# YOUTH SEXUAL HEALTH AND RIGHTS ALLIANCE SITUATIONAL ANALYSIS REPORT

JUNE 2018

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# Acronyms

| | |
|---|---|
| *AGYW* | *Adolescent Girls and Young Women* |
| *AIDS* | *Acquired Immune Deficiency Syndrome* |
| *AYPs* | *Adolescents and Young Persons* |
| *CSOs* | *Civil Society Organisations* |
| *FGD* | *Focus Group Discussion* |
| *FGM* | *Female Genital Mutilation* |
| *FMoH* | *Federal Ministry of Health* |
| *HIV* | *Human Immunodeficiency Virus* |
| *INGO* | *International Non-Governmental Organisation* |
| *KII* | *Key Informant Interviews* |
| *NGO* | *Non-Governmental Organisation* |
| *SRH* | *Sexuality and Reproductive Health* |
| *SRHR* | *Sexuality and Reproductive Health Rights* |
| *STI* | *Sexually Transmitted Infection* |
| *STD* | *Sexually Transmitted Disease* |
| *SDP* | *State Development Plan* |
| *VVF* | *Vesico-Vaginal Fistula* |

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# 1. Introduction

## 1.1 Background

The Youth Sexual Health Alliance is an informal coalition of individuals and youth-focused organizations who advocate for increased access to comprehensive sexual and reproductive health information and services for adolescents and young in Nigeria. The group conducted a situation analysis on the current status of Adolescents and Young Persons (AYPs) in Nigeria with a view to ascertaining the SRH challenges in various communities across Nigeria. This exercise also aims at engaging AYPs in order to understand their knowledge, attitudes, and practices as it pertains to sexuality and reproductive health.

## 1.2 Study Objectives

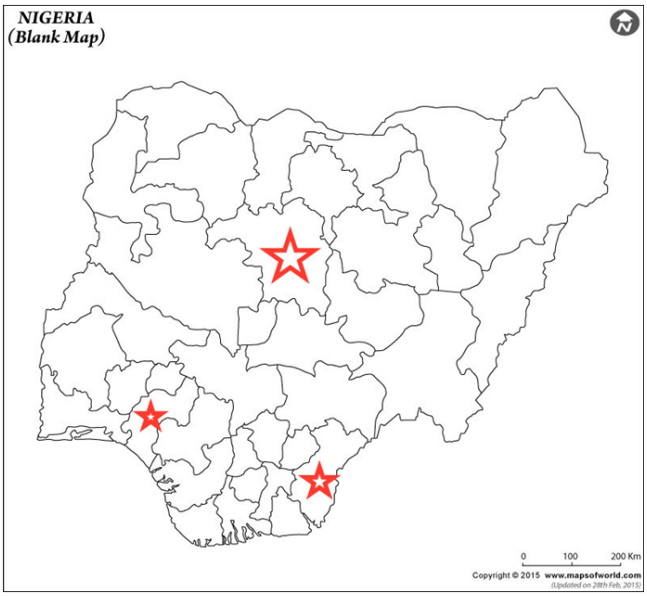
- To create a profile of adolescent and young people's Sexual and Reproductive Health in selected states in Nigeria.
- To understand the economic, political,social,culturalandenvironmental drivers of poor adolescent and young people's sexual and reproductive health around Nigeria.
- To understand the scope and scale of Government, CSOs and Private Sector response to improving adolescent and young people's sexual and reproductive health.
- To understand the views and opinions of adolescent and young people regarding their sexual and reproductive health.

# 2.0 Study Design and Methodology

A qualitative methodology was adopted for this study, using focus group discussions and key informant interviews. In addition, the research teams collected background data from desk reviews and document analysis of grey papers and other country documents.

## 2.1 Study Sites

The study was conducted in Cross River, Kaduna, and Ondo in the South-South, North-West and South-West regions of Nigeria respectively.




## 2.2 Data Collection Methods

To conduct this analysis, a qualitative methodology was adopted using the snowball sampling approach. Each participating organization trained their youth advocates who were already part of the bigger project to collect the data required for the exercise.

***Primary research***

- Focus Group Discussions
- Key informant interviews

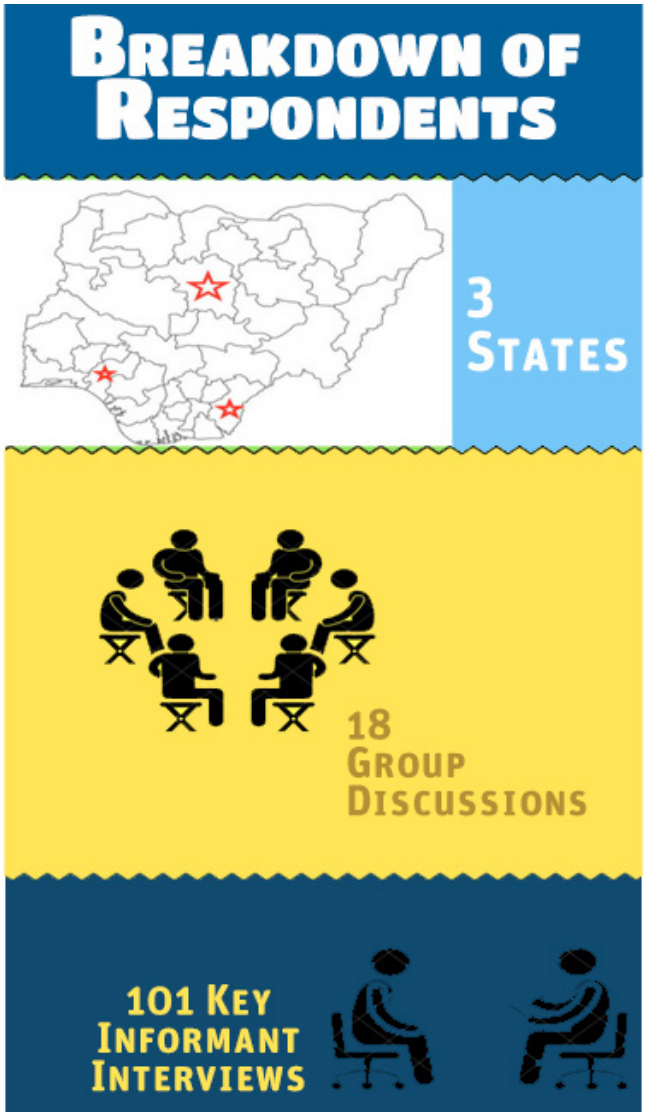
***Secondary research***

- Desk research/Online research

· Literature review

There were 18 FGDs and 101 KIIs conducted in all during the primary research phase, and desk research was conducted during the secondary research phase. In total, over 200 individual respondents were reached for this analysis.

Participants were grouped into different categories: Government officials including LGA and ministry officials, Civil Society Organizations, and International NGO partners. Others were Community Stakeholders comprising of parents of adolescents and young people, teachers,




- 14 Government Officials
- 13 CSO/INGO Partners
- 74 community stakeholders
- 18 Focus groups

traditional/religious leaders, and health workers. The last category of respondents were groups of AYPs in school and out of school.

## Gender Representation

There was a representation of male and female respondents with a slight difference in the ratio. A total of 143 male persons and a total of 138 female persons participated in this study.

