EXTENT OF ADOLESCENTS' KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN NIGERIA: IMPLICATIONS FOR DEVELOPMENT

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ABSTRACT
Adolescents constitute an important segment of every society but unfortunately; this large but vulnerable group is not adequately prepared for sexual and reproductive life. Most of them lack basic information about their bodies, sexuality, contraception and sexually transmitted infections (STIs) including Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). This study focuses on 1,350 adolescents in four secondary schools selected through a rigorous sampling technique. Results show that most adolescents are reluctant to discuss sexuality – a corollary of the silence and secrecy associated with sexual matters in Africa. The study also reveals that adolescents are poorly informed and this has far-reaching implications for their well-being and national development. The findings reecho the need for parents and interested stakeholders to provide adolescents with accurate information to forestall their acquiescence to misinformation from unreliable sources.

Key Words: Adolescents, Sexual Health, Sexual Rights, Reproductive Health, Reproductive Rights, Development.

INTRODUCTION

The period of adolescence is seen as a critical period in most parts of the world. It is a transitional period that marks the end of childhood and the beginning of adulthood and it concerns individuals within the ages of 10 and 19 years. Variations abound in the consideration of this period. While some scholars put the onset of adolescence at 10 years, some situate it at 15 years. The height of adolescence is set at 19 years and sometimes raised as high as 24 years. The World Health Organization (WHO [19981]) puts the period of adolescence between 10 and 19 years of age.

Although adolescence is characterized by increased physical changes, the interpretations of these changes and responses to them differ across cultures. Biological manifestations of adolescence have also changed over time. Age at the onset of menarche has been declining because of improved health and nutrition (WHO 1995) and formal schooling has increasingly extended into the late teenage years for both sexes (Irvin 2000). Adolescence has three stages and each stage has exclusive patterns of change in behaviour and sexuality. These, according to PPFA (2004:3), are *early adolescence* (ages 9-13 for girls and 11-15 for boys), *middle adolescence* (ages 13-16 for girls and young women and 14-17 for boys and young men) and *late adolescence* (young women aged 16 and older and young men aged 17 and older).

Adolescents constitute a vital component in every society but unfortunately, this large but vulnerable group is not adequately prepared for sexual and reproductive life as most of

them lack basic information about their bodies, sexuality, contraception and STIs including HIV/AIDS. Adolescents' decisions and behaviours during their teen years can have life – altering and life long consequences for them. It can also have major cost implications for society as a whole. Uninformed or wrongly informed adolescents may have irredeemable and long lasting implications for the family and the society at large since the future of any nation depends on them. What is problematic about the stage is that the result determines the lifestyle of boys and girls in adult life and this includes not only their reproductive life but also their socioeconomic life. That is where the knowledge of sexual and reproductive health and rights of adolescents become imperative.

Reproductive health (RH) involves the state of complete well-being of an individual in its entirety whether physical, emotional or psychological. It does include matters affecting the overall wellbeing of a person. During the International Conference on Population and Development {ICPD} held in Cairo, 1994, RH was defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations, 1996:1).

This definition implies that individuals will be able to have a *satisfying and safe sex life*, *access to safe, effective, affordable and acceptable methods of family planning based on informed choice and dignity* that ensures prevention of and treatment of STIs and prevention and care of HIV/AIDS. Implicit in this definition is also the elimination of harmful practices like female genital mutilation, domestic violence and sexual trafficking. To achieve RH in its totality will entail that reproductive rights (RR) be guaranteed. This involves the recognition of the basic right of individuals to decide freely and responsibly …and to have the information and means to do so. Adolescents are predominantly vulnerable because, in most countries, they lack the necessary information and access to relevant services (UN, 1996:2). So there is the need for appropriate information to be given to all individuals if comprehensive RH and RR are to be achieved in any society.

This is not devoid of Sexuality, Sexual Health (SH) and Sexual Rights (SR) components. Sexuality has been defined as "a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction" (African Regional Sexuality Resource Centre [ARSRC],

2003: 17). It is better captured in this definition that describes it as "the totality of who you are, what you believe, what you feel and how you respond" (Action Health Incorporated [AHI], 2003:192).

