Plan Overview

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Title: Knowledge and utilisation of sexual and reproductive health services among adolescents in AMAC Abuja Nigeria.

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Project abstract:

Aims: Lack of knowledge of sexual and reproductive health among adolescents is the major reason why they are not using the sexual and reproductive health services (SRHS), therefore generating systemic data on the extent of the knowledge and utilisation of SRH service by the adolescents in Abuja Municipal Area Council, (AMAC) is crucial for effective intervention of adolescents' reproductive health services. Hence, this study aim is to assess the level of knowledge and utilisation of SRHS among adolescents in AMAC Abuja Nigeria. To determine health system factors influencing the utilisation of SRHS by adolescents and to explore strategies that can increase the utilisation of SRHS by the adolescents in AMAC. Research question(s): What is the level of knowledge about SRHS among adolescents in Abuja Municipal Area Council? Is Abuja Municipal Area Council adolescents utilising SRHS? What are the factors determine utilisations of SRHS? What are the strategies that can be put in place to scale up adolescents knowledge and utilization of SRHS in AMAC? Statement of problem: I have been working in AMAC primary health centres since May 2010. In different communities as a maternal and child health in charge. As a family planning provider, only two teenagers ever came to access the services and they were both brought by their mothers. Of all the youngsters that are coming for antenatal, delivered in the facilities or bringing their children for immunisation services, when I interviewed them I noticed that apart from a particular tribe, (Hausa) where child marriage is common, all others were unwanted pregnancies. Of all complicated criminal abortions that we cared for, 99% were adolescents. The access to and utilization of SRHS is a primary concern surrounding the promotion of SRH and rights (Braeken, 2012). This made me to think that there is need to access the level of knowledge of SRH among the municipal adolescents, the services utilisations among them and the reasons why they don't use the services. Moreover there is scanty information concerning any study on utilization of SRH especially by adolescents done in AMAC despite the fact that it's well endowed with health facilities offering clinic-based SRHS for adolescents. It is these revelations that prompted this study. Research Setting: The study will be conducted in the AMAC, 50 respondents will be used from 4 secondary schools which will include 2 public and 2 private secondary schools, adolescents that are apprentices and the street hawking adolescents. AMAC is the largest area council in Nigeria Federal Capital Territory. Study

Design and Sampling: The study design will be descriptive cross-sectional survey. Questionnaire will be use to gather data from the adolescents. Data Collection: The data will be collected within four months in 2021with the use of closed-ended pre-tested structured questionnaire. The sample size will be calculated using the research advisor 2006. Inclusion criteria will involves all adolescents whether in school, apprentices or hawking while exclusion criteria will involves adolescents that are not willing to participate in the study will be excluded from the study. Pre-test will be undertaken on adolescents in Bwari Area Council in Abuja to examine the reliability and construct the validity of the instrument. Variables will be measured at nominal level with a Yes or No response. The Independent variable will be the knowledge about SRHS while the dependent variable will be SRHS utilization. Data analysis: Data will be analysed using descriptive statistics. Frequencies and percentages will be used to summarize descriptive statistics. The data will be entered into Epi Info and analyse by SPSS software for windows. The chi-square test will be performed to find out whether there are any association between adolescents knowledge of SRHS and their utilisation. Ethical Considerations: Verbal and written informed consent will be obtained from all participants after soughing out permission from the head of the schools that will participate in the research project. Ethical issues related to anonymity, privacy and confidentiality will be strictly adhered to. The research will be carried out in secondary schools, on the street where adolescents that are hawking or trading can be seen and also where those that are learning skills can be seen. The answers to the research questions will help in identifying to why adolescents are not utilising SRHS and also find out the availability of adolescents and youth friendly services in AMAC. Significance of study: The knowledge gotten from this survey will facilitate the understanding of pattern of demand and utilisation of SRHS among the adolescents in AMAC. Health providers may utilise information generated from the survey to improve service delivery to adolescents. The adolescents may benefit from awareness drive by the health providers targeting them and this in turn may equip them with adequate information to help them make informed SRH choices. The reports will help in decision making through intensive advocacy with parents, media, communities and policy makers. The researcher will work base on the survey outcome with village chiefs, ward development committees, schools, health workers, religious and women leaders to create an integrated approach to provide adolescents with SRH education and can contribute by filling the gap untouched by other studies using different predictor variables. Literature review: Nigerians do not give children information on sexuality because discussing sex with them is regarded as a cultural taboo. Studies around the world done in last two decades indicate that adolescents are often unable to utilise essential health services as a result of barriers due to the availability, accessibility, acceptability and equity in health services (13). Studies conducted in Nepal shows that, the reason for not accessing health care were insufficient drugs (61%), distance to health care center (22%), staff unavailability (19%) and money (7%). Sex, ethnicity (9) and distance were found significantly associated with access to health care services (10). Different Studies from different countries have also shown that religion is a major barrier to adolescents? utilization of RHS (3, 6 &5). In a study conducted by Cortez, R., et al 2015 using data from the last three Demographic and Health Surveys (2003, 2008, 2013) and a survey in Karu LGA Nigeria Perceived behavior and practices of adolescents on SRH and associated factors in Kathmandu, Nepal (n=643) to analyze SRH knowledge, fertility and use of SRHS among adolescents in the country. Less than 2 percent of boys and 6.6 percent of girls, aged 15-19 were able to correctly identify when a female is most likely to get pregnant during the menstrual cycle, for example. Data from Karu LGA also show low levels of contraceptive knowledge (roughly 45 percent), with male condoms being the most well-known method (61% boys and 55% girls). Among sexually active adolescents, only 17 percent of boys and 5 percent of girls were using contraceptives. One of the key reasons for this is fear of social stigma. Participants in the study, particularly girls, indicate that they would not ask their partners to use condoms because it may be perceived as a sign of infidelity or promiscuity (1). A study in Tanzania reported that adolescents do not seek formal treatment for reproductive health problems as a result of shame and fear of disclosure (8).