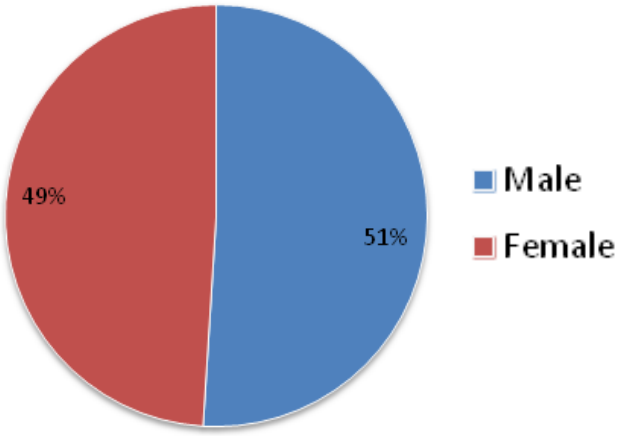



*Figure 3 Gender Representation Percentages*

## Anonymity

To ensure the integrity of this study, the identities of the participants in this study have been protected and responses 'anonymized'. Personal identifier information has been redacted from the report.

## 2.3 Data Analysis

Data analysis was conducted using thematic analysis. The goal was to find patterns, link them by themes, and connect

them back to the research questions. The data was analyzed using both Microsoft Excel and Microsoft Word.

## 2.4 Limitations

***Some of the limitations encountered in the course of this project include the following:***

- Bureaucratic bottlenecks which made it difficult to reach some of the international organizations identified as target groups to be included in the study.
- Distrust on the part of some participants limited their participation in the key informant interviews, as they were uncertain of the anonymity of their responses.
- SRH issues were regarded as being rather sensitive. As such, participants seemed to self-censor during the KIIs and FGDs.
- The Language of the people in the communities was also a barrier reaching community stakeholders and out of school young people.
- The inexperience of the youth advocates may have contributed to poor data collection during the focus group discussions.

# 3.0 Main Findings

## 3.1 Situational Overview

Nigeria has a population of about 180 million people and is the most populated country in Sub-Saharan Africa. About 22 percent of the country's population is made up of adolescents between the ages of 10-19 years, so it stands to reason that the largest population of young people in Sub-Saharan Africa between the ages of 10-19, currently reside in Nigeria. ("World Health Organization: Density per 1000: data by country. http://apps.who.int/gho/data/node.main.A1444 (2015). Accessed 1 Oct 2015.," n.d.)

### *Maternal Mortality and Unintended Pregnancies in Adolescents in Nigeria*

With a sizeable young people population such as this, it is significant that Nigeria is also high on the list of countries with poor health system indices like Maternal Mortality Ratio, of which Nigeria ranks at 14% of the national global burden, from approximately 814 deaths per 100,000 in 2015, (WHO, UNICEF, UNFPA, 2015) to pregnancy-related deaths of 1089 per 100,000. And 25.6% of deaths in women of reproductive age were due to pregnancy-related causes. (National Bureau of Statistics & National Population Commission, 2017).

The average fertility rate in Nigerian women in 2015 was 5.6, and a young woman between the ages of 15-19 years contributed 109 live births to every 1000 live births in 2015, an average of more than 10 percent, even higher in some parts of the country, such as the North-western region with 171 live births per 1000 in women aged 15-19. (UNICEF, 2016).

Even though it is difficult to estimate the percentage of overall abortion statistics in Nigeria related to adolescent girls and young women because of the lack of disaggregated data, there are approximately 1.25 million nationally and 33 abortions per 1000 women in 2012 (Bankole et al., 2015) among women

aged 15-49. Based on the modeling of the national abortion figures, it can be estimated that adolescent girls and young women make up a large percentage of unintended pregnancies in that population, which was 35.9%, resulting in a procured induced abortion of 33.5% in a study done in South-Western Nigeria in 2012. (Lamina, 2015)

### *HIV Prevalence Rates in Adolescents and Knowledge, Attitudes and Practices*

Another indicator of the burden of unmet needs in adolescents in Nigeria is the HIV prevalence rate and the percentage of new infections contributed by adolescents and young people. By 2016, 240,000 adolescents (ages 10-19) were living with HIV, and they make up 7% of the total number of people living with HIV in the entire country, (National Bureau of Statistics, 2017) with poorer health outcomes than adolescents living elsewhere in the world in the same condition.

Only 24 percent of young women aged 15-24 and 34 percent of young men in the same age range have comprehensive knowledge about HIV. And comprehensive knowledge is higher among youth in urban areas than those in rural areas (NDHS, 2013).

HIV transmission in adolescents and young people is closely related to knowledge, attitude, and practice in adolescents about the means of HIV transmission, with a national survey in 2017 demonstrating only 29% of young women, and 27.9% of young men were able to correctly identify ways of preventing HIV and major myths around transmission (National Bureau of Statistics & National Population Commission, 2017)(Adedimeji, Omololu, & Odutolu, 2007).

### *Early Sexual Debut and Adolescent Marriage*

The median age for sexual debut in Nigeria is 18 years, although, amongst adolescent girls, it is lower at 15 years, compared to adolescent boys, for whom it is 16 years.

In regions where there are more young people out of school in the country, the age of sexual debut in adolescents is even lower. This can be attributed to various reasons such, lack of education and access to health interventions programmes that are delivered through the school system. Often these interventions are not also replicated at the community level which unfortunately reduces the intervention effect on the young people outside the school system (Arnold et al., 2012).

Early and forced marriage is also a factor that compounds early sexual debut, as regions that have lower legal ages for marriage also have high rates of the early sexual debut, as seen in the North-West and North-East regions. Poverty is considered a determinant of early and forced marriages, although the effects of poverty on early sexual debut have not shown strong statistical correlation. The national policy sets the age of consent for marriage at 18 years, although the existence of parallel legal systems such as Sharia law and customary laws permits marriages to be contracted legally before that age, effectively making the age of consent unenforceable nationally.

### *Use of Sexual and Reproductive Health Services by Adolescents*

Low usage of sexual and reproductive

health services by adolescents is a serious issue of concern, due to a myriad of reasons including availability, accessibility, privacy and confidentiality, inappropriate service design, cost and discriminatory attitudes of providers.

This creates a service environment where young people prefer to use SRH services from informal providers outside the prescribed ones because they "offer" the characteristics that are missing in the former (Oye-Adeniran, Adewole, Umoh, Fapohunda, & Iwere, 2004).

An adolescent girl or a young woman, for instance, is less likely to access contraceptive services within the formal healthsystemduetofearofembarrassment and stigmatization. She is also less likely to receive standard antenatal and postnatal services and is more likely than any other pregnant woman to deliver at home with no skilled birth attendant involved (Ebeigbe & Gharoro, 2007).

Specific research demonstrates the preference of adolescents for SRH services from patent medicine vendors, chemists, auxiliary nurses and traditional healers for contraceptives, and if need be, for abortion services (Oye-Adeniran, Umoh, & Nnatu, 2002).

The adolescent birth rate in the Millennium Development Goals Survey of 2014 is estimated to be 74 per 1000 live births, nationwide ("THE MILLENNIUM DEVELOPMENT GOALS PERFORMANCE TRACKING SURVEY 2015 REPORT," 2015).

### *Policy Environment for Sexual and Reproductive Health for Adolescents and Young People in Nigeria*

The Nigerian policy space has shown improvement over the years through the development of policies and guidelines that addresses the needs of adolescents and young people even though there are still documented and evident gaps in the ratification, enforcement and intrinsic adoption by institutions and communities.

