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# ADDRESSING ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN NIGER

DISCUSSION PAPER JANUARY 2016

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WORLD BANK GROUP
Health, Nutrition & Population

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**January 2016**

# Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## Addressing Adolescent Sexual and Reproductive Health in Niger

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Paper prepared for Health, Nutrition, and Population Global Practice (HNP GP), Washington DC, USA.
This work was supported by the Bank-Netherland Partnership Program (BNPP), which is managed by the World Bank.

**Abstract**: The aim of the study is to better understand adolescents' sexual and reproductive health (SRH) needs in order to inform the design of interventions and policies that improve access to and use of adolescent SRH services in Niger. A mixed-methods study was conducted and included: (i) a quantitative analysis of Niger's Demographic Health Survey/Multiple Indicator Cluster Survey (DHS/MICS) 2012; (ii) 17 focus group discussions conducted in urban and rural areas among 128 adolescents; and (iii) a set of recommendations to improve access to and use of SRH services for adolescents in the country. The study found that age at first marriage among adolescent females is 15.7 years and is followed soon thereafter by sexual debut (15.9 years). According to focus group discussions (FGDs), adolescents boys and girls start spending time together at 12 years in urban areas and 10 years in rural areas; this may lead to sexual intercourse in exchange for material and financial resources. Over 70 percent of adolescents have given birth by 18 years of age. Although knowledge about modern contraception is high (73 percent among female adolescents 15-19 years of age), the majority of adolescent girls do not use contraception due to societal and cultural beliefs. Moreover, FGDs reveal that the main barriers to use of SRH services is a lack of privacy and confidentiality, as well as finances, despite the government's elimination of user fees. The government has increased supply side interventions for adolescents and prioritized adolescents on the national agenda by approving the Family Planning Action Plan (2012-2020) and the National Plan for Adolescent Sexual and Reproductive Health (2011), however these plans need to be monitored and evaluated to determine their effectiveness in reaching this population group. There is also a need to increase multi-sectoral demand-side interventions in the country.

**Keywords**: Sexual and reproductive health, adolescent, access to sexual and reproductive health services, adolescent marriage and childbearing.

**Disclaimer**: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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# ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANBEF | National Nigerien Association for the Wellbeing of the Family (*Association nigérienne du bien-être familial*) |
| ANC | Antenatal Care |
| ASRH | Adolescent Sexual and Reproductive Health |
| AYH | Adolescent and Youth Health |
| AYSRH | Adolescent and Youth Sexual and Reproductive Health |
| BNPP | Bank Netherlands Partnership Program |
| CSI | Integrated Health Centre |
| CSO | Civil Society Organization |
| EA | Elective Abortion |
| EFA | Education For All |
| FGD | Focus Group Discussions |
| FP | Family Planning |
| GBV | Gender-Based Violence |
| GDP | Gross Domestic Product |
| HDI | Human Development Index |
| ICPD | International Conference on Population and Development |
| IEC | Information, Education, Communication |
| IGAs | Income Generating Activities |
| LMICs | Low and Middle Income Countries |
| MCH | Maternal and Child Health |
| MDC | Mobile Digital Cinema |
| MDGs | Millennium Development Goals |
| MMR | Maternal Mortality Ratio |
| MPA | Minimum Package of Activities |
| DHS/MICS | Niger Demographic and Health Survey-Multiple Indicator Cluster Survey |
| NGO | Non-Governmental Organization |
| NICTs | New Information & Communication Technologies |
| PE | Peer Educator/Education |
| PMA | Minimum Package of Activities |
| PPP | Purchasing Power Parity |
| RH | Reproductive Health |
| SDGs | Sustainable Development Goals |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health Rights |
| STIs | Sexually Transmitted Infections |
| UEMOA | West African Economic and Monetary Union |
| UHC | Universal Health Coverage |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |

# FIGURES AND TABLES

## Figures



## Tables

# ACKNOWLEDGEMENTS

This report was prepared by World Bank staff and a team of consultants that included Rafael Cortez (Senior Economist, and Task Team Leader, HNP GP), Helene Barroy (Economist, HNP GP), Nora Lejean (Consultant, HNP GP) and Hui Wang (Junior Professional, HNP GP). We are grateful to the contributions from Djibrilla Karamoko (Senior Health Specialist, HNP GP) for their continuous operational support that facilitated the data collection and analysis, and technical dialogue at the country level. We would also like to thank Meaghen Quinlan-Davidson (Consultant, HNP GP) for her technical and editorial support and feeback to the document.

We gratefully acknowledge the partnership and support of the Ministry of Health that permitted the Bank team to complete this task. The authors would like to thank Dr. Abdou Aissatou Laouali (Secretaire General Adjoint, Ministère de la Population, Promotion de la Femme et Protection de l'Enfant), Dr. Idrissa Maiga Mahamadou (Secretaire General, Ministère de la Sante Publique) and Dr. Adama Kemou (Directrice de la Santé Maternelle-MSP) for their valuable feedback and operational support.

This study was part of a multi-country analysis conducted under the World Bank's Economic Sector Work (P130031) on Adolescent Sexual Reproductive Health, and it was funded by the Bank - Netherlands Partnerhisp Program (BNPP) (TF098378), which was managed by the World Bank

The authors are grateful to the World Bank for publishing this report as an HNP Discussion Paper.

# PREFACE

Adolescents and youth[1] (10-24 years of age) represent 31.0 percent of the total population in Niger today (UN DESA, 2015), the largest cohort of young people in the country's history. These young people play an important role in Nigerien society, however, they face challenges to reaching their sexual and reproductive health (SRH) potential, such as early marriage and childbearing. In 2012, for example, the median age at first marriage among young women was 15.7 years while the adolescent fertility rate was estimated at 210 births per 1,000 15-19 year olds (DHS/MICS, 2012). Importantly, early marriage and childbearing are associated with an increased risk of experiencing unplanned pregnancies, unsafe abortions, sexually transmitted infections (STIs), and maternal mortality and morbidity. They are also negatively associated with a range of health and development outcomes, including poorer educational outcomes and a higher risk of exposure to violence. Adolescent childbearing affects not only the health of young women and their children but also the mother and child's long-term education and employment trajectories. Ultimately, inadequate access to health information and services, as well as inequitable gender norms, contribute to a lack of knowledge and awareness about puberty, sexuality, and basic human rights.

Although over twenty years have passed since the International Conference on Population and Development (ICPD) first put adolescent sexual and reproductive health rights (SRHR) on the political and public agenda, support and protection for adolescent SRH (ASRH) and SRHR programs and policies have developed at a slower pace in Niger. Adolescents and youth in the country lack knowledge about their SRH and SRHR, while access to quality health services is limited. Given that these young people are the next generation of adults, they will greatly influence the achievement of the sustainable developmenent goals (SDGs). Therefore, investments in multi-sectoral SRH interventions should be prioritized, taking into consideration equity and rights, within the universal health coverage (UHC) framework.

Acknowledging the importance of SRH, the World Bank Group, with support from the Bank Netherlands Partnership Program (BNPP) Trust Fund, is pleased to present *Addressing Adolescent Sexual and Reproductive Health in Niger*. This report is based on data collected through quantitative and qualititve research, presenting the opportunities and challenges that adolescents in Niger face to meeting their SRH needs.

Protecting the health and wellbeing of adolescents and youth is a priority for the World Bank Group. This report is intended for visionary leaders responsible for shaping social policies and for decision makers concerned with the comprehensive health and development of adolescents and youth. It is our hope that, by disseminating evidence on ASRH and policies at the country level, decision-makers and key stakeholders will invest in the improvement of adolescent and youth SRH, thereby securing the health and well-being of future generations.

[1] The World Health Organization (WHO) defines young people as individuals between the ages of 10 and 24 years of age. Adolescents represent the 10–19-year-old age group and youth the 15–24-year-old age group.

# PART I - INTRODUCTION

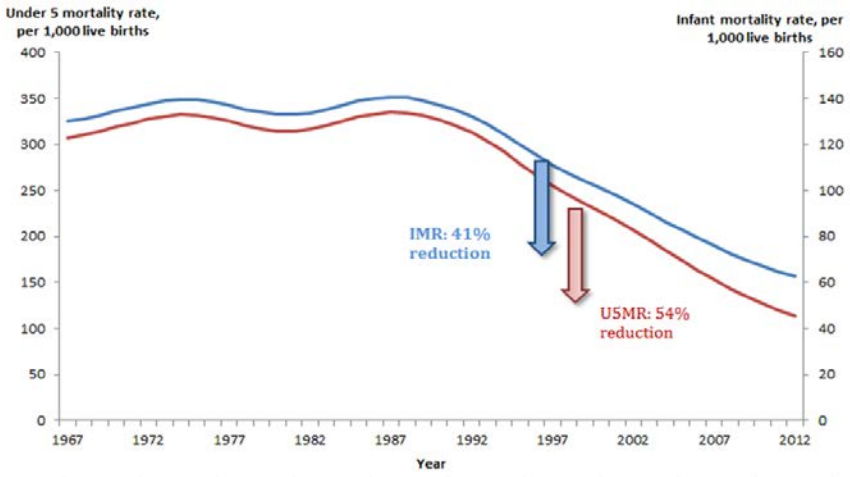
1. **The Republic of Niger is a landlocked sub-Saharan African country, with 50.3 percent of the population living below the poverty line (WBG, 2011).** In 2013, the country's social indicators were among the worst in the world. For example, less than half (47.5 percent) of the population had access to health centers within a 5 km distance; 29 percent of the population was literate, while primary school enrollment stood at 59 percent; and more than half of the population in rural areas did not have access to drinking water. In 2012, the country ranked last out of 187 countries in the United Nations Devleopment Programe (UNDP) Human Development Index (HDI), with a gross domestic product (GDP) per capita in purchasing power parity (PPP) of US$ 701 in 2010, one of the lowest in the world (WBG, 2014).

2. **There has been significant improvement, in recent years, in infant and under-five health and access to health services in the country.** Infant and child mortality rates have declined sharply in Niger since the beginning of the 21st century. The infant mortality rate fell from 107 deaths per 1,000 live births in 1998 to 63 deaths in 2012, representing a 41 percent reduction over 12 years. Similar trends were found with the under five mortality rate, which fell from 245 deaths per 1,000 live births to 114 deaths over the same period, signifying a 54 percent decline (Figure 1). In addition, use of curative child health care services improved with the removal of user fees in 2007 and the introduction of an effective Child Survival Strategy. Challenges remain, however, to ensuring effective coverage of life-saving interventions for newborns as neonatal mortality has not declined as rapidly as infant and under-five mortality (Lagarde, Barroy and Palmer 2012; Barroy 2013).

3. **Niger has the highest total fertility rate in the world, estimated at 7.6 children per woman in 2012.** This rate varies by residence, education, and wealth quintile. The fertility rate is higher in rural areas at 8.1 births per woman in comparison to 5.6 births per woman in urban areas (Figure 2) (WBG, 2014). Women without an education have a total fertility rate of 8.0 births per woman in comparison to women with a secondary education or higher at 4.9 births per woman. Meanwhile women in the poorest quintile have an average of 8.2 births per woman in comparison to 6.1 births per woman in the wealthiest quintile.

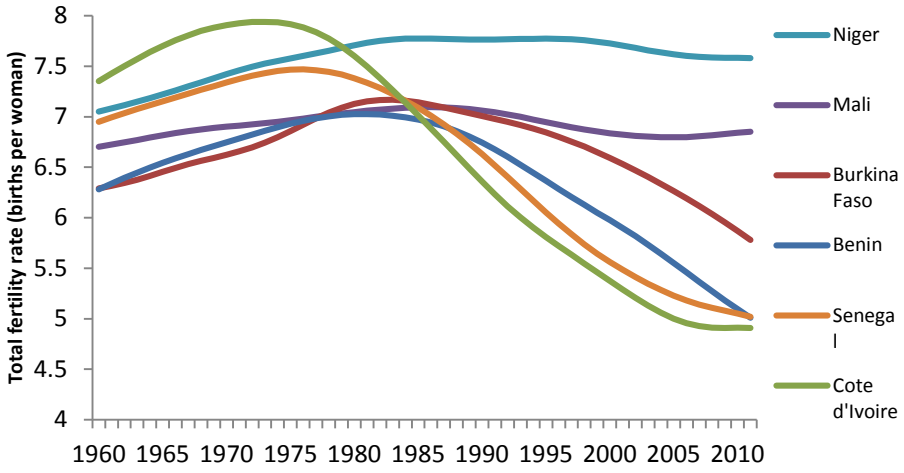
4. **The population of Niger was estimated at over 17 million inhabitants in 2012, with an inter-census population growth rate of 3.9 percent, one of the highest in the world.** If this growth rate continues, the population will double within the next 15 years. In addition, Niger has a predominately young population, with 50 percent of the population below 15 years of age. This is particularly concerning as there has been limited investment in human capital, raising concerns about the country's ability to eventually benefit from the demographic dividend; this transition has not yet started in Niger, despite increased use of contraception and a sharp decline in infant and child mortality (Guengant 2012).

