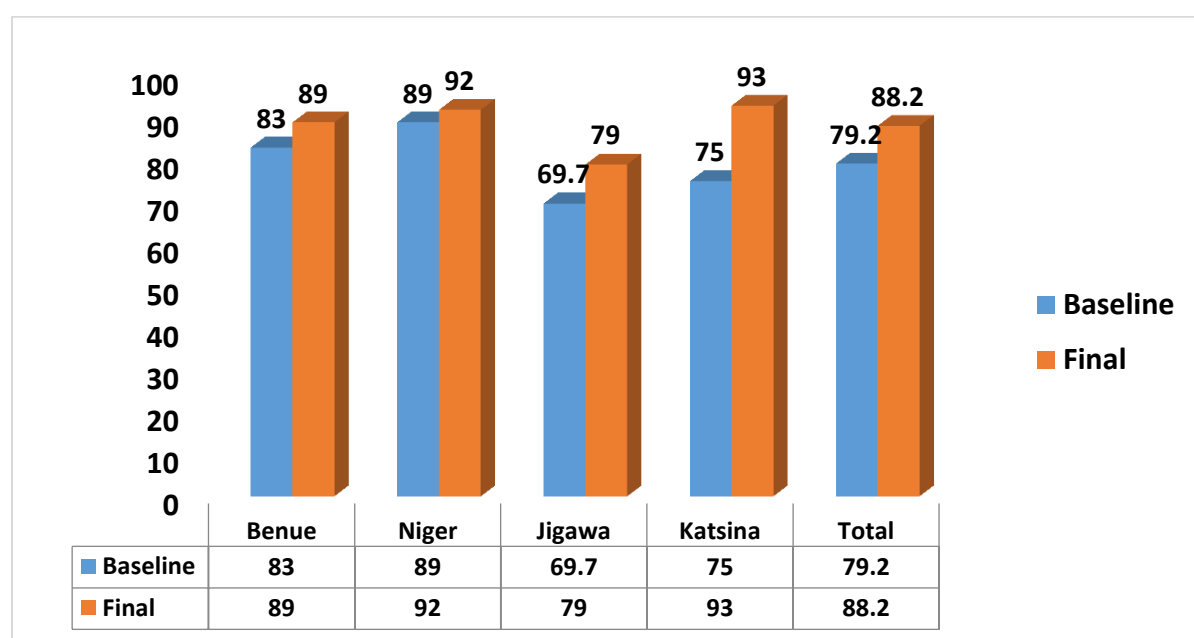


Figure 4.3.7: Percent distribution of duty bearer's support of RHS by State and survey Status

Adolescent and Young People Perception of parents support for Y-Access program

Table 4.3.3 presents the adolescent and young people perception about duty leader's support towards ARH services within their respective communities. About four out of every five respondents opined that their parents and the elders/ in the community support the adolescent and young people's use of RH services. Over half of the respondents were of the opinion that parents of adolescent and young people in their communities discuss RH issues with their children; with about two thirds discussing STIs, drug abuse and teenage pregnancy. Most parents/guardians shied away from discussing sexual abuse, puberty and abortion with their children.

Table 4.3.3 Young people's perception of parents support for Y-Access program

Variables	Benue	Niger	Jigawa	Katsina	All States
Parents/elders in the community support ARH in the past 3 ½ years					
Yes	323(80.8)	345(86.0)	320(80.2)	313(78.2)	1301(81.3)
No	77(19.2)	56(14.0)	79(19.8)	87(21.8)	299(18.7)
Do your parents support your use of RH services					
Yes	318(79.5)	313(78.1)	313(78.4)	332(83.0)	1276(79.8)
No	82(20.5)	88(21.9)	86(21.6)	68(17.0)	324(20.2)
Parents ever discussed sex related matters with you					
No	191(47.8)	207(51.6)	196(49.1)	269(67.2)	863(53.9)
Yes	209(52.2)	194(48.4)	203(50.9)	131(32.8)	737(46.1)
If yes, list the RH issues					
STIs	43(30.1)	106(53.3)	50(23.8)	41(29.7)	240(31.5)
Drug Abuse	15(7.0)	30(15.1)	78(37.1)	28(20.3)	151(19.8)
Teenage Pregnancy	32(15.0)	34(17.1)	27(12.9)	10(7.2)	103(13.5)
Contraception	49(22.9)	13(6.5)	8(3.8)	9(6.5)	79(10.4)
Abstinence	46(21.5)	3(1.5)	5(2.4)	5(3.6)	59(7.8)
Sexual Abuse	9(4.2)	1(0.5)	32(15.2)	13(9.4)	55(7.2)
Puberty	10(4.7)	11(5.5)	10(4.8)	14(10.1)	45(5.9)
Abortion	10(4.7)	1(0.5)	0(0.0)	18(13.0)	29(3.8)

4.4: UNINTENDED POSITIVE OUTCOMES OF THE PROJECT

The main goal of the intervention programme was to reduce the impact of poverty by improving the reproductive health status of adolescence and young people in the 16 LGAs. In the course of the intervention, other unintended positive outcome were observed. Amongst these include:

- i. **Reduction in Psychoactive substance abuse.** At close of the project, less than a tenth of the adolescent and young people in the 16 LGAs smoke cigarette (7.4%) and or takes alcohol (8.9%). Intake of other psychoactive substances reduced remarkably. This was

achieved through awareness anti-drug programme targeting most-at-risk youth in the communities. The activities were carried out in collaboration with staff of the National Drug Law Enforcement Agency (NDLEA). The NDLEA also planned to set up drop in centres for drug dependent, treatment and rehabilitation of young people with drug related problems.

