

REPRODUCTIVE HEALTH ISSUES OF THE ADOLESCENT IN AFRICA: REVIEW AND COMMENTARY.

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Summary There are yet many unmet reproductive health needs for the African adolescents despite the many reproductive health programmes which have been initiated in the last decade. It appears that the gains of the programmes are not yet being felt across the continent. In this era of HIV/AIDS and the peculiar reproductive health problems of the African youth, there is an increasing need to identify the critical issues and constraints. It is widely believed that much of the constraints are cultural. It is also believed that much of the required interventions will be social in nature. There are cultural constraints in programmes design and implementation, and in services acceptance, access and utilization. It is therefore important to identify the cultural value-foundations of some of the reproductive health issues and determine how to configure such issues in programmes and programmatic approaches.

Key Words: Reproductive health, Africans, Adolescent, Culture

Introduction

Reproductive health has been defined as a state of complete social, physical and physiological well-being in all matters of reproductive system (Shane, 1992). This will include the social and medical support that enables women go through pregnancy and childbirth. Every year over half a million women in developing countries die in pregnancy or childbirth regardless of the safe motherhood initiative of 1987. The last decade witnessed an increased global attention to reproductive health. The United Nations General Assembly in July 1997 affirmed its commitment to make reproductive health universally available by the year 2015. Earlier in 1994, The Women conference had adopted reproductive health center themes in its plan of action. The 1994 UN Conference on population and development held in Cairo prioritized the youth for the current decade. It is re-assuring that many non-governmental organizations and governments are stepping up their advocacy and actions in reproductive health matters. Many programmes are being introduced in many countries of Africa though some have not been as successful as anticipated. Many studies have shown that the adolescents are disproportionately negatively affected by poor reproductive health programmes

(Tetteh, 2000). The WHO estimates that 60% of all new HIV - infections occur in adolescents aged 15 - 19 and that females are 5 times more likely to be infected than males; and by the age of 19, 33% of them are infected (ICAF, 1993). In general, adolescents face special difficulties, which impact negatively on their reproductive health. This is related in part to their physical, psychological and physiological immaturity, and partly due to the socio - cultural constraints which the young faces. The fear of adult recriminations prevents the adolescent from telling or asking! There are legal hurdles, which they have to scale in order to access information and services in many parts of Africa. This includes restrictive abortion laws, high legal fees and the absence of protective legislations. The adolescent is also generally naïve. He is an immediate gain thinker who is largely unable to fully understand the consequences of his actions and is thus more likely to indulge in risky behaviors that negatively impact reproductive health (Trude, 1999). For instance, adolescent pregnancy is a growing source of alarm in many countries (ICAF, 1994). However, the adolescent is also at an intense learning stage of life, behaviors learnt at this stage are more likely to be carried into adult life (Kulia, Metcalf, et al, 1990). Therefore, the adolescent is not only a high-risk group; it is also the age - group for whom preventive reproductive health investment

promises to have a sustainable and multiplier effects in the future.

The Peculiar Reproductive Health Circumstance Of The Adolescent In Africa.

Reproductive health needs vary widely with age groups as well as the individual's experiences (Ekwe, 1996). It varies with the level of poverty and the particular policies of the country (PRB, 1995). In most countries of Africa, many cultural traditions and mass poverty complicate the adolescent's reproductive health problems. This is even more so for the girl given the culturally entrained gender inequities in this part of the world. Many reproductive health services that had been planned in isolation of the understanding of some of the value-foundations of these cultural practices have had limited success. It is hardly surprising that despite many years of campaigns against female genital mutilation or circumcision, millions of women still go through varied forms of genital mutilations in Africa (Adinma, Agbai, and Okeke, 1994). Much of this failure is due to inadequate culture-specific research and information by as much as inadequate resources. For instance, experience has shown that legislation against this practice in Africa is successful to the extent that its cultural roots is understood and addressed accordingly. Of the peculiar reproductive health problems of the adolescent in Africa, the girl-child is most at risk.

The focus of this article is the identification of the negative impact of some of the cultural foundations of some issues of the adolescent reproductive health in Africa. The goal is to bring into focus these culture-specific factors as a means of enriching the planning of programmes and programmatic approaches of reproductive health problems in Africa and for the age group at greater risk. The point here is that the adolescent should be a major target of programmes and that much of the action needed will be social in nature. They should be actions, which should derive from culture-specific research and need assessment. Reproductive health services stand better chances of acceptability and utilization if they are adolescent-friendly and situated within their own cultural milieu.