The National Reproductive Health Policy and Strategy (2001) not only created an overarching framework for addressing SRH but also made possible Nigeria's largest SRH programme; Family Life and HIV Education.

This was a precursor to the National School Health Policy (2006), which was the first comprehensive policy on adolescent health, emphasizing importance of information and youth-friendly service, the National Policy on Health and Development of Adolescents and Young People in Nigeria (2007), the Gender Policy (2008), and the National Youth Policy (2009), all creating an emphasis on SRH with a focus on adolescents and young people.

In response to the prevalence rate of HIV among adolescents, a National HIV Strategy for adolescents and young people was created in 2016, recognizing negative provider attitudes to young people living with HIV.

In spite of all these policies as outlined earlier, challenges remain in terms of difficulties with service providers and implementer buy-in, as discriminatory attitudes still exist from socio-cultural factors of patriarchy, age-based hegemony, and puritanical attitudes about sex (Rai, Singh, & Singh, 2012).

Also affecting the implementation of these

policies are customs, traditions and other legal frameworks that contribute, to high rates of such early marriages, gender and sexual abuse, unintended pregnancies and pregnancy-related mortalities, without a concomitant encouragement to improve access to SRH services.

The age of consent, in theory, can be seen as a positive policy to address early and forced marriage among other adolescent SRH issues, but a conundrum is created where this policy is also understood to mean that adolescents under the age of 18 cannot freely access SRH services without the consent of their parents, caregivers, guardians or partners.

The restrictive abortion laws in Nigeria have a negative impact on the health and wellbeing of adolescent girls and young women because young people account for the majority of unwanted pregnancies and unsafe abortion complications. The is because the law further restricts their access within the formal health system to legal and safe termination of unintended pregnancies (Oye-Adeniran, Long, & Adewole, 2004).

The legal restrictions instead promote usage of unqualified health providers to procure abortions leading to increased pregnancy-related morbidity and mortality.

Additionally, the Violence against Persons (Prohibition) Act (VAPP Act) was passed into law on the 25th of May 2015 by the Former President Goodluck Ebele Jonathan. The VAPP Act serves as a legal instrument to protect all persons including adolescents and young people from all forms of violence and abuse. However, the VAPP Act is only applicable within the FCT Abuja and three states in Nigeria. For it to become a national law, it needs to be passed in 23 out of the 36 states of the Federation.

## 3.2 Findings from Interviews and Focus Groups

As mentioned earlier, participants in this study were selected persons in government agencies responsible for SRH and HIV/AIDS programmes of AYPs: State ministries of health, State agencies for the control of AIDS, youth-focused government agencies, etc. In addition, people who were considered community stakeholders and AYPs themselves were also interviewed. This ensured that there was a diversity of voices and perspectives represented. Yet, the responses were essentially unanimous. AYPs in Nigeria is an untapped human resource with many opportunities for growth beset by many challenges including lack of access to adequate and basic health care, education and even food. Where SRH programmes exist for AYPs they are poorly funded and there is a low engagement of AYPs in developing such programmes/ interventions.

***Some general health challenges encountered by AYPs in communities were the following:***

- Malnutrition
- Malaria
- Maternal Mortality
- Lack of adequate health facilities
- The absence of youth-friendly health facilities
- Poor sanitation
- Drugs and Substance abuse
- Unsafe sex

- Sexual violence
- Unsafe abortions
- Early marriage

### 3.2.1 Main SRH Challenges


*Figure 4 Word Cloud of Main SRH Challenges of AYPs*

According to the participants in the study, there are several SRH challenges encountered by AYPs. Some of these challenges are due to inadequate education, lack of information, harmful cultural practices and/or poor policy framework and implementation. The main SRH challenges of AYPs center around Safe Sex Practices, Sexual Violence, Family Planning/Reproductive Health, and Harmful Cultural Practices.

The topmost SRH concerns of AYPs are teenage pregnancies, unsafe abortions, and HIV/AIDS. They also mentioned STIs, STDs and sexual abuse. The other challenges identified are:

- Early marriage
- Rape
- Forced Cohabitation
- Vesico-Vaginal Fistula
- Female Genital Mutilation
- Lack of access to contraceptives
- Lack of access to male and female condoms
- Lack of information

### 3.2.2 Factors Affecting Sexual and Reproductive Health for AYPs

The factors affecting sexual and reproductive health for adolescents and young persons can be classified into social, cultural, economic, and political challenges.

### Social Factors

There are many social factors which affect the reproductive health of adolescents and young persons. Some of these factors identified were access to social and traditional media, peer pressure, religion, and lack of social amenities. These factors could lead to both positive and negative outcomes. Some of those negative outcomes include drug and substance abuse, and exposure to pornographic materials through social media.

***"AYP tend to have misguided information connecting to their sexual lives and their rights, e.g. wrong information from peers such as at a particular age, one is to have had sexual intercourse." – KII with community stakeholder in Kaduna***

***"Lack of incorporation of sex education into school curriculum has left many***

***adolescents in ignorance about their sexual and reproductive health." – KII with a government official***

However, social factors could also lead to positive outcomes if properly harnessed. For instance, social media could be used to share SRH related information. AYPs can use the media for networking and communicating with their peers around the world and this might expand their worldview positively. Social gatherings in youth centers and other youth-friendly facilities can also influence AYPs positively.

***"They get more knowledge of their reproductive health and rights through socializing." – Community stakeholder in Ondo State***

## Cultural Factors

Study participants also identified some cultural factors that affect the sexual and reproductive health and rights of adolescents. A recurring issue was the issue of early marriage. A good number of the respondents believe that early marriage can negatively impact the SRH of AGYW in their communities.

***Depending on the location e.g. Northern part of the state, early teenage marriage is rampant. This has negatively impacted AYPs leading many into contracting VVF while in some southern parts of the state FGM is a concern." – KII with a government representative in Kaduna***

However, some respondents also believe that early marriage plays a positive role as it limits "immorality". Some other cultural factors that were mentioned by respondents included harmful cultural practices, for example, female genital mutilation, and 'Wankan Jego', a postpartum steam bath that can be harmful to a young mother.

Furthermore, cultural and social norms place limits on open communication between parents and adolescents thereby creating a knowledge and trust gap on issues of sexuality and reproductive health.

***"Our norms and other cultural practices limit the AYPs from accessing factual information about their sexual reproductive health and rights." - CSO Representative***

Nevertheless, many of the study participants said that some cultural practices were positive and they promote "good morals and chastity" among adolescents and young people.

## Economic Factors

A key economic factor that affects or creates SRH issues for AYPs in Nigeria is poverty. Poverty can affect the choices that young people especially adolescent girls make about their sexual and reproductive health. It can also lead to an absence of choice when young people do not have the resources they need to protect themselves from STIs, unplanned pregnancies or even afford menstrual care.

Scarcity captures mental cognitive capacity (Mullainathan & Shafir, 2014) and poverty creates a situation where access to financial resources becomes the priority - 'top of mind' - and AYPs are not concerned about the consequences of high-risk sexual behaviors in the short term. They are more invested in taking care of their daily/immediate needs.

***"The economy is very harsh, young people are looking for every means to meet daily needs." – KII with CSO Partner***

### Political Factors

The poor policy framework at the state level is one of the political factors that influence SRHR for AYPs. For instance, Kaduna State does not have an AYP SRH policy document and although the state targets AYPs in some of its SRH activities, they could be seen as add-ons and not originally created for AYPs.

