**Research Article**
Volume 9:S5, 2021

Journal of Child and Adolescent Behavior

ISSN: 2375-4494

Open Access

# Sexual and Reproductive Health Utilization and Satisfaction among Adolescents in Northern Nigeria: Impact of REACH Project Educational Intervention

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## Abstract

**Objective:** The aim of the study was to evaluate the impacts of Reaching and Empowering Adolescents to make informed Choices for their Health (REACH) project intervention in utilization and satisfaction of Adolescents' Sexual and Reproductive Health (ASRH).

**Methodology:** This was a mixed methods study which collected both quantitative data (via a structured household survey and a health facility survey) and qualitative data (via Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs)). The primary study population was male and female adolescents aged between 10 and 19 years within the three states (Gombe, Katsina and Zamfara).

**Results:** The finding of this project shows that, there is an increase in utilization of SRH services by adolescents as compared to the base line. Similarly, the result shows that married girls were more likely than unmarried girls to report using SRH services: 86% and 44% respectively ($\chi 2$ $p<0.001$). The same was true of boys, but the difference between married and unmarried boys was much smaller: 48% and 40% respectively. Similarly, there was an increase in the satisfaction with ASRH services as compared to base line.

**Conclusion:** REACH project educational intervention is effective in increasing utilization of Adolescents Sexual and Reproductive Health (ASRH) services.

**Keywords:** Adolescents • Adolescents' sexual and reproductive health • Structured household survey • Health facility survey

**Abbreviations:** REACH: Reaching and Empowering Adolescents to make informed Choices for their Health; LGA's: Local Government Authorities; ASRH: Adolescents Sexual and Reproductive Health; EL: End Line; BL: Base Line.

## Introduction

The World Health Organization (WHO) defines "adolescents" as individuals in 10–19 years old and "youth" as 15-24 years old [1]. Together, adolescents and youth are referred to as young people, encompassing the ages of 10-24 years. Studies have established what can increase access and utilization for SRH among adolescents. However, a lack of scientifically sound data on the effectiveness of services that target young people in sub-Saharan Africa, especially in comparison to the magnitude of Adolescents Sexual and Reproductive Health (ASRH) challenges in the region [2]. There is a gap in adolescents' access to Sexual and Reproductive Health (SRH) services and information, which has not been fully addressed. In addition, adolescents have now been included in the World Health Organization's Global strategy for women's, children's and adolescents' health (2016-2030), and this indicate the unique health challenges facing young people [3]. This is one of the reason for the implementation of REACH project by the save the children International in Nigeria.

The Reaching and Empowering Adolescents to make informed Choices for their Health (REACH) project was funded by Global Affairs Canada and implemented by Save the Children (SC) between April 2018 and August 2021. Over its three years of implementation, it aimed to improve the Sexual and Reproductive Health (SRH) of adolescent boys and girls aged 10-19 within three Nigerian states: Gombe, Zamfara and Katsina.

REACH aimed to increase accessibility to high-quality and gender-responsive Adolescent Sexual and Reproductive Health (ASRH) services targeted towards Very Young Adolescents (VYAs) aged 10 to 14 years old and older adolescents aged 15 to 19 years old. The project aimed to engage 100,000 adolescents. In addition to improving access to SRH services, the REACH project also aimed to empower married and unmarried girls to participate actively in decisions surrounding their own Sexual and Reproductive Health and Rights (SRHR), as well as engaging with the parents, caregivers and spouses of adolescent girls in order to facilitate improved awareness of SRHR throughout the three states. Lastly, the project aimed to facilitate and integrate the use of evidence-based policies and programmatic decision-making surrounding Adolescent Sexual and Reproductive Health and Rights (ASRHR) within Nigeria. Specific project objectives included: Improving access to high quality, gender-responsive and adolescent-friendly SRH services for unmarried and married adolescent girls and boys; increasing the decision-making of married and unmarried adolescent girls about their own SRHR; and improving the integration of civil society contributions and evidence-based best practices in ASRHR policy design and implementation at local and state levels [4].

