Scaling Agency for Gender Empowerment & Strategic Gravidity: A Comprehensive Sexual & Reproductive Health Rights Programme for Ekiti State, Nigeria

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Abstract

Upon the exhaustion of the Millennium Development Goals in 2015, the United Nations established a new set of benchmarks and targets as part of the UN 2030 Agenda for Sustainable Development. Among these 17 Sustainable Development Goals (SDGs), we sought to wed SDG3 (Good Health & Well-Being), SDG4 (Quality Education), SDG5 (Gender Equality), and SDG17 (Partnerships For The Goals) to bilaterally construct a culturally competent sexual health modality to provide increased knowledge sharing and capacity building for at-risk women and girls in Ekiti State, Nigeria. Globally, an estimated 25 million unsafe abortions are performed each year with 97% of procedures attained in either developing or underdeveloped countries. Nigeria currently sustains restrictive laws surrounding abortion care, with limited investments in family planning and reproductive health services. Ergo, Nigeria endures low contraceptive prevalence coupled with analogous gravidity and parity, which are predictively resolved through dangerous clandestine procedures. These illegal abortions routine lead to complications and profoundly contribute to the inclined maternal mortality rate, which is among the highest in the world. Approximately 3,000 Nigerian women and girls undergo and fail to survive unsafe abortions annually, the majority of which are young primigarvidae between the ages of 15 – 24. Foisted against this insight, we designed a comprehensive sexual & reproductive health rights (SRHR) curriculum to be implemented within the Ekiti State of Nigeria. Our portable SRHR education programme is designed for low resource ecosystems with limited infrastructure, is easily scalable with modular programming designed to increase both individual and community awareness concerning sexual and reproductive health rights of women, to secure reproductive health autonomy of women, and to positively influence the plasticity of social norms for female agency in both reproductive health and abortion services. Currently, monitoring and evaluation is underway and will remain a conduit of findings, limitations, and shall inform future community programming needs and efforts.

Key words: sexual health, human rights, gender empowerment, sustainable development

Background

Globally, an estimated 25 million unsafe abortions are performed each year (Ganatra et al., 2015). The vast majority (97%) of these dangerous procedures are attained in developing countries at an alarming statistic of 97% (Ganatra et al., 2015). According to the World Health Organization (WHO), approximately 8% of total maternal mortality can be attributed to precarious abortion care services (Kim, Tuncalp, Ganatra, & Gulmezoglu, 2014). Regions with restrictive policies to abortion services yield a significant increase in the incidence rate of clandestine abortions, with restrictive regions averaging more than four times the number of unsafe abortions performed than areas with less obstructive access (DESA, 2014). The average maternal mortality rate is three times higher in regions with restrictive access to legal abortion services compared to regions with less restrictive access (DESA, 2014). Complications related to unsafe abortions can have devastating and life-threatening consequences and the restrictive nature of Nigeria's abortion laws place women at a greater risk for experiencing disability or death (Prada et al., 2015; Say, et al., 2014).

Nigeria

Nigeria remains the largest economy of Sub Saharan states, which is heavily leveraged alongside a rich hydrocarbon investment portfolio. Though following the 2008 global financial crisis, pecuniary inputs became increasingly diversified through other sectors including telecommunications and technology, agriculture and a flourishing service industry. Yet though the auspicious diversification ensures a robust economy and attractive trade profile, these achievements provided little modification or diminution within the regional insolvency and poverty felt by the mounting majority of the country. Despite all the positive socioeconomic indicators, currently over 111 million Nigerians still live in extreme poverty.

Understanding the long-term implications of a climbing birthrate in a locus to where the majority suffer inaccess to quality education and healthcare, and less favorable economic opportunities for the future, it is imperative to create dialogue of sensible family planning (Olsen, & Pillar, 2013) and to recognize women as the knowledge bearers and sharers, but also to promote an ecosystem to which their own reproductive health rights remain as an intact unalienable human right, but also to cultivate socially normative restructuring (Okonofua, 2009) necessary to include women in the this dialogue, for eventually to achieve complete autonomy of self and complete parity.