Young people fear stigma and repercussions or judgment from providers, family and communities which hinder them from accessing SRHS, particularly unmarried adolescents and especially girls (11) shyness was the most commonly reported reason among adolescent boys (69%) and the second commonest reason for adolescent girls for not accessing SRH services in a study conducted in Nepal (11), this include finding it difficult to discuss issues related to SRH and the embarrassment associated with genital examination especially if the provider is known or of the opposite sex. Studies have reported on the preference of adolescents to see health providers of the same sex as a barrier to utilization of SRHS (2&7). Woog et al, 2015 in their research said in some cases even where the health facilities exist, there is not enough trained staff to provide the needed services and supplies of drugs and contraceptives are limited (12). Likewise Jonas et al 2017 in their study also revealed that Health workers behaviours can also significantly hinder adolescents? utilization of RHS. Services need to be provided in a youth-friendly environment with health workers that are welcoming and supportive towards adolescents seeking care (4). It is clear that interventions which aim to address the negative attitudes of health workers are likely to improve adolescents? SRHS utilization (4). Aims: Lack of knowledge of sexual and reproductive health among adolescents is the major reason why they are not using the sexual and reproductive health services (SRHS), therefore generating systemic data on the extent of the knowledge and utilisation of SRH service by the adolescents in Abuja Municipal Area Council, (AMAC) is crucial for effective intervention of adolescents' reproductive health services. Hence, this study aim is to assess the level of knowledge and utilisation of SRHS among adolescents in AMAC Abuja Nigeria. To determine health system factors influencing the utilisation of SRHS by adolescents and to explore strategies that can increase the utilisation of SRHS by the adolescents in AMAC. Research question(s): What is the level of knowledge about SRHS among adolescents in Abuja Municipal Area Council? Is Abuja Municipal Area Council adolescents utilising SRHS? What are the factors determine utilisations of SRHS? What are the strategies that can be put in place to scale up adolescents knowledge and utilization of SRHS in AMAC? Statement of problem: I have been working in AMAC primary health centres since May 2010. In different communities as a maternal and child health in charge. As a family planning provider, only two teenagers ever came to access the services and they were both brought by their mothers. Of all the youngsters that are coming for antenatal, delivered in the facilities or bringing their children for immunisation services, when I interviewed them I noticed that apart from a particular tribe, (Hausa) where child marriage is common, all others were unwanted pregnancies. Of all complicated criminal abortions that we cared for, 99% were adolescents. The access to and utilization of SRHS is a primary concern surrounding the promotion of SRH and rights (Braeken, 2012). This made me to think that there is need to access the level of knowledge of SRH among the municipal adolescents, the services utilisations among them and the reasons why they don't use the services. Moreover there is scanty information concerning any study on utilization of SRH especially by adolescents done in AMAC despite the fact that it's well endowed with health facilities offering clinic-based SRHS for adolescents. It is these revelations that prompted this study. Research Setting: The study will be conducted in the AMAC, 50 respondents will be used from 4 secondary schools which will include 2 public and 2 private secondary schools, adolescents that are apprentices and the street hawking adolescents. AMAC is the largest area council in Nigeria Federal Capital Territory. Study Design and Sampling: The study design will be descriptive cross-sectional survey. Questionnaire will be use to gather data from the adolescents. Data Collection: The data will be collected within four months in 2021with the use of closed-ended pre-tested structured questionnaire. The sample size will be calculated using the research advisor 2006. Inclusion criteria will involves all adolescents whether in school, apprentices or hawking while exclusion criteria will involves adolescents that are not willing to participate in the study will be excluded from the study. Pre-test will be undertaken on adolescents in Bwari Area Council in Abuja to examine the reliability and construct the validity of the instrument. Variables will be measured at nominal level with a Yes or No response. The Independent variable will be the knowledge about SRHS while the dependent variable will be SRHS utilization. Data analysis:

