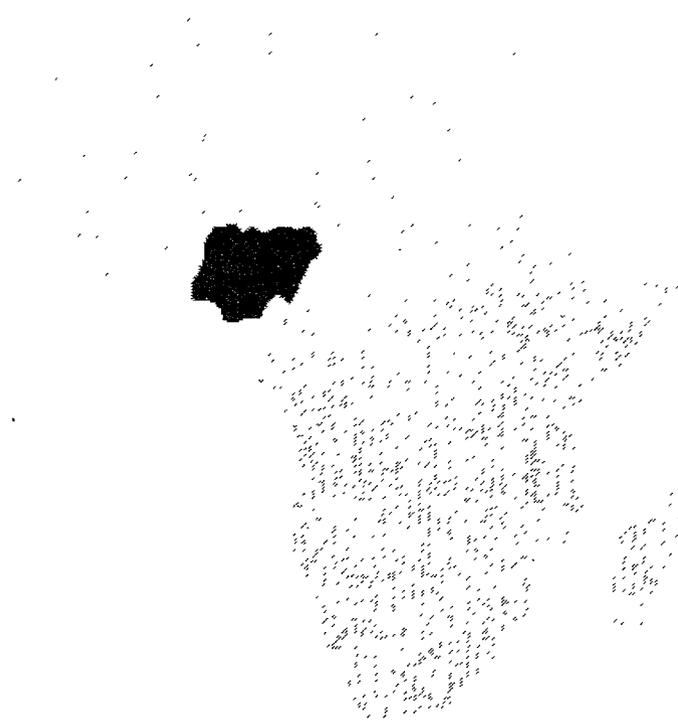


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YOUTH AND REPRODUCTIVE HEALTH IN AFRICA



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Assessment of Adolescent Reproductive Health in Nigeria

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The Centre for Development and Population Activities
with the support of the United Nations Population Fund (UNFPA) Africa Division
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PCAAA-855

**THE CENTRE FOR DEVELOPMENT AND
POPULATION ACTIVITIES
(CEDPA)**

**UNITED NATIONS POPULATION FUND
(UNFPA)**

**ASSESSMENT OF ADOLESCENT REPRODUCTIVE
HEALTH IN NIGERIA**

By

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January 1997

CONTENTS

EXECUTIVE SUMMARY	i
1. INTRODUCTION	
1.1 Methodology	4
2. NIGERIA: COUNTRY PROFILE	
2.1 Geography	6
2.2 History	6
2.3 Economy	7
2.4 Population	10
2.5 Population Policy and Family Planning Programs	14
3. ADOLESCENT SOCIO-ECONOMIC AND CULTURAL CONDITIONS	
3.1 Size of Adolescent Population	16
3.2 Educational Attainment	16
3.3 Marriage	21
3.4 Economic Activity	23
3.5 Religion	25
3.6 National Policy on Adolescent Health and Welfare	26
3.7 Abortion Laws	27
3.8 Access to Family Planning	29
3.9 New Initiatives: Policy for Adolescent Health and Welfare	30
4. ADOLESCENT REPRODUCTIVE BEHAVIOR	
4.1 Sexual Activity of Adolescents	32
4.2 Teenage Pregnancy and Fertility	35
4.3 Trends in Adolescent Childbearing	38
4.4 Knowledge and Use of Contraception	38
4.5 Sources of Information on Sexuality	41
4.6 Adolescent/Adult Relationships	44

5.	IMPLICATIONS OF ADOLESCENT SEXUALITY	
5.1	Age at Menarche	46
5.2	Early Childbearing	46
5.3	Incidence of Abortion	48
5.4	Sexually Transmitted Diseases, HIV/AIDS.....	52
6.	PROFILES OF YOUTH-FOCUSED NGOS	
6.1	Services Provided	57
6.11	General Health Care Services	58
6.12	Multi-Service Centres.....	58
6.13	Community Outreach Services.....	59
6.14	Information, Education and Communication (IEC) Services.....	59
6.15	Abortions.....	61
6.16	Safe Pregnancy and School Re-Entry Support	61
6.17	Functional Literacy and Vocational Training	62
6.18	Citizenship and Leadership Training.....	62
6.19	Advocacy.....	62
6.2	Service Providers' Perceptions of Adolescent Needs.....	62
7.	DISCUSSION	64
8.	RECOMMENDATIONS	67
	REFERENCES	69

APPENDICES

Appendix I:	Proposed Policy on Adolescent Health in Nigeria	74
Appendix II:	Organizations Visited and Persons Interviewed	81
Appendix III:	Members of Nigerian Association for the Promotion of Adolescent Health	84
Appendix IV:	Communique: Adolescent Health Education Workshop for Youth-Focused NGOs	90
Appendix V:	Focus Group Guide	93
Appendix VI:	The NGO Questionnaire	94

Appendix VII:	The Nigerian Association for the Promotion of Adolescent Health and Development	96
Appendix VII:	History of Census-Taking in Nigeria	99

LIST OF TABLES

Table 1.	Nigeria: Demographic Indicators.....	13
Table 2.	Enrolment in Primary and Secondary Schools (Selected Years, 1960—1990).....	17
Table 3.	Adolescents: Educational Level.....	18
Table 4.	Percentage of Sexually Experienced Youth and Adults With Two or More Sexual Partners.....	34
Table 5.	Teenage Pregnancy and Motherhood.....	36
Table 6.	Percentage Change in Adolescent Fertility Rates (15-19, 20-24) For 0-3 and 4-7 Years Before DHS, Nigeria 1990.....	37
Table 7.	Understanding of Contraceptives.....	39
Table 8.	Monthly Incidence of Abortion in 10 States (1984).....	48
Table 9.	Characteristics of Women with Complications Following Abortion....	51
Table 10.	Distribution of STD Cases at the Special Clinic, UCH, 1988-89.....	54

Executive Summary

In Nigeria, rates of adolescent fertility are high, and although the incidence of abortion and sexually transmitted diseases (including HIV/AIDS) is unknown, evidence on the morbidity and mortality associated with STDs and abortion indicate that they constitute a serious public health problem. Adolescents, particularly those in urban centers, express a high level of knowledge of modern methods of contraception and awareness of the causes of common STDs. Yet urban adolescents continue to record high rates of illegally induced abortion, and demonstrate little regard for their own reproductive health. This pattern indicates that the factors behind adolescent sexual behavior, and their use of reproductive health services, are still poorly understood. Hence the need for a country assessment to solve this riddle and to find ways of both safeguarding and improving the health and general welfare of adolescents.

Information for this assessment was obtained from secondary sources and new information gathered through Focus Group Discussions (FGDs) with adolescents, and through structured interviews with officials from key government ministries and non-governmental organizations (NGOs) dealing with youth. This report describes:

- The socio-economic conditions of adolescents;
- The policies that influence their welfare;
- Various aspects of adolescent reproductive behavior and their implications;
- Activities of various youth-focused NGOs and their effects.

The adolescent population is growing quickly, and today accounts for about 20 percent of the total Nigerian population. While teenagers in general are better educated than the adult population, the male educational advantage over the female persists. Marriage is virtually universal, and the median age at marriage is low (about 17 years), although there are significant regional variations. In recent years, economic depression and resulting cutbacks in government

social spending have greatly reduced employment and training opportunities for teenagers. Youth-oriented programs proposed in the National Population Policy have remained largely unimplemented. Restrictive abortion laws are detrimental to the health of adolescents, and must be addressed as part of new efforts to fashion a more comprehensive policy on adolescent health and welfare.

Adolescents are becoming mature at earlier ages (age at menarche is declining), while modernization has weakened the traditional social constraints which once guarded and guided young people. A growing proportion of adolescents not only initiate sexual intercourse at early ages, but also engage multiple sexual partners. Despite their knowledge of modern contraceptive methods, only an insignificant proportion use them. Hence a high incidence of illegally induced abortions, which are the preferred solutions to unwanted pregnancies. A 1994 estimate puts the yearly number of abortions in the country at 700,000, compared to an estimated 500,000 in 1980. Most cases are unmarried secondary-school girls. Restrictions on abortion force women to rely on illegal abortions; and as most young people are poor, they often use unqualified abortionists, with frequent severe health consequences which include sterility and death.

A significant proportion of teenage pregnancy occurs in marriage. Young mothers who are themselves still growing usually require specialized care. Yet most teenage mothers do not receive antenatal treatment. In 1990, over two fifths (43.2 percent) of mothers under 20 did not receive antenatal care, increasing risk of morbidity and mortality among both mothers and children. Of 96 maternal deaths reported in Kaduna (1976-1977), 56 percent of the women who died were not booked in a hospital. Babies born to teenage mothers run a 44 percent greater risk than average of dying. This pattern of pregnancy and childbearing not only impairs the health of the child-mothers but also has serious economic and demographic effects.

Data on sexually transmitted diseases (STDs) are very scanty. However, knowledge of STDs, including AIDS, is very widespread among the adolescent population.

There are several youth-focused NGOs, and these are being organized to forge stronger links under the aegis of the newly inaugurated Nigerian Association for the Promotion of Adolescent Health and Development (NAPAHD). Most youth programs are devoted to dissemination of information, education, and communications (IEC) materials, training of volunteer peer educators, and youth outreach. Only a few organize comprehensive services which include family planning services and vocational training. Many of the NGOs are new, and require both financial and technical support from established youth-focused NGOs and donor agencies.

RECOMMENDATIONS

1. Efforts made in this study to describe and assess activities that target adolescents should be regarded only as first step. A detailed evaluation of youth-serving NGOs should be undertaken to determine whether their services are beneficial to adolescent reproductive health.
2. At least four youth centres should be created in each of the four health zones, to address regional and ethnic variations in adolescent socio-economic conditions, and their reproductive response. The centres should be launched by supporting and strengthening the most promising existing NGO in each zone.
3. To bolster the efficiency of individuals and newer youth-focused NGOs, we recommend increased efforts to create a network of youth-serving organizations, so that new NGOs, individuals, and established groups can learn from and train each other, increasing their knowledge, capability, and impact on adolescent sexual behavior.
4. In addition to creation of four (4) zonal centres, evaluation of successful youth-focused organizations whose programs and methods should be expanded and replicated elsewhere.
5. Programs need to move beyond IEC materials and peer counseling. They need to include

better-structured family life education, and to provide family planning services, to encourage adolescents to delay sexual activity, protect themselves against unwanted pregnancies, and safeguard their reproductive health.

6. Because of the widespread distrust of adults in general, and parents in particular, as sources of information on reproductive health, parents need to receive training to help them guide their children through adolescence.
7. Continuing efforts by representatives of NGOs and of the Ministries of Education, Information and Health, who drafted the Youth Policy, and by the Committee on Adolescent Health and Committee Against Unwanted Pregnancy of the Nigeria Medical Association, should be intensified to ensure liberalization of existing abortion laws.

1. INTRODUCTION

"Well... we all know that African elders are a bit hypocritical; they were not ready to face the problem we face now when they were growing up as adolescents; [they look on us] as if we are a bunch of ignoramuses. I think the worst thing [about being an adolescent] is lack of understanding by the elders. This is the time when everything seems so confused; we youth have adult body and not an adult mind, but now elders don't seem to want to appreciate this fact. It would be a bit better if they can see things from the youths' perspective." (Male Adolescent, Lagos, August, 27, 1995)

Adolescence is the period of transition during which girls become women and boys become men. It is an important time for developing life-long behaviors which may be good and positive depending on the influences to which adolescents are exposed. As the introductory quote adolescence can be difficult and confusing to young people, who face a lot of challenges particularly those arising from coping with their sexuality and safeguarding their reproductive health. Thus it is urgent to address adolescent issues generally, and to design special services to avoid likely pitfalls, particularly sexually transmitted diseases (STDs), including HIV/AIDS, and unwanted pregnancies that may lead to illegally induced abortions which can change or destroy lives.

There is no universal definition of adolescence. Biologically, it is defined as the

period of progressive transition between childhood and adult life which begins, among females, with the onset of menstruation. Socially, however, adolescence is the period between the onset of menstruation and marriage. Defined thus, the adolescent period may be short if marriage follows soon after menarche; or long, if for reasons such as education or apprenticeship, a long period elapses before marriage. In this assessment, in keeping with the proposed "Policy on Adolescent Health in Nigeria" (see Appendix I) adolescents are defined as persons within the age group 10 and 24 years. An age definition helpful for precisely determining the size of adolescent populations for intervention programs. This definition notwithstanding, in this report, the term "adolescents" is used interchangeably with "teenagers" and "youth."

In Nigeria, interest in adolescent pregnancy, sexual behavior and reproductive health is keen. Concerns include perceived levels of teenage pregnancy, incidence of illegally induced abortion and the economic and social repercussions of early childbearing. A high level of adolescent fertility, coupled with the large size of the adolescent population (about one third of the country's total population are adolescents aged 10-24 years) result in yearly additions of thousands of infants to total population. The demographic impact of this large number of adolescents in a country with a tradition of early marriage is tremendous.

As every national survey has revealed¹, early marriages are common, although the National Policy on Population seeks to raise the minimum age for entry into marriage to 18 years for girls and to 25 years for boys. Pregnant

A high level of adolescent fertility, coupled with the large size of the adolescent population (about one third of the country's total population), result in yearly additions of thousands of infants to the total population. The demographic impact of this large number of adolescents, in a country with a tradition of early marriage, is tremendous.

women under 18 face an elevated risk of morbidity and mortality as do their children (Harrison et al, 1988; Harrison, 1990; NDHS, 1990; Fakeye, 1992; Ojanuga, 1992; Njokanma et al, 1994). Among the problems are retardation of foetal growth, labour complications, low birth weight and anaemia (Liskin et al, 1985; Harrison et al, 1988; Harrison, 1990; Fakeye, 1992). Research conducted by Harrison and his colleagues in Ahmadu Bello Teaching Hospital, Zaria, shows that pregnancy in a girl child who is still growing means increased nutritional requirements for the growth of the foetus and the mother herself (Harrison, 1990). Other very important consequences of early marriages and unprotected adolescent sexual

behavior include complications in labour which can result in infant and maternal morbidity and mortality; illegally induced abortions with adverse consequences; and the risk of STDs,

including HIV/AIDS.

¹Two important national surveys which are utilized in this study are the 1981/82 National Fertility Survey (NFS) which is a component of the World Fertility Survey, and the 1990 Nigeria Demographic and Health Survey (NDHS).

Throughout the country, rapid urbanization and modernization factors, such as increased female education and increased employment opportunities for women, are changing many traditional values and social practices, including traditional premarital sexual behavior.² As I have written elsewhere, traditional, pre-literate Nigerian society did not allow unchaperoned socializing among boys and girls in their early teens. There were strict codes of behavior, and penalties prescribed for transgressors. Indeed, the traditional custodians of cultural values (village heads, elders, parents and elderly relatives) went to great lengths to ensure parallel developments of teenagers. It was usual for boys and girls to be educated in separate institutions supervised by teachers of the appropriate sex.

Traditionally, girls who were found to be virgins on their wedding nights were rewarded, while non-virgins were heavily punished for this sin against society. For example, among the Yoruba:

²This section draws from the author's previous publication (Makinwa-Adebusoye, 1991).

"A bride who is found unchaste is ...sometimes severely punished, to the extent of having her tied and severely flogged, thus compelling her to name her violator so as to have him severely fined. No ornaments are allowed her and she may be ordered to perform errands out of doors unveiled the next day, or she may be sent out with a pitcher for water! Otherwise, a bride is never seen out of doors for 12 months at least after her marriage, except closely veiled, and with attendants." (Johnson, 1921: 115).

Similar traditions were observed among Nigeria's ethnic groups. However, in recent years, attitudes have changed regarding the importance of virginity, the timing of marriage, the selection of a marriage partner, and pre-marital sexual relationships (Feyisetan and Pebley, 1989; Makinwa-Adebusoye, 1991).

Extensive research has shown that a large proportion of women with unwanted pregnancies choose to end them with abortion (Makinwa, 1981; Nichols et al, 1986; Odejide, 1986; Nnatu, 1988; Unuigbo et al, 1988, 1990; Makinwa-Adebusoye, 1991; Emuveyan, 1994). Because teenage pregnancy outside wedlock is culturally unacceptable, and existing abortion laws are

highly restrictive, many teenagers resort to illegal procedures, often by untrained persons, endangering their health and their prospects of future pregnancy (Odejide, 1986; Unuigbo et al, 1988, 1990; Makinwa-Adebusoye, 1991; Archibong, 1991; Adekunle and Ladipo, 1992).

The aim of this report is to provide an assessment of the reproductive behavior and the socioeconomic condition of adolescents in Nigeria. Specific objectives are: (I) to identify issues pertinent to the sexuality and fertility of adolescents as well as their socio-economic conditions, (ii) to identify groups and organizations potentially or actively serving youth in various capacities, and assess the impact of their programs and their financial and management needs.

1.1 Methodology

This report makes use of secondary data from the literature on adolescent reproductive health in Nigeria, and from two national surveys: the 1981/82 NFS and the 1990 NDHS. These are supplemented with primary data from two sources: (1) focus group discussions (FGDs) with the key

stakeholders, female and male adolescents, and (2) structured interview with youth-focused non-governmental organizations (NGOs). A series of single-sex FGDs were held with in-school³, out-of-school, and mixed (in- and out-of-school) took place in ten states drawn from each of the country's four health zones. NGOs working to improve youth welfare and reproductive health were identified from published and unpublished directories, from information supplied by knowledgeable officials in the country offices of the U.S. Agency for International Development (USAID) and the United Nations Fund for Population Affairs (UNFPA), the Centre for Development and Population Activities (CEDPA) resident advisor in Nigeria, and interviews with representatives of international organizations and of some key youth-focused NGOs. In addition, questionnaires were administered to officials of participating NGOs at a workshop on in-school family life education, held in September, 1995³. The list of NGO's visited and those who were interviewed is attached as Appendix II.

³ The workshop was attended by about 20 youth-oriented NGOs and government agencies in Ogere from September 27 to 30, 1995.

A team of three researchers (occasionally assisted by an interested official of an NGO included in the study) randomly selected participants. The focus topics included sexuality/sex education; age at initiation of sexual intercourse; perceptions of youth on the causes and dangers of early childbearing; knowledge, attitudes and use of family planning; knowledge, attitudes and use of induced abortion; knowledge and attitudes regarding STDs including HIV/AIDS; whom to trust for counseling on personal matters (menstruation, dating, contraception and, sexually transmitted diseases; and RECOMMENDATIONS from youth for a youth-focussed program.

The structured questionnaire for service providers and staff of youth-focused NGOs addressed the following issues: particulars of the NGO—name, contact

person, address, objective(s)—its activities and categories of youth served (in- or out-of-school); types of activities such as family planning and youth counseling; NGO's affiliation with a nearby health facility for referral service. Furthermore, respondents in each category of respondents were asked for their opinion about the best person to provide health/family planning counseling, and about the ideal location in the community for a youth reproductive health facility. Other information sought included opinion on whether or not the clientele and their parents, as well as the community, would be supportive of the NGO's provision of reproductive health services and other youth programs.

The FGD guide and the NGOs' questionnaire are attached to this assessment as Appendices V and VI, respectively.

