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Last, but not least, I thank my wife, Lelia, for her support and forbearance towards a husband whose mind was constantly preoccupied.

ACRONYMS

AHI	Action Health Incorporated
APPER	African Priority Programme for Economic Recovery
CASSAD	Centre for African Settlement Studies and Development
ECA (UNECA)	United Nations Economic Commission for Africa
FAO	Food and Agricultural Organisation of the United Nations
FC	Female Circumcision
FCT	Federal Capital Territory (Abuja)
FEAP	Family Economic Advancement Programme
FIDA	Federation of International Women Lawyers
FHS	Family Health Services
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FOS	Federal Office of Statistics
FLS	Forward Looking Strategies for the Advancement of Women
FSP	Family Support Programme
FTC	Federal Technical College
GADA	Gender And Development Action
GDP	Gross Domestic Product
IAC	Inter-African Committee On Traditional Practices Affecting The Health Of Women And Children
ICAN	Institute of Chartered Accountant of Nigeria
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
JSS	Junior Secondary School
LBW	Lower Birth Weight
LPA	Lagos Plan of Action
MCA	Matrimonial Causes Act

NAWOJ	National Association Of Women Journalist
NBC	National Broadcasting Commission
NCP	National Council for Population
NCWS	National Council of Women Society
NDHS	Nigeria Demographic and Health Survey
NFS	Nigeria Fertility Survey
NGO	Non Governmental Organisation
NPC	National Population Commission
NRC	National Republic Convention
OAU	Organisation of Africa Unity
ODA	Overseas Deveopment Administration
PFA	Platform For Action
PHC	Primary Health Care
PPFN	Planned Parenthood Federation of Nigeria
QLS	Quality Of Life Survey
RTI	Reproductive Tract Infection
SDP	Social Democratic Party
SFH	Society For Family Health
SIDA	Swedish International Development Authority
SSS	Senior Secondary School
STD	Sexually Transmitted Diseases
UBTH	University of Benin Teaching Hospital
UN	United Nations
UNDP	United Nations Development Programme
UNIFEM	United Nations Fund For Women
UNFPA	United Nations Population Fund for Action
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VAW	Violence Against Women
WEM	Women Empowerment Movement
WFS	World Fertility Survey
WHARC	Women's Health Action Research Centre
WIN	Women In Nigeria
WJP	Women Justice Programme
WHO	World Health Organisation
WHO/AFRO	World Health Organisation Regional Office For Africa
WPPA	World Population Plan for Action

CONTENTS

FOREWORD

The country Nigeria is made up of a wide expanse of landmass of 923,768 square kilometers that is blessed with fertile soil and green vegetation. It is situated in the West African sub-region with an estimated population of about 120 million inhabitants. It is the most populous country in black Africa.

Like many developing countries of the world, the health problems are numerous. Maternal death rate is estimated to be as high as 1500 per 100,000, this incidentally is the highest in the world.

Adolescent reproductive health is said to be the poorest in the world. Early marriages of girls is quite prevalent, and there is the tendency for many of them to embark on pregnancy as early as 13 - 14 years of age, have babies as they come and never stop until nature says so. Overall, the life time risk of a Nigerian woman dying from pregnancy, childbirth or pregnancy related causes is about 1 in 20. Births to mothers too young, or too old. Births that are too closely spaced, too many and unsafe abortions resulting from unwanted pregnancy are the major factors that contribute to maternal deaths.

Women are further exposed to a lot of risks during their reproductive life due to harmful traditional practices such as female circumcision or female genital mutilation (FGM), lack of or poor existence of facilities especially in the rural areas, poverty coupled with poor nutrition and lack of/or access to resources, land education etc., necessary to make life meaningful.

Fertility remains high in Nigeria; at current fertility level, Nigerian women will have an average of 6 children by the end of their reproductive years. Knowledge of contraception remains low, with less than half of all women age 15 - 49 knowing of any method.

Preventive and curative health services have yet to reach many women and children. Mothers receive no antenatal care for one - third of births and over 60 per cent of all babies are born at home. Only one third of births are assisted by doctors, trained nurses or midwives. Women received antenatal care from a traditional birth attendant (TBA) for only 4 per cent of births.

There is a strong association between education and receiving antenatal care. Births to women with no education are about as likely to receive some kind of care as not; whereas it is unlikely that a birth to a woman who has had some education will receive no antenatal care.

The infant mortality rate is high. Nearly 1 in 5 children dies before their fifth birthday. Of every 1,000 babies born 87 die during their first year of life. These problems are more severe in rural areas and in the North.

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NOTE

The designations employed and the presentation of the materials in this dissertation do not imply the expression of any opinion whatsoever on the part of the author nor that of the agencies mentioned concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Where the designation "country or area" is used it covers as appropriate, countries, territories, cities or areas.

The designations "developed" and "developing" countries/economies/world, or North; North-east; North-west, South; South-east; South-west; rural or urban are intended for statistical convenience and do not, necessarily, express a judgement about the stage reached by a particular country or area in the development process; nor is it intended as a form of demarcation.

Any mis-representation is highly regretted.

E. A. W

PREFACE

There are but a few of unforeseen and unprepared - for headaches which are encountered by the man who decides to devote his professional life to the field of research in the Quality of life and Reproductive Rights of Women. What is expected of him appears to be the impossible. Physician, Lawyer, Political scientist, Economist, Educator, Sociologist etc. Must he be all these and more? In the literal sense this, of course, would not be possible. It is not too much to expect, however, that he have at least an understanding of the fundamental principles involved in the various related fields. Experience will teach him much, but at least a modicum of information before hand might be helpful. It is with this in mind and with the hope of stimulating an interest for further study that this dissertation is presented.

PROJECT REPORT

INTRODUCTION

Nigeria is a vast country covering a land area of approximately 923,768 square kilometers on the West Coast of Africa. The Republic of Benin borders on the west, Cameroon on the east, the Gulf of Guinea on the south, and Chad to the north. The national census figure for the country in 1991 was 88.9 million, of which women account for 43,969,970. Of the total population, women of reproductive age comprise about 20 per cent and adolescents about 23 per cent. Nigeria is the most populous country in Africa and ranks amongst the ten most populous countries of the world with the current fertility rate put at 6.0. Currently there exists 36 states plus the Federal Capital - Abuja.

With annual growth rate of 2.86 per cent, the country's population in 1996 was approximated at 102.2 million. These figures are lower than the United Nations' projected figures for 1990 and 1996, which were 108 and 115 million respectively. Nigeria's population has been characterized by a high rate, which resulted in a growth from a relatively stable high birth rate and a steadily declining death rate. The high growth rate of Nigeria's population s, rather than the sheer size, is the major cause of concern for population experts and policy planners. It has been argued that, even if Nigeria's population size were lower than the current estimated figure of 102.46 million, policy planners still have cause to worry as long as the rate of population growth exceeds the rate of growth of the economy.

At the current rate of population growth, Nigeria's population will double every 24 years. The current level of consumption can, therefore, be maintained only if production of goods and provision of services (education, road, health facilities, electricity and portable water) would also double every 24 years. For the country to experience economic development (measured by increased productivity and investment, more equitable distribution of resources, reduction in the number of people below the poverty line, sustainability and empowerment), the production of goods and services in Nigeria will have to double in less than 24 years. Unfortunately, this is almost impossible to envisage as all available evidence indicates that the growth of the economy has been lower than the growth rate of the population.

The Land And The People

Nigeria is a country of vast cultural diversity consisting of over 380 different ethnic groups with an equal number of distinct languages and dialects. Most Nigerians including those residing in urban areas are strongly influenced by the cultural and traditional norms of their ethnic origin. Therefore, a clear understanding of the socio-cultural factors that influence the attitudes and behaviours of the people towards family issues is absolutely necessary for effective programme development, audience segmentation, design of appropriate messages and materials as well as in monitoring and evaluation.

The three most prominent languages are Hausa, Ibo, and Yoruba, Amongst the others are Edo, Efik, Fulani, Ibibio, Igala, Ijaw, Ika, Itshekiri Kalabari, Kanuri, Tiv, and Urhobo. The Hausa-Fulani are mostly Muslim and inhabit the Northern part of the country; the Ibo are mainly Christian and occupy the South-eastern parts; while the Yoruba amongst whom are both Muslims and Christians, inhabit the South-western part of the country. Besides Christianity and Islam, traditional religion is also widely practiced in different parts of the country, and traditional medical practices flourish. As can be seen from the results of the study, the status of women in country is not only determined and compounded by religious complexities, the absence of a uniform legal framework and the existence of various customs and traditions play a crucial role. In many of these cultures is to be found the extended family system that includes parents, grand-parents, children including step-children and a network of kin and blood relatives.

SCOPE, MATERIALS AND METHODS

The conceptual framework adopted for this study was designed to elucidate broad issues of global policy significance relative to socio-economic development, regional or geographical setting, marriage patterns, maternal and child health, and the quality of life of the girl child and women including level of education.

A number of indicators were used to assess the legal status of women and their reproductive rights, minimum age of marriage; single-parenthood, rights to divorce, abortion law, harmful traditional practices affecting the health of women, female genital mutilation and widow-hood rites.

Literature Review And Data Collections

Existing literatures were reviewed to determine what has been done in the project's area of concern and to identify and review changes in law and policy if any at different points in time. Fortunately, previous works have been done in the various areas.

Materials reviewed include position papers from recent and past seminars, conferences, and workshops, as well as the communiqués from meetings of governmental and non-governmental organisations and international agencies.

Reports from the World Fertility Survey (WFS) and The Nigeria Demographic Health Survey (NDHS) as well as various works and reports from other agencies such as UN, UNDP, UNFPA, UNICEF, WHO, Civil Liberty Organisation (CLO), IAC, Society of Family Health (SFH), etc., all provided useful information for the framework of this dissertation.

In order to ascertain any disparity between the law and actual social practice, some court decisions on relevant cases were reviewed and the result compared with those of the structured interviews and the survey. It was also necessary to review other legal and policy documents as well as state edicts, the laws of the federation, the Federal Constitution of Nigeria 1979, as well as international instruments to which Nigeria is a party.

The research made ample use of individual testimonies narrated first hand during the structured interviews granted. It also made use of available cases to illustrate the claims made in the findings, as well as detailed literature review to highlight different schools of thought with respect to the issues under study.

The literature review also made use of both published and unpublished materials, journals, newspaper reports, etc, etc. These along with other works already done including the WFS and NDHS, presented the basis of which the analysis of data were tested and contrasted.

Limitations

The socio-political situation in the country and the tension generated at the time of the study threw many people into a state of panic, fear and total confusion.

In the sample states, not every local government could be visited due to limited funds. Not all person scheduled for the structured interviews could be reach due to bureaucratic bottlenecks. Ironically the offices of the state women's commissions were not helpful except at the Ministry of Women Affairs in Abuja.

Other constraints arise from poor response as many people expect financial gratification. The fact is that not many could comprehend the importance of research at a time when many are confronted by myriad of economic and social problems. The general attitude was characterised by cynicism and despair.

1. THE GIRL CHILD

In many countries today, the girl child has a lower status and enjoys fewer childhood rights, opportunities, and benefits than the male child who has the first call on family and community resources. With the girl child begins the process of inequality that the adult woman finds so difficult to overcome [7,8].

Even poverty is not an over riding factor in childhood development, gender inhibits equal opportunities for the female child. Customs and laws frequently make the girl child the lesser child. Family preferences tend to favour boys over girls; family dicisions in the distribution of food, labour, health care, and access to school and other life changing opportunities usually benefit boys more than girls [7]

Although age at marriage has increased and adolescent fertility rates have declined worldwide, early marriage of girls is quite prevalent. It is estimated that of girls aged 15 years, 18 per cent in Asia, 16 per cent in Africa, and 8 per cent in Latin America are married. By contrast, boys marry when they are considerably older as is evident from the marrital status data of several developed and developing countries.

The fact that gender specific data on children's health are often not available or not sufficiently reliable is a telling comment on the neglect of the gender dimension in child health. However, trend analysis of data from 1945 to 1983 reveals that higher female mortality in early childhood appears to be concentrated in countries with a high preference for sons over daughters and a correspondingly lower status and lesser care accorded to girls and women.

In 30 developing countries, death rates for girls between the ages of one and four years have been found to be higher than or equal to the death rates for boys. This contrasts with the industrialised countries where deaths of boys in the one-to-four age group are consistently higher than the rate for girls.

Adolescent Reproductive Health

According to a recent newspaper publication, adolescents in the country are gradually being caught between tradition and the influx of western cultures, brought about by the technological revolution [11].

Over half of the country's estimated 100 million inhabitants are below the age of 25 and many of the females obviously victims of the cultural mix are now getting pregnant, having a baby or procuring an abortion [11].

The situation is not different in sexually transmitted diseases and The Acquired Immune Deficiency Disease Syndrome (AIDS), adolescent between the age bracket of 15 to 29 years account for 62 per cent of the cumulative AIDS cases. Infact, the present status of adolescent reproductive in the country has been ranked among the poorest in the world according to the 1996 World Population Report released in Lagos [11,12,17].

Mrs Nike Esiet, Project consultant of Action Health Incorporated (AHI) a Lagos based non-governmental organisation attributes this gloomy trend in adolescent sexuality to ignorance, ineffective national policy on family life education, growing sexual permissiveness as a result of urbanization and social changes and limited access to counselling and contraceptive services in the country [11,16]

Other factors that contribute to the low socio-economic status of women include other harmful traditional practices, poor health facilities and low educational levels.

Some of the notable factors that shape women's reproductive health are level of education, economic power, decision making and access to affordable and qualitative health care delivery systems.

The World Health Organization (WHO) believes that:

> The status of girls and women in society, and how
> They are treated or mistreated, is a crucial deter-
> minat of their health. Educational opportunities
> **For girls and women affect their status and the**
> Control they have over their own lives, their health,
> And their fertility in a powerful way.

The WHO went further to observe that:

> In the same vein, equal opportunities for women in
> Other areas of their lives - for example in the judicial,
> Legislative, educational and employment sectors
> Would also directly promote and protect their health
> And well being.

Plate 1.1 A young mother and her children. Although the average age of marriage is increasing worldwide millions of women begin childbearing in their teens. (Source: UNFPA).

2. VIOLENCE AGAINST WOMEN

Violence against women by Awake correspondence in Nigeria published in Awake! January 8, 1997., indicated that: From the womb to the grave, women fall victim to violence, according to the United Nations Human Development Report 1995. Studies from around the world revealed the following [4]:

Before birth. In some countries test are made to determine whether a fetus is male or female. Females are often aborted.

In childhood. In Barbados, Canada, the Netherlands, New Zealand, Norway, and the United States, 1 woman in 3 reports having been sexually abused during childhood or adolescence. In Asia and elsewhere, about one million children - mostly girls are forced into prostitution and *early marriages* each year. Millions of girls worldwide suffer genital mutilation [10]

In Adulthood. In Chile, Mexico, Pupua New Guinea, and the Republic of Korea, 2 out of every 3 married women are victims of domestic violence. In Canada, New Zealand, the United Kingdom, and the United States, 1 woman in 6 has been raped [1,2].

In later life. More than half the women murdered in Bangladesh, Brazil, Kenya, Papua New Guinea, and Thailand were slain by past or present partners. In Africa, South America, several Pacific Islands, and theUnited States, Marital violence is a leading cause of female suicide [13,14,20].

No longer an invisible menance, gender-based violence is now recognised in growing number of national laws and international conventions. In Canada, according to a 1987 report one in every ten women will be assaulted or battered [2,3,9,19,20].

Author Toni Nelson in a 1995 Canadian study found that violence against women costs the country $1.1 billion yearly in medical expenses, community support services and lost work. Moreover, early and forced marriage, including female genital mutilation (FGM) are harmful practices that affect women [1-20]. A doyen on the issue of female genital mutilation, Dr Irene

Thomas (IAC - Nigeria) says: "it is a form of violence against women and it is not just a health issue but a violation of the human rights of women [15].

Violence against women and girls according to a United Nations Development Fund for Women (UNIFEM) document; is considered the most pervasive violation of universal human rights principles, and efforts should be geared towards the eradication of the practice [5,18].

The Declaration on the Elimination of Violence Against Women (VAN) defines violence against women as **"any act of gender** based **violence that results in or is likely to result in physical, sexual or psychological harm or suffering" to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private."** A campaign to Eliminate Violence Against women and girls was launched on July 31st, 1998., the Pan African Women's Day at the Institute of International Affairs, Victorial Island Lagos [5.18].

Co-ordinated by the UNIFEM, in collaboration with other agencies, along with sundry government department as well as Women and Human Rights NGOs. The campaign is intended is to among other things raise public awareness of the dimension and costs of violence against women. This is aimed at changing attitudes and behaviours and to support government to institutionalise policies, legislations and programmes that would deter and prevent violence against women and girls as well as strengthen the capacity of civil society, organisation and institutions, especially the media, human rights networks, education, health etc., to advocate for and implement programmes that will eradicate violence against women.

Giving a broad gender-based violence programme, UNIFEM categorises it as follow [5.18]:

- Physical abuse-battering, sexual assault and abuse, molestation at home, educational institutions, work place, community and society as well as rape, Infanticide, female genital mutilations, incestuous Relationships, control of reproductive rights.
- Psychological abuse-sexual harassment, portrayal of Women as sex objects by the media, the judicial System and institutions of society, their treatment as Perpetual minors.
- Restricted access to sources of power (economic, Political and social)- to education, landed and move-able property, health, nutrition, decision-making, legal support.
- Commodification of women - trafficking, force Prostitution, commercialization of women's bodies.

International Instruments Emphasing Rights of Women And Girls And Elimination Of Violence Against Women:

- Universal Declaration of Human Rights Adopted December 10, 1948.
- The Convention of the Elimination of All Forms of

Discrimination Against Women, Adopted December 16, 1979, Entered into force September 3, 1981.

- The Convention of the Rights of the Child, adopted November 20, 1989.
- The International Covenant on Economic, Social and Cultural Rights, adopted December 16, 1966, entered into force 1976.
- The International Covenant on Civil and Political Rights, adopted, December 16, 1966, entered into force March 23, 1976.
- The Convention Against Torture and other Cruel Inhuman, or Degrading Treatment or Punishment, adopted December 10, 1984, entered into force June 26, 1987, and
- The International Convention on the Elimination of All Forms of Racial Discrimination, adopted December 21, 1965, entered into force January 4, 1969.

In Nigeria, studies shows that such violence acts are recorded in all levels of the society, tradition, religion and negative aspect of urbanisation and various manifestations of violence against women in the society, include - early marriages with the attendant risk of Vesico Vaginal Fistula (VVF), Recto Vaginal Fistula (RVF) and Female Genital Mutilation (FGM). Others are lacks of reproductive rights, economic, social and political subjugation of women, lack of or access to facilities such as health, education etc [9].

Efforts to address this problem should indeed be seen as a critical yardstick against which to measure overall advances in empowerment and in the promotion and employment of fundamental human rights by all societies [5,8,18].

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1. GENDER DISPARITY

Women As Bread Winners

The National census of 1991 puts Nigeria's total population at 88.5 million; of this number, 44 million are female, half of who are 15 years and above. The 15-44 years age group, which is the active age group, constitutes 50 per cent of the total population and the proportion of women in this age group has consistently remained higher than men (male 20 per cent, female 22 per cent) [47,56].

The proportion of female heads of households is 19 per cent, in urban and 14 per cent in rural areas. Since 19 per cent of male heads of households have two or more wives [57], and in most polygamous families in Nigeria (especially in the rural areas where polygamy predominates) women have greater responsibilities for their children's welfare and education than in monogamous families [47,48,103,105]. It is generally believed that in at least 30 per cent of households in Nigeria, women are either **dejure or defacto** heads of households [47,56,57]. Infact in the face of present economic realities, even in urban monogamous families, women are assuming increasing financial contributions to augment family income [1,13,18,47,48].

Unfortunately, however, despite their numerical strength in the active age group and their rapidly growing responsibilities as breadwinners in the families, women in Nigeria lag far behind men in most indicators of socioeconomic development [1,16,42,47,48,71,76,94,107].

Women constitute the majority of the poor, the unemployed, and the socially disadvantaged in Nigeria and they are the hardest hit by the current economic recession [8,13,16,42,43,47,79,81,94].

According to the 1996 estimates from the National Population Commission, about 50 per cent of the total population of the country are women [56,100]. 70 per cent of this population including some 31 million women, reside and work in the rural area [100]. 51 per cent of these rural dwellers (or 16 million rural women) are below the poverty line, comprising groups among the most vulnerable ones to poverty. Indeed, it has been also been estimated that women makes up 70 per cent of the agricultural workforce in Nigeria [5,47,48,56,57,107]. In the urban areas, she is engaged in the informal sector, which covers, for instance, such activities as trading, dressmaking, hairdressing, etc. Socially, she is the first intellectual, emotional, and spiritual contact with the next generation of the country's population. Yet, in terms of adult functional literacy, illiterate women represent 61 per cent of the female population as compared to 38 per cent of the adult men [47,56,81,100].

During the busy agricultural seasons, rural women's sixteen hours working day would continue to be filled by such tedious tasks as walking to the field, collecting firewood and water, grinding grains, cooking and other domestic chores, in addition to the tasks of ploughing, hoeing or weeding (Table 2.1). If rural areas are to be transformed, the women who are cultivating them need assistance. As male migration continued, women's dependency ratios rose on the farms where they remained to care for their dependents and to produce the family food [1,2,6,53,90].

The division of rural labour by gender (% of total labour in hours)

	Men	Women
Cuts down the forest; stakes out the fields	95	5
Turns the soil	70	30
Plants the seeds and cuttings	50	50
Hoes and weeds	30	70
Harvests	40	60
Transports crops home from the fields	20	80
Stores the crops	20	80
Processes the food crops	10	90
Markets the excess (including transport to market)	40	60
Trims the tree crops	90	10
Carries the water fuel	10	90
Cares for domestic animals and cleans the stables	50	50
Hunts	90	10
Feeds and cares for the young, the men and the aged	5	95

TABLE 2.1

Source: Margaret C Snyder & Mary Tadesses

PRODUCTIVE HOURS/DAY BY GENDER: SELECTED COUNTRIES

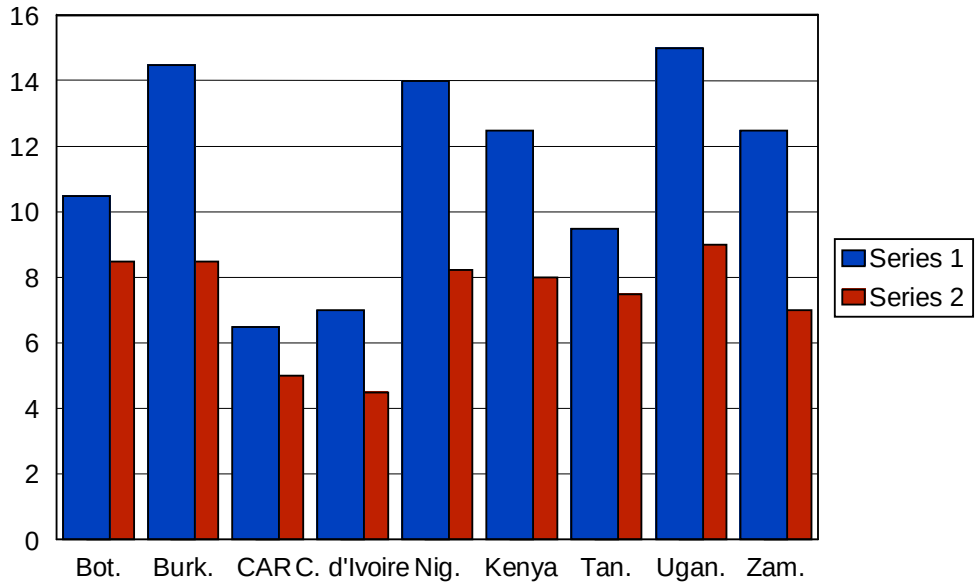


FIGURE 2.1

SOURCE:

DAILY TIMES

Even when both spouses worked on the farm, the pressures on women were enormous. "The less agriculture is mechanized, the more women are employed in it", and yet when agriculture is mechanized, the toilsome handwork is relegated to women. For every gain, there seemed to be a setback. Evidence showed that the increase of acreage under cultivation when crop rotation was introduced obliged women to spend more time in the fields throughout the year. As a result it became more difficult for them to attend literacy classes and meetings on nutrition, childcare, improved gardening and handicrafts [53].

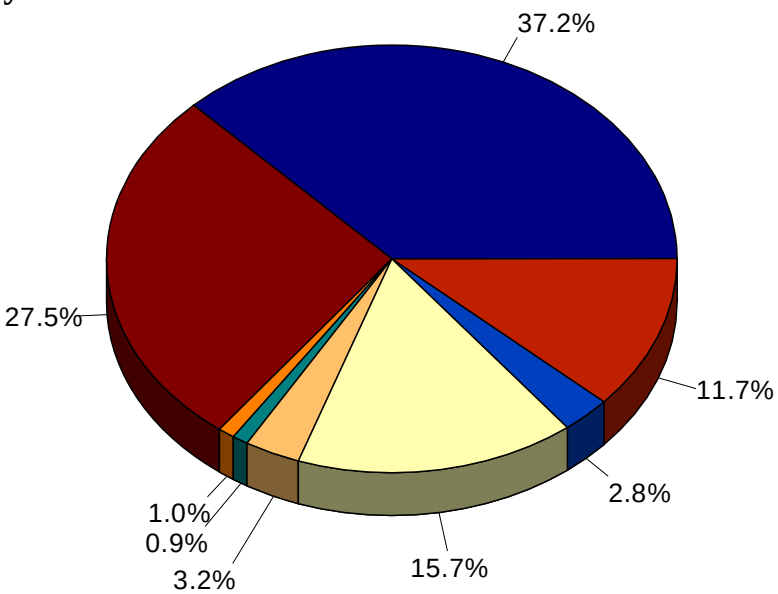
Noting the preponderance of women in agriculture in the rural areas, and in the informal sector in the urban areas, it is clear that they play critical role in the country's ability to increase its productivity, its earning from economic activities, and its ability to build the individual, community, as well as national wealth [88].