Data will be analysed using descriptive statistics. Frequencies and percentages will be used to summarize descriptive statistics. The data will be entered into Epi Info and analyse by SPSS software for windows. The chi-square test will be performed to find out whether there are any association between adolescents knowledge of SRHS and their utilisation. Ethical Considerations: Verbal and written informed consent will be obtained from all participants after soughing out permission from the head of the schools that will participate in the research project. Ethical issues related to anonymity, privacy and confidentiality will be strictly adhered to. The research will be carried out in secondary schools, on the street where adolescents that are hawking or trading can be seen and also where those that are learning skills can be seen. The answers to the research questions will help in identifying to why adolescents are not utilising SRHS and also find out the availability of adolescents and youth friendly services in AMAC. Significance of study: The knowledge gotten from this survey will facilitate the understanding of pattern of demand and utilisation of SRHS among the adolescents in AMAC. Health providers may utilise information generated from the survey to improve service delivery to adolescents. The adolescents may benefit from awareness drive by the health providers targeting them and this in turn may equip them with adequate information to help them make informed SRH choices. The reports will help in decision making through intensive advocacy with parents, media, communities and policy makers. The researcher will work base on the survey outcome with village chiefs, ward development committees, schools, health workers, religious and women leaders to create an integrated approach to provide adolescents with SRH education and can contribute by filling the gap untouched by other studies using different predictor variables. Literature review: Nigerians do not give children information on sexuality because discussing sex with them is regarded as a cultural taboo. Studies around the world done in last two decades indicate that adolescents are often unable to utilise essential health services as a result of barriers due to the availability, accessibility, acceptability and equity in health services (13). Studies conducted in Nepal shows that, the reason for not accessing health care were insufficient drugs (61%), distance to health care center (22%), staff unavailability (19%) and money (7%). Sex, ethnicity (9) and distance were found significantly associated with access to health care services (10). Different Studies from different countries have also shown that religion is a major barrier to adolescents? utilization of RHS (3, 6 &5). In a study conducted by Cortez, R., et al 2015 using data from the last three Demographic and Health Surveys (2003, 2008, 2013) and a survey in Karu LGA Nigeria Perceived behavior and practices of adolescents on SRH and associated factors in Kathmandu, Nepal (n=643) to analyze SRH knowledge, fertility and use of SRHS among adolescents in the country. Less than 2 percent of boys and 6.6 percent of girls, aged 15-19 were able to correctly identify when a female is most likely to get pregnant during the menstrual cycle, for example. Data from Karu LGA also show low levels of contraceptive knowledge (roughly 45 percent), with male condoms being the most well-known method (61% boys and 55% girls). Among sexually active adolescents, only 17 percent of boys and 5 percent of girls were using contraceptives. One of the key reasons for this is fear of social stigma. Participants in the study, particularly girls, indicate that they would not ask their partners to use condoms because it may be perceived as a sign of infidelity or promiscuity (1). A study in Tanzania reported that adolescents do not seek formal treatment for reproductive health problems as a result of shame and fear of disclosure (8). Young people fear stigma and repercussions or judgment from providers, family and communities which hinder them from accessing SRHS, particularly unmarried adolescents and especially girls (11) shyness was the most commonly reported reason among adolescent boys (69%) and the second commonest reason for adolescent girls for not accessing SRH services in a study conducted in Nepal (11), this include finding it difficult to discuss issues related to SRH and the embarrassment associated with genital examination especially if the provider is known or of the opposite sex. Studies have reported on the preference of adolescents to see health providers of the same sex as a barrier to utilization of SRHS (2&7). Woog et al, 2015 in their research said in some cases even where the health facilities exist, there is not enough trained staff to provide the needed services and supplies of drugs and contraceptives are

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Knowledge and utilisation of sexual and reproductive health services among adolescents in AMAC Abuja Nigeria.

