

Coming to Terms with Politics and Gender: The Evolution of an Adolescent Reproductive Health Program in Nigeria

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Nigeria, the most populous country in Africa, has a young population. Twenty percent of its estimated 123 million inhabitants are between the ages of 10 and 19, and another 30 percent are in the first decade of life. In addition to normal adolescent struggles with identity, the transition to adulthood for young Nigerians has been complicated by economic, political, and cultural turmoil. The health and education sectors have been deeply affected by years of neglect, material shortages, and corruption; job scarcity has forced hoards of young people into hawking merchandise along the crowded streets of the metropolis; and globalization, rapid urbanization, and a media-saturated environment have disrupted the traditional culture in which children become young adults.

Adolescents in Nigeria face serious reproductive health risks, many the result of cultural and parental pressures and the stark differentiation of the roles and prospects of adolescent girls and boys.¹ One set of health challenges is the result of early marriage for girls, which is often justified as a cultural imperative and undertaken at the behest of families concerned about finding suitable husbands for their daughters before they are deemed unacceptable for the marriage market (e.g., because they have conceived out of wedlock). Nigerian law specifies no minimum age of marriage, and age at marriage among females is among the lowest in the world. Further, once married, many girls have very little choice but to end their schooling and become pregnant.² This is particularly striking in the northeast part of the country, where girls tend to marry in mid-adolescence (median age at marriage among 25–29-year-olds was 14.9) and half become mothers by age 18.0; girls in the southwest typically delay marriage until later adolescence (median age at marriage among 25–29-year-olds was 20.5) and childbirth until after age 20 (Federal Office of Statistics [Nigeria] and IRD/Macro International 1992).

Sexual activity among unmarried adolescents is also rising and carries its own risks. According to one study of urban in-school youth, 72 percent of males and 82 percent of females have had sexual intercourse by the age of 20 (Makinwa-Adebusoye 1992). Unprotected sexual activity among unmarried girls results in a high demand for abortion, which is usually performed under unsafe conditions. A small study among adolescent females in Lagos showed that 24 percent of sexually active respondents had had at least one abortion, and less than half of these young women had had the procedure performed by a medical doctor (Odujinrin 1991).

Hence while all adolescents face significant sexual and reproductive health challenges, the degree and nature of their risk vary substantially by gender. In particular, early pregnancy—both within and outside of marriage—is a serious risk faced exclusively by young females. Both unsafe abortion and early childbearing contribute to one of the highest maternal mortality ratios in the world.³

Girls are also at high risk of acquiring HIV. One of every 20 Nigerians is currently HIV-positive. However, the rate among girls (4.4–5.9 percent) is higher than that among boys (1.7–3.4 percent) (UNAIDS 2000), which is indicative of girls' greater social and physiological vulnerability.

Both male and female adolescents have trouble gaining access to basic information about how to protect their health. In a study among adolescents in five schools in and around the city of Lagos, knowledge about HIV was uneven: 76 percent had heard of AIDS but over one-third believed that HIV infection could be spread through kissing. In two semiurban schools, one-fifth of students rejected the statement that HIV is transmitted through sexual intercourse (Oloko and Omoboye 1993). Of the 30 percent of girls 15–19 years old who attend school, 43 percent have heard of one modern contraceptive, compared to 37 percent of out-of-school girls (Population Council tabulations of 1990 Nigeria DHS data from Federal Office of Statistics [Nigeria] and IRD/Macro International 1992).

There are strong links between girls' economic disadvantage and their reproductive health. For example, it is a fairly common practice for single girls still in school to assist parents by selling goods after school to contribute toward financing their own schooling and their families' livelihoods. This activity renders them vulnerable to many pressures, and some must resort to exchanging sexual favors for cash—for example, older men buy the inexpensive food or household items the girls sell for a high price in exchange for sex. When the young girl returns home with a larger-than-expected "take," her economically distressed parents may praise her rather than question the source of the money. According to one study, this is common even among female university students, who enjoy relative economic advantage: Up to 18 percent are in relation-

ships in which they exchange sex for favors or material rewards (Uwakwe, Mansaray, and Onwu 1994).

