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Promoting an Enabling Environment for Adolescent Sexual and Reproductive Health Intervention Programs in Nigeria: Towards Family Planning 2020

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Abstract

This article on adolescent sexual and reproductive health is based on the ecological framework and it identifies the core elements for building and maintaining a conducive climate for Adolescent Sexual and Reproductive Health (ASRH). The ecological framework approach is hinged on the key elements that are necessary in the creation of an enabling environment for ASRH. The components of the ecological framework include individuals, relationships, the community and the society as a whole. At the individual level, adolescents are empowered to boost their self-esteem and improve their decision-making capacity. At the level of relationship, parental support and communication with peers and significant others are encouraged to create support networks for the adolescents. At the level of the community, the community stakeholders are engaged to create an enabling environment foe ASRH programs. Finally, at the highest level, which is the society, efforts to influence policies and regulations that protect and promote the adolescents' rights on ASRH issues should be put into consideration.

Keywords: *Adolescent, Sexual and Reproductive Health, enabling environment.*

Introduction

Evidence has shown that increasing the availability of ASRH services such as contraceptives for instance and improving the quality of service delivery, is not enough to promote positive health outcomes in adolescents (Denno, Hoopes & Chandra-Mouli, 2015). This is largely due to the fact that adolescents' sexual and reproductive health (SRH) in Nigeria is highly impacted by an array of sociocultural, political, and economical issues (Cortez, Seemeen, Edmore & Odutolu. 2015). These determinants raise the level of susceptibility of adolescents' sexual and reproductive health risks such as transactional sex, unsafe sex, forced sexual intercourse and unwanted pregnancy (Alubo, 2001). According to Omo-Aghoja (2013), there is a need to address the underlying issues by engaging the stakeholders involved such as parents/guardians, community leaders, religious leaders and high level decision makers, to enable the young people gain access to their rights on Sexual and Reproductive Health (SRH) issues while promoting the acceptance of holistic ASRH services by the general populace. This type of family, community and societal engagement on ASRH is known as "creating an enabling environment or safe spaces" (Browne & Oddsdottir 2013).

Creating an enabling environment to enhance the effectiveness of SRH programs that function at multifactorial levels with the adolescents, their families, their communities and the society could be a complex process.

Development partners and those involved in the design and implementation of ASRH programs would derive some benefits from the conceptual application of the core elements of creating an enabling environment that this paper focuses on. Therefore, this paper draws a conceptual model based on the ecological approach proposed by Bronfenbrenner (1979) that describes the core elements that works together to facilitate an enabling environment for SRH and promote the rights of adolescents.

Applying the ecological framework to adolescent sexual and reproductive health

An enabling environment was aptly defined by Turmen (2000) as "a set of interrelated conditions legal, political, social, economic, legal, and cultural, among others that affect the ability of young

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people to lead healthy lives and gain access to needed services, information, and products." Grown, Gupta & Pande (2005) also submitted that the creation of an enabling environment goes beyond individuals and extends to other structures such as community gatekeepers, policy makers and other stakeholders that are important to the shaping of ASRH outcomes.

The ecological framework would form the framework of this paper for the purpose of describing the key elements and determinant factors required for creating an enabling environment for ASRH programs.

The ecological framework is founded on four guiding rules. Firstly, it recognizes the interactive influential factors of individual relationships, organizational influence, impact of the community, and the effect of policy. Secondly, the ecological framework states that these factors continuously interact at various levels. Thirdly, the ecological framework requires emphasis on specific health behaviors and results as it identifies the factors that tend to precipitate a particular behavior and the result at all levels of the ecological framework. Lastly, the ecological framework posits that ASRH programs that focus on addressing the key factors at various levels are likely to be more effective than those that focus on only one factor (Figure 1).