**Figure 1: Trends in Infant and Child Mortality in Niger, 1998-2012**




*Source:* World Development Indicators 2014

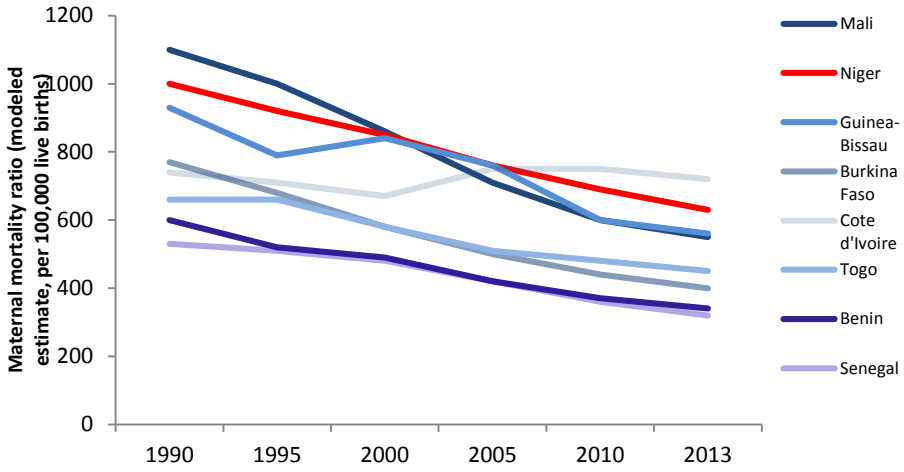
**Figure 2: Trends in Total Fertility Rate in Niger and the Sub-region, 1990-2013**




*Source*: World Development Indicators 2014

5. **Progress towards the reduction of maternal mortality has been modest.** Niger has a higher maternal mortality ratio (MMR) in comparison to other countries in the West African Economic and Monetary Union (UEMOA) region (Figure 3). The MMR declined from 1,000 per 100,000 live births in 1990 to 630 per 100,000 in 2012, representing a 37 percent decrease in 20 years. Although mortality reduction gains have occurred, the achievement of MDG 5 (175 per 100,000 live births) will not be attained in the country by 2015 (World Bank, 2014).

**Figure 3: Trends in Maternal Mortality Ratios in Niger and the Sub-region, 1990-2013**

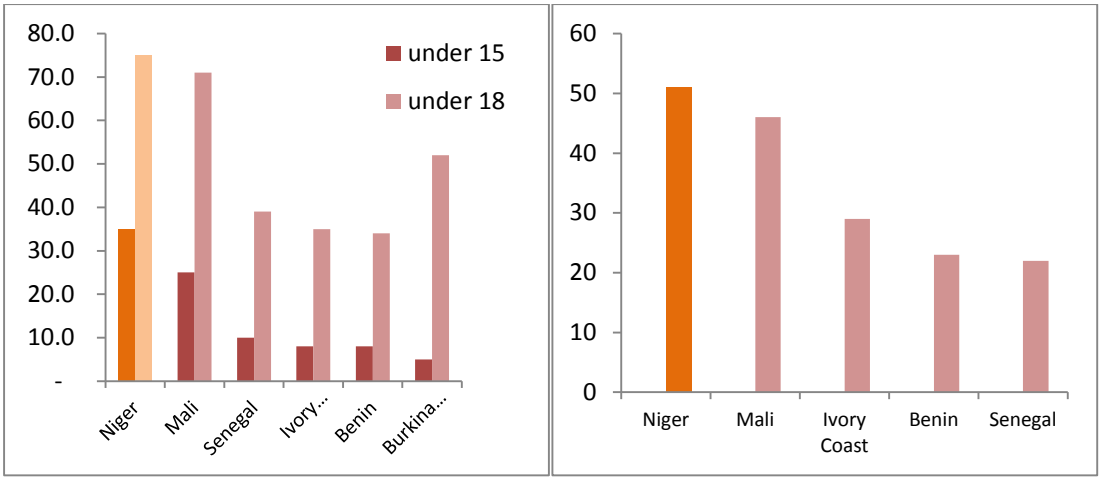



*Source*: World Development Indicators 2014

6. **Early marriage and childbearing have been identified as key drivers to high fertility and maternal mortality in sub-Saharan Africa (PRB, 2011).** In Niger, the median age of first marriage and childbearing for women is 15.7 years and 18 years respectively, the youngest in the region (DHS/MICS, 2012) (Figures 4 and 5). Meanwhile, trends in marriage and childbearing have not changed significantly over the past two decades in the country. Importantly, adolescent fertility and childbearing not only increases the young woman's risk of poor pregnancy outcomes but also maternal death. In fact, adolescent (15-19 years of age) maternal deaths account for over one third (34.4 percent) of all deaths among women in Niger. Additionally, early marriage and childbearing has long-term consequences on the adolescent mother and child, impacting their education and employment prospects (WHO 2011, World Bank 2001).

7. **Women in Niger are disadvantaged from a young age.** Niger ranks near the bottom of the gender-related development index (155$^{th}$ out of 157 countries). Young women face limited educational opportunities, arranged marriages, and female genital cutting (over 90 percent experience cutting). Once married, women move in with their husband's family where men have legal authority over their wives and mothers in-law have strong intra-familial power. Moreover, the feminization of poverty illustrates gender inequality issues in the country. For example, in 2008 per capita consumption was 45 percent lower in households headed by women; they also had less access to credit (17.5 percent of demand met as against 27.4 percent for men) and limited employment opportunities (27.4 percent access for 51.1 percent of the workforce) (IMF, 2013).

**Figures 4 and 5: Percent of Married Adolescents at 15 years and 18 years of age (left); and Percent of Women who Gave Birth Before 18 years of age (right) in Niger and the Sub-region, Last Year Available**



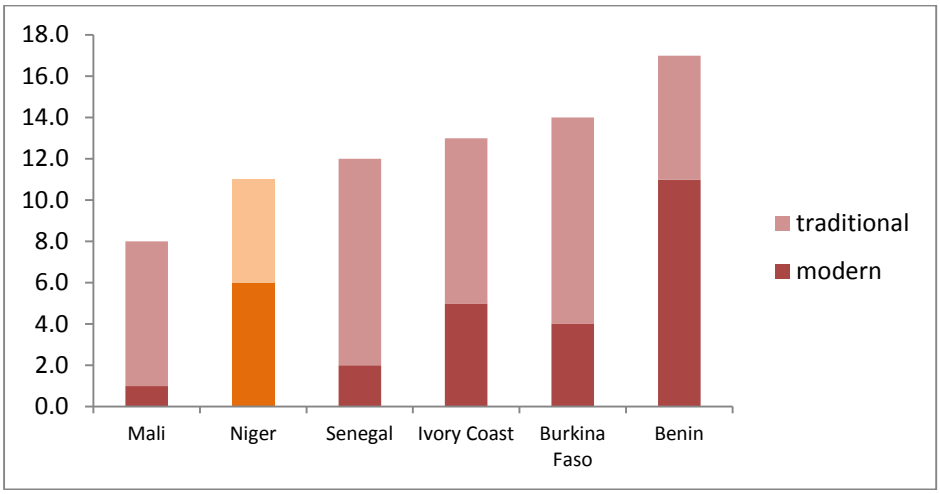

*Source:* DHS (Bénin 2006 ; Burkina Faso 2003 ; Côte d'Ivoire 2007 ; Guinée 2005 ; Mali 2006 ; Niger 2006 ; and Sénégal 2005)

8. **Limited access and use of health and family planning (FP) services among women, combined with low education, is prevalent, particularly among females in rural areas.** Use of (and demand for) modern family planning among women (regardless of age) is estimated to be lower in Niger than in the rest of the sub-region, except Mali (Figure 6). Contraceptive prevalence has, however, increased in recent years, from 5 percent in 2006 to 12 percent (DHS/MICS, 2012). One study found that women do not demand contraception as they are "prohibited by their husbands and imams because they denounce "Western" notions like birth control." Women also are less likely to utilize contraception due to financial constraints. The government is working to overcome this on the supply side, by reducing finances to FP commodities, however, the literature indicates that thus far there has been little effect (Guengant 2012).

9. **Coverage of SRH services is low in Niger.** Health service coverage, measured by the proportion of people living within a radius of 0-5 km from an Integrated Health Centre (CSI), was estimated at 47.5 percent in 2011[2]. In theory, it is the proportion of the population with access to the Minimum Package of Activities (PMA). The proportion has been declining since 2010 due to slowdown in investments for the construction of CSIs. It indicates that less than one out of every two persons is covered by the health system, excluding health posts[3] (figure 7).

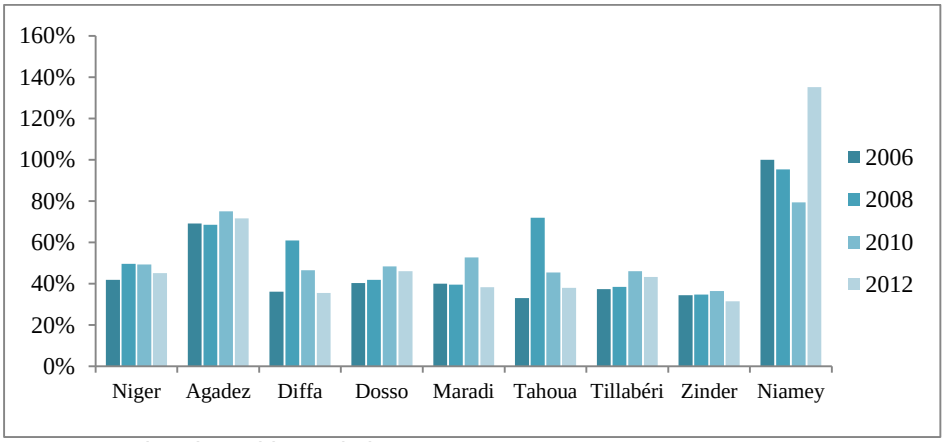
[2] SNIS, Statistical Year Book, 2011
[3] Case de Santé

**Figure 6: Percent of Women of Childbearing Age using Modern and Traditional Contraceptive Methods in Niger and the Sub-region, Last Year Available**




*Source:* DHS (Bénin 2006 ; Burkina Faso 2003 ; Côte d'Ivoire 2007 ; Guinée 2005 ; Mali 2006 ; Niger 2006 and Sénégal 2005)

**Figure 7: Percent of Population with Access to Health Centers that Offer Essential Services in Niger, 2005**




*Source:* National Health Statistics 2012

10. **According to national health statistics, Niger has made progress in increasing antenatal care (ANC) coverage in recent years**. The proportion of pregnant women, regardless of age, who went to a health facility for an ANC visit increased from 46 percent in 2006 to 83 percent in 2012.

11. **At the national level, the percentage of births attended by skilled health personnel increased between 2006 and 2012 (from 18 to 29 percent).** Furthermore, the percentage of women in urban areas who benefitted from the assistance of skilled health personnel at birth was estimated at 83 percent in 2012, in comparison to 21 percent in rural areas. Regional inequalities in births attended by skilled health personnel also exist with 57 percent of births attended by a skilled health personnel in Diffa in comparison to 98 percent in Niamey. The spatial distribution of skilled birth attendants indicates wide disparities between Niamey and rural areas. The ratio between the two groups is almost 3 to 1 (World Bank, 2014).

12. **Removal of user fees for maternal and child health (MCH) services has been positive in Niger.** Evidence indicates that in Niger, the removal of user fees for children under five

(curative services) and pregnant women (ANC, c-Sections) has contributed to an increase in the use of services (Lagarde, Barroy and Palmer 2012).

13. **Nigerien women are dissatisfied with the "state of consultation and hospitalization rooms and the cramped premises, all of which are major obstacles to privacy. In addition, the waiting time is too long, and there are delays due to staff absences"** (MSP, 2011). A 2008 User Satisfaction Survey found that 40 percent of patients were dissatisfied with the quality of health care and services. For example, 27 percent of visitors were informed about HIV/AIDS transmission and prevention methods, while 28 percent were offered an HIV test (DHS/MICS, 2012).