SH, on the other hand, is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. It requires a positive and respectable approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free from coercion, discrimination and violence. For sexual health to be attained and maintained in any social setting, the sexual rights of all persons must be respected, protected and fulfilled.
Sexual rights necessitate that all persons, irrespective of sex, be free from coercion, discrimination and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide to be sexually active or not;
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life (*www.who.int/reproductive-health/gender/sexual_health.html)*

The three elements of sexuality, SH and SR are interrelated and interwoven and one cannot be achieved in the absence of the other two. So sexuality, simply put, is the full attainment of SH and SR in any given society.

The sexual and reproductive health {SRH} of young people is linked to other basic needs like decent jobs and wages. The greatest hindrance against adolescents' knowledge of SRH and rights in Nigeria is a patriarchal and sexist hostility. Nigerian cultures frown upon open discussions of SRH. Words used to express SRH are often indirect to reflect the silence expected in such matters. The doctrines of Christianity and Islam tend to

validate this patriarchal and sexist hostility. Adolescents cannot openly discuss or ask questions about SRH. The belief is that such matters belong to the realm of marriage. Despite this belief, sexual activities go on among adolescents in Nigeria. Indeed, adolescents the world over are sexually active but the age of sexual debut varies from country to country. Adolescents bear the risk of more vulnerability to STIs and HIV/AIDS because they indulge in multiple short-term relationships and practice unsafe sex (UNAIDS, 2000). This underscores the need to know the extent of Adolescents' knowledge of SRH and rights and makes their sexual behaviour of concern to public health practitioners and policy makers.

THE PROBLEM

All over the world, adolescents' involvement in early and risky sexual activity is well documented. Following adolescents' risky behaviour, about 10% of births worldwide is accredited to them. Each year, 15 million girls aged 15-19 have babies; girls under 16 years are twice as likely to die in childbirth as women in their early twenties; and 2-4 million adolescents in developing countries have unsafe abortion every year. Eleven percent of young women aged 15-19 has an unmet need for contraception; and worldwide more than half of all new HIV infections occur in people under age 25 and 7 in 10 new cases of STDs occur among people aged 15-24 years (UNICEF, 1998; WHO, 1997). In Zambia, one in six urban youth aged 15-19 years is HIV positive (Zambian Sentinel Survey, 1999 in Human Development Initiative [HDI], 2001) yet, by age 19 only 16% of Zambian youth report that they have never had sex (Zambian Behaviour Survey, 1998 in HDI, 2001) and 64% of girls and 70% of boys think they are not at risk of contracting HIV (Zambian Demographic Health Survey, 1996 in HDI, 2001). A survey that involved unmarried Zambian females aged 13-20 years revealed that of those who had sex two months earlier, only 10% used contraception (Family Health International [FHI], 2000). Majority of the youths are sexually experienced by the age of 19 and as many as 71% of boys and 34% of girls have had sex at age 14 (UNICEF nd).

The Nigeria Demographic and Health Survey {NDHS} [1999] report a population of 115 million with an estimate of 136 million by the year 2015. Out of this, 47% are below age 19; 42% are in the 10-24 age category, 23% are in the 10-19 age group and 19% are between ages 15-24. However, the survey reports that about 50% of all Nigerians

infected with HIV are adolescents and young adults. Projections to 2010 propose that more than 2 million young adults will be HIV positive. Thirty percent and 25% of male and female teenagers respectively do not know how to avoid HIV and 7 in 10 male and female teenagers believe they have no risk at all of contracting HIV.

There is the need for adequate information on SRH to stem the tide of high vulnerability among this young group. Saying no to sex can be very difficult for many young people. While boys often engage in sex because it is pleasurable, a sign of manhood, fun and a form of entertainment and recreation, girls do so for exchange of money/gifts/favours, to prove love to a boyfriend, to keep the boyfriend from leaving and because of coercion (HDI, 2001:23-24). So to be able to manage their sexual and reproductive lives properly, adolescents must be equipped with the right knowledge to decide consciously whether, when and with whom to become sexually active, to avoid nonconsensual sex, sexual violence and abuse; to plan pregnancies and have access to safe abortion (HDI, 2001:24).