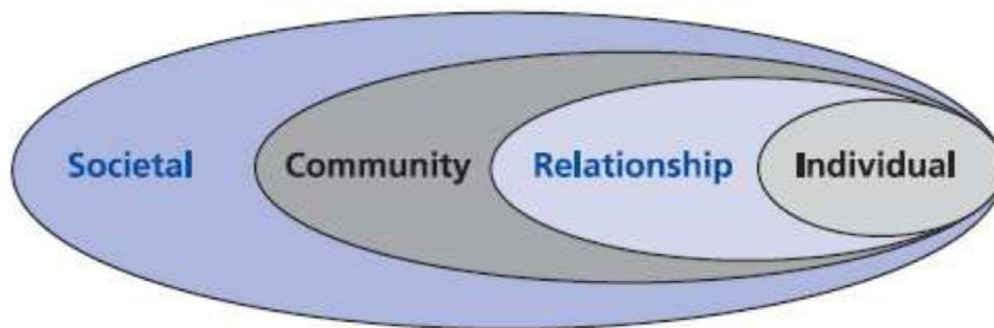

Figure 1. Ecological model for an enabling environment for shaping adolescent sexual and reproductive health

The application of this framework to SRH programs for adolescents
Implies that:

1. At the individualized level, the adolescents require empowerment socially and economically to build their capacity on making decisions and income generating activities.
2. At the relationship level, relationships should be built to support good health behaviors among adolescents. It is also of utmost importance for adolescents to recognize their rights and have uninhibited access to SRH services.
3. At the level of the community, comes a requirement to engender the acceptance of free access to information on ASRH and good quality services to reduce the vulnerability of adolescents to risky sexual behaviors.
4. At the societal level, the promotion of laws and policies that are tied to the health, economic, educational and social sectors and to engender the realization of the human rights of adolescents.

Program interventions aimed at the improvement of adolescent SRH are positive environment enablers for better SRH outcomes for adolescents. This article evaluated some SRH projects targeted at adolescents to assess the impact and gaps in intervention based on the capacity of the program to create an enabling environment for the intervention.

Determinant factors for creating an enabling environment

Interventions at Individual level

Building the capacity of adolescents economically through skills acquisition contributes immensely to ASRH programs as poverty and inadequate resources leads to greater vulnerability for young girls (Boyle, Racine & Georgiades, 2006). For instance, research from sub-Sahara Africa reveals that young women aged 15-24 years are more vulnerable to Sexually Transmitted Infections, unwanted pregnancies and HIV as a result of transactional sex to meet their basic needs, financial demands and other necessities (Dunkle, et al. 2014; Madise, Zulu & Ciera 2007; Jewkes & Morrell 2012). Several interventions have incorporated economic empowerment into their programs to reduce the

vulnerability of adolescent to SRH issues. This is based on the premise that if adolescent girls are economically empowered, there would be a reduction in transactional sex.

The A360 adolescent health program in Nigeria included economic empowerment in their package for adolescent girls. This is done through frequently conducted skill acquisition programs such as soap making, bead making, air freshener processing, etc. This approach has drawn more girls into the program as the parents and community as a whole are eager for their adolescents to acquire these skills. After the skills classes, trained facilitators will take the floor to educate the adolescent girls on their sexual and reproductive health. Those who require further counseling and services on contraception will be referred to trained contraceptive service providers for further counseling.

Creation of safe space for adolescent girls

In this part of the world, we have a culture of silence on issues of sexuality especially for girls. Thus it is difficult for an average teenage girl in Nigeria to discuss or express her worries about sexual and reproductive health issues. This is usually the case within families and communities. Moreover girls have limited opportunities to express themselves due to lack of confidentiality and the judgmental attitude of health service providers.

Several ASRH programs have adopted the safe spaces model. This model involves the provision of a physical space where adolescents are able to meet regularly. The adolescents are supported by a mentor who provides skills such as information on SRH, assertiveness, negotiation skills, and/or vocational training with time set aside for recreation and socialization (Population Council 2011). The basis of the safe space approach is to ensure the safety of the girls, build their capacity, and integrate them into a system that enhances assess to positive SRH outcomes (Glennerster & Takavarasha 2010).

Safe space intervention programs have been introduced to Nigeria, Egypt, India, Kenya, Rwanda, Uganda, Guatemala, Tanzania, Burkina Faso, and Ethiopia with most of them targeting girls of ages 15 to 17 years though some programs focus on younger girls between ages 10 to 14 years as some of them actually become sexually active before the age of 15 years (Browne & Oddsdottir 2013).