2. NIGERIA: COUNTRY PROFILE

1.1 Geography

The Federal Republic of Nigeria, one of the largest countries in Africa, covers an area of 923,768 square kilometers extending from the Gulf of Guinea in the south to the edge of the Sahara Desert in the north. It shares its northern border with the Republic of Niger, its eastern border with Chad and the Republic of Cameroon; and it is bounded on the west by the Republic of Benin. It has an estimated population of 96 million persons (National Population Commission, 1995), making Nigeria the most populous country in Africa⁴.

The country has two major climatic belts resulting from the influence of two main wind systems. The cool, moist South-West Monsoon winds bring rain from April till about October, while the dry North East Trade Winds (the Harmattan) are responsible for the hot and dry season which is felt mainly between the months of December and February. The two major vegetation belts

which arise from these wind systems run parallel to each other from east to west, are the coastal rain forest belt, and the interior Savanna grasslands, which become drier and less grassy at the northern fringes bordering the Sahara Desert. The humid south produces export crops including coffee, cocoa and timber, while the drier grasslands favor the growth of cotton, groundnuts and cow hides and skins.

2.2 History

While the history of various ethnic groups who inhabited kingdoms and emirates predates the advent of colonization, the geographical entity known as Nigeria came into being in 1914, under British rule. In 1946, the country was partitioned into three semi-autonomous administrative regions: Northern, Eastern and Western. By the early 1950s, each region was governed by an elected legislative body and an executive council in which the majority of members were Nigerians. At independence on October 1, 1960, Nigeria was a federation of these three regions under a parliamentary system

⁴The population estimated by the United Nations is higher (108.4 million in 1994).

of government.

The Western Region was subsequently partitioned to create a fourth region named the Mid-West, and on October 1, 1963, Nigeria became a Republic⁵. The first attempt at parliamentary democratic rule was abruptly terminated through a *coup d'etat* by soldiers who leveled various allegations of incompetence against the civilian regime.⁶ In 1967, under the guise of promoting even economic development of all the country's component parts, the military government partitioned the existing four regions into 12 states. Nevertheless, a secession bid by the former Eastern Region (which declared itself the Republic of Biafra) on May 30, 1967, led to a civil war from 1967 until January 12, 1970. In 1976, seven additional states were created. The military held the reins of power until 1979 when a civilian government was elected under a new constitution patterned after the American presidential system. The Second Republic

⁵Once a Republic, Nigeria ceased to owe allegiance to the British Crown, even though it retained its membership in the Commonwealth.

⁶In contrast to military rule, the periods of civilian, democratic rule are referred to, in Nigerian history, as "republics." Thus, the period from independence day, October 1, 1960 until the *coup d'etat* of January 15, 1966 is known as the First Republic.

lasted barely four years before its termination in December, 1983 through another *coup d'etat*. In 1988, the creation of two new states increased the number of the constituent states in Nigeria to 21. Nine new states were created in 1991, bringing the total number to 30 plus Abuja, the Federal Capital Territory⁷. Today, Nigeria is only a nominal federation being governed as a unitary state under a Supreme Military Council.

2.3 Economy

The Nigerian economy during the colonial period (1914-1960) was based on revenue derived mainly from agricultural exports and proceeds from mining. Small-holder peasant farmers were responsible for the production of cocoa, coffee, rubber and timber in the Western Region; palm produce (palm oil and kernels) in the Eastern Region; and cotton, groundnut, hides and skins in the Northern Region. The major minerals were tin and columbite from the central plateau in

⁷Seemingly intractable environmental problems, notably shortage of housing stock, proliferation of slums and the perennial traffic jam in the former capital, the port city of Lagos, resulted in the relocation of the capital to Abuja in December, 1992.

the vicinity of the city of Jos; and coal from the Eastern Highlands around the city of Enugu. Although revenue from the export of agricultural and mining products financed investments in Nigerian infrastructure, the products mainly provided cheap raw material for industries in more developed countries.

In the decade after independence (1960-1970), Nigeria pursued a deliberate policy of import-substitution industrialization, which led to the establishment of many light industries such as food processing, textiles and fabrication of metal and plastic wares (Elegalam, 1985). These were financed by agricultural exports and export taxes, funneled through government-owned regional marketing boards.⁸ During this period Gross National Product grew at the rate of about 3.2 per cent per annum (Okigbo, 1985). This urban-oriented development strategy, however, exacerbated rural-urban migration.

⁸Marketing Boards were government-owned monopolies for the sale of the agricultural commodities produced in each region. These marketing boards have been criticized for making excessive profits at the cost of peasant farmers, who became discouraged, and reduced production. At present, Nigeria, the world's leading producer of palm oil, in the 1960s, now imports oil for home consumption.

The decade 1971 to 1981 was one of unparalleled economic prosperity in Nigeria due to a dramatic increase in oil-related earnings. In the five-year period between 1969 and 1974, oil production increased to a level of 2.5 million barrels a day while the price of crude oil rose to \$11.7 per barrel. By 1980, the price of petroleum reached an unprecedented \$40 per barrel, and revenue rose from 4.733 billion Naira to 9.825 billion Naira in 1980.

As a result of increased oil revenue, the national Gross Domestic Product rose from 3.9 billion in 1970 to 36.1 billion in 1980, growing at an average rate of about 9 percent per annum (Okigbo, 1985). These increases were also reflected in various Development Plans;⁹ increased revenue encouraged government-funded investments in all sectors of the economy. The budget expenditure for the Second National Development Plan (1970-1974) was 3.192 billion Naira, which increased, in the Third National Development Plan (1975-1980), to 30 billion Naira. The aborted Fourth

⁹From about 1962 until 1989, when long term plans were introduced, the Nigerian economy was guided by a series of five-year Development Plans.

National Development Plan (1981-85), was projected at 82.5 billion Naira. The main thrust of the Development Plans was rapid industrialization, which required large investments in vehicle assembly plants, oil refining and petrochemicals. This led to great expansion in the production and import of consumer goods, and increases in commerce and banking. There was also a rapid increase in the number of educational institutions at all levels—primary, secondary and tertiary. Comparable investments took place, as well, in large-scale irrigation schemes, transportation networks, housing, water supply and other urban infrastructural facilities. The construction of the New Federal Capital, Abuja, in the geographical centre of the country was also begun.

The oil glut in the early 1980s led to a drastic reduction in the volume of oil production: from 2.054 million barrels per day in 1980 to 1.294 million barrels per day in 1982. There was a corresponding drop in

oil revenue; from 9.825 billion Naira in 1980 to 5.161 billion Naira in 1982. Besides the fall in revenue, the administration had exhausted accumulated reserves and incurred

Recent provisional estimates indicate that over 45 percent of the population can be classified as existing below the poverty line...It is becoming increasingly difficult for parents, who must now pay exorbitant prices for school books, uniforms and school levies to keep adolescent children in school. Primary school enrolment, which was close to 100 percent in 1980, is now below 70 percent.

huge external and internal debts. As a result, a sizeable proportion of earnings (about 50 percent in 1985) was spent on debt servicing. As a result of the downward trend in the economy,

the GDP per capita has maintained a negative annual growth rate of -0.4 between 1980 and 1992, with an annual inflation rate of 19.2 percent (Alan Guttmacher Institute, 1995). GDP per capita in 1992 was \$US 320, less than a third of GDP in the early 1980s.

The worsening economic situation led to the introduction, in 1986, of the Structural Adjustment Program (SAP). This program, one of a number of measures taken to nourish economic recovery, advocates overall cuts in government expenditure on social services, including health and

education. Consequently, many workers have been laid off in the public and private sectors as part of government's efforts to cut costs. Meanwhile, galloping inflation has drastically reduced real incomes, while unemployment has grown rapidly and is still rising. Moreover, past neglect of the agricultural sector, and concentration on urban development and industrialization, increased the pace of rural-urban migrations. Job shortages and rising inflation are also responsible for a new and pernicious type of migration, the "brain drain." Thousands of highly trained professionals have left the country to seek employment elsewhere (Mbanefoh, 1993).

Recent provisional estimates indicate that over 45 percent of the population can be classified as existing below the poverty line, while about 60 percent of this group can be classified as belonging to the "core" poor (Okunmadewa, 1995). The incidence of poverty is directly related to the drastic declines in per capita income. Overall, per capita income has declined from over \$1,000 in 1980 to \$320 in 1992, and below \$200 in 1994. The average inflation rate which was about 7 percent per annum in 1990 rose to

45 percent in 1992 and is now over 60 percent today (Okunmadewa, 1995).

Increasing poverty in the overall population has greatly affected Nigeria's youth. It is becoming increasingly difficult for parents, who must now pay exorbitant prices for school books, uniforms and school levies to keep adolescent children in school. Primary school enrolment, which was close to 100 percent in 1980, is now below 70 percent (World Bank, 1993). Moreover, adolescent school leavers can no longer, as in the past, readily find employment in urban areas. Therefore, to assist their parents and sustain themselves, an increasing number of adolescents work for others, or are self employed in the urban, informal sector—mainly as street traders, exposed to the "street culture" and its attendant behavior, which includes early initiation to sexual intercourse.

2.4 Population

Assessment of past demographic levels and trends in Nigeria is made difficult by the inaccuracy and incompleteness of previous censuses. Although the first attempt

at census-taking dates as far back as 1866, subsequent attempts (ending with the 1973 census) to conduct a national census have not been successful. At present, only the provisional figures are available from the latest census, which was conducted in 1991. Vital registration data are also generally lacking. Similarly, while the first vital registration center was established in Lagos, in 1863, vital registration remains limited to several large cities and a few rural areas.

Despite uncertainties surrounding population figures, there is no doubt that Nigeria's population has been growing very fast. This is evident in findings from three national sample surveys which were conducted between 1980 and 1990, namely; the 1980 National Demographic Sample Survey (NDSS), the 1981/82 NFS and the 1990 NDHS. Evidence from the three surveys reveal that the population has been growing rapidly because of high fertility levels over many years, during which mortality rates (still high by world standards) have been on the decline.

The combination of high fertility and declining mortality levels is responsible for

the high annual rate of growth, about 3 per cent per annum. Furthermore, Nigeria has a youthful population. About 47 percent of the total population are aged below 15 years. The result is a dependency ratio of 1, which places a heavy dependency responsibility on adults.¹⁰

The level of infant mortality has declined markedly in response to improved standard of living and public health campaigns, such as the Expanded Programme on Immunization (EPI), which provides inoculations against common childhood diseases like diphtheria, whooping cough, tetanus and polio. In consequence, the crude death rate has declined from about 27 deaths per 1000 persons in the 1960s to 13-16 deaths per 1000 persons at present (Federal Republic of Nigeria, 1988).

Although still predominantly rural, the Nigerian population has become more urbanized. The population in urban centers

¹⁰A dependency ratio is the ratio of the number of persons age 0 to 14 and 65 and over divided by the number of persons age 15 to 64. A dependency ratio of 1 means that, in Nigeria, one adult worker is responsible for one dependent, as compared with the situation in developed countries where dependency ratios are closer to .5, implying that two adults are responsible for one dependent person.

(of 20,000 or more population) increased from about 23 percent in the early 1980s to about 39 percent at present (Table 1). There exists wide variations in proportion urban across the 30 states, ranging from less than 1 percent in predominantly rural Kebbi state, to more than 80 percent in Lagos state.

The southwest region has the highest urban population (nearly 40 percent), and it includes the Lagos metropolitan area, which alone contains more than one quarter of the country's total urban population.

Nigeria ranks as the third most densely populated country in Africa (after Mauritius and Rwanda). Its average population density (87 persons per square kilometer in 1994) is five times that of Africa's 17 persons per square kilometer. Within the country, there are three major zones of high population density: 1) in the southeast covering the four predominantly Igbo-speaking states (Abia, Anambra, Enugu and Imo states) and the coastal areas of Cross River and Akwa Ibom states including Port Harcourt, the country's second largest port; 2) in the highly urbanized

southwestern region, including the coastal areas around Lagos, the country's premier port and most populous city; 3) in north-central Nigeria and centered around the cities of Kano and Kaduna. Separating the northern and southern zones of high density are vast areas of sparse population (where the population density is below average). These areas, known as the Middle Belt, cover most of Benue, Kogi, Kwara, Niger and Plateau states.

Nigeria is a country of great cultural diversity, home to over 250 ethnic groups, each with its own distinct language and way of life. Of the country's total population of about 88.5 million people, the eight largest ethnic groups (Igbo, Yoruba, Hausa, Fulani, Kanuri, Ibibio, Tiv and Ijaw) account for nearly 70 percent. The three largest ethnic groups (Igbo, Yoruba and Hausa) account for about 50 percent of the total population. Although internal migration has spread members of different ethnic groups throughout the country, there exist well-defined, homogeneous ethnic enclaves.

Table 1. Nigeria: Demographic Indicators

<i>Indicator</i>	<i>NFS 1981/82 and NDSS 1980</i>	<i>United Nations 1994</i>
<i>Population (millions)</i>	84.7	108.4
<i>Population growth rate per annum</i>	3	3
<i>Percent urban</i>	23	39 ^a
<i>Crude birth rate per 1,000</i>	46	45
<i>Crude death rate per 1,000</i>	16	15
<i>Total fertility rate</i>	6.3	6.0 ^b
<i>Infant mortality rate</i>	85	81 ^a
<i>Life expectancy at birth</i>	48	50

Sources: NDHS, 1990^b; United Nations, 1994; Alan Guttmacher Institute, 1995^a

The Igbo, the largest ethnic group, predominate in Abia, Anambra, Delta, Enugu, and Imo states, which together constitute one of the most densely populated regions of the country. The Yoruba, another of the three most populous ethnic groups, live mainly in cities, and are the predominant group in the densely populated and highly urbanized southwest (made up of Ogun, Ondo, Oshun, Oyo, Kwara and Lagos states). As a result of extensive intermarriage, areas inhabited by the Hausa and Fulani ethnic groups are hardly separable and consist of Bauchi, Kaduna, Katsina, Kebbi and Sokoto states. Other large groups include the Kanuri, concentrated in Borno and Yobe states; the Tiv, who mainly inhabit Benue and Plateau states; the Ibibio, who

predominate in Cross River and Akwa Ibom states; the Ijaw, the major group in Rivers state, and the Edo in Edo state.¹¹

According to the 1980 National Demographic Sample Survey (NDSS), almost half of the population (48.5 percent) is Christian, 40.5 percent are Moslem, 9.5 percent adhere to traditional religions, and 1 percent claim no religious affiliation. Because of the strong correlation between religious affiliation and the various demographic indicators discussed in this

¹¹Considerations of the intense rivalry between the major ethnic and religious groups for the political domination of the country led to the non-inclusion of questions on ethnic origin and religious affiliation in the 1991 census. The 1980 National Demographic Sample Survey remains the best available relative distribution of the ethnic and religious groupings.

study, it is worthwhile to note that the Hausa and Fulani in the northwest and the Kanuri in the northeast are predominantly Moslem; while in the southeast, the Igbo are predominantly Christian (the majority profess the Roman Catholic faith). Other ethnic groups in the southeast mainly belong to a variety of Christian denominations. The Yoruba of southwestern Nigeria are almost evenly divided among Christians and Moslems.

2.5 Population Policy and Family Planning Programs

In 1988 the Nigerian government, realizing the adverse effects of rapid population growth on national development and individual welfare, launched the National Policy on Population (Federal Ministry of Health, 1988). The goals of the policy are:

- Improving living standards and quality of life for all Nigerians;
- Promoting health and welfare, especially by preventing premature death and illness among high-risk mothers and children;

- Reducing population growth through voluntary fertility regulation methods which are compatible with national economic and social goals; and
- Achieving a more even distribution of population between urban and rural areas.

To achieve these objectives, and to promote public awareness of population growth and its adverse effects on development, the government adopted the following strategies:

- Mobilization of public and private agencies to provide family planning services as part of an integrated maternal and child health service to ensure that family planning becomes easily accessible to all couples who wish to regulate their fertility;
- Integrating family planning services into the Primary Health Care system throughout the country;
- Providing public information, education and communication on the

advantages of small families; and

- Promoting both urban and rural development.

The large-scale distribution of modern methods of contraception are relatively new in the country¹². A decade ago, the NFS found that less than one per cent of women aged 15 to 49 years were using modern methods. Since then, organized family planning has received great impetus from two related developments: the recognition of family planning as part of the state public health system and, since 1983, a

major collaborative effort between the Federal Ministry of Health, USAID and UNFPA. The former¹³ led to the establishment (in 1987) of the position of a family planning coordinator in each state, and the latter resulted in the massive distribution of large quantities of pills, injectables, IUDs, vaginal foaming tablets and condoms. So it is reasonable to deduce that the period 1983 to 1989 marked the beginnings of a government-sponsored, national family planning program, which made large quantities of commodities available.

¹²Concern about the number of illegal, induced abortions led to the establishment of the first family planning clinic in Lagos in 1958. However, this was the only clinic until 1964, when the Family Planning Council of Nigeria was formed by the National Council of Women's Societies, with assistance from the Pathfinder Fund, the International Planned Parenthood Federation (IPPF) and the Unitarian Universalist Service Committee. This council was subsequently reorganized and renamed Planned Parenthood Federation of Nigeria (PPFN), an affiliate of IPPF. Until recently, inadequate funding and supplies of commodities restricted PPFN to a few, large urban centres.

¹³Through its Department of Population Activities and Community Development, the Ministry (recently renamed Federal Ministry of Health and Social Services) oversees the implementation of the national population policy.

3. ADOLESCENT SOCIO-ECONOMIC AND CULTURAL CONDITIONS

3.1 Size of the Adolescent Population

Today, nearly 35 million persons—about one in every three Nigerians—is between the ages of 10 and 24. In the last decade, 1980 to 1990, the number of adolescents (aged 10 to 24 years) increased by about 30 percent, from an estimated 22.8 million to about 29.5 million. In the next 10 years, from 1990 to 2000, their number will increase to 40.8 million¹⁴ (UN, 1994). The large number of couples of child-bearing ages, together with decades of stable, high overall fertility rates, are behind this phenomenon. The adolescent population is projected to increase more quickly than the country's total population in the year 2000.

¹⁴Other estimated figures are higher. According to the Population Reference Bureau, in 1994, Nigeria had an estimated adolescent population (aged 10-24) of 39.1 million, or 32 percent of total population. This number is projected to increase to more than double its 1994 size by the year 2025.

3.2 Educational Attainment

Following independence in 1960, successive Nigerian governments, seeking to recover from a poor start, correct existing imbalance, and expand enrollment at all levels of education, have allocated a sizeable proportion of their annual budgets to the education sector. The result has been a spectacular increase in the number enrolled in all levels of the educational system. As shown in Table 2, within five years of the introduction of the Universal Primary Education (UPE) scheme, primary school enrolment more than doubled, rising from 6,165,547 in 1975-76 to 13,777,973 in 1980-81. Thereafter, enrolment figures rose steadily until the introduction of the Structural Adjustment Program (SAP) in 1986.

From Awka and Lagos in the south, to Kano and Maiduguri in the north, adolescents in focus group discussions repeatedly expressed concern about the diminishing opportunities for formal and vocational education, as well as deteriorating school standards. They blamed these societal ills on the country's present economic misfortune, which had impoverished their parents and guardians.