Reproductive rights, including whether to and when to have children or how many, is

alien to many cultural groups of Africa. Thus studied social action and time will be required to foster this understanding. We are all certain, for instance, that the young girl is naturally and socially disadvantaged to negotiate safer sex. This situation is even worse for the girl-child who lives in a culture where gender inequity is an accepted way of life.

1. **Age at first sex:** The median age at first sex in Africa varies from 16 in Nigeria (Brabin, Obunge, et al, 1995), 15 in Uganda (Agyei and Epema, 1992) to 14 in Gambia (Kane et al, 1993). It is believed that adolescents are becoming sexually active at younger ages. There are thus really unprepared for the consequences of sex. In a study of Nigerian teenagers, most respondents identified the element of force in their first sexual experiences (Nwobodo, 1997). This kind of sex is more probably unplanned and unlikely to be safe. Such young girls are culturally restrained to report many cases of sexual violence against them for fear of being stigmatized and running the risks of never getting married (ICAF, 1993). Sex, as yet, cannot be publicly discussed in many cultures of Africa and parents are usually at a loss when confronted with such cases as rape because of the negative publicity. It is still strange for parents or teachers to discuss sexual matters with adolescents.

It is common to find young girls getting involved in street trading in cities, apparently to augment the family income. Many of these girls become easy prey to dubious customers and suffer all kinds of child molestation. The health hazards of juvenile street trading have been well documented (Kulia and Metcalf, 1990). The absence of socio-legal support for such victims let offenders think of this felony as minor. Given the obvious high level of sexual activity by the young, it should be reasonable to accept the fact and equip the young with reproductive health information in the overall interest of the society. A major opening here is to introduce reproductive health education into the formal and informal school curricula. Many informal instructional homes in the villages of Africa proved to be veritable sources of information dissemination for family planning programmes.

2. *Access To Reproductive Health Information And Services:*

There is a general paucity of reproductive health information and services across Africa most especially for the young (Ngmaryo, 1996), but wide regional variations exist. The general level of reproductive health education in sub-Saharan Africa is low. It has been estimated to be between 16 and 14 percent in parts of Africa (UNICEF, 1996). And when it is available, accessibility becomes a peculiar problem for the adolescent because, first, their parents are reluctant to allow a free flow. Besides, they may present blocks when their adolescent children seek information from them. This is assuming they are informed themselves. Seeking information in all matters concerning sex is culturally perceived as a sign of promiscuity. Parental resistance is probably the greater obstacle to adolescents seeking information and services. Sometimes, however, affordability is the obstacle. In the absence of information - misinformation thrives. For instance, it was at a time feared that condoms were impregnated with viruses in a local population in Nigeria and a popular sanitary pad was also, rumored to contain the HIV -virus. This is not to dismiss such rumours since they cannot as yet be verified.

The rural populace is often less informed and studies have shown that the rural woman is not only hard to reach but much more difficult to change her attitudes which are ingrained in her culture (Nwobodo, 1997). For instance, only 20 % of sexually active adolescents reportedly use contraceptives in Nigeria due to cultural barriers (Adinma, Agbai and Okeke, 1994). These culturally imposed obstacles to the democratization of reproductive health information stand a better chance of being redressed by the inculcation of a carefully planned culture-compatible reproductive health education in the curriculum of primary and secondary schools. It can also be incorporated in the programmes of the many existing traditional training institutions. Programme planners should exploit such socio - cultural institutions as age - grades clubs, brides - grooming homes and even the local places of worship. In each case, selecting and imparting what is relevant. Many programmes on family planning campaigns got remarkable successes when using these existing institutions and social structures (Passages, 1993).

3. *Early marriage:* - Early marriage can be described as violence against the girl-child. Most of such marriages are contracted without the consent of the "bride". Sometimes, the arrangement is made shortly after the birth of the girl (Dagne, 1994). Early marriage means subservience to the older husband and limited life options; it means early childbirth and maybe larger families. By the age of 20, 50% of women in Africa are married (Friedman, 1992). In Ethiopia, age 13 is quite common (Dagne, 1994). And in northern Nigeria, the age of 13 is also common. In this era of AIDS/HIV, older men target teenage girls whom they consider safer sex partners for marriage. In Mali, early marriage is the greatest cause of young girls dropping out of schools (Hirsch and Parker, 1992).

There are increased risks of obstetric problems with early teenage childbirth. The very high incidence of vesico-vaginal fistula in northern Nigeria is directly associated with early marriage and childbirth. This age-long cultural practice has survived largely as a learned norm. The young girls who are not married see themselves as failing in one respect, just as their parents may become desperate. Some studies have linked the eagerness to marry off young girls to family poverty (Ulin, 1992). While this may be an underlying factor, it is unlikely to be the case if the young could see good career options well ahead and look up to new role models. It has been suggested that by involving the religious institutions in contracting traditional and civil marriages, this practice could be reduced. The value-foundation of early marriage is yet to be fully understood. It is certain that only when this is studied can a workable programme be developed.