BRIEF LITERATURE REVIEW

In Nigeria, access to information on SRH is limited thus exacerbating the incidence of STIs and HIV/AIDS and in turn the mortality rate. Literature on SRH in Nigeria shows that many adolescents indulge in premarital sex (Goddard, 1995, Izugbara, 2001, Izugbara and McGill, 2003). A national survey carried out in the 1980s and 1990s show that 80% of males and 65% of females indulge in sexual activity before age 20 (Izugbara, 2005:17).

Oloko and Omoloye (1993) in a study amongst secondary school students reported that 40% of them already experienced sexual intercourse. Ladipo et al., (1986) reported that in Calabar, 54% of female and 52 % of male adolescents had sex before age 15. Similar studies in rural and urban areas of Enugu, Kaduna, Lagos, Onitsha and Zaria show that sexual activity amongst adolescents is high (Adebusoye, 1992). Despite the fact that most adolescents in Nigeria are sexually active, evidence show that they lack access to RH services (UNAIDS, 2000). The study by Ogunlayi (2005) to ascertain the SRH and rights among adolescents in South Western Nigeria (Ikeja and Ikorodu LGAs) revealed that majority of the respondents (60.3%) in Ikeja LGA and (62.3%) in Ikorodu LGA knew of their SRH rights but lacked knowledge of the content of the rights. Most of them were

unaware of SRH programmes for adolescents while those who were aware could not access them due to cultural barriers. A similar study in Bida LGA in Niger state by Odimegwu et al., (2002) revealed poor knowledge of SRH rights and use of modern contraception. The Bida study showed that parents shy away from discussing SRH with their children believing that such may expose them to sexual misbehaviour.

Among adolescent university students in Ibadan, 48% indicated having multiple partners (Oladapo and Breiger, 1994). These studies corroborate the assertion that most adolescents are sexually experienced with a tendency towards multiple partnerships (Sunmola et al., 2002). However, the multiplicity of partners exposes them to the risks of pregnancy, STIs and HIV/AIDS infections. The risk of pregnancy equally exposes them to illicit abortion, which is injurious to health. One of the dangers inherent in this is the possibility of contracting the HIV/AIDS virus. Amongst scholars, some factors have been identified as impediments to adolescents' knowledge of SRH and their rights. These factors include poverty, wrong information, cultural bias, language barrier, lack of access to SRH programmes and the sexual exploitation of the girl child.

SRH is not only a health issue but an economic and development issue. Adolescents who constitute the future productive force of the society are vulnerable to STIs and HIV/AIDS due to their inability to access the right information and thus make the right choices. Their inability to make the right choices is due to the inconsistent use of contraceptives. One of the reasons given for non-use of contraceptives is lack of awareness. Another reason is lack of power to negotiate contraceptive use with sexual partners. This is especially valid for female adolescents. Their vulnerability is also not unconnected with little factual information, too little guidance by parents about sexual responsibility and little access to health care. These impediments constitute a hindrance to sustainable development.

THEORETICAL FRAMEWORK

Emile Durkheim (1938) in his analysis of *Social Facts* has argued that society has a reality of its own over and above the individuals who comprise it. Societal members are constrained by *Social Facts* and by "ways of acting, thinking and feeling, external to the individual and endowed with a power of coercion, by reason of which they control him"

(cited in Haralambos et al., 2000:1035). So beliefs and moral codes are passed on from one generation to the next and shared by the individuals who make up a society. That is to say it is not the consciousness of the individual that directs behaviour, but common beliefs and sentiments that transcend the individual and shape his/her consciousness. By implication the society is much more than the individuals and as such the individual must be meant to act in a way acceptable to the society. In doing so, however, the individual feels they are acting out of choice without knowing that their actions are being constrained by the social fact of the situation. He concludes by arguing that the explanation for the continuing existence of a *Social fact* lies in its function, that is, in its usefulness for society.

Durkheim's view can be seen in the usefulness societal members attach to non-exposure of adolescents to knowledge of sexual and reproductive health and rights. For most African societies, lack of knowledge on sexual matters entails safety as it is assumed that if adolescents are not exposed to such knowledge the likelihood of getting involved, and consequently becoming a victim, will be slim. This has not been the case as studies have, over the years, shown adolescent's high exploratory nature (Odimegwu et al., 2002; Oladapo and Breiger, 1994; Adebusoye, 1992; Ladipo et al.,1986; Oloko and Omoloye, 1993; Goddard, 1995, Izugbara, 2001, Izugbara and McGill, 2003) and this has made it necessary to empower them with adequate knowledge. So, if ample information is not provided to adolescents, the society suffers the consequences of producing what *social Facts* is meant to control or avoid.