At the secondary level also, a combination of rapidly expanded facilities and several measures which effectively reduced the private cost of education resulted in very large increases in enrolment. For example, in the five-year period between 1975/76 to 1980/81, secondary school enrolment nearly quadrupled, increasing from 601,652 in 1975-76 to 2,342,701 in 1980-81. While 12 percent of males and 6 percent of females were enrolled in secondary schools around 1975, the

corresponding figures two decades later, around 1994, are 24 percent for males and 17 percent for the females (PRB, 1994). This spectacular increase in secondary enrolment figures was accompanied by equally impressive expansion in teachers' training and in university education. At present, there are a total of 39 federal and state-owned universities in the country. Many of these universities were first established during the brief years of the petroleum boom between 1980 and 1984.

Table 2. Enrolment in Primary and Secondary Schools: Selected Years, 1960-1990

<i>Year</i>	<i>Primary</i>		<i>Secondary</i>	
	<i>Enrolment</i>	<i>As % of those aged 6-11 years</i>	<i>Enrolment</i>	<i>As % of those aged 12-17 years</i>
1960	2,912,618	42.0	135,364	3.0
1975/76	6,165,547		601,652	
1980/81	13,777,973	91.0	2,342,701	19.0
1982/83	14,676,608		3,186,898	
1983/84	14,383,486		3,017,635	
1984/85	13,025,297	80.1	2,988,174	24.9
1987	11,540,178	66.5	2,934,349	22.9
1989	12,721,087	68.7	2,723,791	19.9
1990	13,617,249		2,901,993	

Source: Fed. Rep. of Nigeria, Statistics of Education in Nigeria tables 1.6, 1.21, and table 2.31 World Bank, tables A-7 and A-8.

Economic adversity and the introduction of the SAP in 1986 led to a drastic drop in

enrolment figures. Barely one year after the introduction of SAP, there was a drop in

primary school enrolment of more than 1 million, or a decline of over 15 percent. The nearly universal enrolment (99 percent) of six-year-olds entering the education system for 1984/85, the year preceding the introduction of SAP, dropped by nearly 10 percent to 89.7 percent by 1987. The enrolment rate for 6-year-olds has since remained well below the pre-SAP rate.

The reductions in school enrollment resulted from withdrawal of government subsidies. Before the SAP, school fees were greatly reduced or eliminated, and in the

southwest, primary and secondary school students received free supplies of textbooks (between 1979 and 1983); and university undergraduates received a substantial subsistence allowance as well as free tuition. Not only did the various grants cease after the introduction of the SAP, but also various levies were introduced while SAP-induced inflation has increased the price of books, school uniforms and other supplies.

Although female adolescents have gained in educational attainment over the years, male educational advantage over

Table 3. Adolescents, Educational Level, 1990

<i>LEVEL</i>	<i>MALE</i>			<i>FEMALE</i>		
	10-14	15-19	20-24	10-14	15-19	20-24
<i>None</i>	21.7	20.6	23.0	34.1	33.6	42.0
<i>Primary</i>	58.8	36.7	27.4	49.1	31.6	25.2
<i>Secondary and Over</i>	7.0	35.3	45.2	6.7	28.6	30.0
<i>Missing</i>	12.4	7.5	4.5	10.1	6.2	3.0
<i>Total</i>	100.0	100.0	100.0	100.0	100.0	100.0

Source: Extracted from Table 2.4, NDHS, 1990

females has persisted. In 1990, girls at every age group were more likely than boys to have received no education, while higher percentages of boys than girls were enrolled in primary and secondary schools (Table 3). By 1991, there were 76 girls per 100 boys in primary school and 74 girls per 100 boys in secondary schools (Alan Guttmacher Institute, 1995). Nor have young women had easy access to vocational and technical training; in the period 1983-1985, less than 10 percent of all enrolled students in vocational training schools were girls (Fed. Ministry of Education, 1989).

The practice of child marriage means that much lower proportions of girls in northern Nigeria, where the custom is widespread, have the opportunity for formal education. Focus group discussions (FGDs) with female participants in Kano, though not representing universal opinions, shed some light on adolescents' perception of the value of education and the relationship between early marriage and girls' education. From the discussion, it became apparent that the majority of the female FGD participants were in agreement that "girls should be educated so as not to depend on a man wholly." The

suggestion (by a discussant) that "non-educated [girls] should be married out" elicited a vehement "No, no, no, they shouldn't; they should be taught a trade so as to be useful while married," while another girl demanded rhetorically, "How can a man tell me to drop out of school because he is ready to marry me? No way."

In describing how early marriage can curtail schooling, another girl stated:

"Nobody finishes her education before the age of 21, so for a girl to marry before the age of 21, she has to get married when she will still be in school; let me inform you, the moment you are married, there will be no way you will enjoy your education....it is not possible in Nigeria." (Kano, female FGD participant, August, 1995)

But another female participant who preferred marriage to education said:

"Education is not a means of getting someone to marry you, so it depends on the choice of the lady who wants to be educated or who wants to finish her education before marriage. Even the men don't want to marry someone who is educated." (Kano, female FGD participant, August, 1995)

From Awka and Lagos in the south, to Kano and Maiduguri in the north, adolescents who were involved in various

FGDs repeatedly expressed concern about the diminishing opportunities for formal and vocational education, as well as deteriorating school standards. They blamed these societal ills on the country's present economic misfortune, which had impoverished their parents and guardians.

A complaint by a young male FGD participant in Awka (Enugu state) is typical. He said:

"We had wanted education, but we are being frustrated by the state of things in the country....now education has, for many people become an impossibility." (Male FGD participant, Awka, August 9, 1995)

A variation of the same complaint was articulated by a male discussant in Lagos:

"Our parents don't give us financial support. Our educational system is below standard. Very poor. Vocational training is poor; for example, mechanics have no uniform so [the public] identifies them with mental patients." (Male FGD participant, Lagos, August 27, 1995)

The expectations and aspirations of youth resident in the northern states regarding education are not different from those of their counterparts in the southern states. This is evident from the following

extracts from focus group discussions in Benue, Borno, Kaduna and Niger states.

A female participant in an FGD in Makurdi, Benue state, said:

"Our schools lack qualified teachers. Even the few qualified teachers are not willing to teach; they ignore the class prefect when [they] are called to duty. We want to study. Qualified teachers should be sent to our schools. At school, we have an empty box with nothing in it as a first aid box...we have no tablets in the school-so no medical care for we students, even at the dying point." (Female FGD participant, Makurdi, August 13, 1995)

A male FGD participant in Borno state agreed:

"We are lacking good education, we lack (educational) facilities, teachers don't attend classes. We don't know what is wrong with the school management, our classes are always closed before the end of the day. We have complained but they refused to listen to our complaints." (Male FGD participant, Maiduguri, August 16, 1995).

Another participant from Kaduna, Kaduna state, said:

"Education is one of our problems. The school no longer function like before, they go on strike every time, and the course one is supposed to study for four years, one studies it for

seven years. This is discouraging because there should be a specific time for education and after that marriage. This make some girls drop out.” (Female FGD participant, Kaduna, August 19, 1995)

A female participant Niger state articulated the problem of girls in that town:

“Our problem in Minna is, some girls don't have good education [because] some parents feel reluctant to send their children to school. They discourage girls to study. It is a big problem (Female FGD participant, Minna, August 21, 1995)

3.3 Marriage

In Nigeria, where marriage is almost universal, the median age at first marriage is 17 years, at which age half of Nigeria's women are married (NDHS, 1990). Between the NFS, 1981/82 and 1990, the average age at marriage increased slightly by about one-half year, and among those aged 15-24 years, there has been a shift from marrying during the mid-teens to the later teen years. Whereas in 1981/82, more than half (51.8 percent) of women were married at age 15, by 1990, this percentage had declined markedly to 28.4 percent (NDHS, 1990).

The average marriage age, however,

differs markedly according to women's educational attainment, and place and region of residence. Both the NFS and the NDHS recorded lower than average age at first marriage among women residing in the Northeast and the Northwest¹⁵. In 1990, the median age at marriage were 15.2 years and 15.4 years for women in the Northeast and the Northwest respectively. In these northern zones, the home of the Hausa, Fulani and Kanuri ethnic groups, the Muslim religion predominates, and child marriage is common.

The rationale for early marriage is that it ensures that girls are virgins until marriage. Thus bringing not only honor but added financial gain to her family. For example, in the traditional Hausa society, the husband of a virgin bride sent gifts of kola and money to the bride's parents, whereas nothing is sent to the parents of a bride who was not found a virgin (Madauci *et al*, 1968). Today, the situation is different; bridegrooms now routinely send money and kola to parents-in-law irrespective of the bride's virginal status (Madauci *et al*, 1968).

¹⁵The Northeast consists of Borno, Kano, Bauchi, Plateau and Gongola States. The Northwest consists of Sokoto, Kebbi, Katsina, Kaduna, Niger and Kwara states.

Adolescents are not unaware of this custom as evident from the following contributions by two male adolescents during an FGD in Kano. One two observed that:

“Our parents observe marrying out their daughters (early) as a culture.”

A second participant amplified the last observation stating that:

“...parents don't allow their daughters to be too long in their house before they marry them out, so s he may be courting with a man while in school, but if a girl marries, it will solve the problem of pregnancy in school. It will be known that she stays with her husband, so pregnancy will not be a thing of fear to the parents.” (Male FGD participants, Kano, August, 1995).

In support of the second viewpoint, a male participant in Minna offered the following rationale for early marriage:

“Some girls at their tender age, they go looking for men, so the parents wanting them to stop such acts will give them out in marriage.” (Male FGD participant, Minna, August 21, 1995).

Among the Igbo and Yoruba, emphasis on premarital chastity has also diminished. Uchendu (1965) contends that the influence of Western culture has weakened emphasis on virginity. Similarly,

among the Yoruba, researchers have also reported high incidence of premarital sexual relations (Ladipo *et al* , 1983, Orubuloye, 1987). Both Igbo and Yoruba girls in the southern states, spend several years to acquire Western education or vocational training. Hence, ethnographic studies revealed that Yoruba girls seldom marry until they were 20 years old (Fadipe, 1970). In support of this fact the NDHS omitted the median age at marriage for the Southwest because “less than 50 percent of the women aged 20-24 were first married by age 20.”

Both the NFS and the NDHS reveal that girls in urban areas and those of high educational attainment marry later. Thus, there is a difference of more than 4 years in the median age at marriage between adolescents with no education and those who have completed primary school or higher. While the median age at first marriage is below the national average by 2 years (15 years) among women with no education, the highest average age at marriage (18.9 years) is recorded for women who have had secondary and higher education (NDHS, 1990).

The explanation for the positive correlation between women's education and their age at first marriage lies in the perceived incompatibility of school attendance and pregnancy and childbirth. Pregnant teenagers are generally expelled from school.

Informal training in various apprenticeships may have a similar effect as formal schooling by leading to postponement of age at first marriage.

3.4 Economic Activity

Due to their enrolment in schools, the employment rate of adolescents in the 15-24 age group is not expected to be as high as that of adults 25 years and older. According to the 1962/63 census, about one third (36.8 percent) of adolescents aged 15-19 were in the labour force. Participation in the labour force varied markedly by sex; while 56.1 percent of males were employed, the census recorded only 19.2 percent of females as

Young people account for the majority of the unemployed...In consequence, adolescents are more dependent than ever before on the informal sector. They engage in a variety of activities, which now include foraging in rubbish dumps from which they salvage recyclable items such as bottles, bits of metal and plastic.

employed. However, female employment is likely underreported, because the census did

not consider as "employment" the type of work most adolescent girls are most likely to be involved in, such as unpaid housework or family business.

Data from the International Labour

Organization for 1980 depicts similar activity patterns: high activity rates for boys and low rates for girls. Compared to the overall activity rate among adolescents aged 10-14 in West Africa (31 percent), boys had an above average activity rate (41 percent) while that of girls was below average (22 percent) or about half the boys' rate (UNDP/ILO, 1987). Because, as previously shown, about 60 percent of boys in the 10-14 age group are in school, it is reasonable to assume that the figures for West Africa are representative of the activity rates in Nigeria, where training and formal education are not separated from work in the home or on the farm for adolescent boys and girls.

School-going adolescents routinely assist their parents in farming activities. Both young men and women also take on a variety of wage employment, working intermittently or permanently as domestic servants, hawkers of assorted wares and cooked food, and carriers in rural and urban markets. In addition, a large majority of adolescents are apprentices, who live with the master or mistress for several years, providing work and domestic labour. Adolescent traders who sell items ranging from automobile windscreen wipers to buttons and needles on major roads, particularly during "traffic jams" are a familiar sight in many cities in the southern states. In the Muslim areas of northern Nigeria, adolescents are vital to the trading activities of secluded women in purdah. The women are wholly dependent on adolescent girls and boys to hawk the cooked food which they prepare within their walled compounds (Polly Hill, 1969).

In recent years, the depressed state of the economy has drastically reduced opportunity for wage employment for all subgroups of the population, including youth. According to available statistics,

young people account for the majority of the unemployed. In urban areas, 57.2 percent of unemployed males and 69.5 percent of unemployed females belong to the age group of 15-24 years. In rural areas, 73.3 percent of unemployed males, and 65.6 percent of females, belong to the same age group (Fed. Office of Statistics, 1991). In consequence, adolescents are more dependent than ever before on the informal sector. They engage in a variety of activities, which now include foraging in rubbish dumps from which they salvage recyclable items such as bottles, bits of metal and plastic.

In the various FGDs, unemployment ranked high on the reported list of problems confronting teenagers. In Jos (Plateau state), a discussant in an all-boys group articulated the group's concern:

"We [youth] worry about unemployment because we have heard a lot about it and seen a lot of it. It is something we fear....Jos has its own unemployment problems. Most people don't stay in Jos, they rush to Lagos. Lagos is too competitive, it makes employment very difficult." (Male FGD participant, Jos, August 14, 1995)

In Minna, a participant in an all-boys group blamed unemployment for major societal ills.

In his words:

"The major disadvantage [of youth] is unemployment, which leads school leavers to engage in stealing, armed robbery and also drug smuggling, etc." (Male FGD participant, Minna, August 21, 1995)

A female discussant in Lagos described the employment of young boys as carriers as "child abuse" noting that:

"...if you go to Ojuelegba market, you will find boys who are abused, who fend for themselves through hard labour, by carrying wares for the affluent..." (Female FGD participant, Lagos, August 27, 1995).

Although no formal study has been made of the relationship between adolescent work and their fertility, it has been suggested that apprenticeship may have the same effect as formal education, delaying marriage, particularly among girls (National Academy of Science, 1993). On the other hand, some commentators have attributed early initiation to sexual intercourse to the fact that young girls who hawk consumable become streetwise, and are occasional victims of rape by older men posing as prospective customers (Obot, 1986). Street trading may also result in failure of adolescent traders to complete their education, according to a female FGD participant in Kaduna:

"... there are drop outs in secondary schools, and this is due to the parents' faults. They send their children to hawk for them and also to combine education with this hawking business. It is too tedious for the children, who think they can't combine these things and make a success out of it. After dropping out of school, the next thing they think of is marriage. Some parents don't have money to finance their children's education, so they force their children to hawk." (Female FGD participant, Kaduna, August 19, 1995)

3.5 Religion

Parents customarily bring up their children in their own religion. Hence, religions affiliation among Nigeria's youth is most likely to reflect national pattern, which is described above. The influence of religion on youth and their reproductive behavior is very limited, and is only apparent in such stereotypical viewpoints on family planning. Thus, during FGDs, youth in the Muslim North are more likely than their counterpart in the southern states to say that they do not use any contraceptive method because it is against their religion. In the words of a male FGD participant in Maiduguri (Borno, Northeastern Health Zone):

"We don't like family planning centres but they are located in the

community, but it against our religion." (Male FGD participant, Maiduguri, August 16, 1995)

3.6 National Policy on Adolescent Health and Welfare

A national policy for youth (defined as any person within the age range of above twelve to thirty years) has been in existence since 1983. The policy underscored the importance of the nation's youth stating that "youth are the corner-stone of the nation," and that the period of youth is "a particularly sensitive, energetic, active and potentially productive phase in the lives of its citizens." In 1983, the government adopted a policy which has been described as "a sensitive, progressive, creative and tolerant youth development policy aimed at encouraging the maximum expression of youthful creativity, ingenuity and freedom, providing an appropriate environment and structure for self-expression, self-analysis and self-actualization" (Ministry of Youth, 1983).

However, the policy emphasizes recreational and vocational activities, not

adolescent health, even though one of its objectives is "to provide solutions to youth problems, such as drug abuse and addiction, unemployment, etc."

By 1988, when the new National Population Policy was drafted, concern over the large adolescent population and its contribution to fertility levels led to the devotion of a whole section (Section 5.5) to explicit prescriptions to control adolescent fertility. These are:

- Programmes to meet the young people's needs and provide adequate resources for social and economic opportunities;
- Educational and vocational training facilities to prepare for an economically and socially more active life for the youth of both sexes;
- Special programmes to reduce the high number of school drop-outs who contribute to a rising rates of unemployment, delinquency and crime in urban and rural areas. Continuing educational programmes focusing on practical and technical training that provide ample opportunities for gainful employment;
- Incorporation of population and family life education into formal and vocational training to help young

people prepare for responsible parenthood;

- Introduction of appropriate legislation to improve the rights of children and thereby help to control all forms of child exploitation, neglect and abuse; and
- Introduction of a national code of ethics to encourage male youths to marry no earlier than 25 years, and female youths no earlier than 18 years.

These proposals, like most of the other laudable and ambitious prescriptions in

the National

Population Policy, continue to exist in writing only. No attempt is being made, either by law or moral persuasion, to improve the living conditions of adolescents. In spite of half-hearted attempts to keep female adolescents in school,

it remains acceptable practice for fathers to marry off their daughters at very young ages.

As previously discussed, the present economic depression and the Structural Adjustment Policy have led to drastic cuts in

government contributions to the education and health sectors, resulting in recent years in decreasing opportunities for formal and vocational training for adolescent boys and girls.

3.7 Abortion Laws

Existing health laws, particularly abortion laws, cannot be said to favor adolescents with unwanted pregnancies.

Nigeria's abortion legislation is an unrevised

colonial legacy which is highly restrictive.

Abortion is explicitly illegal, and is only permissible on narrow medical grounds—when pregnancy becomes a threat to a woman's life.

Specifically, sections 228 and 229 of the Criminal Code provide that

At present, abortion laws mainly work against the interest of youth. Female adolescents and even married women wishing to terminate unwanted pregnancies must resort to illegal procurement of abortion. Because [few can afford the high fees of qualified doctors, the majority of abortions are performed by untrained personnel. The consequences for women's health are dire. The law also discriminates against the poor, since the rich can procure high-cost abortions from qualified physicians.

“Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses force of any kind, or uses any other means

whatever is guilty of a felony and is liable to imprisonment for fourteen years.

"Any woman who with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her is guilty of a felony and is liable to imprisonment for seven years."