4. *Adolescents and Unwanted Pregnancy:* Several factors contribute to high rates of teen pregnancy. Adolescent pregnancy is a growing source of alarm in most countries of the world. The proximate causes include unavailability and inaccessibility to contraception. In many parts of Africa, many young girls get undue exposure to sexual exploitation when they engage in street trading and other forms of child labor (Ekwe, 1996). At times, sheer ignorance, naiveté, illiteracy and culturally entrained low self-esteem make an adolescent girl easy prey to older men. There is as yet, little social support for girl victims of sexual-abuse in situations when pregnancy results.

Early-teenage pregnancy incidence is higher among rural girls compared to their urban and better-educated counterparts (Okonofua et al, 1997). By the age of 25, a woman would have developed physiologically for childbirth and may have built up sufficient self-confidence/self-esteem to define herself in a marriage. Such defined persons are likely to afford and seek induced abortion though it is still mostly illegal in Africa. On the other hand, the adolescent girl is five - times more likely to die during pregnancy and childbirth compared to woman aged 20 - 25 (El Mouelhy et al, 1994). Here again, educational empowerment of adolescents, fostering of social support institutions that are adolescents - friendly, are widely advocated options. These could be coupled to a policy of democratization of contraceptives information and use. Child-bearing under the age of 16 carries high risks of morbidity for both mother and offspring. These are to be weighed against the religious and social resistance to induced abortion. The African adolescent is severely handicapped in situations such as this because having the unwanted baby means a definitive societal stigmatization. There are few adolescent-friendly reproductive health agencies. Virtually none exists in most of rural Africa. This partly accounts for the high incidence of unwanted pregnancies in the rural areas.

5. **Unsafe Abortion:** The adolescent is less likely to use contraceptives and thus more likely to seek unsafe abortion (Okonofua et al, 1997). Abortion is largely illegal and restrictive in most of Africa. Restrictive abortion laws means that fewer qualified persons are willing to render that service, thus leaving the large clientele underserved. It is a taboo among the Igbos of Nigeria, as in many other African cultures, to have a baby out of wedlock. The clientele is thus a desperate one, which is constrained to seek help from the ever-available quacks, usually under unsafe medical settings. It is reported that 60% of abortion-related complications occur in the adolescent age group (Friedman, 1992). Unsafe abortion can be viewed as a vicious cycle for the unfortunate girl - child. This cycle begins from her relative disadvantage to access information and contraception which makes her more likely to have unwanted pregnancy, and because of the cultural and social taboos, she is more likely to seek abortion, which is more often under unsafe settings, and thus more likely to develop complications. This cycle is even more vicious given her immature reproductive system.

This Unsafe Abortion -Cycle has been well constructed by Okonofua (Okonofua et al, 1997). The rising incidence of teen abortion may be indicative of rising cases of coercive or commercial sex, poor empowerment of women or lack of affordable contraception (Trude, 1999). In a culture characterized by female subservience, restrictive abortion laws, low use or access to contraception and poor resources, and one in which many young persons have limited health-seeking behavior and other constraints; abortion is likely to be even much more complicated.

Unsafe abortion remains a most contentious issue across the world. It has been observed that the rising profile of HIV/AIDS in Africa has been increasing the practice of safer sex among adolescents (Attawell, 1997). The reinforcement of this attitudinal change is thus one way of curbing the incidence of induced abortion in the continent.

6. **Female Genital Mutilation (FGM):** It has been estimated that over 100 million African women have had one of many forms of female genital mutilation (WHO/UNICEF/UNFPA, 1997). This may even be an underestimation. FGM may take place at anytime during infancy or childhood or just before marriage. The cultural-value foundation of this practice includes curbing female promiscuity and preservation of premarital chastity. However, this age-long harmful practice predisposes the victim to painful intercourse, recurrent urinary tract infections and obstructed labor later in life. The immediate complications include haemorrhage, shock, infection and urine retention. Besides, it carries immense psychosocial consequences (Shane, 1992). While FGM is treated as an act of violence against children in Europe and North America, FGM practices have survived in Africa and the Middle East despite the unequivocal opposition to all forms of it by many governments and official health organizations such as the World Health Organizations (WHO). Egypt launched a national campaign against FGM in 1994 but had to reverse to a medicalization policy just two weeks later due to pressures from traditionalists (Anonymous, 1995). Kenya has also experimented with this so-called medicalization (Heise, 1994); but the WHO is unequivocal that FGM in any of its forms should not be practiced by any health professional in any setting-including hospitals or other health