- ii. **Engagement of Service Providers in Other Health Related Events.** The local government councils across the 4 project states recognized the capacities of the trained PEs and engaged them in different health activities within communities such as immunization, community sensitization among others. In this regard discussions have reached advanced stage with the state NDLEA office in Katsina state to train more youths on creating awareness on the effect of drug abuse on young people, management of youths engaged in drug abuse and referrals for rehabilitation
- iii. **Political Will and Commitment:** The government of Jigawa state has indicated her intention to replicate the project strategies in other LGAs to create awareness amongst young people on SRH issues and also provide them income generation skills as indicated in the costed ASRH plan developed. In a similar development, a Philanthropists from Mashi Local government of Katsina State, established scholarship scheme to support some of the beneficiaries in furthering their education at various levels.

LOGFRAME INDICATORS AND FINAL EVALUATION SUMMARY

NAME OF ORGANIZATION: Association for Reproductive and Family Health (ARFH)

PROJECT NAME: Final Evaluation on "Improving Youth Reproductive Health in 4- Northern Nigeria States

CONSULTANT: Department of Epidemiology and Community Health, Benue State University Makurdi

Note Green **Indicator was achieved**

: Yellow **indicates:**

Yellow **indicates:** **Indicator was almost achieved**

Red **indicates:** **There was improvement but indicator was not achieved**

Table 5.0. Final evaluation Impact Summary

INDICATOR	BASELINE:	TARGET: Feb 16	FINAL EVALUATION	PROGRESS SUMMARY
Impact: Improved reproductive health status of adolescents and young people in 4 States of Northern Nigeria, contributing to the achievement of MDG 5 & 6				
Impact indicator 1	Sept 2012			
Percentage of adolescent girls (15-19yrs) who have begun child bearing.	National Average: 22.5% (Benue: 22.5%; Jigawa: 51.7%; Katsina: 53.3%; Niger: 27.3%)		Total Average=5.1%; Benue= 3.5%; Niger= 4.4%; Jigawa=5.9%; Katsina=7.8% Overall reduction rate 38.4%	Achieved
Impact Indicator 2				
HIV Prevalence rate (among 15-24 year olds)	National Average: 3.8% (Benue: 12.1%; Jigawa: 1.3%; Katsina: 2.2%; Niger: 5.3%)		Proportion of adolescent and young people tested for HIV and received their results was high	Achieved: The programme was able to solve the bottle necks that affects the uptake of HCT
Outcome: Adolescents and young people in 16 target LGAs of Northern Nigeria have improved access to, and make use of, quality comprehensive reproductive health services.				
Outcome Indicator 1	Baseline: April 2013	Target: Feb 16		

Number of SRH client visits to target formal service delivery points disaggregated by type of service (Contraceptives provision and counselling, ANC, Delivery, HCT, STI testing/treatment, Pregnancy testing), age and sex	228,914 (206,242 Females; 22,672 Males; 110,752 10-19 years; 118,162 20-24 years) a) Contraceptives: 18,572 b) ANC: 103,900 c) Delivery: 21,798 d) HCT: 57,218 e) STI testing/treatment 5,270 f) Pregnancy testing 22,156	765,739 (686,078 Females; 79,661 Males; 365,638 10-19 years; 400,101 20-24 years) a) Contraceptives: 61,087 b) ANC: 341,855 c) Delivery: 72,348 d) HCT: 198,968 e) STI testing/treatment 18,010 f) Pregnancy testing 73,471	1,016,131 (731,580 Females; 284,551 Males; 522,257 10-19 years; 493,874 20-24 years) a) Contraceptives: 283,711 b) ANC: 179,971 c) Delivery: 59,767 d) HCT: 293,284 e) STI testing/treatment 133,489 f) Pregnancy testing 65,909	Achieved: Above target
Outcome Indicator 2	Baseline: Sept 2012	Target: Feb 16		
Number of SRH clients visits to target informal service delivery points disaggregated by type of service (Counselling/information, Contraceptives, Pregnancy-Delivery, ANC, PNC, PAC), age and sex.	0	253,800 (129,438 Females; 124,362 Males; 180,198 10-19 years; 73,602 20-24 years) a) Contraceptives: 50,760 b) Counselling: 63,450 c) Pregnancy: 139,590	605,682 (355,031 females; 250,651 males; 336,072 10-19 years; 269,610 20-24 years) a) Contraceptives: 201,156 b) RH Counselling: 214,126 c) Pregnancy: 72,257	Achieved: Above target
Outcome Indicator 3	Baseline: Sep 2012	Milestone 3: Feb 16		
Proportion and estimated number of adolescents and young people who self-reported accessing SRH Services.	25.9% (26,143)	36.0%	Overall, 73.0% of the respondents (adolescent and young people) reported to have self –reported accessing RHS at either formal or informal service delivery points within the three and half years of Y-Access implementation.	Achieved: Above target