However, as Okagbue (1990) noted, the police rarely prosecute the woman concerned, chiefly because her evidence is necessary to convict an abortionist. Section 230 of the Criminal Code further provides that:

"Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child is guilty of a felony and liable to imprisonment for three years."

The only circumstances when abortion is permissible is when it is performed to save the woman's life as stated in section 297 of the Criminal Code.

"A person is not criminally responsible for performing in good

faith and with reasonable care and skill a surgical operation... upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable, having regard to the patient's state at the time and all the circumstances of the case."

Attempts to liberalize the abortion laws have not been successful. In 1981, during the second Republic, the Nigerian Society for Gynecology and Obstetrics sponsored a Termination of Pregnancy Bill in the House of Representatives of the National Assembly. The bill, which was closely modeled after the English Abortion Act of 1967, provided for abortion on the recommendation of two registered practitioners where the continuance of the pregnancy "involved risk to the life of a pregnant women, or of injury to her physical or mental health or any existing children of her family greater than if the pregnancy were terminated;" or when "there is substantial risk that if the child were born it would suffer such physical and mental abnormalities as to be seriously handicapped".

The bill further provided that abortion could only be performed in health centres, maternity homes and clinics

approved by the Ministry of Health. It proposed a gestation limit of 12 weeks, after which abortion will only be obtained if the mother's life was in danger.

The bill did not pass because of opposition by religious leaders and conservative women's groups. The former objected because they felt abortion was tantamount to murder, while the latter thought that abortion will lead to a general decline in moral standards particularly to an increase in sexual promiscuity.

At present, abortion laws mainly work against the interest of youth. Female adolescents and even married women wishing to terminate unwanted pregnancies must resort to illegal procurement of abortion. Because only an insignificant proportion of those requiring abortion can afford the high fees of qualified doctors, the majority of abortions are performed by untrained personnel. The consequences for women's health are dire. The law also discriminates against the poor, since the rich can procure high-cost abortions from qualified physicians.

3.8 Access to Family Planning

Male and female adolescents do not have easy access to contraceptives, as society disapproves of premarital sex. Likewise, society's ethical and moral feelings are prejudicial to adolescents' access to family planning. Thus, teenagers are usually frightened away from family planning facilities by the censorial stance of some service providers. Many adolescents expressed the fear of this censorship in FGDs:

"There may be stigma attached when one is seen going to [family planning clinics]. That is why they are not good. We don't go to clinics because of the questions the officials ask. We are scared of these questions... because at the chemist, there will be little or no question. What they do is to sell the drug you required to you."
(Female FGD participant, Jos, August 14, 1995)

A girl in Kano explained:

"No, we don't go [to family planning clinics], and we don't see anybody of our age going to places like that. Girls prefer to go to private clinics... this is due to the fear of being seen by relatives. Some private hospitals are very good, with good doctors and nurses, while government hospitals

Girls prefer to go to private clinics... this is due to the fear of being seen by relatives. Some private hospitals are very good, with good doctors and nurses, while government hospitals [are a] time wasting venture." (Female FGD participant, Kano, August 17, 1995)

3.9 New Initiatives: Policy for Adolescent Health and Welfare

In the course of this year, international donor agencies, notably the MacArthur and the Ford Foundations, have provided impetus for three major types of activities aimed at improving the health and overall welfare of adolescents in Nigeria:

- **Policy on adolescent health.** Representatives of international agencies, concerned NGOs and representatives of the Federal Ministry of Health are in the process of preparing a more comprehensive policy on adolescent health. The policy includes prescriptions to enhance young people's physical and mental development, promote responsible sexual behavior, prevent substance abuse and overcome disadvantages such as extreme

poverty, homelessness and physical disability. The policy also details the roles and responsibility of each of the "major partners" in youth welfare: federal and state Ministries of Health, departments of Primary Health Care in local governments, and international agencies which would provide technical and financial support for the implementation of programmes. The draft of this Policy for Adolescent Health and Welfare is attached as Appendix I.

- **Workshop on Adolescent Health and Education.** From 29 May to 2 June, 1995, a workshop on adolescent health and education for youth-focused NGOs took place in Calabar, Cross River state, under the auspices of the Inter-Agency Forum on Adolescent Health and the Primary Health Care and Disease Prevention Department of the Federal Ministry of Health and Social Services. Participating NGOs received training in order to improve their capacity to address the health and social development of young persons. RECOMMENDATIONS

adopted at the conclusion of the workshop called on the Federal Ministry of Health to expedite necessary actions to transform the draft National Policy on Adolescent Health into a legal framework for youth health initiatives; urged education authorities to permit pregnant school girls to continue in school; urged NGOs to undertake closer co-operation and collaboration through networking; urged government at all levels to increase public spending on social development regardless of economic recession. The Communique is attached as Appendix IV to this report.

- **Meeting on Adolescent Health.** The Nigerian Chapter of the African Association for the Promotion of Adolescent Health (NAPAHD) which was inaugurated on December 8, 1994, held its annual general meeting on November 8 to 9, 1995 at Abeokuta. NAPAHD's goal is to promote adolescent health and development by forming a network of youth-serving organizations and individuals in Nigeria. Relevant information on NAPAHD are attached as Appendix III in this report.

4. ADOLESCENT REPRODUCTIVE BEHAVIOR

This section presents evidence from the literature on: adolescent sexual activity and fertility rates; knowledge of reproductive biology; contraceptive knowledge and use; knowledge and incidence of sexually transmitted diseases, including HIV/AIDS; and adolescents' source of information and counseling.

4.1 Sexual Activity of Adolescents

Several studies have indicated that sexual activity is particularly high among unmarried youth; that it has become more common over time as Nigerian society has undergone marked social change; and that premarital sexual behavior is more common among women in urban centers (Feyisetan

Sexual activity...has become more common [among Nigerian adolescents] as Nigerian society has undergone marked social change...While knowledge of family planning methods is now more widespread, usage of contraception is low among younger women.

and Pebley, 1989; Gyepi Garbrah, 1985; Nichols *et al*, 1986; Makinwa-Adebusoye, 1991, 1992; Odujirin, 1991; Ogbuagu and Charles, 1993; Oloko and Omoboye, 1993; Omorodion, 1993; Omu *et al*, 1981; Onwuamana, 1982; Oyeneye and Kawonise, 1993; Renne, 1993).

As previously discussed, the high incidence of premarital sexuality is attributable to increasing moral latitudes and the slackening of traditional requirement for pre-marital chastity. An ever-increasing number of adolescents migrate from rural homes to urban centres in search of jobs, opportunities for higher learning, or apprenticeships, thus breaking away from constraints traditionally applied by family members and village

communities. Moreover, in times of rapid social change, external forces, notably peer groups and the mass media, become more influential than parents or community elders on adolescent behavior.

Evidence from the 1990 Nigeria Demographic Health Survey (NDHS) has not only confirmed the high incidence of premarital sexuality in urban centres, but also has revealed that the incidence of premarital sexual behavior is not limited to urban centers. While 30.9 percent of never-married urban women aged 15-19 have had sexual intercourse, 21.3 percent of their rural counterparts also have. In addition, 48.4 percent of all sexually experienced adolescents in rural and urban areas have had sexual intercourse by age 15.

During recent FGDs in various parts of the country, adolescents proffered several reasons for early initiation of sexual intercourse. In Kano, female participants offered the following explanations:

"Some people decide not to go to school, becoming a whore, looking for material things in life, moving from one man to another."
(Female FGD participant, Kano, August 17, 1995)

Another girl said,

"Money is problem, girls want to be flashy without job, so they hawk themselves, which is too bad."
(Female FGD participant, Kaduna, August 19, 1995)

According to a young man in a boy's group:

"People who do these things [sexual intercourse] are those who live in densely populated areas, who have people to talk with [of the] opposite sex. The things that make boys meet with girls and girls meet with boys are too much exposure, music about sex, and also films. Our parents also give out their children too early."
(Male FGD participant, Kano, August 17, 1995)

This view is supported by female focus group participants in other cities and states.

A Jos participant stated:

"But girls start having sex ...when they first experience their menstruation period. It is temptation and also some want to experience it. Also the need for money is involved. They go for money in exchange for love making." (Female FGD participant, Jos, August 14, 1995)

Adolescent sexuality in urban and rural areas of Nigeria is also associated with multiple sexual partners, increasing the prevalence of sexually transmitted diseases. In a study of reproductive behavior among

youth aged 12-14 in five Nigerian cities, Makinwa-Adebusoye (1991) found that 32.1 percent of girls and 57.7 percent of boys who were sexually experienced had two or more sexual partners. Other studies have shown that involvement with multiple sexual partners is not confined to urban centers alone. For example, in his study of ever-married women in Ekiti District of Ondo State, Orubuloye (1991) found that a very high 85 percent of women who had engaged in premarital sex had two or more

partners (81.25 among women in rural areas and 88.61 among urban women). Similarly, in a study of secondary school girls in Lagos, Odujirin (1991) found that of the 29 percent who have had sexual experience, 33.7 percent had more than two lifetime partners.

As shown in Table 4, several other studies have documented the practice of having a multiplicity of sexual partners in several parts of the country.

Table 4. Percentage of Youths and Adults With Two or More Sexual Partners

<i>Author and Year</i>	<i>Study Population</i>	<i>Percentage of study population that is sexually active</i>		<i>Percentage of sexually active with two or more sexual partners</i>	
		<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
<i>Onwuanam 1982</i>	Urban. Secondary school boys and girls 14-19 years; Oshogbo, Ile, Ife, and Ilesha	68.3 ^a	42.5 ^a	NA	NA
<i>Nichols et al. 1986</i>	Urban. Never married male and female; 15-25 years; Ibadan	78.6 ^a 59.6 ^b	54.8 ^a 40.3 ^b	NR NR	NR NR
<i>Orubuloye et al. 1991</i>	Urban. Males, 17-50 years, and females, 17-45 years; Ado Ekiti	100.0 ^a 86.0 ^b	98.0 ^a 92.0 ^b	94.0 ^a 54.0 ^b	87.0 ^a 49.0 ^b
	Rural. Males, 17-50 years, and females, 17-45 years; Ado Ekiti	98.0 ^a 79.0 ^b	97.0 ^a 76.0 ^b	94.0 ^a 48.0 ^b	75.0 ^a 26.0 ^b

<i>Makinwa -Adebusoye 1991</i>	Urban. Males, females 12-24 yrs; Enugu, Kaduna, Lagos, Onitsha and Zaria	37.5 ^a 28.1 ^b	44.1 ^a 36.2 ^b	NR 57.7 ^b	NR 32.1 ^b
<i>Oni 1992</i>	Urban. Males 15-54 years; Ondo, Ondo State	94.5	NA	80.9 ^a 57.0 ^b	NA
<i>Ogbuagu and Charles 1993</i>	Urban. Males and females; 15-60 years; Calabar	90.3 ^a	88.2 ^a	39.3 ^d	20.8 ^d
<i>Oguntimehin 1992</i>	Urban. Males, 17-50; females 15-49 years; Ado-Ekiti	NR	NR	94.0 ^a 54.0 ^b	87.0 ^a 51.5 ^b
	Rural. Males, 17-50; females 15-49 years; Ado-Ekiti	NR	NR	94.0 ^a 48.0 ^b	75.0 ^a 26.0 ^b
<i>Omorodion 1993</i>	Urban. Ever married women 15-65 years; Benin City	NA	100.0 ^a 35.0 ^c	NA	72.0 ^a 69.0 ^c
<i>Oyeneye and Kawonise 1993</i>	Urban. Males 17-50 years; females 15-45 years; Ijebu-Ode	100.0	100.0	97.0 ^a 49.0 ^b	90.0 ^a 22.0 ^b

- a After marriage
b Lifetime
c never married
d male and female

4.2 Teenage pregnancy and Fertility

Evidence on the contribution of adolescents to overall fertility is provided by both the 1981/82 NFS and the 1990 NDHS. According to the NFS, the contribution of youth to the overall fertility level (marital and extra-marital) is very high. Female

teenagers (aged 15-19), who represented 21.6 percent of all sampled women, contributed 13.7 per cent of reported births. Moreover, this group accounted for about 10.4 percent of the female sample who were pregnant at the time of the Nigeria Fertility Survey, 1981/82.

Table 5: Teenage Pregnancy and Motherhood

<i>Percentage of teenagers 15-19 who are mothers or pregnant with their first child, by selected background characteristics, Nigeria 1990.</i>				
<i>Background</i>	<i>Mothers</i>	<i>First Pregnancy</i>	<i>Percentage Who Have Begun Child-bearing</i>	<i>Number of Teenagers</i>
<i>Age</i>				
<i>15</i>	9.3	3.9	13.1	373
<i>16</i>	14.9	5.9	20.8	322
<i>17</i>	24.7	5.5	30.2	326
<i>18</i>	34.4	5.0	39.3	333
<i>19</i>	39.0	3.8	42.8	259
<i>Residence</i>				
<i>Urban</i>	14.6	2.8	17.4	462
<i>Rural</i>	27.0	5.6	32.7	1,150
<i>Education</i>				
<i>No education</i>	43.4	8.6	52.1	545
<i>Some primary</i>	19.2	7.4	26.6	193
<i>Completed primary</i>	18.1	3.1	21.2	329
<i>Some secondary</i>	7.0	1.2	8.2	372
<i>Completed secondary/higher</i>	11.2	1.0	12.2	169
<i>Region</i>				
<i>Northeast</i>	39.5	10.7	50.2	352
<i>Northwest</i>	40.7	5.6	46.2	308
<i>Southeast</i>	13.9	2.9	16.7	570
<i>Southwest</i>	9.1	1.6	10.8	381
<i>Total</i>	23.5	4.8	28.3	1,612

Source: NDHS, 1990. Table 3.9.

Nearly a decade later, the NDHS revealed that adolescents contributed 16 percent of total births. As shown in Table 5, about half of the teenagers became mothers before the age of 20, and about 12 percent had their first birth before age 15. Teenage pregnancy and childbirth, however, varies greatly according to the teenagers' region of residence and educational attainment: 43.4

percent of adolescent girls with no education, in contrast to 11.2 percent of those who had completed secondary or higher education, were mothers or pregnant at the time of the survey. Moreover, teenagers residing in the Northeast and Northwest are almost four times as likely as women in the Southwest to have had a child or to be pregnant at survey time.

Table 6: Percentage Change in Adolescent (15-19; 20-24) Fertility Rates for 0-3 and 4-7 years before the DHS, Nigeria, 1990

<i>Background characteristics</i>	<i>Percent Change in Adolescent Fertility Rates (Ages 15-19) (Births per 1,000 Women)</i>	<i>Percent Change in Adolescent Fertility Rates (ages 20-24) (Births per 1,000 Women)</i>	<i>Percent Change in TFR (15-49) (Births per 1,000 Women)</i>
<i>Place of residence</i>			
<i>Urban</i>	-26.2	-25.2	-22.9
<i>Rural</i>	-16.7	-5.1	-14.5
<i>Region</i>			
<i>SE</i>	-27.9	0.3	-13.2
<i>SW</i>	-21.7	-25.3	-34.0
<i>NW</i>	-9.2	-10.2	-13.1
<i>NE</i>	-15.0	-9.2	-6.6
<i>Education</i>			
<i>None</i>	-14.9	-11.6	-16.5
<i>Primary</i>	-11.5	-1.6	-9.5
<i>Secondary +</i>	-16.0	0.3	-21.1

Source: Extracted from Table 3.1, Makinwa-Adebusoye and Bamikale Feyisetan (1994)

4.3 Trends in Adolescent Childbearing

To monitor changes in adolescent fertility levels and ensure comparability of data, age specific fertility rates (ASFRs) are calculated for two time periods; 0-3 years and 4-7 years before the 1990 NDHS. The results presented in Table 6 reveal that adolescent fertility has been on a slight decline in the recent past.

Total fertility rate (TFR, referring to all women 15-49) declined by more than one child, from 7.4 in the 4-7 years, to 6.2 in the 0-3 years before the survey. This decline is reflected across all subgroups of the adolescent population; in urban or rural areas, across regions irrespective of educational attainment. The characteristic north/south demographic divide is also evident in the pattern of teenage fertility; declines are lowest in the Northwest due to the custom of child marriage. The decline is more pronounced in the southern zones, in urban areas and among the highly educated.

The reasons for the largest declines in the south and among the highly educated, as previously mentioned, lie in the

incompatibility of formal education with childbearing and, possibly, postponement of marriage due to apprenticeships in urban areas.

4.4 Knowledge and Use of Contraceptives

While knowledge of family planning methods is now more widespread, contraceptive use is low among younger women. According to the NFS, only 4.7 and 3.5 percent of youth used one or more efficient methods. Nearly a decade later, and after the official adoption of a national population policy to curtail childbearing, the 1990 NDHS revealed that only 8.3 percent of girls in the age group 15-19, and 18 percent of those in the age group 20-24 had ever used a modern contraceptive method.

Contraceptive methods are not often used during the first sexual intercourse, mainly because of the belief that a single encounter will not lead to pregnancy. For example, a 1991 study of adolescents in five major urban centres revealed that 30 percent of male and female adolescents sampled did not realise that the first intercourse could result in pregnancy (Makinwa-Adebusoye,

Table 7. Percent distribution of adolescents aged 15-19 and 20-24, and of all women who know at least one modern contraceptive method, who know a source (for information or services) and who have ever used a contraceptive method, Nigeria, 1990.

	<i>% of Adolescents 15-19</i>	<i>% of Adolescents 20-24</i>	<i>% of Women 15-49</i>
CONTRACEPTIVE KNOWLEDGE			
<i>Know Any Method</i>	31.7	45.3	43.6
<i>Know a Modern Method</i>	30.5	42.1	41.2
<i>Know a Source for Modern Method</i>	23.0	31.8	31.2
CONTRACEPTIVE USE			
<i>Any Method</i>	8.3	18.0	15.2
<i>Modern Method</i>	4.0	10.1	9.0
<i>Any Traditional method</i>	5.9	12.8	9.3
<i>Number of Women</i>	1,612	1,676	8,781

Source: Extracted from Table 4.1 and Table 4.3, NDHS, 1990.

1991). When adolescents use contraceptives, they rely on traditional methods, which are less effective than modern methods.

Low usage of contraceptives does not connote lack of contraceptive knowledge. Table 7 shows that, in general, adolescents are more knowledgeable than the total of sampled women. The average figures conceal the fact that higher proportions of

adolescents who reside in urban centres are knowledgeable about modern contraceptives. A survey of urban adolescents conducted in 1988 revealed that nearly 60 percent of urban adolescents have heard of modern contraceptive methods (Makinwa-Adebusoye, 1991). Furthermore, in the course of most of the recent FGDs with youth from different parts of the country, both female and male adolescents

spontaneously mentioned specific types of contraceptives. Knowledge does not, however, lead invariably to adoption of contraception.

Girls themselves were not any more willing to use contraceptive devices. In several FGDs, girls gave various reasons for their aversion to contraception.