Geopolitics

Nigeria is comprised of 36 states and one Federal Capital Territory, which gained its Independence from the United Kingdom in 1960. Geopolitical features amid the official government of the south, and the more volatile standing of the north may also contribute to obstructive and languishing regulatory reproductive health rights reforms and the restrictive abortion perceptions by policymakers (Okonofua, 2009). In the northern sectors of Nigeria, large swaths are under various influence by illegally armed groups such as Ansaru, Boko Haram, and the Islamic State of Iraq and ash-Sham (CIA, 2018). These illegally armed groups unilaterally aspire to disrupt and dismantle the formal government of Nigeria, and install a form of an Islamic state unique to each respective dogma; nonetheless ensuring a form of sharia law and further limiting women's capacity for sexual and reproductive health rights. In these efforts, these armed groups would inversely contract the contemporary developments reducing the inequalities among

genders, and equity traps involving class or religion athwart the region (Bebbington, Dani, Haan, & Walton, 2008). Unfortunately at this time, the Republic of Nigeria does not hold the monopoly on violence, with various armed groups still contest control across the north, and athwart the Niger Delta (CIA, 2018).

Beyond the distressing statistic establishing inaccess to abortion care services (including post care) is surging maternal mortality rates, its moral implication further contracts healthcare providers and workers into a precarious state of either Hippocratically fulfilling the interest of life, health, and welfare of the patient, or to sustain trepidation with current regulatory and administrative bodies and its sharp imposition of severe penal punishments. With contemporary circumstances such as the once similar scenario in Colombia (Prada, Biddlecom, & Singh, 2011), abortion care reform can foist positive maternal outcomes usurping the unwarrantably preventable outcomes currently afflicting young mothers today in Nigeria.

In 2015, at the exhaustion of the Millennium Development Goals (MDGs) the United Nations established a new set of social development benchmarks and targets as part of the UN 2030 Agenda for Sustainable Development. Among these 17 Sustainable Development Goals (SDGs), this program sought to wed SDG3 (Good Health & Well-Being), SDG4 (Quality Education), and SDG5 (Gender Equality), to construct a culturally competent modality to provide knowledge sharing and capacity building for at-risk women and girls in Ekiti State, Nigeria.

Education

The contemporary predecessor hitherto the United Nations 2030 Agenda for Sustainable Development included the backing of the Millennium Development Goal: *Quality Education* (World Bank, 2011), and *Education for All* (UNESCO, 2011) which was positioned to address, delimit, and to create equitable education for all. Seemingly upon demand, the international community has historically shared a profound fecundity to develop shortsighted solutions that did not devise symmetry of either equilibrium of access or attainment.

The United Nations Sustainable Development Agenda of 2030 considered and outlined assorted international social guarantees that all member states agreed, nonetheless the timeworn global avowal: *education is a fundamental human right* – as previously sanctioned in Article 26 of the Universal Declaration of Human Rights (UDHR, 1948). Though enthusiastically reformed by the United Nations General Assembly in 1948, there still remains a perpetual obstruction to universal access of quality education. This fecund interloping interference of education is woefully conserved as an archaic bane of progress that impedes economic development by diminishing the human capital pool and their capacity to conceivably procure and nurture the intellectual capital to both participate meaningfully in the market economy, and to sustain basic human development and good health. Further contracting access are the known obstructions that young women and girls face to subscribe to the same education as their male counterparts (UNESCO, 2013).

Male students within the Nigerian education system complete approximately nine years of pedagogical instruction, compared to the eight years that their female counterparts complete (UNESCO, 2013). Adolescent females are at an elevated risk for dropping out of school due to pregnancy or issues related to menstruation. Currently, only 41% of adult Nigerian females are literate, which befalls the literacy percentile of Nigerian men

by some 20% (total literacy rate for adult Nigerian males 61%) and for women living in analogous regions of Sub-Saharan Africa (59%) (UNESCO, 2013). Not only do women in Nigerian attend fewer years of school, but they also have less representation within the country's labor force (National Population Commission & ICF International, 2014). Findings also suggest that increasing the number of years adolescents attend school (in Sub Saharan Africa) has the prospective to delay sexual debut, first marriage, and first pregnancy for females (Speizer, Guilkey, Calhoun, Corroon, & O'Hara, 2017).

Gravidity & Parity

Nigeria currently endures low contraceptive prevalence coupled with analogous gravidity and parity, which are resolved through dangerous clandestine procedures. These illegal abortions routinely lead to complications and profoundly contribute to the inclined maternal mortality rate (Henshaw, et al., 2008). Globally, Nigerian births account for the highest burden of infants born infected with the human immunodeficiency virus (HIV), stemming a total 220,000 children aged 0 to 14 living with HIV. It is anticipated that only 34% of those living with HIV in Nigeria have knowledge of their HIV status (UNAIDS, 2017b). Together, an estimated 3,100,000 Nigerian adults and children are living with HIV/AIDS (UNAIDS, 2017a). The adult HIV prevalence rate is currently at 2.8% for those aged 15 to 49, and crowning several adjacent countries, requiring timely and sensitive responsiveness. HIV infection remains a shared burden for Nigeria, with corresponding morbidity and mortality contributing negatively to adult productivity and further diminishing the quality of life of those infected, as well as devastating maternal and child health outcomes (Henshaw, et al., 2008), and a high number of infants and children orphaned due to infection (1,800,000) (UNAIDS, 2017a).