14. **While supply and demand-side determinants to accessing reproductive health services among reproductive-aged women have been documented, little information has been gathered on adolescents in Niger**. Evidence from low and middle-income countries (LMICs) indicates that major barriers to accessing SRH and FP services are associated with socio-cultural norms and economic conditions, as well as supply-side constraints related to the availability and quality of health services (Table 1) (Chowdury, 2013). However, there is a lack of evidence on the barriers that Nigerien adolescents face, as well as their needs, in comparison to older age groups. In addition, there is a lack of evidence on policies that can better address those needs and barriers in order to improve ASRH and FP outcomes.

15. **This study aims to inform country policy-makers and development partners about ASRH needs within Niger's development context.** The overall objective is to help in the design of better tailored interventions and policies that aim to improve access and use of ASRH services in the country. Using the framework of analysis below (Figure 8), the study will address the following specific objectives:

    (i) Investigate adolescent's socio-economic profile
    (ii) Analyze ASRH status and its determinants from a demand and supply-side perspective
    (iii) Assess effectiveness of existing adolescent friendly initiatives and programs
    (iv) Recommend a set of policy options to improve access and use of services for adolescents in Niger

16. The study uses a mixed methods approach that includes the following:

- An analysis of the most recent Niger DHS/MICS data (2012) focusing on adolescent health.
- 17 focus group discussions (FGDs) conducted in 18 urban neighbourhoods and 2 rural villages among 128 adolescents 10-19 years of age. Groups were divided by age (10-14 and 15-19 years) and education status (in school or out-of-school). Eighty-six adolescents were interviewed in urban areas and forty-two adolescents were interviewed in rural aras. FGDs were conducted in order to understand the experiences, difficulties, and challenges that adolescents (10-19 years of age) face regarding their SRH.
- Policy and program review, including interviews with stakeholders and beneficiaries', as well as on-site visits.

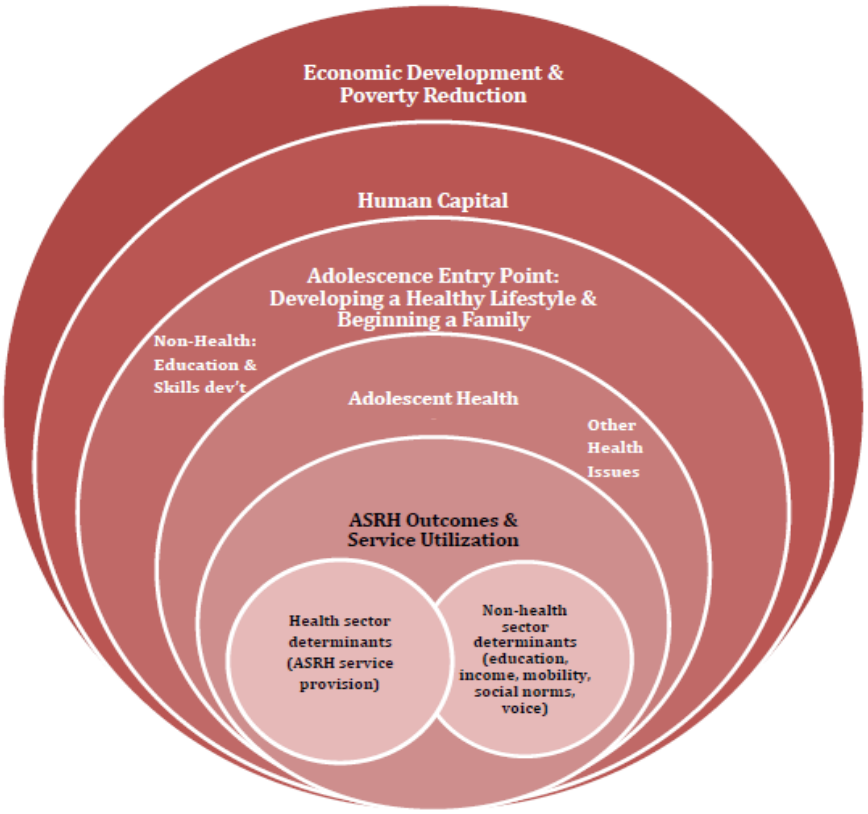
**Table 1: Main Barriers to using Family Planning Services and Commodities in Low and Middle Income Countries, 2013**

| Type of Barrier | Description | Where is it Manifested in the FP Processes | Individuals affected by barrier |
|---|---|---|---|
| **Socio Cultural** | Religious or cultural restrictions on acceptance of contraceptives | Supply-side: At every step of the FP process<br>Demand-side: Prior to making a decision to seek information on FP or making a choice on accepting a method; also affects continuation of use | Acceptor both male and female; Can affect provider behavior |
| **Quality of care** | Lack of 'Quality'[4] in provision of FP services | Supply-side: At every step of the FP process<br>Demand-side: making a choice on attending FP counseling, as well as, prior to making a choice on accepting the method; also affects continuation of use | Acceptor both male and female; Affects provider behavior and ability to offer FP services |
| **Gender-based** | Gendered view of women's role; lack of decision-making power by women | Supply-side: At every step of the FP process<br>Demand-side: Prior to making a decision to seek information on FP or making a choice on accepting a method; also affects continuation of use | Acceptor both male and female; Can affect provider behavior |
| **Political** | Policies that restrict or limit use of FP | Supply-side: Affects the overall provision of FP services<br>Demand-side: Prior to making a decision to seek information on FP or making a choice on accepting a method; also affects continuation of use | Acceptor both male and female; Affects provider behavior and ability to offer FP services |
| **Infrastructural** | Geographic distance to FP services | Supply-side: At every step of the FP process<br>Demand-side: Prior to making a decision to seek information on FP or making a choice on accepting a method; also affects continuation of use | Acceptor both male and female; Affects provider behavior and ability to offer FP services |
| **Economic** | Price of FP method and opportunity cost of utilizing FP services; Cost of setting up FP services in countries and funds available for FP | Supply -side: At every step of the FP process<br><br>Demand-side: Prior to making a decision to seek information on FP or making a choice on accepting a method; also affects continuation of use | Acceptor both male and female; Affects ability of governments and providers to offer FP services |

*Source:* Adapted from Chowdhury et al. 2013

[4]Quality FP service is described as having six key elements that clients perceive to be critical for making an informed choice. These are: choice of method, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services (Bruce 2009).

**Figure 8: Framework of Analysis: Adolescence within Development, 2013**

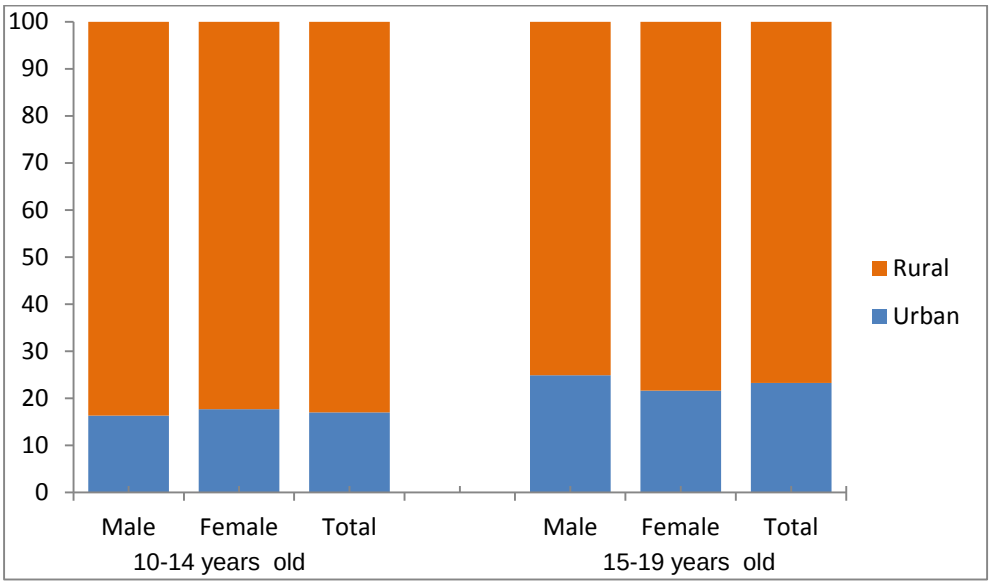



*Source:* World Bank 2013

# PART II - ADOLESCENTS IN NIGER: GROWING UP IN SOCIO-ECONOMIC HARDSHIP

17. **Adolescents (10-19 years of age) represent almost a quarter of the population (23.4 percent) in Niger and are largely affected by poverty.** When analyzed by age group, adolescents 10 to 14 years and 15 to 19 years represent 13.2 percent and 10.2 percent of the population respectively. Approximately 80 percent of adolescents live in rural areas (Figure 9), while 64 percent live below the poverty line. Disparities exist between urban and rural areas in Niger. Niamey, the capital of the country, is home to the wealthiest population, with over 92 percent of the wealthiest households. Meanwhile, 8 percent of the rural population is considered rich (DHS/MICS, 2012).

**Figure 9: Percent of Adolescents (10-19 years of age) by Age and Residence (Urban/Rural) in Niger, 2012**




*Source:* Niger DHS/MICS 2012

## *School Enrollment*

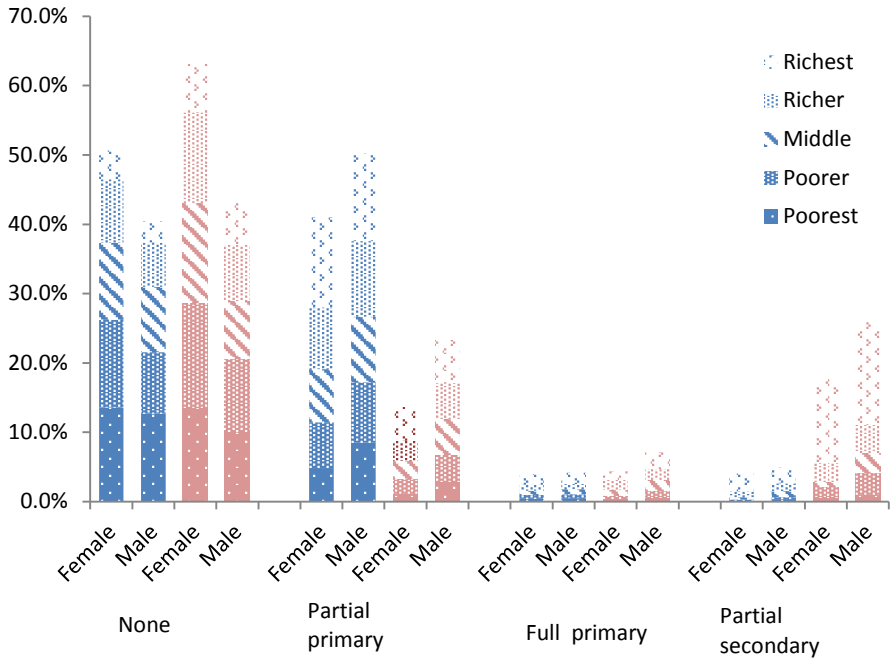
18. **Access to school is limited for Nigerien adolescents.** School enrollment among adolescents 15 to 19 years of age is low. Among adolescent girls 15-19 years of age, 63.0 percent have no education while 0 percent have completed secondary education. In addition, approximately 4 percent of adolescent females 15-19 years of age and 7 percent of boys the same age completed primary school in 2012. Although educational achievement has improved over the years, girls are more vulnerable than boys to not receiving an education (Table 2). Low enrollment and completion rates among adolescent females in secondary school may be attributed to having to be placed in foster families in order to attend school. Also, participation in housework and early marriage contribute to low enrollment and completion rates. As illustrated in figure 10, the wealthier the family (as measured by the wealth index), the greater the likelihood of attaining a higher education for both adolescent boys and girls (DHS/MICS, 2012).