Some of the reasons for low contraceptive usage by adolescents were mentioned in the

In focus group discussions, boys showed little interest in contraception, regarding it as the domain of girls. Girls themselves were not any more willing to use contraceptive devices.

course of the different FGDs. The reasons are similar to findings from national surveys. However, current misconceptions and fears about contraceptives are best presented in the words of the

adolescents. In FGDs, boys showed little interest in contraception, regarding it as the domain of girls. This viewpoint is evident

in the following contribution by a male discussant in Benue state:

"We have little or no idea of family planning. We are not yet married, what concerns us with family planners? Family planning instructors are mostly found in girls' schools."
(Male FGD participant, Makurdi, August 13, 1995)

A participant in an all-female FGD in Jos (Plateau state) spoke for many of her co-discussants when she said:

"We don't go [to family planning clinics] because the people [family planning service provider] question us too much which we try to avoid."
(Female FGD participant, Jos, August 14, 1995)

In Makurdi (Benue state) a female participant was not contradicted by other members of the group when she declared:

"What do we need it for, we don't use family devices, we practice menstrual circle system, and we ask our men to use a condom. Some do, some complain that they don't feel satisfied." (Female FGD participant, Makurdi, August 13, 1995)

Besides their need for confidentiality, adolescent girls prefer the chemist's shop to avoid "the problem of the hospital." A female

discussant in Kaduna explained their preference thus:

"...we go to nearby chemist,... The problems of the hospital is the behaviour of the nurses, they are harsh towards the girls, unlike the doctors. The nurses should be advised to behave well, they discourage ladies from hospital. Aggressive nurses should not be allowed to be the nurses." (Female FGD participant, Kaduna, August 19, 1995).

In Minna the girls preferred the chemist's shop for another reason:

"Condoms are used to prevent pregnancies, but some girls buy these from the chemist and the chemists don't ask you what you want them for, all they want is the money." (Female FGD participant, Minna, August 21, 1995)

Lack of confidentiality is a major concern of adolescent boys.

"Some don't want to be seen... We have been hearing of family planning, we don't use it because as we said earlier we don't need it. But the youth around use condoms mostly. Also they use foaming tablets... Some prefer chemist to clinics because of questioning." (Male FGD participant, Ibadan, August 24, 1995)

Boys in Lagos also underscore the lack confidentiality:

"We are aware of family planning, we don't go to clinics but we are aware that some clinics have these devices which are not for free rather for sale, so we can't afford, and when we go to hospitals they only counsel us without free drugs, we are discouraged." (Male FGD participant, Lagos, August 27, 1995).

An erroneous but widespread belief about family planning was repeated by a Lagos girl who volunteered the following information:

"We have heard of family planning, also we have heard of AIDS, but we don't practice [family planning]. Some girls do use it but it is not good for girls that have not given birth to use it. It is good for those who have finished giving birth." (Female FGD participant, Lagos, August 27, 1995)

4.5 Sources of Information on Sexuality

Evidence from the study by Makinwa-Adebusoye (1991) revealed that in spite of their high level of sexual activity, a remarkably large proportion of young, urban population displayed ignorance or incomplete knowledge of important facts and figures on reproduction.

According to Makinwa-Adebusoye, about 60 percent of the adolescent respondents replied to enquires about their

main source of information on reproductive health and contraception. Their response patterns revealed that many adult relatives either failed to discuss the facts of life with wards, or young people preferred not to discuss such issues with adult relatives. The study revealed that the most important source of information on family planning was a friend or schoolmate; 46.1 percent of male and 38.7 per cent of female respondents mentioned "friend" or "schoolmate" as their source of information. The mass media was the second important source of information. Three times as many females than males were likely to have obtained information from a nurse. For young persons of both sexes, aunts, mothers and other relatives were the least important as sources of information. Also, friends and schoolmates were reported (in the absence of female relatives) as those with whom to discuss intimate subjects, including sexual intercourse and child-spacing.

The same response patterns were observed in the recent FGDs with youth. Adolescents reported obtaining information on reproductive health

"Our first source of information [on reproductive health] is our friends."

and family planning mainly from friends, the mass media, and in some cases, from the school system. For examples, a male participant in Calabar stated:

"Our first source of information [on reproductive health] is our friends." (Male FGD participant, Calabar, August 11, 1995)

From a male participant in Awka:

"We got to know everything about sex through film shows on the television and we trust these sources of information." (Male FGD participant, Awka, August 9, 1995)

From a female participant in Makurdi:

"We hear all these things from our friends, who are more experienced than us. Sir, I do listen to their gist and at the long run practice what they have done to know how it feels. We also hear them from radio, school, newspapers i.e. posters, and to crown it all, they teach us at school." (Female FGD participant, Makurdi, August 13, 1995)

And from a female participant in Kano:

"We get our information from teachers, friends, experienced friends, and also mothers. We are always ashamed when our mothers counsel us on sexual matters, but when we are with friends we feel free, and also when teachers tell us we feel free, but when a man tells us about these things we feel shy." (Female FGD participant,

Kano, August 17, 1995)

It was also revealed that some young people do obtain their information from NGOs working with youth. For example, a female participant stated:

"You know what sir, I attend Holy Child Secondary School at Goldie Street, and opposite our school is the office of the Women in Nigeria (WIN). They come to our school to lecture us on how to have sexual intercourse with our friends with little or no danger, they come regularly before but now they have gone for more training and they hardly come again." (Female FGD participant, Calabar, August 11, 1995)

And from a male participant in Jos:

"Some people come from Planned Parenthood Federation (PPFN) to come and tell us about problems in sex. It is not always often, it is once in a while. (Male FGD participant, Jos, August 14, 1995)

Adolescents reported that it was easier and safer to discuss personal problems and sexual matters in the following preferred order - with friends, mothers, teachers or doctors/nurses, and lastly fathers. For example, a female participant in Lagos stated:

"If we have problems, we talk to our friends and some youths talk to their parents, i.e. mothers." (Female FGD participant, Lagos, August 27, 1995)

From a male participant in Ibadan:

"We can't discuss such things with parents, rather some talk with friends, but some do tell their parents. And when they are infected with diseases, they do go to the hospitals and also to the native doctors." (Male FGD participant, Ibadan, August 24, 1995)

And from a female participant in Jos:

"I will talk to my mother. But some of us talk to their friends because some parents are too harsh. We talk to our mother rather than our father because of the closeness, and it depends on the type of problem. But if it comes to reproductive health, I talk to my mother." (Female FGD participant, Jos, August 14, 1995)

Although adolescents find it easier to discuss with friends than with parents, they also expressed the wish that parents could be more understanding. As stated by a female participant in Jos:

"Our parents should listen to their children and understand them. They shouldn't be too strict on us because it may lead us to start unwanted things. Girls are scared of questions. The girls who use family planning use it wrongly and it affects them." (Female FGD participant, Jos, August 14, 1995)

Although adolescents' major sources of information include their peers, they generally reported trusting these sources of information. However, Makinwa-Adebusoye

(1991) observed that the information received from friends and the media may be incomplete and even wrong. In order to test their knowledge, Makinwa-Adebusoye queried respondents on whether or not pregnancy was possible at the first sexual intercourse, and on their knowledge of the "safe period." The answers revealed that less than half of these relatively well educated, urban, young people realised that the chances of pregnancy are high even if sexual intercourse occurred only that first time. Unfortunately, as reported by Adetoro *et al* (1991), in some areas, neither the educational system nor the family is prepared to teach family life education to prevent unwanted pregnancies.

4.6 Adolescent/Adult Relationships

Although it is understood that discussing sexuality with parents and informed adults can help protect their health, most adolescents encountered in FGDs distrust adults. There is a general failure of openness in the adult-youth relationship, which some youth ascribe to "African culture," while others describe adults' attitude to their sexuality as hypocritical. Although a few of the adolescents mentioned

that they would discuss personal matters with either their father or mother, a significant proportion of the youth do not seek advice from their parents, preferring alternatives sources, particularly their peers. Excerpts from various FGDs with either all-boys' or all-girls' groups bring out the salient points on adolescent-adult-parent-relationships:

"We talk to our mothers [when we have problems], but our friends are the ones we discuss freely with because they tell us solutions without us fearing them." (Female FGD participant, Calabar, August 11, 1995)

In-school boys said:

"...If you contact diseases the best person to confide in should be your friend who will give the necessary advice... Parents are harsh..., so if you feel you want to discourse with your parents about contacting diseases, then go ahead, but be prepared to face the trouble they will extend to you due to their impatience. Even if I want to tell my parents, I don't think I can call both together for such discussion, I will first of all talk to my mother because she is the closest pal to me. But if I put a girl in a family way, then the best thing I can do to avoid my parents being angry at me is to deny the baby and the mother or to seek abortion." (Male FGD participant,

Calabar, August 11, 1995)

In-school girls in Makurdi said:

"We don't like to confide in our parents, rather we will confide in our friends when we have sexually related problems." (Female FGD participant, Makurdi, August 13, 1995)

An out-of-school girl in Makurdi said:

"If it is diseases, I talk it over with my mother and that depends on whether I am experienced or not. But I will prefer to tell the doctor, but in the absence of a doctor I tell my mother." (Female FGD participant, Makurdi, August 13, 1995)

In-school and out-of school girls, Kano:

"We discuss with our parents, i.e. our mothers, one reason to this is that we are closer to our mothers all of the time, she can answer our questions in a soft manner. Most of us stay with our mothers, and the question of father doesn't come, in, and our mothers are like us, they have one

way or the other experienced these feelings of ours in their transition. Our fathers don't use to be at home." (Female FGD participant, Kano, August 17, 1995)

In-school girls in Ibadan:

"When we have problems, we talk to our parents, but we do talk to our friends...We know that there are some problems we cant tell our parents like noticing something in your private health ...I was having some pains in my breast but I didn't want my mum to know so I prefer to tell it to my friends. When we have financial problems we do talk to our parents." (Female FGD participant, Ibadan, August 24, 1995)

From another in-school-girl, Ibadan:

"We don't talk to our parents when we contact STDs, they won't expect you to have such things. We better tell our friends. And also we go to the private hospital which we prefer to the public because of secrecy." (Female FGD participant, Ibadan, August 24, 1995)

5. IMPLICATIONS OF ADOLESCENT SEXUAL BEHAVIOR

5.1 Age at Menarche

While the median age at marriage is increasing (by about one half year between 1981/82 and 1990), the age at menarche continues to decline. In his survey of 2,220 school girls in the late 1960s, Akingba put the average age at menarche at

13.95 years (cited in Morgan, 1975). By 1979, Sogbanmu and Aregbesola surveyed 119 secondary school girls and obtained 13.85 years as the mean age at menarche (Sogbanmu and Aregbesola, 1979). The declining trend in age at menarche was revealed in a 1988 survey by the author, comparing age at menarche among young women in three age groups; early teens (15-17), late teens (18-19), and young adults (20-24). The survey revealed girls in their early teens

had menstruated at earlier ages than older

women; the largest proportions of girls who had menstruated by age 12 and by age 14 were found among girls in their early teens

(Makinwa-Adebusoye, 1991).

5.2 Early Childbearing

A significant proportion of teenage

pregnancy occurs in marriage, as evidenced by the low median age at marriage (17.1 years). Young mothers, who are themselves still growing, usually require specialized care— various combinations of anti-malaria drugs, folic acid and iron—to ensure both foetal and maternal growth. Harrison and his colleagues at the Ahmadu Bello Teaching hospital reported increases in height of up to

16 centimetres during pregnancy in primigravidae aged 16 and under (Harrison *et al*, 1984, 1988). Yet most

teenage mothers do not receive antenatal

Young mothers, who are themselves still growing, usually require specialized care...to ensure both foetal and maternal growth. Yet most teenage mothers do not receive antenatal treatment, perhaps because they cannot afford it.

Babies born to teenage mothers are at greatest risk of infant mortality.

treatment, perhaps because they cannot afford it. According to the 1990 NDHS, over two fifths (43.2 percent) of mothers who were less than 20 years of age did not receive antenatal care. These proportions vary by region, increasing to 54.7 percent in the Northeast and 52.4 percent in the Northwest, while corresponding percentages are 19.6 percent in the Southeast and 7.7 percent in the Southwest. In northern Nigeria, where child marriage is widespread, lack of antenatal care contributes to increased mortality among the young mothers and their children. Of 96 maternal deaths reported in Kaduna (1976-1977), 56 percent of the women who died were not booked in a hospital, and were seen when labor was advanced; and 17 percent had attended a clinic only once (Caffrey, 1979).

Babies born to teenage mothers are at greatest risk of infant mortality; their risk of dying is 44 percent higher than normal. This pattern of pregnancy and childbearing not only impairs the health of the child-mothers, but also has serious economic and demographic effects. These young mothers usually have less financial and other resources than older mothers; they also tend

to be inexperienced in child care, are at increased risks of premature and underweight babies weighing under 2.5 kilograms. They are also physiologically immature, and suffer from a range of disorders (such as pre-eclampsia) associated with pregnancy and delivery. Thus, an alarming proportion, more than 2 out of 5 (41.54 percent) Nigerian babies born between 1985 and 1990 risked illness and death before their first birthday (NDHS, 1990).

The highest infant mortality rates are among children born to teenage mothers. The 1990 NDHS revealed that, in Nigeria, the single most important factor in child survival is the age of mother. When mother's age is less than 20 years, mortality rate for children under 5 is 228.53 deaths per 1000 live births. This is much higher than the national average rate of 191.01 deaths per 1,000.

In addition, early childbearing, by curtailing the number of years spent in formal education or learning vocational skills, perpetuates gender inequality in educational and vocational training and

subsequently, in employment.

5.3 Incidence of Abortion

Because abortion law is highly restrictive, women with unwanted pregnancy have to rely on illegally induced abortion. The incidence of abortion in Nigeria is unknown, although it is generally accepted that it is high, and evidence on the morbidity and mortality associated with abortion

indicates that it is a serious health problem, especially among adolescents. Although the number of illegally induced abortions annually performed in Nigeria can only be surmised, estimates from various hospital-based studies of obstetric patients and of women presenting at hospitals with abortion-related complications, as well as from surveys of adolescents which include abortion history, yield valuable information.

Table 8: Number and selected characteristics of cases of abortion recorded per month in 10 states (1984).

<i>State</i>	<i>Cases per Month</i>	<i>Percent Under 20 years</i>	<i>Percent Unmarried</i>	<i>Percent With Secondary or Higher</i>
<i>Anambra</i>	103	58	85	68
<i>Rivers</i>	80	57	85	70
<i>Kaduna</i>	13	65	90	20
<i>Kano</i>	40	65	90	20
<i>Lagos</i>	125	45	85	60
<i>Ogun</i>	150	55	80	60
<i>Ondo</i>	100	55	85	60
<i>Oyo</i>	81	55	80	60

Source: Okagbue, 1990

In 1980, a ministerial committee of inquiry reported an estimate of 500,000 illegally induced abortions each year, and indicated that abortion is widespread among unmarried and married women. More recently, Emuveyan (1994) reported that at least 700,000 abortions are performed each year.

Neither boys nor girls consider abortion immoral, and they use it whenever needed... The main reasons for choosing abortion are: lack of readiness to have an infant, fear of interruption in schooling, and lack of financial support. However, for the pregnant school girl, the most important reason for procuring abortion is shame.

In order to "gather and compile information sufficiently indicative of the incidence of abortion" in the country, Isabella Okagbue (1984) conducted a study of several sampled hospitals in each of 8 states, covering both the northern and southern parts of the country. As shown in Table 8, most of the cases reported were single women (85 percent), most of whom had a secondary school education or had been to a higher institution of learning (60 percent). It is only in the two northern states, Kano and Kaduna, that a large proportion (45 percent) had no formal education.

Other studies have reported a high incidence of abortion among adolescents.

For example in her survey of adolescents, Makinwa-Adebusoye (1991) found that one out of every 20 reported pregnancies ended

in abortion. Other studies emanating from various university teaching hospitals have also reported high incidence among adolescents. For example, in their study

of 192 adolescents admitted to the University of Ilorin Teaching Hospital for septic illegal abortions in the period 1987 to 1989, Adetoro and others (1991) reported an abortion rate of 94.6 per 1,000 deliveries. Moreover, adolescents made up 74.4 percent of all induced abortions, which accounted for 60.3 percent of all gynecological admissions (Table 9).

Indeed, evidence from FGDs (August, 1995) make it clear that neither boys nor girls in the south or in the north, consider abortion immoral, and they use it whenever needed so that their education is not in jeopardy.

A girl in Awka discussed the ease of obtaining abortion in the following words:

"Modernization or civilization has really wiped out the issue of dropouts in school. Pregnancies are removed or aborted before they attain the month of birth, so the issue of dropouts in school is out of the way." (Female FGD participant, Awka, August 9, 1995)

A male participant from Jos said:

"Young men worry about pregnancies, if they are involved. If my own girl friend is pregnant I shall contact friends to contribute so that I can get rid of the something....If my girl friend is pregnant I shall tell any friend when the pregnancy is young to know if they can assist. If the girl refuses to abort it, then it will deprive me of my education, so I must refuse. If am in love with the girl and she loves me in return then I have to explain the implication of having baby to her. We need to plan together, I will rather want her to terminate it." (Male FGD participant, Jos, August 14, 1995)

The main reasons for choosing abortion are: lack of readiness to have an infant, fear of interruption in schooling, and lack of financial support (Emuveyan, 1994; Archibong, 1991; Adetoro *et al*, 1991; Makinwa-Adebusoye, 1991; Odejide, 1986; Oronsaye and Odiase, 1983; Makinwa,

1981). However, as I have written elsewhere (Makinwa, 1981), for the pregnant school girl, the most important reason for procuring abortion is shame.

"The students concerned are merely trading one set of disgrace for another. When the school girl becomes pregnant, if she does not abort the foetus, she is expelled from school. She loses her chance at education and also incurs the wrath of her parents or guardians, who regard her as ungrateful, because of the embarrassment and dishonor her pregnancy and expulsion from school brings them. Therefore, filled with remorse, and tormented by the taunts and jibes of her usually hypocritical school mates and relations, and afraid to face her parents' wrath or their attempt to marry her off to her partner in crime to save 'the family name,' the unfortunate school girl is pushed to rid herself of her pregnancy at all costs." (Makinwa, 1981)

Corroborating this viewpoint, a female FGD participant poignantly described the plight of a pregnant schoolgirl:

"When a girl is pregnant a girl becomes useless...[pregnancy] leads to dropouts among girls, because she will be shy coming to school..."(Female FGD participant, Kano, August 17, 1995)

Since most of the youth are poor,

they often resort to unqualified abortionists. Archibong (1991) found that licensed physicians represented only 18.4 percent of the abortionists mentioned by patients for induced abortion-related cases at the University of Calabar Teaching Hospital. Other abortionists include chemists and owners of the ubiquitous (in urban centres) patent medicine stores, who administer a variety of drugs orally or intravenously, and/or penetrate the uterine cavity with sharp metal rods such as bicycle

spokes (Archibong, 1991; Makinwa-Adebusoye, 1991).