FIGURE 2.2

Time use by adults out of 1440 minutes per day

Minutes per day

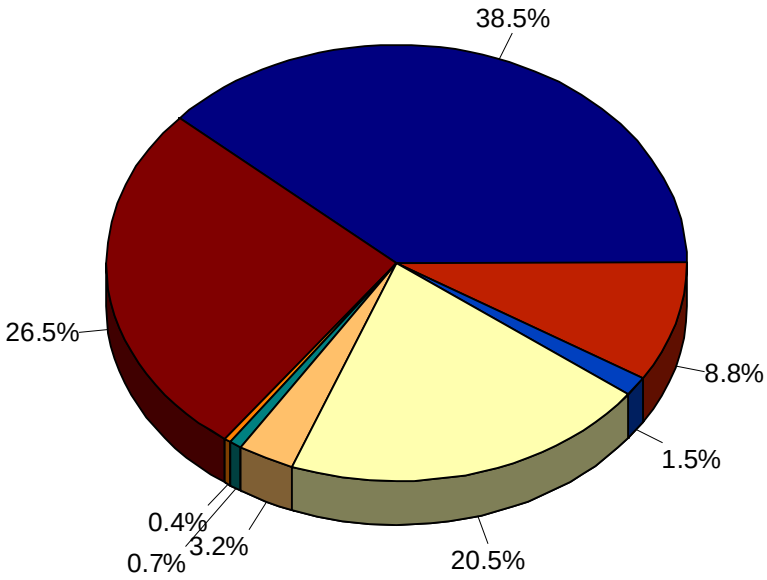
A



All Adults

Minutes per day

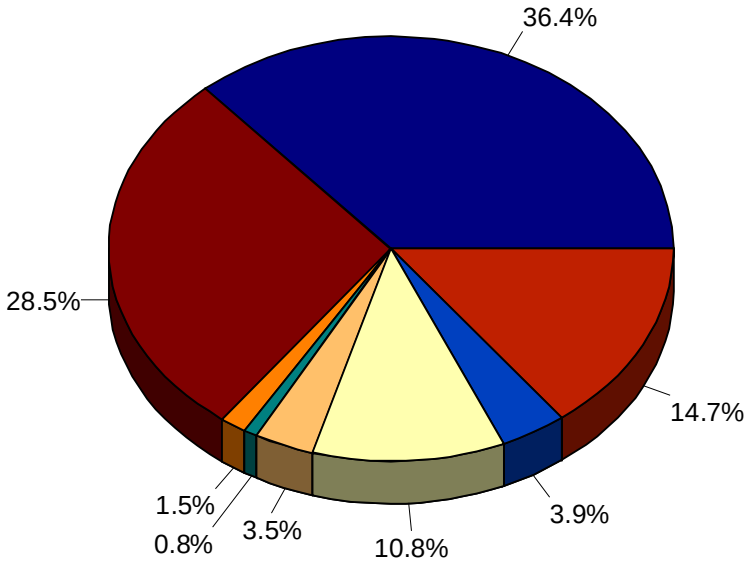
B



Women

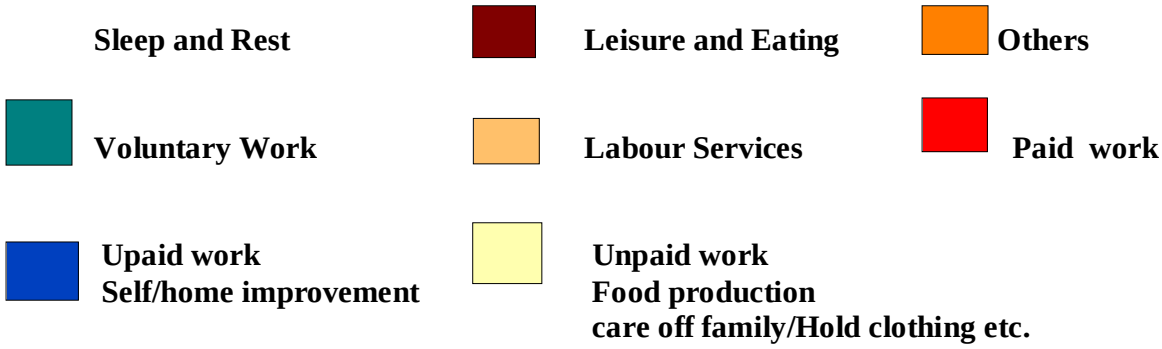
Minutes per day

C



Men

Keys



Gender Disparity

The studies of the Women Research and Documentation Centre, University of Ibadan have also shown that there are significant gender differentials in the incidence of poverty in Nigeria [47]. In rural areas, for example, although women work longer hours than men, they earn less than 40 per cent of the average rural income, and only 60 per cent of men's wage in the same occupation categories. In fact 72 per cent of rural women reported an annual income of below N2, 000; 22 per cent below N5000; and 5 per cent reported an annual income of above N5000; [47,81,93]. Women are also marginalized in the modern labour force. Nigeria women in the modern industrial sector are mostly employed as nurses, cooks, secretaries, receptionists and other jobs regarded as suitable for women [47]. In the public sector only one per cent of women are in the top levels of the bureaucracy [77,92]. In 1988 for example, of the 259,219 staff in the Federal civil service, only 33,605 or 12.9 per cent of the total, were women. The greatest proportion of women (31 per cent) were found in Grade Levels 01-02 while 9.4 per cent and 6.7 per cent were on GL 17 and 16 respectively (Table 2.2). In general female employment in the formal economy is very low [80,92,112].

Distribution of Staff in the Federal Civil Service in 1988

Level	Male	Female	% Female
17	40	6	15.0
16	253	8	9.4
15	475	51	10.7
14	891	93	10.4
13	1435	202	14.1
12	2289	376	16.4
10	3918	848	21.6
9	5354	1236	23.1
8	7620	1851	24.3
05-07	79873	8810	11.0
03-04	99791	12524	12.6
01-02	23590	7583	31.1

	225,614	33605	12.9

TABLE 2.2
Source: Adelabu, M.A. (1995).

Furthermore, males dominate all the positions in the education industry. For instance, according to Nigerian University Commission Annual Report of 1990, in 20 Federal Universities, there were 954 male Professors and 53 female professors (about 5.3 per cent). The proportion of female academic teachers was 9.7 per cent. In addition, the national statistics of teachers in primary and post primary institutions in the country show that there have always been more male teachers (almost 80 per cent in primary and more than 80 per cent in post primary schools) than female teachers, even though teaching is regarded as a profession for women (Table 2.3).

Distribution of Teachers in Nigeria

Primary/Secondary Schools in 1959, 1963 and 1970

	Primary Schools				Secondary Schools			
	Males		Females		Male		Female	
Dates	**Numbers**	**%**	**Numbers**	**%**	**Numbers**	**%**		
1959	75944	79.7	19315	20.3	4750	83.6	933	16.4
1963	75623	80.3	18553	19.7	8763	80.4	2142	19.6
1970	78743	76.3	24,409	23.7	11,424	83.4	2266	161.6

TABLE 2.3
Source: Grace Alele Williams (1976)

Among the various roles performed by women in Nigeria's traditional society, the domicialiary and procreative roles occupied the pride of place. Many factors served to maintain the traditional roles, all of which relate directly or indirectly to the expression of power. People have prejudices about women, which cause them to limit the options available to them in terms of jobs and political power among others [112].

The Nigerian woman has many things in common with her counterparts elsewhere, especially in developing countries. She has limited access to and control of productive resources such as land, credit and technology [47]. This is largely due to the prevailing dominance of patriarchal ideology, which prevent men from religuishing their traditional control over productive resources. Although on the average 53 per cent of Nigerian rural women are engaged in farming and food processing activities, 63 per cent of these women farmers depend on their husbands for their land and only about 7 per cent have access to credit (UNICEF/Obafemi Awolowo University PIC study, 1993) [1,46,47].

The subordinate social position of women, which constitutes their gender identity, is also reflected in the communication struture of society, especially in the oral, visual and print media. Several modern feminist communication theorists have presented this reality of the passive and

inferior locus of women in sometimes rather extreme but vivid terms. This assertion is an incisive analysis of how women are presented in the news media. These views seems to agree with that of HAROLD ROBINS in his novel **"The Lonely Lady":** pp. 398, "Ladies and gentlemen of the Academy . . . If I were to tell you that I'm not thrilled and happy at this moment I would be very wrong . . . Still, there is within a lingering doubt and a feeling of sadness. Did I earn this award as writer, or as a woman? . . . [49,102,107,109,110,111].

No doubt this is again a somewhat extreme and highly modern analysis of women in modern communication, but there is no gainsaying the fact that women as a gender tend to be presented in a light which corresponds with their already accepted powerless inferior status in society. According to Mrs. Ada Okwuosa at a three days workshop held at the National Centre for Women Development Abuja - "True to style, when journalist distinguish between serious prime-time news and the not-so-serious or soft news", they unguardedly often reflect gender bias." "Events that feature women as centre actors are often couched in less serious or comical language and pushed to the human interest "soft news" category while similar events in which men feature, such as protests and conferences, would be presented in the "hard news" category [58,107].

The issue of women and the media was one of the twelve critical areas of concern addressed at the Fourth World Conference on Women held in Beijing in September, 1995 [4,8,23,107]. That conference provided the most recent global and comprehensive blue print for women in development. Nigeria was one of the 185 countries that endorsed the Beijing Platform of Action. A part of paragraph 35 under chapter 11 (Global Framework) states as follows: " . . . until women participate equally in both the technical and decision making areas of the mass media, including the arts, they will continue to be misrepresented and awareness of the reality of women's lives will continue to be lacking . . ." Recently, bias against women scientists in case of gender disparity echoed on the SCIENCE AND TECHNO-LOGY column of the '**The Economist',** May 24th - 30th 1997. pp. 87 [73,81,92].

The Gloomy Trend

Gender equality needs to be a clear objective and measure of childhood development [51]. The 1990s could be said to be the decade in which, finally, every opportunity is given to the female child to acquire equal status to ensure that she grows and develops to her full potential in every nation, ensuring equitable access to health, nutrition, work parity, and education [1].

More boys than girls enroll for primary schools and dropout rate is higher for girls than boys in a majority of states. Regional disparity in female enrollment is quite pronounced. In some Southern states such as Lagos, Cross River, Ogun, Oyo, Delta, etc., female enrollment in primary schools is almost equal to that of males, whereas in Northern states such as Sokoto, Taraba, Kebbi, and Katsina, enrollment of girls is relatively low. Also whereas girls dropout of school to get married mostly, boys do so to take up apprenticeship [51].

Enrollment of Girls in Secondary School

In general, there had been an increase in the number of girls in secondary schools in Nigeria to the extent that there were almost as many girls as there were boys in the schools.

Total School Population in the Selected Schools

Schools	Male	Female	Total
St. Anne	-	2088	2088
St. Patrick	1663	-	1663
International School	840	629	1469
Total	2503	2623	5116
% of Total	48.8	51.2	100.0

TABLE 2.4
Source: CASSAD, 1993

In the three schools represented in the study, female students constituted 51.2 per cent of total school population, (Table 2.4) while in the school studied by one of the workshop presenters; they accounted for 45.3, per cent (Table 2.5) [112].

Immanuel College High School, Ibadan:
Enrollment Figure 1994/95 Session

Class	Male	Female	Total
Jss 1	273	153	426
Jss 2	246	187	433
Jss 3	127	122	249
SSS 1	205	218	423
SSS 2	199	212	411
SSS 3	166	74	190
Total	1166	966	2132

TABLE 2.5
Source: Alegbeleye, M.O. (1994)

These constitute great leaps from earlier shares of only 20 per cent, 28.4 per cent and 33.6 per cent for 1959, 1969 and 1970, respectively. While the situation may be partly due to the nature of the sample, there is no doubt that interest in female education has improved tremendously in Nigeria in the recent time.

Drop-Out Rates Between the Sexes in the Sampled Schools

	Percentage Drop-Out for **Girls**		Percentage Drop-Out for **Boys**	
Schools	1986/1991	1987/1992	1986/1991	1987/1992
St. Anne	28.2	22.9	-	-
St. Patrick	-	-	8.7	3
International School	5.0	4.6	3.5	4.2
Total	33.2	27.5	12.2	7.2

XXX

TABLE 2.6
Source: CASSAD, 1993.

In fact, in many parts of the Eastern Nigeria, particularly Anambra, Imo, Abia and Enugu States, females are reported to constitute a dominant proportion of total enrollments at the secondary level of education.

It was disturbing, however, to find that more than one-fifth (27.5 per cent) of the girls admitted into the secondary schools, compared to less than one-tenth of the boys, (7.2 per cent) failed to complete their education on schedule. Despite the fact that boys and girls received equal opportunities in most schools in terms of their admission to form one, male/female attrition ration was 1:3 (Table 2.6).

The high rate of attrition among girls is not surprising in view of the social problems of unwanted pregnancies and early marriages (Table 2.7).

Percentage Distribution of Married Women and Age at First Marriage

Age at Marriage	Relative Percentage	Cumulative Percentage
9	1.1	1.1
10	2.4	3.5
11	3.5	7.0
12	7.2	14.2
13	10.1	24.3
14	12.7	37.0
15	14.8	51.8

TABLE 2.7
Source: Adelabu, M.A. (1995)

Because the girl child is exclusively targeted for family socialization necessary for the entrenchment of gender roles for child-care and other nurturing activities of family members, she has little or no time for leisure and for studies like the boy child. And as both boys and girls approach adolescence, gender disparity in status and self-esteem in favour of the boy child becomes undeniable [47,81,108]. Existing disparities in the primary/secondary school systems include administrative practices that penalize pregnant schoolgirls with dismissal while male offenders are left in the school system. Textbooks and teaching methods reinforce sexual stereotyping [47], while conflicting time tables often schedule home economics and science subjects at the same time. In addition, the programmes of most women education centres are heavily geared towards domestic subjects, with little emphasis on measures for empowering women [5,43,44,51,65,81,108].

It is becoming increasingly apparent that these gender gaps have not arisen by mere historical accident; rather they are caused by the societal pattern of gender discrimination, which

reduces women's access to resources [2]. For instance, in some societies women cannot legally own land, and for this reason are deprived from the collateral that would have given them access to credit. In many instances widows have no right to inherit their deceased husbands' unless sanctioned by them [8,10,80]. The case of Mrs Caroline Mgbofor Mojekwu of the Oli-Ekpe custom brought against her by Augustine readily comes to the mind.

Mrs. Omeligbvo was tricked into believing that her sick husband sent his brother to collect his bank passbook and car keys. Having collected the items, he later came back with other relatives to inform her of her husband's death [10].

"They took everything and sold the only landed property we had", she said. These are some instances in some communities where most widows lose and become despondent because they have no capital, no connections and have no provider. This surely would have a great impact on the mental and physical health of widows. And mostly affected are indigent young widows who cannot afford the legal fees involved in going to court, and those married under the customary marriage law and have no male child. The older ones are not so much affected, especially if they have grown up male children [10].

Mrs. Roseline Omotosho, Nigeria's first female Chief judge, with the Lagos state High court, who retired in 1994; and has been widowed for about 15 years was lucky to escape the experience of other widows. Her husband left a will, so she was not denied access to her husband's property.

Many cultural beliefs inhibit women from fighting property rights. Among the Urhobos in Delta State, a widow is not entitled to anything from her husbands' family, and if she is still young, she will be given out to one of the husband's brothers as a wife. If she refuses, she is expected to move out of the house and refund the dowry paid on her by her late husband [10].

Widows among the Binis of Edo State have no right to property except their children. Among the Ebirras in Kogi State, a widow is not entitled to any property except if willed by her husband. A family once stopped a priest from performing the funeral rites for a man because his kinsmen could not get his bank passbook and other documents from the wife [10].

Among the Igbos in parts of Imo State, widows have no right to their husband's property. A widow is also expected to slaughter a goat for the family after the mourning period. On this occasion, she is expected to choose any man from the family as husband. Like the Urhobos of Delta State, she is ejected from her home if she fails to make a choice. In Anambra State, widows have to right to inherit their husband's property because they are regarded as property.

Among the Yorubas, women are entitled to property in their father's house as well as their husbands, particularly if they have children for their husbands' [10].

Under Islamic religion, a widow is entitled to her husband's property. The woman is expected accordingly to remarry after mourning. Widows and children are the only ones that have the right to inherit a man's property [10].

Mrs. Priscillia Kuye, a former Chairman of the Nigerian Bar Association says that denial of widows access to their husband's estate contravenes Article 15.2 of UN Convention on the Elimination of all forms of Discrimination Against Women for which Nigeria is a signatory [10].

Theresa Akumadu, Head, women's Right Projects, Civil Liberties Organisation said: "Maybe we would start from the awareness so that more people will make a will before they die. That is, if they really want their wives and children to benefit."

Widowhood Rites

To many women in Nigeria, widowhood shall continue to be a dreadful experience. In nearly all the states in the country, widows are subjected to various rites and unhealthy sanitary conditions [66,74,80].

Among those of Edo and Delta states, the mourning period is usually seven days with some slight variations. During the mourning period, the widow eats from unwashed plates using the left hand. It is part of the practice to wash the legs of the dead man and ask his widow to drink the water, or, in the alternative, to swear before an oracle in the presence of the elders that she is innocent of his death. Water from the copse is atimes used in some cases. The reason for this practice, as well as in many other areas where it occurs, is to make the widow prove her innocence regarding the death of her husband. The standard belief is that once a man dies, his wife may in all probability have had a hand in his death [66,74].

At the end of the mourning period, the woman is made to run around the house or to the Deceased husband's farm and back stark naked in broad daylight. Before she does this however, the villagers would be warned ahead of time to stay indoors. She is then expected to remove her mourning clothes after performing other minor rites. She is free to go about her normal life after this ritual. The husband's family members would then meet to find out if there is anyone wishing to keep her as a wife. Usually, the first son of her husband, other than her own sons, inherits her. In the absence of such a stepson, any of the husband's brothers, relatives, or elders could inherit her [66,74].

The situation is not very different from what obtains in other places. The general practice is that the widow is required to shave her hair, eat from unwashed plates, and stay indoor for months with poor sanitary measures. The gravity of the practices depends, however, on the demands of individual families and to some extent on the goodwill or the lack of it between the widow and her husband's relatives. In an extreme case, she may be required to drink the water used in bathing the body of her deceased husband. This happens in a situation where she is suspected of having had a hand in the death of her husband, and in-order to prove her innocence or guilt. The belief is rife that unless a widow performs these rites, the spirit of her late husband would continue to haunt her [74].

In Abia, Anambra, Cross River, Ebonyi, Enugu and Rivers's states, there is a consensus that widows are treated in the same manner. Though it was noted that these practices are no longer religiously pursued. However, the widow still has to mourn the husband for six months to one year, shave her hair in the presence of the married daughters of the land - the **Umuada,** and is denied access to any comfort or hygiene. The widow is also expected to wail twice, in the morning and evening. In certain cases her eyes are rubbed with Mentholatum to produce tears; this is to demonstrate her grief. She is made to sit and sleep on a mat on the bare floor for days lasting from ten to 90 days or more. She is not permitted to have a bath until after the burial of the deceased husband and she had observed the traditional rites to severe her links with the husband. It is believed she would incur the wrath of the gods and her ancestors if these rites are not observed as well as that of the late husband who will continue to haunt her. With these beliefs, it is surprising that women not only comply but also enforce the practice in the event that a widow is found to be reluctant or uncooperative. Penalties for noncompliance include accusing the widow of the death of her husband, which means social ostracism and annulling her children's right to their late father's property [74].

Among the communities of Owerri province, as well as other localities in the state, a woman is expected to mourn for one year and not allowed to step out of the house for the first 40 days, or to cook or touch any food meant for other members of the family. This is because she is seen as unclean until she has undergone all the relevant traditional rites. In some cases, the widow is allowed to eat only with her left hand or to be spoon-fed by someone else in order to disengage her from the dead [66,74].

In Afikpo locality, the period of mourning is shorter. In addition to the practices described above, she is not allowed to speak aloud. She cannot eat any food cooked in her home and she is not permitted to see the body of her late husband. She puts only black garments to signify her sorrow for between 21 and 40 days, after which she may resume her normal activities. In this locality, the widow is also stripped of her husband's property soon after the ceremonies are over. Usually her husband's relatives inherit her husband's property, to the utter detriment of the widow and her children. Similarly around Calabar, widows have no right to their husband's estate. Upon the death of her husband, she is expected to remarry and forfeit her rights to her husband's property. Where the widow is too old to remarry, "she can elect to marry her first son. By so doing she remains in the family and attaches her inheritance rights to that of the son [74].

In Rivers State, the widow is made to swim across a river and is thrown across the body of the deceased several times. The essence of the ritual is the same in the various communities: to prove the innocence or guilt of the widow in respect of the husband's death.

Research found that in addition to the rites described above, widows are usually made to hand over their deceased husbands' belongings to his relatives starting from car(s) to houses and even household items [74].

Among the Christian communities of Bauchi State, a widow is required to stay indoors for seven days and it is all over. In exceptional cases, she may be required to put on dark clothes, and only in extreme cases, as reported in Tangalewaja, is a widow asked or forced to drink the water from the washing of the corpse of her late husband. The reason is the same as that held in other areas - i.e. to prove her innocence or guilt in the death of her husband.

Similarly, among the Christian communities of Plateau state who are found in almost all the local government areas of the state, the period of mourning varies from three months, (in the lower Plateau communities such as Akwanga) to 12 months, (in the Shendam area). The rite and practices a widow may undergo vary from place to place but the rites were generally found to have undergone modification from the extreme traditional dictates of the past. This is mostly due to the influence of Christianity. In some cases, she may be asked to shave her hair, but in other places where the period of mourning is rather short, this may not be required. She is not permitted to take part in social functions during this period. However, a lot of sympathy is accorded the widow by the extended family because traditionally she is supposed to be married to them and not to her deceased husband only [74].

In the Muslim communities of Plateau and Bauchi states, there is little or no variation. The widow goes through a traditional 40-day mourning period called the **takaba** and another 30-day **idda,** periods; there is no special mode of dressing although she is expected to be in a sober mood. There are also no special rites such as those found among the Igbos, the Edos and people of Delta or the Cross River State. However, the widow remains incommunicado except to members of the immediate family of her deceased husband and her own family relatives. This cannot be said to be the standard practice in all the Muslim societies of Northern Nigeria, although eslewhere it is the same with slight variations as custom may dictate. In the Muslim

communities of Kano State, for instance, the **takaba** period is four months and ten days. During the period, she is required to remain indoors where only close relatives may have access to her. The responsibility of looking after the widow lies with the eldest son or the brother of her deceased husband until she remarries. Custody of her children and responsibility for their upkeep is also given to the eldest brother or male relative of her husband or to her father if she goes back home with the children because they are still too young to be separated from her. Islamic law does not permit the making of a will but does take care of the woman though not on equal terms as applies when the man is the widower [74].

2. WOMEN AND LEADERSHIP

For three days, from May 5 - 7 1997., Abuja played host to Africa's First Ladies at the Summit on Peace and Humanitarian issue [45].

War, ethnic rivalry, violent crimes, draught and famine have eroded whatever morsel of peace that existed in most countries in the African continent. Incidence in Liberia, Rwanda, Afghanistan, Somalia and Zaire, buttress this point [5,28,47,61,65,105].

This increasing incidence of civil war in the continent was what led to the just concluded Africa First Ladies Summit, initiated by Nigerian's first lady, Mrs. Maryam Abacha. Specifically, she was motivated by the fact that children and women are the most vulnerable groups in such devastating war situations [3,28,40,68].

While lamenting the increasing number of refugees and displaced persons in Africa, participants said wars in Africa have seriously undermined the efforts by groups to address the challenges posed by the refugee problems, towards a permanent solution [33,40,69,104].

The first ladies noted the efforts of countries granting asylum and described it as symptoms of hospitality - fatique. However, the dwindling assistance from donor governments and organisations was attributed to the fact that the act of generousity was becoming heavier, and the means of sustaining it were diminishing [28,40,55,68].

The Secretary - General of the Organisation of African Unity (OAU), Dr. Salim Ahmed Salim who attended; addressed the summit saying that the first ladies had moved at the right time, asserting that the involvement in peace efforts as well in mobilising support aimed at curbing the plight of refugees and displaced persons was most commendable [28,65].

His words: "I believe that our first ladies and other participants would be guided by the fact that Africa is a continent in transition where three great things are happening simultaneously."

While enumerating the three issues as the struggle for democracy, which he believed women have great roles to play, the attainment of economic power and development, which requires the united and concerted efforts of all men, women and youths for the promotion of socioeconomic development in the continent; and the struggle for peace, security and stability in Africa [28,68].

Dr Salim expatiated further that African countries must try to blot the image already created in the west, that the Africa continent is overwhelmed with war and conflicts, resulting in the sufferings of million of people [3,28].

The first ladies after their three-day deliberations came out with a fifteen point communiqué, which was read by the chairman of the conference Mrs. Maryam Abacha.

They appealed to countries locked in armed conflicts in the continent to desist from using children as soldiers, saying that it amounted to child abuse aside being barbaric and callous [28,68,78,91].

They condemned the use of landmines in wars and suggested a global ban on the practice by calling on African governments to assist in the clearance of such where they exist, and mobilise relief and rehabilitation services for victims [28,40].

While pressing for more women involvement in decision-making bodies of the countries, the first ladies decried illegal arms trafficking across the continents' border [31,70,81].

They also lamented the incidence of child labour and prostitution, while calling on the international community to assist by placing a ban on them [11,12,22,28,30,35,40,42,61,69,83, 91,95].

The resolutions reached were later presented to an assembly of Heads of State and Government of the United Nations (UN) and Organisation of Africa Unity (OAU) in Harare, Zimbabwe.

Consequently, it was a happy Mrs. Maryam Abacha that took the stage to address the Organisation of Africa Unity (OAU) when it held its 33rd Conference of Heads of State and Government, in Harare - Zimbabwe with the following words: "It is a great pleasure and honour for me to address you today on behalf of all African First Ladies in my capacity as the leader of the African First Ladies Peace Mission. This is indeed a historic occasion as it is the first time in the 34 years of the Organisation of Africa Unity (OAU) that a First Lady is given the rare privilege of addressing this summit. It is therefore with a sense of responsibility that I come before you to express our collective concern as First Ladies and as mothers, for the peace, stability and development of Africa" [37].

Explaining the basis of their efforts, she said, "I should like to assure you from the beginning that the principal objective of the Africa First Ladies Peace Mission is not to duplicate the efforts which you and the leaders of Africa have over the years been deploying for the prevention, management and resolution of conflicts in Africa. Our aim is to provide the necessary support and encouragement to you, to stand firmly beside you as wives and mothers, in your collective search for peaceful solutions to the many conflicts plaguing our continent" [32,37,65].

She further explained: "Women constitute over 50 per cent of the total population in our continent. They are major participants in the agricultural sector, which is the backbone of our various economies. They are, however, almost totally absent from the decision-making organs of our countries and from the organised sectors of our economies. More significantly, women and children constitute the overwhelming majority of the refugees and the displaced persons that are the real victim of the numerous conflicts in our continent [83,91,108]. It is my belief and conviction that enduring peace and sustainable development can only be achieved in Africa if women are fully involved in all aspects of our national and continental development efforts" [32, 37,42,65,69,70,78].

"We as First Ladies, and as wives and mothers can not afford to sit by and watch while charitable organisations from outside Africa struggle to feed and cloth the millions of our fellow citizens who are suffering in refugee and rehabilitation camps" [37].

While conceding that the task of ensuring peace in the continent was no doubt a daunting one, Mrs. Abacha proposed the establishment of African Committee of Elders. In her words: "I wish to submit, therefore for the consideration of this summit, a proposal to establish an African Committee of Elders to be drawn from among former Heads of State and government, retired legal luminaries, former First Ladies, eminent African men and women as well as distinguished intellectuals" [37].

"This committee, if established, will assist in all regions of our continent and work towards the promotion of global peace."

Women and Politics

The political history of Pre-colonial Nigeria cannot be appropriately reconstructed without mentioning the roles played by some great women in the shaping of events in their communities [63]. Such great women include Queen Amina, and Kotal Kanta, in the building of great kingdoms like Zaria and Kebbi respectively. The same could be said of the great amazons of Dahomey (now Benin Republic), which at the zenith of its glory, stretched to most parts of what is today Western Nigeria. There are indeed several other cases of women political leaders who called the shots in their respective empires and kingdoms of what today constitutes the Nigeria Nation [63].

In the colonial times however, politics then was basically centred around the demand for improved conditions of living and later, for the end of colonialism itself. Although women did not form the nucleus of the early agitators, their contributions as epitomised by the famous Aba women's riots for tax reforms in 1929, the likes of Mrs. Olufumilayo Ransome-Kuti, Margaret Ekpo and Hajia Gambo Sawaba, were quite noticeable and indeed, helped immensely in attainment of independence in 1960. Their contributions then were largely through political activism [17,42,63].

With the attainment of independence, the political profile of women began to rise. It started with the appointment of Mrs. Waraola Esen, into parliament as a senator, by the then government of Alhaji Tafawa Balewa. She was the only woman in parliament at the centre. Apart from her however, the indefatigable activist, Mrs. Margaret Ekpo, was an elected member of the Eastern House of Assembly [63].

Between 1966 and 1978, when military held sway, no woman was appointed federal ministers or a military governor. In 1983, Chief (Mrs.) Franca Afegbua got elected senator in the former Bendel State. Nine years after, Mrs. Buknor Akerele, repeated Afegbua's feat from Lagos State. In both instances, they were the only female senators. Things however, took a better shape in 1992, as a number of women were elected to the house of representatives; some of them include Mrs. Rebecca Apedzen, Ms Ada Mark (Benue), Mrs. Victoria Akwanwa, Mrs. Beret Ketebu (Rivers) among others. Hajia Kingibe however lost her bid for senatorial seat in Maiduguri, Bornu State. Many women were elected to the state houses though none was elected speaker or held key positions except in Benue, Chief (Mrs.) Joy Ofere, became the minority leader of the house [63].

The closest a woman came to the state house in any state was Alhaja Ojikutu who was elected deputy governor to Sir Michael Otedola of Lagos. Mrs. Pamela Sadauki was appointed deputy governor of Kaduna State just like Mrs. Latifat Okunnu in Lagos, during the transition programme of President Ibrahim Babangida [63].

The above instances in addition to occasional ministerial slots, have been the best of Nigerian women politically. Their bids to the Government House have been a Herculean task hampered by socio-cultural and religious prejudicess, lack of resources, inaccessibility to the media, conspiracy of the men politicians and more, which all combined to derail the gubernational or presidential ambition of women [63].

In Nigeria, the campaign for women suffrage has assumed an extreme dimension involving women in politics and political party formation. This has brought the gender war into the political theatre and thus a moderating factor has become inevitable [35,38,39,60,62,71,95,96].

This is the point of contention of many women wing of political parties and many of them have about plans to mobilise women in the party to take active roles in the emerging political dispensation [74,95,96].

Against popular demand that it was time women occupied major political offices in the country, Mrs. Branco Rhodes expressed the belief that women's participation in politics need not be visible. Women play important roles in national development and they could be as effective in the background as in the forefront.

In the past, political analysts dissecting the peculiar circumstances of the African culture and tradition said certain religious and cultural beliefs forbade women from taking active roles in politics, one of such was the issue of women in purdah, a religious practice common to the Muslim sect [34,38,39,58,60]. However, recent developments have rendered some of these beliefs irrelevant [74]. A recent survey in the Northern states where the purdah practice is rooted reveal that there had been a massive turnout of women in purdah at the on-going transition programme.