While acknowledging the existence of social structure, Weber (1978) is not of the opinion that the society determines the actions of the individuals. To him, a social action was an action carried out by an individual to which a meaning is attached but takes into cognizance the behaviour of others. In other words, if an action does not put into consideration other people's behaviour the action cannot be seen as social in its context.
For a better understanding, Weber distinguished two types of understanding – *direct observational and explanatory understanding*. The former involves observing an event and giving it an interpretation based on that – like seeing two teenagers of the opposite sex talking in low tones and keeping quiet when somebody approaches. The latter entails understanding the meaning of an act in terms of the motives that have given rise to it. So

explanatory understanding requires that one understand why the teenagers are speaking in low tones. Has it to do with having a date or discussing take home assignment? Their speaking in low tones makes the discussion suspicious since this may connote something immoral that they would not like to be heard or associated with. This is what the observer must do to be able to give the action an interpretation that is acceptable. So, Weber concludes that to achieve this type of understanding, one must put him/herself in the position of the person whose behaviour one wishes to explain.

Both perspectives are seen to be complimentary to the issue under discussion. If proper interpretation is to be given to adolescents' behavioural pattern, there is need to not only equip them with the right knowledge that will help them act in a manner that is commensurate with societal values but also have the right atmosphere to interprete their behaviour adequately by being responsible for their actions.

DATA AND METHODS

Data for this study come from a survey of in-school adolescents in Lagos State, Nigeria. The state, the former capital of Nigeria, is still the commercial nerve centre of the country. The urban nature of the state has implications for the wellbeing of the study targets especially as it affects transportation, housing, health and education. The study focuses on in-school adolescents who are expected to be comparatively liberal because of their schooling status. Using a multi-stage sampling technique, the study obtained data from 1350 adolescents in State–owned senior secondary schools. State-owned secondary schools are classified as junior or senior schools and categorized into Local Educational Districts (LED).

One Local Educational District (LED), the Mainland LED, was selected out of the six in the state using a simple random sampling technique. Schools in Mainland LED were stratified into co-educational, boys' only and girls' only schools. Two schools were purposively selected from the co-educational stratum and one from each of the other stratum. Table 1 shows the distribution of the adolescents by school and by sex. The research instrument, a self-administered questionnaire with both close and open-ended questions, has 116 items, which included demographic questions as well as questions on sexual and reproductive health and rights knowledge, sources of knowledge, understanding and exercise of sexual rights and access to family planning services.

Others are questions meant to tap information on the respondents' knowledge of sexuality and sexual behaviour.

Table 1: Distribution of adolescents by school and by sex

School	Male		Female		Total	
	No.	%	No	%	No	%
Girls' Only	---	--	318	23.5	318	23.5
Boys' Only	317	23.5			317	23.5
Co-educational	295	21.8	420	31.1	715	53.0
Total	612	45.3	738	54.6	1350	100.0

Source: fieldwork 2006

FINDINGS

Background characteristics.

The respondents are aged 12-21 years with the mean age of 16.09 years. The mean age for males is 16.32 years and that of females 15.85 years. They are spread across senior secondary one (SS1) to senior secondary three (SS3). They are all day students that go to school from home. More than two-thirds live with both parents and less than one-third live with one of the parents with or without a partner or a relation (Table 2). Most respondents (34%) claim to live in three or more bedroom apartment with a sitting room compared with 18 % that live in two bedrooms with a sitting and 25 % that stay in one bedroom and a sitting and another 19 % that stay in one room apartment.