The resulting medical and health problems, including sterility or death, are well known, and have been documented in several studies (e.g. Archibong, 1991; Adetoro and others, 1991). These also result in social and economic losses, including termination of schooling, which jeopardizes future employment, and the high costs of medical care (in physicians' time, cost of

Table 9: Characteristics of Women With Complications Following Induced Abortion

<i>Location and Year</i>	<i>Number of Women</i>	<i>Age (years)</i>	<i>Parity</i>	<i>Marital Status</i>	<i>Education</i>	<i>Previous Induced Abortion</i>	<i>Contraceptive Use</i>	<i>Location</i>
<i>Lagos University Teaching Hospital 1967</i>	31	66% under 24	48% primi-gravid	76% single	-	-	12% had used contraceptives	Urban
<i>University of Benin Teaching Hospital 1974-75</i>	59	86% under 22; 95% under 26	81% nulli-parous	93% single or divorced	64% were secondary school students or graduates; 69% had completed primary school	39% (15% more than one)	-	Urban

<i>University of Calabar Teaching Hospital 1985-88</i>	147	72% aged 13-19	31.6% had already a birth			11%	5.1% had used contra-ceptive	Urban
<i>University of Ilorin Teaching Hospital</i>	192	72.5% aged 15-19						Urban
<i>Benin City</i>	160	81.2% aged 15-19		Single				Urban
<i>Emugu, Kaduna, Lagos, Onitsha, Zaria</i>	112	100% aged 15-24				50.6% reported previous induced abortion; 49.4% more than one		Urban

Sources: See References

drugs and retention of hospital beds), which cannot be ignored (Akinla and Adadevoh, 1969; Akingba and Gbajumo, 1970; Makinwa, 1981; Opaneye, 1899).

5.4 Sexually Transmitted Diseases

Data on sexually transmitted diseases (STDs) are very scanty for several reasons, including the stigma attached to STDs, severity of the diseases, and the fact that, unlike other disease, government has not given any specific reporting directive for of

STDs, with the exception of AIDS, which is relatively new but known to have no cure. However, knowledge of STDs, including AIDS, is very widespread among the adolescent population. The 1991 survey of adolescents in five urban centers revealed that more than three quarters of female adolescents have heard of AIDS and Gonorrhoea (75.5 percent and 75.3 percent respectively). Male adolescents were more knowledgeable; about four fifths of the boys (80.2 percent) knew of AIDS and 80.7 percent knew of gonorrhoea. These two

types of STDs were also the most frequently mentioned during recent FGDs with male and female adolescents in ten of the 30 states. Another frequently mentioned STD is syphilis, even though it does not appear to be widespread in the country (Adekunle and Ladipo, 1992).

Because management of STDs is mainly left to private physicians, pharmacists and herbalists, who are preferred to government-owned hospitals (for privacy), it is almost impossible to gather reliable statistics on STDs (excluding AIDS, for which there is a special national program). There are, however, specialized STD clinics in some of the university teaching hospitals. Data on the cases seen at the Special Treatment Clinic of the University College Hospital, Ibadan, which treats about 1,500 new cases annually, provide some valuable information (Adekunle and Ladipo, 1992). Table 10 shows distribution of STD cases seen at the Special Treatment Clinic, UCH, 1988 and 1989.

Although there is no government-sponsored organized program regarding other STDs, the AIDS scare has given rise to several youth-focussed activities including

talks and the preparation of a special curriculum for the Prevention of AIDS and Drug Abuse for secondary School students (Igbokwe, 1988). Most of the activities (mainly preparation and distribution of LE and C materials) are by NGOs (Appendix VI) who reach youth in their various catchment areas through talk shows, peer counseling etc. The spin-over on various programmes on AIDS has greatly improved the awareness among youth. During FGDs several groups mentioned the use of condoms by boys to prevent disease (meaning STDs particularly AIDS).

However, awareness does not connote use of condoms or other desirable attitudinal changes such as abstinence from sex. In fact, contributions from FGDs strongly suggest that youth do not, as yet, view the consequences of HIV/AIDS very seriously. The following contribution of a male participant to a discussion on STDs and AIDS during an all-boys FGD in Kano bears this out:

“Young men here are sexually active. Our people are aware of AIDS, they know HIV and also gonorrhoea. AIDS has no cure, so they don't mind other diseases like gonorrhoea, they believe that all diseases have cure and

that even AIDS will have cure one day, so they are not all that worried because they have not seen anybody

with it before. So, they still hear but don't believe." (Male FGD participant, Kano, August 17, 1995)

Table 10: Distribution of STD Cases Seen at the Special Treatment Clinic, UCH, by Patients' Sex, 1988 and 1989

STD	1988				1989			
	Male		Female		Male		Female	
	N	%	N	%	N	%	N	%
<i>NSU, nongonococcal urethritis, PGU</i>	239	42.1	7	1.2	335	38.9	-	-
<i>Bacterial vaginitis</i>	-	-	141	24.9	-	-	134	18.9
<i>Candidiasis</i>	10	1.8	175	30.9	-	-	254	35.8
<i>Trichomonal infection</i>	6	1.1	95	16.8	8	0.9	103	14.5
<i>Gonococcal infection</i>	170	29.9	99	17.5	346	40.3	153	21.6
<i>Herpes genitalis</i>	47	8.3	1	0.2	44	5.1	5	0.7
<i>Tinea cruris</i>	28	4.9	13	2.0	35	4.1	30	5.2
<i>Genital warts</i>	19	3.3	24	4.2	14	1.6	20	2.8
<i>Lymphogranuloma venereum</i>	25	4.4	3	0.5	42	4.8	5	0.7
<i>Treponema disease</i>	2	0.3	5	0.8	9	1.0	1	0.1
<i>Chancroid</i>	22	3.8	2	0.3	27	3.7	4	0.5
Total	568	99.9	565	99.3	860	99.8	709	100.8

Source: Courtesy of Dr. F.A.B. Adeyemi-Doro, UCH, Ibadan, personal communication.

6. PROFILE OF YOUTH-FOCUSED NGOS

A total of 49 NGOs from 13 states of Nigeria were interviewed for this exercise. An inventory of NGOs interviewed is attached as Appendix II.

In Health Zone A, 13 NGOs were interviewed: four in Awka, capital of Anambra state; one in Owerri, capital of Imo state; five in Calabar, capital of Cross River state; and two in Makurdi, capital of Benue state. Out of the 13 visited, only eight were found to have functioning youth-focused programmes. These are:

- (1) Centre for Sustained Campaign Against AIDS and STDs (CSCAASD International) (Awka)
- (2) Imo Youth Network Programme (Owerri)
- (3) Amity Club of Nigeria (Calabar)
- (4) Nigeria Youth AIDS Programme (NYAP) (Calabar).
- (5) Women In Nigeria (Calabar)
- (6) Girls Power Initiative (GPI) (Calabar)
- (7) National Council of Women Societies (NCWS) (Calabar)
- (8) Adolescent Reproductive Health - Committee of Friends Against Adolescent Pregnancy (Calabar).

The Anambra State Chapter of PPFN, which was also visited was found to

be relatively new and was scheduled to be launched on August 17, 1995.

The main activities of the NGOs with youth-focused programmes include reproductive health education, peer health education training, and provision of information, education, and counseling (IEC) on family planning, AIDS and STDs. These are being carried out through seminars, symposia and rallies. NYAP, for example, has established resource centres for this purpose. Two of the youth-focused organizations, NCWS and GPI, also provide vocational and leadership training to youth.

In Health Zone B, 24 NGOs were interviewed: 17 in Lagos, capital of Lagos state; five in Ibadan, capital of Oyo state; and two in Osogbo, capital of Osun state. Out of the 24 interviewed, seventeen were confirmed to have youth-focused programmes. These are:

- (1) AIDS-Must-Go Group of Nigeria Youth for Christ International (Lagos)
- (2) Women's Action Society (Lagos)
- (3) Women Advancement Forum (Lagos)

- (4) All-Nigeria United Nations Students' and Youth Association (Lagos)
- (5) Community Life Project (Lagos)
- (6) National Youth Council of Nigeria (Lagos)
- (7) United Nations of Youth Network Nigeria (Lagos)
- (8) Lone Star Consultants (Lagos)
- (9) Centre for Education on Population, AIDS and Drug Abuse (Lagos)
- (10) Society for Family Health (Lagos)
- (11) PPFN (Lagos)
- (12) Nigerian Educational Research and Development Council (Lagos)
- (13) Association for Reproductive and Family Health (Ibadan)
- (14) Sheriff Guards of Nigeria (Ibadan)
- (15) Family Health and Population Action Committee (Ibadan)
- (16) Staywell Health Care (Ibadan)
- (17) Life Vanguarders (Osogbo)

The main services provided by 12 of these NGOs include reproductive health education, family life education, peer health education training, and IEC on AIDS and STDs. Some also provide family planning (FP) materials. These activities are carried out through workshops, dramas, and provision of materials at youth centres.

The main activities provided for youth by the remaining five NGOs include vocational and leadership training, and provision of recreational facilities. These services are provided through workshops,

camping trips, and meetings at youth centres.

In Health Zone C, six NGOs were interviewed: two in Kaduna, capital of Kaduna state; one in Birnin Kebbi, capital of Kebbi state; and three in Minna, capital of Niger state. Out of the six NGOs interviewed, only four had youth-focused programmes. These are:

- (1) The Women Commission (Birnin Kebbi)
- (2) Multiuse Service Approach to Adolescent Reproductive Health (Kaduna)
- (3) Rotary International (Minna)
- (4) Association of Lady Pharmacists of Nigeria (Minna).

Two of these NGOs provide family life education and reproductive health services. One NGO (The Rotary International) is involved in leadership training through a yearly "Rotary Youth Leadership Award" programme, and is forming youth clubs such as Rotaract and Interact Clubs. The fourth NGO (The Association of Lady Pharmacists of Nigeria) is involved in the treatment and rehabilitation of drug addicts, and in the provision of first aid boxes in secondary schools.

In Health Zone D, seven NGOs

were visited: one in Bauchi, capital of Bauchi state; three in Jos, capital of Plateau state; two in Kano, capital of Kano state; and one in Maiduguri, capital of Borno state. Out of the seven NGOs, five have youth-focused programmes. There are:

- (1) National Association of Nigerian Nurses and Midwives (NANNM), Bauchi Branch.
- (2) National Council of Women Societies, Jos Branch
- (3) The Girls' Brigade (Jos)
- (4) Grassroot Health Organization of Nigeria (Kano)
- (5) Adolescent Health & Information Project (Kano).

Two of these NGOs provide family life education and reproductive health services. The remaining three are involved in vocational and leadership training.

6.1 Services Provided

As highlighted above, most NGOs focus on intervening before problems arise. Interventions include promotion of adolescent reproductive health, prevention of unwanted pregnancies and sexually transmitted diseases, and provision of vocational and leadership training. However, a few also provide curative services. Examples of these are the Drug

Addicts Rehabilitation Centre Project in Minna, Nigeria state, set up by the Association of Lady Pharmacists of Nigeria; the Association for Reproductive and Family Health in Ibadan, and the Centre for Sustained Campaign Against AIDS and STDs in Awka, are also involved in the treatment of STDs. Some are also involved in policy and advocacy.

Services usually take the form of preventive health care, IEC interventions, and job skills training, and are typically provided in fixed centres established by the NGOs. The majority offer outreach activities in the community to achieve wider coverage and bigger impact. This way, they can reach both in-school and out-of-school youth. Activities are usually in the form of lectures, seminars, symposia, rallies, film shows, dramas and workshops.

Generally, youth-focused NGOs providing reproductive health services like family planning services and IEC on STDs are more predominant in the southern than in the northern states of the country— more in the health Zone A and B than in Zone C and D. This is probably due to the predominance

of the Islamic religion in the north, which has not fully supported the idea of family planning.

6.11 General health care services. These services are typically offered in clinic settings provided by public and private health institutions. However, some NGOs do offer health care services, especially family planning services and treatment of STDs. These services are offered both in fixed centres established by these NGOs and through outreach services established in the community. Examples of such outreach services are the Market-Based Family Planning Projects of the National Council of Women Societies (Jos Branch, Jos, Plateau State), the Centre for Education on Population, AIDS and Drug Abuse (CEPADA) in Lagos; and the out-reach services for auto mechanics provided by Staywell Health Care in Ibadan, Oyo State. These NGOs provide family planning commodities, treatment of STDs and referral services.

Even though the public health institutions provide all types of health care adolescents may need, the services are

underused. Focus group discussions with youth (both boys and girls) revealed, as earlier highlighted, that adolescents preferred not to use public health institutions to meet their reproductive health needs, primarily because of the stigma attached, and because they worry about lack of confidentiality and judgmental attitudes on the part of the staff. As such, adolescents prefer the private hospitals and NGO services, where they believe not too many questions will be asked and a high degree of confidentiality will be achieved.

6.12 Multi-service centres. Three NGOs provide a range of services that may include general health care, family planning, family life education, health education, information, education and counseling on AIDS and STDs, treatment of STDs, peer health education training, self-esteem building, leadership training, and job skills training. These multi-services NGOs are the Family Health and Population Action Committee (FAHPAC) and the Association for Reproductive and Family Health (ARFH), both based in Ibadan, Oyo State, Zone B; and the Community Life Project, based in Lagos, also in Zone B. These NGOs,

besides providing resources in fixed centres, are also involved in outreach services and provide for both in- and out-of-school youth.

The staff of these multi-service NGOs believe that multi-service centres provide the approach to meet adolescent needs, given the stigma attached to family planning or reproductive health centres. In the northern part of the country, where family planning has not been fully accepted, almost all NGOs include vocational training and counseling as part of their services, to encourage parents to allow their children to attend these centres. Examples of such northern NGOs are the Adolescent Health and Information Project (AHIP) based in Kano, Kano State, and the Multi-Dimensional Approach to Adolescent Health Services, established by the Women's Commission in Birnin Kebbi, Kebbi State.

Funding for the multi-service centres come from both the public and private sectors. While some organizations, like ARFH, have enjoyed funding from such organizations like the American Ford Foundation and the Overseas Development Administration (British), others, like

FAHPAC, have been dependent on voluntary donations from philanthropists and monthly membership fees. Adolescent programmes established by such organizations like the Women's Commission, on the other hand, receive funds from the public sector.

6.13 Community outreach services. As earlier stated, the majority of youth-focused NGOs employ outreach services to achieve wider coverage and greater impact. These outreach services are typically provided in marketplaces, work places such as mechanics' workshops, schools and community centres. In the marketplaces and work places, activities usually involve information, education and counseling (IEC) on family planning and STDs. Information dissemination usually takes place through seminars, workshops, films and dramas. NGOs also provide commodities and referral services in the schools and community centres, and sometimes arrange workshops on job skills training and leadership training.

6.14 Information, education and communication (IEC). All youth-focussed NGOs provide IEC services. These include family life education (FLE) programmes in

schools and through outreach services in the community, peer and other types of counseling services in fixed centres established by NGOs, and media presentations.

Although family life education is offered in most secondary schools in the southern parts of the country (Health Zones A and B), the case is not the same in the northern parts (Zones C and D) except in a few private schools. Family Life Education (FLE) in secondary schools generally focuses on anatomical, biological and physiological changes related to maturation, and also include sexuality and fertility information. It is this sexuality and fertility information aspect that prevents FLE being included in the curricula in the northern states. As a result, adolescents in the north are wholly dependent on NGOs and media presentations for family life education. These NGOs reach the adolescents mainly through outreach services in the schools and in the community centres.

Adolescents in the south have access to FLE not only in the secondary schools, but also through public health institutions,

NGOs and mass media. The Nigerian Educational Research and Development Council based in Lagos is very active in FLE.

Individual and group counseling is one of the most commonly offered adolescent services. Young people frequently express the need to "have someone to talk to;" and service providers find counseling critically important. This counseling is offered by either professionals or adolescent peers.

All NGOs have professional counselors; only a few offer peer counseling services. These NGOs provide peer counseling training and then employ the peer counselors to counsel adolescents. The Nigeria Youth AIDS Programme (NYAP), based in Calabar, Cross River State, provides such peer counseling. NYAP has a well-organised peer training programme, and even had one of the peer counselors sent to the 1995 Fourth World Conference on Women in Beijing, China. Other NGOs offering peer counseling include the Community Life Project based in Lagos, and the Adolescent Health and Information Project (AHIP) based in Kano. Peer counselors help NGOs

to reach more in- and out-of-school youth, and to achieve more impact.

The third type of service that educates and informs adolescents involve the media. A number of musicians, theatre groups and radio talk programmes target adolescents, and provide them with information and education. Such programmes are usually sponsored by NGOs. An example is the condom advertisement (Molue Gold Circle Condom) on national television, sponsored by the Lagos-based Society for Family Health. Representatives of NGOs also appear frequently on television talk programmes to inform and educate youth. For example, Dr. Grace Delano, of the Association for Reproductive and Family Health (ARFH) in Ibadan, appears regularly on television. Other NGOs, like Ibadan's Staywell Health Care, Calabar's NYAP, and the Planned Parenthood Federation of Nigeria, produce IEC materials like posters and leaflets. Adolescents have reported the usefulness of these media presentations. In a recent FGD, an in-school male participant stated:

"We hear all [this information on reproductive health] through radio programmes, there is one going on

named 'Why die in silence?' So everything you want to know is put on the air for your hearing." (Male FGD participant, Calabar, August 11, 1995).

6.15 Abortions. NGOs working with young people realise that abortions are on the increase among the adolescent population, despite under-reporting by the Ministry of Health. However, the objective of NGOs with regard to abortion is prevention—to provide reproductive health services and information to reduce adolescent unwanted pregnancies, and by extension reduce incidence of abortions. None of the NGOs interviewed provides abortion services.

6.16 Safe pregnancy and school re-entry support. None of the NGOs interviewed indicated being involved in pre- and post-natal care services for pregnant adolescents. However, they do provide referral services. Some NGOs also focus on school re-entry support. The objective is to help adolescent mothers finish secondary school and avoid a second pregnancy during adolescence. The National Council of Women Societies (NCWS), the Calabar and Jos Branches, the

Adolescent Health and Information Project (AHIP) in Kano, and the Family Health and Population Action Committee (FAHPAC) in Ibadan provide this support.

6.17 Functional literacy and vocational training. A considerable number of NGOs focus on functional literacy and vocational training to help adolescents who, for one reason or the other, did not start school or had to drop out. Such NGOs usually provide literacy classes in fixed centres and put on job skills training workshops. Once adolescents have enough training to take up jobs, the NGOs also provide placement services. Typical services are those provided by NCWS, Calabar branch, where female adolescents are taught such trades as sewing, hairdressing and typing. The Jos branch of NCWS provides vocational training on income generating activities. AHIP, in Kano, provides functional literacy and vocational training for "Almajiri" (street children); while the Community Life Project and the Women's Action Society, both in Lagos, provide job skills training and then set students up in small scale business ventures after training.

6.18 Citizenship and Leadership

Training. Some youth-focused NGOs focus on citizenship and leadership training to produce disciplined, resourceful citizens and future leaders from the adolescent population. NGOs providing such services include the Girls' Brigade based in Jos, the Rotary Club of Minna, Niger state (also applicable to all Rotary Clubs in other states), the Sheriff Guards Organization in Ibadan, and the United Nations of Youth Network Nigeria, based in Lagos.

6.19 Advocacy. A number of NGOs are involved in advocating for increased attention to the needs of adolescents, including attention to their reproductive health needs. Such NGOs include the United Nations of Youth Network Nigeria and the Lone Star Consultants, both in Lagos.