Participants in the study were also of the opinion that some political actors recruit AYPs for nefarious activities like political thuggery while providing them with resources to acquire drugs and other harmful substances.

***"The AYPs are often used as political thugs and in most cases, they are given hard drugs to take in order to disrupt the peace of the society." – Community stakeholder, Kaduna***

***No law to support the AYPs SRHR in Kaduna State which is the highest in terms of sexual violence in the north west states. – CSO Partner, Kaduna***

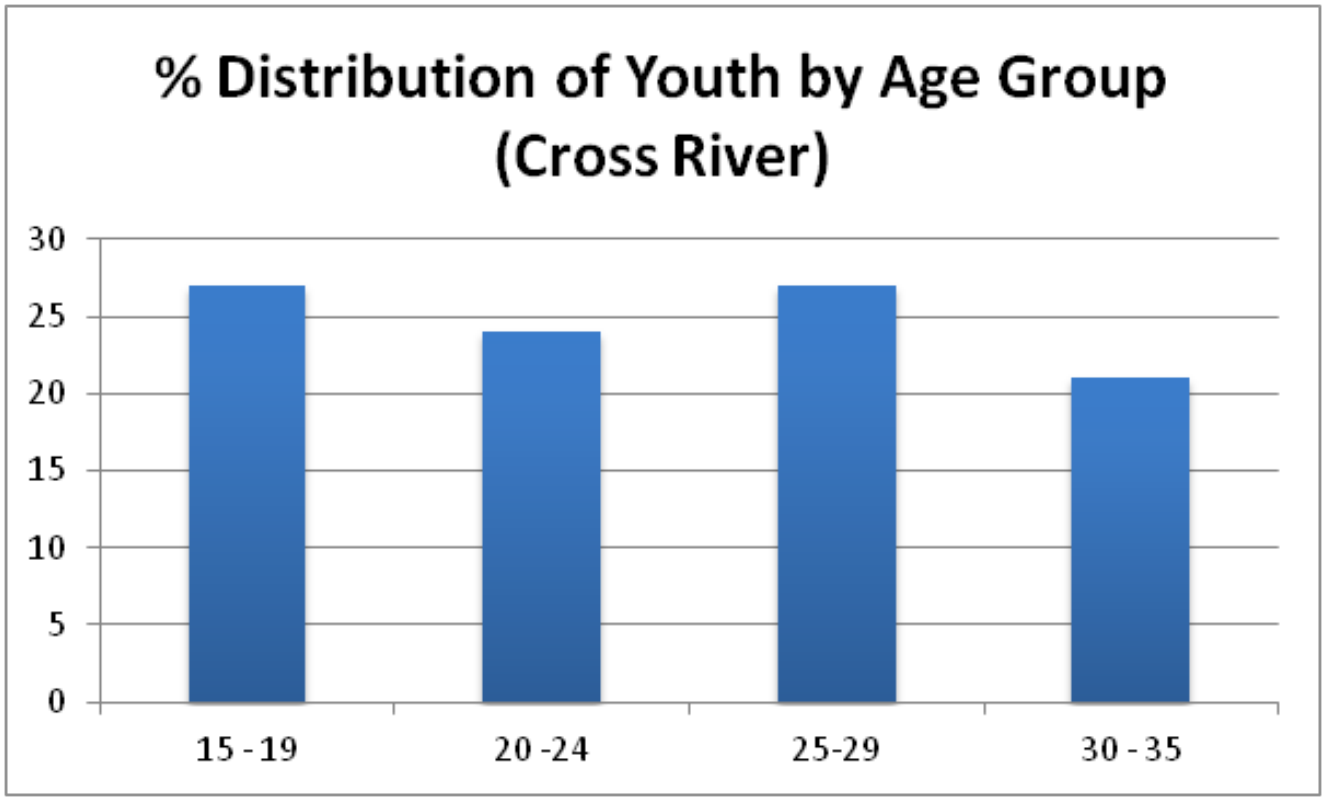
## 4.0 Analysis by State

### 4.1 Cross River

Key informant interviews and FGDs for the Cross River State situation analysis were conducted in 3 local government areas namely: Akpabuyo LGA, Ogoja LGA, and Yakurr LGA. Community stakeholders including teachers, health workers, traditional leaders, and religious leaders were interviewed. State and local government officials were also interviewed. Lastly, young men and women from the three LGAs participated in several focus group discussions.

The National Youth Baseline Survey conducted by the National Bureau of Statistics in 2012 found that 51 percent of youths in Cross River State are adolescents and young people from ages 15 to 24. The overall HIV prevalence rate is 7.7 percent and higher than the national average (Chamberlain Diala, Seyi Olujimi, Folami Harris, & Kale Feyisetan, 2011).