Outcome Indicator 4	Baseline: Sep 2012	Milestone 3: Feb 16		
Number of formal and informal service providers providing SRH services to adolescents and young people disaggregated by type.	0	768 (Formal Health Service providers: 154; Informal Health service providers: 614)	767 (132 formal HSP; 635 Informal providers)	Achieved
Outcome Indicator 5	Baseline: Nov 2012	Target: Feb 16		
Proportion and estimated number of adolescents and young people who reported using a method of contraception during the last sexual activity within the last twelve months	26.1% (266,183)	36% (367,150)	59.2% of 412 who had sex within the last 12 months reported using at least a method of contraception	Achieved: Above target
Outcome Indicator 6	Baseline: Sept 2012	Target: Feb 16		
Number of states with costed ASRH plans	0	4	All the 4 states have costed plans	Achieved
Output 1: Increased capacity of target health service outlets (and community level delivery points) to deliver comprehensive youth sexual and reproductive health services				
Output Indicator 1.1	Baseline: Sept 2012	Target: Feb 16		
Proportion and number of formal health facilities with improvements in at least three out of four youth friendliness domains: A) Availability of clear written guidelines for serving young people. B) Involvement of young people C) Availability of educational materials targeting young people. D) Collection of age disaggregated data	0	60% (80)	<ul style="list-style-type: none"> ○ Availability of clear written guidelines for serving young people (100.0%) ○ Involvement of young people (100.0%) ○ Availability of educational materials targeting young people (100.0%) ○ Collection of age disaggregated data (100.0%) 	Achieved: Above Target
Output Indicator 1.2	Baseline: Sept	Target: Feb 16		

	2012			
Number of health service providers trained in adolescent and young people sexual and reproductive health service provision at (a) formal service delivery points and (b) informal delivery points disaggregated by sex and designation (TBAs or PMVs).	0	Total: 960 (402 Males; 558 Females) (a) 192 formal HSPs (b)768 (384TBAs, 384PMVs)	Total: 917 (480 females, 437 males) , formal HSPs=190, TBAs= 374, PMVs= 353	Achieved: Total = 4.5% below target Males: 19.4% above target Females : 21.7% below target Formal HSDPs Informal HSDPs= 1.0% below target Informal HSDPs= 5.3% below target
Output Indicator 1.3	Baseline: Dec 2013	Target: Feb 16		
Proportion and number of formal health service providers with adequate and sustained knowledge on adolescent sexual reproductive health issues and youth friendly service delivery	6.9% (13)	50% (96)	Results of pre-training and post training exercises 79.0% (132)	Achieved : 58% above target
Output Indicator 1.4	Baseline: Sept 2012	Target: Feb 16		
Number of community level service delivery points (TBAs/PEs) provided with the project FP seed stock, who provide non-prescriptive contraceptives.	0	468	178	Not achieved: 61.9% below target
Output 2: Adolescents and young people in the target areas are empowered with the knowledge and skills to access SRH information and services				
Output Indicator 2.1	Baseline: Sept 2012	Target: Feb 16		

Number of times young people were reached with SRH information disaggregated by age and sex.	0	788425 (182,872 Males; 605,553 Females) (429,870 10-19 years; 358,555 20-24 years)	1,095,466 (SMS: 25,057; Hotline: 1,348-817 males,531 females; Health facility and TBA/PMVs Records:1,069,061 - 386,172 males, 682,889 females; U-19:567,334, U-24:501,727)	Achieved: Above target
Output Indicator 2.2	Baseline: Nov 2012	Target: Feb 16		
Proportion and estimated number of young people reporting (a) good knowledge and (b) positive attitudes towards SRH.	(a) 43.5% (443,639) (b) 47.6% (485,453)	(a) 60% (611,916) (b) 67% (683,306)	(a)78.2% (33,750) (b) 59.8% (14,349)	Achieved : But the attitudinal score is 7.2% short of the final target and 30.8% of the adolescent and young people still have misconception of use of mosquito's nets as a means of preventing STIs
Output Indicator 2.3	Baseline: Sept 2012	Target: Feb 16		
Number of project activities with Youth participation	Nil	At least 15 project activities	15 project activities: Health service providers' trainings; TBAs/PMVs trainings; IEC development and adaptation workshop; Baseline Survey, Youth led assessment of health facilities; PE educators training; PET training; Stakeholder's consultative workshop; AHD Plan development workshop; voucher scheme, Youth Advocacy training; community based	Achieved