Participation in Politics

A report by Nie (1974) on the study of political participation in six nations indicates that Nigerians follow the general patterns. Participation by voting increased for both men and women up to the age of forty. Those in their fifties are more likely to vote than people in their thirties, but women over sixty participate less than men, but Nigerian women are on a per with women in Austria and Japan and far more active than Indian women [14,15,29,62].

Post (1963: 446-7) reports that 48 per cent of the men and 52 per cent of the women in Western Region were registered in 1959. Only eighteen of the sixty-two constituencies had a higher proportion of men than of women registered. Women were not allowed to vote in the North, but enthusiasm among the men was great in 1959 [46].

Prevalence of Islam in the North, with its injunctions on the seclusion of women, has limited female participation here. Nevertheless, a few women have attained political prominence.

Yoruba women, on the other hand, have been able to use wealth gained in trading to take chieftaincy tittles. Forde (1951:20) indicates that 'palace women' had influence in the choice of a new Alafin of Oyo. Leaders of marketing associations had direct access to the Oba and later developed strong ties with political leaders' [52].

The influence of Ibo women was less direct, since village assemblies were men's affairs. However, the pax Britannia increased the opportunities for trading, thus improving both their economic and political status [52].

Both men and women who were concerned about *political* and voter literacy sometimes said that women should wait until when they could read and write before they can vote (though no one seriously proposed placing this limitation on men).

The first administrator of the defunct National Republic Convention (NRC) strongly advised women politicians to forget any presidential or governorship posts for now.

Alhaja Okunnu, a former deputy governor of Lagos state spoke to Sunday Champion at the weekend. She described any aspiration into such high political offices by any woman politician as too ambitious and in sharp contrast with the current low levels of political mobilization, awareness and participation among Nigerian women generally [19,59].

"We must first have an agenda to develop the women folk politically to muster enough relevance and participation in political activities at all levels before aspiring to such post," she posited.

Some of the Southern men however, just did not trust women would exercise their right properly. There are some that believe that to include women would be 'cheating', since women would just act in political office(s) or vote as their husbands told them to. But the enthusiasm and level of information of many market women are such that the advice may go the other way, at least occasionally [59].

The complete accord between the men and women might be considered highly unusual for a developing country, unless it was assumed that the women were merely repeating their husbands' opinions. But Nigerian women are highly interested in politics and well able to express their own ideas about it. Not for them the passive "let the men do it" attitude so resented by the women's liberation movement in America [52]. Larger majorities are in the labour force, mostly as farmers or traders. As traders they are better able to keep up with events, at least at local level, than husbands whose occupations allow them less contact with the public. Most of their political interest and activity is concentrated on the market place - the availability of stalls, cost of commodities, taxes, etc. But this gives them sufficient framework for rating the efficiency of a government and its response to the needs of ordinary people [52].

This positive attitude towards achievement is expressed today by the giving of *honourary Doctorate degrees* and chieftaincy titles to men and women who have been successful in the modern political and economic system, thus tying new goals to both *academic* and traditional ones [62,74].

Market traders are often well organized according to market and commodity sold. While their associations are primarily economic, they take on political functions when necessary to influence the government to provide more stalls, lower rates and moderate regulations which, the traders see as hindering business. Their leaders are known to speak for large numbers of women who can be mobilized easily to demonstrate in defence of their interest.

The evidence from Lagos suggests that market women there were (naturally) mainly concerned with market affairs, but were well able to evaluate various parties in terms of their best interests. While women, may certainly have not won every battle, they are considered a political force to be reckoned with in the political front.

Participation in Marketing according to sex

Area	Male %	Female %
Copperbelt (Zambia) (late 1950s)	59	51
Rhodesia (late 1950s)	majority in larger markets	majority in smaller markets
N. Somalia (late 1950s)	-	Women dominate the open market
Hausa (Nigeria) (late 1950s)	men dominate the public markets	women trade from the homes
Dakar (Senegal) (1959)	40	60
Brazzaville (Congo) (1963)	34	66
Nigeria (1963)	30	70 (of petty traders)
Ghana (1960)	16	84
Benin (1967)	11	89

TABLE 2.8
Source: Margaret Snyder & Mary Tadesse

Moving Forward

March 8 is a significant day for women the world over. It is in observance of International Women's Day - a day set aside by the United Nations to pay tribute to the world's status and immense contributions to national development [20,79].

The problems of women are global and constitute stumbling blocks to their and advancement. These problems revolve round their low status, inequality, poor educational opportunities, lack of access to adequate health care service, low economic status and different forms of violence [42,93,98,102]. They are confronted with rigid socio-cultural barriers and are locked in a vicious poverty cycle [40]. Put differently, these issues are strongly tied to poverty and powerlessness [20,25,81,84,85,87,88,89,93,100,101].

These problems that have been the lot of women were what informed the United Nations' decision to declare the year 1975 - 1985 as the decade for women after the first world conference in 1975 in Mexico to mark the International Women Year. Two other conferences to mark the decade's midpoint and conclusion were held in Copenhagen, Denmark and Nairobi, Kenya in 1980 and 1985 respectively [20].

Since the UN's historic declaration of March 8 as the International Women's Day world wide, attention has now been focused on women's problems and their needs. Over time, nations have come to realize that women have become latent forces that are vital to the progress and development of a nation [20]. They can longer be ignored, marginalised or oppressed [97,102].

The Soroptimist International, a world wide women's organisation founded in 1921 at San Francisco United States celebrated its 75th year of fruitful existence in 1996 [7].

The Nigerian branch of the organisation was not left out in the celebration. It organised a symposium titled: **"Wither The Nigerian Women?"** [7].

For the plight of the Nigerian woman to be properly understood, Professor Gabriel Olusanya in his address took a trip down memory lane and reminisced through precolonial and colonial period [7].

Professor Olusanya debunked the vague impression that African women were mere chattels, exploited and maltreated by the male. This view according to him "is too broad or general to be meaningful in the bewildering diversity and complexity of Africa . . . Even within the context of Nigeria, the complexity is such that broad statements often times fail to capture the different realities of the Nigerian society. For Nigeria, like most African countries, is a multi-ethnic state. This is not to deny that there are matters that cannot be generalized, but such generalities must be based on close studies and not mere impressions [5,7,77.98]."

In absolving Nigeria of the general of the subservient role of women during the precolonial era, Olusanya argued that our traditional system provided women not only an opportunity to have a say in matters that affected their lives, particularly in public domain, but in some cases an opportunity even to rise to the highest level of political hierarchy [7,77,86].

He cited the examples of Queen Amina who succeeded her mother, Queen Bakwa Turunku to be the Queen of Zaria, and expanded enormously the bounds of her kingdom. Also Queen Kambase of Bonny in the Former Rivers State provides additional proof that women in our traditional societies were invested with full sovereignty and placed at the apex of political authority [7].

In Yoruba society of the South Western Nigeria, women were represented in the traditional governing council by the Iyalode who sat and deliberated with all important male chiefs at the regular meetings over the general affairs of the state. Efunsetan Aniwura Ibrahim and Madam Tinubu the Iyalode of Egba, readily come to mind as example [7].

In the field of education and Islam, some Nigerian women have distinguished themselves in the past. Notably Asmau, the daughter of Shehu Uthman Dan Fodio, a distinguished scholar who had to her credit books on religious matters. Thus the belief that Islam does not encourage education of women is not borne out by historical fact [7].

Professor Olusanya did not deny the fact that there were serious cultural constraints on the part of women of those days, most of which still exist till today. These women operated in a milieu in which women started life with a handicap, but few broke through these constraints and barriers and rose to leadership position [7,81].

Olusanya brought out a sharp contrast in his comparison of the pre-colonial era with the colonial one. Colonisation he said brought about a substantial diminution of women's role, if not its total elimination without eliminating the constraints. In other words, women became more disadvantaged during the colonial period vis avis men [7,84].

The colonialists, ignorant of our history and traditions did not accord women any place in their own arrangements. Western education which, was a means of achieving progress, importance and fame was denied women. Even when they were trained, they were encouraged

to fulfil their roles at home and provide supportive roles for their husbands. This however, was not strange because women in England at this time were given essentially the same kind of training, and they had no vote until 1928 [7,84].

This brought about the disparity in education between men and women, a fact that has contributed substantially to the inability of women competing effectively with their male counter parts until recent times. These women, however, were not apathetic nor indifferent to the way they were governed. Inactivity and indifference would have run counter to their traditions.

Market women were the backbone of Herbert Macualay's Nigerian Democratic Party. They threw their weight behind him in his political aspirations. Also, the Aba women riot of 1929 in which women demonstrated against the excesses of warrant chiefs, showed beyond doubt the passionate commitment to justice and good order by our women and their willingness to sacrifice themselves for the good of the society [7,17,42,52].

Recently the First Lady, Mrs. Maryam Abacha announced the creation of ministries of women affairs and social development in all the 36 states of the federation as a further step to move the cause of women forward. In her words at a conference in Abuja: "I have the mandate of the Head of state and Commander in Chief of the Armed Forces, General Sani Abacha, and the Chief of General Staff (CGS), Lt. General Oladipo Diya, to announce to you all the creation with effect from today, Ministry of Women Affairs in all state of the federation" [26,67].

Earlier in her address to mark the International Women's Day, Mrs. Abacha said this theme: "Eradication of Feminine Poverty" was apt, adding that in Nigeria, the Family Support Programme (FSP) had taken the initiative through the launching of the Family Economic Advancement Programme (FEAP) [32,64,67].

She said that FEAP, the FSP hoped to achieve a great level of poverty eradication in rural areas where, she said, the menace was most prevalent [38,62,67].

She further said government also hoped to use the programme as a stepping stone towards the achievements of sustainable industrialisation through cottage industry development in rural areas.

Mrs. Abacha appealed to the men folk to allow their women to contribute in the economic and political development of the country, adding that none of the two dominant religions in the country forbade women from participating in the development of their country and their economic empowerment [26,31,34,38,67].

Gender Equity

"The essence of gender equity in democracy embodies the concept of government by the people of a nation, government by the elected representatives of the people. It embraces social equality and the right by all to take part in decision making at all levels and a fair deal for all its citizens" [25,27,29,64].

That was Mrs. Aba Omotunde Sagoe, former Secretary to the Lagos State Government at the second annual lecture of the Nigerian Association of Women Journalist (NAWOJ), Lagos State Council sponsored by the Freidrich Ebert Foundation [64].

Delivering a note at the lecture titled: “Gender equity in democracy: Necessary tool for national development,” Professor Sagoe pointed out that in democracy, the nation and everyone male and female must be on equal footing. Most especially all must have equal opportunity, and collective will to develop the nation [40,64].

She also noted that by creation, both men and woman have common task of exercising dominion over the earth. The big question therefore is can we say that today, women have equal share of the bounties or equal opportunities to share these bounties? [40,81].

With a simple NO! as answer, Professor Sagoe went ahead to back her argument with a letter titled: "To Women", written by Pope John Paul II in 1995 that if women had equal chances with men, the society would have further progressed spiritually, morally and indeed technologically [64].

According to her, the problem stems from the plural role given to women by God which has made them focus on family with attendant requisites of love, affection, gentleness, empathy and philanthropy, which are exploited by the menfolk. In effect, women worldwide “have been brought to the downtrodden side and we are reduced to having to demand for our God given rights in the scheme of things.”

Giving statistics on how the affairs of the nations is being run, her lecture painted a glaring picture that one group of the society (the men), has been dominating and representing the interest of the other half without consultation or their consent. But then, some laws of the nations are gender bias. Moreso, with failure of democracy in post-independence Nigeria where out of 37 years of self rule, only nine had been by elected Nigerians, creates an impediment to involvement of women in decision making process. This is self explanatory since military regime is a male-oriented class that only accepts token women into its membership, capable women in the army, she said are not easily promoted and their ranks are pegged [64].

Accordingly, the transition programme, she advised, is an opening for women to participate actively in government. That is the only way they can change whatever negative ways they felt politics as well as the affairs of the nation are being operated. To this regard, she called for a collective effort to strengthen, consolidate, and build up confidence in women adding that female journalists, and other media practitioners should not relent in their good work of assisting in the democratisation process by advancing women’s courses [25,34,40,64].

Political and legal data

Country	Date of independence	Date of women's vote	Paliamentary seates occupied	CEDAW[1] Signed	CEDAW[1] Ratified
Algeria	1962	1962	10.0		1986
Angola	1975	1975	9.5		1992
Benin	1960	1956	6.3	1981	
Botswana	1966	1965	5.0		
Burkina Faso	1960	1965	5.6		1987
Burundi	1962	1961	9.9	1980	
Cameroun	1960	1946	12.2	1983	
Cape Verde	1975	1975	7.6		1980
Central African Republic	1960	1986	4.0		1991
Chad	1960		1.0		
Comoros	1975	1956			
Congo	1960	1963		1980	1982
Côte d'Ivoire	1960	1956	4.6	1980	
Djibouti	1977	1946	0.0		
Eqypt	1952	1956	2.2	1980	1981
Equatorial Guinea	1968	1963			1984
Ethiopia		1958		1980	1981
Gabon	1960	1956	5.8	1980	1983
Gambia	1965	1960	7.8	1980	
Ghana	1956		7.5	1980	1986
Guinea	1958			1980	1982
Guinea-Bissau	1974	1977	12.7	1980	1985
Kenya	1963	1963	3.0		1984
Lesotho	1966	1.5		1980	
Liberia		1946	6.1		1984
Libyan Arab Jamahiriya	1969	1969			1989
Madagascar	1960	1959		1980	1989
Malawi	1964	1964	11.6		1987
Mali	1960	1956	2.3	1985	1985
Mauritania			0.0		
Mauritius	1968	1956	3.0		1984
Morocco	1956	1963	0.7		1993
Mozambique	1975	1975	15.7		
Namibia	1990	1989	6.9		1992
Niger	1960	1948	6.0		

Nigeria	1960		2.2	1984	1985
Rwanda	1962	1961	17.1	1980	1981
Sáo Tomé and Principe	1975	1975	10.9		
Senegal	1960	1945	11.7	1980	1985
Seychelles	1976	1948	45.8		1992
Sierra Leone	1961	1951		1988	1988
Somalia	1960	1956		1956	
South Africa		1994[2]	2.8	1993	
Sudan	1956	1953	4.6		
Swaziland	1968	1968			
Togo	1960	1956	6.3		1983
Tunisia	1956	1956	4.3	1980	1985
Uganda	1962	1962	12.6	1980	1985
United Republic of Tanzania	1961	1959	11.2	1980	1985
Western Sahara	1976				
Zaire	1960	1967		1980	1986
Zambia	1964	1962	6.2	1980	1985
Zimbabwe	1980	1957[3]	12.0		1991

TABLE 2.9

Notes

1. Convention on the Elimination of Discrimination against Women
2. 1994 for all women
3. 1957 only British women voted.

Source: Margaret C. Snyder & Mary Tadesse

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1. PREGNANCY AND CHILDBIRTH

Pregnancy is often described as a physiological process which should end in a joyous and happy note for the family but this is not often so in this country. For many years, evidence shows that the maternal mortality and morbidity are on the increase; and the causes of death in Nigeria are mostly preventable [18,25,31].

This situation has existed for several years, but because child bearing is virtually inevitable, our traditional societies have come to accept the risk as normal and unavoidable [18].

Whenever there is any death arising from child bearing, what comes to mind is the helplessness and vulnerability of women.

The burden of child bearing and maternal mortality on African women is indeed very heavy. According to Dr Fre Sai of the University of Ghana: "For every woman who dies, there are 50 to 100 others who are going to have to suffer short, medium or long-term consequences from their pregnancies and deliveries. The effect of this problem is so enormous given the number of women still experiencing complications from child bearing in Africa" [18,25].

It is paradoxical that maternal mortality has worsened in Nigeria despite the launching of the Safe Mother Initiative nine years ago by the World Health Organisation (WHO), the World Bank and UNFPA, which aimed to reduce by half the number of maternal death by the year 2000 [4,9,10,18,31].

In Nigeria, available information indicates that the higher incidence of maternal mortality is deeply rooted in the multitude of health, cultural, religious, political and socio-economic problems, which affect girls and women. Many girls are born prematurely and with low birth weight because their own mothers were malnourished, ill, and were overworked during pregnancies [7,9,28,31].

In many parts of Nigeria, laws or customs often prevent women from using family planning services. Women are expected to obtain permission from their husbands to be able to obtain contraceptives and other health services [9,18,30,32].

Also, in some parts of Nigeria, a woman cannot leave her home or village without her husband's permission or a male relative even she is desperately in need to medical care within a short time [9,18].

Girls are forced to marry at an early age ranging from 9 to 14 years, while pressures are often mounted on them to begin child bearing early to prove their fertility. These attitudes pose substantial threat to the physical and mental health of these mothers and their infants [10,17,18, 23,24,27,31,33,34].

Men still dominate as decision-makers in the family, community and government. It would be necessary to make the men who are the decision-makers at all levels to understand why there is a need to change the pervading customary laws relating to women. Decisions affecting women's health should at the best be left for the women to decide.

In particular, men need to be sensitised about maternal health programmes, to broaden their understanding of social, economic and political issues relating to women's status and needs. They need to understand the importance of supporting women's activities and programmes designed to improve women's health and social well being.

Adolescent Reproduction and Early Childbearing

Adolescent reproduction and early child bearing exact a heavy toil on young mothers and their children. National statistics from Nigeria as well countries like Bangladesh, the Dominican Republic, El-Salvador, Jamaica, Japan, Malaysia, the United Republic of Tanzania [11,22], and the United States of America indicates that girls 15-19 years are twice as likely to die in child birth as mothers 20-24 years old [12,15]. The risks can be five times as high for girls under 15 years of age [10,17,18,23-25, 27,31,33,34].

In Nigeria the most significant indicators of women/girls under development is the high rate of maternal mortality. About 1500 out of 100,000 mothers die during delivery or shortly after. And for every woman, who dies, 30 more suffer serious pregnancy related injuries. This rate is incidentally one of the highest in the world [3,5,8,9,11,14,16, 18, 19,25, 29,31].

The high maternal mortality rate (MMR) is also essential with the low status of women in this country. Whereby women are generally not involved in taking major decisions that affect the level of national investment in maternal health services and others closely control their health behaviour. For instance, only 18 per cent of married women have used a modern method of family planning in their lives [12]. Thus beyond poor physical access to health services, strong male resistance to use of family planning services by them and their wives, as a means of controlling female sexuality is one of the contributing factors to **too early, too many** and **too closely spaced** pregnancies and also the underlying cause of high MMR [9,13,16,19,20,22,31].

The process of bringing new life into the world is a major cause of death and disability among young women in developing countries, according to The Progress Of Nations report from the United Nations Children Fund (UNICEF) [19].

UNICEF Executive Director Carol Bellamy said: "It is no exaggeration to say that this is one of the most neglected tragedies of our times, when 1,600 women some in their teens - die every day during pregnancy or childbirth and many of these deaths are deadly preventable [3,14,18-20,31]."

The data show that one in 13 women in sub-Saharan Africa dies of maternal causes, as does one in 35 in South Asia. The figure for Western Europe is one woman in 3,200. In the United States, it is one in 3,300. In Canada, it is one in 7,300 [16,18-20].

The most common causes of death during pregnancy and childbirth each year include 140,000 from haemorrhage; 75,000 from attempting to abort themselves; 100,000 from sepsis; 40,000 from obstructed labours [9,18,19,25].

In the 1990s so far, three million young women have died in one or more of these ways. In addition, one quarter of all adult women in the developing world are affected by injuries related to pregnancy and childbirth. These injuries are painful, humiliating and often permanent, says the UNICEF report. The most distressing is **fistula,** which leaves an estimated 80,000 women a year injured and incontinent, most of the victims are Nigerians, untreated and somewhere between 500,000 and one million women are living with the problem at this moment says the report [1,2,3,5,9,11,13,14,16,19,20,29].

If the toll of maternal death and injury is to be reduced, says UNICEF, then the silence that surrounds the issue has to be broken. Family planning services should be available to all that need them; good quality health care should be provided before, during and after pregnancy. Women need better education and better nutrition. But above all else, every pregnant woman

needs access to skilled obstetric care to the same obstetric skills that made the difference in the industrialized world in the early part of this century. The report notes that in the United Kingdom for example, it was not until the 1930s, when modern obstetrics care began to cope with obstructed labour, haemorrhage and infection, that death rates began their sharp fall to today's levels [9,13,18-20].

According to the report, the delivery of adequate obstetric care to women in developing countries would not be expensive. Affordable basic training in obstetric care could be provided for doctors, midwives and nurses. This would ensure safer deliveries for most pregnant women.

"Maternal mortality remains unacceptably high", remarks WHO's Director General. Dr Nakajima stressed that: "Child birth is not a disease and does not require the use of expensive drugs or sophisticated technologies. The presence of a trained, skilled attendant at birth is a critical determinant of the outcome, both for the mother and the baby" [1,2].

Identifying Risk Factors

Perhaps more persuasive than these statistical attempts to determine the contribution of medical services to increased health is Victor R. Fuchs' (who shall live) excellent discussion of the causes of death by age [7]. Fuchs examines the contribution of living standards, lifestyle, and medical services to the decline in infant mortality rates since 1900 and to causes of adult deaths. The large decline in infant mortality rates from 1900 to the present has been due largely to rising living standards, the spread of literacy and education, a large decline in the birth rate, possibly chlorination of the water supply and pasteurization of milk, the introduction of antimicrobial *remedies* etc in the 1930s. "It is important to realise that medical care played almost no role in this decline. It was not until fairly recently (late 1960s) that maternal and infant services were extended to underserved families and intensive care units were provided for premature infants who are at high risk. Fuchs also points out that in other developed countries with fewer medical services than the United States and a large proportion of home births delivered by a *skilled* midwife, infant mortality rates are lower than in the United States. Specific medical service programmes targeted to high-risk pregnancies are likely to make a larger contribution to decreases in infant and *maternal* mortality than merely making more medical services generally available to the entire population. For example, in countries where medical services are provided free, as in Great Britain, the infant mortality rate is still not as low as that achieved in other developed countries. The lowest infant mortality rates in 1970 (13 per 1,000 live births) were those of the Netherlands, Scandinavia, Australia, and New Zealand [11].

The results of various studies by different institutions and organisations including the World Fertility Survey (WFS), and The Nigeria Demographic and Health Survey (NDHS), showed that women who died in pregnancy were younger and of poorer socio-economic status as compared to women who survived. Women aged 20 years or less were four times more likely to die during pregnancy as compared to those aged more than 20 years. High child mortality (relative to infant) is experienced by children born to mothers who are uneducated, who live in rural areas, and who have limited access to basic facilities.

Women's education had a strong ameliorating effect on the risk of dying during pregnancy. The higher the educational level of the woman, the lower the odd ratios for dying during pregnancy. Even a primary level education significantly protected women from dying as compared to no education [3,11,15].

2. HARMFUL TRADITIONAL PRACTICES AFFECTING WOMEN AND GIRLS

Nigeria, according to the report of a national baseline survey of harmful traditional practices affecting women and girls in the country accounts for 10 to 15 per cent of maternal deaths recorded globally each year. Such deaths are believed to be contributed to in no small way by what the report classifies as 'Harmful Delivery Practices (HDP)."

Harmful Delivery Practices refer to those practices which through ignorance and blind adherence to tradition, make the task of child bearing a difficult and sometimes fatal endeavour, and are believed to contribute to the high maternal and mortality rates. Socio-cultural values and norms, which dictate childbearing attitudes and behaviour also, increase the rate of these deaths. In most African societies, the successful outcome of reproduction is secured by magico religious rituals and observances, some of which may not be exactly favourable to the mother and child. To promoters of these practices however, they are functional to the process [30,32].

Listed among these harmful practices are circumcision during pregnancy and at child birth, hot baths, forced squatting during labour, fattening, tying of wrapper, massaging the womb, daily consumption of alcohol, sacrifices for fertility, uvulectomy, bellcut, incision on the womb with incantations, application of native medicine and charms, etc.

Other practices include keeping the mother naked for hours after delivery, insistence on total privacy in some areas and show of bravery in other areas during delivery.

Cultural beliefs and values support these harmful practices, but the immediate predisposing factor is the pattern of healthcare resort during pregnancy and at childbirth. It is not surprising therefore, that these harmful practices, along with unsafe and unhygienic home deliveries are still very much the order of the day.

Among the Igbos, harmful prenatal practices include recourse to prayers and fate when pregnancy becomes difficult, the administration of herbs when a pregnant woman has oedema of the feet or hands, or to reduce the size of the baby, to make delivery easier. Traditional Igbo women in the first stage of labour are asked to undertake strenuous exercises, such as going to distant markets or carrying heavy loads. The belief is that such exercises activate the uterine muscles to work harder to expel the foetus and sometimes to take the mind off the pains. However, such exercises could lead to exhaustion and other complications. Incisions are sometimes made on a pregnant woman's abdomen, chest and back and herbs are applied to ward off evil. Possible consequences include loss of blood, infection, and tetanus.

In the cases of breech delivery, where the feet sometimes appears first, impatient traditional birth attendants (TBA) may pull on the leg with force causing permanent disability to child or damage to the birth canal.

After delivery, the umbilical cord is sometimes cut with a curved knife or other unsterilised instruments, leading to infection. Sometimes all the blood is squeezed from the cord, which could lead to severe jaundice some hours after birth.

In the Northern part of the country, it is culturally forbidden for a woman in labour to be seen. This traditional practice still prevails where there are no public health services or where delivery is not attended to by trained TBAs and midwives. The dangers from this practice become obvious where childbirth is prolonged and complicated, putting at risk, the lives of the

mother and child. In most cases, the husband has to be consulted before a case can be referred to a hospital.

The **Yanka Gishiri** cut restricted to some Northern states such as Kaduna, Kano and parts of Borno state, is usually performed by local barbers **(Wanzamai)** or TBAs in obstructed labour, it is performed to widen the birth canal, so that the child can come out. It consists of a blind incision into the anterior part of the vagina. Where repeated cuttings occur, the result is damage to the bladder, leading to Vesico-Vaginal Fistula (VVF), haemorrhage, infection and anaemia.

The **Wankin Jego** (hot bath) is another such harmful practice prevalent in the North. This refers to the traditional bathing of newly delivered women in very hot water prepared with local herbs at an unbearable temperature. She is also made to sit over the almost boiling water. In some areas, it consists of heating the room and bed after delivery, using open fires. The reason for this practice is said to be the erroneous belief that hot water scares away any incoming disease keeps the woman and aids the involution of the uterus. However, this is a false belief, which may result in burns and scalds.

Other practices include the use of charms or herbs to control fertility. Local spermicides such as common salt, laundry blue or potash are also in use. These corrosive and sometimes poisonous substances are either taken orally or used for douching after sex. In churches, blessed water is used as well as olive oil. Sacrifices are offered to the head of the women with fowls, fish, and yams to bring luck during pregnancy and delivery etc, etc [9,30,32].

Interestingly, too much of orthodox medicine can be harmful. In some developing countries, WHO notes that the growing trend towards medicalisation could be countered productive. Such practices as shaving the pubic area, giving enemas, routine electronic fetal monitoring, routine episiotomy, induction of labour and frequent use of caesarian delivery, can be expensive [5] and may increase rate of complications. “Over medicalisation can lead to high rates of unnecessary caesarian deliveries and other unnecessary surgical procedures during pregnancy and childbirth,” says WHO.

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1. RISKS AND COMPLICATIONS

Teen Pregnancy

"I was 15 and pregnant," said Ann. "I didn't know what to do - get an abortion, put the baby up for adoption, or what?" Ann was just one of over a million teenage girls in the United who got pregnant that year [1].

While in a few tragic cases a girl becomes pregnant because of rape, teen pregnancy is usually the result of willing participation in premarital sex. In many events, a pregnancy confronts an unwed girl with several agonizing choices: should she get married? Is abortion the answer? Granted, it takes two to make a baby, and by all rights the father of the child should carry his load of responsibility. But more often than not, it is the girl (perhaps with her parents' help) who is left to make those tough choices. And what she decides will have a lasting effect on the physical, emotional, and spiritual well being of her and the child she carries [1].

In many Nigerian societies, women often have no say over their own marriages and girls are often given out in marriage at a very tender age. Available data shows that in some parts of the country, girls as young as nine or ten years are given away in marriage, shortly after their first menstruation. Despite campaigns against early marriage, millions of adolescents girls in Nigeria are still being forced into the practice, thereby putting their health at risk [17,25,35,44, 67].

The tragic death of Miss Semira Adamu, a 20- year old Nigerian in the hands of the Belgium Police at Brussels on the 22nd of September 1998. while being forcefully deported best describes the situation [68,69].