establishments (Panos, 1993). This is one good example of how culture affects modernization in Africa even when the benefits of such practices cannot be justified. In Nigeria, there are unenforced laws against FGM because of cultural barriers. FGM is commonly believed to reduce promiscuity in girls but perhaps it has survived mostly because women have come to accept it as a rite to womanhood. The practice, which is deeply rooted in unfounded traditional belief, is carried out without consent on infants whereas the adult looks forward to it as it were. It is important to medically challenge this belief as part of the programme for its eradication. FGM is reportedly on the decline among urban/educated and younger women in Nigeria (Adinma, 1997). This is an indication that as the cultural value fades with education and general awareness, the negative and unjustifiable practices will go with them.

7. Adolescent and Sexually Transmitted Diseases/HIV: The adolescent is definitely underserved in the provision of care for sexually transmitted diseases/AIDS in most developing countries. The WHO reports that STDs, and recently the HIV/AIDS, constitute a most serious reproductive health problem for the young. It is estimated that 60% of all new HIV infections occur among the 15 - 24 year olds. By far, most of these new infections occur in sub-Saharan Africa. Prospective husbands are increasingly seeking younger girls in the belief that they are HIV-free. However, in an STD clinic in Ibadan, Nigeria, 22% of the female clients who were aged 10 and above had one STD or the other (Brabin, 1996). And in a study in a rural area of southeast Nigeria, it was found that over 42% of sexually active adolescents had experienced an abortion or one sexually transmitted disease or the other (Brabin et al, 1995). Adolescents, in general, face difficulties in accessing available reproductive health care services. Besides, the younger girl is physiologically more vulnerable to STDs including HIV due to her immature reproductive tract. There is a thriving herbal medicine trade in Nigeria. It is the all-STD cure preparation. These are usually affordable and accessible to the young. The efficacy of these preparations remains doubtful but they certainly encourage unsafe sex by giving a largely false sense of magic cure for all STDs including HIV/AIDS. Many girls, like most women, are at a cultural disadvantage to negotiate the use of condoms with their male partners. Also, female condoms are still unpopular, difficult to use and

expensive. More importantly, the male attitude to female-initiated condom use can be very negative. The female runs the risk of being termed "spoilt". It should be a point in campaign programme to encourage young females to protect themselves regardless of this prejudice. The fundamental issue however, will be to improve the status of women in the African society through education and vocational training. It is only the confident female that can negotiate safer sex with her male partner.

8. Sexual Violence and The Adolescent: There are many reports of sexual violence against adolescents in all parts of the world. In Africa, data is scant which is mostly due to under-reporting and under-documentation. The peak age of vulnerability to sexual violence in the USA is 7 and 13 years for boys and girls respectively. Data from a rape crisis center in Nigeria indicate that most female victims are 15 years and under. In all cases, younger age is the most outstanding risk factor. In a survey in Nigeria, this author found that most adolescent girls indicated the application of "force" in their first sexual experiences (Nwobodo, 1997). This finding is indicative of coercion. Older men are known to entice naïve young girls into relationships with gifts and money. The circumstances for sexual violence vary widely in Africa; this will include family poverty and individual peculiarities, community characteristics and social conflicts like wars and homelessness. Child labour, abuse and neglect are predisposing factors. An adult who has been abused can report to the authorities for redress or to seek protection. However, most young ones are reluctant to report to their parents for fear of recriminations. Indeed, sexual violence has been termed a hidden burden, which is mostly borne by women (Heiss et al, 1994). Gender-based violence as defined by the United Nations Population Fund is violence involving men and women in whom the female is usually the victim and which is derived from unequal power in relationships between men and women. It includes battering, rape, childhood sex abuse, FGM, coercion, intimidation and early marriage. Many health workers in Africa do not have the time, training, support or resources to help victims of violence. And the young is certainly unable to adequately help himself. There is the need to create awareness but more importantly to provide channels for redress such as special courts, police hotlines, and rehabilitation centers

and make hospitals document and report sexual abuse cases presenting for treatments.

Conclusions And Recommendations

The reproductive health situation of the adolescent girls and boys in Africa is precarious and requires to be comprehensively addressed. The dearth of reliable working data is a serious constraint in advocacy and policy formulation. African governments wishing to plan reproductive health programmes should first identify cultural factors that could negatively impact such programmes. These constraints expectedly vary for the different ethno-geographic areas. It would therefore, be fruitful for different African governments planning reproductive health programmes to institute extensive culture-specific research even for restricted ethno-geographic areas with a view to identifying the cultural traditions and practices that negate the reproductive health of especially the adolescent age - group which is arguably at greater risk. By as much also, programmes must be developed within the context of cultural peculiarities giving attention to potential problems of translation of particular concepts. This would assist in the designing of functional reproductive health programmes.