Fifteen percent (205) sleep in a room alone, 24% (331) sleep with one person, 26% (357) sleep with 2 persons and 33% (453) sleep with 3 or more persons in a room. Six hundred and five (44%) share a room with someone of the same sex, 205 (15%) with the opposite sex and 283 (21%) with both sexes. Money spent daily by respondents range from five

Naira* (₦5) to ₦1000 with a mean daily expenses of ₦280 mostly spent on feeding (903 or 65%), transportation (282 or 20%) or both (143 or 10.3%). Sources of money are mostly from parents/guardians (1194 or 86%), relations (45 or 3.3%), gifts from boy/girlfriend (42 or 3%) and trading (42 or 3%). *$1 = ₦120

The education of the respondents is sponsored in this descending order: both parents (748{54%}, father (389{28%}, mother (163{12%}, self (24{2%} and elder sibling (11{0.8%} among others. Most of their parents have secondary education and above. In terms of their future ambition, 979 (71%) would like to be highly qualified professionals such as medical doctors, engineers, architects, bankers etc., 75 (5.4%) would like to be business men/women or actors/actresses while 40 (3%), 30 (2.2%) and 33 (2.4%) would want to become civil servants, teachers and nurses respectively. These background characteristics provide insights into the lifestyles the adolescents will adopt and the coping mechanisms available to them. The next section focuses on the sexual and reproductive health and rights of the respondents,

KNOWLEDGE OF SRH AND RIGHTS OF IN-SCHOOL ADOLESCENTS

In trying to approach the subject matter, the respondents' sexual activities were explored and out of 1350 adolescents, 258 (19.1%) indicated that they had ever had sex as opposed to 1031 (76.4%) who had not and 61(4.5%) who did not respond to the question. Of the 258 who have ever had sex, 180 (69.8%) are males and the rest 78(30.2%) are females. Age at first intercourse range from as low as 9 years to 21 years with a mean of 14.86 years. Only about 15% (205) have a sleeping room to themselves, 24% (331) share a room with one person, 26% (357) with two persons and 34% (453) with three or more persons. While 605 (44.9%) share their rooms with people of the same sex, 205 (15.2%) and 283 (21%) share their rooms with people of opposite sex and both sexes respectively. This is significant as it may affect the sexual behaviour of adolescents. Sharing a room and sleeping space with people of opposite sex has implications for adolescents' sexual development. Their inquisitiveness and exploratory nature and relative powerlessness heighten their vulnerability.

Further probe shows that more than 258 had indulged in sexual activity. Circumstances that led to their first sexual intercourse reveal that 132 were 'playing'; 21 were at a party; 18 were persuaded by their partners; 94 believed they were expressing affection/love; 14 were curious; 11 were forced/raped; 9 were starting marital life; 9 had financial difficulties and 14 could not disclose their reason. This gave 328 respondents as opposed to 258 who indicated that they have ever had sex. Indication of last sexual intercourse with partner also shows that more than the number (270) is sexually active as 73 had sex within the last 7 days; 47 within the last 4 weeks; 61 within the last 3 months and 89 within the last 12 months. These responses show adolescents' reluctance in discussing issues of sexuality, which is not unconnected with the usual silence that surrounds the subject.

In trying to ascertain adolescents' knowledge of their SRH and rights, they were asked if they had a right to say no to sex. The results reveal that a significant number of adolescents know they have a right to say no to sex (Table 3). On whether this right had been infringed upon, 446 (39.7%) of 1124 adolescents agree it had been infringed upon with male respondents reporting higher percentage (49%) than the females (36%). Categories of people that had infringed on their right include their boy/girl friends (175 or 39.2%), class/school mate (82 or 18.4%), playmate (80 or 17.9%), teacher (52 or 11.7%), stranger (34 or 7.6%), a relation (15 or 3.4%) and husband/wife (8 or 1.8%).

Some were bold to complain to authorities when this happened. As many as 342(76.9%) of the 446 reported the incidence to boy/girl friend (153), parents (112), class teacher (40) and head teacher (25). In spite of this bold step, 172 (50.3%) reported that nothing was done to the culprit, 66 (19.3%) said the culprit was arraigned before the school authorities, 53 (15.5%) before the community members, 19 (5.6%) before the law court and 14 (4.1%) were only reprimanded.

Fifty-one percent (167) of the sexually active adolescents believe they can say no to sex when their partner wants sex while the rest think otherwise. This right to say no is usually not respected as 50 (30%) claim their partners attempt to force them, 44 (26%) said the partner tries to convince them and the rest [73(44%)] said their partners agree with them. Regardless of this, some adolescents (114) consented to sex with a stranger and this took

place some days (36 or 32%), weeks (32 or 28%) or months (46 or 40%) before the survey.