Miss Adamu had fled Nigeria in March Ostensibly to avoid a forced marriage to a 65-year old man who already had three wives [46]. She had escaped from Kaduna her state to Togo whence she arrived in Belgium where she thought she might secure a safe haven, but that was not to be.

Risks Of Early Childbearing

The world's nearly 1.1 billion 10-19 years old girls need to be protected from the risks of early childbearing if society is to benefit from their full potential, a new study warns [67,78].
The sheer numbers of young people as well as the values, health, education and productive skills they attain - will profoundly affect the future of society says the study "Risks and Realities of Early Childbearing Worldwide" [54].

"This basic fact strongly argues that increased attention should be given to the well being of adolescents worldwide" [67].

The Alan Guttmacher Society of the United States in collaboration with the London-based International Planned Parenthood Foundation (IPPF) [5,7] carried out the study.

"The cheer size of the group commands attention: they numbered nearly 1.1 billion in 1995; 913 million of them in developing countries and 160 million in developed countries. China and India - the world's two most populous nations - were home of nearly 200 million youngsters [58,74,78].

The comprehensive study conducted in 44 developing and five developed countries - covering 75 per cent of the world's population estimates that there are 15 million births to adolescents girls each year, accounting for slightly over 10 per cent of all births worldwide [54].

The situation is not different in sexually transmitted diseases and Acquired Immune Deficiency Syndrome (AIDS), adolescent between the age bracket, of 15 to 29 years account for 62 per cent of the cumulative AIDS cases [6,13-15,17,26,35,41,43,50,56,63,76].

In fact, the present status of adolescent reproductive health in the country have been ranked among the poorest in the world according to the 1997 world Population Report released in Lagos [29].

Dr (Mrs.) Olu Odiakosa of the Primary Health Family Planning Unit explains at the Ifako Community Outreach programme put together by Action Health incorporated (AHI), that the country is witnessing a new trend in adolescent reproductive health as many young people are now coming down with all kinds of Urinary Tract Infections (UTI) that are persistent and recurrent [36,49].

On maternal health, she says adolescents under 20 years old suffer more pregnancy, and delivery complications such as toxaemia, anaemia, premature delivery, prolonged labour, Vesico-Vaginal-Fistula (VVF), than do women age 20 or more [16,17,26,44,53,62,67].

Mrs. Nike Esiet, project consultant of AHI, attributes this gloomy trend in adolescent sexuality to ignorance, ineffective national policy on family life education, growing sexual permissiveness as a result of urbanization and social changes and limited access to counseling and contraceptive services in the country [12,53,67].

The attendant risks for young girls are enormous: childbearing during adolescence is complicated and potentially dangerous to both mother and child [17,26,44,57,58,62,67,78].

If the pelvis is undersized because of incomplete skeletal growth she may suffer prolonged or obstructed labour, cervical trauma and death [67].

The risk of death during childbirth is 30 per cent greater or two to four times higher among mothers' aged 17 or younger than among those ages 20 or more [67,77].

"We normally say that children born to mothers under the age of 18 is hazardous - but here we are talking about the 13, 14 and 15 years olds, whose bodies are not even mature", said Premila Senanayake, Assistant Secretary General of the London based International Planned Parenthood Foundation (IPPF)" [26,44,62,67,78].

"It can be physically and emotionally devastating for the mother. They drop out and lose on education", she added.

"The effect on the baby can be equally devastating - very often, it is premature, and subject to infection and malnutrition. Mortality and morbidity rates are higher among infants born to young mothers".

For one, teenage pregnancy is a major cause of school drop out among school girls in Nigeria: 52 per cent of them were expelled from school, while 20 per cent were too ashamed to return; 15-19 could not return because their parents refused to pay their tuition, 8-10 per cent were forced to marry and only 5-6 per cent got re-admitted into school.

Recently in far away America, - Covington, Kentucky (KY), two student entering their senior year at Grant High School were denied membership into the National Honour Society allegedly because they were pregnant [65].

Beyond the career stunting consequences of teenage pregnancy, such girls have higher chances of ending up, as single parents while their kids are more likely to be abandoned [1,5,9,10,23,29,31,34,45,52,55,56,60,76-78].

Role of the opposite sex partner

The choices of adolescents may strongly affect their educational attainment and employment opportunities, in fact, the entire direction of their lives [52]. Collectively, their choices have significant consequences for the future of their communities, their countries and the rest of the world [67].

The report of the IPPF study considered teenagers as a group, male and female, though it concedes that the reproductive behaviour of young men has not been studied as much as that of young women. But it also points to the part young males play in the problem - the fact that in many cases they force young girls into sexual intercourse: sexual abuse, incest and rape are troubling realities in developing and developed countries alike. In Uganda, nearly half of sexually active primary schools girls report being forced to have sex. In Nigeria, seven in 10 women who had sex before the age of 14 report being lured or forced into it, mostly by adults [2,4,5,7,8,11,12,20,29,42,75].

Senanayake says it is essential to educate adolescent males about their responsibilities: "We have always stressed the fact that since child-bearing takes two people, it is the responsibility of both parents [1,78].

PERCENTAGE OF ADOLESCENTS, REPORTED TO HAVE EXPERIENCED INTERCOURSE BY A CERTAIN AGE IN SELECTED COUNTRIES

		% Ever having intercourse	
Country	Age	Females	Males
Australia	20	58	47
Germany	16	35	30
Israel	14-19	42	11
Japan	16-21	15	7
Nigeria	14-19	68	43
Republic of Korea	12-21	17	4

TABLE 4.1

An important factor in early childbearing is what population experts called the **Biosocial Gap** [75].

The term seeks to describe a recent trend - females in today's world are attaining puberty earlier, while marriage itself occurs later.

This means sexual intercourse before marriage is becoming common place - but it is often without precautions and with all the attendant risks or early childbearing and sexually transmitted diseases.

Worldwide, youngmen and women are increasingly attending school together, and this increased interaction may also contribute to the incidence of sexual relationship prior to marriage [67].

In most sub-Saharan Africa countries, 40 per cent or more of 20-24 years old women have sexual intercourse prior to their first marriage and before the age of 20 [31,33].

In African and Latin American countries, as many as 30 per cent of women report having premarital sex before their 20th birthday - and the actual level may be even be higher.

Widespread migration of people from rural areas to cities and towns, one of the most significant factors altering the face of the developing world - also has its reproductive health implications, not the least for adolescents.

Sexual activities among adolescents

In a study carried out by a Lagos - based Society for Family Health (SFH), makers of cool condom, supported by John Hopkins University USA communications programme, the AIDSCAP programme of the USAID, British Overseas Development Administration (ODA), *it was discovered that more and more Nigerian teenage boys and girls are involved in increased sexual activities* at an increasing young age [73].

The study was carried in three zones in Nigeria, notably: Lagos, Oyo, Kano, Plateau, Rivers and Enugu, "interviewing respondents in their homes, on the street, in the markets, motor parks, and in vocational institutions." The result shows that "more boys (43.6 per cent) were on sexual relationships" which had led to unsafe consequences including abortion and reproductive tract infection (RTI).

Among sexually experienced respondents, 17.4 per cent reported ever having been pregnant or having made someone pregnant. Over 12 per cent admitted ever having made a partner pregnant, the SFH study notes.

The young people surveyed in the study admitted having serious and non- - serious partners (about 68.9 per cent) with a higher percentage of girls (79.1 per cent) having serious partners than boys (63.1 per cent).

According to the survey, the adolescent confirmed that they met their first sexual partners in their homes. The number of females who confirmed this were higher than males. Only 7.8 per cent of girls reported that they met their partners at work. The number of boys who met their partners at work is relatively lower, just 2.9 per cent. Another shocking revelation is that "the school was also an important place where (about 30 per cent) males met their first partners while half of this figure represent the number of females who met their partners at school. One of the reasons why there may have been an increase in Sexually Transmitted Diseases (STD) is that these young lads have more than two partners [50,73].

The numbers of those who have higher partners are those out of school. Those who live in cities probably have many partners to play tango with than those in the villages. In the western part of Nigeria however, the report further indicates that people appear to be having more sexual partners. Northerners follow the Westerners while the Easterners are at the bottom of the ladder on the number of sexual partners per individual [73].

On Pregnancy and Pregnancy Outcome the study reported that 69.9 per cent of those who confirmed that they had become pregnant were first timers. About 23 per cent had become pregnant twice among the teenagers while about 8 per cent had been pregnant more than two times. In the case of schoolgirls, about 20 per cent had been pregnant with the "prevalence of ever having been pregnant relatively higher among Catholic sexually experienced respondents at 25 per cent." "Protestants reported 59 pregnancies (about 18.7 per cent) and Moslems the lowest level of 38 (2.6 per cent)," the report adds.

The report found out that boys do not always use contraceptives such as condom because; "some of us prefer sex without condom for more sensation and satisfaction."

Some boys also claim: "We are tired of always having to use condom. We are so anxious that we have no time to put in on." This anxiety and lack of self control often leads to *everlasting* problem and torture. The SFH report further states that some respondents "felt embarrassed about using condom, as this was seen as drawing attention before the sex - act happened. But unknown to these boys, the real embarrassment and ugliness will reach a peak when the girl is put in the family way [58,70].

The report found out that there is also coerced sex of pressure from partners who say: "you do not love me if you do not have sex with me" or you do not "trust me if you insist on me using condom." "There are also economic reasons (girls who do not have pocket money or money for their school fees). SHF notes that "The porosive sampling strategy of this study did not provide a representative sample of Nigerian youth," adding that nevertheless, the findings provide an insight into reproductive health issues [58].

The report was worried that the level of unemployment was about 44 per cent amongst out of school youth. It adds further that, "several explanations may be proffered for the high level of unemployment among out-of-school adolescents, these include the possibility that secondary school education is of poor quality and does not prepare the adolescent for increasing competition in the employment field; the unemployment rate may be high on account of the current economic recession, or it may be that families can only afford to educate their children to secondary school level, whereas preference is given by employers to graduates" [1,8].

Dr. Andrew Ananie Arkutu, at the National Conference on Adolescent Reproductive Health held in Abuja from 26-29 January 1999. explained that studies in Ilorin and Ile-Ife have shown that 55 per cent of sexually active girls had multiple sex partners. According to many studies and surveys by Nigerian scholars, between 42 and 79 per cent of adolescents are sexually active, and surveys undertaken in the country have been remarkably consistent in demonstrating low levels of contraceptive knowledge and practice.

In another recent study carried out by Brabin and other researchers titled: "Reproductive Tract Infections and Abortion among Adolescent girls in rural Nigeria, 33 per cent of the 900 teenage girls under the age of 17 years studied in the country, had a typical type of reproductive tract infection (either sexually or non - sexually transmitted), usually trichomoniasis or candida" [38]. The Panos Institute of London report on its part confirmed that "eight per cent of the teenage girls complained of lower abdominal pain lasting for more than three weeks, which could be a sign of pelvic inflammatory disease." In fact, Brabin and other researchers indicated

that "of the girls younger than 19 years, 24 per cent has had an abortion. They are worried that this trend is dangerous and unsafe in a country where facilities for treatment are virtually non-existent.

Current Panos report on Reproductive Health globally says that there are other studies which have shown remarkably high sexually transmitted diseases (STD) rates among teenagers in rural Nigeria. This report likened Nigeria to other countries such as India, and Egypt where the population figure is increasingly high [8,38].

THE PANDEMIC OF STDS

BACTERIA	**MINIMAL ESTIMATE OF YEARLY INCIDENCE**
Gonorrhoea	25 million
Syphilis	3.5 million
Chancroid	2 million
VIRAL	
Genital Herpes	20 million
HIV infection	1 million

TABLE 4.2
Sources: WHO

The World Health Organisation (WHO) figures show that every year, there are 333 million new cases of curable sexually transmitted diseases. Cases of gonorrhoea are "highest in sub-Saharan Africa." In the case of Trichonomiasis Disease (which causes vaginal irritation and greenish discharge in females) the fear is that those who are infected may not know that they are carriers.

Results of epidemiological surveys which identified targets for prevention and treatment of sexually transmitted diseases among youths was presented recently at the 5th International Congress of the Society of Gynaecology and Obstetrics of Nigeria (SOGON). The study presented in Benin City by a team of medical experts from the University of Benin Teaching Hospital (UBTH), showed that many of the students were unaware that STDs could be spread through sex.

Of the 65 per cent of respondents who reported sexual intercourse experience, 40 per cent of girls and 29 per cent of boys reported they have had STDs. 510 students were randomly selected for the study, which used a structured questionnaire based on qualitative research.

Average age of the student was 18 years. The study team included Professor Friday Okonofua, Dr V.O. Otoide, P. Coplan; M. Temin; E. Renne; J. I. Ogonor; F. Omorodion; K. Heggen Hougen and J. Kaufman.

Miss Bimbo Okunlola, Assistant Programme Manager of Action Health Incorporated (AHI), said in an article in THE GUARDIAN: "We tend to ignore a lot of things in Nigeria, and we tend to take a lot for granted . . ." [51].

"How many virgins can you find among teenagers these days. They listen to immoral music and watch immoral movies. That is enough to excite and entice them to want to experiment with sex . . ."

Rev. Sister Maria Resurectta Nzeribe, Secretary of Medical Department, Catholic Secretariat of Nigeria in the same article says:

"Statistics from some local counseling centres and fertility clinics reveal that about 20-25 per cent of our young girls have got pregnant at least once before completing six years of secondary school. Does this information not reveal the extent of the moral decadence of our dear country? It is, in short, betrayal of our envied African moral culture. I strongly believe that the only way out of this, is to hold our heads high and stick to our rich moral values of African family and culture which advocates chastity before marriage and faithfulness in marriage."

Okunlola adds, "None says premarital sex is okay, but what can we do? These teenagers and adolescents will have sex, if they will, no matter what you say. How do you prevent a university undergraduate from having sex for instance? You must be joking, when most young people do not believe they are having a relationship until sex is involved. Some others will tell you they have to test their sexual compatibility with their future partner so that they don't pick a wrong marriage partner. How do you beat that?"

Speaking at a seminar on "Teenage Pregnancy" held at a Queen's College, Yaba, Lagos, Dr. Florence Ebam Akin-Aina of the Federal Technical College (FTC) Akoka, Lagos, observed that adolescents encounter troubles which are associated with aggressiveness, alcoholism, drug abuse, smoking and truancy, sexual impropriety leading to unplanned and unwanted pregnancy, rebelliousness and destructiveness [52].

She adds: "These troubles are directly traceable to non conformity with adult and societal values and clashes with authority figures and institutions. Adolescents also encounter problems with satisfying their financial needs and independence."

Akin-Aina described the teenage period as that "of critical life events such as the choice of life careers, moulding of personal life beliefs, values and the formation of appropriate heterosexual and social behaviour patterns.

She lamented that despite an impressive arrays of actions, legislations, conventions and treaties aimed at improving the status of women by the United Nations, the place of a woman in Nigeria is still below expectation.

According to her: "The gross secondary enrolment rates in 1980 and 1990 for boys and girls were 54 and 28 per cent respectively, which indicates that fewer females proceed from primary to secondary school.

In her address, Mrs. Esther Ibeh, the organiser of the seminar, observed that the consequences of teenage pregnancy could lead to abortion or death, early and unstable marriage, single motherhood, dependency, poor health, joblessness, maternal or child mortality and HIV/AIDS.

Prince Tony Momoh
One time Minister of Information and Culture:

"What seems to be the case is that everybody has given up. Everybody seems to recognise that society is decedent and morally bankrupt. Since we can't help it, why not accept it."

"We are ignoring the first things that ought to have been done. That is, ensuring that Nigeria flourishes on the strength of its moral if not spiritual foundation, moral law being a very diluted form of spiritual law" [12].

"Things are not bad for want of legislation in this country. We should go to the basics . . ."

"The first step we took officially to distance ourselves from these basics of life was when we barred missionaries from ruling schools and insisted that all schools should be state-owned. The moral standards have since collapsed. It's not too late to start all over again. Otherwise, we will discover that condoms and other preventive palliatives will never result in the discipline of the individual, which should be decisive in these matters" [37].

"Teenagers seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex: Movies, radio and TV tell them that sex is romantic, exciting, titillating . . .yet, at the same time, young people get the message good girls should say no" [71,72].

- The Alan Guttmacher Institute

Today, promiscuous sexual behaviour is the main propagator of AIDS in Africa. Simply put "Sexual rules have largely broken down," explains AIDS researcher Dawn Mokhobo. The journal 'Africa Affairs' says "sub-Saharan Africa puts considerable value on children but minimal value on marriage. Sexuality outside of marriage, even . . . if it leads to pregnancy, is not disapproved of strongly. According to 'Nature', the typical route that the infection follows starts with the prostitute, says the report: "Female prostitutes serve to seed the epidemic in most monogamous women through contact with promiscuous husbands" [6,13,14,15,17,35,41,47,57,63,75].

Not many are willing to change their behaviour. The Panos Document on AIDS in Africa tells the following experience of a medical researcher in Zaire: "One night, after I had been doing blood tests in rural area with some Zairean medical colleagues, they went off with some of the local girls. They slept with them and only one of them used condom." When he asked them about the risk, they laughed, saying that you couldn't give up living just because you might get a disease." Yes, casual sex is considered by many to be "living" - fun, entertainment.

As in many other parts of the world, youths are particularly prone to promiscuity. A recent survey conducted among 377 youths in South Africa revealed that over 75 per cent had engaged in sexual intercourse. Similarly, a missionary in South Central Africa observed that there are "few girls aged 15 who are not yet pregnant." He adds: "You see a young, single girl, and you think to yourself, next year at this time, she will be pregnant.

2. EARLY MARRIAGE AND CHILBEARING AMONG ADOLESCENTS

Early and force marriage enjoys legal backing in some parts of the country. Indeed the Matrimonial Causes Act (MCA) does not define marriage age as such, but recognises that persons under 21 years age can enter a marriage provided parental consent is received. Customarily, there are different positions on the issue. The Age of Marriage Law of Eastern Nigeria puts it at 16 and goes ahead to void any marriage that is contracted between parties that are under 16 years of age. Common law puts the minimum age of marriage at puberty (which is 14 for boys and 12 for girls). The Matrimonial Causes Act simply implies it by stating that one of the grounds upon which a marriage shall be void is when either of the parties is not of marriageable age. It does not define the marriageable age. In Islamic law, marriage can be concluded for girls and virgin daughters by their parents and this practice is known as **Ijbar** [46,48].

Given these inconsistencies in the law on the issue, the reality is that child marriages are contracted with impunity. The practice is common among both the Christian and Muslim communities alike, but with a high prevalence among the Hausa Muslims of Northern Nigeria. Its incidence is also remarkable among the Christian communities of Bauchi, Plateau, Benue and the other Northern states. It is found to be rampant in the Orlu, Orsu and Ideato Local Government Areas of Imo State. In these communities, a female child is seen as a liability to the parents and investment in their education is considered a waste of family resources since she will eventually be married to another family. Thus, the parents would rather give them out in marriage early to avoid having to drain family funds in their education. Another reason for the practice is the economic gain that accrues to the girl's family upon her marriage [48].

In some parts of Northern Nigeria, young girls are given out in marriage to men old enough to be their fathers. Most suitors in this case are usually 30 to 40 years older than the girls they want to marry. Research findings show that economic consideration rather than religion, remains the principal factor responsible for this practice [47,66]. For instance in Orlu and Ideato, the bride price is quite high. These girls are very often treated as articles or property and subjected to violence at the least sign of insubordination, having been 'bought' at a very high price. Another reason adduced for the practice is the need to curb immorality and promiscuity. It is believed that when girls are married out as early as possible, it forestalls the incidence of unwanted pregnancies and sexual laxity associated with teenage years. Another aspect is the case where young girls are withdrawn from school and given out in marriage at very tender age. This is prevalent in the North [46,48,67].

There is no fixed minimum age of marriage among the Hausa-Fulani and the average age of marriage is anytime between 12 to 16 years of age, that is, at puberty - indicated by her first menstruation. Once she attains puberty, it becomes her father's responsibility to get her married off to a suitor of his choice. Girls are atimes withdrawn from school for marriage. Young girls are sometimes given in marriage clearly in settlement of debts and or for financial gratuity [18,48,67].

The Teenage Mothers

When Menurat Gamba got married, she was just 12. It was an age when she could not fully understand what the whole concept of marriage was all about. Worse still, she never had the opportunity of having any formal education; neither did she have any vocational skill. Her parents never considered it necessary educating her since they believed education was a form of investment from which the parents of the girl child may never benefit [18].

She had been married for six years now. Predictably she has no means of livelihood. She relies solely on her husband who unfortunately had been retrenched from a plastic Industry in Lagos, where he works as a factory worker *for everything*. Faced with hunger and starvation. Menurat had since left her matrimonial home along with her four kids to stay with her parents.

Rabi Landa was withdrawn and given out to her husband in marriage at the age of 15. During her second year in secondary school, her parents married her off to this wealthy man who had earlier married three wives. After marriage, she never had the opportunity to complete her secondary education. She became a full time housewife. Since her marriage, all her financial needs could not be met by her husband who coincidentally had married a fifth wife, and had since diverted his attention to his new bride. Rabi had since resorted to street trading by hawking groundnuts, sweets and other petty item [18].

Her daily returns, however, is not enough for the care and feeding of herself and her children since her husband no longer care about her. Rabi now blames her parents and culture for her plight. Hear her: "Right from when I was going to marry Alhaji, I knew it may not be rosy but I had no choice . . . it is not easy for a girl to be so bold to challenge the decisions of her parents and even you cannot disengage yourself from such culture."

Mallam Saheed Mohammed agrees with the views of Rabi. He says traditional culture often castigates western education, seen largely as a form of corruption for girls. The belief is that if a girl is too exposed before marriage, no man may want to solicit her hands in marriage, because she may be too bold for her husband.

For Kemi Agboola, 17, who may soon put to bed, all attempts at abortion failed. Her story: "My getting pregnant was not deliberate. It was a mistake. Even when I knew I was pregnant, I tried all means of abortion so my parents would not know, you know I am still in school. But my tommy would not come down, so it is like I just had to keep it by force and it has not been easy for me. I've missed school, my friends and everything it takes to be a free person. I don't want to be a mother at this age. I plan to return to school after the baby. Sometimes, I feel ashamed of myself when people look at me and hiss."

Miss Agboola was in SSS when she became pregnant, although she was lucky to have a fairly comfortable parent; the father of the baby she is expecting is still seeking admission to the University.

Taiye yet a teenager had to lay off school due to her pregnant state. She got pregnant for the first time in her life at fourteen when she had barely started to have her period, though she secured an abortion. But less than a year later, she got pregnant again to the same person responsible for the first one - a nineteen-year-old-fellow. Her regret is that she had to drop out of school. She also regrets having had a child for someone she never hopes to marry.

Kuburat and Ejiro were yet another issue. Kuburat got pregnant at about fourteen which was her first experience to Kamoru - 18. Although Kamoru did not deny responsibility, he was an apprentice welder yet to find his feet.

Ejiro is the only daughter of a family of six of which she is the fourth. Her mother is a contractor in Warri, Delta State and a single parent too. She receives male friends for most of the hours in the day and had, at one time, introduced her daughter to a man who indicated his interest - her mother's business partner!

"I finished my SSS Exams at sixteen waiting for my JAMB, when I found that my health was somehow failing me . . . I did not suspect anything near pregnancy. I dare not complain to my mother because she would only worsen things for me. She has never given me a positive or helping advice before."

"My Mummy's business partner, Mr. Odafe, did not deny responsibility but he is married with kids already. He does not have any plan to make me a second wife, there are so many children born out-off wedlock like mine anyway."

"I intend to go back to the University to study law. My mother will look after Ese (the boy) for me." If Ejiro still considers school, for Helen Edosien 18, marriage is the priority for now.

A native of Edo state. She already had a two-year-old baby girl. She was impregnated at the age of 15.

"Am I not old enough to get pregnant? It is not a mistake at all. I'm a fashion designer . . . my fiancée is a motor mechanic . . . my parents even supported me, so why should I feel bad about it."

Indeed, the story of teenage pregnancy or motherhood is not a new one. In the old traditional societies, women were usually given off to marriage before they attained the age of 20. But the place of these young wives were always assured. Then, sudden pregnancy was often the catalyst to the solemnization of wedlock. But the changing economic weather has significantly altered that attitude now [40]. A tendency which Guidance and Counseling expert and lecturer at University of Lagos, Dr. Ngozi Osarenren, fears could aggravate the maladjustment in the society.

In the past, succour usually come for these mothers through the extended family super-structure [31]. This ensured that there are a number of aunts, uncles, stepfathers, and stepmothers they could fall back on for sustenance and affection. But this tradition has virtually been pulled down now with harsh living condition of most Nigerians [40].

What all this translates to is the isolation of the adolescent mothers and their unwelcome offspring. They are indeed the new social destitute. They are to be seen behind makeshift counters at the street corners, hawking sweets and cigarettes with the little one playing under the furniture, streets or just roaming around. They knock at the door in the morning asking if there are any clothes to be laundered. Those without self-pride would simply go abegging [40].

For them, it is a sudden transition form a life of dependence to one of forced responsibilities, now forsaken by those who put them in the family way. They are full of regret and self pity [2,3,5,8,40].

From what however, happened recently, government seemed poised to improve the lots of these married/teenage mothers.

Recently the Zamfara State Administrator, Lt. Col. Jubril Yakubu announced the establishment of a secondary school solely for married women in the state. He said the school would impact western education on women especially those who were given out in marriage at early age. The school will also teach the women various trades and skills. Although the establishment of the school had been received with mixed feelings, it is with the aim of providing the tools for economic empowerment of these teenage mothers/housewives [18].

Mrs. Nkechi Chukwuma a schoolteacher sees this programme as capable of revolutionalising the educational system, especially in the North as it relates to the girl child.

For Zanab Ibrahim, a lawyer, the establishment of this secondary school will eventually remove women from the age long perpetual cycle of ignorance. "If you train a woman, you have trained a nation. If these women are well equipped educationally, they will ensure that their daughters are never denied formal education even in their father's house."

Zanab's views is that the initiative could help break the age-long distorted cultural tradition that portray an educated girl as a bad investment for her immediate family because she will eventually marry and leave her family of orientation.

This perception is supported by Mr. Ayo Olu Awopetu, who sees female education as a spring board for sustainable economical development which will invariably enable a majority of the nation's women stop relying on their husbands for everything, and suffering in the process.

Rabiat Mohammed, a nurse sees the establishment of such a school as capable of enabling such illiterate mothers appreciates the need for Expanded Programme on Immunisation and Family Planning services.

The fact that education liberates the mind is the stance of Dr Tom Obiyia, a sociologist, who lectures at the University of Lagos. In his view on the long run, such category of women come to appreciate life better, appreciate their husbands, and children better and impact their knowledge on these kids, and ensure that the issue of early child marriage is brought to an end [18].

Mrs. Bolaji Akingbogun, Executive Director of Child Aid International, a Lagos based NGO outfit believed that "if these women eventually get liberated, they will challenge the age-long culture and traditions." "Some could even begin to reject certain obnoxious attitudes of their husbands, of-course their eyes will become opened to realities, and this will make the issue of early marriage of girls to gradually become extinct."

Mrs. Akingbogun foresees difficulties on the parts of men who will have to allow their wives to abandon the home front and all its gamuts of domestic chores, care of kids and marital obligations in search of western education. She proffers that except government enacts an edict to enforce this programme; it might not be easy to break the chauvinistic attitude of men who might be reluctant to allow their wives to attend such school. She also argues that this programme will actually come to stay only if the husbands of these married women are adequately made to understand why their wives must be in such school.

"The Sokoto Primary Education Board will soon embark on an enlightenment campaign to educate parents on the need to retain their female children in schools," its Chairman Mohammed Bello Magwari has said. He observed that the most serious problem facing women education in the state is not their enrolment but how to retain them in school [39,53].

Speaking in Sokoto at the prize - giving ceremony of the Talent hunt competition for primary school girls in the state, he noted that while girls enrolment in schools had increased considerably since the inception of the board, less than half of those enrolled remained in schools to complete their programmes [54].

The talent - hunt he disclosed, was jointly organised and sponsored by the board and the State Women Commission to encourage girls who were already in schools to be more conscious of the important of education as well as attract those yet to start schooling, among other things.

The Chairperson of the State Women Commission Hajiya Aishatu Umar Hassan, said that education was a necessary medium through which women could compete on equal footing with men in the labour market.

“Education will enable them to understand, defend and promote their rights to freely participate in political, social and other aspects of life with little or no hindrance”, she declared.

In a similar vain, the Plateau state government recently indicated its intention to prosecute parents who withdraw their from school for early marriages in the state [37].

Speaking at a fashion parade tagged: “The African Princess” organised by Attitude and Fatima in conjunction with the Family Support Programme (FSP) in the state, the Plateaus State Military Administrator, Col. Habitu Shuaibu, said that such measures were considered expedient to serve as deterent to those who were in the habit of perpetrating such acts.