### *Figure 5 Distribution by Age-group (Cross River)*



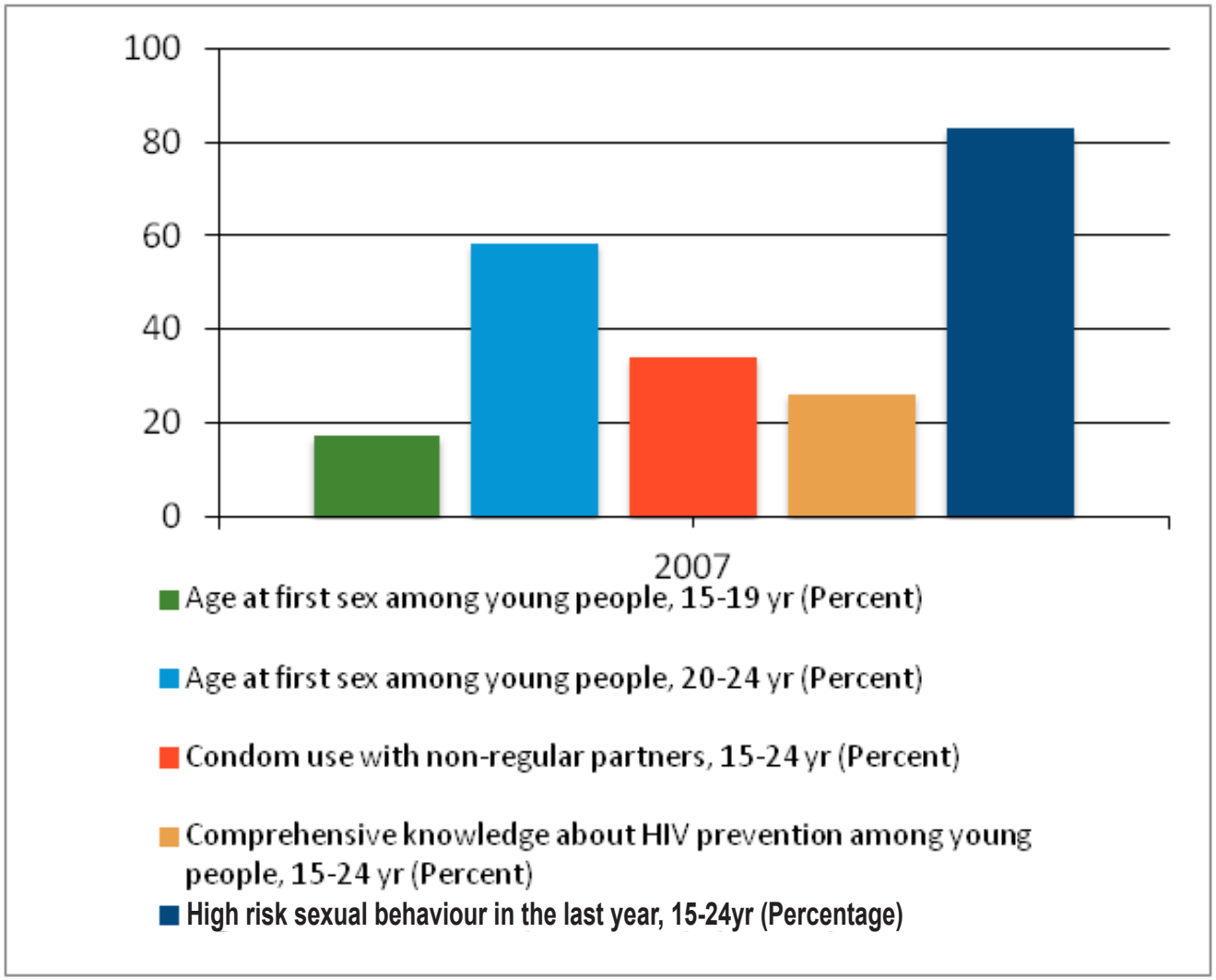

*Source (National Bureau of Statistics Nigeria., 2012)*

### *Knowledge, Attitudes, and Practices of Sexual Behaviour amongst AYPs in Cross River*

The average age at sexual debut is 15 and approximately 58 percent of young people aged 20-24 had their first sexual encounter within this age range.

A recent study by the National Population Council found that 80 percent of AYPs in Cross River engaged in high-risk sexual behaviors in the year preceding the study. This is consistent with the fact that only 34 percent of them reported condom use with non-regular partners. Comprehensive knowledge about HIV prevention is limited to 26 percent of the 15 to 24 age group.

*Figure 6 Sexual Behaviours & Knowledge (Cross River)*




*Source: (NBS, 2014)*

## Main SRHR Issues in Cross River

The main challenges identified in Chapter 3, were similar across the 3 states analyzed for this study. However, some issues seemed to be more widespread in Cross River. These include:

## Female Genital Mutilation

In Cross River, 32 percent of women aged 15 to 49 have experienced some form of FGM ranging from cutting with no flesh removed to infibulation. Cross River State has the third highest number of cases of FGM in the South-South region of Nigeria.

## Forced Cohabitation

There are no readily available official figures on forced cohabitation in Cross River, but it appears to be a fairly common practice. A good number of participants in the study mentioned it as one of the leading sexual & reproductive health rights issues facing adolescents and young people in the state.

***"Many young persons for lack of what to do (gainful employment) resort to sex work. The males are trafficked,***

***and the females started cohabiting and have children for different men as early as ages 19 or 20." – Religious leader***

Respondents saw cohabitation as one of the negative impacts of economic factors such as poverty and lack of access to education.

## Sexual Violence

In Cross River State, 20 percent of women of reproductive age have experienced some form of sexual violence. The state has the third highest incidences of sexual violence in Nigeria. In contrast, Kaduna has four percent and Ondo has five percent prevalence of sexual violence against women and adolescent girls (NDHS, 2014).

This shows that Cross River has a sexual violence issue that needs to be urgently addressed.

Sexual violence here is interpreted to mean rape, being physically forced to perform a sexual act against a person's will and/or using threats or other means to coerce someone into performing a sexual act.

## Policy Framework

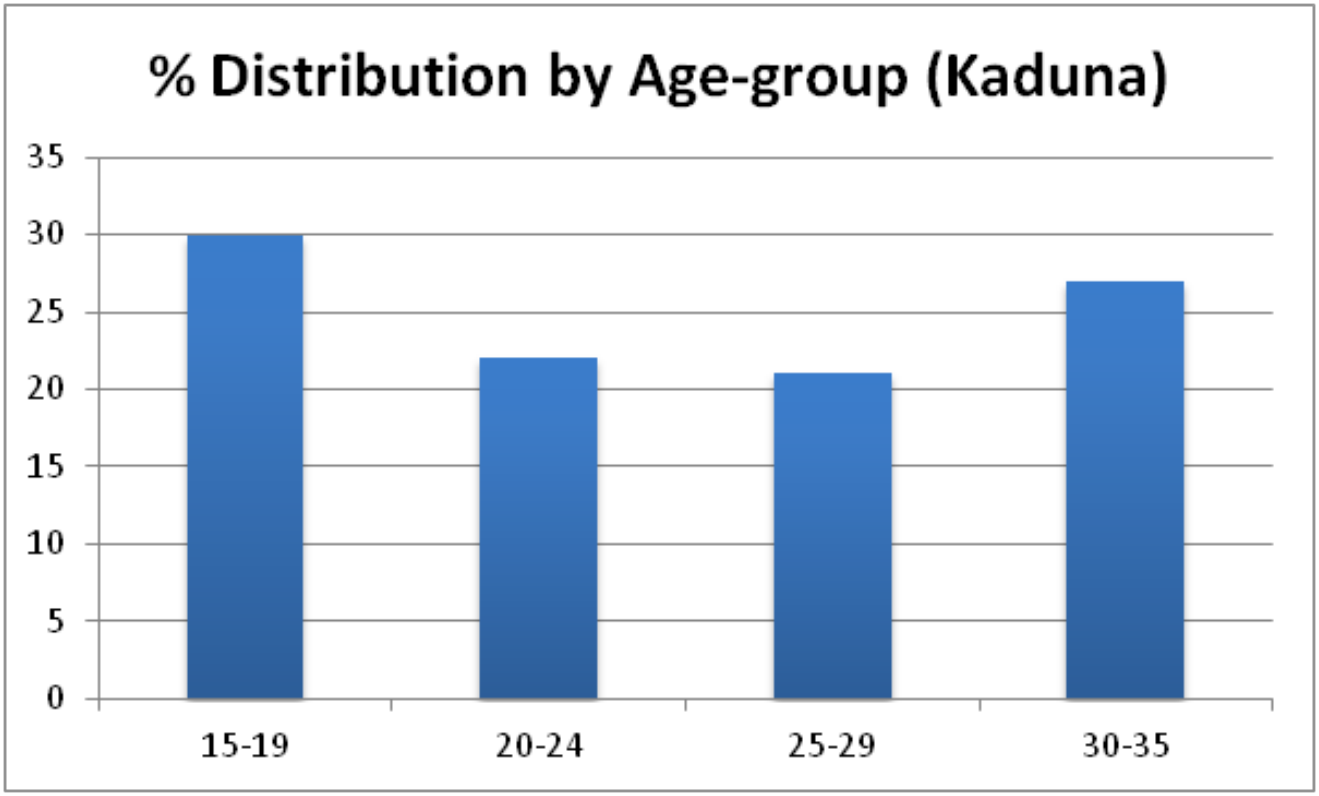
The Cross River State Government enacted an anti-domestic violence law in 2005 named, "A Law to Prohibit Domestic Violence against Women and Maltreatment of Widows". The law criminalizes domestic violence and harmful traditional widowhood practices against women. 'Woman' was defined as a person of the female sex up to and above 18 years old.

# 4.2 Kaduna

Key informant interviews and FGDs for the Kaduna State Situation Analysis were conducted in 3 local government areas namely: Chikun LGA, Kachia LGA, and Sabon Gari LGA. Community stakeholders including teachers, health workers, traditional leaders, and religious leaders were interviewed. State and local government officials were also interviewed. Lastly, young men and women from the 3 LGAs participated in several focus group discussions.