Age at which the adolescents heard about sex for the first time range from 5 – 20 years with a mean of 11.47 years. About 200 (14.8%) heard about sex when they were 9 years or less, 834 (61.8%) were aged between 10 and 15, 51 (3.8%) were above 15 and the rest 265 (19.6%) did not respond to the question. Sources of information were mostly from school teacher (277), class/school mate (274), mother (166), friend/acquaintance (135) and radio/television (117). When disaggregated by gender, both sexes got to hear of sex when most of them were between ages 10 – 14 but more male adolescents were empowered with sexuality education in their early years (21.7%) than their female counterparts (15.7%).

The three most important sources of information for the adolescents by gender are school teacher (30.7%), class/school mate (24.4%) and mother (21.5%) for the females and class/school mate (27.1%), class teacher (20.1%) and friend/acquaintance (19.2%) for the males. However, mothers are more likely to discuss sexuality matters with their daughters than their sons and this is not unconnected with the high vulnerability of the former to unwanted pregnancies rather than safe sex.

Number of current sexual partners show that most adolescents have one sexual partner but more male than female have multiple sexual partners. The first sexual partners of respondents were mostly adolescents in their teens with a mean age of 16.65 years. This is further demonstrated by the fact that they are mainly students and circumstances frequently cited that led to it are *playing together* (132), *affection/love* (94) and *party* (21) among others. However, other responses such as *persuasion by partner* (18), *forced/raped* (11), and *curiosity* (14) show that there are other factors, which predispose adolescents to the risk of STIs and HIV/AIDS.

The adolescents also believe that their sexual partners had other sexual partners (172), which put their health in a precarious position yet, 44 cannot refuse their partners sex for fear of losing them. For those who say no, they still face the problem of being forced to accept (47) or being convinced (81). Of greater relevance is that some adolescents even

have sex with somebody they don't know as some of them admitted that they did so *days ago* (36), *weeks ago* (32) and *months ago* (44).

While 70% introduce their friends to their parents, 18% don't and reasons advanced for not doing so are *for precautionary measures* (91), *parents may misunderstand that* (24), *I don't like it* (83), *parents don't approve* (46). For those who do, they think it's important their parents know their friends (545 or 57%), no reason to hide them (88 or 9%) since they believe they are of good behaviour, for parental advise/counsel (97 or 10%), have understanding parents (87 or 9%). The rest (140 or 15%) were silent on the issue. On the whole, more female than male adolescents introduce their friends to their parents, which probably may be to allay fears parents may have on such company especially for their female children. Despite the reasons given above, 232 (17%) do not allow their friends to visit them at home mainly because parents don't just like it (137 or 59%) and they think they will mislead them (87 or 24%) among others.

For those that are sexually active, responses to whether they are likely to discuss their sexual partners with parents show that some do (150) while some (170) do not. Reasons given for the former include but are not limited to *for guidance, intimacy with parents, secrecy is unhealthy and too young for that* while the latter specified *fear, no intimacy with parents, personal/confidential and obscene* in that order.

Some of them were able to enumerate the consequences of premarital sex as *unwanted pregnancy (243), abortion (14), death (50), STIs/HIV/AIDS (143), ambition terminated (84)* but the rest did not respond. Sixty-two of the sexually active adolescents (25 males and 37 females) agree that they had made someone pregnant or been pregnant respectively, and while 40 had the baby, 22 had an illegal abortion. Only 138 of the sexually active respondents (comprising 100 male and 38 females) had made use of contraceptive devices, which were largely obtained, from chemist shop (80) and friends (39) by both sexes. However, 25 did not use any contraceptive device during their last sexual exercise mainly because they do not like it (mostly males) and their partner had refused (mostly females). Eighty eight respondents (47 males and 41 females) admitted to have suffered from STIs in the past and 41 (26 males and 15 females) are still suffering from the disease at the time of survey yet, they have not done anything to cure or even

protect their partners and only an insignificant number (8) claim to use condom during sex.

An appreciable number (1040) have heard of HIV/AIDS, some know victims in their schools, family and neighourhood and although majority will treat them without discrimination if they are in the same class with them, 220 think otherwise. Those who would treat HIV positive people without discrimination would do so because they are human beings in the first instance, they need love, it can happen to anyone, there is no need to fear and there is need to learn more about how infected people feel. Those who would avoid HIV positive people would do so strictly for fear of infection.