Traditionally, adolescents were guided through the transition to adulthood by mentoring from older community members, initiation rites, and cultural restrictions on sexual activity both inside and outside of marriage. For example, if an unmarried girl had sexual relations with a man—freely or against her will—her partner could be identified and sanctions could be imposed. Adults also shared information (albeit sometimes incorrect information) about sexuality and reproduction in “age-group associations,” where girls and boys of a certain age experienced socialization rites together. Socioeconomic pressures, AIDS, and the influence of Western media have increased the need of adolescents for accurate sexual and reproductive health education; unfortunately, as Nigeria modernizes, the traditional vehicles for such education have weakened and providing such education for adolescents remains a contentious issue. Efforts to meet adolescents’ needs are constantly attacked by influential individuals and groups (some religion-based, some fearful of the loss of “tradition and cultural distinction”) who believe that such information will encourage adolescents to become sexually active.

Nigeria’s policymakers have shaped the country’s modern population agenda with attention to growth rates, but have not considered the close links between large families, early marriage, women’s status (including their access to and control of resources), and poverty. Nor has there been much public discussion of adolescent sexuality and reproduction. The public schools’ population education program provides only broad-based demographic information and guidelines on the government’s “preferred family size.” Even in anatomy lessons, teachers often fail to use the proper terminology for the vulva or penis, referring instead to “private parts.” An exceptional new pamphlet on HIV produced for the public schools acknowledges that young people are sexually active but sends the message that “bad” adolescents have sex and get HIV. Most public-sector education campaigns are not specifically directed at adolescents, and health services designed especially for unmarried or recently married adolescents are almost nonexistent.

THE CREATION OF ACTION HEALTH

It was against this backdrop in 1989 that eight individuals—drawn from the fields of medicine, education, law, psychology, and journalism—created Action Health, Incorporated, a nongovernmental organization (NGO) dedicated to improving the health and upholding the rights of adolescents in Nigeria. We understood from the onset that the larger policy and cultural milieu would prove an obstacle to our work. With

time we came to understand that gender issues are inseparable from other adolescent issues, and gender dynamics both within and beyond our own program would significantly hinder our efforts. This case study is the story of how Action Health has encountered and confronted these challenges.

Our fundamental premise was that adolescents themselves could best define their own needs and concerns. We initially decided to focus our efforts on secondary school students, who represent a small but rising proportion of Nigeria's total adolescent population. We reasoned that these students are potential leaders of their generation, and that changes in their attitudes and circumstances would have far-reaching effects in Nigerian society. From a practical standpoint, these adolescents are nominally under the control of the educational system, and it was our hope that this system would be the standard-bearer for a more progressive and supportive attitude toward this age group. Finally, secondary school students are much easier to find than their more numerous out-of-school counterparts.

We began by consulting secondary school students and some of the adults who were influential in their lives. The first activity carried out with the adolescents was a school-based workshop on teenage pregnancy and drug abuse, which was held in a section of Lagos close to Action Health's home office. The 150 students who participated were drawn from 33 coeducational, all-girls, and all-boys schools. Discussions began in mixed-sex groups and were followed by the submission of anonymous questions, which allowed us to deal with more sensitive (and salient) issues.

As students articulated their concerns, it became clear that some issues were more pertinent to boys and others more relevant to girls. For example, girls felt substantial pressure to have sex; as such, their questions often revolved around power in their relationships and how they could begin relationships with trustworthy men. They were also concerned about menstruation, its management, and how it related to their sexuality. They asked whether sex helps reduce menstrual cramps, whether a person could have sexual intercourse and still be considered a virgin, and whether boys "have to" have sex to be healthy. Boys were more concerned about attracting female attention, issues of sexual performance, and the functioning of the penis (e.g., whether masturbation "wastes their energy or sperm"). Both boys and girls struggled with how to keep their friends without compromising their own self-esteem or their parents' trust.

Relationships with parents were a central concern. Students actively struggled with getting their parents to listen to them and with how and when to ask parents difficult questions about sex, love, and their future. They felt that no one listened to or cared about their problems. Parents were described as leaving children to fend for themselves. Many of the students described being sent off to school with no food and no funds to get

Box 1. Students’ communiqué on teen pregnancy

In their communiqué, the students identified a range of factors underlying teen pregnancy and drug use, along with recommended solutions. The following items are adapted from the section of the document that addressed pregnancy.