In Kaduna State, 52 percent of the youth population is made up of AYPs ages 15 to 24. About seven percent of the population are teenagers living with HIV. This makes Kaduna State one of the states with the highest prevalence of HIV amongst AYPs (DailyPost, 2017).

### *Figure 7 % Distribution of Youth by Age-group (Kaduna)*



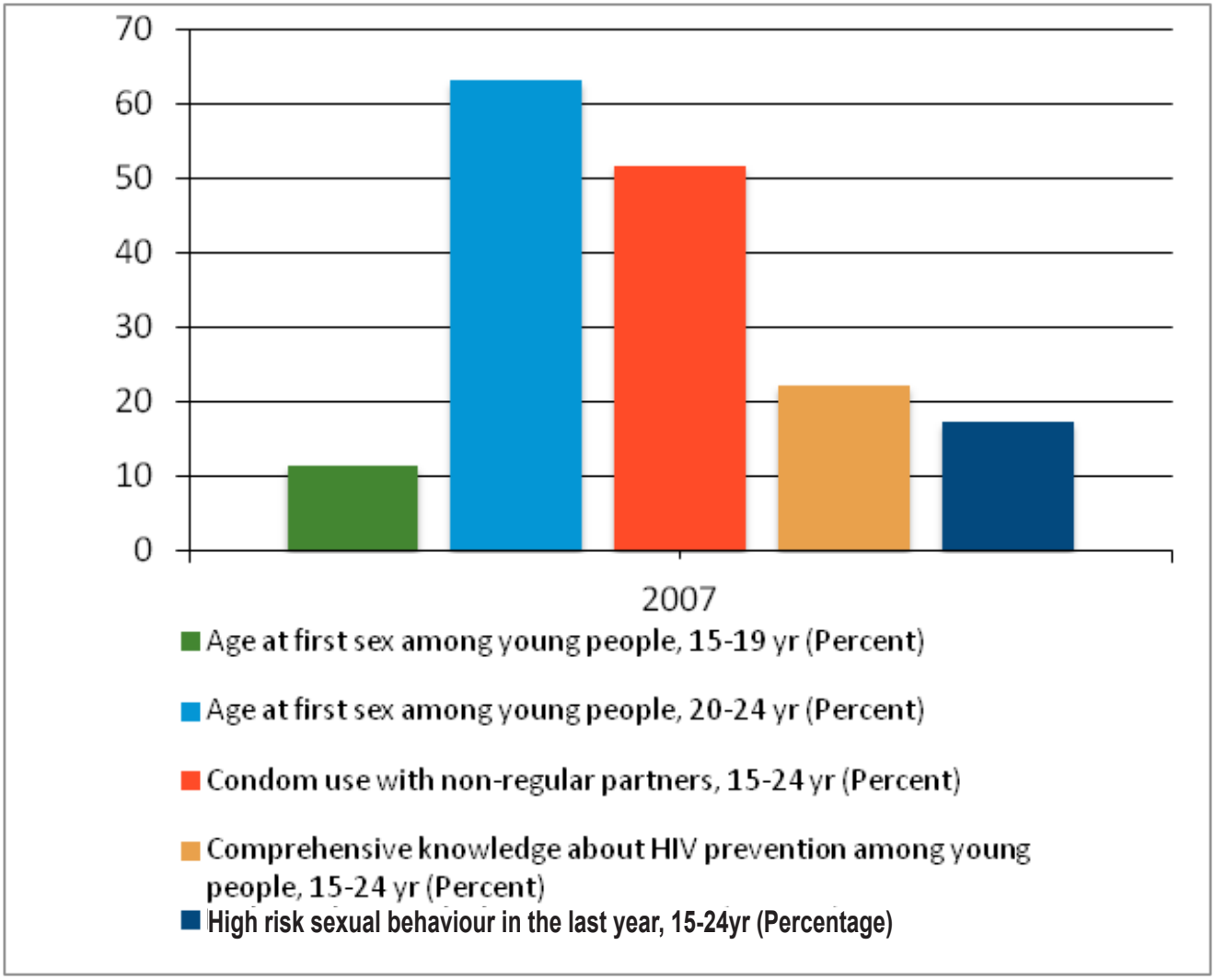

*Source (National Bureau of Statistics Nigeria., 2012)*

## *Knowledge, Attitudes, and Practices of Sexual Behaviour amongst AYPs in Kaduna*

Approximately 52% of AYPs, 15 to 24 use condoms with non-regular partners in Kaduna and only about 17% of them engaged in high-risk sexual behaviors in the year preceding the survey. This shows some level of awareness of safe sex practices. However, only about 22% of AYPs in Kaduna have a comprehensive knowledge of HIV prevention.

Female Genital Mutilation is somewhat widespread in Kaduna with a prevalence rate of 25% in girls and women aged 15 to 49 (NDHS, 2014).