The administrator maintained that it was the conviction of the government that education was not a privilege, but a right that must not be denied the child, irrespective of sex, pointing that the state government was committed to the success of the girl child education as envisaged in the programme of action embarked upon by the FSP.

Col. Shuaibu emphasized that in view of some cultural practices that were inimical to the educational development of children, efforts shall be geared towards enlightenment programmes and campaigns to make parents appreciate the need to give their children proper education [37].

3. THE ISSUE OF UNWANTED PREGNANCY

About 30 millions abortions are performed in developing countries annually, while one out of four births is unwanted and unplanned [70].

Two organisations engaged in population issues, the John Hopkins University Communication and the National Council for Population (NCP) have warned that efforts to check population explosion in Nigeria may not pay off as incidence of early childbearing among adolescents remain on the increase [53.55,58,60].

Results have shown that when high numbers of teenagers give birth, they contribute to rapid population growth, impose heavy pressure on scarce resources and often times disrupt the social development programmes designed to improve their well being. This is besides the fact that many births that occur to adolescents are unwanted.

The number of births to adolescents' women has serious implications for Nigeria's health, political, social and economic future [60,66].

The WHO says: "when a large proportion of births in a country are to teenagers, the length of time between generations is short, contributing to a rapid population growth rate."

Adolescent women generally receive poor pre and postnatal care partly because they do not plan ahead for pregnancy. They are usually unable to cope with the responsibility of raising a child while adolescent parenthood increases the incidence of child rejection, abuse and infanticide.

Adolescent parenthood usually halts the education for many young women and puts a heavy burden on the young couples, which ultimately increase poverty rates and under-development [18,23,28,29,31,52,53,55,56,60,76,78].

Chiwuzie and Akpakpan in Benin City and Douglas and Ladipo in Ibadan demonstrated that 36.6 per cent and 50 per cent respectively of sexually active girls have been pregnant at least once. Two-thirds of those out of school in the study by Douglas, et al, had been pregnant. Nearly all of these pregnancies were unwanted and unplanned. Sixty-eight (68) per cent of them, according to Chiwuzie, ended in induced and unsafe abortion.

Dr Charles Eregie of the Institute of Child Health, University of Benin Teaching Hospital (UBTH) painted a pathetic picture of the adolescent girl. The picture, it was agreed must be repainted by society if the cycle of under development is to be broken. Otherwise, Eregie submitted, "the inter generational cycle of growth failure will persist." "Its consequences will affect not only the person, but also the local and national economy [20,23,61,62].

According to Eregie, adolescents continue to grow . . . The growth demand on adolescent's results in babies of Lower Birth Weight (LBW) than those born by older women of the same nutritional status.

Dr Eregie further explained, "every other LBW baby comes with the disadvantage because of its mothers own earlier growth failure resulting in short stature. Many of such babies grow up with the disadvantage continuing. More than 43 per cent are stunted, 9.2 wasted, and 35.7 underweight when they reach their fifth birthday. Out of the lot, 19.1 per cent die. Many of those who survives go through life unable to reach their full academic or physical potential" [20,23,61,64].

Prohibiting Abortion

Although induced abortion has been proscribed for a very long time by the criminal codes of all countries, as well as by religious laws, one cannot avoid the fact that it is practiced all over the world by millions of women in distress year after year.

Inspite of the threat of severe, sometimes draconian punishments, abortion remains the most widely used means of fertility control [70]. As such it is (and this most) characteristic feature of pregnancy termination is too often overlooked and exclusively women's problem [24,25,38,58,66].

In recent years the legal approach to induced abortion has undergone change towards liberalization of the law in large parts of the world, both in developed and developing countries [24,25,43,46,59,66,70]. As Dr. Christopher Tietze wrote in a recently delivered paper "Legal Abortion in the World Today." [47]:

> *Among the countries of the world, the legal status of induced abortion ranges from complete prohibition to elective abortion at the request of the pregnant woman. The situation as of early 1978 can be summarized as follows: About 9 per cent of the world's population live in countries where abortion is prohibited without exception, and 11 per cent in countries where it is permitted only to save the life of the pregnant woman. About 14 per cent live under statutes authorizing abortion on broader medical grounds, that is, to avert a threat to the woman's health rather than to her life (with mental health specifically mentioned in several countries) and sometimes on eugenic or fetal indication (known genetic or other impairment of the fetus or increased risk of such impairment) and/or juridical indication (rape, incest, etc.) as well. Twenty-six per cent of the world's population reside in countries in which social factors, such as inadequate income, substandard housing, unmarried status, and the like may be taken into consideration in the evaluation of the threat to the woman's health (social-medical indication) or adverse social conditions alone, without reference to health, may justify termination of pregnancy. Countries allowing abortion on request without specifying reasons either for all women or at least for some categories (as a rule defined in terms of age, number of children, and/or duration of pregnancy) account for 40 per cent. In the latter group of countries, abortions on medial grounds are generally permitted beyond the gestational limit prescribed for elective abortion.*
>
> *It should be noted that the abortion statutes of many countries are not strictly enforced, and some abortions on medical grounds are probably tolerated in most countries. It is well known that in some countries with restrictive laws abortions can be obtained from physicians openly and without interference from the authorities. Conversely, legal authorization of elective abortion does not guarantee that abortion on request is actually available to all women who may want their pregnancies terminated. Lack of medical personnel and facilities or conservative attitudes among physicians and hospital administrators may effectively curtail access to abortion, especially for economically or socially deprived women.*
>
> *Over the past fifteen years a number of countries have liberalized their abortion laws to various degrees, notably Austria, Canada, Denmark, Finland, France, Germany, Great Britain, India, Iran, Italy, the Republic of Korea, Singapore, Sweden, Tunisia, and the United States. Four countries, all in Eastern Europe, have adopted more restrictive legislation than previously in force: Bulgaria, Czechoslovakia, Hungary, and Romania.*

Major reasons advanced by advocates of less restrictive legislation in matters of abortion, and especially of abortion on request, have been considerations of public health (to combat illegal abortion with is associated morbidity), social justice (to give poor women access to abortion previously available only to the well-to-do), and women's rights (to secure the right of all women to control their own bodies). A desire to curb population growth, in the interest of economic and social development, has been an explicit reason for the adoption of nonrestrictive abortion laws in only a few countries, such as Singapore and Tunisia. The majority of countries permitting abortion at the request of the pregnant woman or on broadly interpreted social-medical or social indications have low birth rates and some of them actively pursue pronatalist population policies.

Professor Frank Osiro Giwa-Osagie while speaking at a symposium on abortion in Lagos said, "In some countries like Zambia, the U.S.A., U.K., and Romania, abortion laws has been amended and the benefits accruing from the amendment include the stabilisation of abortion statistics, increased use of contraception because of better services, increased documentation of cases and numbers [19,21,24,25,43,58,66]. Moreover, he noted that research has shown that most of those who die from abortion fall within the low-income group [24]. He argues that liberalizing, legalizing or amending the abortion laws will as a matter of fact be giving legal effect to a practice already on the ground.

Mrs. Isabelle Okagbue, a senior research fellow at the Faculty of Law, University of Lagos, commenting on abortion and the law recently said, "There are few countries without certain parameters guiding abortion. It is rather misleading for legalization to be seen as making abortion free under all conditions. What we mean when we discuss legalization of abortion is really liberalization."

Mrs. O. A. Ipaye of the department of Law, Lagos State University, Ojo, believes that the law should not have a blanket provision criminalising abortion [42]. The law should recognise certain situation where abortion may be justified. She exemplified with cases like under-aged pregnancy and rape, both of which may be tenable excuses for abortion. Beyond this, she appeals that, just as in civil and political rights, a woman should have a right to carry or not carry a baby, irrespective of what people's opinion is [59].

Professor Olawiyola Adetoro Provost of Obafemi Awolowo College of Health Science, Sagamu, at the 11th Inaugrual lecture of Ogun State University, Ago-Iwoye, identified the problems of abortion as a threat to safe motherhood. Irrespective of the general attitudes to abortion, Adetoro said "it must recognise the magnitude and complexities of the problems facing the women with unwanted pregnancy."

According to Adetoro a professor of Obstetrics and Gynaecology; about 75 million women all over the world suffer from unwanted pregnancies, many of who will want to procure abortion, despite the negative attitude to it" [49].

Adetoro regretted that in most developing countries safe abortion is not available, posing threat to women who often risk their lives and health undertaking unsafe abortion.

In the lecture titled" "The womb and the woman at the crossroads: which way forward?" Prof. Adetoro explained "that an estimated 23 million unsafe abortions occurred yearly, killing over 70,000 women; 90 per cent of these cases takes place in the developing countries", 3.7 million cases occur in Africa alone.

He frowned at the low acceptance of family planning in Nigeria despite the adverse consequences of uncontrolled fertility and unplanned pregnancy on the womb and the woman.

With an average of 90 million people being born annually, the Professor said if the trend was not checked, by the year 2100, the whole universe would be covered by just human beings without any forest.

In Nigeria, the annual growth rate of 3 per cent of the population according to Prof. Adetoro was very high, ranking among the highest in the world. Many women especially those that are poor and live in rural areas face unplanned pregnancy following inadequate information and education on family planning services. The dangers of this, Prof. Adetoro explained, are often severe and may be fatal [21,56,66].

As the world population moves towards the six billion marks by June 16, 1999 (UN), it beholds on mankind to make conscious reproductive choice to balance resources with the growing number.

. . . On this World Population Day, let us reflect on the right to choose and the joy of planning which a planned family achieves. Let us safeguard the future today by making the right choices. - PICB

"For all women and men, but for young women especially, ensuring choice is all-important. This depends largely on their education: education gives confidence. It depends on their access to reproductive health services, including family planning: the information and the means to choose. And it depends crucially on the behaviour of men. Men as fathers, husbands, teachers and leaders must be prepared to acknowledge women's right to make choices and to support the choices they make."

Dr. Nafis Sadiq, -UNFPA Executive Director

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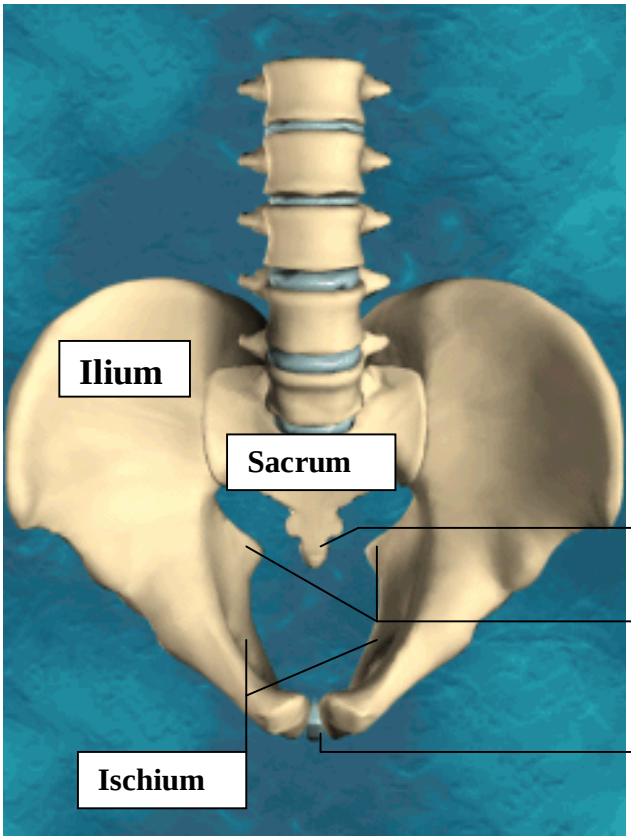
1. THE FEMALE PELVIS

The Bony Pelvis

The bony pelvis [3] of the female forms a bony canal through which the fetus must pass during the process of birth, and if the canal is of average shape and dimensions, the baby normal size will negotiate it without difficulty. But pelves vary in size and shape, even within normal limits, and could be affected by gross deformities due to maldevelopment, accidents or disease. Fortunately such cases are rare [2,3,4,7,11,12,14,16].

FIGURE 5. 1 THE BONY PELVIS



The pelvis is composed of four bones, two **innominate** or **hipbones,** the **sacrum** and **coccyx.** The innominate consist of three parts the **ilium, ischium** and **Os pubis** (*Latin-Pubes - private parts)* [2,3,4,11,12,16].

The ilium is the large flared-out part, and the concave anterior surface is known as the **iliac fossa.** The upper curved border is called the **iliac crest,** the terminal points of which are known as the **anterior superior** and the **posterior superior iliac spines** [3,4,11,16].

The ischium is the lowest part of the innominate bone, and upon the large prominence called the **tuberosities** of the ischium, the body rests upon when is in a sitting position [3,4,11,16].

The os pubis consists of a body, a superior and an inferior ramus: the two inferior rami forming the pubic arch; at the symphysis pubis two bones meet [3,4,16].

The sacrum is a wedge shaped bone composed of five sacral vertebrae: the centre of the upper surface of the first sacral vertebra being known as the **promontory** [11,12,15] of the sacrum. Because it encroaches on the antero-posterior diameter of the pelvic inlet and in some cases may prevent the fetal head from entering the brim; it is an important landmark in obstetrics.

The coccyx is a small bone consisting of four coccygeal vertebrae; tiny nodules bone fussed together [2,3,4,8,11,12,14,16].

There are four pelvic joints: **two sacro-iliac, the symphysis pubic** and the **sacro-coccygeal.** In the non-pregnant state there is very little movement in these joints, but during pregnancy a certain amount of softening and stretching of the ligament takes place, probably due to endocrine activity, which results in slight separation of the joint [4,8,9,12,11,14,16].

The bony pelvis is divided into two parts, the **false** and the **true** pelvis. The false pelvis is that part above the brim and consists mainly of the flared-out iliac bones. It has little obstetrical importance [3,8,11,14,16].

The True Pelvis

The true pelvis is the curved bony canal through which the fetus must pass during birth. It consists of a **brim, cavity** and **outlet.**

The pelvic brim is bounded posteriorly by the promontory and alae of the sacrum, and, in front by the pubic bones. Where the superior ramus of the pubic bone meets the ilium a roughed area known as the **iliopectineal eminence** is formed [4,7,8,11,13,14,].

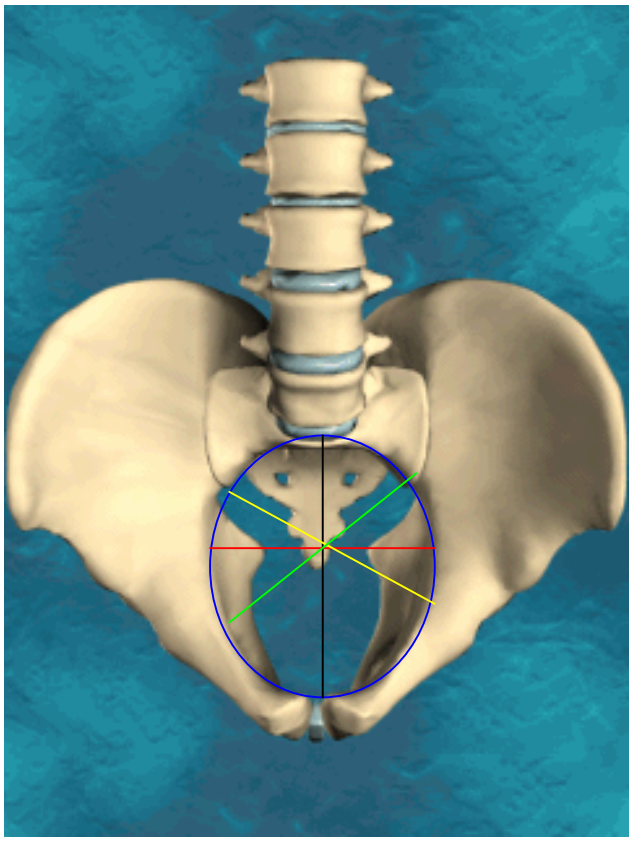
Three diameters are measured:

1. The **anterior-posterior diameter** is measured from sacral promontory to a point 1.25cm down, on the posterior surface of the symphysis pubis, and measured 12cm. This measurement is known as the **Obstetrical Conjugates.**

2. The **Oblique diameters** of the brim are measured from the sacro-iliac joints to the ilio-pectineal eminence on the opposite sides, are named right and left according to the sides from which they are measured. Both are 12cm in length.

3. The **transverse diameter is** the widest part of the brim, and extends from side to side, immediately behind the ilio-pectineal eminence. It measures 13cm, but is encroached on by the psoas muscles. The fetal head commonly enters in the transverse diameter of the pelvic brim.

FIGURE 5.2 PELVIC MEASUREMNTS



- **Brim or inlet of female pelvis**
- **Transverse diameter**
- **Anterior Posterior diameter**
- **Right Oblique**
- **Left Oblique**

Types Of Pelvis

The female pelves have been classified into four parent groups, according to the shape of the brim [4,11,16].

1. The **gynaecoid** or true female pelvis has a round brim (inlet).
2. The **android** has a heart shaped brim.
3. **Anthropoid** has an oval brim, narrow in the transverse.

4. The **platypelloid**, or simple flat pelvis, has a kidney shaped brim, narrow in the anterior-posterior diameter.

Pelvic Inclination

When a woman is standing in the upright position, her pelvis is not at right angles to her spine, as one might think; the inlet slope at angle of 60^{o} with the floor; the tip of the sacrum will be on a level with the summit of the symphysis pubis. The inclination of the cavity is 30^{o}, and at the outlet the inclination is only 11^{o}, being nearly horizontal. In some Negro women, the inclination of the plane of the brim is nearer 90^{o} and this causes delay in engagement of the head during labour. The average pelvic inclination amongst Japanese is 40^{o} and amongst Americans 60^{o} [4,11].

Races which rarely squat have a greater angle, those which habitually squat a lesser one [4,11].

The Ideal Pelvis

1. The brim should be round, or oval transversely with no undue projection of the of the sacral promontory. The anterior-posterior diameter (obstetric conjugate) should measure 12cm and the available transverse diameter 12.5cm. In the erect position the pelvic brim should be inclined at an angle of 60^{o} to horizontal.

2. The cavity should be shallow with straight sidewalls from which the ischial spines do not project unduly. The sacrum should have a smooth concave curve, from above downwards, and the sacro-sciatic notches should be large, the sacrospinous ligament being at least 3.5cm long.

3. The pubic arch should be rounded and the intuberous distance at least 10cm. From the above indications, the gynaecoid pelvis, falls within the limits specified and is eminently suited for childbearing. The brim is round, except where it is encroached upon by the promontory of the sacrum. The cavity is shallow with a broad well-curved sacrum. The greater sciatic notch is wide, the pubic arch forms a right angle, and the iliac crest is broad and well curved. This pelvis would be found in a woman of average build, whose hips are broader than her shoulders - height over 1.5 metres, with shoe size 4 or larger, and in whom no deformity is present [4,11]. Pelves vary in size and shape as much as faces and feet, and women's shoes range from size 2 to 10, with nine widths in each of the average sizes.

Factors Which Influence Pelvic Shape

Gross deformities of pelvic shape due to the effects of childhood rickets or adult oesteomalacia are relatively uncommon because of rising affluence and better dietary habits in the developed countries; and because sunshine is and calcium are relatively abundant in the developing countries. Minor alterations in shape, however, have been observed more frequently [4].

Although racial factors influence the size of the pelvis - and races of small stature are likely to have small pelves - the factor do seem to have much effect in producing abnormal shapes. Minor abnormalities of shape are due to inadequate nutrition in infancy and childhood, particularly just before puberty when pelvic bone growth is rapid and the bones are still malleable. Amongst Scottish women a height of less than 155cm (6.1in) is associated with a significantly higher incidence of minor pelvic deformities, particularly flattening of the brim.

These small, women are often in poor health and the combination of poor health, small body stature and minor pelvic deformities are probably due to poor living conditions, poor nutrition and poor hygiene [4].

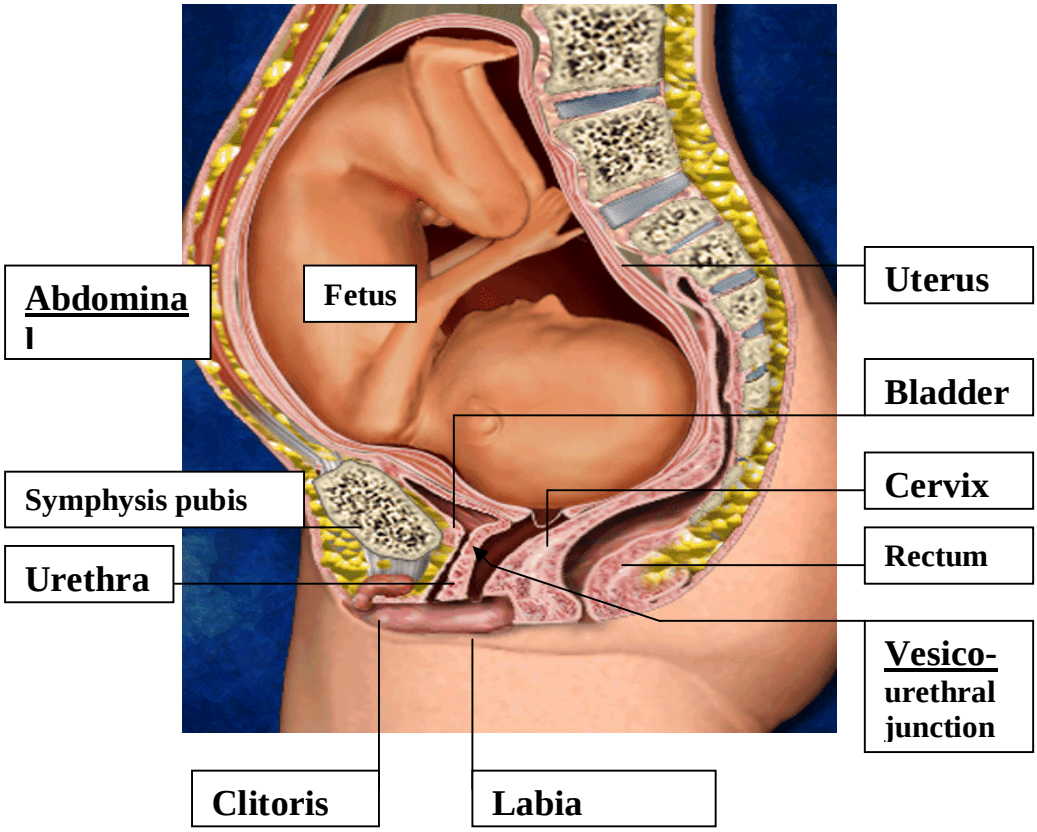
The Pelvic Floor

The main elements in the pelvic floor is the group of muscles collectively known as the **levator ani**, which arise from the lateral pelvic wall and decussate in the midline between the urethra, the vagina and rectum. The levator ani arises from the pelvic aspect of the pubis, from the condensed fascia, known as the **white line,** which covers the obturator internus muscle, and from the pelvis aspect of the ischial spine. From this broad origin, the fibres sweep downwards, backwards and medially to be inserted into the upper vagina, the perineal body, the anal canal, the ano-coccygeal body, the lateral border of the coccyx and the lower part of the sacrum. The sides of the muscle slope downwards and forwards forming a gutter or sling, through which the urethra, vagina and rectum pass. To some extent the vagina is supported by this sling, but to a much greater extent the rectum lies suspended by the sling of the levator ani. When the leading part of the fetal head impinges on the gutter formed by the two-levator ani muscles it tends to rotate in an anterior direction [4,11].

Above the levator ani muscles are the vessels supplying the uterus and cervix, the ureters and the condensations of areola tissue which ensheathes the bladder, rectum and cervix uteri and is called the **cardinal ligament** [7,8,]. In fact it is not a ligament, but a composite mass of tissue formed from the areolar tissue, collagen and the muscle walls of the venous plexi which surrounds the cervix. With full dilatation of the cervix, this tissue is drawn out of the way, but should the patient attempt to push the fetus through an undilated cervix, permanent lengthening of the cardinal ligament is likely [4,11].

Anteriorly to the cervix is the bladder, with the bladder base and neck (the vesico-urethral junction) resting on a condensation of fascia, the interdigitating fibres of the levator ani and the muscular wall of the vagina. Should the anterior vaginal wall be damaged during delivery, prolapse of the bladder is likely. This is known as a **cystocele** [4].

FIGURE 5.3A **THE FEMALE GENERATIVE ORGANS**



As the fetal head descends into the pelvis the bladder base is lifted upwards and forwards appearing to rotate about the vesico-urethral junction. The amount of movement depends upon the size of the fetal head; the tighter the fit, the greater the movement. At the same time the vesico-urethral junction and urethra are pushed closer to the posterior surface of the symphysis pubis. In cases of obstructed labour or traumatic forceps delivery, these two organs, the lower part of the bladder base and vesico-urethral angle, are subject to pressure or damage, which may eventuate in a **vesico-vaginal fistula** [4].

The descending head also presses on the rectum but it is rarely damaged since it is well protected by fat, and has the hollow of the sacrum into which it could retreat. Lying behind the rectum and emerging from the sacral foramina are the nerves, which form the sciatic plexus. These nerves may be subjected to pressure by the fetal head, or may be damaged by the application of forceps, but permanent injury is uncommon [4].

In summary the structures related to the upper concave surface of the pelvic floor are [4]:

1. The bladder anteriorly, resting on the pubo-coccygeus portion of the levator ani.
2. The uterus and vagina behind the bladder, the vagina passing through the gap between the levatores (hiatus urogenitalis).

3. The broad ligaments and pelvic connective tissue, containing the uterine venous plexuses.

4. The ureters, which lie on the pelvic floor beneath the broad ligaments, and pass forwards to the bladder. They are in close relationship to the lateral vaginal fornices and cervix.

5. The uterine arteries above the ureters, and the vaginal arteries below the ureters.

6. The rectum lying behind the uterus and vagina and passing through the gap between the levatores (the hiatus rectalis).

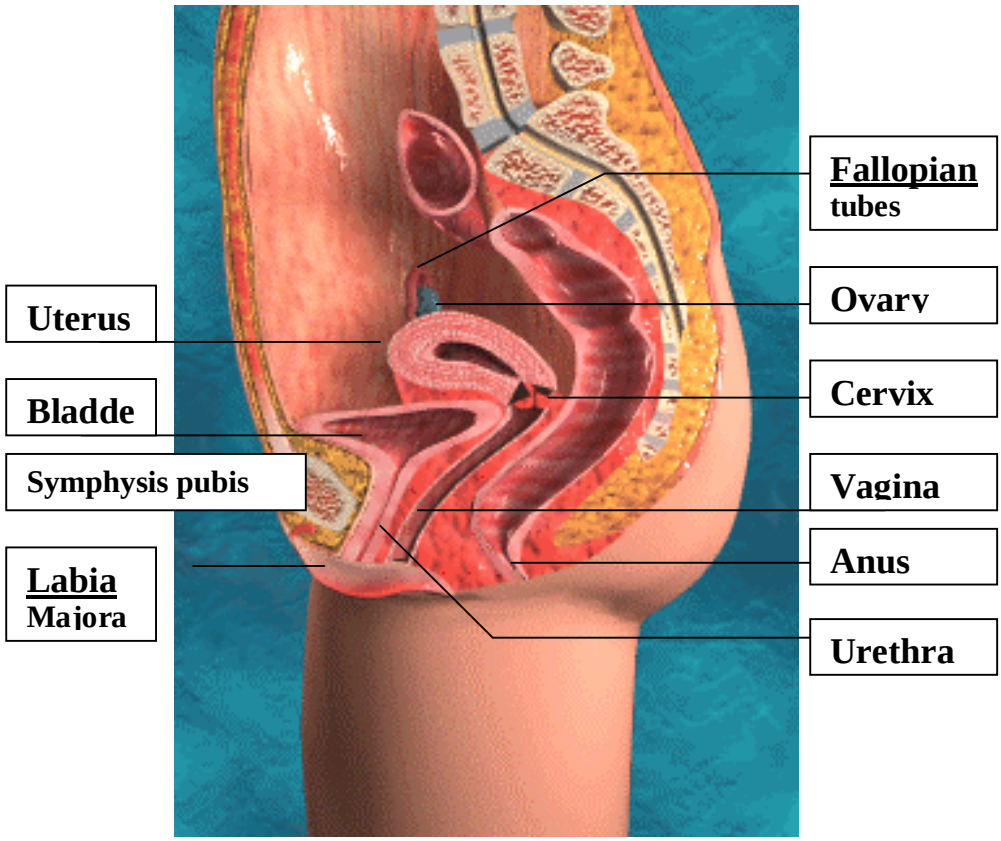
7. Between the levatores, and penetrated by the urethra and the vagina, is the superior layer of condensed tissue known as the **urogenital diaphragm.**

2. THE FEMALE GENERATIVE ORGANS

The Vulva

The term **vulva** is applied to the external genital organs, extending from the mons veneris to the perineum [2,4,5,6,9,10,11,14,15-17]. The **labia majora** or greater lips are two

FIGURE 5.3B THE FEMALE GENERATIVE ORGANS



elongated large folds of skin, which contain sweat glands, and hair follicles embedded in fat. The size of the labia majora varies considerably. In infancy and in old age they are small, and the fat is not present; in the reproductive years, between puberty and the menopause [1], they are well filled with fatty tissue. In front (viewed from between the legs), they arise anteriorly (joined together) in the pad of fat lying over the pubic area and which are called the Mount **of Venus** (**mons veneris**) by the ancient anatomists [3], when they noted that it was most developed in the reproductive years. Both of the labia, and mons veneris, are covered with hair, the quantity of which varies from woman to woman [2,5-7,9,11,14-17].