Problem	Solution
Personal	
Lack of maturity, self-discipline	Adopt principles of self-control and discipline
Peer group influence	Make good friends, positive peers
Familial	
Parents’ inability to provide for children	Parents should care more for children, seek to meet their needs and have rapport
Parents’ exposing their children to promiscuity through their own actions	
Unhappy and broken homes	
Parents’ reluctance to discuss sexuality	Parents should discuss sexuality with children
Societal	
Availability of pornography	Reorient societal values, priorities, and morals
Overly materialistic values	
General level of poverty	Provide community youth centers, recreation facilities
Schools	
Low level of awareness	Establish peer counseling, sexuality education, symposia, and other public educational events; involve teachers’ union and parent–teacher association
Sexual harassment by male teachers	Impose penalties for sexual harassment by teachers
Female students who take advantage of their femininity to secure favor from male teachers	
Male students exploiting female students	Control sexual harassment
Blues parties (dance parties where maximum body contact is encouraged)	Supervision and prohibition of these events by local authorities

food, and some felt that their parents didn’t care if something bad happened to them. Again, gender differences emerged: Girls spoke of being blamed when they reported teachers who pressured them to have sex in exchange for a passing grade. The students asked for a “safe place” to talk with their peers and with other adults who would listen to them, stating, “Parents talk down at us,” and “We’d like to know all there is to know from people as young as ourselves, because they’ll tell us the truth.”

The workshop participants produced a communiqué (see Box 1) that reflected many of these concerns and included a summary of their major health problems and a list of their needs. This communiqué was used to initiate discussion with other students through new clubs, existing structures, and informal student networks, and it provided a basis for additional input from other students (and eventually from parents and teachers).

We carried out a parallel set of activities with teachers, parents, parent–teacher associations, and school principals from the selected schools, along with local community leaders. Just as girls’ and boys’ differing perceptions and expectations were gender-related, so were those of the adults in their lives. The characteristics of a “good girl” were viewed as very different from those of a “good boy.” Although the intensity varied, girls were often the focus of adult concerns. They questioned what a girl who was tardy or absent at school might be doing, whether girls and boys were distracted from learning by their emerging sexuality, whether young people were modestly enough dressed (many schools have dress codes), and the extent to which gangs of boys posed threats to girls’ safety.

On the basis of these preliminary consultations, we decided to move forward with two initiatives: a school-based peer-education program and a youth center, both in central Lagos. Despite their pioneering nature, our initial aims for these projects were modest. We had little idea of the ways in which time and events would force us to redefine our approach.

THE SCHOOL-BASED PROGRAM: PEER-LED HEALTH AND LIFE-PLANNING CLUBS

One teenager was selected from each of the original 33 public schools in the district to serve as peer educators. The peer educators—many of whom had participated in the original teenage pregnancy and drug abuse workshop—would provide information to fellow students. Action Health would provide training, ongoing support, and evaluation of this program.

The schools already had a functioning club system, so the peer educators decided to make use of this familiar structure for their work. They established health and life-planning clubs that would meet once a week to discuss and receive factual information on sexual health and development. In keeping with the requirements of the schools, however, information about preventing pregnancy had to be limited to abstinence. We brought the 33 peer educators together every three months for a peer-education forum, in which we provided them with material support, opportunities for discussion, awards, guidance on content, and assistance in formalizing the curriculum.

We simultaneously trained volunteer adult mentors—teachers and parents who would form connections with the young people and assist the clubs’ efforts. Mentors were selected on the basis of students’ assessments of which adults were already most responsive and sensitive to students’ sexual health concerns. In addition to training the mentors, we also routinely participated in health club activities to be sure that the factual information provided was correct and to dispel prevailing myths about topics such as sexuality.

The clubs attracted wide attention at the schools. In many cases, between 80 and 200 adolescents in a school of several thousand students would participate. With a single peer educator responsible for the sexual and reproductive health enlightenment of two to three thousand students, we quickly saw the need for additional resources. With additional funding, the program began training two to six new peer educators in each school every year. We selected students who had at least one year of school left and were therefore old enough to be respected and knowledgeable but not yet at the point of graduation. As we expanded the number of peer educators, we faced more broadly the issue of selection. Initially, peer educators were chosen by school principals, presumably on the basis of academic performance and their appeal to adults. Later, as students participated in nominating peer educators, the criteria shifted toward an emphasis on an individual's flexibility, approachability, and popularity.

Having teenagers work with trained adult mentors proved an effective approach. While students felt comfortable discussing some issues among themselves, they began to seek out the adult mentors to air other problems. Some girls disclosed to the adult mentor that a teacher was pressuring them for sex; others reported incest. Teachers also offered support to girls who were being pressured to leave school. Together with Action Health staff, these teachers created small teams that, with the girls' consent, would visit those families seeking to remove their daughters from school to encourage them to reconsider.

Although the clubs were succeeding in their initial objectives, we began to sense the limits of our approach. First, we were learning that gender issues had a great deal of influence on club leadership, participation, and dynamics. The peer educators were more active in schools for girls than in those for boys. In coeducational schools, female peer educators had difficulty sustaining leadership positions; hence, these girls were the least active of all the peer educators in the program, despite the fact that there tended to be more girls than boys in the coeducational clubs.