Data and software outputs

The data and software outputs your research will generate

The data will display statistical information derived from each individual reporting adolescents. Data will be obtained from AMAC adolescents both in school and out school ones. The raw data will be selectively imputed based upon the variables used and analysed for the purpose of the project. Data outputs will be of value to others within my research community, adolescents, teachers, health provider's wider research, innovation, and stakeholder communities. Outputs will be published in journals, presented at meetings, or made available to others on request.

When you intend to share your data and software

Outputs will be shared with end-users within three months of the end of the grant. Data will be as open as possible to commercial and non-commercial users. The data created in this project will be made available after they have been published, patented, or publicly disclosed in invention disclosures, conferences or seminars. They can be provided in the forms of electronic copies of notebook pages, raw electronic data files, or electronic processed data files in the forms of figures or tables. There will be no charge for the access to the data. The data created in this project will be governed in line with Wellcome Sanger Institute data sharing policy regarding intellectual property, record retention, and data management. The data will be aaccessible, available, locatable and citable. The users will be able to manipulate the data to their specific needs. Data will not display any sensitive information and will only be used for educational/future use. It is the goal of the publisher to maintain 5years of data and to increase the sample population each year in order to get valid results. Null and negative findings and data as well as data supporting new findings will be shared with the community and policy makers so as to avoid unnecessary waste and duplication. Since the research will be conducted on the field, the researcher will ensure that at all times more than one copy of the data exists, and that every copy can easily be accounted for and located. Laptops, external drives, voice recorders etc will be encrypted and put in place for appropriate data transfer processes from these to secure storage.

Where your data and software will be made available

: The retained data will be used for years to come. The data will be made available within 6 months of article publication date. Data underpinning articles would be made available upon publication and end of the project data would be made available after project lifetime and accessible for a minimum period of 10 years

How your data and software will be accessible to others

. There will be no charge for the access to the data. The data created in this project will be governed in line withWellcome Sanger Institute data sharing policy regarding intellectual property, record retention, and data management. The data will be aaccessible, available, locatable and citable. The users will be able to manipulate the data to their specific needs. Data will not display any sensitive information and will only be used for educational/future use. It is the goal of the publisher to maintain 5years of data and to increase the sample population each year in order to get valid results. Null and negative findings and data as well as data supporting new findings will be shared with the community and policy makers so as to avoid unnecessary waste and duplication.

Whether limits to data and software sharing are required

There will be no limit to the data sharing

How datasets and software will be preserved

Any re-use and re-distribution of unpublished data require permission by the PI. The data will be used and preserved indefinitely and opportunities will be explored through github and other sites that provide open data to the public. It is expected this dataset will be of interest to those beyond the literature community.Data will be backed up in paper forms and google forms by the data scientist.

No sensitive data will be collected and all data collected will be anonymised. The procedures for backup and preservation of data include copying files onto a secure and safe drive that will be used for quick data restorations and emergency situations. Only data we intend to publish will be collected.

Research materials

What materials your research will produce and how these will be made available

Data will be obtained from AMAC adolescents both in school and out school ones. The raw data will be selectively imputed based upon the variables used and analysed for the purpose of the project. Data outputs will be of value to others within my research community, adolescents, teachers, health provider's wider research, innovation, and stakeholder communities. Outputs will be published in journals, presented at meetings, or made available to others on request. The research materials will be distributed by the researcher to other researchers that asked for them and will be available to the wider research community so as to advance the development of sexual and reproductive health benefits.the data will display statistical information derived from each individual reporting adolescents.

Intellectual property

What IP your research will generate

Creating public exhibitions, printing of IEC materials in support of sexual and reproductive health services, commissioning reports, films, broadcasts, dramas and artworks

How IP will be protected

Intellectual property concerns will be brought to the attention of the Wellcome-funded IP. Potential issues will be discussed with them. The researcher will ensure that the results of the research are applied for the public good.

How IP will be used to achieve health benefits

It will be used in creating public exhibitions, printing of IEC materials in support of sexual and reproductive health services, commissioning reports, films, broadcasts, dramas and artworks.

Required resources

You should consider what resources you may need to deliver your plan and outline where dedicated resources are required.

Support for one dedicated data manager on full time bases will needed
Research assistants will be trained on data and software management to deliver the proposed research
Purchasing of software to deliver your proposed research
Funds needed to acquire supercomputer and other shared facilities
Costs of operating an access committee and data access mechanism throughout the period of data collection
Costs of preparing, sharing data, software and materials with users
Costs of ingesting secondary data, code and materials from users
Costs associated with accessing data, software or materials from others researchers that you need to take forward your proposed research
Costs of ingestion or deposition to recognised subject repositories for data, code and materials
Printing of IEC materials in support of sexual and reproductive health services,