The pubic hair on the abdominal side of the mons veneris terminates in a straight line, while in the male the hair stretches upward in an inverted **'V' to** reach the umbilicus [3]. The inner surfaces of the labia majora are free from hair, and are separated by a small groove from the thin **labia minora**, which guard the entrance to the vagina [2,6,7,9,15].

The labia minora (the small lips) are delicate folds of skin, which contain fatty tissue. They vary in size, and it was once believed that large minora were due to masturbation, which at that time was considered evil.

In front, the labia minora split into two folds, one of which passes over and the other under the clitoris, and at the back they join to form the **fourchette**, which is always torn during childbirth. In the reproductive years, the labia minora are hidden by the enlarged labia majora, but in childhood and old age the labia minora appear more prominent because the labia majora are relatively small [3].

The **clitoris** is the exact female equivalent of the male penis. It serves as a useful landmark in locating the urethral orifice for catheterisation if following childbirth; extensive vulva bruising and laceration are present [3]. The fold of labia minora, which passes over it, is equivalent to the male foreskin (prepuce). It is called the **hood** and it covers and protects the sensitive end (or glans) of the clitoris [6,14].

The fold of the skin, which passes under the clitoris, is the equivalent of the small band of tissue, which joins the glans of the penis to the skin, which covers it. It is called the **frenulum** [3,6].

The clitoris is made up of tissue, which fills with blood during sexual excitement. The end of the clitoris is often very sensitive to touch, but the area along the shaft of the clitoris, if stimulated, produce sexual arousal in the same way that a man is sexually aroused when the shaft of his penis is stimulated. In sexual intercourse, the movement of the man's penis in the vagina indirectly stimulates the clitoris and can lead to the woman having an organism [3]. Many women do not experience an organism during sexual intercourse but have deeply satisfying organisms if they masturbate their clitoral area with their finger or hand.

The clitoris varies considerably. As sexual excitement mounts, the clitoris increases in size. Again this varies considerably between individuals [3,6].

The cleft below the clitoris and between the labia minora is called the **vestibule** (or entrance). Just below the clitoris about 2.5cm is the external opening of the urethra. In old women the urethral orifice may stretch and the lining of the lower part of the urethra may be exposed [2,3,6,9-11,16,17].

Below the external urethral orifice is the **hymen**, which surrounds the **vaginal orifice** [2,3,5-7,9,10]. The hymen is a thin incomplete fold of membrane, which has one or more apertures in it. It varies considerably in shape and in elasticity, but is generally stretched or torn during the first attempt at sexual intercourse. The tearing is usually followed by a minute amount of bleeding. In many culture in Nigeria and some parts of Africa, the rupture of the hymen and the consequent bleeding, is considered a sign that the girl was a virgin at the time of marriage, and the bed is inspected on the morning after the first night of the honey moon for evidence of blood [3]. Although an intact hymen is considered a sign of virginity, it is not a reliable sign, as in some cases coitus fails to cause a tear, and in others the hymen may have been torn previously by exploring fingers, either of the girl herself or of her sexual partner. The stretching and tearing of the hymen at a first intercourse may be painful, particularly if the partners are apprehensive or ignorant of sexual matters. If the couples are well adjusted, the discomfort is minimal. Childbirth causes a much greater tearing of the hymen and after delivery

only a few tags remain. They are called **carunculae myrtiformes** [3,6]. Just outside the hymen, still within the vestibule but deep beneath the skin, are two collections of erectile tissues, which fills with blood during sexual arousal. Deep in the backward part of the vestibule are two pea-sized glands, which also secrete fluid during sexual arousal and moisten the entrance to the vagina, so that the penis may more readily enter without discomfort. These may occasionally become infected. They are known as **Batholin's glands** [3-9,14].

The area of the vulva between the posterior fourchette, and anus, and the muscles which lie under the skin, form a pyramid-shaped wedge of tissue separating the vagina and the rectum. It is called the **perineum** [3,4,6-8,14], and of considerable importance in childbirth.

Some women have never looked at their own or any other woman's external genitals, and consequently are concerned that they may be abnormal; this can easily be done with the aid of a mirror [3]. This reluctance to look at one's own genitals is a feminine trait and has its origin in the attitudes that many mothers give their daughters about their genitals. These attitudes are that the external genitals are private and ugly and should never be touched or played with, have a smell, and are dirty. Such indoctrination in childhood is sad and creates negative consequences to a woman's image of her own body and in her sexual response [3,6]. Even the medical word for the external genitals of a woman - *pudenlum*, which is derived from the Latin word - *pudere* "to be ashamed" [15], is unfair. A woman should not be ashamed of or disgusted by her external genitals and should look at them to become familiar with their shape and features. However, biological variations are very wide, particularly in length and shapes of the labia minora.

The Perineum

The perineum [8] is the area extending from the fourchette to the anus, and forms the base of the perineal body - a triangular mass of connective tissue, muscle and fat, 4cm x 4cm. The perineal body fills the wedge - shaped area between the lower end of the rectum [2,4] and vagina, and forms a central attachment for the mescals and fascia of the pelvic floor. When, during the second stage of labour [2,4], the perineal body is flattened out by the descending fetal head, the perineum elongates and becomes so thin that it is liable to tear. Where the fourchette only is torn, it is a **first-degree** tear. **Second degree** tear when it is beyond the fourchette and not involving the rectum or anus. In the **third degree** tear, the anal sphincter is torn the rectum occasionally [2,3,5-11,13-17].

The Vagina

The vagina [2] is a muscular tube, which stretches upwards and backwards from the vestibule to reach the uterus. As well as being muscular, it contains a well-developed network of veins, which becomes distended in sexual arousal [2,5,6]. Normally the walls of the vagina lie close together, the vagina being a potential cavity which is distended by intra-vaginal tampons

used during menstruation [2], by the penis during sexual intercourse; and during childbirth, when it stretches very considerably to permit the baby to be born [3,5,6]. The vagina is about 9cm ($3^3/_4$ in) long. The upper end of the vagina known as the vault is divided into four arches or fornices by the cervix (or neck) of the uterus which projects down into it. The largest arch, known as the **posterior fornix**, is behind the cervix, the one in front is **anterior fornix**, and on the right and left sides are two **lateral fornics**.

The vagina lies between the bladder in front and the rectum (or back - passage) behind. At the sides it is surrounded and protected by the strong muscles of the floor of the pelvis. Unless the vagina has been damaged, injured or tightened at operation of has not developed due to an absence of sex hormones; its size is adequate for sexual intercourse. A woman who menstruates, [2,5,6] has a sized vagina and difficulty at intercourse is not due to her being small made. This is a myth [3]. The cause lies not in the vagina, but in a mental fear of sexual intercourse, which leads the woman to tighten the muscles, which support the vagina to such an extent that sexual intercourse is painful [1,2,4,5,8,10,11,12].

The Vagina is a remarkable organ. Not only is it capable of great distension, it maintains a clean environment. The cells which forms its walls are 30 cells deep, lying on each other like the bricks of a house wall - into four coats and is lined with stratified epithelium which is similar to skin, without the horny layer. This epithelium thrown into ridges or rugae which tends to be obliterated with repeated childbearing [3]. The outer connective tissue coat is richly supplied with blood vessels, mainly from the vagina arteries and branches of the uterine arteries [4,5,8,10,11,12,16]. The muscular wall is not well developed and the vagina is capable of great distension [3,6]. In the reproductive years, the top layer of cell is constantly being shed into the vagina [3,11] where the cells are acted upon by a small bacillus - **'Döder-lein's bacillus'**, a normal inhabitant of the vagina to produce lactic acid. The lactic acid then kills any contaminating germs, which may happen to get into the vagina. Because of this cleansing, vaginal douches are unnecessary [3]. In childhood, the wall of the vagina is thin, and production of lactic acid does not take place. However, this is of little importance, because the vagina is not usually contaminated at this age [3]. During pregnancy, the vaginal secretion is increased, but if it is profuse, red, purulent, frothy or irritating, this should be investigated. In old age, the lining becomes thin once again, and few cells are shed. Because of this, little or no lactic acid is formed, contaminating germs may multiply; this sometimes results in inflammation of the vagina [1-6,8,10,11,12,14,16].

Anatomical relations of the vagina

The lower half of the anterior wall of the vagina is in close contact with the urethra, which runs parallel to it; the upper half is in contact with the bladder. When obtaining a urethral smear for gonococci the gloved finger is inserted into the vagina, and by stroking its anterior wall, secretion can be milked from the urethra [11]. During labour, if difficulty is encountered in inserting a catheter, the gloved finger placed against the anterior wall of the vagina can be used as a guide to direct the catheter into the bladder and thus avoid injury to the urethra [11].

The lower third of the posterior vaginal wall adjoins the perineal body; the middle part is in apposition with the rectum. The upper part is in contact with the peritoneum at the base of the pouch of Douglas. Laterally, the vagina is in relation to the levator ani muscle of the pelvic floor [11].

The Uterus

The uterus is an even more remarkable organ than the vagina [3]. It is a hollow muscular organ shaped like a flattened pear. It is situated in the cavity of the true pelvis, behind the bladder and in front of the rectum. In it the fertilised ovum embeds, is nourished and protected for 40 weeks until, during labour, the fetus is expelled by the powerful contractions of the uterine muscle [2-6,10,10-14,16,17].

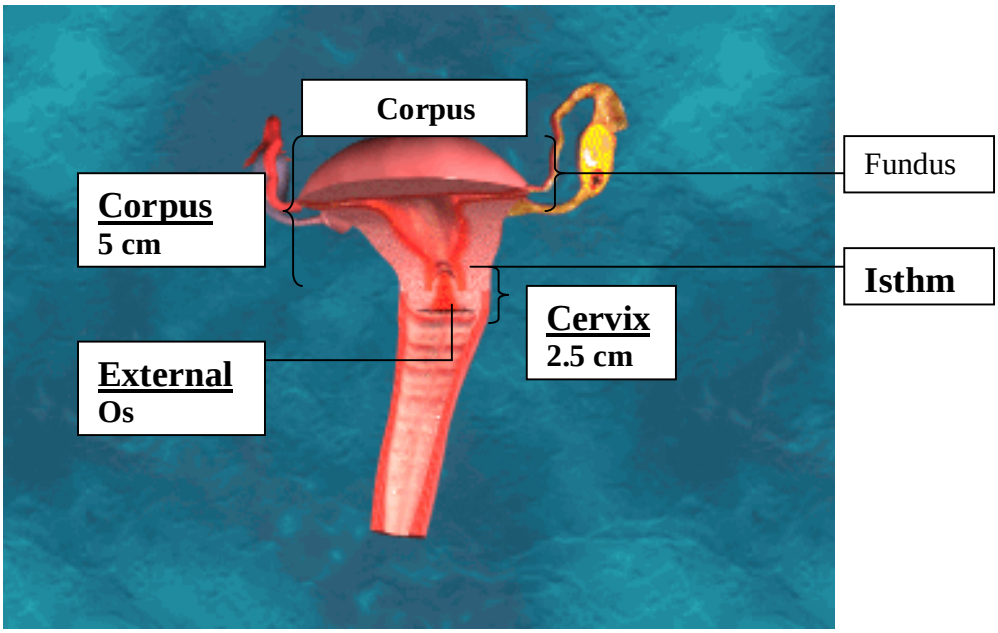


FIGURE 5.4 UTERUS

The non-pregnant uterus weighs about 60g and measures 7.5x5x2.5cm. The corpus or body is 5cm long, the cervix 2.5cm long; the upper part of the corpus is 5cm broad. The walls of the uterus are 1.25cm thick, and as the anterior and posterior walls area in apposition, the thickness of the uterus is 2.5cm [2-7,11,16].

The corpus or body forms the greater part of the uterus and the rounded upper part of the corpus above the insertion of the fallopian tube is known as the **fundus**. The angle where the fallopian tube is inserted is known as the **cornu** or horn. The body gradually tapers downwards and the constricted area immediately above the cervix is known as the **isthmus,** which distends during pregnancy to form the lower uterine segment [11].

The **endometrium** lines the body of the uterus and consists of columnar epithelium, glands which produce an alkaline secretion, and stroma or connective cells capable of the rapid regeneration necessary following menstruation. It is also a rich source of prostaglandins. The endometrium is richly supplied with blood and is about 1.5mm thick. When embedding of the fertilised ovum occurs the endometrium becomes known as the **decidua**, which would be shed after labour and delivery [4,5.6.9,10,11,13,14,16].

The **myometrium** or muscle coat has very great expansible properties. It forms seven - eighths of the thickness of the uterine wall and consists of three layers, an inner circular layer of fibres, a thick intermediate layer, the fibres of which form an encircling figure of eight arrangement [4,] surrounding the blood vessels, and by constricting them act as living ligatures to control bleeding during the third state of labour. The fibres of the outer muscle layer are arranged longitudinally and because they are four times more plentiful in the fundus the decreasing gradient plays a part in the expulsion of the fetus [4,11].

The **perimetrium** is a layer of peritoneum, which covers the uterus except at the sides, beyond which it extends to form the broad ligaments. The perimetrium is firmly attached to the uterine wall except at the lower anterior part where, at the level of the isthmus, the peritoneum is reflected on to the bladder [11].

Position Of The Uterus

The uterus lies in a position, which is almost horizontal, when the woman stands erect. It leans forwards, and this position is known as **anteversion**; it bends forward on itself, producing anteflexion, with the fundus resting on the bladder (Fig 3B). When this position of anteflexion and anteversion is maintained, prolapsed is less likely to occur. In about 10 per cent of women the uterus lies bent backwards. The is called **retroversion** [3,11]. In the past it was considered a serious condition, causing backache, sterility and many other complaints. There were many operations devised for its correction. Today it is known that unless the retroversion is due to infection or to a peculiar condition known as **endometriosis**, it is unimportant and is not the cause of the symptoms, which were attributed to it. Surgery is not needed and the patient can be reassured that the position of the uterus is normal for her; although in the condition when the uterus is backwardly displaced or retroverted, it lies in the same axis as the vagina and is more liable to prolapse. The uterus is maintained in position by four pairs of ligaments and indirectly by the pelvic floor. It is capable of a wide range of movements; a full bladder alters its position from the horizontal to vertical: a distended colon pushes it downwards and forwards [3,6,8,13,14,16].

The Cervix

The cervix or neck is the lowest part of the uterus and the vaginal portion projects into the vault of the vagina. The cervical canal is 2.5cm long, and the constricted area where the cervix and isthmus meet forms what is known as the **internal os** (mouth): the **external os** is a small round opening at the lowest point of the uterus, but after childbirth, it is a transverse slit (FIG. 5.4) [11,16,17].

In structure the cervix differs from the body of the uterus, containing fewer muscle cells and more collagen fibres. Lining the canal is mucous membrane, with glands of the deep racemose type which secrete glairy alkaline mucus. The mucosa covering the outer surface of the cervix is similar to the stratified epithelium of the vagina [11]. The mucous membrane lining the canal is thrown up into anterior and posterior folds, from which circular folds radiate to give the appearance of a tree trunk and branches. The folds are given the name **arbor vitae uteri** [5,6,14]. As it is readily accessible for examination, early changes in the cells indicating cancer or other serious complaint can readily be diagnosed [3,5,6].

The Fallopian Tubes

The fallopian (oviduct) *(Gabriel Fallopius - Anatomist)* [2,15] tubes are two muscular canals, extending each from the cornu of the uterus and opening into the perineal cavity near the ovaries. Each tube measures about 11cm in length and is enveloped in the upper fold of the broad ligament. The ciliated mucous membrane, lining the tube, produces a current of lymph, which, in conjunction with the rhythmic peristaltic action of the muscle coat furthers the passage of the ovum from the ovary along the tube to the uterus [6,4,11,12,13,14,16,17].

The outer end of each fallopian tube is divided into long finger-like processes, and it is thought that these sweep up the egg when it is expelled from the ovary [3].

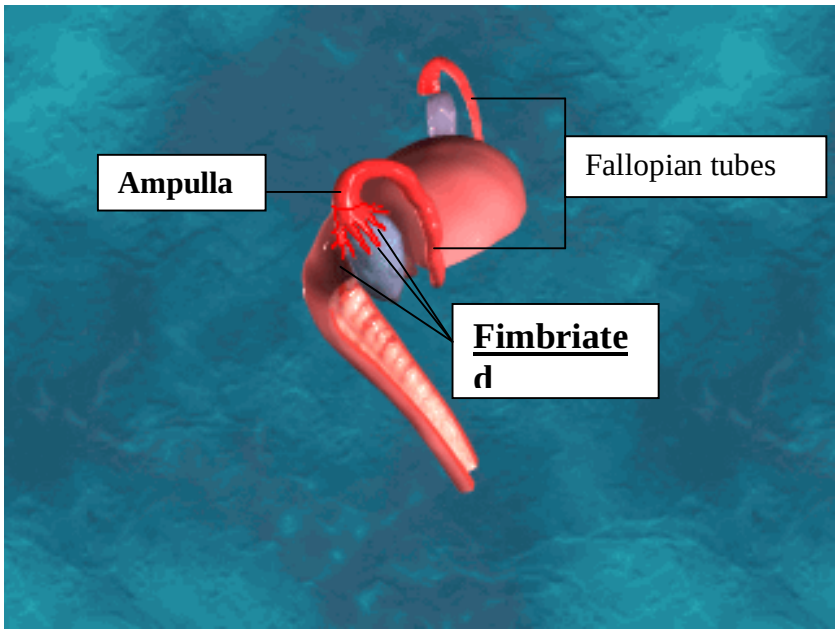


FIGURE 5.5 THE FALLOPIAN TUBES

The fallopian tube is of great importance, as it is within it (the ampulla) that fertilisation of the ovum usually occurs, and it is likely, that its secretions help to nourish the fertilized egg as it is moved by the cells towards the uterus. Four parts of the tube are described [11]:

The **interstitial** passes through the 1.25cm thickness of the uterine wall. Its lumen is about 1mm in diameter (the size of a common pin).

The **itshmus** is the narrow part, immediately adjoining the uterus.

The **ampulla** is the wider portion in which fertilisation of the ovum usually occurs.

The **infundibulum** is the funnel-shaped extremity, the terminal margins of which are fimbriated (fringed); one of the longer fimbria being in contact with the ovary, the **fimbria ovarica.**

The Ovaries

The ovaries are two small organs (about the size of an unshelled almond}, 4cm long, 2cm broad, and 1.25cm thick [3,6,11,16].

In the infant they are small, delicate, thin structures, but after puberty they enlarge to reach the adult proportions. After menopause, they become small and wrinkled, and in old are less than half their adult size [3,6,11,16].

They are situated on the posterior surface of the broad ligaments to which they attached by the mesovarium. Blood vessels and nerves enter the ovary at the hilum, a stalk-like structure, on its anterior edge [11]. One end of the ovary is attached to the cornu of the uterus by the ovarian ligament, which is about 2.5cm long, the other end is connected to the pelvic wall by the suspensory or infundibulo-pelvic ligament. The ovary is brought into contact with the fallopian tube by the fimbria ovarica.

The ovary consists of a medulla and a cortex. The medulla is a supporting framework of connective tissue, blood vessels and nerves, but the cortex (covering or bark) is the important functioning part and is composed of germinal epithelium, stroma cells and Graafian follicles [6,11]. The germinal epithelium lies over the tunica albuginea and forms the surface of the ovary. Primordial follicles are contained in the ovarian cortex where the formation of primary oocytes proceeds: 100,000 being present in each ovary at birth. During the years preceding puberty some of the primordia follicles begin to mature but not until puberty do they ripen, come to the surface and rupture to liberate an ovum [3-7,9,10,11,13,14,16].

The mature Graafian follicle is about 10mm in diameter and consists of an outer layer or **theca externa,** which is lined with **theca interna**. Inside the theca interna is a layer known as the **membrana granulosa,** which contains a clear fluid, the **liquor folliculi.** At one end of the follicle the cells of the membrana granulosa are heaped up to surround the ovum [2,3,5,11,14,16].

As can be appreciated the passage within the genital tract extends from the vestibule, along the vagina through the cervix and uterus, and along the tubes to the ovaries. It is because of this that the male spermatozoa can reach the female egg for fertilisation to take place within the body [3].

Functions of the Ovary

Ovulation, which consists of the rupture of the ripened Graafian follicle and the expulsion of the ovum, takes place once every month in a normal healthy woman from puberty to menopause approximately 14 days previous to the first day of the next menstrual period (between the 12th and 16th days after the beginning of the last menstrual period) [3,5,6,14,16]. One follicle matures and comes to the surface of the ovary, ruptures and allows the ovum to escape into the fimbriated end of the tube, cupped underneath it at this time. The corpus luteum or yellow body is formed in the ruptured Graafian follicle. If the ovum is not fertilised, it dies; the corpus luteum degenerates

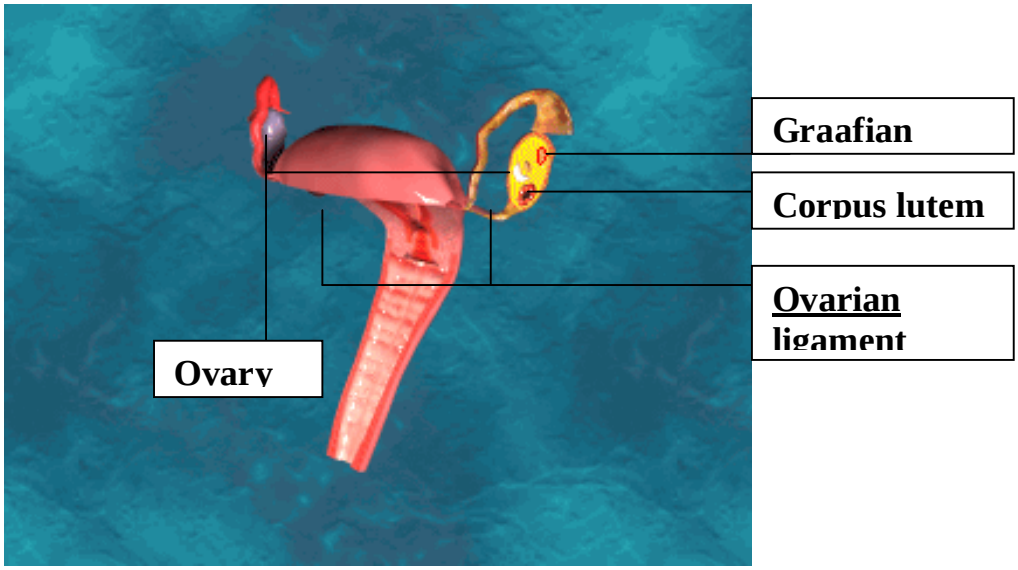


FIGURE 5.6 THE OVARIES

and is gradually replaced by hyaline tissue (the corpul albicans), which allows the ovary to heal where rupture has taken place, without the formation or scar tissue [11].

Endocrine action. The ovary produces progestogens and oesteogens. Oestriol, oestradiol and oestrone are ovarian hormones but oestriol is excreted in the urine in larger quatities than the other oestrogens [3,5,11].

Oestrogens

The oestrogens under the influence of the follicle-stimulating hormone (FSH) of the anterior pituitary gland are produced by joint action of granulosa cells and theca lutein cells. Oestrogens have widespread metabolic effects; they are also concerned with the endometrium, the growth of the breasts, vaginal epithelium, and cervical glands [3,6,11].

During pregnancy the feto-placental unit is intimately associated in the production of oestrogens. In the fetal adrenals a steroid is metabolised and carried to the placenta where it acts as a precursor in the elaboration of oestriol, which is essentially a growth hormone concerned with growth of the fetus, decidua, myometrium and breasts. This hormone is exreted in the urine of the pregnant woman, and gives some indications of fetal well being.

When conditions exists that could impair fetal growth the termination of pregnancy would be considered after the 34th week in order to promote fetal survival, so assays of urinary or plasma oestriol are made and if low, this signifies that the feto-placental unit is not functioning properly: when below a critical level fetal death may be imminent [11].

Progestogens

Progesterone and related compounds produced by the corpus luteum, under the influence of the luteinising hormone (LH) of the anterior pituitary gland are responsible for the secretory phase - the second two weeks - of the menstrual cycle. Progestogens can only affect tissues that have previously been acted on by oestrogens [5,11].

In early pregnancy progesterone is produced by the corpus luteum, and by the syncytiotrophoblast under the stimulation of chorionic gonadotrophin. Later the placenta produces increasing quantities; the adrenal cortex may also be involved [11].

Progesterone causes proliferation of the decidua to meet the nutritional needs of the growing embryo and is also concerned with the alveolar growth of the breasts. It may play some part in maintaining fluid and electrolyte balance. Progesterone is thought to be metabolished by the feto-placental unit and excreted in the urine as pregnanediol. Urinary pregnanediol assays reflect functioning of the corpus luteum and is employed in cases of infertility to determine whether ovulation has occurred. They are not of value in later pregnancy [3,6.11].

Other hormones produced by the anterior pituitary include prolactin - which initiates lactation when the breast has been acted on by oestrogens, progestogens and corticotrophin. The anterior pituitary under the influence of the releasing hormones of the hypothalamus and the ovarian hormones, by a feedback process, interact on each other, stimulating or inhibiting as required and so maintaining an optimal hormonal balance [6,11].

The posterior pituitary (neurohypophysis) produces two hormones the release of which is controlled by the hypothalamus [11].

1. Oxytocin brings about contraction of smooth muscle fibres of the reproductive tract and the mammary cells during suckling.

2. Vasopressin, the anti-diuretic hormones play a major role in the reabsorption of water by the kidney tubules and may be concerned in the production of Hypertensive State during pregnancy.

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1. FISTULA (Fistula, a pipe) [20]

A fistula is an (un-natural) channel, leading from some natural cavity, such as the duct of a gland, or the interior of the bowels, to the surface. It may be a communication between two such cavities, where none should exists, as for example, a direct communication between the bladder and bowel

Causes

Sometimes a child is born with a fistula, as a result of some defect in development, for example, a fistula from the thyroid gland to the surface; but as a rule, the cause of the formation is either disease or injury. Often, the blockage of the duct of a gland leads to a fistula and the escape of the secretion from the gland on to the surface. Thus a salivary fistula may form on the face as a result of blockage by concretion of the salivary duct in the cheek instead of into the mouth. Injury may be the cause also.

For example, if the pelvis be fractured, the urethra may be torn across, so that urine, instead of being properly voided, passes among the tissues, and, by a process of suppuration, gradually bursts its way out through the skin, forming a permanent urinary fistula.

Fistula from the bowel or bladder occasionally arises in women as a result of injury during protracted childbirth [5-8]. Disease is another cause; thus an abscess may form at the side of the lower end of the bowel, and, bursting into the bowel on one side, and through the skin on the other, forms a fistula. This 'fistula in ano' forms the best known and most important variety of fistula. The abscess which produces the fistula may be tuberculous or an acute abscess due to the ordinary causes. Sometimes a fish-bone or pin, which has been swallowed, travels through the whole digestive canal without doing damage, till it reaches this point, where it lodges and produces a fistula.

Treatment

As a rule, a fistula is extremely hard to close, especially after it has persisted for some time. The treatment consists in an operation to restore the natural channel, be it salivary duct, or urethra, or bowel. This is effected by appropriate means in each locality, and when it is attained the fistula heals quickly under simple dressings, *although this may not be so in certain cases.*

'Fistula in ano' is a very troublesome condition, and is kept from healing by the constant entrance into it of material from the bowel. It is only to be cured by dividing the tissues which separate it from the bowel, and, each day, after the bowels move, packing the wound in such a way as to compel it to heal gradually from its deepest part. The process of healing is therefore a tedious one.

2. VESICO-VAGINAL FISTULA (VVF)

Girls who are married very young usually give birth early as well, and early childbearing poses particular risks to these adolescent mothers because of their physical immaturity. Among the risks faced by adolescent mothers is **Vesico-Vaginal Fistula (VVF)** which involves a rupture of parts of the bladder, urethra and bowel, leading to physical and psychological pains and damages [3,5-10,13,15-18,21,22,23].