Gender dynamics also influenced the way that students responded to the peer-led sessions. Girls tended to be willing to ask questions but were shy about acting in role-plays. Boys were less trusting of the peer educators, but they participated easily in inventing and enacting role-play scenarios. In the coeducational schools, the participants tended to be less trusting at first because they felt they might be judged as "sexually active" in front of members of the other sex; but once discussions got underway, girls participated as actively as boys.

As was true in the initial workshop, the content of students' concerns tended to be gender-specific. A common dilemma enacted by girls was how to remove themselves from a sexual situation without getting hurt or raped. As female peer educator Adeola Olunloyo explains, "The girls themselves think girls are the weak ones, the

Box 2. Teaching girls how to reduce their risk of date or acquaintance rape

- Set sexual limits at the beginning of a relationship
- Go on group dates rather than going out alone with a boy
- On a date, avoid alcoholic drinks
- At a party or on a date, avoid any bottled drink that is not opened in your presence (to avoid being drugged)
- Before accepting gifts, be sure that there are no strings attached and no expectations of sexual favors; avoid accepting expensive gifts to avoid being accused of “leading him on”
- “There is no such thing as a free Coke!”

obedient ones.” When given the role of resisting a sexual advance, many girls screamed and kicked in an attempt to get free. The peer educators emphasized the need for girls to develop and use negotiation skills, be assertive but diplomatic, and be smart as a way to be powerful. Noting that most rape in their community is perpetrated by acquaintances, they also taught girls how to reduce their risk of “date rape” (see Box 2).

Boys, on the other hand, tended to mock the abstinence message and wanted to enact scenarios in which it was already assumed that intercourse would take place. Since males are expected to want sex all the time, boys felt ridiculed if the scenario depicted a boy resisting sexual advances; since they are expected to be in control, they felt equally ridiculed in a role-play in which a girl resisted a boy’s sexual advances in a way that bruised his ego.⁴ According to Olunloyo, “Guys feel a girl is supposed to want sex.” The boys therefore preferred to jump ahead to negotiating the use of condoms. Although condom use is technically a taboo subject, the boys wanted to role-play how to negotiate condom use without making the girl feel as though she was being accused of being a prostitute and without losing the upper hand in the relationship. They were also concerned about reduced physical sensitivity associated with condom use.

Gender issues were not the only challenge we faced. Another was related to external political realities. Young people were requesting information about contraception, safe sex practices, setting and negotiating sexual limits, power differentials in relationships, and sexual abuse. We had been clearly directed by the school authorities, however, to limit information regarding prevention of pregnancy and sexually transmitted infections (STIs) to abstinence. Topics such as contraception, treatment for STIs, and the fundamentals of sexuality were “out of bounds” for Nigerian schools. In fact, the very first sexuality education sessions intentionally concealed the sexuality component within a discussion of broader health issues, including malaria and diarrhea.

We recognized the need to provide more in-depth information on sexuality and reproductive health and on the social issues that bear on them than was possible in the

schools. We also realized that there is probably no truly “gender-neutral” territory. The venue for addressing these issues in program design was the community-based youth center.

THE YOUTH CENTER: CREATING A SAFE SPACE FOR GIRLS AND BOYS

We hoped to create a safe space where any young person 10–21 years old could have a productive learning experience. Hence when we opened a youth center, we planned activities that would overcome some of the limits of the school-based program. First, we offered educational sessions on reproductive and sexual health, where young people could receive information that schools considered taboo. Second, we generally held these sessions between 2:00 and 5:00 in the afternoon, when both in-school and out-of-school young people could attend. Third, we organized gender-neutral social activities, such as board games and table tennis.

Our approach to the educational sessions evolved significantly. When we began, our approach to the presentation of material was very pedagogic, as is typical for Nigeria. In part, this style reflected our own lack of knowledge about how to effectively engage and equip youth. Over time, we began using more participatory and diverse educational approaches, including films, role-plays, games, and structured exercises such as quizzes and debates. We also organized a number of initiatives to involve young people in producing their own magazine and videos. The magazine, *Growing Up*, is published quarterly and is distributed to in-school clubs, libraries, school boards, Ministry of Education officials, and other agencies. Producing the magazine teaches adolescents marketable skills in word processing and desktop publishing, and the magazine itself addresses generic adolescent concerns (e.g., fostering better communication with parents), gender-specific issues (e.g., concerns boys have about growing up and girls’ concerns about female genital cutting), and policy issues. The videos highlight the divergent experiences of boys and girls. For example, one adolescent produced a video entitled “Dimming Stars,” which is the story of a girl who, after reluctantly agreeing to have sex with her longtime boyfriend, gets pregnant and is expelled from school, while the consequences to the boyfriend are negligible.