Nigeria features a fertility rate of 5.5 children per woman (World Bank Group, 2016). Approximately 9.2 million women and girls become pregnant each year (APHRC, 2017). One quarter of the 9.2 million pregnancies are unintended, and more than half of these unintended pregnancies end in abortion (Bankole et al., 2015). It is estimated that at least 14% of women aged 15-49 and 22% of sexually active unmarried women have unmet needs for family planning services and modern contraceptive methods (Bankole et al., 2015; National Population Commission & ICF International, 2014).

The leading cause of death for young women aged 15-19 in Nigeria has been attributed to pregnancy-related complications. Adolescent mothers are at an elevated risk for experiencing both short-term (Prada, et al., 2015), and lifelong health complications or for premature death, secondary to pregnancy complications and childbirth (APHRC, 2017; Henshaw, et al., 2008). Though the preponderance of covariates leading to maternal mortality in Nigeria is avoidable, clandestinely preformed unsafe abortions remain among the principal causes of death (APHRC, 2017). These arrangements of unsafe abortions historically lead to detrimental socioeconomic consequences as well (Prada, et al., 2015) either through a direct causation / correlation or through a negative externality of the procedure itself.

Sexual & Reproductive Health Rights Programme

At its core, human rights education (HRE) should not only inform individuals of the rights they have as individuals, or of the rights of their fellow citizens, but it should also increase individual agency in acting on said human rights, as well as inspire them to advocate for collective action and ultimately, influence policy change (Okomofua, 2009).

The Comprehensive Sexual and Reproductive Health Rights Programme developed for the Sephamid Bridge Foundation of Abuja, Nigeria builds on prevention education and advocacy principles in order to reach its overarching goals related to sexual and reproductive health rights. Programme officers, school counselors, docents, and community volunteers work together to provide young people and girls the skillset to best enhance their own lives, as well as gather the social capital impetus to create the necessary future policy improvements within their respective region, and to influence policy (. The programme foists the concepts of gender empowerment and women's rights to young men and boys (UNESCO, 2014), encouraging male counterparts to become cognizant and active mouthpieces for women's rights.

The three objectives of the Comprehensive Sexual and Reproductive Health Rights Programme are:

1. Increase individual awareness concerning sexual and reproductive health rights

2. Improve community support for the agency of women in their own sexual and reproductive health

3. Favorably shift local norms regarding female agency in sexual and reproductive health and abortion services

The comprehensive model encompasses lessons on principal causes of unsafe abortions, including current national and regional regulations and laws including infringing normative social standards surrounding contraception and abortion, and gender empowerment. Activities essential to programme success include garnering community support via establishing relationships with key community influencers, securing and training staff and local volunteers, implementing programme curriculum with fidelity, and completing a mixed methods evaluation in order to gauge programme success and inform on the potential for moving the program forward. The main themes of the programme align with the targets of SDG3, SDG4, and SDG5.

Key potential risks associated with this project included a lack of community buy-in, having limited availability of community volunteers, and experiencing a low participation rate for our target population. In order to acquire community buy-in, we utilized existing networks to recruit influential community leaders and partners to support the SRHR project. We expanded our network, and engaged our preexisting networks within the local school and healthcare systems, to recruit a sufficient number of community volunteers. We also expanded our target population pool and offered creative incentives to active participants (Vegas, 2005; INEE, 2009) so to secure a high participation rate throughout our program. Here, The Foundation has established rapport with key influencers within the Ekiti State and has began implementation of the Sexual and Reproductive Health Rights Programme within the local school system. Further preparations for scaling include:

1. Securing additional SRHR Programme developers and community volunteers

2. Fortifying additional relationships and commitments from school counselors and staff,

3. Acquiring necessary physical materials cyclically, and to develop a surplus (where cyclic demands exceeds supply)

4. Informing finalized curriculum with ongoing M&E outcomes

5. Improving recruitment materials and participant incentives.

Methods

The arrangement and administrative structure of the Comprehensive Sexual and Reproductive Health Rights Programme was first informed by evidence-based curricula and then tailored to meet the specific needs of Ekiti State. By espousing various tenants of the Sustainable Development Goals, and by maintaining austerity in program design, practicality and scalability, our hope stood to safeguard a comprehensive SRHR programme that could withstand temporal modification pro re nata whilst conserving the modularity essential for regional or communal changes. An extensive literature review was conducted of peer-reviewed articles in academic journals to first identify and distinguish effective themes in sexual and reproductive health education among Sub-Saharan Africa and along the Sahel. Successful evaluations of evidence-based sexual health and gender empowerment programs in Sub-Saharan Africa, and human rights education programs implemented in developing regions. Following the identification of themes and existing programs, the authors reviewed existing curricula and materials targeting developing regions, specifically those in Sub-Saharan Africa. Representatives from Sephamid Bridge Foundation and community members within the Ekiti State were then consulted to review potential curricula modules, topics, and themes.

Review of curricula and consultation with representatives from the Ekiti State resulted in the selection of an updated and tailored version of the L.iF.E. (Life and Family Education) curriculum, originally developed for Zambia by the authors and alterations to be incorporated within the L.IF.E. curriculum include:

1. Addition of a sexual and reproductive health rights module, which included Nigerian laws

2. Addition of a lesson on abortion, which includes an overview of unsafe procedures

3. Expansion of partner communication and gender empowerment themes

4. Addition of a lesson on advocacy for sexual and reproductive health and human rights

Monitoring & Evaluation

Program outcomes and impacts will be measured through multiphasic mixed-methods analysis & evaluations. These evaluations will interpret the familiarity and acquaintance of variable knowledge sets and acumen by program participants and principal stakeholders as well as quality control indicators developed for program facilitators, docents, and other parties outside the scope of the principal stakeholders. M&E examinations shall further elucidate participant such as familiarity of current regulations and restrictions regarding SRHR, including others, and will measure knowledge gained by each participant through an assortment of pre and post measurements (both qualitative & quantitative) and their weighted variables, respectively. We will serve as external evaluation consultants to oversee Sephamid's evaluators and provide best practices in terms of data oversight, best practices, validity, and reliability. The Asset Procurement Group, another nongovernmental organization based in New York, will

continue to buttress preliminary and future evaluation and impact evaluations. These results will inform future developers and facilitators of potential adaptive modifications that would best improve community outcomes.

Conclusion

The Government of the Federal Republic of Nigeria (2010) committed to the social contract of the Millennium Development Goals (MDGs) and sustained the positive effects across the MDGs through its exhaustion in 2015. During United Nations General Assembly week of 2015, the Federal Republic of Nigeria overtly decreed in concert with other United Nations member states to the stoic commitment of achieving all 17 Sustainable Development Goals (SDGs). The seventeenth SDG, *Partnerships for the Goals*, is among the most imperative to amplify and synergize grassroots momentum and scalability of realizing the SDGs. Here, an international partnership with Asset Procurement Group and the Sephamid Bridge Foundation worked jointly to discover real-time needs congruently with those of the stakeholders to enhance impact and foci amid the emergent disparities found in health, education access and attainment, as well those found within specific human rights' domains.

The Comprehensive Sexual & Reproductive Health Rights Programme was developed by espousing various SDGs, whilst encouraging scalability, sustainability, and agency for young women and girls of Ekiti State, Nigeria. This inclusive, culturally competent programme was fastened to increase both individual and community awareness concerning sexual and reproductive health rights of women, improve community support for the agency of women in their own sexual and reproductive health, and to positively influence the social norms of female support in sexual and reproductive health and abortion services, buttressing Ekiti State in realizing SDG3 (Good Health & Well-Being), SDG4 (Quality Education), and SDG5 (Gender Equality) as well as reinforcing ongoing labors to build and nurture SDG17 (Partnerships for the Goals).

References

African Population and Health Research Center. (2017). Maternal health in Nigeria: facts and figures. Retrieved from: http://aphrc.org/wp-content/uploads/2017 /06/APHRC-2017-fact-sheet-Maternal-Health-in-Nigeria-Facts-and-Figures.pdf

Bankole, A., Adewole, I., Hussain, R., Awolude, O., Singh, S., & Akinyemi, J. (2015). The incidence of abortion in Nigeria. *International Perspectives on Sexual and Reproductive Health, 41*(4):170–181.

Bebbington, A., Dani, A., Haan, A., & Walton, W. (2008). Institutional Pathways of Equity: Addressing Inequality Traps. World Bank Group. Washington, DC.