Professor Friday Okonofua of the Women's Health and Action Research Centre - Obafemi Awolowo University - Ife, in a recent article in Weekend Times, Saturday, November 23, l996. pp4, admits though the disability does not kill, "most of the girls that have the problem are abandoned by their husbands", he observes - "These girls frequently become outcasts in the community, often turning to begging." Apart from early childbearing, VVF is also cause by traditional **Gishiri** cuts of the vagina walls practiced by some tribes in Kaduna, Kano and parts of Borno states [3,8,22].

In severe cases, there is also abnormal communication between the vagina and rectum thus leading to free passage of faecal wastes. And the woman will be stinking seriously - **Recto-Vaginal Fistula (RVF)** [6,8,15,20,21].

Anatomical and certain physiological problems can be identified as primary causes of the problem in kid mothers and small women. Chief among these is the disproportion between the pelvis and the size of the baby's head during delivery including prolonged labour [5-8,22].

If the pelvis is contracted or narrows, and the baby's head is larger, if not properly handled, it could lead to VVF. This large head will exert a lot of pressure on the pelvis and subsequently the bladder, muscles and nerves around the birth canal. This could lead to breakage or tear [5-8,19,22].

At the Jummai Yahaya Abdulkarim VVF complex of the Sokoto Specialist Hospital, Sokoto; in the 30 bed ward some teenage mothers - cum patients huddle in the centre of the ward singing their sorrows away in tear [8].

"We were once the pride of our parent and husband," they chorus in mournful notes. |But now, we are like lepers, driven to the bush, never loved, never wanted by anybody" [8,19].

Mrs. Sahiya Ibrahim is 17. She is a divorcee and VVF patient from Argungu, Kebbi State. She got married at about 12, around l992. And she didn't have many problems getting pregnant. But the pregnancy almost claimed her life.

"From the first month to the ninth month," she recalls, "I didn't have much problems . . . . Problems started as I became due. "I was in labour for three days but I could not deliver . . . " She was delivered of a dead baby through caesarean *section* on the third day to safe her life.

Although she successfully pulled through the operation, Sahiya came round to meet a fresh problem - VVF. And *her husband who is in his 20s had since abandoned her.*

Like Sahiya, Rabi's problem started four yeas ago when she had a child that died during delivery. She had been in labour in the village for four days before she was rushed to the hospital in Sokoto. The baby was *delivered by caesarian section*. Shortly after the operation, *she discovered she could no longer* control her urinary activity.

"In the last three years, I have had four operations," she continues "yet it has not stopped. In fact, I am waiting for the fifth operation . . . "

Like Sahiyam she too was thrown into the cold by her husband at her greatest hour of need.

Now 22, Laila, a resident of Mama Tudu, Sokoto North local Government Area of Sokoto state, was withdrawn from school at the age of 12 and given in marriage to a man old enough to be her grandfather.

At about age 13, she got pregnant. Like *most VVF patient, she had prolonged labour, lasting* three days. And when she finally delivered the baby, it was stillborn.

"At first, she *recounts* - my husband showed some understanding. He was coming to the hospital, bringing food and clothes for me. After a while, he stopped coming, leaving the problem to me and my parents."

Perhaps it was in recognition of these facts that a vocational centre to rehabilitate Vesico Vaginal Fistulae patients was built in Kaduna state by the local chapter of the National Council of Women Society (NCWS) [5,11].

Commissioning the centre, wife of the State Administrator and Chairperson, Family Support Programme (FSP), Mrs. Grace Angattiya Chamah, said the centre was very vital to the patients' education 'as the functional significance of modern civilisation [10,11]

The local president of the society, Hajiya Nana Babajo, said the council, in collaboration with the Agency for Mass Education and Da'awah Group of Islam, has designed a programme to enable the VVF victims be literate in reading, writing and Arithmetic [11].

Mrs. Babajo said although VVF victims might have lost a certain part of their self-control, they have not lost their self-respect, adding that it was in recognition of the fact that the council viewed it as a challenge to assist the victim [5,11,13].

Prevention

When it lays its tentacles on a woman, especially one exposed to sex and motherhood in her teens, its effects can be really devastating, even irredeemable . . . It proscribes her love life, turns her to a nonperson and tosses her into the wilderness of life, left to roam alone [6,8].

From the testimonies of its victims, VVF breaks and destroys marital bonds with reckless abandon.

The greatest problems are 'rejection' by husband and even family. The husband deserts her. She comes to her own family, she can't get any reprieve or succour. She becomes an outcast.

So how could the situation be arrested or curtailed? The first rule here, according to Dr. Alhassan of the Sokoto Specialist Hospital, is to avoid predisposing factors like early marriage, early exposure to sex, education of women on the significance of early and regular ante-natal care [6,7,8,17].

Regardless of age, it is important for pregnant women to begin antenatal clinic early and be regular. This helps to identify risk factors.

Traditional midwives and birth attendants should be properly *groomed* to reduce the incidence of VVF. Same goes for midwives and birth attendants in religious homes. Parents, too, should be properly educated on the dangers of early marriage [8,10,12].

Although the success rate in VVF surgeries is not high, the Sokoto state Commissioner for Health, Hajia Balaraba Bara'atu Buda said it is impossible to lose the battle [8].

Buda, who spoke with Sunday Concord recently in Sokoto, based her confidence on the efforts government had made and is still making to combat the scourge [8].

Between l995 and l996, 302 cases were successfully operated. And the government picked all the bills. It still doe's [8].

"Other organisations like the Family Support Programme, National Council for Women Societies and the Federated Organisation of Muslim Women Association (FORMWAN) have been very helpful" the Health Commissioner acknowledged [6,8].

Already the Sokoto state Ministry of Health in conjunction with the Ministries of Information and Education, have embarked on a massive enlightenment campaign to discourage the phenomenon of early marriage, appealing to the conscience of parents [13]. The co-operating ministries engage the use of the electronic media and drama performances by the state Cultural Troupe to mirror the evil effects of early marriage.

"There is a subsisting edict banning withdrawal of children from schools for early marriage or child labour. Also, emphasis is being laid on female education," adds the Commissioner [8].

At a recent International workshop on Vesico-Vaginal Fistulae (VVF), organised by the National Foundation on VVF in Abuja, many hypothesis were propounded with respect to the causes, effects and complications [17].

Poverty was identified as both a cause and a consequence of VVF [2,17]. Dr. Oladepo Shittu, of the Ahmadu Bello University Teaching Hospital, Zaria (ABUTH) pointed out that: "Although there has been an absence of reliable data, direct and indirect parameters were used to capture the picture in the Northern Zone" which, he said, originate from the rural areas and appear to constitute the source of the highest incidence of VVF in this country" [17].

Dr Irene Thomas of IAC (Nigeria) however, decried the cultures and traditional practices that impact negatively on the health and thriftiness of women.

Lending more weight to the problem of tradition, the Minister of State in the Federal Ministry of Health, Professor Iyorwuese Hagher, said, "social conditions existing within family structures and part of our traditions need to be changed" [17].

Dr Paul Hilton from the Royal Victoria Infarmatory, Newcastle upon Tyne - England, revealed at the forum that VVF in the developing world contrast widely with those of the developed countries in terms of causes and frequencies. In a developing country, Hilton said, about one to two cases are seen in every 1,000 deliveries and between 50,000 and 100,000 new cases emerge each year, whereas in U.K., one case is seen in about 1,300 hysterectomies and about 152 new cases each year [2].

According to Hilton, the conditions in the U.K., are unfortunate outcomes of surgical interventions rather than through complications arising from childbirth [17].

According to Dr Shittu, what began as a purely clinical matter in the l960s has now translated to sociocultural and economic issues.

Decrying the disadvantage of illiteracy, he said this is the cause of early marriage, sustained poverty, poor and negative cultural practices and malnutrition [2,16,17,19].

Early marriage, according to the UNDP report of the Baseline survey of Positive and Harmful Traditional Practices Affecting Women and Girls in Nigeria, is a class phenomenon, as much as it is bound by culture and religion. Other factors identified as being responsible for the phenomenon include the collapse of the educational system as well as household poverty which are reversing the achievements of the past even in areas which hitherto had high rates of female literacy and enrolment [19]. Other causes are ignorance, cost of education and unseriousness of girls. This indicates a mix of the traditional and the modern among the underlying causes of early marriage [19,20].

Among the female children sampled for the report, aggregate mean age at marriage is 16.7. Zonal comparisons indicate that the lowest mean age at marriage is, in the Northeast and Northwest, 15.2 and 14.5 respectively. The lowest rates of early marriage in the North are, Kebbi 11.3 per cent, Sokoto 14.2 per cent, Kano 14.3 per cent, Borno 14.8 per cent, and Adamawa 14.7 per cent [4,19].

The number of cases of VVF nationwide, says the report, is estimated at 150,000 with about 70 per cent of this in the northern part of the country. The incidence of VVF is estimated at 2 per cent per 1000 deliveries.

Victims of VVF are usually girls married off at an early age, usually between 10-14 years, with no formal education and independent source of income. More often than not, because of their rather poor lot, they are malnourished and stunted in growth. They either have no access to, or for some other reasons, do not use maternal and child care services for pre-natal and post-natal care. Victims are usually ostracised by the family and society, thus ending up in begging or prostitution as a last resort. In 80-90 per cent of cases, they are divorced by the husbands who put them in the misery in the first place [8,19,22].

Available data show a high prevalence of VVF in Kaduna, Sokoto, Borno, Bauchi, Kano, Kebbi, Zamfara. Though it is more prevalent in the North, cases have been reported in Lagos, Edo, Oyo, Enugu, Anambra, and Abia states [19]. A few more cases are also reported in all states of the middle belt. In the South-South, it is significant in Rivers, Akwa Ibom and Cross River states. The report sounds a note of warning that with the incidence of teenage pregnancy estimated at 46.2 per cent in the North-West, and 50.2 per cent in the North-East, VVF is likely to become more widespread and more prevalent than currently estimated [19].

Other fallout's of early pregnancy include exacerbated pregnancy symptoms, chronic anaemia, pre-exclampsia, higher risk of maternal and child morbidity and mortality, prolonged reproductive period with repeated pregnancies, leading to childbirth complications, broken homes, social ostracisation and prostitution.

Mean age at marriage was 16.7. For adult when sampled for the report, aggregate mean age at first intercourse was 17.7, and at first marriage 18.7. At first pregnancy, aggregate mean age was 19.9 and at first childbirth, 20.4.

The Northwest presented a mean age of 15.1 at first intercourse and first marriage, first pregnancy of 17.2 and first birth of 17.7. The indications of early marriage and pregnancy are higher in the Northeast than the Northwest with Borno presenting the lowest rates and Taraba the highest [19].

In the Middle Belt, Benue and Plateau presented higher rates while it is lowest in Kwara, Kogi and the Federal Capital Territory - Abuja.

In the South, the South-South contrasts with the Southeast and Southwest, which reflects the influence of higher levels of education. Abia has the highest rates in the Southeast, with mean age at first pregnancy of 22.7. Edo in the Southwest presents a mean age at first pregnancy of 23 years.

The reproductive health problems associated with early marriage depress education the most in the Northwest where marriage and pregnancy also start early. The greater problems are in Jigawa and Kaduna states. The Northeast reflects higher levels of education although withdrawal rates are high, as high as 41 per cent in Taraba State.

Of the 484 female children who are already mothers sampled for the report, 46.4 per cent are from the South-South, 12.2 per cent from the Southwest and 11.1 per cent are from the Northeast [20].

C

The states, which have the highest proportions of married teenagers, are Katsina, Jigawa, Kano, Sokoto, Borno and Osun. The majority (79.1 per cent) of married teenagers are already mothers. The highest proportion from the South-South is 32.9 per cent. The Northwest follows this, and surprisingly Osun State where the Islamic population practices early marriage; and poverty also adversely affects female education.

Among the number of these teenage mothers who reported complications during pregnancy and at childbirth, the most critical are shortage of blood, recorded by 27.6 per cent of the mothers, and difficult labour by 62.0 per cent [20].

In Kano, Kebbi, Sokoto, Borno, Adamawa and Kaduna states, expected age at marriage ranges between 15.1 and 16.9, a range which cuts through the female child's educational career and requires the child to leave school early. Such traditional attitudes are expressed by fathers in Sokoto and Adamawa states who expect their girls to marry as early as the age of 14. On the other hand, with the exception of Kano where the expected age at marriage for boys is 17.9, it is generally believed that boys should marry at a much older age than girls should. For both boys and girls, the expected age at marriage is lower in the North than in the South where children generally stay much longer in school [19,20].

Plate 6.1 VVF Victims thrown to the wilderness lonely and rejected.

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1. FEMALE GENITAL MUTILATION

Female genital mutilation (FGM) commonly referred to as Female circumcision (FC) has been condemned in recent times as "The most pervasive violation of women rights [29,75,104]. According to the Hosken report [50,57], about 60 per cent of Nigerian women are genitally mutilated in one or the other. Others are Mali 75 per cent, Gambia 80 per cent, Eritrea 80 per cent, Sudan 85 per cent, Sierra Leone 90 per cent, Ethiopia 99 per cent, Djibouti 99 per cent and Somalia 99 per cent [24,44,50,51,84,108,111].

A summary of the US State Department's Country reports on human rights practices for l993 outlined the status of female genital mutilation worldwide [111], including the prevalence and interventions initiated to eliminate the practice in 27 African countries [20,97-99,110,111]. A worldwide survey of female genital mutilation based on a literature search and fieldwork in Africa prepared for a WHO seminar on Traditional Practices Affecting the Health of Women and Children held in Khartoum, Sudan in l979, revealed the prevalence of the practice, with procedures ranging from excision to infibulation, in a number of African countries [23,45,94,96,102,108]. While this report does not provide exact information in quantitative terms, it gives a sound indication of the extent of the practice in Africa. Similarly, national studies conducted in Sierra Leone, Sudan and Nigeria have established that female genital mutilation procedures were being undertaken in those countries [20,41,45,46,56,58,99,110,111].

While immediate and long-term health consequences have been observed in various health care institutions in a number of countries in Africa, there are no systematically documented studies that enable health care providers to bring out the direct association or linkage between the observed complications and female genital mutilation. Current scientific data on the health consequences of the practice are therefore grossly inadequate, and its impact cannot be assessed with any creditable level of accuracy [111]. However, studies by midwives, physicians, obstetricians, public health nurses, physical and health educator, sociologists, political scientist, public administration and scattered testimonies by girls and women who have undergone genital mutilation are however, widespread, and provide an insight into the situation.

Female genital mutilation and conditions affecting women continue to feature regularly in many International conferences and conventions such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979) the Convention on the Rights of the Child (1989), the Goals of the World Summit for Children (1990), United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children, the Declaration and Programme of Action of the World Summit for Social Development (1995), and in Africa, the African Charter on the Rights and Welfare of the Child adopted by the Organisation of African Unity (OAU) (1990), and the OAU Declaration on the African Plan of Action concerning the situation of women in Africa (1995), which covers violence against women [7,18,19,30,78,101,110,111].

The Declaration and Programme of Action of the International Conference on Population and Development (Cairo, 1994) included recommendations in regard to female genital mutilation, which commit governments and communities to take urgent steps to stop the practice and to protect women and girls from all such similar unnecessary and dangerous practices [11,31].

The Platform for Action of the Fourth World Conference on Women (Beijing, 1995) included a special section on the girl child and urged governments, international organisations

and non-governmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation [17,73,111].

In l984, WHO co-sponsored a major seminar on Traditional Practices Affecting the Health of Women and Children, held in Dakar, Senegal. This seminar led to the creation of the Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children. IAC now has national committees established in 24 African countries [81]. In 1985, IAC presented a report by non-governmental organisations on workshops on harmful traditional practices during the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace [80,111].

In l987, WHO collaborated with UNICEF and other organisations in bringing together, in Ethiopia, 29 African countries to participate in a Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa. Participants drew up a plan of action aimed at addressing the following harmful practices: early childhood marriage and teenage pregnancies, female genital mutilation and related hazards, practices related to delivery and child spacing, and nutritional taboos [111].

In September 1993, the WHO Regional Committee for Africa adopted resolution AFR/RC43/R6, which requested the Regional Office to accelerate routine collection of data on female genital mutilation. This was reinforced during the Forty-seventh World Health Assembly in May 1994, when the Assembly adopted resolution WH47.10, which urged member states: to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any social community or sub-group; to establish national policies to abolish female genital mutilation and other harmful traditional practices; and to collaborate with non-governmental groups active in this field, draw on their experiences and expertise and, where such groups do not exist, encourage their establishment. The resolution also requested WHO to strengthen its technical support and co-operation with member states in implementing the measures specified and to continue global and regional collaboration with networks of non-governmental organisations, United Nations bodies and other agencies in order to establish national, regional and global strategies for the abolition of harmful traditional practices. The need to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels was recognized [111].

In July 1995, WHO convened a Technical Working Group on Female Genital Mutilation in Geneva, Switzerland to begin the process of developing standards and norms related to the practice and to make recommendations for further activities [47].

WHO has also actively participated in many national and regional meetings arranged by different organisations. The most recent were the United Nations Human Rights Commission Seminar on Traditional Practices held in Ouagadougou, Burkina Faso in May 1991 and two sponsored by IAC in Addis Ababa, Ethiopia in 1990 and 1994 [111].

The World Health Organisation Regional Office for Africa (WHO/AFRO) in l997 released a Plan of Action on elimination of Female Genital Mutilation (FGM) on the continent [111].

Launched by the organisations' Regional Director for Africa, Dr. Ebrahim Malick Samba, at a colourful ceremony attended by women dignitaries and leading personalities in Brazzaville, Congo, the plan is a broad strategy to support and coordinate the implementation of countries activities for the prevention and elimination of FMG and other harmful traditional practices which affect the health of women and children in Africa.

The organisation's plan to accelerate the elimination of the practice in the next two decades is to be executed in three phases. The short - term implementation phase covers three years

(1996-1998) and is estimated to cost 2.1 million dollars. It will be followed by an eight - years medium term (1999-2006) and a nine-year long-term (2007-2015) implementation phases to be developed and costed on an ongoing basis [111].

2. FGM - A Violence Against Women

Female genital mutilation (FGM), recently recognised by the U.S. Board of Immigration Appeals as grounds for asylum, is just one aspect of the increasingly visible problem of violence against women, reports World Watch magazine. As the effort to end FGM achieves heightened awareness; it bring attention to violence against women as a human rights abuse with tremendous hidden costs to society [23,93,101].

The recent asylum case in the United States brought by 19 years old Fauziy Kasinga of Togo sets an important precedent. "Her insistence on her right not to be mutilated and on the moral obligation of others to shield her from violence if they can - has made the threat she faces a matter of conscience, or politics, and policy," says author Toni Nelson [22].

The practice of FGM, which affects more than 100 million women and girls in Africa, is rooted in men's efforts to control women's emotions and sexual behaviour [45], explains Nelson [22]. Even though FGM itself may seem just a grotesque anomaly to people brought up in cultures where it isn't practiced FGM is grounded in attitudes and assumptions that are, unfortunately all too common [22,45,96].

The practice entails the partial or complete removal of the clitoris. In some tribes, the labia minora are also affected. In the communities where it is practiced, parents regard female circumcision as a deeply entrenched cultural tradition, which they are powerless to change. The traditional logic behind this practice is that it ensures chastity and prevents promiscuity. But "this does not hold water" according to Professor Okonofua of the Women's Health and Action Research Centre - Obafemi Awolowo University, Ife. "Instead the psychological effects stay with the victim and could even prime her to go seek for sexual succour recklessly and arbitrarily" [22-25,45,49,57,76,94,96,102,108,111].

Elders in the cultures that performs this ritual believes that the clitoris is something evil which reduces men to impotence and kills male children at birth. Medically, however, female genital mutilation is a risky operation especially when performed by traditional healers with unsterilized knives and razor blades [45,96]. In extreme cases, the operation results in death due to complications often from tetanus infection. It is also associated with maternal morbidity and mortality [22-25,49,75,90,96,106-108,111].

FGM therefore has serious consequences for the physical, social and the mental well being of women as well as for the stability of societies, which approve of it [14,45,49,90,111].

Circumcised women are frigid and may experience pain during sexual intercourse [42]. This behaviour may incense their husbands who may in turn engage in extra marital intercourse with uncircumcised women in order to achieve a truly fulfilling sex life, this in turn leads to a high incidence of infidelity, marital instability and/or divorce [45]. These trends expose these societies to the adverse by-products of modernization such as emotional disorders, juvenile delinquency, crimes, *homeless, and street children* [45].

In a recent article published by the Daily Times/Wednesday, February 26, l997. pp4 [21], Chairperson of the Enugu State Family Support Programme (FSP) Mrs. Hapsatu Ahman condemned the practice. Similarly, an article published by 'THE GUARDIAN', Wednesday, October 2, l996. pp7 quoted Cote d'Ivoire had drafted a bill to ban female circumcision because it entails "gratuitous and useless" suffering, a member of the government said in Abidjan [92].

"The draft bill is ready. It will be discussed by the government very shortly," said Albertine Gnanazan Hepie, Minister for Family and Promotion of Women. "These matters have to be

treated with both justice and firmness," she said on Monday at the inauguration of the National Committee Against Harmful Traditional Practices led by Agnes Huei Bah who did excisions for 40 years until she realised the risks it entailed for women [92].

The minister said she regretted that "customs, deeply rooted in the culture and tradition of ethnic groups, should be perpetuated, integrated and accepted, in spite of the dangers to which they expose those who support them [22-25,45,49,92,96,108,111].

"These mutilations are not justified either on religious or scientific grounds," she said, recalling their "serious consequences for the physical and psychological health of the women [92,111].

In another article published by the same GUARDIAN, Saturday, July 20, 1996., pp4, Eqypt's health minister Ismail Sallam announced a ban on the circumcision of girls in state hospitals [26,91].

Sallam quoted by the government daily Al-Akhbar said female excision would be banned in "all hospitals, clinics and medical centres of the health ministry."

"All doctors and nurses, who work in these establishments are considered forbidden to practice this un-Islamic custom," he added [26,91].

As the world marks the international Women's Day on the 8th of March, (l997), various bodies and individuals urge more commitment to the recommendations by the International Conference and Development (ICPD) and the Beijing Women's Conference [90].

Besides they enjoined global attention to the practice of Female Genital Mutilation (FGM) as a violence act on women [90].

The Inter-African Committee on Traditional Practices (IAC) enjoined the world to use this year's celebration to condemn genital mutilation as an extreme form of violence against millions of women and girl children [90,101,102].

Mrs. Berham Ras-Works, the President of IAC noted: "Female genital mutilation has survived for too long as a result of the silence of women while enduring so much pain and the indifference of society." [90].

FGM, according to her, violates human rights principles to health, life, and freedom from cruel and degrading treatment as well as discrimination [22,90,98,101].

Mrs. Ras-Works listed the long and short term consequences of FGM as haemorrhage, acute infections, bleeding from adjacent organs and violent pain, including obstetric complications, psychological trauma and increased risk of contracting diseases such as AIDS [23-25,86,93,95,105,108,111].

Prevalence of FGM in Nigeria

Female genital mutilation (FGM) or Female Circumcision (FC) is widespread in Nigeria. According various studies and a document released by the IAC (Nigeria) and CLO, it is estimated that more 50 per cent of Nigeria girls and women have undergone the procedure while many more are still being subjected to it every year in spite of the efforts and the various resolutions adopted and recommendations made by WHO to prevent and eliminate the practice. The slow progress towards elimination can be partly explained by the lack of planned coordinated programmes, lack of monitoring and evaluation of activities, inadequate documentation and limited resources [1,2,16,22,45,46,50,51,53,54-64-66,67-72,74,88,96,111].

During the study tour, more than 1000 victims of FGM between the ages of 18-49 with qualification of at least primary education were identified and interviewed. It was discovered that the practice is prevalent in nearly all the states of the federation. In Abia, Anambra, Delta, Ebonyi, Edo, Ekiti, Enugu, Imo, Ondo, Osun and Oyo states, there was more than 90 per cent prevalence of female genital mutilation, compared to 30 per cent in Lagos. Moreover, it was discovered that the practice is mostly conducted and carried out by women, mostly elderly women [45,46,56,57,87,96].

Respondents confirmed they learnt of the practice from their parents especially through their mothers, and want the practice to be eradicated. They also called on the govenment to ensure that FGM is ban throughout the country through appropriate legislation [87].

More than 90 per cent sampled who were neither aware or were ignorant of the risk also had their daughters genitals mutilated. Only a small section wants the practice to continue, this section however belong to the rural and uneducated rank; while those with little education wants the practice eliminated because as they put it "it hurts and is painful." These goes to confirm that education have a role to play in the elimination of FGM [87].

Elderly women especially in rural areas were blamed for always insisting that their daughters or daughters-in-law undergo the same experiences they went through during their time. However, majorities if not all of them are uneducated [87].

FGM is rife among the Urhobos of Delta state [59,67], Ishan and Bini in Edo state [59], and among the Owu Yoruba in Abeokuta, Ibadan (IAC), and Ilorin [64]. There are also reports about FGM among Kanuris in the far North; in the Oyi Local Government Area of Anambra State; and among the Ibibios in Akwa Ibom State (Akpabio, l995). Chukwu Abba (l993) also reports that FGM is widespread among the Idoma speaking people of Benue State [45]. The Kwale of Delta State and indigenes of Ekiti and Ondo states for instance, believe that a baby will die if its head touches the mother's clitoris during delivery. The people of Ife and Ibadan believe that circumcision curtails female promiscuity, this also is the belief in many places, while the Urhobo says it helps to preserve virginity [43,45,52,96].

The age at which the operation is performed varies according to ethnic and religious group, but it is usually anytime between birth and puberty [48,93].

The case of the Okpe of Delta State who perform FGM as a rite of passage can be cited to illustrate the procedure [70].

"When an Okpe young female is age 12 and above, she could be circumcised if the parents feels she is matured enough at puberty and are financially alright. The celebrant in this case may be age 16 and 21 with or without her prior knowledge of the operation, though she would not object to it when the circumcisor eventually arrived because she believed it was time for her. The victims' atimes may be younger or older. And atimes pregnant for five month to six or seven months - a time during which pregnant women can be circumcised as tradition demands [45,70].

Immediately after circumcision had been performed, a special trench is dugged. This trench would then be lined with sticks and covered with mats to shade her from the public or give her some kind of privacy at bath. Only the circumcised and sometimes the husband can take bath at this special place. In this case the husband bears the cost of the ceremony as part of marriage rites.

The circumcised during this period ranging from one to three months is made special items exclusive to her only and sometimes the husband. She has a special beaded crown and clothes dyed with camwood (Ukpama) and laced with cowries and "pennies". Young ones known as

“Ukovhwa” minister to the celebrant (Ovhwa). The body of the celebrant (Ovhwa) would be rubbed with canwood - ukpama that gives her a "red appearance, which marks her as the one undergoing the rite . . ."

She is expected to remain indoors until the ceremony is terminated with her visit to the market on the market day. This is especially done in the cases of marriage rites. And the husband is made to pay for the cost of circumcision as part of the bride price if the girl have been so circumcised in her early age.

Age at Circumcision

The age at which circumcision is performed varies from one ethnic group to another in Nigeria. It is performed in some communities during infancy in the first eight days or two weeks of life, as is the case among Owu people in Abeokuta [3]. Yorubas of Ibadan [66], the Igbo in the East [38] and among the Muslims in some parts of the North.

The cultural preferences for timing of female circumcision in parts of Edo/Delta states range from before the third month (Bini) to during adolescence (Esan and Etsako) or prior to marriage (Ijaw) to during a woman's first pregnancy [55].

FGM is performed at a much later stage in the life of girls and women (i.e. between 13 and 18 years) in Okpe community in Delta state [70], and among the Ibibio in Akwa Ibom State [10]. Further more they are circumcised during pregnancy and just before they deliver their first baby.

Finally, the ijaws apart from sharing many traditions with other ethnic groups in the Edo/Delta states stand out as a group because they also perform circumcision after death. Myers et al., (1985) [59] made this assertion on the basis of the work of Penawou (1980) [74] on the Ijaws [45}:

> At the death of an "uncircumcised female, crying is prohibited till the corpse is circumcised and the usual ceremonies performed. This is done by the diviner placing one kobo coin inside the coffin after excision and saying as follows: "me oke esein ge; this is what we can offer you. . . "

Most people therefore endeavour to perform the ceremony just to avoid the shame of being given one kobo at death [59].

The Procedure

Prior to FGM, items like olili (among the Urhobos) (red chalk) or Ujei (among the Igbos), Lali (Hausa) are rubbed on the genitals. Long knives or razor blades (e.g., Aguba or Ikpa a triangular shaped razor among Igbos) are used for cutting [45,96,108]. Native soap mixed with oil or juice of the 'agbiligba' leaf or the juices of a piece of ‘anuilinwa’ stick are applied to the wound after the operation. Some circumcisors used their mouth to spray alcohol on to the cut after the procedure, while the circumcised are advised to use medicinal herbs to treat until the wounds are healed [45].