**Table 2: Percentage of Adolescents by Education Level (10 to 19 years) in Niger, 2012**

| Sex | Age | None | Partial Primary | Full Primary | Partial Secondary | Full Secondary |
|---|---|---|---|---|---|---|
| **Females** | 10 to 14 | 50.6 | 41.1 | 4.0 | 4.0 | 0 |
| | 15 to 19 | 63.0 | 13.5 | 4.4 | 18.0 | 0.1 |
| **Males** | 10 to 14 | 40.3 | 50.3 | 4.1 | 4.9 | 0.0 |
| | 15 to 19 | 43.3 | 23.1 | 7.1 | 26.0 | 0.1 |

*Source:* Niger DHS/MICS 2012

**Figure 10: Education Level by Adolescent Age (10-14 and 15-19 years), Sex and Wealth Quintile in Niger, 2012**




*Note:* Blue and red bars represent those at 10-14 and 15-19 years of age, respectively
*Source:* Niger DHS/MICS 2012

## *Young People in the Workforce*

**19. A majority of adolescents work.** Adolescents less than 14 years of age are most likely to work in the family business, on family land, or contribute to housework. In fact, 74 percent of adolescent boys (12-14 years of age) and over 80 percent of adolescent girls the same age work in the family business or on family land. They also engage in external economic activity (14 hours per week more or less). Among adolescents 15 years of age and older, 58 percent of young men and 15 percent of young women are employed in wage-based work activities. The majority of males are employed in agriculture (65.3 percent), while females work mainly in sales (60.7 percent) (DHS/MICS, 2012).

20. **A large portion of adolescents are placed in foster care.** Overall 35.9 percent of children aged 10 to 17 years do not live with either of their biological parents, while 19.5 percent of them lost one or both parents. Whether for work activities or for ensuring access to nearby schools, a large proportion of adolescents are placed/entrusted with members of the broader family or community. This is also likely to influence their social and economic vulnerability (DHS/MICS 2012).

### *Cultural Norms about Young People*

21. **Cultural and social norms tend to disempower adolescents in Nigerien society.** Although the child is seen as a blessing and opportunity for the family, considered worthy of investment, a vast hierarchical structure exists to ensure that young people obey their elders. This restricts their ability to express themselves and make decisions within their family and community. For adults, *youth* represents inexperience and recklessness, a phase in which young people lack the clarity of mind and the wisdom required to know what is good or bad for them (Lejean, 2014).

22. **The prevalence of the division of employment based on gender indicates that men and women work in separate areas.** Adolescent girls build their identity in the private and domestic sphere, while boys do so publicly. This leads to different opportunities for both sexes. A 2010 survey (Lafia Matassa, 2010) found that adolescent girls' vulnerabilities are mostly driven by social status and gender bias in social relationships. The patriarchal nature of Nigerien society may restrict young girls from their right to free speech and decision making power. According to Lafia Matassa (2010), the study found that society emphasizes the reproduction for girls, thus limiting their development and learning opportunities.

**Table 3: Percentage of Young Women that have Experienced Gender-Based Violence, by Age and Type in Niger, 2011**

| Type of Violence | Under 10 years | 10-14 years | 15-18 years | 19-25 years | Over 25 years |
|---|---|---|---|---|---|
| **Physical Violence** | 3.7 | 5.4 | 15.6 | 30.7 | 44.6 |
| **Sexual Violence** | 22.2 | 28.5 | 28.1 | 12.6 | 8.6 |
| **Psychological or Emotional Violence** | 4.4 | 4.6 | 13.1 | 27.6 | 50.3 |
| **Cultural Violence** | 47.4 | 5.3 | 5.3 | 15.8 | 26.3 |
| **Economic Violence** | 15.2 | 1.5 | 3.8 | 17.4 | 62.1 |
| **Overall** | 11.8 | 11.5 | 17.5 | 23.5 | 35.6 |

*Source:* NIS/Oxfam/UNFPA 2011

23. **Evidence on sexual violence among adolescents in Niger is mixed.** A 2011 study found that nearly 30 percent of adolescents 15-18 years of age were victims of sexual violence. Sexual violence is more likely to affect younger adolescents (26 percent of victims of sexual violence were younger than 18 years) than older adolescents and young women (12.6 percent of 19-25 year olds and 8.6 percent of 25 year olds experienced sexual violence). The study also revealed that violence against women is mainly perpetrated by men who are older than 25 years (50 percent), most of which occurs within marriage (NIS/Oxfam/UNFPA 2011) (Table 3). In contrast, adolescents in the FGDs stated that sexual violence was rare in Niger as it was socially condemned. Victims of sexual violence were often young women who went out late at night. FGDs revealed that in urban areas, sexual violence victims seek justice through the authorities, however in rural areas families are more likely to handle the retribution as opposed to the authorities.

# PART III - ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN NIGER: STATUS AND MAIN DETERMINANTS

24. **Early marriage and childbearing greatly affect maternal and child health.** Maternal mortality accounts for 35 percent of all deaths to adolescents 15 to 19 years of age (DHS/MICS 2012). Early childbearing also increases the risk for dystocia, fistula, and other damaging outcomes to the reproductive system (WHO, 2011). Births to adolescents 15-19 years of age have the greatest risk of infant and child mortality, as well as a higher risk of morbidity and mortality for the young mother. In addition, evidence (Ousmane et al. 2013 ; Nayama et al, 2007) from Niger has found that neonatal mortality is high among adolescent pregnancies. Fifteen percent of children born from a sample of 1,659 married adolescent girls were stillborn or died soon after birth. Also, 14 percent of adolescent mothers gave birth to a child weighing less than 2.5 kilograms. Although data is scarce, there is evidence indicating that elective abortion (EA) among adolescents negatively influences their chance of survival. A recent study found that out of 151 EA cases performed on adolescents below 19 years of age, 13 deaths were reported (about 10 percent) during or following the intervention (Nayama et al, 2009).

## *Marriage, Sexual Debut, and Childbearing: An Early Start for Adolescent Girls*

### *Gender interactions before marriage*

25. **Adolescent boys and girls begin to interact before marriage**. FGDs held in urban Niamey indicate that girls and boys start spending time together at 12 years of age; in rural areas, they start spending time together at 10 years. In urban settings, school may explain the early onset of spending time together. Adolescents in FGDs stated that by the time they reach middle school, some girls think they are grown-up and therefore entitled to start chatting with boys.

26. **Adult behavior may influence when and how girls and boys begin to spend time together.** Given limited adequate housing, parents and children often have to sleep in the same room. In the FGDs, adolescents stated that this may lead to becoming sexually active at a younger age because they may witness parental sexual behaviour. FGDs also revealed that peer pressure may influence early onset of sexual activity. Young people often want to immitate their friends who are already in a relationship.

27. **Flirting leads to premarital sex, which is occurring at increasingly younger ages due to financial and material reasons, despite societal disapproval.** Adolescents in FGDs stated that girls often initiate sex at younger ages than boys because of money and material benefits. According to FGDs, girls in rural areas sleep with boys for less cash than girls in urban areas. Parents' response to premarital sex varies with some tolerating or encouraging the behaviour, as they rely on their daughters' financial resources obtained from dating.

*Early marriage as social promotion for women*

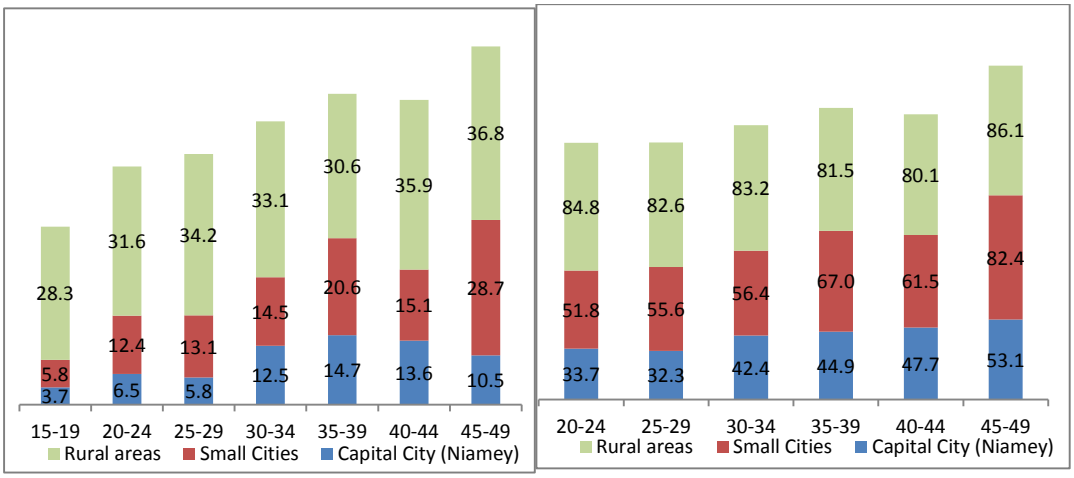
28. **Women are more likely to marry at younger ages than their male counterparts.** Sixty-one percent of females aged 15 to 19 are already married in comparison to almost three percent of men the same age (DHS/MICS, 2012). Among 15-19 year old married women, 19.5 percent are in a polygamous marriage. Nationally, the median age at first marriage is 15.7 years for women and 24.2 years for men, but disparities exist between urban and rural areas. Female median age at first marriage is 19.5 years in Niamey and 15.6 years in rural areas. For men, the median age is 28.7 years in Niamey and 24 years in rural areas. In addition to urban living, education is also associated with marriage delay. Age at first marriage for women without an education is 15.6 years in comparison to 21.1 years for women who have a secondary education or higher (DHS/MICS, 2012).

29. **In many cases, marriage is seen as a socially valued-option for adolescent girls, moreso than schooling or professional training.** Given that marriage is perceived as enhancing their social standing and increasing their dignity and respectability within the community, early marriage is valued in Niger. Marriage also serves a social purpose: preventing potential family humiliation associated with early sexual behavior and premarital pregnancies (IntHEC, 2010). This was confirmed in FGDs, as adolescents (14-15 years of age) stated that early marriage was socially valued and prevented "the shame of having an unplanned pregnancy". In Niger, men value youth and virginity; for them, marriage positively contributes to "body control" and limits "bad behaviors". For girls, unmarried adolescents are considered "old maids". Their single status is considered a sign of their inability to be "useful to the society".

30. **Given that the median age at first marriage for young women is similar to the median age at first sexual intercourse (15.9 years), it can therefore be determined that sexual initiation begins with marriage.** Also, young women become sexually active at younger ages in comparison to their male counterparts. For example, among women 15-25 years of age, 24.5 percent reported that sexual initiation began before 15 years of age, in comparison to 1.1 percent of men the same age. Similarly, 73.9 percent of women aged 15 to 24 years stated that their first sexual experience occurred before they turned 18 years, compared to 10.9 percent for men of the same age (DHS/MICS, 2012). Disparities in age at sexual debut exist between urban and rural areas as well.

31. **Trends indicate that rural female adolescents (15-19 years) are more likely to initiate sex before 15 and 18 years of age in comparison to their urban counterparts** (Figures 11 and 12). Regression analyses indicate that education and place of residence have a significant impact on sexual initiation before 18 years of age. In fact, for each additional year of education, the likelihood of early marriage is reduced by 4.5 percent; meanwhile, rural residence increases the likelihood of early marriage by 18 percent (DHS/MICS, 2012).

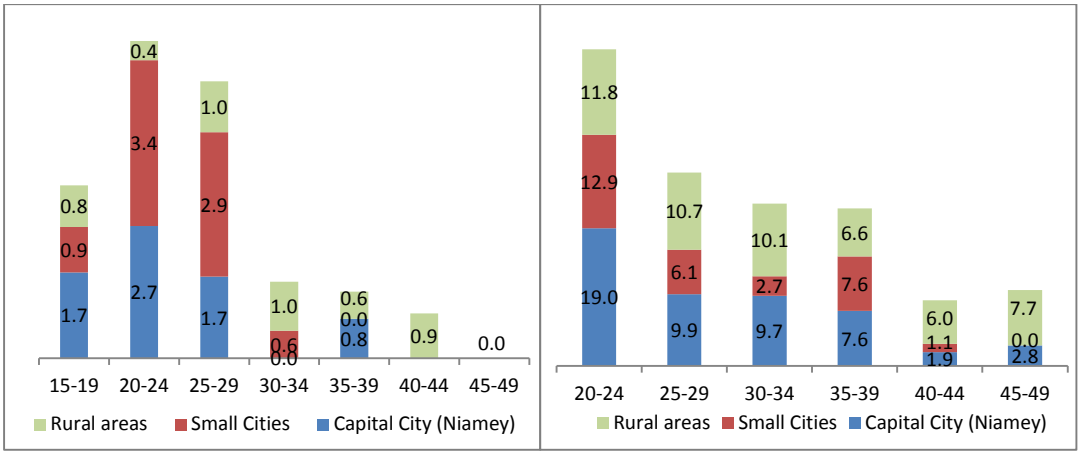
**Figures 11 and 12: Percentage of Female Adolescents Experiencing First Sex before their 15 years of age (left) and 18 years of age (right) in Niger, 2012**




*Source:* Niger DHS/MICS 2012

32. **Adolescent boys are less likely to initiate sex at a young age in comparison to their female counterparts, regardless of urban/rural residence**. It appears that adolescent boys initiate sex before 18 years of age. Although a larger proportion of adolescent boys initiate sex in rural areas before 15 years and 18 years of age, this difference decreases over time (Figure 13 and 14).