			distribution of contraceptives, Advocacy meeting with traditional and religious leaders; Youth led activities-film shows, quiz competitions, dramas, final evaluation; Advocacy meeting with traditional and religious leaders; Youth led activities-film shows, quiz competitions, dramas	
Output Indicator 2.4	Baseline: Sept 2012	Target: Feb 16		
Number of adolescents and YPs trained as PEs disaggregated by age, sex and in/out school	0	1600 (784 Males; 816 Females) (1136 10-19 years; 464 20-24 years) (800 In-school; 800 out-of-school)	1587 (908 Males; 679 Females) (438 10-19 years; 1149 20-24 years) (1122 Out of School; 465 In-School) 64.5% had attended FLHE and 79.0% found the class very useful	Achieved: (99.2%)
Output Indicator 2.5	Baseline: Sept 2012	Target: Feb 16		
Number of times young people were referred by trained peer educators for SRH services	0	17,920	7,850	Not Achieved: Achievemnt is 56.2% short of target
Output Indicator 2.6	Baseline: Sept 2012	Target: Feb 16		
Number of Corps members trained as Peer Educator Trainers (PETs) in the four states disaggregated by sex	0	1120 (560 Males; 560 Females)	899 (554 Males; 345 Females)	Achieved: 80.3%
Number of ETs that work with in-school youths after their training		899 (554 Males; 345 Females)	899 (554 Males; 345 Females)	Achieved
Output Indicator 2.7	Baseline: Sept 2012	Target: Feb 16		
Number of FLHE Teachers sensitized on	0	2240	998	Not Achieved

Youth Friendly Services.				
Output 3: Young people benefit from reduced financial barriers to access SRH services				
Output Indicator 3.1	Baseline: Sept 2012	Target: Feb 16		
Number of young people receiving the service vouchers (in Benue state)	0	300 (75 males; 225 females)	239 young people (156F, 83M)	Achieved
Output Indicator 3.2	Baseline: Sept 2012	Target: Feb 16		
Number of young people redeeming the vouchers at service delivery points for SRH services.	0	175 (60 males; 115 females)	223 (151F, 72M)	Achieved: above target
Output Indicator 3.3	Baseline: Sept 2012	Target: Feb 16		
Number of young people completing the IGA capacity building (a. vocational skills training (VST) b. (Apprenticeship Placement-(AP)) disaggregated by age and sex	0	Total: 360 A) VST: 64 Males, 96 Females; 110 10-19 years, 50 20-24 years B) AP: 200 Females; 120 10-19 years, 80 20-24 years	437 (VST: 98 Males, 112 Females; 100 10-19 years, 110 20-24 years. AP: 227 Females; 39 10-19 years, 188 20-24 years)	Achieved
Output Indicator 3.4	Baseline: Sept 2012	Target: Feb 16		
Number of young person's receiving IGA grants to establish micro-enterprises disaggregated by age and sex	0	160 (64 Males, 96 Females) (104 10-19 years, 56 20-24 years)	210 (98 Males, 112 Females; 37 10-19 years, 173 20-24 years)	Achieved
Output Indicator 3.5	Baseline: Sept 2012	Target: Feb 16		
Number of cooperative societies formed with members.	0	20 (10 members each)	20 (10 members each)	Achieved
Output 4: Target communities, young people, local duty bearers have increased awareness of the importance of youth SRH and improved capacity to advocate for improved SRH at the local and state level				
Output Indicator 4.1	Baseline: Sept 2012	Target: Feb 16		
Number of duty bearers (parents, teachers, community leaders and religious leaders) and policy makers reached	0	1,400	2,387.	Achieved: 70.5% above target

with messages on Youth SRH.				
Output Indicator 4.2	Baseline: Nov 2012	Target: Feb 16		
Proportion and numbers of duty bearers who report willingness to support young people to access SRH information and services (parents, teachers, community leaders and religious leaders).	79.2%	95% (375)	88.2%	Improvement but the target was not met (6.8% short of target)
Output Indicator 4.3	Baseline: Sept 2012	Target: Feb 16		
Number of Young People and adult allies (selected duty bearers willing to become SRH advocates for adolescents and young people) trained on SRH advocacy disaggregated by sex	0	240 (168 Males; 72 Females)	237 (179 Males; 58 Females)	Achieved
Output Indicator 4.4	Baseline: Sept 2012	Target: Feb 16		
Number of young people and adult allies to have conducted an advocacy visit at least once for sexual and reproductive health issues with policy makers and decision makers at the local level	0	192 (134 Males; 58 Females)	237 (179 Males, 58 Females)	Achieved

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

Discussion

The Y-Access project implemented in four northern states in Nigeria was evaluated to gain a better understanding of the impact of the project on the health status of the adolescent and young people in the communities where the project was implemented. The survey specific objective was to provide empirical evidence to assess the grantees' record of achievement; the extent to which the project performed well/good value for money spent and the knowledge, behaviour and utilization of reproductive health services amongst adolescents and young people in the target local government areas. The different strategies (including peer education, training of health providers, advocacy, voucher scheme, income generated activities etc.) used for the project implementation was also systematically analyzed for their effectiveness to encourage continuity and expansion to other parts of the country.