Reproductive health education could be part of formal and informal educational curricula in Africa. In rural Nigeria, prospective brides for instance, are sent for home training under older/ more experienced women. Such institutions could play important roles in reproductive health education. The *Family Support Programme* is a government funded, well-accepted women empowerment agency in Nigeria. The incorporation of reproductive health education into the socio-cultural activities of such agencies would not only save resources but it can extend the reaches. It is also, likely to improve the chances of acceptance of reproductive health programmes. The South African MAP (Tetteh, 2000) and Kenyan teens programme (ICAF, 1993) have proven that success can be achieved with adolescent-friendly reproductive health services situated within the cultural milieu of the beneficiaries and by using existing traditional institutional structures.

The involvement of adolescents in planning of programmes often helps the planners to understand and use the required socio-cultural

situations. Furthermore, it eliminates the risks of conflicts with perceived traditional norms many of which are sacred to the people. The integration of previously well-accepted programmes like the Immunization programmes with reproductive health programmes, clearly improves the chances of its acceptance.

The importance of traditional rulers in the advocacy of the reproductive rights of women has been identified as worthy of greater exploitation because of their close contact with people at the grassroots and influence in advocating for edicts to protect especially young girls (Haliru and Rakiya, 2002). Religious leaders are influential in most of Africa. Certainly most religious faiths in Africa do not antagonize well-articulated health programmes except induced abortion; but induced abortion is only one in a broad spectrum of reproductive health problems. Age - grades are cohesive traditional clubs commonly found in most of rural Africa. This group has a well-defined membership, which is based on year of birth. These cohesive groups could easily be harnessed as a group to raise acceptability of service and for other social actions necessary to foster better adolescent reproductive health.

Legislation is a useful operational framework. However laws which cannot be enforced are useless. Legislations are needed to institute social shelters for victims of sexual violence or adolescents at risks. Adolescents-friendly reproductive health services and legal aid can be developed. For instance, special police units and telephone hot lines for adolescents in need can be put in place and popularized. Such support services have acculturation roles for positive behavioural changes. The sexually abused girls/boys, and sometimes their parents, are at a loss as to where to get help when in need such as when a young girl has been assaulted. Every reproductive health worker in most parts of Africa would have found himself in this dilemma at one time or the other. It can be quite frustrating for a health care provider to turn away an adolescent who has made an effort to get help because institutionalized structures for assistance do not exist.

It can be concluded that adolescents everywhere face special reproductive health difficulties. The difficulties facing the adolescent in Africa are confounded by both lack of resources and ignorance but more so by age-long

cultural practices and beliefs. These cultural traditions have to be understood in context and in content when programmes are to be planned. For instance, the value foundations for FGM in different cultural areas must be understood and configured into any programme for its eradication.

Reproductive health problems are major health issues. The adolescents are clearly at greater risk. The many governments of Africa just need to do a lot more in the interest of its leaders of tomorrow. And this may also form part of a comprehensive approach to address the problem of HIV/AIDS pandemic in Africa. In a way, this should be a common concern for the international community as well given the migration patterns, tourism, international sex trafficking and globalization of the world economy. Programmes and laws should pay attention to these cultural factors in addition to adolescent confidentiality, accessibility and affordability of service with little bureaucracy. Bureaucracy and inappropriate guidelines sometimes stifle programme's implementation.

While broad programme guidelines could be planned and promulgated at the state level, there should be sufficient devolution of functions to the community levels or specific cultural

groups who should retain the latitude to determine their specific programmes strategies including resource allocation. A central role for these culture-area groups would include clarifying values, dispelling myths and negative taboos. In general, approaches must be non-judgmental because experience has shown that such can engender varied forms of resistance. However, the state levels shall retain monitoring functions for quality assurance and logistical support. The adolescent should be specially considered in all reproductive health programmes, which should emphasize confidentiality and accessibility of service. Popular radio /television media have a proven record of success as a means of reaching the adolescents in the cities. Community-based age-grades, clubs of sorts and other traditional institutions easily reach the rural areas and such institutions should be exploited.

To improve the reproductive health needs of the adolescent in Africa, there should be: Research with focus on youth pertaining their cultural constraints, Community mobilization, Dedicated clinical and social reproductive health services for the youth and Flexible collaboration among existing traditional and interventionist institutions.

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