**Figures 13 and 14: Percentage of Male Adolescents Experiencing First Sex before 15 years of age (left) and 18 years of age (right) in Niger, 2012**




*Source:* Niger DHS/MICS 2012

### *Early childbearing*

33. **Given the large proportion of adolescent girls marrying and initiating sex at a young age, they become mothers before the age of 19 years.** The median age at first childbirth is 18.5 years in Niger. However, 30.8 percent of them have had their first child by 16 years of age (table 4). These numbers mask disparities between rural and urban areas. In 2012, the adolescent birth rate in rural areas was more than twice that of urban areas (231.2 births in comparison to 112.2 births per 1,000 15-19 year olds respectively) (Figure 15). In addition, adolescent fertility was three times higher among adolescents without an

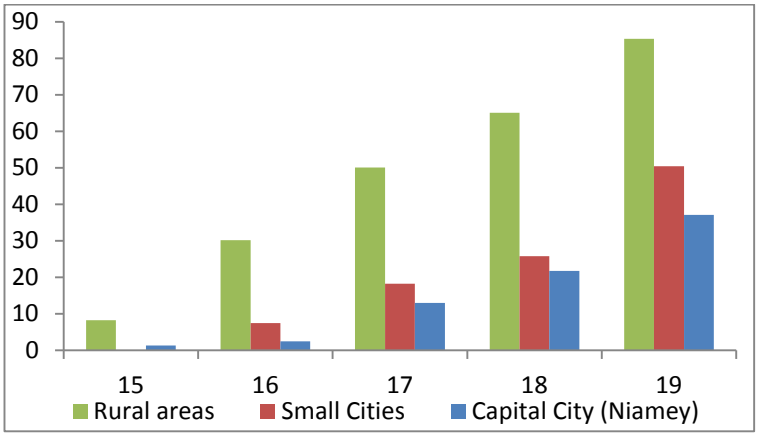
education (50 percent) in comparison to adolescents with a secondary education or higher (15 percent). Furthermore, although the adolescent fertility rate declined between the 1992 and 2006 DHS surveys, it increased between 2006 and 2012 (from 199 births in 2006 to 206 births per 1,000 15-19 year olds in 2012) (DHS/MICS, 2012).

**Table 4: Percentage of Female Adolescents (15 to 19 years of age) who have Given Birth or are Pregnant by Age in Niger, 2012**

| Age | Percent of women |
|---|---|
| **15** | 6.6 |
| **16** | 24.2 |
| **17** | 42.3 |
| **18** | 57.0 |
| **19** | 74.7 |

*Source:* Niger DHS/MICS 2012

**Figure 15: Percentage of Female Adolescents (15 to 19 years of age) who are Mothers by Place of Residence in Niger, 2012**




*Source:* Niger DHS/MICS 2012

34. **Inequalities in early childbearing exist between wealth quintiles, with poorer adolescent girls (15-19 years of age) more likely to give birth than their wealthier counterparts.** Almost 70 percent of the poorest 20-24 year olds had a child before 18 years of age in comparison to 41 percent of their wealthier counterparts. Furthermore, trends indicate that early childbearing is decreasing among wealthier quintiles in comparison to their poorer counterparts (World Bank 2011).

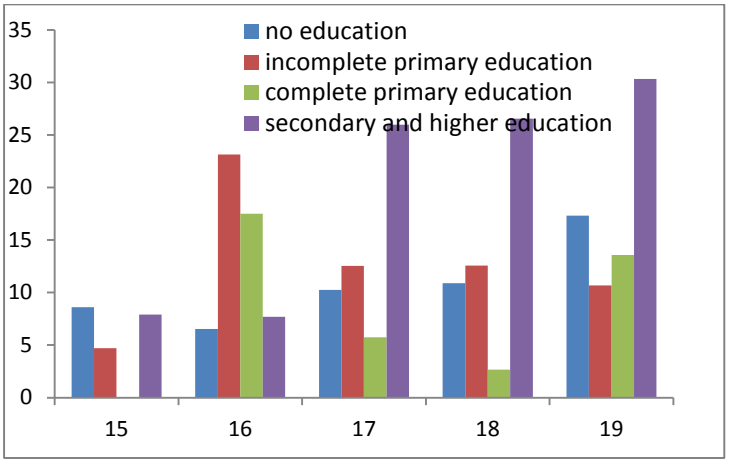
35. **Adolescent (15 to 19 years of age) live births represent 20.6 percent of all births born each year in the country**. Adolescents are also more likely to have shorter birth intervals (26.5 months among 15-19 year olds in comparison to 29.6 months among 20-29 year olds and 32.1 months among 30-39 year olds) and a smaller desired family size in comparison to their older counterparts (8.1 children among 15-19 year olds in comparison to 8.6 among 20-24 year olds and 9.1 among 25-29 year olds) (DHS/MICS, 2012).

## *Knowledge about Sexual and Reproductive Health issues*

### *Reproductive cycle*

36. **Female adolescents (15-19 years of age) have limited knowledge about their fertile period.** According to the DHS/MICS (2012), 12.3 percent of female adolescents (15-19 years of age) knew that they were most fertile in the middle of their cycle. Awareness of the fertile period increases with age, as 7.2 percent of female adolescents 15 years of age knew about their fertile period in comparison to 18.8 percent of their 19 year old female counterparts. Education also affects awareness of the fertile period: 19.3 percent of adolescents (15 to 19 years) who completed high school and beyond knew when they were fertile, in comparison to 10.5 percent of those without an education (figure 16). Analyses indicate that poverty and residence are not associated with awareness about the fertile period (DHS/MICS, 2012).

**Figure 16: Percentage of Female Adolescents with Knowledge of Fertile Period, by Age and Level of Education in Niger, 2012**




*Source:* Niger DHS/MICS 2012

### *Family planning*

37. **Knowledge about modern contraception has improved among adolescents over time.** Although female adolescents lack awareness about their reproductive cycle and fertile period, their knowledge of modern family planning methods is high and has improved over time. In 2012, it was estimated that 73 percent of female adolescents (15-19 years of age) were knowledgeable about contraceptive methods at the national level. This knowledge increases with age, as more than 80 percent (83.4 percent) of female adolescents 18 years of age (83.4 percent) were aware of modern family planning methods (table 5) (DHS/MICS, 2012).

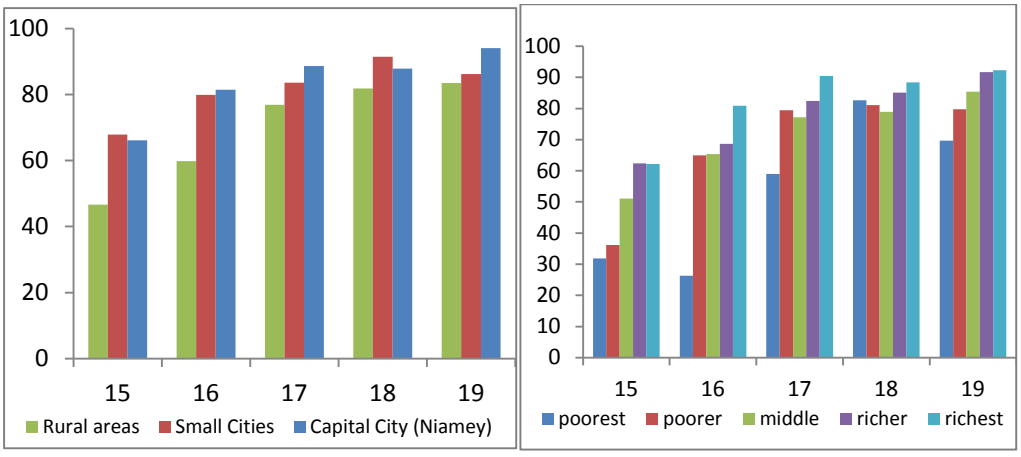
**Table 5: Percentage of Adolescents (15-19 years) who are Aware of a Modern Contraceptive Method by Age in Niger, 2012**

| Age (years) | No Awareness or Traditional Method | Knows a modern method |
|---|---|---|
| **15** | 48.8 | 51.2 |
| **16** | 35.3 | 64.7 |
| **17** | 21.2 | 78.8 |
| **18** | 16.6 | 83.4 |
| **19** | 14.6 | 85.4 |
| **Total** | 27.0 | 73.0 |

*Source:* Niger DHS/MICS 2012

38. **Wealth, residence, and education influence the level of FP awareness.** Knowledge of modern contraceptive methods is higher in urban than in rural areas (Figure 17), particularly among the youngest adolescents. Similar trends are found among wealthier female adolescents, particularly among younger adolescents in comparison to their poorer counterparts (Figure 18). In fact, 54.9 percent of the poorest female adolescents (15 to 19 years of age) were aware of a modern method, compared to 83.2 percent of their richer counterparts. Education also influences awareness of modern contraceptive methods. Almost 70 percent (68.5 percent) of young women aged 15 to 19 who never attended school were aware of at least one modern method, in comparison to 83.8 percent among those who completed high school (DHS/MICS, 2012).

**Figure 17 and 18: Percentage of Adolescents (15-19 years) with Knowledge of Modern Contraceptive Methods by Place of Residence and Economic Status in Niger, 2012**




*Source:* Niger DHS/MICS 2012

39. **While quantitative surveys indicate that adolescents are generally aware of the existence of modern contraception, FGDs reveal that youth may lack precise knowledge about the exact role, utility, and prescription of contraception.** FGDs reflected the misperceptions associated with the use of contraception (see section 2.3). In particular, rural adolescent females (15-19 years) have limited knowledge about the role of modern FP commodities, and how to access and use them. It was also revealed that girls tend to also prefer using “non-visible” methods (i.e pills) to avoid disclosure to relatives and/or spouses.

40. **Although adolescents (15 to 19 years) have heard about HIV (80.5 percent of females, 90.8 percent of males), their in-depth knowledge is limited.** In fact, 12.3 percent of 15 to 19 year old females have a comprehensive understanding of HIV prevention and transmission, in comparison to 21.3 percent of adolescent males of the same age. Further, 13.3 percent of adolescent females (15-19 years) and 39.4 percent of adolescent males the same age know where they can buy condoms. However, knowledge of a condom supply source increases with age (DHS/MICS, 2012) (table 6).

41. **Knowledge of condom supply sources vary by residence, education, and wealth quintile.** Almost 30 percent (27.6 percent) of urban adolescents between 15 and 19 years of age know one condom supply source, in comparison to 9.7 percent of their rural counterparts. Furthermore, 10.1 percent of adolescents (15-19 years of age) without an education knew of one condom supply source, compared to 26.4 percent for those with at least some secondary education. In addition, 8.5 percent of adolescents (15-19 years of age) in the poorest quintile know about one condom supply source, in comparison to 25.5 percent of adolescents in the wealthiest quintile (DHS/MICS, 2012).

**Table 6: Percentage of Adolescents with Knowledge of a Condom Supply Source by Age (15 to 19 years) in Niger, 2012**

| Age (years) | Knowledge of Condom Supply Source | |
|---|---|---|
| | No knowledge | Knowledge of one source |
| **15** | 93.3 | 6.7 |
| **16** | 88.5 | 11.5 |
| **17** | 86.8 | 13.2 |
| **18** | 83.4 | 16.6 |
| **19** | 78.1 | 21.9 |

*Source:* Niger DHS/MICS 2012

**Table 7: Percentage of Female Adolescents (15-19 years of age) with Knowledge of at Least One Condom Supply Source by Economic Status in Niger, 2012**

| | Economic status | Knowledge of Condom Supply Source | |
|---|---|---|---|
| | | No knowledge | Knowledge of one source |
| **Economic Status** | Poorest | 91.5% | 8.5% |
| | Poor | 93.6% | 6.4% |
| | Average | 87.8% | 12.2% |
| | Rich | 89.4% | 10.6% |
| | Richest | 74.5% | 25.5% |
| **Total** | | 86.3% | 13.7% |

*Source:* Niger DHS/MICS 2012

### *Values and Perceptions of Modern Family Planning and ASRH services*

42. **The main barriers to adolescent use of FP services are social and cultural beliefs and values.** In 2006, almost 50 percent of adolescents (15-19 years of age) (42.6 percent) surveyed opposed use of FP services due to social and religious values and misperceptions about FP commodities for medical reasons (DHS 2006)[5]. In fact, mores couples were opposed to FP due to social and cultural beliefs and values (28.9 percent) than couples that were opposed to FP due to medical reasons (8.9 percent) (DHS 2006).