We also began formalizing our educational programs by posting a monthly schedule of topics and activities. This schedule includes a range of activities—for example, the showing of a film; a body awareness class; student-produced videos; Anonymous Questions Day; a personal empowerment skills workshop; and observation of a special day such as World AIDS Day or Women’s Health Day. A library, printed materials, and one-on-one sessions with an educator—if needed—complemented the monthly schedule of activities.

As in the school-based program, we were achieving real successes but facing the inescapable and central reality of gender-based power differences. A prime example of this problem arose in addressing condom use. Girls, duly informed about contraceptives, would still explain, “I can’t request for a condom to be used because my boyfriend will believe I am a loose girl.” On the other hand, even boys who had never used condoms would often say that the condom is not effective and “robs you of pleasure.” Another example of how gender dynamics manifested themselves was more painful for Action Health as an institution. We knew that some adult men in authority felt they could provoke and even exploit girls sexually. We came to the painful realization that this danger could exist even in our adolescent reproductive health program.⁵

From our experiences in the schools and the youth center, we learned important lessons about promoting health awareness among adolescents:

- The idea of reproductive health is inadequate unless one grapples with such issues as power in sexual relations, power between the sexes, and power between generations; we would have to challenge, in particular, the notion that men have a greater right to pleasure than do women and girls.
- Parental and adult values may themselves be antagonistic to the welfare of adolescents, especially adolescent girls.

As we learned these lessons, our program evolved in several important ways. Our educational curriculum—both in the school-based peer-education program and at the youth center—became more gender-sensitive. With girls, we began to include discussion of female-controlled or female-initiated contraceptive methods, and to emphasize strategies to encourage males to wear condoms. In discussions with boys, we sought to help them recognize their responsibility to themselves and their partners, including being more open to condom use. We also decided as an institution that, to maintain the sexual safety and acceptability of our centers for adolescent girls, we would employ only females as adult mentors. We decided that the only males we would train to join the staff were boys we identified through the peer-education clubs who seemed to internalize and demonstrate respectful attitudes toward females.

As we began addressing these gender issues, we were again confronted by harsh realities—this time external political opposition. Individuals and church groups were increasingly attacking Action Health for “sharing too much information with young people and for talking about family planning.” An anonymous letter published in a national newspaper in late 1992 alleged that Action Health “corrupts” children by promoting family planning.

As a result, the Commissioner for Education banned the program from operating in any government school in Lagos State. Most parents then refused to allow their children to visit an officially discredited organization, and even the youth center was deserted. Action Health was in crisis.

THE TURNING POINT

Faced with the government shutdown, we had to reassess our program both politically and in terms of content. We followed our basic philosophy of consulting with young people. The peer educators urged us to push at the highest political level for a lifting of the ban. Parents and trustees helped us to organize meetings with influential government officials. For example, one trustee had worked in the Institute of Child Health at the Lagos University Teaching Hospital and had key contacts in the Ministry of Education. We distributed press information kits clarifying the organization's purposes and sponsorship and offered journalists the opportunity to visit the youth center, meet with the young people, and debunk the negative public perception. As frightening as the prospect of confronting the government seemed, we were determined to defend all we had achieved on behalf of young people in our country.

After three months of targeted efforts to educate local journalists, accurate and fair newspaper reports began to appear. In reaction to this turning tide, the government asked the principals of secondary schools in which we had worked to express their views of Action Health's activities. One principal after another reported that the school-based program was providing valuable information and skills that young people needed but that were not provided in the school curriculum. The government conceded that it had taken action without "looking at the merits of the case." A memorandum issued by the Lagos State Ministry of Education reinstated the school program, allowing us to resume our activities.

While this was a remarkable victory for Action Health, we were not content simply to re-establish the school-based program. Perhaps emboldened by our success in the policy arena, we decided to advocate for more meaningful adolescent sexuality education, which meant challenging the constraints on discussions of adolescent sexuality initially imposed by school administrators and communities. We wished to move beyond perfunctory public health messages on malaria and diarrhea prevention simply to give the sexuality information an acceptable "cover." One important limitation remained, however: Discussion of contraception in the classroom continued to be prohibited. We would still have to refer students in need of such information to the youth center, where we provided increasingly comprehensive information on STIs; contraception; the importance of seeking timely services for

sexual abuse, incest, and menstrual irregularities; pregnancy options; and how to negotiate sexual encounters.