6.2 Service Providers' Perceptions of Adolescent Needs

NGO service providers feel that they can best meet the primary needs of adolescents through prevention-oriented interventions to help avoid unwanted pregnancies, infection with STDs and AIDS,

school-leaving, and unemployment. They felt their services should include IEC, counseling, provision of family planning commodities, and job skills training. Staff are also aware that adolescents sometimes find it difficult discussing with adults, whether in schools, hospitals or NGO-established centres, and are thus training peer counselors

to make it easier for adolescents to discuss their problems. NGO employees also expressed the need to educate parents about adolescent issues, especially on the problems associated with early marriages, and the need to discuss reproductive issues with their children, and to encourage adolescents, especially girls, to pursue education.

7. DISCUSSION

This discussion presents key issues for improving adolescent reproductive health and related services in Nigeria. The needs expressed here represent those mentioned by adolescents and NGO staff, as well as those observed by the needs assessment team in Nigeria.

Need #1: Adolescents need better education.

Withdrawal of government subsidies has resulted in a drastic drop in school enrolment. Even for those who stay in school, the quality of education is now low compared to the 1970s. There is a need to improve the content and quality of education of adolescents to improve adolescents' prospects for gainful employment and a healthy family life.

Need #2: Services need to reach more adolescents.

The needs assessment team observed that only a limited number of adolescents utilize the NGO-established service centres, despite the multipurpose nature of some of these centres. Focus group discussions with adolescents revealed that this underutilization occurs mainly because young people do not know the centres exist, although there are other reasons, such as reluctance to talk to the centres' adult staff. Youth-focused NGOs need to publicize their services and to educate youth regarding off-site presentations, that they can attend at their convenience.

Need #3: Youth-focussed NGOs need more resource materials.

Despite the enthusiasm and dedication of staff of youth-focused NGOs, inadequate funding and materials hamper the reach and quality of their services. There is a need to improve the quantity and quality of resource materials of youth-focused NGOs, such as IEC materials, transportation, FP commodities, vocational training materials, and funds for workshops and advertisements.

Need #4: Reproductive health programmes need to target male adolescents more.

Focus group discussions with male adolescents revealed that some believe that reproductive health services are designed for females only, and that all the males need to know is where to obtain condoms. Consequently, male adolescents act on less information, putting themselves and their sexual partners at greater risk. There is, therefore, a need to target male adolescents more on reproductive health services.

Need #5: Parents need to learn how to guide adolescents.

Focus group discussions revealed that a general lack of communication between parents and adolescents prevents parents from offering guidance to their children. Even though adolescents expressed their desire to talk to their parents about personal matters, they believe that parents are either unwilling to talk, or not knowledgeable enough. There is, therefore, a need to educate and assist parents about ways to guide young people.

Need #6: Youth centres need to train and employ more peer counselors.

Focus group discussions revealed that adolescents are more comfortable discussing personal matters with peers than with adults. There is a need to train more peer counselors to staff NGO youth centres to encourage utilization of the centres.

Need #7: Adolescent mothers need to be helped back to school.

The needs assessment team observed that only a few NGOs provide programmes to help teenage mothers back to school to complete their education. There is a need for more NGOs to provide school re-entry programmes for adolescent mothers.

Need #8: Programme approaches to adolescent reproductive health need to be evaluated.

Although programme staff were found to be enthusiastic and dedicated, there is a need to evaluate whether programme efforts are improving adolescent reproductive health.

8. RECOMMENDATIONS

1. Efforts made in this study to describe and assess activities that target adolescents should be regarded only as first step. A detailed evaluation of youth-serving NGOs should be undertaken to determine whether their services are beneficial to adolescent reproductive health.
2. At least four youth centres should be created in each of the four health zones, to address regional and ethnic variations in adolescent socio-economic conditions, and their reproductive response. The centres should be launched by supporting and strengthening the most promising existing NGO in each zone.
3. To bolster the efficiency of individuals and newer youth-focused NGOs, we recommend increased efforts to create a network of youth-serving organizations, so that new NGOs, individuals, and established groups can learn from and train each other, increasing their knowledge, capability, and impact on adolescent sexual behavior.
4. In addition to creation of four (4) zonal centres, the evaluation suggested in Recommendation 1 should also identify successful youth-focused organizations whose programs and methods should be expanded and replicated elsewhere.
5. Programs need to move beyond IEC materials and peer counseling. They need to include better-structured family life education, and to provide family planning services, to encourage adolescents to delay sexual activity, protect themselves against unwanted pregnancies, and safeguard their reproductive health.
6. Because of the widespread distrust of adults in general, and parents in particular, as sources of information on reproductive health, parents need to receive training to help them guide their children through adolescence.

7. Continuing efforts by representatives of NGOs and of the Ministries of Education, Information and Health, who drafted the Youth Policy, and by the Committee on Adolescent Health and Committee Against Unwanted Pregnancy of the Nigeria Medical Association, should be intensified to ensure liberalization of existing abortion laws.

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APPENDIX I

PROPOSED POLICY ON ADOLESCENT HEALTH IN NIGERIA

1. Introduction

1.1 *The Multidisciplinary and Multisectoral Dimensions of Adolescent Health*

Health includes not only people's physical, mental and social well-being but also their educational development, proper participation in community activities and ability to contribute to the socio-economic development of their community. The active participation of adolescents in health plans and interventions is bound to make these plans and interventions more acceptable to them, and stimulates their untapped resources for overall development.

Perspectives on the problems of the health of adolescents must come from a broad disciplinary spectrum to reflect the breadth of experiences that shape their development. These include medicine, education, counseling, religion, sociology, anthropology, psychology, social psychology, economics, mass communication, law, politics, arts, science, agriculture, geography, etc.

Thus, although led by the health sector, the success of any efforts to improve young people's health must depend upon the support of other relevant sectors, such as: federal and state ministries and parastatals, departments in local government administrations, business groups, human rights movements, adult and youth organizations, professional groups, and other NOGs.

Indeed, implementation of this policy must be evaluated as much in relation to the commitment of non-health sectors to, and concrete support for, the specific projects and strategies applied as on other indicators of the health of adolescents.

The promotion of health as a basis of development and the prevention of health problems as a cost-effective strategy must be emphasized along with the care and rehabilitation of those in need.

The approaches and methods for achieving this must recognize the need for a high level of participation by the population in the planning and implementation of health and health-related activities in their own community.

2. The Rationale for a Youth Health Policy

Adolescence is important as the transition between infancy and adulthood; between innocence and experience. Most national health programmes provide for children and the aged, recognizing their susceptibility to certain diseases due to biological factors. Because adolescents are less vulnerable to these diseases of childhood and the elderly, no emphasis has been placed in this country on the health needs of this age group.

Although the "National Health Policy and Strategy To Achieve Health for All Nigerians" of 1988 provides an open-ended framework for all persons living in Nigeria to have access to health care services, a specific policy on adolescent health is necessary on the following premises:

- 2.1 In adolescence, the effects of debilitating childhood illnesses and nutritional deficiencies manifest in psychological and other problems.
- 2.2 Adolescents are more prone to injury than any other group, in that they are more physically mobile and less mentally inhibited in this mobility.
- 2.3 Adolescence is the period when individuals develop their capabilities by trying out new behaviours, skills, opportunities, hobbies and relationships, each of which has health implications.
- 2.4 In Nigeria, as in other societies, young people are more involved in community work, sports and combat operations, etc., and therefore more prone to physical injury.
- 2.5 Because adolescents form about 30 percent of the population, Adolescent Health is a crucial delivery strategy in such contexts as AIDS/STD and drug abuse control programmes, which present monstrous and largely unfamiliar challenges.
- 2.6 When unfavourable economic conditions impose serious hardship on adolescents they are tempted into risky and antisocial behaviours and practices, such as violent crime, unsafe sexual activities, etc. which pose a health challenge.

3. Policy Declaration

- 3.1 Whereas all governments of Nigeria realize that young persons have peculiar health needs that must be urgently met and agree that a specific policy is required to address and meet these peculiar needs; and
- 3.2 Whereas all governments in Nigeria recognize that the health problems of adolescents have different dimensions which can only be adequately tackled through a multidisciplinary approach and in a multisectoral context;
- 3.3 Therefore, all governments of Nigeria hereby adopt, and undertake to subscribe to, this National Policy on Adolescent Youth Health, with the following objectives:
 - I) to obtain and instill sound and appropriate knowledge in adolescents;
 - ii) to create an appropriate climate for policies and laws necessary for meeting adolescent health needs;
 - iii) to train and sensitize adolescents and other relevant groups in the skills needed to promote effective health care and healthy behaviour;

- iv) to facilitate the provision of effective and accessible information, guidance and services for the promotion of health, the prevention of problems and the treatment and rehabilitation of those in need;
- v) to facilitate the acquisition of new knowledge with regard to interactions between adolescents and those who may provide them health care, or influence their behaviour, including biomedical and psychosocial issues related to adolescent's physical, mental and social development.

3.5 Towards achieving the objectives of this Policy, there shall be established and inaugurated:

- a) A National Programme on Adolescent Health to undertake direct service provision, basic and operational research, development and adoption of special methodologies, the systematic collection, analysis and dissemination of information relevant to the health of adolescents.
- b) A National Committee on Adolescent Health, which shall coordinate the implementation of the Policy through a proper administration of the Programme. The composition of this Committee shall reflect not only the multidisciplinary and multisectoral imperatives of the Programme but also the national geopolitical, religious, cultural and other characteristics.

3.6 The secretariat of the National Programme on Adolescent Health shall be headed by a management officer in the Federal Ministry of Health, who shall be appointed by the Minister of Health. The appointee, liaising with the various partners in the programme, shall put in place a national strategy appropriate to national needs, and mobilize resources to meet these needs.

3.7 Each state, under the auspices of the Ministry of Health, shall establish a State Adolescent Health Committee, which shall operate a State Adolescent Health Programme along the lines described in 3.5 (b) above.

3.8 Each local government, under the auspices of the Primary Health Care Department, shall establish an LGA Adolescent Health Committee, which shall operate an LGA Adolescent Health Programme as described in 3.5 (b) above.

3.9 This Policy compels each partner to commit a specified percentage of its annual budget to adolescent health, to facilitate all activities consistent with the Adolescent Health Policy within its areas of jurisdiction.

3.10 The governments of Nigeria shall collaborate with bilateral and multilateral organizations in the implementation of the Adolescent Health Policy/Programme.

3.11 To enable all partners play their role to their fullest potential, this Policy compels the spelling out, by these partners, of mutually agreed duties and responsibilities pertaining to both

general and specific projects, activities or tasks, under appropriate memoranda of understanding.

4. Principles Guiding Projects for Young People's Health

4.1 Adolescence, for the purpose of this Policy, shall apply to persons within the 10-24 years bracket;

4.2 All adolescent health interventions shall be undertaken in the context, and according to the principles of primary health care;

4.3 All projects shall be closely related to the communal experience, as an assurance of sustainability; but while they will recognize existing cultural sensibilities, they will discourage traditions proven to be harmful.

4.4 Mechanisms for direct participation (in design, implementation, including delivery; and evaluation) by adolescents shall be built into all projects;

4.5 All initiatives in adolescent health shall recognize the social disparities among the group—in terms of material well-being; social status; prejudices; intellectual attainments; social perception; taste; and attitudes because these have implications for choice of medium, language, content, tenor and idioms of messages, role models; etc;

4.6 Adolescent health initiatives should aim to promote the capacity of young people to relate to all ages; and to appreciate that relationship with the opposite sex should be based on mutual respect;

4.7 All initiatives should seek to promote optimal health, emotional maturity, moral and intellectual development and economic independence;

4.8 For cost-effectiveness, initiatives should be promotive and preventive in orientation;

4.9 Programmes for improving health of adolescents must recognize the diversity of contexts and situations in which adolescents' needs can be met.

On the premise that adolescents everywhere are influenced by similar factors, it is safe to expect that, when these factors are duly observed, programmes for adolescents can be implicated with relative ease.

5. National Adolescent Health Strategy

5.1 Types of Programmes for Young People's Health

Although adolescent health problems vary from one socio-cultural setting to another, the

following shall constitute the foci of the Programme: Sexual behaviour, reproductive health, nutrition, accidents, drug abuse; education; career and employment; alcohol consumption; smoking; and traditional practices; parental responsibilities and social adjustment. Different initiatives will be required from one setting to another to translate this Policy into realistic strategies to meet specific targets and achieve well defined objectives. Thus, different, but vertically operated, projects can be grouped under the following broad categories:

a) Overall development

This involves provision of comprehensive services, including health care, health education, vocational guidance and training, sports and recreational facilities, and social and legal support, to adolescents in settings to which they are positively disposed.

b) Psychosocial development

Programmes under this category emphasize healthy mental and social growth as a basis for meeting the challenges of adolescence. Many of such programmes offer family planning and employment opportunities.

c) Sexual and reproductive health

Emphasis here is on responsible sexual behaviour and positive attitudes to sexuality as a means of preventing unwanted pregnancies or avoiding sexually transmitted diseases. These issues can be incorporated in school curricula. But direct services provision may also be undertaken—such as special clinics for adolescents within existing facilities; outreach activities in schools and other places to which adolescents are attracted.

d) Problem behaviours

These programmes concentrate on preventing substance abuse, sexual and physical abuse, violence, suicide, accidental injuries, and usually involve provision of personal and job skills training, counseling, and recreational activities.

There is also emphasis on promotion of healthy lifestyles. The scope for media action is wide here, and this will include the use of positive role models to discredit harmful habits.

e) Overcoming disadvantage

In this category are projects to help adolescents surmount problems of extreme poverty, homelessness, physical disability, abandonment, stigmatization or unemployment.

Interventions include provision of comprehensive health and social services, vocational training, health education, etc.

f) Programme support

Under this category are those strategic initiatives aimed at increasing the potential of specific interventions to have impact on adolescents health. These include needs assessment, advocacy, basic and operational research; and other surveys relevant adolescent health. They also include coordination of partnership between specialized institutions in media materials production; the identification of the human and material

resources for programme support; and the protocol for the monitoring and evaluation of the programme.

6. Roles and Functions of Major Partners

6.1 *The Federal Ministry of Health* shall provide overall strategic support for the implementation of this policy. Related to this, it shall:

- a) Ensure that this Policy is adopted, and protected under the laws of the country;
- b) Appoint as focal point a management officer in the Department of Primary Health Care and Disease Control of the Ministry, who shall liaise with other partners in the implementation of adolescent health;
- c) Secure and nurture local and external agency cooperation and support for the Programme;
- d) Provide support for advocacy, publicity, training, research, evaluation and monitoring and other forms of impetus for and inputs to the Programme, consistent with the National Health Policy and Strategy to Achieve Health for All Nigerians;
- e) Set up and inaugurate a National Committee on Adolescent Health, which shall be multidisciplinary and multisectoral in scope;
- f) Provide a secretariat to facilitate the activities of the National Committee on Adolescent Health;
- g) Assist all the state and local governments of the federation and the Federal Capital Territory in the development and implementation of adolescent health programmes.

6.2 *The State Ministry of Health* shall:

- a) Set up and inaugurate a state Committee on Adolescent Health, to which it shall appoint representatives of different disciplines and callings, which committee shall see to the development of an Adolescent Health Programme on the Principles of Primary health Care;
- b) Appoint a management officer in the Ministry as state coordinator of the Adolescent Health programme who shall administer the state secretariat of the Programme;
- c) Enact and enforce the necessary legislations; undertake advocacy, research, monitoring and evaluation, and other initiatives necessary for the success and sustainability of the Programme;
- d) Commit a reasonable proportion of budgetary allocation to health for adolescent health to ensure the success of the Programme.

6.3 *Local government PHC departments* shall:

- a) Identify the various factors within or outside the LGA that affect the health of adolescents, including local habits, practices or attitudes promotive or harmful to health, and the resources available for combating adolescent health problems;
- b) Set up and inaugurate an LGA Committee on Adolescent Health comprising representatives of a cross section of the LGA—other departments of the LG, e.g. the Local Education Authority (LEA), LGA offices of state ministries and parastatals; traditional institutions; the media, religious women's groups; youth organizations; age grades; etc.;
- c) Undertake advocacy for institutional and communal support for, and popular participation in, initiatives related to the promotion of adolescent health;
- d) Appoint a qualified health personnel as Coordinator of the LGA Adolescent Health Programme;
- e) Provide a secretariat for close coordination of the activities of the LGA Adolescent Health Committee;
- f) Budget annually for specific activities aimed at combating the problems confronting adolescents, as well as those aimed at reinforcing health-promoting behaviours.

6.4 *International agencies* shall be requested to provide technical and financial support for the implementation of the Policy/Programme consistent with their global mandates and national priorities. In this regard, each agency shall:

- a) Assign a project officer as focal point for adolescent health;
- b) Facilitate the development of a National programme on Adolescent Health consistent with the Policy;
- c) Facilitate the necessary basic and operational relevant to adolescent health;
- d) Facilitate the monitoring and evaluation of the different levels of adolescent health policy and programme implementation;
- e) Commit a specified proportion of its annual programme budget to providing personnel, training, material, logistic and other appropriate forms of support;
- f) Facilitate the process of experience sharing between and among the key players in programmes for adolescent health in different situations.

6.5 *Other partners* shall include individuals, relevant ministries and extra-ministerial departments, institutions, specialized agencies, non-governmental organizations, local people's organizations, etc, interested in adolescent health in general or in particular aspects of the Programme, who/which are willing to match such interest with specific resources.

They shall play such roles and discharge such responsibilities as are consistent with their mandates, and as may be assigned, requested or commissioned by the national, state or LGA committee on adolescent health. For effective coordination, such resources shall be channeled through the National Committee on Adolescent Health.

APPENDIX II

Organizations Visited and Persons Interviewed

August 8-10, 1995
Awka, Anambra

- (1) Centre for Sustained Campaign
Against AIDS and STDs
Dr. Cliff Okafor
- (2) PPFN, Anambra State Chapter.
Mr. Nnamdi Mekoh
- (3) Ukamaka Women's Cooperative
Mrs. C. Iwenofu

August 10 - 12
Calabar, Cross River

- (1) Amity Club of Nigeria
Godwin Mbeke
- (2) Nigeria Youth AIDS Programme
(NYAP)
Mr. Iyeme Efem
- (3) National Council of Women Societies
(NCWS), Calabar Branch
Mrs C. Atuaka
- (4) Women In Nigeria-Adolescent
Awareness of Reproductive Health
Project (ARHP)
Gwyneth Okon

August 12 - 13
Makurdi, Benue

NGOs visited were not functional

August 13 - 15
Jos, Plateau

- (1) National Council of Women Societies
(Market-Based Family Planning
Project)
Mrs J.A. Kwakfut

- (2) Girls Brigade
Mrs M.M. Ibvori.