Just like any evaluation of behavioral change intervention, the conclusions that can be drawn in these findings are heavily dependent on the extent to which the intervention was implemented and designed. In the conceptual framework of the evaluation, it was presumed that sexual and psychological development of adolescents take place under the influence of contextual and antecedent factors like the individual/members of the community, peer groups/partners, families/households and gatekeepers. The influence of most of these presumed factors exert higher impact on sexual behaviours of the primary beneficiaries of the Y-Access project (adolescent and young people). Majority of the presumed correlates and the indicators was demonstrated in the findings of this survey. Over the years, there was tremendous achievement in disaggregated reproductive health services provided by type, sex and age above the annual targets (Figure 4.2.1). The utilization of services demonstrated must have resulted from the conducive environment which the Y-Access project contributed to creating and the effect of the project on the adolescent and young people who are the primary beneficiaries of the project.

Regarding the first impact indicator (i.e. the percentage of adolescent girls [15-19 years] who have begun child bearing), the overall percentage reduction of 38.4% in this evaluation is an evidence of the contribution of Y-Access project to the health status of adolescents and young people and also the impact to the achievements of the MDG goals 5 and 6. Also in this survey,

there was great improvement in the adolescent and young people's opinion regarding the possibility of a young girl becoming pregnant or a young man impregnating a young girl at first sex (Table 4.1.1). In this final evaluation survey, ninety percent of the interviewed adolescent and young people had never been pregnant/ (females) or impregnated any girl (Males). The 9.8% prevalence (Figure 4.1.1) is far below the national average (22.5%) at baseline. The probable reasons for these findings could be that the community mobilization activities of the project gained a wider publicity within the project implementing communities thereby maximizing the conceptual framework of the behavioural change model hypothesized in the beginning.²⁶ Furthermore, different strategies (peer education, training of health providers, advocacy, voucher scheme and income generated activities) used for the project implementation must have influenced the behaviour of the beneficiaries by reducing the barriers hindering the utilization of RHS.

In the absence of effective contraception, the probability of pregnancy is highly dependent upon the frequency of intercourse. Therefore, information on sexual activity can be used to refine measures of exposure to pregnancy. A higher proportion of the adolescent and young people had delayed sex initiation at the closed of the project survey (28.1%) as compared to the baseline survey (36.2%) (Figure 4.2.2). This is further demonstrated in the adolescent and young people's choice of abstinence and use of condoms as the predominate preference for prevention of unwanted pregnancies. Other contributing evidence in this survey, is the reduction in the prevalence of sexual intercourse among the adolescent and young people. The adolescents and young people's choice of contraception in this survey may be influenced by changes in the programmatic efforts and emphasis in Y-Access access project. For instance when there was attrition of trained health service providers; the trained service providers who were still in the project were encouraged to conduct step down trainings to others and they did. Refresher trainings were also organized by implementing partners to strengthen the capacity of the health providers. Secondly, when there was prolonged health workers strike action in the public health facilities, engagement of community-based service delivery points such as TBAs/PMVs was encouraged. The strategies employed in turn helped in overcoming barriers to contraceptive use like service costs and distance, lack of awareness, embarrassment, lack of confidentiality and privacy, and negative provider attitudes reported in many Sub-Saharan African countries.^{13,}

^{14.18.19-19} These suggests need for scaling up of training of the health providers and other project intervention activities employed in the Y-Access project.

Another key impact indicator considered in this survey as indicated in the logframe of the project was reduction in the prevalence of HIV and other sexually transmitted infections among 15-24 years (Impact indicator 2). However, HIV testing was not conducted in this survey, making it difficult to practically assess this indicator. Even though HIV testing was not conducted, certain conceptual assumptions on the correlates of HIV reduction as reported by many researchers are still consistent with the findings of this survey. For instance, the uptake of HIV test among the young people in this final evaluation findings was high (Figure 4.1.2). This is probably due to geographical spread and financial access (free testing) to HCT services available at the Y-Access SDPs. Increase in HCT uptake in this survey is in support of the proposed change model of the final evaluation²⁶. Similarly, the prevalence of STIs increased at the close of the project (39.7%) probably due to increased service delivery points (SPDs), case detection rate and improved treatment services. Use of informal health service delivery points for treatment of STIs is reduced at close of the project as compared to baseline. By implication, the Y- Access project must have contributed to reducing issues of stigmatization and other factors hindering the uptake of HCT, therefore extension of the intervention to other parts of Nigeria will help in prevention and control of STIs (including HIV/AIDS) in Nigeria.