Education has also been found to be one of the factors that engender positive SRH outcomes

As it tends to increase contraceptive use and prevent early marriage (Mmari & Sabherwal.

2013; Grown, Gupta & Pande 2005; Boyle, Racine & Georgiades, 2006; Little 2009; Gakidou et al 2009).

Additionally, a review from countries in east, south, and central parts of Africa revealed that secondary education has been strongly associated with reduction in risky sexual behavior and the rate of HIV transmission (Hargreaves & Boler 2006).

Engagement of parents

Parents and the family members are important stakeholders in the knowledge of sexual and reproductive health made available to young people (Biddlecom, Awusabo-Asare & Bankole, 2009; Bastien, Kajula, & Muhwezi 2011).

Research work conducted in Africa reveals that the exchange of information on sexual and reproductive health issues is often a taboo and thus rarely discussed (Shtarkshall, Santelli & Hirsch 2007). These barriers in SRH communication between parents are their adolescents can be attributed to ignorance, reliance on schools to educate the children on such issues and the notion that discussing sex with adolescents will encourage an early sexual debut (Bastien, Kajula, & Muhwezi 2011).

A good example of parental involvement is the parent-centered program that was conducted to promote communication in the families of seventh graders and encourage a higher level of parental involvement in their teens' SRH issues. After 3 years of the intervention, the teens reported less sexual activities and STI than their peers who were in the control group. (Prado, et. al, 2007).

Partner involvement

Majority of ASRH intervention programs are targeted at girls, leaving the sex partners who are the males out of the program. Studies have shown that o forced sex with a sex partner at first sexual experience also make adolescent girls vulnerable to risky sexual behaviours while the liberty to

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discuss sexual choices with partners reduce risks (Mmari & Sabherwal, 2013). Programs should be aimed at promoting equity and gender by involving men and boys.

Peer education programs

Peers play a significant role in adolescent health and socialization; therefore peer influence is of utmost importance in ASRH as peers can serve as either positive or negative influential factors.

A desk review of research conducted between 1990 and 2010 on "the risk and protective factors for ASRH" discovered the fact that relationship with sexually active peers promotes early sexual debut and increased sexual risks (Mmari & Sabherwal, 2013). Peer training has however been observed to influence positive SRH outcomes (Villa-Torres & Svanemyr, 2015).

Mentoring and role modeling

The inclusion of the mentoring and role model approach is also crucial in the improvement of SRH outcomes (Beaman, et al, 2009). Salem, Ibrahim & Brady (2003) submitted that girls who have older mentors also imbibe leadership qualities and develops a sense of responsibility

Which reduces sexual risks. Thus, some ASRH programs are including mentoring and role model components to their programs.

Community mobilization

Community mobilization has the potential to boost communication in support of ASRH. Through the engagement of the general public, stakeholders and community members get accurate information about ASRH in a manner that is not culturally offensive to promote positive behavioural change. Studies have shown that the engagement of community stakeholders such as traditional rulers, opinion leaders and religious leaders, can enhance the support of the community for ASRH (Kesterton & Cabral de Mello 2010; Denno, Hoopes & Chandra-Mouli, 2015) However, worthy of note is the fact that the process of community mobilization is usually conducted as part of multifaceted interventions, therefore it is difficult to evaluate the direct impact of community mobilization (Denno, Hoopes & Chandra-Moul, 2015)

Male engagement to foster gender-equity norms

The period of adolescence comes with more socialization and gender norms become established in the light of clearly defined sexual roles (Barker, Ricardo & Nascimento, 2007). Majority of adolescent health programs neglect the boys while the focus is on girls (MacQuarrie et al 2015).

Barker et al (2007) reported that programs that integrate men and boys into sexual and reproductive health activities usually have more promising outcomes in terms of promoting gender equity.