43. **Utilization of modern FP services is misperceived and generally not understood by husbands, especially early on in the marriage.** FGDs revealed that husbands physically and verbally condemned the use of contraceptive pills by their adolescent wives. Reasons for opposing the use of contraception early on in the marriage included "perceptions of betrayal" and "misunderstandings about childbearing". Abstinence was perceived as a way among both sexes to ensure birth spacing.

44. **Parents influence social and cultural opposition to SRH related health services among young people.** Parents were strongly opposed to adolescent sexual education in Niger. For example, a majority of parents were opposed to teaching adolescents (12-14 years of age) about how to use a condom (67.8 percent of mothers and 51.8 percent of fathers) (DHS/MICS, 2012).

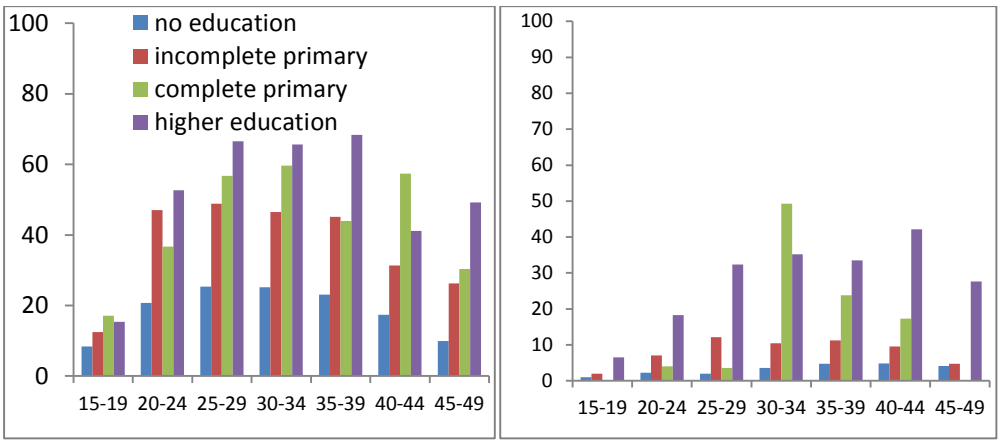
### *Use of SRH and family planning services*

45. **Despite being knowledgeable about modern FP methods, adolescents (less than 19 years of age) rarely use contraception.** 93 percent of adolescents (15-19 years) who are currently married, do not use any form of contraception. Similarly, 93.7 percent of 15-19 year old adolescents did not discuss FP with a health professional, in the field or in a health facility (DHS/MICS, 2012).

46. **An overwhelming majority of adolescents (15 to 19 years) have never been tested for HIV/AIDS, despite having initiated sex.** In fact, 89.4 percent of women and 97 percent of men have never been tested. Furthermore, testing rates remain low among all age groups. Among adolescent females, rates of HIV testing are low but increase with at least a primary education (Figure 19). HIV testing is lower among adolescent males, with primary school completion or higher increasing the testing rate (DHS/MICS, 2012) (Figure 20).

[5] The present study analyzed reasons for non-use of FP services among Nigerien adolescents, including: infrequent sex, respondent opposed, spouse opposed, others opposed, religious prohibition, other opposition to use, health concerns, fear of side effects, inconvenient to use, interfere with body.

**Figures 19 and 20: Percentage of HIV Testing among all Age Groups (including 15-19 year olds) among Females (left) and Males (right) by Education Level in Niger, 2012**




*Source:* Niger DHS/MICS 2012

**47.** Despite Niger's current low prevalence rate for HIV/AIDS (under 1 percent), young people rarely use condoms. The 2011 Second Generation HIV/AIDS Monitoring Survey (CISLS, 2011) shows that young people aged 15 to 24 rarely use a condom. In fact, 36 percent who were never married did not use a condom during their latest sexual encounter. Analysis shows that young people find it difficult to negotiate ways to prevent unprotected sex, when there is a potential or actual risk (Table 8).

**Table 8: Percentage of Adolescents (15-19 years) that Negotiate Protected Sex with a Spouse by Sex in Niger, 2012**

| Age (15-19 years) | Refuse sex with spouse if they know that they engage in sex with other women/men | Ask spouse to use a condom during sex if they know he/she has a STI |
|---|---|---|
| Females | 54.4 | 65.7 |
| Males | 55.0 | 79.0 |

*Source:* Niger DHS/MICS 2012

## *Access and Use of SRH Services among Adolescents*

### *Antenatal care coverage*

**48. For adolescents, access to adequate ANC services is limited and varies by residence, education, and wealth.** In fact, 16.4 percent of adolescents (15 to 19 years of age) did not receive any ANC during their pregnancy. Furthermore, 82.1 percent of rural female adolescents (15-19 years) attended at least one ANC visit, in comparison to 98.1 percent of urban adolescents. Moreover, 81.5 percent of adolescents without an education had at least one ANC visit, in comparison to those who had at least a secondary education

(100 percent). In addition, 70.4 percent of the poorest adolescents had at least one ANC visit in comparison to 91.1 percent of wealthier adolescents (DHS/MICs, 2012).

### *Delivering at home*

49. **Although female adolescents (15 to 19 years of age) attend ANC, they do not deliver in formal health facilities.** Indeed, 63.4 percent deliver outside of the health facility, without skilled birth attendants, and often at home (table 9). In addition, of the young women (less than 20 years of age) who delivered in a health facility in 2012, most delivered in a public health facility (32.5 percent) in comparison to a private health facility (0.4 percent) (DHS/MICS, 2012).

**Table 9: Number and Percent of Female Adolescents (15-19 years) in Place of Delivery**

| Place | N | Percent |
|---|---|---|
| **Elsewhere** | 379 | 63.4 |
| **Public or Private Health Institution** | 219 | 36.6 |
| **Total** | 598 | 100.0 |

*Source:* Niger DHS/MICS 2012

50. **Residence, wealth, and education influence the labour and delivery site for female adolescents**. In urban areas, 18.2 percent of female adolescents aged 15 to 19 years gave birth most recently outside of a health facility, without medical assistance, compared to 68 percent in rural areas. Young women (less than 20 years of age) were most likely to be assisted by traditional birth attendants (32.5 percent) followed by nurses/midwives (31.8 percent), or parents (24.8 percent). They were least likely to be assisted by doctors (0.7 percent). Also variations exist between economic groups: 78.4 percent of the poorest adolescents do not give birth in a health facility in comparison to 36 percent of the richest. In terms of education levels, 68.7 percent of female adolescents aged 15-19 without an education gave birth most recently outside of a health facility and without proper medical assistance, compared to 38.6 percent of those with at least a primary education (DHS/MICS 2012).

### *Main barriers to accessing health services*

51. **Among female adolescents (15-19 years of age), 64.5 percent stated that they faced at least one problem when trying to access SRH services** (table 10). A lack of financial resources was cited as the main barrier to accessing health services (52.3 percent), while distance and transportation constitute the two other main barriers (for respectively 38.7 percent and 38.3 percent of the surveyed female adolescents). It is worth noting that in over 20 percent of the cases adolescents need approval to seek healthcare from their family or their husbands/in-laws (DHS/MICS 2012).

**Table 10. Percentage of 15-19 year old Females who Stated they had Problems Accessing SRH Services in Niger, 2012**

| | Problems faced in accessing health care services | | | | | |
|---|---|---|---|---|---|---|
| **Age** | **Permission** | **Money** | **Distance** | **Transportation** | **Not wanting to go alone** | **Have at least one problem accessing health care** |
| **15-19** | 22.0 | 52.3 | 38.7 | 38.3 | 31.6 | 64.5 |

*Source:* Niger DHS/MICS, 2012

52. **Adolescents are reluctant to use formal health care services.** FGDs revelaed that location, purpose, and utility of health services are generally ignored among adolescents. Unmarried adolescents tend to seek self-medication first and then traditional medicine when health issues emerge. Adolescents are also swayed by misinformation about condoms, the existence and effectiveness of remedies, and the role of health practitioners in adolescent health issues.

53. **Low quality SRH services and a lack of adolescent-friendly approaches within public facilities are main supply-side barriers.** Adolescent respondents in FGDs highlighted the lack of privacy in public facilities and the importance of confidentiality *("not being seen by neighbors")* in order for them to effectively use SRH services and avoid stigma and discrimination among the family and community.

54. **A 2013 Gender and Health Survey found inadequate behavior from health personnel toward adolescents' health issues.** Only 37.5 percent of surveyed adolescent boys and 25 percent of girls used SRH counseling services. The barriers to health services most cited among adolescent females and males at the community level were a lack of money to buy medications, unavailability of staff, and prior negative experiences. For example, bad reception, absences, and delays. The study recommended greater stakeholder involvement, particularly the participation of young women in the management of health facilities, providing attention to their needs and the organization of health care service delivery (World Bank, 2014). The FGDs revealed that non-accompanied adolescents and youth are stigmatized if they attend health facilities alone. Social norms in the country encourage adolescents to use health services with relatives.

# PART IV - NATIONAL STRATEGIES AND INTERVENTIONS IN SUPPORT OF ASRH: BEST PRACTICES AND CHALLENGES

### *National Strategies: Focus on Supply*

#### *An increase in youth issues within the national agenda*

55. **Adolescent-friendly policies are increasingly being mainstreamed within national strategies** for poverty reduction, health, education and employment. As an example, the 2011 National Strategy for Economic and Social Development aims by 2024 to "ensure that adolescents and youth are able to contribute to the country's sustainable development". Four main pillars directly refer to adolescents and their role in economic progress: (i) population control through increased use of FP services; (ii) integration of young people in the economy through inclusive growth, increased involvement in decision-making and professional skills development; (iii) improvement in adolescent and youth SRH through free provision and community-based distribution of FP commodities; and (iv) reduction of gender-based inequalities, focusing on education and employment. However, according to the mid-term review, adolescent specific outputs and the national capacity to effectively mainstream adolescent and youth SRH issues across programs needs to be strengthened and prioritized (MSP, 2011).

56. **In the development of the SRH agenda, adolescent and youth issues in the policy formulation process have been prioritized in Niger.** The adoption of the Reproductive Health Law in 2006 marked a milestone in acknowledging SRHR as a top priority for government action, particularly for young women. It recognized the right to access adequate health care and prevention services for pregnant and reproductive-aged women. Decrees in 2006 and 2007 also eased financial access for women to SRH services, by removing user fees for ANC, c-sections, and gynecological cancers in all public health facilities.

57. **The Family Planning Action Plan (2012-2020) incorporates adolescent specific issues.** The Action Plan aims to reduce maternal and child mortality in Niger, by increasing contraceptive use from 12 percent in 2010 to 25 percent in 2015 and 50 percent by 2020. The goal is to enhance FP delivery mechanisms, by mainstreaming FP throughout the private and public sectors, while setting-up mobile clinics in remote areas. It also seeks to increase demand for FP, including combatting misperceptions related to FP through mass media campaigns; national information communication technology strategies (NICTs); or through community mobilization, with support from religious and traditional leaders, local elected officials, women's and youth groups. For adolescents, the action plan also seeks to improve the way FP is taught in middle and high school classes, and in adolescent education generally through in-school peer mentoring programs (MSP, 2012).

58. **Adolescent-focused policies have been incorporated into the agenda within recent years.** A National Youth Plan adopted in 1998, acknowledged the right to health for adolescents and youth (article 9) without discrimination, and access to health education and information (article 10 et 11). The Plan did not, however, contain provisions for SRH. In 2011, a Strategic Action Plan for Youth was adopted with the aim to "reduce the vulnerability and improve the wellbeing of at least 70 percent of young Nigeriens aged 15 to 35 years by 2014". The Plan outlines three key actions for adolescents: (i) increasing awareness and access to information and media to improve youth protection against risks;

(ii) developing youth support centers providing a minimum wellbeing package including health education; and (iii) professional skills development (MSP, 2011).

59. **A National Plan for ASRH was adopted in 2011 in Niger**. Niger was one of the first countries to introduce strategic guidance for the sector in the sub-region. The Action Plan outlines four main strategic pillars: (1) improving access to information that responds to adolescent and youth needs; (2) improving adolescents and youth access to, and use of, health services; (3) promoting an environment supportive of adolescent and youth health; and (4) improving the management of operations targeting adolescents and youth. The Action Plan is detailed in table 11 below (MSP, 2011).