In reducing HIV and other STIs prevalence, providing information about STIs and access to condom and other modern contraceptives through behavioural change communication (BCC), peer educators and youth friendly services are required. Interestingly, this survey has demonstrated the evidence of Y-Access project in these areas. The findings in this survey has indicated increased contraceptive use. This final survey has also showed that most sexually active adolescent and young people relied more on condom to protect themselves (88.4% in the past three and half years) and 60.2% of them use it consistently (Consistent use: defined as those who always use condom during sexual intercourse with non-marital sexual partners) (Table 4.2.3). The dual protection messages of condom in particular may have contributed to the behavioural changes demonstrated by this survey. The findings in this study are far above the estimated national multiple cluster indicator survey of 2011.²⁸ This indicates that exposure to the Y-Access intervention resulted in increased use of condoms and other contraceptives. This is probably due to increased availability of contraceptive commodities, cost reduction

interventions, public awareness and perceived change in sexual behaviour which were benefited directly from the Y-Access intervention activities. The level of contraceptive use in this survey is in line with other data from Nigeria^{29,31} and other African countries³². Looking at the dual protective function of condom use in terms of prevention of STIs and pregnancy, the supply of the commodity should be encouraged as an alternative option to abstinence among adolescent and young people. Even though condom use is high in this survey, the failure of this final survey to measure the HIV status of the adolescent and young people is a limitation in terms of the impact assessment of the Y-Access project (Impact indicator 2).

Estimated number of adolescent and young people with good knowledge and attitude towards RH is an important indicator of the final evaluation. At close of the project, the overall knowledge score increased to 78.2% (18.2% above target) and attitudes supportive of sexual and reproductive health services had increased significantly, but the achievement was 7.2% short of the project target. (Figure 4.3.6). Abstaining from sex was highest (65.5%), followed by use of condoms (42.3%) and finally faithfulness to sexual partners (4.9%). On HIV/AIDS issues, majority of the adolescent and young people agreed with abstaining from sex (93.2%), use of condom (91.8%), not sharing of sharp subjects (91.2%) and avoiding transfusion of unscreened blood (86.8%). Misconception on use of mosquito nets as method of prevention of HIV still existed among 30.8% of adolescent and young people. The reported misconception in this survey may account for the few individuals who reported not to have ever heard of SRH (Figure 3.1.7). Also in this final survey, more than half (53.0%) of the adolescent and young people still believed that it is unfair to deny boyfriend or girlfriend sexual intercourse, 50.4% consider buying of condoms embarrassing, 43.0% consider use of condom a displeasure (Table 3.1.20). A higher proportion (45.0%) of the respondents disagree that they are not at risk of contracting STIs including HIV/AIDS and slightly above half (51.1%) disagree that it is only those who are sexually promiscuous that stands the risk of contracting STI (Table 3.1.21). By implication, despite the success of the Y-Access project, there is need for more awareness campaign and advocacy for continuation and expansion of RH. At baseline less than half (47.6%) of the adolescent and young people had negative attitude towards RH services.

There is wide disparity in the adolescent and young people's level of awareness of syphilis as compared to other sexually transmitted infections across the project implementing states both at baseline and even at close of the project. This may imply that the project did not

focus on syphilis. However, the overall knowledge score of methods of prevention of STIS (including HIV/AIDS) was good with final evaluation and baseline difference of 14.3%. These findings are supported by other studies where knowledge of syphilis amongst Nigerian young people was reported low.^{30,31} Since presence of other STIs increases the chances of HIV/AIDS, there is need increase awareness campaign on knowledge of other STIS.

In Y-Access project, one of the predicted assumption of outcome is increased access and utilization to quality and comprehensive RH services by adolescent and young people in the targeted SDPs in the 16 target LGAs (Outcome indicator 1). The focus of the Y-Access project in this indicator was on both formal and informal service delivery points. The project target of the total number of SRH clients who visited the formal service delivery points disaggregated by type of service was achieved above the expected target. The closeness of the RH service delivery points and the flexible schedule of available services (Table 3.3.3) must have contributed to the increased access and utilization of the services by the adolescent and young people. Furthermore, about 90% of the young people in this survey reported that contraceptive services are free. By implication, almost all the young people living in the communities in three and half years when the Y-Access programme was implemented must have accessed at least one of the RH services provided. The findings from this survey also indicates that the Y-Access project created good opportunities for the adolescent and young people in the four northern states in Nigeria for accessing RHS at different SDPs and of making a choice of type of services required and time convenient to access the services.

For effective management and utilization of the RHS, the annual report and the final survey findings demonstrated the achievements made by the Y-Access project in strengthening the capacity of formal and informal (TBAs and PMVs) health service providers. This survey shows that within the three and half years of the implementation of the project, 917 formal and informal health providers (480 females, 437 males; formal 190 HSPs, 374 TBAs, and 353 PMVs) were trained on delivery of youth-friendly reproductive health information, basic services and referrals.

Among those trained, 86.0% had adequate and sustained knowledge on adolescent sexual reproductive health issues and youth friendly service delivery throughout the period of the Y-Access project. The training of TBAs and the PMVs who are based within the communities and are known and well patronized by community members is indeed an added advantage for

delivery of quality RH services. The trainings they received from the project empowered them to reach specific groups of young people usually missed by formal health system. The training also built good relationship between the formal and informal reproductive health service providers, thereby facilitating good referral systems this survey has demonstrated.