*Figure 8 Sexual Behaviour & Knowledge of AYPs (Kaduna)*




*Source (National Bureau of Statistics Nigeria., 2012)*

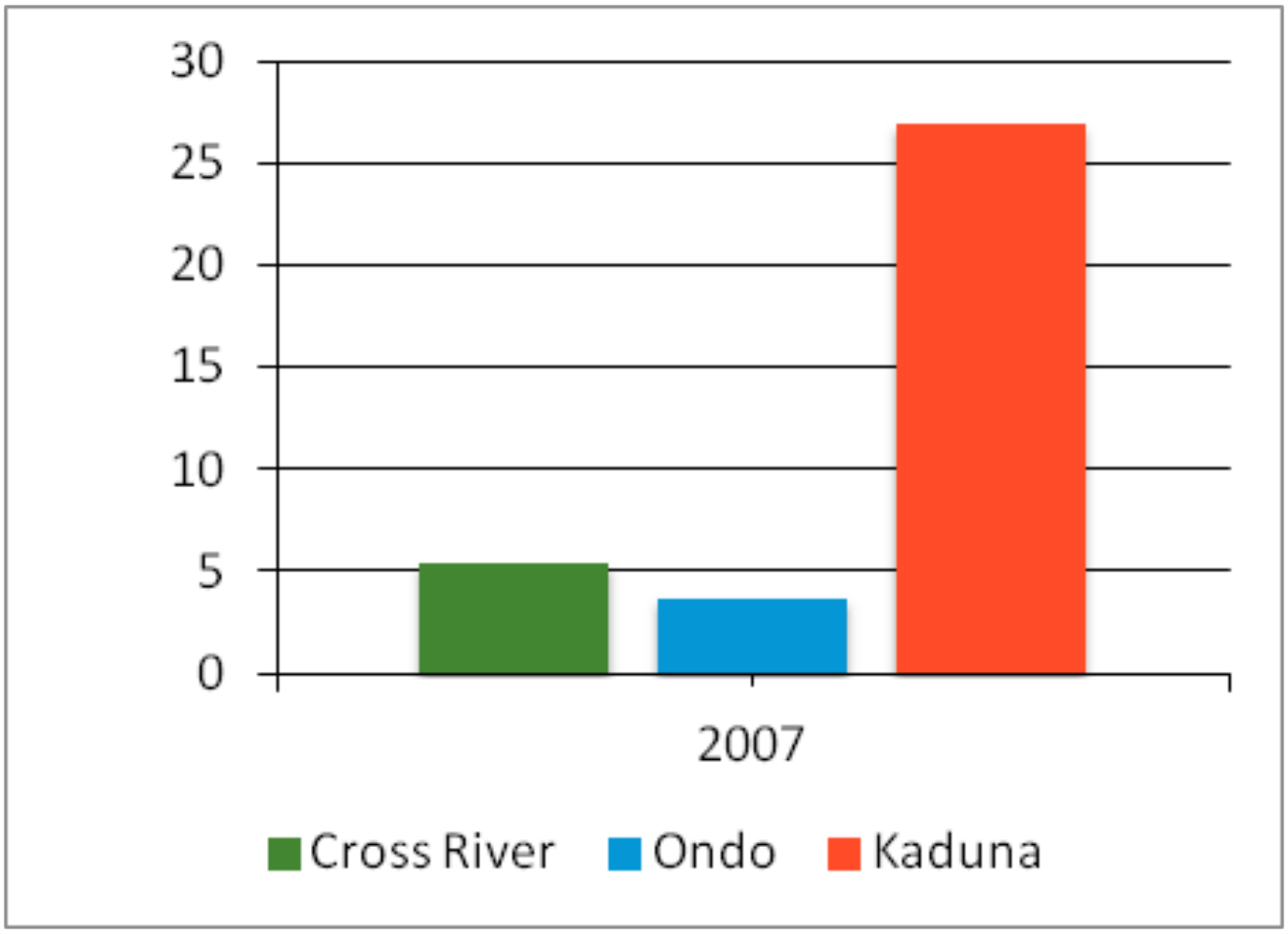
## Early Marriage

In Kaduna State, 53% of youth between ages 15 to 35 are married and a large percentage of this number, 69%, are adolescent girls and young women (National Bureau of Statistics Nigeria., 2012). The available data do not provide information on what proportion of the figure are AGYW in the 15-19 age bracket. However, the 2007 study referenced in the figure following, shows that 27% of young women between ages 15 to 19 are married, as opposed to approximately 5% in Cross River and 4% in Ondo (NBS). And research has shown a correlation between high rates of girls out of school and high rates of early marriages (Osunyikanmi, 2014).

## Teenage Pregnancy

With the high numbers of adolescents and young women in marriages, it is not surprising that 21 percent of teenagers aged 15 to 19 have been pregnant in Kaduna, although this is not the highest percentage in the North-west zone.

*Figure 9 Percentage of Young Women Ages 15-19, Currently Married*




### *AYPs Policy Framework in Kaduna State*

The Violence Against Persons Prohibition Act is yet to be adopted in Kaduna nor does the state have a Gender and Equal Opportunities Law. The state authorities seem to recognize the existence of this gap:

***"The key challenges and/or constraints with respect to social development and welfare in Kaduna State include the following:***

- Non-passage of the bill against Gender-Based Violence (GBV);
- Socio-cultural, political, and economic norms which enhance gender imbalance in the society
- Increased poverty and deprivation among youths;..." Source (Kaduna State Government, 2015)

To address these gaps, the Kaduna State government in its Kaduna State Development Plan (SDP), 2016-2020 has a social welfare and development policy thrust, which is:

***"The economic empowerment of women and the vulnerable groups through skills acquisition, reduction***

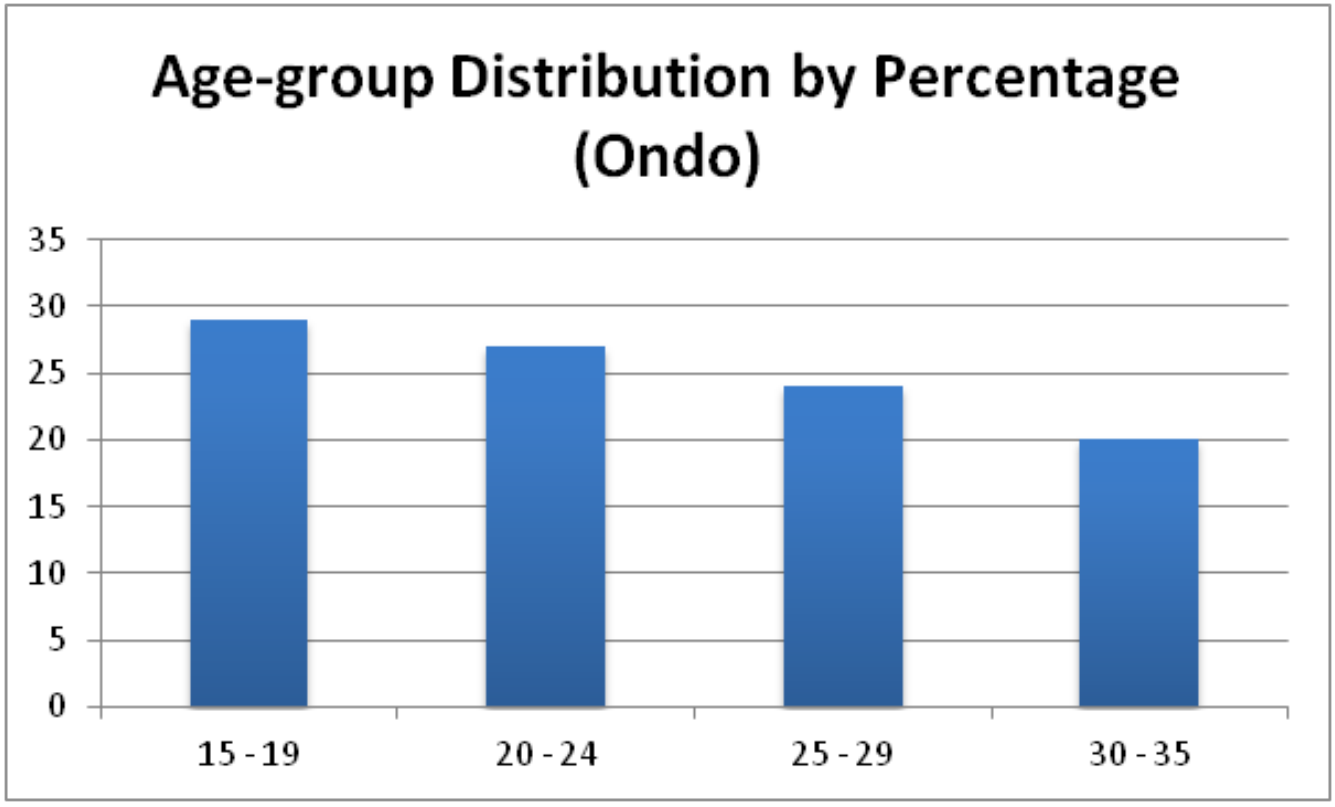
***of youth unemployment through engaging them in productive and sporting activities, encouraging competition and excellence, and the pursuit of careers in sports and entertainment, and the implementation of a sustainable safety net for the vulnerable groups." (Kaduna State Government, 2015)***

The SDP does not give precedence to or even mention the sexual and reproductive health of adolescents and young persons. In the health sector brief of the plan, provision is made for free HIV testing services and free healthcare of pregnant women. Other SRH services are not mentioned.