The REACH Base Line (BL) study was conducted in August 2018. The project implementation plan called for a Mid-Term Review (MTR) in the first quarter of 2020 and an End Line (EL) evaluation in the third quarter of 2021. However, due to the COVID-19 pandemic, the MTR was delayed until the third quarter of 2020. As this was so close to the end of the programme, Save the

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**Received:** 15 November 2021; **Accepted:** 29 November 2021; **Published:** 06 December 2021

Children decided that the MTR should form the basis for the EL evaluation, and that the EL data collection should consist of some targeted qualitative work to assess:

- The elements of the project which were implemented in its later stages.
- The extent to which the MTR's main recommendations had been implemented during the final months of the project. This report contains data from both the MTR and the additional EL qualitative work, which taken together form the full EL evaluation.

## Methodology

This was a mixed methods study which collected both quantitative data (*via* a structured household survey and a health facility survey) and qualitative data (*via* Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs)). The primary study population was male and female adolescents aged between 10 and 19 years within the three states (Gombe, Katsina and Zamfara). The study also covered key influencers: parents of adolescent girls, adult husbands of adolescent girls, health facility staff, State and Local Government Area (LGA) administrators, Patent and Proprietary Medicine Vendors (PPMVs), traditional and religious leaders, and REACH facilitators.

**Table 1.** Selection of villages/communities for the household survey.

| State | LGA | Community |
|---|---|---|
| Gombe | Balanga | Bambam |
| | | Talasse |
| | Dukku | Dukku Chiroma |
| | | Malala |
| Katsina | Rimi | Abukur |
| | | Tsagero |
| | Sandamu | Fago |
| | | Rijiyar Tsamiya |
| Zamfara | Kaura Namoda | Kasuwar Daji |
| | | Kurya |
| | | Kurya Madaro |
| | Talata Mafara | Galadima |
| | | Matusgi |
| | | Yar Rinesi |

### Sample size and sampling strategy

**Household survey:** The survey used a multi-stage cluster sample with 4 stages: state, LGA, village/community and individual. All three REACH states were selected: Gombe, Katsina and Zamfara. Within each state, two LGAs were selected, making a total of six LGAs.

Villages/communities were sampled at random from the list of catchment communities located within 5 km of the programme's target health facilities. Initially two villages/communities were selected in each of the 6 LGAs, but there were very few married 10-14 year-olds in these villages/communities, so two additional ones were selected in the two LGAs in Zamfara state. Thus, 14 communities were selected, with the number of communities selected per LGA approximately proportional to the size of the target population. Two of the 14 communities were also included in the BL sample (Table 1).

The aim was to conduct approximately 400 interviews per state (1,200 in totals); including adolescents aged 10-19, parents of adolescent girls and adult husbands of adolescent girls. Households were selected using a random walk method, with enumerators stopping at every second or third household (depending on the size of the village/community). At each sampled household, enumerators asked if any eligible respondents were resident and available at the time of the visit. If so, the interview was conducted immediately. If an eligible household was identified but the eligible respondent was not available when the enumerator visited, the enumerator returned at a different time of day to conduct the interview. If the eligible respondent was still not available at the return visit, the household was replaced by another, using the same sampling method.

**Adolescents:** To be eligible for interview, an adolescent had to: be aged 10-19 (inclusive) on the day of the interview, be resident in one of the sampled communities and have benefited from the REACH programme.

Enumerators were instructed to ensure that, within each age and sex group (boys 10-14, girls 10-14, boys 15-19 and girls 15-19) the sample included both married and unmarried adolescents. In the event, even with the addition of two new villages/communities (see above), the enumerators were not able to find many married 10-14 year-olds who met the inclusion criteria. They therefore supplemented the sample with additional married 15-19 year-olds, to ensure that the sample contained sufficient married adolescents for separate analysis. This deliberate over-sampling of married adolescents is almost certainly the reason why the EL found higher rates of adolescent marriage than did the BL.

## Results

The results were depicted by the given Tables 2 and 3 and Figures 1 and 2

**Table 2.** Socio-demographic characteristics of the respondents by marital status.

| Age group | Sex | Marital status | Gombe state | | Katsina state | | Zamfara state | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | Balanga LGA | Dukku LGA | Rimi LGA | Sandamu LGA | Kaura Namoda LGA | Talata Mafara LGA | |
| 10-14 | Boy | Married | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Unmarried | 19 | 19 | 18 | 20 | 19 | 20 | 115 |
| | Girl | Married | 0 | 0 | 0 | 0 | 0 | 36 | 36 |
| | | Unmarried | 19 | 16 | 19 | 19 | 20 | 17 | 110 |
| 15-19 | Boy | Married | 16 | 15 | 0 | 15 | 0 | 0 | 46 |
| | | Unmarried | 19 | 19 | 19 | 38 | 27 | 27 | 149 |
| | Girl | Married | 38 | 34 | 38 | 38 | 19 | 20 | 187 |
| | | Unmarried | 19 | 20 | 19 | 18 | 28 | 27 | 131 |
| Total | | | 130 | 123 | 113 | 148 | 113 | 147 | 774 |