August 15 - 16
Maiduguri, Borno

NGOs were not functional

August 16 - 18
Kano, Kano State

- (1) Grassroots Health Organization of
Nigeria (GHO)
Mrs. Amina Sambo
- (2) Adolescent Health & Information
Project (AHIP)
Mrs. Mairo V. Bello

August 18 - 20
Kaduna, Kaduna

NGOs were not functional

August 20 - 21
Minna, Niger State

- (1) Rotary International (Rotary Youth
Activities)
Dr. Bayo Olatinwo
- (2) Association of Lady Pharmacists of
Nigeria-Drug Addicts Rehabilitation
Centre Project
Hajia Mainuna Aliyu

August 22 - 25
Ibadan, Oyo State

- (1) Association for Reproductive and
Family Health (ARFH)

- Mrs E. Delano
- (2) Sheriff Guards of Nigeria (Family Planning Project)
Mr. M.A. Habeeb
- (3) Family Health and Population Action Committee (FAHPAC)
Mrs. B.S. Omotosho
- (4) Staywell Health Care
Dr. Fisayo Fagbemi

**August 28 - 31
Lagos, Lagos State**

- (1) AIDS - Must - Go Group of Nigeria Youth for Christ International
Mrs. Adagogo-Jaja
- (2) Women's Action Society (WAS)
Prof B.A. Folarin
- (3) Women Advancement Forum
Mrs. Adenike Yesufu
- (4) All-Nigeria United Nations Students' and Youth Association (ANUNSA) - Community Development Services Programme.
Mr. O.D. Oshota
- (5) National Youth Council of Nigeria (Youth Counselling Centre/Clinic Project)
Mr. Segun Ibidapo
- (6) United Nations of Youth Network of Nigeria
Mr. A. Ladapo-Ogunleye
- (7) Society For Family Health
Mr. Z.A. Akinyemi
- (8) Lone Star Consultants - Teen Life Counsellors
Mr. H.A. Hassan-Olajokun

**Sept 6, 1995
Osogbo, Osun State**

- (1) Life Vanguards
Dr. O. Odutolu

The following NGOs were interviewed at an Adolescent Health Education Workshop in Ibadan, October 5, 1995.

1. Imo Youth Network Programme, Owerri, Imo state, Zone A.
Contact person: Mrs Felicia Iheaka
Activities provided: Family life education and reproductive health services.
2. Girls Power Initiative, Calabar, Cross River state, Zone A.
Contact person: Dr (Mrs) Bene E. Madunagu
Activities provided: Provision of information, education, and communication on sexuality and reproductive health issues; skill and leadership training.
3. Adolescent Reproductive Health Committee Of Friends Against Adolescent Pregnancy, Calabar, Cross River state, Zone A
Contact person: Mrs Clara Ofere
Activities provided: Counselling, family life education, and reproductive health services.
4. National Association of Nigerian Nurses and Midwives, Bauchi Branch, Bauchi, Bauchi state, Zone D
Contact person: Mrs Janet Ibinola
Activities provided: Family life education and reproductive health services
5. Multi-Dimensional Approach to Adolescent Health Services, Birnin Kebbi, Kebbi state, Zone C
Contact person; Women Commission

staff, Kebbi state
 Activities provided: Family life education, distribution of IEC materials, counselling, and referral services.

6. Multi-Use Service Approach to Adolescent Reproductive Health, Kaduna, Kaduna state, Zone C.
 Contact person: Mrs Namiji
 Activities provided: Family life education, counselling, reproductive health services.
7. Adolescent Reproductive Health Project, PPFN, Lagos, Zone B
 Contact person: Dr. A.B. Sulaiman
 Activities provided: Counselling, training, distribution of commodities and IEC materials.

Focus Group Discussion Participants

August 9, 1995, Awka, Anambra State, Zone A

- In-school girls
- Mixed (In- and out-of-school) boys

August 11, Calabar, Cross River State, Zone A

- Out-of-school boys
- Out-of-school girls
- In-school girls
- In-school boys

August 13, Makurdi, Benue State, Zone A

- mixed (In- and out-of-school) boys
- in-school girls
- out- of- school girls

August 14, Jos, Plateau State, Zone D

- mixed (In- and out-of-school) girls
- mixed (In- and out-of-school)

boys

August 16, Maiduguri, Borno State, Zone D

- mixed (In- and out-of-school) boys

August 17, Kano, Kano State, Zone D

- mixed (In- and out-of-school) boys
- mixed (In- and out-of-school) girls

August 19, Kaduna, Kaduna State, Zone C

- mixed (In- and out-of-school) girls
- mixed (In- and out-of-school) boys

August 21, Minna, Niger State, Zone C

- mixed (In- and out-of-school) boys
- mixed (In- and out-of-school) girls

August 24, Ibadan, Oyo State, Zone B

- in-school girls
- in-school boys

August 25, Ibadan

- out-of-school girls

August 27, Lagos, Lagos State, Zone B

- out-of-school boys
- in-school boys
- mixed (In- and out-of-school) girls

APPENDIX III

Members of the Nigerian Association for the Promotion of Adolescent Health

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APPENDIX IV

Communique: Adolescent Health Education Workshop for Youth-Focused NGOs

1. *Preamble*

A workshop on Adolescent Health Education for youth-focused non-governmental organizations (NGOs) was held in Calabar, Cross River State from 29 May to 2 June 1995 on the theme: "Programming for ADH in Nigeria." Its opening, on 29 May 1995, was officiated by the Hon. Commissioner for Health, Cross River State, Dr. Maurice Asuquo. The workshop was held under the auspices of the Inter-Agency Forum on Adolescent Health in collaboration with the Primary Health Care and Disease Prevention Department of the Federal Ministry of Health against the background of various health and health-related challenges and a climate of social crisis underpinned by a worsening national economy. The challenges include those presented by HIV/AIDS, drug abuse, mass unemployment, and a disturbing population growth pattern, with implication for environmental resources.

The objectives of the workshop were:

- I. To provide participating NGOs with a broad perspective on the global program for ADH as a multi-disciplinary/sectoral framework for addressing the health and social development of young persons.
- ii. To improve the capacity of participating NGOs to plan, implement, document and evaluate programs for improving the Health and social development of young persons.
- iii. To assist participants to gain skills to objectively appraise their current activities to better respond to the specific health needs of young persons.
- iv. To promote collaboration/networking among NGOs in the planning and implementation of youth related activities.

Participants, representing different NGOs, received training in health and health-related areas to achieve these objectives.

2. *Observations*

- a) Although the health of young persons was ignored in the past, participants noted, with satisfaction, the increasing interest of the health service delivery system in Nigeria in the health and development of young persons, exemplified by the development of a draft National Policy/on Adolescent Health through the support of WHO.

- b) Participants welcomed the close collaboration among international development agencies in Nigeria to reflect the consensus that global partnership for health has inspired, and noted, in particular, the efforts of UNICEF, WHO, UNFPA, USAID/AIDSCAP and ODA towards the organization of the workshop.
- c) Participants viewed, with dismay, the imposition of 40 percent import duties on family planning commodities.
- d) Participants were disturbed by the high incidence of young persons, particularly girl-children, being forced to end their educational careers on account of pregnancy.
- e) Participants noted the obstacles to effective sexuality education in many parts of Nigeria.
- f) Participants recognized the increasing potential of NGOs to support the nation's health care delivery system through advocacy, resource mobilization and direct service delivery.
- g) Participants noted the disparities among NGOs in terms of resource capability, competence and orientation.
- h) Participants noted the reduction in public spending on social development as a result of economic recession.
- I) Participants noted that operation of Primary Health Care is yet to respond to the needs of young persons in and out of school.
- j) Participants noted that the educational system at present inadequately addresses the health of young persons in all their manifestations.

3. *Recommendations*

- a) Participants urge the Federal Ministry of Health to expedite the necessary actions to transform the draft National Policy on Adolescent Health into a legal framework for youth health initiatives.
- b) Participants urge international development agencies to widen the scope for collaboration and match this with increased material support for youth health activities.
- c) Participants strongly urge the Federal Government of Nigeria to remove, as a matter of urgency, the current 40 percent import duties on family planning commodities.
- d) Participants urge educational authorities to remove all obstacles in the way of young persons, particularly school girls who get pregnant, by resuming their educational careers in agreeable settings.
- e) Participants urge state and local governments to remove all obstacles to effective sexuality education in local communities.
- f) Participants urge NGOs to intensify their support for the nation's health care delivery system through advocacy
- g) To obviate the disparities among NGOs in their operations, NGOs are encouraged to undertake closer cooperation and collaboration through networking.

- h) Participants urge governments, at all levels, to increase public spendings on social development, regardless of economic recession.
- I) Participants urge the National Primary Health Care Development Agency to respond more ambitiously, and in an integrated way, to the needs of young persons in and out of school.
- j) Participants urge all sectors and disciplines within the national dispensation to see young persons as a resource and not a liability, and to take the necessary actions to address their peculiar needs.

APPENDIX V

SUB-SAHARAN AFRICA NIGERIA ADOLESCENT REPRODUCTIVE HEALTH PROGRAMME

FOCUS GROUP GUIDE FOR ADOLESCENTS

1. What is the best thing about being your age?
2. What is the worst?
3. What are the major concerns in your life?
(If health is not mentioned, inquire? How about reproductive health?).
4. Who do you talk to when you have problems?
5. What is the best age to have sexual relations for the first time? Among boys? Among girls?
6. At what age does sexual activity normally begin among adolescent in this community?
Among boys? Among girls?
7. What made you start sexual activity when you did?
8. Who normally initiates a sexual encounter, the boy or the girl?
9. What are the negative consequences of being sexually active?
(If not mentioned, inquire about STDs, AIDS, abortions, school dropouts).
10. What/Who is your source of information about reproduction, sex, and personal growth?
Do you trust this source of information?
(Any gender differences in source of information?)
11. Do you discuss such personal things with your parents?
12. Do you use reproductive health services like family planning clinics? Public or private? Why the choice?
13. What do you think of the service centres used and services rendered?
14. What would be an ideal place and approach to help you meet your needs?
15. What is the best age for a girl to marry? How about a boy?

APPENDIX VI

**Sub-Saharan Africa
Nigeria
Adolescent Reproductive Health Programme**

QUESTIONNAIRE FOR NGOs

1. Project Name.....
.....
2. Contact Person.....
3. Address and Phone/Fax.....
.....
4. When was your organization founded?.....
5. Who is the funding agency for your project?.....
.....
6. What is your organization's mission/purpose?.....
.....
7. Is your organization a youth-focused organization?.....
.....
8. Does your organization provide services to youth who are enrolled in school or drop-outs?
 1. Students.....
 2. Drop-outs.....
 3. Both.....
9. What are the main activities provided for youth?.....
.....
10. Does your organization currently provide family planning or reproductive health services/activities to adults or youth?
.....
- 10a. If so, please list the key services and activities.....
.....
.....
11. Does your organization have entertainment programs for youth?
.....
12. Does your organization train and utilize peer counselors in programs?.....
13. Does your organization give off-site presentations or offer outreach activities in the community? If so, give examples.
.....

14. What type of publicity does the organization use to advertise its services?.....
.....
15. What nearby health clinic(s) is your organization affiliated with in order to provide referral services?.....
.....
16. Are you located near a secondary school or university?.....
.....
17. What is the average age of your clients?.....
18. How are clients referred to your organization?.....
.....
19. What staff positions comprise your organization?.....
.....
20. Who is the best person to provide health/family planning counseling at your organization?.....
.....
21. Would your clientele be receptive to reproductive health services/activities?.....
.....
22. What is the ideal location in this community for a youth reproductive health program/clinic?
 1. School.....
 2. Youth/community center.....
 3. Mosque/Church.....
 4. Hospital.....
 5. Other health clinic.....
23. Would the community and clients' parents be supportive of your organization's providing reproductive health services?.....
.....

APPENDIX VII

Nigerian Association for the Promotion of Adolescent Health and Development

Background:

The Nigerian Chapter of the African for the Promotion of Adolescent Health was informed by the mandate resolved at the First Inter-Africa Conference on Adolescent Health held in , Nairobi Kenya in March 1992 where the African Association for the Promotion of Adolescent Health (AAPAH) was formed. Among the set objectives of AAPAH are to:

- oversee adolescent reproductive health programs
- facilitate the exchange of information and ideas between youth serving organization
- lobby with a unified voice for the attention of government, health care providers and other agencies to the needs of youth
- jointly search for viable solutions to the problems of early pregnancy, unsafe abortion, sexually transmitted disease and AIDS among African youth

Additionally, AAPAH enjoined other African countries to form national chapters to carry out the same objectives at home. The Ghana and Kenya Association for the Promotion of Adolescent Health (GAPAH) and (KAPAH) has been launched.

Between 1992 and December 1994 when the Nigerian chapter was launched, efforts were made to fund raise from different organizations, while identification of Youth Serving Organizations (YSO) in Nigeria was undertaken by the Advocates for Youth and Association for Reproductive and Family Health respectively.

Hitherto, some 25 organizations were identified and with a small grant raised by the Advocates from the Nigerian Ford Foundations office made an inaugural meeting possible on 8th December, 1994, at Ibadan. The organizations in this network comprise 8 Non-Governmental organizations which constitute the West African Youth Initiative (WAYI) and who are presently running a pilot project to test the feasibility of using the peer approach to reach young people.

Goal:

Promotion of adolescent health and development through the formation of network of Youth Serving Organizations and individuals in Nigeria.

Objectives:

- (I) Prepare a forum for design and implementation of Youth Programmes to better prepare youth for the future, through sexuality education and skills development
- (ii) Evolve strategies for lobbying Government officials, politician, religious organizations as

well as meaning individuals to mobilize support for the provision of resources and infrastructure for developing and servicing the various social, economic and health needs of youth

- (iii) Establish a mechanism that will ensure effective networking among youth serving organizations for the promotion of adolescent and youth related development issues
- (iv) Inform and educate the public about adolescent sexual and reproductive health issues
- (v) Influence a review of Government policies that will favour the youth and adolescent health promotion through the implementation of existing policies and the development of new positive policies

Strategy:

Our major strategies include:

- (I) Networking among youth serving organizations and individuals for the promotion of adolescent health and development. We will engage in drive to increase membership.
- (ii) Lobbying Government to positively promote the adolescent health and development especially in the provision of resources and infrastructure for developing and servicing the various social, economic and health needs of youths.
- (iii) Engage in youth centred activities:
 - (a) Organization of seminars, workshop and courses e.g.
 - Training of trainers in Management of Adolescent programs
 - Training program in Management of Peer training programs
 - (b) Seminars for youth, especially peer promoters
 - © Health education especially on sexuality and reproductive health and every aspect that affect adolescent health and development. We will educate both the youth and public on these issues creating general awareness as through both print and electronic (Television and Radio) media
- (iv) Publishing of a Newsletter (Magazine) - YOUTH NETWORK. This newsletter will be the official newsletter of NAPAHD and it will be freely circulated amongst members, youths, Government officials, opinion leaders, the press etc. The newsletter or "magazine" will focus on Adolescent health and development.
- (v) Facilitating and strengthening of members through capacity building and technical assistance from NAPAHD. NAPAHD will solicit for support in this respect from Government, international funding agencies, Nigerians and organizations.

NAPAHD will as part of its activities fund PROJECTS of members, providing technical assistance especially in area of project development and management.

NAPAHD will be an important vehicle through which funding agencies can channel their funds, technical assistance and other resources in respect of Adolescent health and development.

NAPAHD will strive to be apolitical and will be sensitive to regional/ethnic issues.

NAPAHD will coordinate and facilitate the activities of youth serving organizations.

* This will however be without prejudice to members who are free to solicit, arrange for funding or financial support for their organization without recourse to NAPAHD.

NAPAHD will work with and through members to reach the community especially at grassroots level. NAPAHD will have a strong training and health education unit to support members activities and carry on its own training and health education activities.

Members will meet regularly and communicate freely with themselves.
An annual general meeting will hold once a year.

APPENDIX VIII

History of Census-Taking in Nigeria

Before the 1991 census, twelve censuses had been conducted in Nigeria. The first census was organized in 1866 and only covered Lagos. The next set of censuses, conducted in 1868, 1871, 1881, 1891 and 1901, were limited to Lagos Colony and its environs.

Decennial censuses for the whole of Nigeria started in 1911. However, the 1911 census, like all the others conducted prior to World War II, were not enumerations of individual persons but included arbitrary estimates of groups of people; they were not universal and they lacked simultaneity. During 1911 and 1921 there was shortage of administrative staff, due to the demands of the First World War. Also, the citizens, who correctly assessed the utility of the census counts for colonial tax allocations, were uncooperative.

In 1931, the census operations were greatly handicapped by the worldwide economic recession and several local problems. There was locust invasion of farms in the north, necessitating the diversion of administrative staff from census duties to locust control, while market women in the southern town of Aba rioted to register their discontent over taxation. Due to the intervention of the Second World War, no census was conducted in 1941. The 1952 census covered the whole country and is regarded as the first modern, national census. However, due to a shortage of qualified personnel, and the fact that the facilities of the office of statistics could not handle data for the whole country if a simultaneous count were undertaken, the census was not conducted simultaneously throughout the country. This census returned a total population of 30.4 million.

The first census after independence was conducted simultaneously from 13-27 May, 1962 and covered the whole country. However, the provisional figures 45,575,000 (22.5 million for the

North, 12.4 million for the East and 10 million for the West; and 675,000 for Lagos), led to a lot of controversies resulting in the cancellation of the census. Another census was conducted between 5-8 November 1963 by the Federal Government without significant further preparations, other than the hiring of a greater number of enumerators. The figure of 55.7 million which is attributed to the 1963 census is a political compromise, arrived at after a heated political debate in the House of Representatives in March 1964. Though politically acceptable, the 1963 figure has been subjected to various rigorous analyses, and it is widely believed to have been inflated and to be less accurate than the 1962 census (see for example, Ekanem, 1972). In spite of years of careful preparation aimed at avoiding the pitfalls of the previous censuses, the 1973 census was also annulled due to several reports of the inflation of figures in some states.

The many years of military rule,¹⁶ and the partitioning of the three regions which existed in 1960 into the present 30 states, have profoundly changed the character of Nigeria's political administration. Under a highly centralized military rule, the population size of each of the small constituent states is no longer of political importance. Thus, it was in an environment favored its success that the 1991 census was conducted. The 1991 census has returned a provisional total population of 88.5 million Nigerians, and although the confirmed figures are still expected, the census is widely believed to have been well conducted according to international standards¹⁷.

¹⁶Of the 34 years following independence (1960 - 1994), the military has ruled the country for about 24 years.

¹⁷The census of 88.5 million falls short of published estimates. For example, the 1990 mid-year population for Nigeria as estimated by the United Nations is 108.5 million, a figure that is 4.5 million less than a previous estimate by the same U.N. in 1988. Moreover, both of these United Nations estimates are less than the 116.7 million mid-1990 estimate by the World Bank. The obvious difference in the provisional figures from the 1991 Census and published projected figures may arise from variations in the base year figures and the choice of annual growth rates or both. The difference of more than 11 million persons in the canceled 1962 census and the politically contrived 1963 census underscores the likely bias that may result from the choice of base year populations. After a rigorous analysis of the wide discrepancies between estimated and provisional census figures, Hobbs (U.S. Bureau of the Census, 1992) concluded:

"While the initial reaction to the 1991 census total is "Where did the people go?" the explanation for the apparent overestimation of Nigeria's total population by the Census Bureau, United Nations, World Bank and even the Nigerian government is simply that the 1963 census enumeration substantially overcounted the number of people in the country."