On whether they are willing to be tested for HIV, 770 (334 males and 436 females) would like to be tested while 580 (278 males and 302 females) do not want and in both cases female adolescents are greater (Table 3). Reason for willingness is *just to know their status* while reasons for lack of willingness include the fear that they can be infected in the process*, and others said 'I just know I do not have it'* and *'I've already been tested'*. However, females are twice more likely to be afraid of infection than the males and males three times more likely not to go for test because they don't like the idea.

DISCUSSION AND CONCLUSION.

The study set out to investigate the extent of knowledge of in-school adolescents on their sexual reproductive health and rights and administered questionnaires to 1,350 adolescents comprising of 612 males and 738 females. The findings had shown that adolescents begin sexual debut at an early age (9years), and are sexually active. A consideration of their social background shows that some adolescents share sleeping space with members of their household who are of the opposite sex. That 36% share sleeping space with others of opposite sex reechoes the need for adequate knowledge of sexual and reproductive heath and rights. Uninformed or poorly informed adolescents might become victims of sexual exploitation or abuse within such circumstances.

The interest in the choice of highly qualified professionals and business as the most preferred life ambition may not be unconnected with the life of affluence associated with the profession and the likelihood that their sexual partners are mostly members of the group.

The inconsistent responses on questions regarding sex show adolescents' reluctance in discussing issues of sexuality, which is not unconnected with the usual silence that surrounds the topic (Bammeke and Nnorom, 2006). Although a greater number admitted that they have right to say no to sex, this result shows that those who should protect them mostly betray adolescents. This is reflected by the fact that the adolescents mentioned teachers and relations as sexual partners. These people should act *in loco parentis* to them.

Even when the bold step of reporting the incidence was taken, they are discouraged by the fact that nothing was done to the culprits as mentioned by 50%. Ignoring the complaints made indicate that the adolescents are not protected and such negligence by the authorities might lead to more serious consequences. First, the culprits might see that as an encouragement to go on. Second, the adolescents might interprete that to mean acceptance. So if society feels that the rights of adolescents should not be infringed upon, their rights to sexuality education as well as the rights to seek redress when it is infringed upon must be ensured.

Sources of information on sexuality matters are mostly from class teacher, classmates and friends/acquaintances. Nevertheless, adolescents rely more on their classmates for information on sexuality and reproductive health matters than their parents, a development that has high implications for their health and well-being. The situation is much more complicated by the knowledge that most of their sexual partners are students who may not only be ignorant of safe sex but may likely patronize unqualified health professionals in times of problem due mainly to lack of finance as well as maintain secrecy.

To complicate matters a significant proportion does not like to introduce their friends to their parents and also do not discuss their sexual partners with them. This is cultural in the sense that even among adults, there is serious inhibition concerning such discussions. The consequence of this is that adolescents seek information from their peers who are also poorly informed. Inadequate information leads to unwanted pregnancy as established by the fact that 62 adolescents had either been pregnant or made someone pregnant.

While 40 had the baby, 22 had an illicit abortion. The reason for the latter may be the fear of exposure by qualified health personnel who are often moralistic. Therefore, if adolescents must seek approved health methods, the health personnel must not be seen to

be judgmental and the decisions of adolescents must be respected. Confidentiality must also be guaranteed, as adolescents would not seek medical help if there were no assurance that their information would not be divulged.

Those that had used contraceptive device obtained them mostly from chemist shops and friends and these sources are highly unreliable. Businesspersons who do not have the required knowledge to administer such mostly own the former. The latter who are also mainly students are as ignorant as their partners are.

Approximately, 43% are not willing to test for HIV/AIDS mainly because they are afraid of being infected through blood; this again reiterates the need to secure confidence of adolescents on health related matters. Cases of victims of HIV infection because of avoidable mistakes in Nigeria may have led to this response. Unless such adolescents are assured of their safety, the likelihood of availing themselves of health services will be thin. This would have severe consequences for the health and well-being of adolescents and ultimately for national development as the health of those who constitute the future of the nation may be jeopardized in the process.