Of course, the more we allowed students to talk about their real health needs, the more we had to face the limits of education alone in meeting those needs. Many students were already having sexual experiences, pleasurable and consensual in some cases, unwanted and abusive in others. These young people complained that the abstinence message did not address their real needs. They wanted to know how to protect themselves more effectively, whether from pregnancy, disease, or exploitative relationships.

Our policy of offering information alone had been put to the test and had come up short. Adolescents facing sexual encounters needed negotiating skills, which we had begun to address at the youth center but not yet in school settings. Many also needed clinical services. For a time we offered referrals, but many young people did not trust the providers or lacked the courage or the funds to follow up. Further, the referral clinics did not provide the individualized education or skills-building that was needed to complement and reinforce our educational programs. Gradually, we explored a possibility that had never been part of our original vision and that would undoubtedly generate renewed public resistance: We opened a teen clinic of our own.

ESTABLISHMENT OF THE CLINIC

Action Health opened its own clinic in a small room within the youth center and offered a wide range of medical and reproductive health services and counseling. The budget (\$5,000) was limited, so we hired one nurse-midwife and depended in part on time and supplies donated by board members. We also charged below-market rates and established a revolving fund for all drugs and pregnancy tests. Some clients still found it difficult to pay and were allowed to pay on very lenient credit terms. The income from the revolving fund helped to offset the impact of inflation on replenishing drug supplies. The clinic was open to any young person using the center and to participants in the school program.

Initially, most clients came for general health concerns such as skin infections or fevers. It took some time for them to trust the clinic personnel with more intimate reproductive health concerns. By treating general medical problems, we were able to attract young people and bring them back for follow-up visits that provided opportunities for discussing reproductive health issues.

To expand the reach of the clinic, we established health awareness outreach clinics in the communities surrounding the youth center. At first, we conducted only

weight and blood pressure checks, along with an orientation about our reproductive health activities. The outreach clinics put clinic staff into the community and enabled them to reach many more young out-of-school girls, who tended to be married and often already had children.

Given the community's positive reception to the mobile clinics, we expanded this effort to the schools themselves, setting up rotating morning clinics in 12 schools. We provided all services on a drop-in basis; follow-up appointments were made at the center-based clinic when necessary. Staff provided a general health exam and counseling and education based on the client's sexual history. We provided pelvic exams and a range of diagnostic tests. While the schools allowed students access to the mobile clinics, they also continued to constrain the type of information we could provide. Ironically, we could test for and treat STIs, but, because we were on school premises, we could not teach students to use condoms for prevention. Pregnancy testing could be carried out, but counseling about abortion was prohibited. For this reason, we offered students the option of receiving their test results at the youth center, where we could provide more comprehensive counseling. The mobile clinics and accompanying outreach have had a significant effect on the youth center clinic's client volume. From an initial eight clients a month in 1993, over 1,300 young people came to the clinic in 2000, each visiting the clinic twice on average. These numbers continue to grow.

As noted earlier, young people's initial visits tended to be for general health concerns such as skin infections, malaria and fevers, and injuries. Today, 50 percent of young people come seeking information about and treatment for suspected reproductive tract infections; sexual abuse or violence; concerns about the effects of female genital cutting (which affects one-third of our clients); premature ejaculation; and a host of other reproductive and sexual health concerns. This suggests that some of the stigma surrounding sexual and reproductive health issues has been overcome, but meeting the expanded range of young clients' needs has also strained the counseling skills of our staff. In response, we organized specially designed training sessions for clinic staff. Clinicians now provide a broadened range of in-house diagnostic tests for reproductive tract infections, including gonorrhea, syphilis, bacterial vaginosis, trichomoniasis, candidiasis, nongonococcal urethritis, and urethritis in addition to diagnostic tests for pregnancy, genotyping for sickle cell disease or traits (to ensure proper genetic counseling before pregnancy), and malaria.

Only one-third of the clients at the clinic are young men. While this is a higher proportion than at many other clinics, we feel that reaching young males is crucial to

improving all adolescents' sexual health outcomes. We are currently seeking feedback from young men regarding why they and their friends do not use the clinic. We are also exploring the possibility of holding a young men's clinic for two hours every week, using a male provider.