Societal level interventions

The implementation of ASRH activities are hinged on the law of the country of intervention. Many countries do not have laws to promote access to contraceptives and safe abortion for adolescents. Moreover, some countries promote child marriage which has a negative impact on adolescent health (Karei E & Erulkar, 2010) Many countries have set their minimum age at marriage at 18 years but when this law is flouted, the culprits are hardly brought to book (Jensen 2013; Mackie 2012). In Nigerian the minimum age of marriage was set at 18 years according to the child rights act that was passed in 2003 but this law was adopted by only 23 states out of the 36 states in Nigeria and child marriage has continued in many parts of the country. There is a need for interventions to curb policies that are dangerous to adolescent health (Erulkar & Muthengi, 2013).

Awareness through mass media/social media

Mass media and social media can be used to raise awareness and shed more light on ASRH issues (WHO, 2009). It has been proven that when mass media is combined with edutainment and linkages to healthcare services, it promotes positive behavior change (WHO, 2006).

Recommendations

1. **Holistic intervention**: ASRH programs should have different approaches that address all the needs of the adolescent. The intervention should include individuals, communities, and the society and policy makers as well.
2. **Setting long term goals**: Behavior change programs require long term interventions. Therefore, positive ASRH program outcomes cannot be achieved through a fire brigade approach. A good anecdote is the stepping stone intervention where the male participants exhibited a more reduced level of violence within 24 months of intervention than at 12 months of intervention (Gibbs et al. 2017).
3. **Inclusion of boys in ASRH programs**: the focus should not be on girls alone for the implementation of ASRH programs. Rather, adolescent boys should be included to promote gender equity.
4. **Inclusion of under 15 adolescents in ASRH programs:** ASRH programs are usually targeted at ages 15 upwards. Whereas, a lot of adolescents experience their sexual debut before the age of 15. Interventions should be expanded to include these younger adolescents and provide age-specific services for them according to their age groups.
5. **Advocacy for youth friendly policies**: stakeholders in the health sector and development work should conduct advocacy to policy makers to create an enabling environment for adolescents to have a better access to improved sexual and reproductive health services.

Conclusion

Improving adolescent sexual and reproductive health includes the promotion of adolescents' access to information, capacity building on life skills, increasing their sense of entitlement and sharpening their decision-making skills. However healthy relationships, supportive family, a positive community and societal network promotes adolescent health.

References

[1].Alubo O. Adolescent reproductive health practices in Nigeria. Afr J Reprod Health. 2001 Dec;5(3):109-19. PMID: 12471935.

[2].Beaman L, Chattopadhyay R, Duflo E, et al. Powerful women: Does exposure reduce bias? QJE 2009; 124:1497e540.

[3].Barker G, Ricardo C, Nascimento M. 2007 Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. Geneva: World Health Organization ePromundo; 2007.

[4].Biddlecom A, Awusabo-Asare K, Bankole A. 2009. Role of parents in adolescent sexual activity and contraceptive use in four African countries. Int Perspect Sex Reprod Health 2009; 35: 72e81.

[5].Boyle M, Racine Y, Georgiades K, 2006. The influence of economic development level, household wealth and maternal education on child health in the developing world. Social Sci Med 2006; 63:2242e54.

[6].Bronfenbrenner V. The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press; 1979.

[7].Browne E, Oddsdottir F. 2013. Safe spaces for girls: Six-country mapping (GSDRC Helpdesk Research Report 937). Birmingham, UK: GSDRC, University of Birmingham; 2013.

[8].Cortez R., Seemeen S., Edmore M., Odutolu O. 2015. Adolescent Sexual and Reproductive Health in Nigeria. Health, nutrition and population global practice knowledge brief; World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/21626 License: CC BY 3.0 IGO."

[9].Denno D, Hoopes A, Chandra-Mouli V. 2015 Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support. J Adolesc Health 2015;56: S22e41.

[10]. Dunkle K, Khandekar R, Brown H, 2014. Transactional sex among women in Soweto, South Africa: Prevalence, risk factors and association with HIV infection. Social Sci Med 2014; 59:1581e92.

[11]. Erulkar A & Muthengi E. 2103 Evaluation of Berhane Hewan: A program to delay child marriage in rural Ethiopia. Int Perspect Sex Reprod Health 2009; 35:6e14.

[12]. Gakidou E, Cowling K, Lozano R, Murray CJ. Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: A systematic analysis. Lancet 2010; 376:959e74.