The Y-Access project proposed risk assessment strategies were effectively implemented. During the implementation phase of the project, insurgence and health workers strike action was observed in some project locations. There were also cases of attrition among the trained health providers in some states. Despite these risks, the project activities were successfully carried out by application of certain strategies. Amongst these includes: step down training by health providers who were initially trained, retraining of health providers by implementing partners and engagement of community-based service delivery points such as TBAs/PMVs. In addition, there was engagement of traditional and religious leaders through advocacy meetings. By implication, the project through the risk mitigation strategies ensured community health networks in project locations and continuation of the activities even after close of the project.

In this final survey, the training and level of participation in RHS of duty bearers in the community where the project was implemented is significant. Within the three and half years 998 (44.6%) teachers were trained on Family Life and HIV Education (FLHE) as against the expected 2240 (100.0%) target. The probable reason could be due to match funding requirement issues. The grant was designed to leverage on activities funded through grants from the Global Fund (GF) that was stopped following a re-alignment of service delivery areas by the GF. This resulted in the project's inability to meet up with match funding requirement as earlier committed despite various efforts explored by ARFH to bridge the gaps. Consequently, we notified the Fund Manager of this and it was reported to DFID. Despite the shortfall in the expected target of the project, over sixty percent of the adolescent and young people within the project community have attended at least a session of FLHE class in secondary schools. Of the total, more than two-third (79.0%) of these adolescent and young people considered the FLHE to be very useful (Table 4.3.6). The level of participation in the findings suggest however that the outcome achieved could have been greater if more teachers were trained on family life and HIV education. The final evaluation findings also revealed that the gatekeepers supported utilization of the services by young people at the SDPs (Table 3.1.32 and Figure 4.3.6). In this final survey, over half of the young people were of the opinion that parents of adolescent and young people in

their communities discuss RH issues with their children; with about two thirds discussing STIs, drug abuse and teenage pregnancy. This is against the baseline findings of most parents/guardians shying away from discussing reproductive health issues with their wards/children.

In terms of costed plans and policy documents, all the states in collaboration with the implementing partners developed their AYHD policy and almost all the formal SDPs visited in the survey had significant improvements in at least three out of four youth friendliness domains (Tables 5.0). The facilities had clear written document for serving young people and there was internal and external supervision and monitoring that kept the programme on track till the end. The finding from this final project survey is consistent to the outcome of similar project in Ethiopia which recorded remarkable changes by engaging government stakeholders at all levels, in each related sector, on strong taskforces, strong partnership and sense of ownership among government stakeholders who played significant roles for the success of the project³³

In order to address the financial barriers to accessing SRH services among young people, the Y-Access project specific objectives included young people empowerment through income generation activities (IGA) in Jigawa and Katsina States and vouchers scheme in three LGAs in Benue State. The beneficiaries were given different types of Vocational Skills Training (VST) like soap making and Apprenticeship Placement (AP), to address issues of poverty. At the close of the project 437 adolescent and young people within the community in Jigawa and Katsina States had VST and 227 had AP. The project also provided IGA grants to 210 persons to establish micro-enterprises (Table 5.0). These young persons in turn later trained other peers on their own, leading to expansion of the skills in the community. In Katsina, one of the trainee married into another community and she trained other family members on soap making. The products (soap) were seen in the market within the communities and were highly patronized. The project also succeeded in the establishment of cooperative societies by the members of the community. A total of 20 were established in each community and that served as a big source of financial empowerment to the members. Similarly, in Benue State where voucher service was provided to some adolescent and young persons, the vouchers were redeemed at service delivery points for SRH services, and that act assisted the project in breaking the financial barriers associated with utilization of reproductive health services by young people. This implies that the Y-Access project empowered a wide range of young people in the project target LGAs through

IGA and Voucher scheme approach. The target of breaking the barrier of poverty set from the inception of the project was achieved.

It is believed that sexual and psychological development of adolescents take place under the influence of contextual and antecedent factors, the gatekeepers inclusive. The framework indicates that the Y-Access interventions affected these antecedents directly by interacting with young people or indirectly by influencing the context within which they live, as well as by enhancing established SRH programmes for the young people. In this final evaluation survey, the number of gatekeepers (parents, teachers, community leaders and religious leaders) and policy makers reached with messages on Youth SRH at the end of three and half years was 2,387. The proportion is above the project expected target of 1400 (70.5% above target). Similarly, the proportion and numbers of gatekeepers who report willingness to support young people to access SRH information and services was 88.2% (Figure 4.3.6). However, this finding is below the expected target of 95.0% (Table 5.0).

In relation to the efficient utilization of funds, the audited report shows that the funds provided for the Y-Access project was maximally utilized. On the whole, the programme was successfully implemented as shown by the achievements of the indicators and their outputs (summarized in Table 5.0). Overall, this evaluation finds that the Y-Access approach of improving the reproductive health of young people was effective and efficient in delivering the intended outputs. The successful factors that facilitated this efficiency and effectiveness include the peer educators approach, supervisory management arrangements and the monitoring and evaluation system of the project. Also, partnerships with other actors and the involvement of both direct (young people) and indirect beneficiaries of the project (the gatekeepers) contributed greatly to the effective running of the project. Such innovative strategies were instrumental in the implementation of the project. The unintended positive outcome observed are highly commendable. Scaling up of Y-Access project to other parts of Nigeria will improve the reproductive health of other adolescent and young people in Nigeria.