At this point, our program has faced and come through many challenges—most of them related either to the overwhelming centrality of gender-based power differences in adolescence or to external political sensitivities about adolescent (and particularly female) sexuality. In recent years, we have also struggled with the fact that we can reach only a tiny fraction of young people in a nation where the sheer magnitude of adolescent health needs dwarfs the combined efforts of all youth-focused NGOs. Furthermore, conservative church representatives—some of whom are clearly supported by U.S. groups—continue to target and lobby against adolescent sexual and reproductive health programs, including Action Health. Hence, we are seeking to maintain a balance between supporting the school-based peer-education program and the absolute necessity of influencing national policy on adolescent health. The final section of this case study reviews some aspects of the evolution of adolescent reproductive and sexual health policy in Nigeria.

A CHANGING NATIONAL SCENE

Our struggles were validated and our efforts reinforced by changes that followed the 1994 International Conference on Population and Development (ICPD). In 1995, Nigeria's National Adolescent Health Policy, which promoted human (adolescent) sexuality as a natural and positive part of life for both sexually active and non-sexually active youth, was adopted. This policy drew on the government's own research findings that adolescents, including secondary school students, were already sexually active, lacked information, and were taking unnecessary health risks (Federal Ministry of Health and Social Services 1994).

Since that time, national-level policy activities have become an even more important element of our work at Action Health. After ICPD, we met with long-standing allies from the NGO and government sectors to develop national guidelines for sexuality education for all age groups. These guidelines (see Box 3), prefaced by a statement from Olikoye Ransome-Kuti, a former, very popular and influential Minister of Health, helped solidify the alliances and offered a shared point of reference.

Our next goal was to develop a comprehensive national adolescent reproductive health agenda and engage those responsible for implementing the agenda. In 1998 we began educating and mobilizing a broader group of NGOs and associations, key government officials, donor agencies, groups of young people, and our colleagues in the

Box 3. Age-specific guidelines for sexuality education

The *Guidelines for Comprehensive Sexuality Education in Nigeria* are based on the following values: Sexuality is a natural and healthy part of living; every person is entitled to dignity and self-worth; individuals express their sexuality in varied ways; sexual relationships should never be coercive or exploitative; all sexual decisions have effects or consequences; and individuals and society benefit when children are able to discuss sexuality with their parents and/or other trusted adults.

The messages that sexuality education should cover are organized under six key topics: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. Each key concept is further delineated into subconcepts. For example, sexual behavior includes sexuality throughout life, masturbation, sexual expression with intimate partners, abstinence, human sexual response, fantasy, and sexual dysfunction. The content of messages appropriate for different developmental stages (i.e., childhood: ages 6–8; preadolescence: ages 9–12; adolescence: ages 13–17; and young adult: ages 18–24) are then outlined.

Sample messages from selected categories are outlined below:

Human development

Reproductive anatomy and physiology

- Each body part has a correct name and specific function.
- Girls and boys have body parts that, when touched, make them feel good.
- At puberty, boys begin to ejaculate and girls begin to menstruate.
- Both men and women can experience sexual pleasure throughout their lives.

Personal skills

Assertiveness

- Everyone, including children, has rights.
- Assertiveness is different from aggressiveness; aggressiveness interferes with the rights of others.
- In the past, females in our society were taught not to be assertive.
- Sometimes, people must choose between actions they believe are best and their friends' actions.
- People always have the right to refuse any person's request for any type of sexual behavior.
- Sexual partners need to communicate clearly about their needs and limits.

Sexual health

Sexual abuse

- Everyone, including children, has rights.
- It is never appropriate to force someone to engage in any kind of sexual behavior.
- People who are raped are never at fault for the rape.
- Sexual harassment (unsolicited sexual advances on a helpless or unwilling individual) can take place at school, work, home, and in the community.
- There are no social, religious, and health reasons for female genital cutting.

Note: These guidelines were developed with substantial input from the Sexuality Information and Education Council of the United States (SIECUS), which has developed flexible guidelines for sexuality education (SIECUS 1996).

Source: National Guidelines Task Force 1996.

media. One year later, the first Nigerian National Conference on Adolescent Reproductive Health was convened by the Federal Ministry of Health and attended by representatives of the Ministries of Health, Education, and Youth and Sports, the Presidency, 100 NGOs, and over 100 young people. Action Health served as the secretariat for this

historic meeting. During preparatory meetings and at the conference itself, there was some conservative political resistance to using the term “sexuality education” in the conference documents, but the language was ultimately retained. The conference and the communiqué signed by representatives of the government of Nigeria, the NGOs present, and our young adolescent guides was a dramatic affirmation of the goals to which Action Health had committed itself nine years before.