DOI: 10.21522/TIJPH.2013.06.04.Art008
ISSN: 2520-3134

[13]. Garbarino J. Adolescent development: An ecological perspective. Columbus, OH: Charles E. Merrill; 1985.
[14]. Glennerster R, Takavarasha K. 2010. Empowering young women: What do we know? Cambridge, MA: Abdul Lateef Jamal Poverty Action Lab, MIT; 2010. #
[15]. Gibbs A., Washington L., Willan S., Ntini L, Jewtes R. 2017. The Stepping Stones and Creating Futures intervention to prevent intimate partner violence and HIV-risk behaviours in Durban, South Africa: study protocol for a cluster randomized control trial, and baseline characteristics. *BMC Public Health*BMC series – open, inclusive and trusted2017**17**:336 https://doi.org/10.1186/s12889-017-4223-x
[16]. Grown C, Gupta G, Pande R. 2005 Taking action to improve women's health through gender equality and women's empowerment. Lancet 2015; 365:541e3.
[17]. Jensen R, Thornton R. Early female marriage in the developing world. Gend Development 2013; 11:9e19.
[18]. Jewkes R, Morrell R. 2012. Sexuality and the limits of agency among South Africanteenage women: Theorising femininities and their connections to HIV risk practices. Social Sci Med 2012; 74:1729e37.
[19]. Karei E & Erulkar A. Building programs to address child marriage: The Berhane Hewan experience in Ethiopia. Washington, DC: Population Council; 2010.
[20]. Kesterton AJ, Cabral de Mello M. Generating demand and community support for sexual and reproductive health services for young people: A review of the literature and programs. Reprod Health 2010;7.
[21]. Little A, Green A. 2009 Successful globalization, education and sustainable development. Int.
[22]. MacQuarrie K., Men and Contraception: Trends in Attitudes and Use, *DHS Analytical Studies,* 2015, Rockville, MD, USA: ICF International, No. 49.
[23]. Madise N, Zulu E, Ciera J. Is poverty a driver for risky sexual behaviour? Evidence from national surveys of adolescents in four African countries. Afr J Reprod Health 2007:83e98.
[24]. Mackie G. Effective rule of law requires construction of a social norm of legal obedience. University of Chicago Political Theory Workshop; 2012.
[25]. Mmari K, Sabherwal S. 2013. A review of risk and protective factors for adolescent sexual and reproductive health in developing countries: An update. J Adolesc Health 2013; 53:562e72.
[26]. Omo-Aghoja L. Sexual and reproductive health: Concepts and current status among Nigerians. Afr J Med Health Sci 2013; 12:103-13.
[27]. Population Council; 2011.Creating "safe spaces" for adolescent girls 2011. New York, NY.
[28]. Population Council and UN Adolescent Girls Task Force. 2012. Girls' leadership and mentoring. Available at: http://www.popcouncil.org/pdfs/2012PGY_GirlsFirst_Leadership.pdf.
[29]. Prado G, Pantin H, Briones E, 2007. A randomized controlled trial of a parent-centered intervention in preventing substance use and HIV risk behaviors in Hispanic adolescents. J Consult Clin Psychol 2007; 75:914e26.
[30]. Salem R, Ibrahim B, Brady M. Negotiating leadership roles: Young women's experiences in rural Upper Egypt. Women's Stud Q 2003; 31:174e91.
[31]. Shtarkshall R, Santelli J, Hirsch J. 2007. Sex education and sexual socialization: Roles foreducators and parents. Perspect Sex Reprod Health 2007; 39:116e9.
[32]. Türmen T. Reproductive rights: How to move forward? Health Hum Rights 2000; 4:31e6.
[33]. Villa-Torres L, Svanemyr J. Ensuring youth's right to participation and promotion of youthleadership in development of sexual and reproductive health policies and programs. J Adolesc Health 2015;56: S51e7.
[34]. World Health Organization; 2006. The effectiveness of mass media in changing HIV/AIDS related behavior among young people in developing countries. Geneva.
[35]. World Health Organization; 2009. Generating demand and community support for sexual and reproductive health services for young people: A review of literature and programmes. Geneva: Department of Child and Adolescent Health and Development.