***Government action towards ASRH: supply-side interventions***

60. **Government interventions have focused on strengthening the supply of adolescent health and wellbeing services.** *Youth centers* have been set up throughout the country. Also, *Counselling Centers* have opened under the leadership of the Ministry of Youth, through the United Nations Population Fund's (UNFPA) support, providing recreational activities, advice, and active counselling to adolescents, including issues related to SRH. Further prioritization needs to be given to the youth centers, however, in order to ensure that they are fully operational, providing access to SRH services and HIV/AIDS testing, particularly in rural areas (Table 12). In contrast, implementation of demand-side interventions have been scarce.

61. **Efforts to increase the national capacity to provide user friendly ASRH services is a priority.** To date, 48 health centers (8 in each province) have been labelled adolescent-friendly, with staff trained on adolescent specific health issues and the provision of adequate services and commodities. Specific guidelines were developed on standards and norms for adolescent-friendly services and health personnel were trained accordingly, with support from development partners, including the World Health Organization (WHO) and UNFPA. Training was provided to over 50 percent of the health personnel in the country. In daily medical practices, however, health provider behavior remains largely influenced by cultural and religious norms that condemn sexual intercourse before marriage and the use of FP commodities before marriage (IntHEC 2010).

62. **Government interventions should be implemented multi-sectorally with inputs from the education, health, and employment sectors**. Strategic partnerships between schools, health facilities, and youth centers should be developed in order to ensure better dissemination of SRH information among adolescents. Importantly, youth centers work as an "entry point" for many adolescents. They can therefore be useful in guiding youth in health care services.

**Table 11: National SRH Adolescent Action Plan (2011-2015)**

| Strategic Pillars | Objectives | Main Activities |
|---|---|---|
| OBJ 1: Improving access to information responsive to needs | Teaching AYH in schools | • Assess the availability of AYH training material in schools<br>• Advocate for the inclusion of AYH in curricula |
| | Promote AYH peer education outside school | • Align existing IEC materials and train providers<br>• Use audiovisual communication channels<br>• Monitor PE activities |
| OBJ 2: Improve adolescent and youth access to, and use of, health services | Ensure that health services are uniformly adapted for adolescents and youth | Disseminate and implement the plan within youth-appropriate standards of health care service |
| | Strengthen AYH capacities and facilities | Enhance the performance of Youth Support Centers and their staff |
| | Begin teaching AYH in basic health training schools | Review curricula and teachers' training |
| | Increase the visibility of the AYSRH Division and Youth Support Centers | Organize round tables, events |
| OBJ 3: Promote an environment supportive of adolescent and youth health | Outreach and monitoring to ensure that existing laws and statutes related to adolescent and youth health are properly enforced | Disseminate and explain current legislation and ensure it is enforced |
| | Ensure that charters, conventions and international treaties on youth and adolescent health are mainstreamed | Disseminate and explain current legislation and ensure it is enforced |
| | Ensure that community leaders are actively and positively involved in implementing AYH operations | Formulate messages to be conveyed in the advocacy plan, and execute the advocacy plan |
| OBJ 4: Improve management of operations targeting adolescents and youth | Better coordinate AYH operations | |
| | Ensure that AYH issues are taken into account in the National Health Information System (NHIS) | • Include AYH data collection tools in the NHIS.<br>• Ensure that the MCHD maintains a database on AYH<br>• Strengthen capacities of operational research structures focusing on AYH<br>• Disseminate research findings |
| | Raise funds for AYH operations | • Build the capacity of managers to raise funds<br>• Advocate for financing |

*Source:* MSP 2011

63. **The political environment has slowed down government efforts towards better integration of adolescent issues in policy and legislation.** For example, legislation on age at first marriage for adolescent girls has become a political and decision making issue in recent years. A law developed to “protect female adolescent students”, initiated by a government coalition was rejected by Parliament. Within Article 6 of this law, parents had to seek permission from a judge before marrying their daughter or face sanctions. This created upheaval within the community and government: religious leaders strongly opposed it and elected representatives refused to vote.

## Table 12: Adolescents Perceptions of Government-supported Youth Centers, Focus Group Discussion, 2014

| YOUTH CENTERS | | | |
|---|---|---|---|
| | **Strengths (what works?)** | **Weaknesses (what does not work?)** | **Suggestions of Young Respondents** |
| **Internally** | ➢ Strong interest among youth of all ages for these centers, which are the only places where they can meet, particularly those who do not attend school.<br>➢ Learning opportunities in some of these centers (hair braiding, weaving, cooking, etc.)<br>➢ Particular interest for games and recreation (soccer, wrestling, dancing, etc.)<br>➢ Learning workshops in rural areas (for example, sawing workshops in Hamdallaye)<br>➢ Diplomas are issued<br>➢ Computer training<br>➢ Youth meeting places<br>➢ Recreation, activities and guidance are possible<br>➢ Training in Islamic education | ➢ Youth centers are not always fully equipped or properly adapted to various youth categories; the youngest (10-14) are not always interested in soccer related activities "*we only go there to watch the older boys play; we cannot play because there is no room for us in teams.*" (FGD, adolescent boys 10-14)<br>➢ According to some respondents, they cannot afford tickets to attend some of the center's events requiring an entrance fee: *"I rarely go to the center because I don't have the money.*"<br>➢ Lack of infrastructure in rural areas (for instance, there is no youth specific facility in Hamdallaye)<br>➢ Youth lack the means necessary to register and attend learning workshops<br>➢ Places where fights can occur<br>➢ Girls may be harassed by boys<br>➢ Older members sometimes push younger ones out<br>➢ Facilities are sometimes too remote for young people | ➢ Create adequate play areas<br>➢ Provide resources and equipment for facilities and workshops<br>➢ Organize preaching and Quran reading sessions<br>➢ Organize SRH awareness raising sessions<br>➢ Establish cafeterias in facilities |
| | **Opportunities (how can this be strengthened?)** | **Threats (what can prevent this?)** | |
| **Externally** | ➢ Increase UNFPA support, which support the creation of youth centers and their activities<br>➢ In rural areas, diversify learning workshops<br>➢ Increase youth center capacities<br>➢ Invite artists in the centers | ➢ Reluctance of some parents to let their children go to the centers, where improper behavior is assumed to take place<br>➢ Facilities are not useable during the rainy season<br>➢ Some youth centers follow the same schedule as schools, thus reducing opportunities for children who attend school<br>➢ Access to these facilities can be dangerous (bandits or drug addicts nearby)<br>➢ Children lie to parents; they do not tell them that they go to the center<br>➢ Sometimes there are bars in the vicinity of a center. | ➢ Sensitize parents so that girls can engage in recreational activities<br>➢ Sensitize parents on various activities offered in youth centers |

### *Need to Scale-Up Demand-Side Interventions*

64. **Actions that generate demand have been implemented on a small scale but are largely under-funded**. The three main activities that have been implemented to generate demand for ASRH services include life skills development, peer education, and behavior change. While these interventions aim to improve knowledge and practices about SRH services, they also contribute to increasing adolescents' position within Nigerien society. For example, adolescent life skills development programs have helped strengthen both individual and collective life skills within several communities. Despite producing good practices, geographical coverage of these interventions remains limited (Box 1).

> *Box 1: Life skills development programs: "Tontines"*
>
> CARE international implemented a program based on traditional community saving systems *(*referred to as *tontines).* Community groups were first developed (with a management committee and bylaws) and then received training and support on financial education and community life. Community group membership fees are paid during weekly meetings, with the *tontine* made available to finance income-generating activities when a group member requests. Community groups also receive support for community diagnostics and planning when an important project needs to be developed and implemented. These groups provide a forum for debate and dialogue, in which members learn about democracy at the local level, citizen participation in government, reproductive health, gender, and gender based violence (GBV). It has been found that young women (15-16 years of age), single or married, have benefited from group skills enhancement, ultimately promoting leadership.
>
> Plan Niger has also provided support to enhancing group skills in Niamey and its surrounding areas, Tillaberi and Dosso. Programs target established groups of young people, especially young women in order to: (i) Increase income through internal resource mobilization; (ii) Expand life skills: SRH, leadership, ability to speak-up, community life/self-esteem/health/communication-listening/conflict management and peace/FP/Leadership/conflict management; and (iii) Promote the leadership skills of young women. This program helps increase participation and prioritization of young participants within each group, providing them a greater voice in advocating with authorities.

65. **Peer education activities are common among youth-oriented organizations, however these programs need to be scaled up.** Peer education activities are practiced on a voluntary basis with many peer-based interventions implemented informally. One of the challenges to these programs is that turnover of peer educators is high, as youth continue on with their studies or become involved in income-generating activities. Also, given that peer educators are unpaid volunteers, they have limited time to invest in these activities. Furthermore, peer education is largely under-supervised and requires greater supervision and guidance in order to be effective on a larger scale (Box 2).

*Box 2: Peer education: DIMOL and ANBEF, two youth-based local initiatives*

DIMOL, a local civil society organization (CSO), includes a sex education program ("DIMOL Adolescents") in which students and teachers go into the community to speak with adolescents and youth in schools and informally. They also participate in community radio programs, providing information on reproductive heath issues. The program also provides “spaces” to improve outreach to young people, in which groups of young people gather to talk about adolescent and youth issues, sometimes separated by gender and age (for example, when discussing SRH issues).

ANBEF, another local organization, relies on peer educators and Youth Action Movements to address low adolescent attendance in health centers. Youth Action Movements, generally students, provide support and tutoring. These young adults are 25 years of age an older. They are tasked with sensitizing young students at school on various topics (for example, SRH, responsible parenthood, early marriage, among others).

66. **Behavior change communication programs have been developed by numerous partners, with good results at small scale.** For example, “My Right, my Voice”, a coalition of NGOs and initiatives (DIMOL, Education for All [EFA], Vie Kandé ni Bayra and Oxfam) partnered to better inform young people about their SRHR. In implementing the "*My Right, My Voice*" Program, partners designed activities to promote and disseminate information on adolescent and youth SRHR by training young people and working with community radios to broadcast weekly programs (Oxfam, 2013). Other communication strategies are being introduced, relying on multiple channels, including mass media, traditional community-based media and innovative solutions (interactive plays, mobile cinema and self-videos) (Box 3).

*Box 3: Multi-media approach to reach adolescents: Amina Sutura*

Anima Sutura, a Niamey-based organization, adopted a multi-media, integrated communication approach. The approach relies on a series of thematic plays based on daily life and is broadcast on national and local radios. These plays are designed to depict people in relatable situations, providing them an opportunity to form an opinion on essential SRH issues. "Plays involving known local actors contain music, proverbs and advice spoken by a typical Nigerien celebrity, such as the *griot* played by the famous singer Fati Mariko. Because he speaks, sings and plays music, the *griot* is in fact the only social celebrity who can say aloud what people think, and what the ideal citizen should do". These broadcasts lead to periodic radio debates. Campaigns last 12 to 32 weeks. Each week, a radio clip on a specific issue is broadcast 3 times a day on all 73 partner radio channels across the country. This is then followed by a national debate on the weekend. While these plays address various topics (e.g., early marriage, abortion, unwanted pregnancy, girl's schooling, HIV, FP, among others), they always focus on prevention and on promoting reproductive health (RH). Anima Sutura also uses a mobile team approach to reach communities, which is composed of facilitators to recruit local relays. Mobile teams provide Listening Clubs and support community radios.

Mobile Digital Cinema (MDC) is a tool used for behaviour change, increasing awareness and disseminating information in order to reach the most remote rural areas through 3 mobile cinema teams (giant screens set above off-road vehicles). The program provides movies and a forum for discussion on practices, behaviours, and social standards, and is popular among adolescents (10-19 years of age). In "fada video", the population is encouraged to film a documentary about SRH issues.

67. **Assessing adolescent and youth activities, through FGDs, provides insight on the usefulness and adequacy of the activity**. Life skills activities are generally well perceived and appreciated by adolescents and youth, and appear to be an appropriate vehicle for initiating income-generating activities among adolescents. Peer education faces inadequate capacity (for both peers and content), however, it seems to be an appropriate channel for condom distribution and informal sex education. Behavior change activities tend to reach their audience when using media and community-based approaches, through trained relays and local media. Scaling-up these pilot activities would reach a larger audience through mass media communication campaigns (Table 13).