**Table 3.** ASRH services utilization and satisfaction.

| | Base Line(BL) | End Line(EL) | REACH project achievement |
|---|---|---|---|
| ASRH utilization | 58% | 86% | 28% |
| Modern family planning | 1.80% | 34% | 32.20% |
| Satisfaction with ASRH | 67% | 95% | 28% |

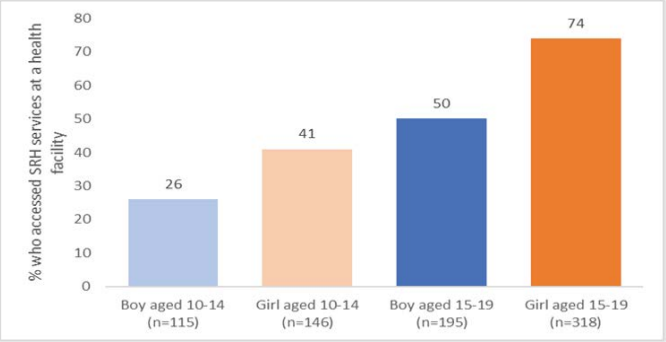


**Figure 1.** Percentage of adolescents reporting that they have accessed sexual and reproductive health information or services at a health facility, by sex and age.

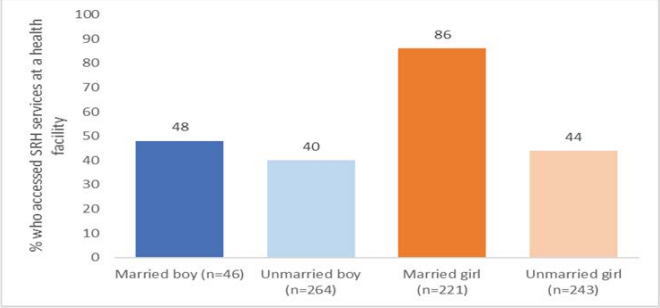


**Figure 2.** Percentage of adolescents reporting that they have accessed sexual and reproductive health information or services at a health facility, by sex and marital status.

## Discussion

The finding of this project shows that, there is an increase in utilization of SRH services by adolescents as compared to base line. Specifically, there was increased in utilization of family planning services with 32.2%. Similarly, the result shows that married girls were more likely than unmarried girls to report using SRH services: 86% and 44% respectively ($\chi^2 p<0.001$). The same was true of boys, but the difference between married and unmarried boys was much smaller: 48% and 40% respectively. The greater use among married girls than among married boys reflects the attitudes described earlier about husbands tending to make the FP decisions and wives tending to put them into practice. These findings are similar to that of Banke-Thomas and Ameh [5,6].

The BL assessment found that 58% of married girls and 47% of married boys said they had received SRH services in a health facility. The equivalent EL figures of 86% and 44% respectively indicate a major increase in married girls' uptake of adolescent SRH services, but no significant change among married boys [7-10].

## Conclusion

Among the 423 adolescents in the household survey who said they had used SRH services, nearly all (96%) expressed satisfaction with these services. On this note, the adolescents reported 28% increase in the utilization of these services. The BL assessment found that 66% of married girls and 70% of married boys were satisfied with the SRH services in health facilities. At EL, 93% of married girls and 98% of married boys were satisfied, indicating significantly increased satisfaction among married service users. This is similar to the finding of Godia, Olenja, and Hofman, but contrary to that of Chandra-Mouli, McCarraher, Phillips, Williamson, Hainsworth.

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**How to cite this article:** Lawali,Yakubu and Adamu Hussaini Rahinatu. "Sexual and Reproductive Health Utilization and Satisfaction among Adolescents in Northern Nigeria: Impact of REACH Project Educational Intervention." *J Child Adolesc Behav* 9 (2021): 429.