There may be other ASRH programmes in addition to the Y-Access in the communities where the Y-Access project was implemented but based on the findings from this final evaluation survey, the hypothesis that the young people make informed decisions regarding their sexual health based on Knowledge, attitude, self-efficiency and leadership capacities developed as a result of Y-Access interventions and Individual /Community, Peers/Partners, Family or

Households, and policy makers in Nigeria mainstream an effective reproductive health intervention through planning, policy, and technical support from Y-Access programme has been proven to be right. In other words, Y-Access project is the best approach on having fewer adolescent and young people with fewer cases of pregnancy and sexual behaviour and attitude towards SRH in expected direction towards achieving MDGs goal 5 and 6.

Conclusion:

The overall objective of this final evaluation survey was to assess the impact of the three and half year Y-Access programme implemented by ARFH in 4 northern states in Nigeria. In light of the survey hypothesis the baseline targeted indicators were compared with the final evaluation findings from the adolescent and young people, the gatekeepers, the policy makers and the service delivery points check list. Yearly report from the program officers were also reviewed. The results show that Y-Access project has contributed to improved reproductive health status of adolescents and young people in 4 States of Northern Nigeria where the project was implemented. The project has resulted in decline in the adolescent pregnancy rate by 38.4%. It has also made an impressive positive outcome in the number of clients who used youth-friendly reproductive health facilities. Uptake of HCT was high with a 54.7% reduction in the number of sexual activities 12 months before surveys. Over eight percent of the sexually active adolescent and young people relied more on condom to protect themselves in the past three and half years and 60.2% of them use it consistently. A wide range of young people in the project target LGAs were financially empowered through IGA and Voucher scheme approach thereby breaking the barrier of poverty in accessing reproductive health services. All the states had developed adolescent and young people costed plan through the Y-Access project and duty bearer's participation and willingness to support young people in accessing quality and comprehensive reproductive health services was significantly improved through the Y-Access project. These suggests that scaling up the programme will improve the reproductive health of other adolescent and young people in other parts of Nigeria.

Proportion and estimated number of young people reporting good knowledge and positive attitudes towards SRH was high. However, there were some misconceptions concerning use of condoms and risk perception of STIs and HIV /AIDS. Target for Client's referral by trained peer educators for SRH services was not achieved. These areas need to be worked upon for optimal improvement in attitude and behaviour towards SRH.

Recommendations:

In view of the findings from the survey the following suggestions are made:

- i. Gradual expansion and scaling up of the project. Expansion of the project should take place in a phased manner in selected LGAs in other zones of the country. As with the Y-Access project, expansion needs to be integrated within the existing health care delivery system and state government need to be fully involved for counterpart funding.
- ii. Youth empowerment activities employed in the Y-Access play a significant role in breaking the poverty barrier in accessing reproductive health. It also help the youth to be recognized and it give them high esteem and sense of belonging. If that can be applied in other sectors, it will help in sustainable development. Therefore, efforts in stimulating sustainability of the IGA should be pursued for government at LGA, State and Federal to have budget that is sufficient for adolescent and young people reproductive health and development policy.
- iii. Community gatekeeper's involvement is key to any successful programme as demonstrated in the Y-Access project. The primary health care unit of the local government authorities should be sensitized and empowered to strengthen existing community structures such as the community health committees.
- iv. Training of informal health providers has proven to be effective in removing barriers that hinder access to RH among young people, hence the lesson learnt from the Y-Access project should be used in establishing similar interventions for young people. This can be effectively carried out through continue education using some of the informal health providers already trained on the Y-Access project. Leadership trainings via the local government primary health care unit and the state/federal government can also be explored.
- v. There is need for more awareness campaigns on issues of HIV prevention because of the misconceptions on prevention methods still identified in this survey. The peer education component and involvement of informal health care providers approach employed in the Y-Access can be further broadened.

- vi. Findings in this study have indicated that the duty bearers are in support of the programme, consequently more efforts should be targeted at enhanced training in this area. The implementing partners (EVA and SWODEN) already established in the communities can be encouraged and supported to carry out the task.
- vii. Youth empowerment activity piloted in the Y –Access project made significant impact in terms of poverty reduction, but the focus in the Y-Access project was mild, therefore in subsequent programme the thematic area should have adequate budgetary allocation for improved impact.
- viii. The adolescent and young people who are the primary beneficiaries of the project were not actively involved in decisions regarding reproductive health services, government at all levels (local, state and federal) should intensify efforts to involve young people in the decision of issues concerning them.
- ix. Additional research beyond the current baseline and final evaluation could also be used to assess the correlates of negative behaviour towards RHS. Comparative or experimental/quasi-experimental survey between the Y-Access implemented communities and control (non-implemented) communities could also illuminate the best approaches for future sexual and reproductive health programmes for adolescent and young Nigerians.

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