**Table 13. Adolescents' Perception of Demand-Side Interventions, Focus Group Discussions, 2014**

| CAPACITY BUILDING ACTIVITIES | | | |
|---|---|---|---|
| | **Strengths** | **Weaknesses** | **Suggestions from Young Respondents** |
| **Internally** | • Opens the mind<br>• Allows youth to share their experiences<br>• Physical activity<br>• Recreational games<br>• Different club meetings<br>• Expands knowledge<br>• Prepares youth for the future and family live | • Few youth capacity building facilities in rural areas<br>• Little focus on young people<br>• Little material and financial support | • Youth lending to start income generating activities<br>• Organize Quran teaching sessions<br>• Improve understanding of issues faced by young people, in order to help them |
| **PEER EDUCATION** | | | |
| | **Strengths** | **Weaknesses** | **Suggestions from Young Respondents** |
| **Internally** | • Awareness raising<br>• Condom distribution<br>• Increase knowledge for better protection | • Lack of teachers and support staff<br>• Few partners<br>• Little information on activities | • Increase large-scale awareness raising sessions<br>• Target adolescent girls<br>• Build fences around schools |

| | | | |
|---|---|---|---|
| | • Guidance on unsafe behaviours<br>• Awareness raising posters<br>• Home economics classes<br>• Knowledge of different contraceptive methods | • Does not reach youth who do not attend school, who only hear from relatives about abstinence and self-esteem<br>• Lack of security on paths walked by children to go to school (bars, thieves, etc)<br>• Might encourage some youth to try intercourse | |
| | **Opportunities** | **Threats** | |
| **Externally** | | • Some parents feel that school "damages" their daughters<br>• Embezzlement and fraud | |
| **BEHAVIOUR CHANGE COMMUNICATION** | | | |
| | **Strengths** | **Weaknesses** | **Suggestions from Young Respondents** |
| **Internally** | • Increasing awareness through radio<br>• Increasing awareness about peace and conflict management<br>• Increasing awareness about unsafe behaviour<br>• Empowerment<br>• Sensitive youth on gender issues<br>• Learn to respect others<br>• Learn not to lie | • Lack of access to radio and television<br>• Few young people are reached, even in urban areas<br>• Language barriers<br>• Lack of time (particularly for employed adolescents)<br>• Peer pressure | • Sensitive parents to keep children in school<br>• Install a public television outlet to sensitize young people<br>• Behavioural change preaching<br>• Outreach in neigbhourhoods and training centers to be closer to young people |
| | **Opportunities** | **Threats** | |
| **Externally** | • Parents can serve as resources for guidance on behavioural change | • Psychological trauma leading to unsafe and violent behaviour among young people | |

**68. Strengthening individual and community potential, as well as female social and institutional networks, has been effective in empowering girls and communities.** Through CSOs, female adolescents acquire tools that give them more control over their socioeconomic environment and ability to make decisions. They are then better equipped to defend their rights. Use of health and other social services have generally increased among supported groups (Box 4).

*Box 4: Holistic, integrated and cross-sectoral approaches for girls' empowerment*

The work conducted by Mercy Corps and Lafia Matassa, that target female adolescents, provides useful insights on the strengths and weaknesses of this type of approach. Mercy Corps has implemented a five-year Food for Peace program since mid-2013, with support from USAID, in the Maradi and Zinder regions. The program reaches an estimated 116,000 beneficiaries in 8 districts and 62 villages. It focuses on health and nutrition, and targets vulnerable populations, particularly pregnant women, breastfeeding mothers, and adolescents 12 to 18 years of age. It seeks to build capacity and empower women and reduce food insecurity and poor nutrition. From 2010 to 2013 two NGOs, Lafia Matassa and Équilibres & Populations, partnered to implement two pilot projects[6] which aimed to improve ASRH by addressing their SRH needs and care, through holistic outreach activities and community mobilization. These projects targeted socially vulnerable (e.g., never enrolled in school, out of school, orphans, among others) female adolescents (10 to 14 years of age) in the rural area of Loga and the urban area of Gamkalley in Niamey. Girls meet twice a week in a secure location (youth center in Niamey, health center in Loga), and prepare and share a meal at the end of the session.

Through this program, girls acquired technical knowledge (financial management, literacy, better awareness of available social and health services and of their rights as users, self-awareness, communication, SRH, gender, among others) and practices (IGAs, sewing, opening a bank account) through training modules. Change was also observed in communities. Through this type of holistic and integrated program, young girls were able to become more actively involved in the community and bring about social change. Furthermore, since all program facilitators were community members, they had a solid knowledge of people, networks, local circumstances and sources of influence, and were able to work closely with communities. As for communities themselves, there has been a noticeable change as well. Communities acknowledged the: (I) capacities, potential, improved image and status of female adolescents.; (II) improved interactions between girls and boys; and (III) commitment and mobilization of community actors (parents, leaders, female relays, health personnel) through their involvement in the project.

[6] "*Youth Challenge: An integrated approach to address the needs of female adolescents in the area of sexual and reproductive health*", with FAD financing, and "*Protecting female adolescents: Meeting the challenge of improving the effectiveness of SRH programs*", with European Union funding. These projects were implemented by NGOs, namely Lafia Matassa in Niger, Céradis in Benin, and Asmade in Burkina Faso, with the technical coordination of another NGO, Équilibres & Populations.

# PART V - CONCLUSIONS AND RECOMMENDATIONS

## Conclusions

The study illustrates the ASRH determinants and the multifaceted challenges that adolescents (10-19 years of age) face to reaching their SRH potential in Niger. Adolescent females are married at a young age (15.7 years), limiting their educational and employment opportunities as most drop out of school in order to start having children. To address this, the government attempted to pass legislation to protect adolescent female's right to education by ensuring that parents seek legal permission for the daughter to leave school and marry, however the bill was met with societal resistance and was not approved. This indicates that barriers to improving adolescent health and development exist at the societal level, such as the positive value that society places on early marriage and pregnancy.

Although Niger's median age at childbirth is 18.5 years, 73.1 percent of adolescents have had a child before reaching 18 years of age. Early childbearing not only places the adolescent mother at risk for poor health outcomes but also ther infant. The government has been working to ensure access to health care and prevention services among pregnant women, including adolescents, by passing the Reproductive Health Law (2006), the National Plan Adolescent Sexual and Reproductive Health (2011), and the Family Planning Action Plan (2012-2020). However, the study suggests that monitoring and evaluation of these plans and policies should be carried out to ensure that they are effectively being implemented and reaching adolescents.

Despite being knowledgeable about modern contraception, use remains low among adolescents. The study found that adolescents do not use contraception because of societal and cultural beliefs. One way that the government is combatting FP misperceptions and increasing FP demand is through the Family Planning Action Plan (2012-2020), by using mass media campaigns to educate the population on the importance of FP. Lafia Matassa and Equilibres et Population have implemented similar programs, to empower adolescents in their SRH.

Adolescents face several barriers to accessing SRH services. In fact, almost 65 percent of adolescent females face at least one barrier to accessing health services. Adolescents do not seek SRH services due to financial reasons, despite legislation eliminating user fees. Also, adolescents do not seek health services due to a lack of privacy and confidentiality. The government has increased efforts to provide adolescent user-friendly SRH services by expanding 48 health centers to include adolescent-friendly health services and trained health personnel.

The analysis also shows that demand-side initiatives are able to effectively promote change at the community level, and have a positive impact on the positioning of a community in favor of young women's health, their role in the family, and in the economy long-term. Such initiatives must therefore be scaled-up to ensure a more profound change in the country. The achievement of those results will additionally require multi-sectoral and well-coordinated interventions in key sectors (health, education, employment and training). In parallel, the supply of services must continue to be adapted, to ease access to adolescent-friendly services, especially in rural areas. Youth centers, such as those already available in Niger,

largely rely on peer education and should be assessed and extended to rural areas depending on future needs of youth. Also, adolescents and youth should be involved in program design and implementation, a critical element for adolescent's empowerment and to ensure effectiveness and sustainability.

Based upon the results of the study, the following recommendations were developed.

| Topics | Diagnostics | Recommendations | Expected results | Main stakeholders |
|---|---|---|---|---|
| **Mainstreaming ASRH in national programs** | - Inclusion of youth and adolescents in government policies and interventions is not operationalized<br>- Attitudes and behaviors toward SRH and FP for adolescents, especially at health facilities, should be improved<br>- Mobilization of traditional and religious leaders on adolescent issues is limited | - Inclusion of youth and adolescents issues should be systematically monitored in health and other programs<br>- Scaling-up of adolescent-friendly training to all health cadres<br>- Inclusion of adolescent-related monitoring indicators in health facility supervision<br>- Tailored approaches should be developed given the Nigerien cultural, religious and ethnic setting to reach out and engage with traditional leaders<br>- School teachers should be mobilized and trained as active relays for SRH and FP youth issues in the community<br>- Decentralized authorities should be involved in ASRH | The forthcoming health strategy explicitly includes provision for adolescents. Local leaders, healthcare providers and school teachers engage more effectively for ASRH. | MoH, communities, development partners |
| **Prioritizing demand-side interventions** | - Supply-side actions are necessary but not sufficient to improve effective use of services<br>- Demand-side interventions have been implemented at small scales and with limited means<br>- Demand-side interventions remain largely unknown to policy makers and leaders | - Demand-side interventions should be financially supported and scaled-up<br>- Dissemination of results from current demand-side initiatives must benefit policy-makers<br>- Demand-side initiatives should be based on best practices and tailored approaches for the Nigerien socio-cultural context<br>- Community-based interventions should include community dialogue with traditional leaders | Demand-side initiatives are better known, socially accepted and scaled-up throughout the country | NGOs, development partners, policy-makers and traditional leaders |
| **Empowering the youth** | - Adolescents are rarely engaged in policy and program design<br>- Their perceptions, attitudes and needs are not adequately considered | - Adolescents' views are better considered and integrated in the design of future adolescent-related strategies and interventions | Adolescents play a stronger role in their community, at school and are better equipped for job markets. | MoH, Youth Ministry, Labor Ministry, development partners |

| | | | | |
|---|---|---|---|---|
| | - Limited access to the media limits their capacity to gain knowledge<br>- Self-esteem remains relatively low among adolescents, especially among the female<br>- Intra-couple bargaining for SR, fertility and FP related issues disadvantage female, against male and in laws<br>- Interventions focusing on women or couples may be insufficient to advance adolescent reproductive health in patriarchal societies such as Niger. | - Youth centers are upgraded, better equipped and staffed throughout the territory<br>- Youth is engaged in community relays/peers identification<br>- Life skills, capacity development programs are scaled-up<br>- Professional training is offered to discolarized adolescents<br>- Future research and programmatic efforts need to address gender norms and consider the influence of other family members, such as mothers-in-law. | | |
| **Designing and implementing multi-sectoral interventions** | - Interventions are implemented in silos,by single and isolated institutions<br>- Lack of coordination across sectors and partners | - Better coordinated and integrated initiatives for youth should be implemented across education, health and job sectors<br>- Flagship initiatives are developed jointly between MoH, Ministry of Youth and Labor.<br>- Schools and health facilities partner to develop joint health/ education sessions, especially in rural areas<br>- Community relays and peer educators are trained on multi-sectoral approaches | Integrated, coordinated and multi-sectoral activities achieve improved ASRH outcomes. | MoH, Youth Ministry, Labor Ministry, Ministry of Education, development partners |

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The aim of the study is to better understand adolescents' sexual and reproductive health (SRH) needs in order to inform the design of interventions and policies that improve access to and use of adolescent SRH services in Niger. A mixed-methods study was conducted and included: (i) a quantitative analysis of Niger's Demographic Health Survey/Multiple Indicator Cluster Survey (DHS/MICS) 2012; (ii) 17 focus group discussions conducted in urban and rural areas among 128 adolescents; and (iii) a set of recommendations to improve access to and use of SRH services for adolescents in the country. The study found that age at first marriage among adolescent females is 15.7 years and is followed soon thereafter by sexual debut (15.9 years). According to focus group discussions (FGDs), adolescents boys and girls start spending time together at 12 years in urban areas and 10 years in rural areas; this may lead to sexual intercourse in exchange for material and financial resources. Over 70 percent of adolescents have given birth by 18 years of age. Although knowledge about modern contraception is high (73 percent among female adolescents 15-19 years of age), the majority of adolescent girls do not use contraception due to societal and cultural beliefs. Moreover, FGDs reveal that the main barriers to use of SRH services is a lack of privacy and confidentiality, as well as finances, despite the government's elimination of user fees. The government has increased supply side interventions for adolescents and prioritized adolescents on the national agenda by approving the Family Planning Action Plan (2012-2020) and the National Plan for Adolescent Sexual and Reproductive Health (2011), however these plans need to be monitored and evaluated to determine their effectiveness in reaching this population group. There is also a need to increase multi-sectoral demand-side interventions in the country.

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