## 4.3 Ondo

Adolescents and young people with ages ranging from 15 to 24 make up 56 percent of the youth population in Ondo State, and about 21 percent of the entire population in the state (Ministry of Economic Planning and Budget & Statistics, Ondo State, 2009)

***Figure 10 Distribution of Youth by Age-group (Ondo)***



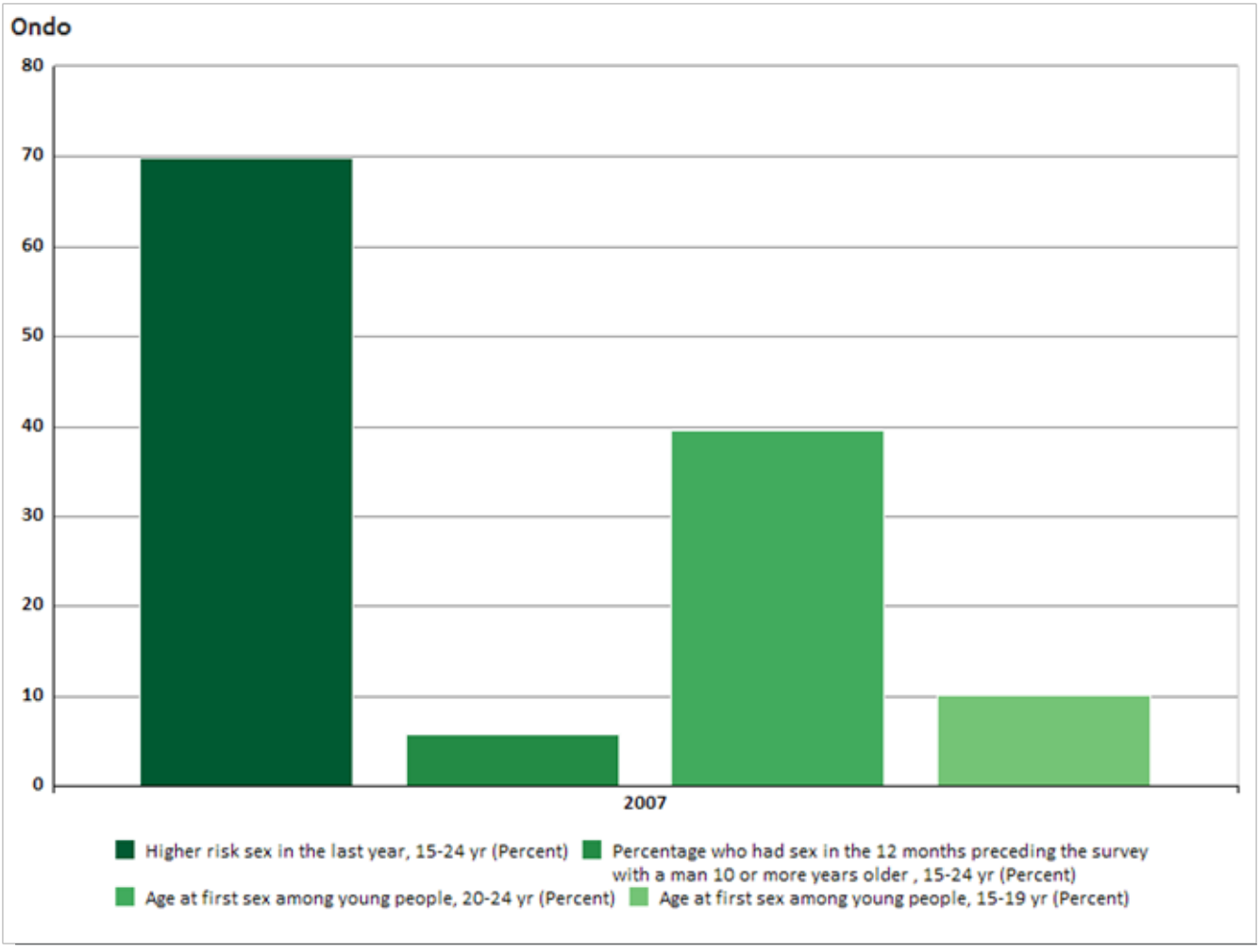

*Source (National Bureau of Statistics Nigeria., 2012)*

***Knowledge, Attitudes, and Practices of Sexual Behaviour amongst AYPs in Ondo***

AYPs with sexual and reproductive health needs make up a significant proportion of Ondo's population. Yet according to a 2007 survey, only about 20 percent of AYPs in the state has a comprehensive

knowledge of HIV prevention. Furthermore, only about 33 percent of AYPs in Ondo State engage in condom use with non-regular partners. In Ondo State, 39% of ages 20-24 and 10% of ages 15 to 19 respectively, reported sexual debut in those age brackets. Invariably, a good number of AYPs in Ondo may be engaging in risky sexual behaviors; in fact, 69% of AYPs reported high-risk sexual behaviors in the year preceding the survey ("Socio-Economics Statistics," 2014).


***Figure 11 Sexual Behaviour of AYP in Ondo***



### *Prevalence of Female Genital Mutilation/ Cutting*

According to the Nigeria Demographic Health Survey of 2013, 45% of girls and women aged 15 to 49 in Ondo have undergone some degree of genital mutilation. Ondo State has the third highest prevalence rate in the South-West region of Nigeria.

## Teenage Pregnancy

Ondo State has the highest rate of teenage pregnancy in the South-west region with about 11 percent of young women from ages 15 to 19 who have begun childbearing. For context, Osun State with the lowest rate of teenage pregnancy in the region is approximately one percent.

## Early Marriage

In Ondo State, 25% of youth between ages 15-35 are married and about four percent of young women aged 15 to 19 are married. While cases of early marriage are not widespread, the number is not entirely insignificant.

## Policy Environment

A 2008 report on gender equality in Ondo State highlighted the state government's efforts in mainstreaming gender and protecting rights of women and girls in the state: “The Ondo State government has been implementing several programmes aimed at empowering women and improving their political, social, economic and health status...The government has also approved laws to improve the social status of women. Prominent among these is the law on the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).”

Also, in 2013, the state government launched the Strategic Framework and Action Plan for the Adolescent and Youth Friendly Health Programme. The Adolescent and Youth Friendly Health Programme were created to guarantee quality health care services to all the young people in the state. The programme offers "integrated services to adolescents and youth with disabilities, young men and women living with HIV/AIDs, youth sex workers amongst others" (Adeleye, 2013).

To combat the issue of female genital mutilation in Ondo, “A bill on harmful traditional practices affecting the health of women and children and related matters”, has been proposed in the Ondo State House of Assembly. This bill is yet to be passed into law (Agidi, 2017).

# 5 Recommendations and Conclusions

- Continuous advocacy is needed for a bill that can be passed into law to address the SRH needs of AYPs. The law should also create an adequate budget line for AYPs' SRHR services.
- Suggested advocacy to the FG and SG to create standing committees on AYPs' SRH issues.
- Social mobilization advocacy for community stakeholders, including traditional and religious leaders.
- Engaging AYPs to ensure that they are at the center of any policies or intervention formulated for them.
- Youth-friendly centers should be built in every LGA and trained health workers should be placed in those centers to attend to the SRHR needs of AYPs.
- CSOsneedtoworktogethertocreate awareness and ensure implementation of SRH programs.
- CSOs should work with the state government to create and adopt proper monitoring tools to monitor the activities of MDAs and CSOs.
- Stakeholders should lobby the government for the implementation of the sex education curriculum (FHLE) in primary and secondary schools.
- Sensitization and enlightenment campaigns should be conducted for AYPs and stakeholders.

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