Action Health has continued to be involved in the follow-up to this conference. We recently succeeded in getting the National Council on Education to approve the integration of sexuality education into the national school curriculum. To operationalize this policy, we served on a national committee to develop a sexuality education curriculum for all Nigerian schools and explore how best to train those who will need to implement this curriculum. We developed a prototype curriculum to guide this process in collaboration with the Nigerian Educational Research and Development Council and the Federal Ministry of Education. The curriculum was formally approved by the National Council on Education in August 2001, and we have launched a process to ensure implementation at the Lagos State level, as well as to collaborate with NGOs working toward implementation in other states. Our work with girls was also highlighted in a documentary film produced by Jane Fonda and the International Women’s Health Coalition for Women 2000: Gender Equality, Development and Peace for the Twenty-first Century, the five-year review of the United Nations conference in Beijing.⁶

There are other promising developments. Nigeria recently joined with almost every other country of the world in signing the U.N. Convention on the Rights of Children, which demarcates age 18 as the end of childhood. This act has facilitated much more discussion about the need to establish—and enforce—a reasonable age of legal marriage. For example, Alhaji Abubakar Alhaji, Saudana of Sokoto, a mullah in the conservative Muslim north of the country, recently indicated that he would strongly support legislation to outlaw marriage before age 18, noting that early marriage disrupts a girl’s education, her job prospects, her career, and her chances for independence. Quoting the adage “If you educate a man, you educate an individual. But if you educate a woman, you educate the community, the society,” he added, “So our people [in the north] have yet to realize that we cannot be educated as a community, as a society, until our women are educated” (Alhaji 2000).

This sentiment was subsequently echoed by President and Commander-in-Chief Olusegun Obasanjo, who stated that “the most important thing we can do for them is to give them education . . . it is only when girls are as educated as boys that they can be as useful in terms of development of the society.” President Obasanjo further declared

his support for comprehensive adolescent programs, including sexuality education, and expressed interest in learning from Action Health's experience, thereby opening the door for a new level of dialogue with the government (Obasanjo 2000).

Even as the country continues to undergo political transition, we work to sustain the political commitments made at the 1999 conference and seek adequate allocation of resources to see these commitments turned into reality. In doing so, we recall the words of one Action Health leader in describing the world in which many Nigerians grow up:

I experienced the deafening silence of parents who would not answer the harmless questions of an inquisitive child—simple questions about my body and my feelings—out of fear that simply talking about such issues would tempt me to “experiment.”

At the level of the individual girl or boy, the community, and the country, Action Health remains committed to overcoming such silence and to pursuing supportive, open, and meaningful dialogue. We continue to address the sexual and reproductive health issues of all adolescents, as well as to raise awareness about the fact that the term “adolescence” may mask the enormous discrepancies in power, opportunity, and risk that face girls as compared to boys. In sustaining our work, we will continue to rely on the wisdom and guidance of the young people who have come this far with us.

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Notes

- 1 For a more complete discussion of adolescent reproductive health issues in Nigeria, see Irvin 2000, which describes gender-sensitive approaches to adolescent sexuality and provides a selected bibliography and program examples based on work supported by the International Women's Health Coalition.
- 2 Marriage generally signals an end to school attendance, so in-school adolescents may generally be considered nonmarried, particularly in the south. However, special vocational schools are being established for married girls in the north.
- 3 The maternal mortality ratio has been estimated at 800 to 1,000 deaths per 100,000 live births. The leading cause of these deaths is complications from unsafe abortion (Federal Ministry of Health and Social Services 1994).

- 4 Staff try to counter these deeply entrenched cultural norms, emphasizing the importance of treating girls as equals and respecting their right to say no. They also attempt to point out the exploitative nature of “sugar mommies” (adult women who offer boys food and drink in exchange for sexual attention), but boys generally say they are flattered by the attention.
- 5 Action Health’s experience is not unique. Research into the acceptability of youth centers for girls has often found that they are ultimately dominated by men and are often places where girls experience sexual harassment rather than support for their reproductive and sexual rights and self-esteem (Erulkar and Mensch 1997; Glover, Erulkar, and Nerquaye-Tetteh 1998; Phiri and Erulkar 1997). It is disturbing that ensuring girls’ rights and meeting their most pressing sexual health needs may depend on the presence of a trusted female for recourse.
- 6 “Generation 2000: Changing Girls’ Realities” is a 15-minute documentary video featuring Action Health and two other Nigerian adolescent programs, produced by Fonda, Inc. and the International Women’s Health Coalition. For more information, contact IWHC at communications@iwhc.org.

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