Berer, M. (2013). Making abortions safe: A matter of good public health policy and practice. *Bulletin of the World Health Organization, 78*(5):580-592.

Central Intelligence Agency. (2018). The World Fact Book. Langley, VA.

Center for Reproductive Rights, Nigeria's abortion provisions, nodate, Retrieved from: http://reproductiverights.org/en/world-abortion-laws/nigeriasabortion-provisions

Cortez, R., Saadat, S., Marinda, E., & Oluwole, O. (2015). Adolescent sexual and reproductive health in Nigeria. Knowledge brief. The World Bank: Washington, D.C.

Ganatra, B., Gerdts, C., Rossieret, C., Johnson, B., Tuncalp, O., Assifi, A.,… Alkerna, L.(2015). Global, regional, and subregional classification of abortions by safety, 2010-2 014: estimates from a Bayesian hierarchical model. *The Lancet, 390*, 2372-2381.

Henshaw, SK et al. (2008). Severity and cost of unsafe abortion complications treated in Nigerian hospitals. *International Family Planning Perspectives, 24*(1); 40-50.

INEE. (2009). INEE Guidance Notes on Teacher Compensation in Fragile States, Situations of Displacement and Post-Crisis Recovery. New York: INEE.

Kim, C., Tuncalp, O., Ganatra, B., & Gulmezoglu, A. (2014). WHO multi-country survey on abortion-related morbidity and mortality in health facilities: a study protocol. *BMJ Global Health, 1*(3*)*.

National Population Commission & ICF International. (2014). Nigeria Demographic and Health Survey 2013, Abuja, Nigeria: National Population Commission; and Rockville, MD, USA: ICF International.

Okonofua, F., et al. (2009). Perceptions of policymakers in Nigeria toward unsafe abortion and maternal mortality. International perspectives on Sexual and Reproductive Health, 35(4); 195-202.

Prada E., Bankole, A., Oladapo, O., Awolude, O., Adewole, I., & Onda, T. (2015). Maternal near-miss due to unsafe abortion and associated short term health and socioeconomic consequences in Nigeria. *African Journal of Reproductive Health 19*(2):52–62.

Prada, E., Biddlecom, A., & Singh, S. (2011). Induced abortion in Colombia: New estimates and change between 1989 and 2008. International Perspectives on Sexual and Reproductive health, 37(3); 114-124.

Say, L., Chou D., Gemmill, A., Tuncalp, O., Moller, A., … Alkema, L.(2014). Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health, 2*(6).

Speizer, I., Guilkey, D., Calhoun, L., Corroon, M., & O'Hara, R. (2017). Examination of youth sexual and reproductive health transitions in Nigeria and Kenya using longitudinal data. *BMC Health*, 17:142

UN Children's Fund (UNICEF). (2007). It's Time to Listen to Us (Facilitators Guide for Focus Groups). Youth Response to the Expert Group Meeting on the Elimination of all Forms of Discrimination and Violence against the Girl Child. New York: UNICEF.

UN Children's Fund (UNICEF). (2002). Evaluation Technical Notes: Children Participating in Research, Monitoring and valuation: Your Responsibilities: Ethics and your Responsibilities as a Manager. New York: UNICEF.

UN Joint Programme on HIV/AIDS (UNAIDS) (2010) UNAIDS Report on the Global AIDS Epidemic.

UN Joint Programme on HIV/AIDS (UNAIDS) (2017a). Country facts sheets: Nigeria. UNAIDS: Geneva, Switzerland.

UN Joint Programme on HIV/AIDS (UNAIDS) (2017b). UNAIDS data 2017. UNAIDS: Geneva, Switzerland.

UN Educational, Scientific and Cultural Organization (UNESCO) (2004). Role of Men and Boys in Promoting Gender Equality – Advocacy Brief. Paris: UNESCO.

UN Educational, Scientific and Cultural Organization (UNESCO). (2013). Adult and youth literacy. National, regional and global trends, 1985- 2015. Retrieved from: http://unesdoc.unesco.org/images/0021/00217 4/217409e.pdf

UN Department of Economic and Social Affairs (DESA). (2014). Abortion policies and reproductive health around the world. Retrieved from: http://www.un.org /en/developmen/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf

Vegas, E. (2005). Incentive to Improve Teaching: Lessons from Latin America. World Bank Group. Washington, DC.

World Bank Group. (2016). Fertility rate, total (births per woman). Nigeria. Retrieved from: https://data.worldbank.org/indicator/S.DYN.TFRT.IN?end=2016&locations=NG&start=2016&view=map