Based on the above discussions, it is recommended that for adolescents to have adequate sexuality and reproductive health and rights:

- Care must be taken in addressing the sexual and health needs of this group through open and unrestricted access.
- Parents must see sexuality education as part of socialization process and take interest in the kinds of company their children keep.
- SRH and rights products must be easily accessible and affordable to adolescents. Where possible, government should introduce centres is schools for adolescents to satisfy their SRH needs. This is not to be misconstrued as exposing them to immoral acts because despite the silence that has shrouded the subject over the years, adolescents have continued with sexual exploration.
- Flowing from this is the need for adolescents to make informed choices regarding their sexual and reproductive health needs. When variety of choices is available, adolescents will be able to select the ones that suit them thereby avoiding more complicated problems.
- Measures should be put in place to protect this young but vulnerable group from those who exploit them because of their positions. This is true of teachers and

relations who are supposed to act in *loco parentis* and who abuse such positions. Policies that define punishments for such exploitation should not be enforced selectively. Anybody found guilty, irrespective of the position in society, should be made to face the music. By so doing, adolescents will not only learn the appropriate behaviour expected of them but will also be encouraged to seek redress when those rights are infringed upon.

- Finally, this study reiterates the need to inform adolescents of the health risks involved in having unprotected sex and be more cautious in their sexual dealings as this may bring to an abrupt end their future ambitions.

It is hoped that if these suggestions are objectively implemented, Nigeria will benefit from the ever growing number of adolescents as this will not only ensure sound health for this group but will also guarantee their utmost contribution to national development.

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APPENDIX.

Table 2: Some Background Characteristics of Respondents.

Variable	No.	Percentage
Fathers Level of Education		
No Education	118	8.7
Primary	82	6.1
Secondary	386	28.6
Post Secondary	562	41.6
Others	99	7.3
No Response (NR)	103	7.6
Total	**1350**	**99.9**
Mother's Level of Education		
No Education	112	8.3
Primary	102	7.6
Secondary	405	30.0
Post Secondary	490	36.3
Others	95	7.0
NR	146	10.8
Total	**1350**	**100.0**
Whom respondents is living with		
Both parents	902	66.8
Father only	79	5.9
Mother only	141	10.4
One parent with partner	37	2.7
Elder Brother	74	5.5
A Relation	45	3.3
NR	72	5.3
Total	**1350**	**99.9**

Table 3: Other Relevant Findings.

Variable	Male	%	Female	%
Do You think you have a right to say No to Sex?				
Yes	449	73.4	656	88.9
No	120	19.6	59	8.0
No Response (NR)	43	7.0	23	3.1
Total	**612**	**100.0**	**738**	**100.0**
If yes, has this right ever been abused?				
Yes	220	49.0	239	36.4
No	200	44.5	405	61.7
No Response (NR)	29	6.5	12	1.8
Total	**449**	**100.0**	**656**	**99.9**
Age Sex was heard about for the first time				

5 – 9	105	21.7	92	15.7
10 -14	329	68.1	421	71.8
15^{+}	49	10.1	73	12.4
Total	**483**	**99.9**	**586**	**99.9**
Sources of Information on Sexual Matters				
Class/school mate	131	27.1	143	24.4
Class teacher	97	20.1	180	30.7
Mother	16	3.3	126	21.5
Friend/acquaintance	93	19.2	42	7.2
Radio/television	75	15.5	42	7.2
Sister/brother	21	4.3	23	3.9
Father	13	2.7	12	2.0
Newspaper	18	3.7	06	1.0
Neighbour	11	2.2	05	0.8
Textbook/novel	01	0.2	07	1.2
NR	07	1.4	-	-
Total	**483**	**99.7**	**586**	**99.9**
Do You Introduce Your Friends to Your Parents?				
Yes	388	63.4	569	77.1
No	144	23.5	100	13.5
NR	80	13.1	69	9.4
Total	**612**	**100.0**	**738**	**100.0**
No. of Current Sexual Partners				
1	54		49	
2	33		16	
3	14		03	
4^{+}	46		06	
NR	33		04	
Total	**180**		**78**	
Willing to be Tested for HIV/AIDS?				
Yes	334	54.6	436	59.1
No	278	45.4	302	40.9
Total	**612**	**100.0**	**738**	**100.0**
If no, Why?				
Can be infected in the process	103	37.1	241	79.8
Don't like it	150	54.0	50	16.6
Already tested	25	8.9	11	3.6
	278	**100.0**	**302**	**100.0**