Circumcision is a family trade and the skills for it are passed down from one generation to other. The circumcisors are also organised into guilds in some ethnic groups, as is the case

among the Yorubas or belong to a network of women who actively participate in fattening rites during formal betrothal (e.g. Ibibio in Akwa Ibom).

Circumcisors can be classified into broad sub-groups - the tradition and formally trained health workers. Among the former are the traditional healers, birth attendants, Hausa barbers, etc, while the latter are nurses and medical doctors' [45].

Yoruba circumcisors are referred to as 'Olola' while the 'Ngozoma' and the 'Wanzami' perform the operation in many parts of the North. Myers et al (1995) [59], report that 92 per cent of the respondents in their study in Edo/Delta states claimed that their FGM was performed by traditional surgeons and 7 per cent by formally trained health workers (e.g. physicians and nurses) [45,70,71].

Plate 7.1 an Okpe young female after circumcision. Young ones known as "**Ukovhwa"** (right) **minister** to the celebrant "**Ovhwa"** (left).

3. CLASSIFICATION

Female genital mutilation comprises all procedures that involve partial or total removal of the female genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons [23,45,53,91,93,99,105,108].

The different types of female genital mutilation known currently to be practiced are as follows:

Type I **Sunna,** The mildest form - means purification according to the religion, but implies the excision of the prepuce (hood) or the clitoris, and sometimes the tips of the clitoris.

Some sexologist once believe that an adherent hood reduces a woman's ability to achieve full sexual pleasure, and devised ways to free the clitoris from the hood. It is unlikely that the procedure has anything more than a psychological effect and had since been abandoned.

Type II **Clitoridectomy** - Excision of the prepuce and clitoris together with partial or total excision of the labia minora.

Type III **Infibulation,** which comes from the *Latin word for 'fibula'* meaning a clasp used by ancient Romans on the penis of their slaves to prevent intercourse. Infibulation at present means the excision of part of all of the external genitalia - the whole of the clitoris, labia minora, and the adjacent parts of the labia majora, and stitching the two sides of the vulva, leaving a small orifice to allow the flow of urine and menstrual blood.

Type IV **Refibulation,** which is performed on women who have lost their infibulation or young mothers after delivery.

Type V **Unclassified:**

= pricking, piercing of incision of the clitoris and/or labia
= stretching of the clitoris and/or labia
= cauterization by burning of the clitoris and surrounding tissue
= scraping (angurya cuts) of the vaginal orifice of cutting (gishiri) of the vagina
introduction of corrosive substances or herbs into the vagina to cause bleeding, or with the aim of tightening or narrowing the vagina, respectively.
= any other procedure that falls under the definition of female genital mutilation given above.

The long and short-term consequences of these procedures have been identified as serious risks to the health and well being of young girls and mothers, and are irreversible.

Type I and II is common from the West Coast of Africa to the east, from Mauritania to Ethiopia. Infibulation (Type III) is widespread and has been reported in Eritrea, Ethiopia, Northern Kenya, Northern Nigeria and some parts of Mali [108].

The Origin of FGM is eclipsed by the passage of time but is believed to have existed worldwide at one time in history for various reasons which all relate to woman's sexuality. Although the practice is not required by any religion [15], many communities justify its continuation due to perceived moral or religious obligations; desire to ensure virginity; bride price or family honour, aesthetics and hygiene and need for social integration [22,23,45,57,94,96,102,108,111].

Dr. Irene Thomas - President, Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children in Nigeria; in a radio programme said, "There cannot be an acceptable religious justification to mutilate a healthy women and young girls in the name of religion. And yet, this is used as a legitimizing factor to continue this gruesome practice" [15,45,96,100,108].

The decision to send a girl child to undergo circumcision is taken by female members of the family, whereas all other major decisions including those relating to the marriage of a family member are taken by the male spouse, father or eldest male in the family [45,87,96].

Female circumcision entails far more than the mutilation itself. It is usually associated with the rites of passage of girls into adult woman-hood, involving training, grooming and the provision of values that maintain domestic stability within the community and enable future mothers to nurture their children in ways that prepare them to live meaningful lives in their societies. It also plays a part in the establishment of women's networks within society which provide a forum for women to share their personal experiences and discuss matters pertaining to their sexuality [27,45,96].

In Africa, Female Circumcision (FC) is practiced in more than 30 countries, including Benin, Burkina Faso, Central African Republic, Chad, Côte d'voire, Djibouti, Eqypt, Ethiopia, Somalia and Sudan. While countries such as Cameroun, Djibouti, Egypt, Ghana and Sudan have laws outlawing FC; the practice still continues [26,108].

"The uncircumcised woman is not respectable in the society," said an African woman speaking through an interpreter in an Inter-African Committee (IAC) video on "traditional practices affecting the health of women and children."

"The sheep of which she has cut the throat is not fit to be eaten," said another [108].

Although the practice has been around for over 3,000 to 4,000 years, it came to prominence recently in the United States when a 32-year-old Nigerian used it in a petition for suspension of her deportation in the United States. Lydia Oluloro, who has been living illegally in the U.S. since 1987, asked a Portland, Oregon, judge to suspend her deportation on the grounds that her two American-born daughters, aged four and six, will be forced to undergo FC in Nigeria [108].

According to Tilman Hasche, Oluloro's lawyer, the judge on 23 March 1994, granted Oluloro's request for suspension of deportation. Although she was denied asylum, suspension of deportation is another immigration benefit that may qualify Oluloro for permanent residency and eventually a U.S. citizenship if she so desires.

Oluloro is a divorcee, said her lawyer, and under Nigerian law, the husband gets custody of the children in case of a divorce. Even though her former husband lives in Portland, she said her husband's family would force the children from her and circumcise them [108].

"There are traditional practices which are intolerable," said Berhane Ras-Work, President of the IAC. "Female Cirmcucision has no reason to persist because of the dangers that they present."

To many Americans, Ras-Work's call and Oluloro's have served as a rallying cry to abolish FC completely.

Two women members of the U.S. Congress - Representatives Patricia Shroeder of Colorado and Barbara Rose-Collins of Michigan - introduced a bill to ban FC because the practice runs contrary to the American attitude and women's place in society [108].

"As communities of African immigrants from nations where FGM is practiced grow in the U.S., we must make it clear they and their rich and proud cultures are welcome in the United States, but the practice of FGM is not" said Congress woman - Shroeder [108].

It is not clear how widespread is the practice in the United States, but some news accounts say health workers in the U.S. have seen an increasing number of immigrants who have been circumcised. According to one account, some Somali refugees paid as much as $3,000 to perform FC on their daughters. In 1996. says another account, a district attorney in Atlanta, Georgia, charged an African-born nurse with child abuse for performing FC on her three year-old niece [108].

Recently, the nightmare of Female circumcision which has continue to haunt hundreds of teenage girls during the August-to-December school vacation was averted, according to a Newspaper report [27]. Some 65 girls became women recently without having to undergo female genital mutilation (FGM) in a simple ceremony organised by a local women's group in Tharaka, a remote village some 200 kilometres from Meru, Kenya [27].

"I am happy I didn't have to go through the nightmare," says l9-year-old Ruth Mukiri, whose batch of graduands was the fourth to have done the "alternative rites of passage" in Tharaka since August 1996. Thus far, a total of some 400 girls *who would have been mutilated* graduated into womanhood in this way [27].

The idea of an alternative rite of passage of girls first came from a group of 20 Tharaka women who had been enlightened on the ills of the practice in 1995. "They came to us for help because they did not want their daughters to be circumcised," says Keriga [27].

The alternative rite of passage is similar to the traditional one except that it does not involve FGM, according to Sam Radeny who works for the Nairobi - based programme for Appropriate Technology in Health (Path), - "During our exclusion of five days, we teach the girls all they would be taught traditionally after which we call the community to celebrate," he says [27].

Jane Memo of Save the Children - Canada, an international organisation funding the anti-FGM drive in Meru, explains that feasting and dancing have to be included as part of the ceremony to show to other members of the Meru community that the only wrong thing about their ceremonies is FGM [27].

Kenya, like many other African countries, has no law explicitly prohibiting FGM although it is a signatory to the United Nations Human Rights Convention, which brands FGM a violation of the rights of girls.

In 1990, Kenya's government announced that it had officially banned FGM, but the country's male-dominated parliament passed no law prohibiting it. In fact in May 1997. a motion seeking to outlaw FGM was defeated in the house [27].

Despite past resolutions and the efforts which are being made by national authorities and bilateral and multilateral agencies to implement them; eradication work on harmful practices such FGM/FC in many parts of Africa including Nigeria is still painfully slow due to a number

of factors earlier expressed. Moreover, women need to be empowered more successfully through information, education and access to resources in order to protect their basic human rights.

The 50 page WHO Regional Plan of Action to Accelerate the Elimination of FGM in Africa, maintains that until there is leadership that will put together a concrete plan of action and take it to African governments, there will be no marked progress towards the elimination of Female genital mutilation [111].

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1. LAWS AND POLICIES

A. Sources of Laws

DOMETIC SOURCES OF LAW

Laws that affect women's legal status - including their reproductive rights – are derive from variety of sources. In Nigeria, military decrees determined the validity of all laws, including the Constitution. The Nigerian legal system is based on English common law, statutory laws, Islamic law, and tribal customary law. Pursuant to state and federal legislation, courts may not enforce customary laws that are ***"repugnant to natural justice, equity and good conscience,"*** "incompatible either directly or by implication with any law . . . in force," or "contrary to public policy." Two sets of criminal laws are in force in Nigeria, the Criminal Code, which applies to the southern states of Nigeria, and the Penal Code, applicable in the northern states. Although the two codes are similar in content, the Penal Code reflects the values of the predominantly Muslim population of the north [70,114].

INTERNATIONAL SOURCES OF LAW

Because international instruments are legally binding, they create an obligation on the part of the government to undertake numerous actions, including those at the national level. A number of international human rights treaties, particularly the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), recognize and promote specific reproductive rights. The government of Nigeria is a party to various international legal instruments, including, inter alia [114]:

¶¶ The International Covenant on Economic, Social and Cultural ***Rights, adopted Dec. 16, 1966, 993 U.N.T.S. 3 (entry into*** force Sept. 3, 1976) (ratified by Nigeria on July 29, 1993).

¶¶ The International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, 999 U.N.T.S. 171 (entry into force Mar. 23, 1976) ratified by Nigeria on July 29, 1993).

¶¶ The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), opened for signature Mar. 1, 1980, 1249 U.N.T.S. 13 (entry into force Sept. 3. 1981) (signed by Nigeria on Apr. 23, 1984 and ratified on June 13, 1985).

¶¶ The International Convention on the Elimination of All Forms of Racial Discrimination, opened for signature Mar. 7, 1966, 660 U.N.T.S. 195 (entry into force Jan. 4, 1969) (ratified by Nigeria on July 22, 1983).

¶¶ Convention on the Rights of the Child, opened for signature

Nov. 20, 1989, G.A. Res. 44/25, U.N.G.A.O.R., 44th Sess., Supp. No. 49, art. 9, at 165, UN Doc. A/44/49, reprinted in 28 I.L.M. 1448 (1989) (entry into force Sept. 2, 1990) (ratified by Nigeria on Apr. 19, 1991).

¶¶ The African Charter on Human and Peoples' Rights, adopted June 26, 1981. OAU doc. CAB/LEG/67/3/Rev.5 (1981), reprinted in 21 I.L.M.58 (1982) (entry into force Oct. 21, 1986) (ratified by Nigeria on July 22, 1983).

B. Health and Population Policies

On 4th February 1988, in response to the perceived adverse socioeconomic consequences of rapid population growth, the government adopted the National Policy on Population for Development, Unity, Progress and Self-Reliance. This policy is designed to achieve the primary goals of decelerating the rate of population growth and improving standards of living [13,25,47,75,76].

Although the National Policy on Population seeks to achieve a number of specific objectives, many of which are set forth in guanratitative terms, unfortunately, the goals and objectives of the policy are yet to be met and implemented [73,75,76,77,80,83].

The National Policy on Population for Development, Unity, and Self-Reliance, states in section 4.1.2: **Population Policy Goals:** "to promote their (people of this Nation) health and welfare, especially through preventing premature death and illness among high risk groups of mothers and children [48]. Sections 4.2.1; 4.2.2; and 4.2.3, of the **Population Policy Objectives** states: [47]

4.2.1. to promote awareness among the citizens of this country of population problems and the effects of rapid population growth on development, within the shortest possible time.

4.2.2. to provide to everyone the necessary information and education on the value of reasonable family size to both the individual family and the future of the nation in achieving self reliance.

4.2.3. to educate all young people on population matters, sexual relationships, fertility regulation and family planning before entering the ages of marriage and child bearing to assist them towards maintaining responsible parenthood and reasonable family sizes within their ability to foster;

4.3 Targets: for this population policy shall be:-

4.3.1.1. For the protection of the health of mother and child, to reduce the proportion of women who get married before the age of

18 years by 50 per cent by 1995 and by 80 per cent by the year 2000;

4.3.1.2. to reduce pregnancy to mothers below 18 years and above 35 years of age by 50 per cent by 1995 and by 90 per cent by the year 2000;

4.3.1.3. to reduce the proportion of women bearing more than four children by 50 per cent by 1995 and by 80 per cent by the year 2000;

4.3.2. to extend the coverage of family planning service to 50 per cent of women of child bearing age by 1995 and 80 per cent by the year 2000;

4.3.3 to direct a significant proportion of the family planning programme in terms of family life education and appropriate family planning service at all adult males by the year 2000;

4.3.4. to reduce the number of children a woman is likely to have during her lifetime, now over 6, to 4 per woman by the year 2000 and reduce the present rate of population growth to 2.5 per cent by 1995 and 2.0 per cent by the year 2000;

4.3.5. to reduce the infant mortality rate to 50 per 1000 live births by the year 1990 and 30 per 1000 live births by the year 2000 and the crude death rate to 10 per 1000 by 1990 and 8 per 1000 by the year 2000;

4.3.6. to make available suitable family life education, family planning information and services to all adolescents by 2000 to enable them to assume responsible parenthood;

4.3.7. and to provide 50 per cent of rural communities with basic social amenities by 1990 and 75 per cent by 2000 in order to stimulate and sustain self-reliant development.

4.3.8. Family planning services shall be available to all persons voluntarily wishing to use them. Priority attention shall be given to reaching high risk clients, for example women under 18 or over 35, those with four or more children, those with previous complicated pregnancies or childbirth, or those with chronic illness which increase the health risk of pregnancy.

The incidence of unwanted pregnancies, abortions, abandoned babies and child abuse has greatly increased in recent times and now constitutes a national social problem. It is necessary to adopt fertility regulation as a code of ethics as stated in section:

5.1: FAMILY PLANNING AND FERTILITY REGULATION

5.1.1. Appropriate measures shall be taken to protect and support the family which is the basic unit of society.

5.1.2. Legislation which protects the family and the institution of marriage shall be enacted and promoted.

5.1.3. In view of current low mean ages at first marriage for females, National programmes. especially in education, shall aim at raising the age at first marriage to at least 18 years.

5.1.4. The value of family planning and child spacing on the stability and wellbeing of the family, shall be promoted and family planning services shall be incorporated into maternal and child Health services.

5.1.5. Government shall ensure the availability and accessibility of family planning services to all couples and individuals seeking such services at affordable prices on a voluntary basis.

5.1.9. Special attention shall be paid to educating and motivating the population at grassroots level on the health, social and demographic values of family planning.

5.1.11. Special emphasis in informational programmes shall be given to reaching the male population with messages of social and economic implications of excessive child bearing and the moral responsibility of procreation.

5.2. MATERNAL AND CHILD HEALTH

5.2.1. Existing health delivery systems shall be reviewed and the implementation of primary health care as the strategy of providing health for all shall be intensified. Maximum community participation in the formulation and management of such services shall be promoted.

5.2.2 Special attention shall be given within the context of primary health care to encourage nutrition, clean water, basic sanitation, immunizations, oral rehydration therapy, birth spacing, fertility regulations and family planning services.

5.2.3. Health policies and programmes shall be integrated into other development sectors such as education, agriculture, employment, urban and regional planning.

5.2.4. Measures shall be taken urgently to increase the level of awareness health and family planning attained by women as an end in itself and because of its close link to child spacing and survival. All available information shall be made easily accessible and disseminated throughout the country.

5.2.5. For the sake of the health of mother and child, specific programmes, including family planning services, shall be devised and put into effect to reduce the incidence of high risk births which occur below the age of 18 years, over the age of 35 years, at intervals of less than two years and more than four in number.

5.3. ROLE AND RESPONSIBILITIES MEN IN FAMILY LIFE

5.3.1. The patriachal family system in the country shall be recognised for stability of the home.

5.3.2. Appropriate information and education programmes shall be designed and implemented to promote awareness by men of their responsibility for adequate caring and for having appropriate family sizes.

5.3.3. Men shall be enlightened on the promotion of health of their spouses and children, especially on the social and health benefits of marrying mature women above 18 years of age, spacing of births of children by at least2 years interval, having an optimum age of 35 years for a spouse to end child bearing.

5.3.4. Men shall be required to lawfully consummate and register marriages with appropriate authorities.

5.3.5. To promote family self-reliance and prevent poverty, men shall be encouraged to have limited number of wives and optimum number of children they can foster within their resources. In addition, men shall be discouraged from having children after the age of 60 years.

5.3.6. Families shall be dissuaded from giving away their daughters in marriage before the age of 18 years.

5.3.7. Appropriate legislation shall be promulgated to discourage and punish men who put underage females in the family way.

5.3.8. Appropriate legislation shall be promulgated to ensure that men provide paternal support for any children they father.

5.4. ROLE AND STATUS OF WOMEN IN DEVELOPMENT

5.4.1. The role of women as mothers and workers shall be recognised in all sectors of the economy and day-care centres for nursing mothers shall be provided on a voluntary basis.

5.4.2. Programmes to reduce the heavy burden of rural women shall include the introduction of appropriate labour saving technology in agriculture, industry and domestic work such as the provision of potable water, rural electrification and affordable readily available fuel.

5.4.3. Programmes designed to foster women's economic independence shall be strengthened, especially the establishment of domestic and village crafts, agro-allied and small scale industries.

5.4.4. Programmes shall be introduced to guarantee equal opportunity between the sexes in education, employment, housing and business.

5.4.5. Intensive action programmes aimed at improving and protecting the legal rights and status of women shall be pursued. All forms of discrimination against women shall be eliminated as provided for in the International Conventions to which the nation is a signatory.

5.4.6 Education for women shall be promoted equally and special population education and information programmes in the areas of fertility, regulation of high risk pregnancies, and health promotion shall be provided.

5.4.7. All employers of labour shall limit paid maternity benefits to four pregnancies that have a least a two year interval.

5.4.8. All employers of labour shall actively promote family planning as a labour code and voluntary social contracts.

5.5. CHILDREN AND YOUTH

5.5.1. Programmes shall be developed to meet the needs of youths, taking cognizance of the dominance of this group in the population and provide adequate resources for social and economic opportunities to the majority of this group.

5.5.2. Educational and vocational training facilities shall be expanded to provide better preparation for an economically and socially more active life for the youth of both sexes with the family and the society.

5.5.3. Special programmes shall be developed to reduce the number of school drop outs who contribute to a rising rate of unemployment, delinquency and crimes in urban and rural areas. Continuing educational programmes for these groups shall focus on practical and technical training that provide ample opportunities for gainful employment.

5.5.4. The education calendar shall be integrated into the nation's agrarian timetable to enable children and youth to contribute usefully to the nation's agricultural and socio-economic pursuits.

5.5.5. Population and family life education shall be incorporated into formal and vocational training to assist young people prepare themselves for responsible parenthood.

5.5.6. Appropriate legislation shall be introduced to help improve the rights of children and thereby help to control all forms of child exploitation, neglect and abuse.

5.5.7. A national code of ethics shall be introduced to encourage male youths to marry not earlier than 18 years.

WORLD POPULATION PLAN OF ACTION
Adopted by the World Population Conference Bucharest, 19-30 August 1974 [53]**.**

B. Principles and objectives of the Plan

14(h) Women have the right to complete integration in the development process particularly by means of equal access to education and equal participation in social, economic, cultural and political life. In addition, the necessary measures should be taken to facilitate this integration with family responsibilities, which should be fully shared by both partners,

15(e) To promote the status of women and expansion of their roles, their full participation in the formulation and implementation of socio-economic policy including

population policies, and the creation of awareness among all women of their current and potential roles in national life.

RECOMMENDATIONS FOR THE FURTHER IMPLEMENTATION OF THE WORLD POPULATION PLAN OF ACTION AND THE MEXICO CITY DECLARATION ON POPULATION AND DEVELOPEMENT
Adopted by the International Conference on Population, Mexico City 6-14 August 1984. [53]**.**

B. The Role and the Status of Women

(15) The World Population Plan of Action (paragraphs 15 (e), 32 (b), 42 and 43) as well as other important international instruments - in particular the 1975 Mexico Plan of Action, the 1980 Copenhagen Programme of Action for the United Nations Decade for Women and the Convention on the Elimination of All Forms of Discrimination against Women (General Assembly resolution 34/180, annex) - stress the urgency of achieving the full integration of women in society on an equal basis with men and of abolishing any form of discrimination against women [92,193].

(16) In view of the slow progress made since 1974 in the achievement of equality for women, the broadening of the role and the improvement of the status of women remain important goals that should be pursued as an end. The achievement of genuine equality with respect to opportunities, responsibilities and rights would guarantee that women could participate fully with men in all aspects of decision-making regarding population and development issues that affect their families, communities and countries.

(17) The ability of women to control their own fertility forms an important basis for the enjoyment of other rights; likewise, the assurance of socio economic opportunities on an equal basis with men and the provision of the necessary services and facilities enable women to take greater responsibility for their reproductive lives. The following recommendations take into account the need for actions to ensure that women can effectively exercise rights equal to those of men in all spheres of economic, social, cultural and political life, and in particular those rights which pertain mostly directly to population concerns.

Recommendation 5

Governments are strongly urged to integrate women fully into all phases of the development process, including planning, policy and decision-making. Governments should pursue more aggressively action progammes aimed at improving and protecting the legal; rights and status of women through efforts to identify and to remove institutional and cultural barriers to women's education, training, employment and access to health care. In addition, Government should provide remedial measures, including mass education programmes, to assist women in attaining equality with men in the social, political and economic life of their countries. The promotion of community support and the collaboration, at the request of Governments, of non-governmental organizations, particularly women's organizations, in expediting these efforts should be given paramount importance.

Recommendation 6

Governments should ensure that women are free to participate in the labour force and are neither restricted from, nor forced to participate in, the labour force for reasons of demographic policy or cultural tradition. Further, the biological role of women in the reproductive process should in no way be used, as a reason for limiting women's to work. Governments should take the initiative in removing any existing barriers to the realization of that right and should create opportunities and conditions such that activities outside the home can be combined with child-rearing and household activities.

Recommendation 7

Governments should provide women, through education, training and employment, with opportunities for personal fulfillment in familial and non-familial roles, as well as for full participation in economic, social and cultural life, while continuing to give due support to their important social role as mothers. To this end, in those countries where childbearing occurs when the mothers are too young, Government policies should encourage delay in the commencement of childbearing.

Recommendation 8

Governments concerned should make efforts to raise the age of entry into marriage in countries in which this age at marriage is still quite low.

Recommendation 9

Governments should promote and encourage, through information, education and communication, as well as through employment legislation and institutional support, where appropriate, the active involvement of men in all areas of family responsibility, including family planning, child-rearing and housework, so that family responsibilities can be fully shared by both partners.

Recommendation 10

All Governments which have not already done so are strongly urged to sign and ratify or accede to the Convention on the Elimination of All Forms of Discrimination against Women.

C. Development of Population Policies

(18) The World Population Plan of Action urges that population policies should not be considered substitutes for socio-economic development policies but rather should be integral components of those policies (paragraph 2). In formulating population policies, Governments

may aim to affect one or more of the following population trends and characteristics, among others, population growth, morbidity and mortality, reproduction, population distribution, internal and international migration and population structure. The Plan also recognizes the sovereignty of nations in the formulation, adoption and implementation of their population policies (paragraph 14), consistent with basic human rights and responsibilities of individuals, couples and families (paragraph 17).

Recommendation 11

Governments are urged to adopt population policies and social and economic development policies that are mutually reinforcing. Such policies should be formulated with particular attention to the individual, the family and community levels, as well as to other factors at the micro-level and macro level. Special emphasis needs to be given to linkage between population trends, labour supply and demand, the problems of unemployment and the creation of productive employment. Governments are urged to share their experience in integrating population policies into other social and economic development policies.

Recommendation 12

Governments are encouraged to provide adequate resources and, where appropriate, to adopt innovative measures for the implementation of population policy. To be effective and successful, population programmes and development activities should be responsive to local values and needs, and those directly affected should be involved in the decision-making process at all levels. Moreover, in these activities, the full participation of the community and concerned non-governmental organizations, in particular women's organizations, should be encouraged.

Recommendation 13

Countries which consider that their population growth rates hinder the attainment of national goals are invited to consider pursuing relevant demographic policies, within the framework of socio-economic development. Such policies should respect human rights, the religious beliefs, philosophical convictions, cultural values and fundamental rights of each individual and couple, to determine the size of its own family.

The World Population Plan for Action (WPPA) underscores the importance of the fundamental right of individuals and couples to decide freely and responsibly the number and spacing of their children. It also calls upon countries to individuals and couples in achieving their desired fertility goals by encouraging appropriate education as well as the means of achieving them.

The key to population stabilization is family size. Stabilization of population will become a reality only when the average size of completed families in the developing countries declines to a level comparable to that currently in the developed countries, which is less than two children per woman.

The results of the World Fertility Survey (WFS) and Fifth population Inquiry indicates that in a majority of country individuals and couples desire smaller families and the government of these countries consider their national levels of fertility as too high. This points to the need of

increasing access to family planning services including those of natural family planning [25,43,53,78,79,80, 91,92,101,107,112].

The access and utilization of family planning services depend on a number of factors, among which are: - the quality of the service and its follow-up; availability of different methods and freedom in their selection; outreach capacity of service coverage; adequacy of supplies and effective management. Over all, the delivery of these services has not been completely satisfactory in the country because a large proportion of the population is rural, illiterate and poor [25,48, 78,79,80].

The WPPA draws attention and invites countries to improve all aspects of women's lives including education, employment, and political participation, as well as their domestic and maternal roles. Experience has shown that in the context of population policy, the educational attainment level and labour force participation of women are particularly important. However, present limitations have made this an un-attainable goal [84,97].

In 1988, Nigeria adopted a National Health Policy and strategy to achieve health for all. Although, the policy seemed to have had within its structure, the entrapments that rendered it ineffective, Professor Umaru Sheu, Pro-chancellor, University of Maiduguri and Chairman, Federal Task Force for National Immunisation, at a recent sitting of the National Council on Health, comprising the Health Minister, Minister of state, Directors General at the both state and federal level, said, "these were not clearly visible when the policy was approved in 1989 [75]." He said, there was then a general feeling of satisfaction that the basis has been laid for national development of the health system.

"Subsequent events brought out some of the difficulties which the implementers of the policy had to face. These difficulties were largely responsible for the rather poor performance of the system," he explains [73,75].

Dr. Chinelo Echeruo, Commissioner for Health, Imo State argues that "the policy ignored a number of health-reform-promoting-factors, such as intersectional collaboration, traditional system, community involvement, weak referral systems" [75,76].

"In fact," Mrs. Echeruo laments! "Everyone is worried with the dwindling fortunes of the health care system. That is why, we think that fine-tuning the policy will be a veritable tonic." However, Alhaji Mohammed Yelwah, Kebbi State Commissioner for Health, thinks that the system collapsed because the constitutional assignment responsibilities was not matched by funding and the availability of trained manpower.

"In Kebbi State, the bulk of the responsibility of PHC is still resting on the state government even though by the medical distinction it is not the headache of the state government," he pointed out.

Dr. S.E. Samuel, Kogi State Commissioner for Health, contends that there has not been a clear-cut distinction in the implementation of the policy. Besides, he says, the policy had been plagued with financial hiccups [75,76].

Health Minister, Dr. Ikechukwu Madubike, blames the failure of the policy on weak political will, poor intersectional collaboration, lack of relevant, accurate and reliable information [73,77].

At the end of the deliberations, the council voted for a revision of the policy and went ahead to effect the review. It also approved for implementation a National Health Plan for the period of 1996 to 2005 [16,75].

C. The Constitutional Rights Of Women As persons

Under a decree drafted about fives years ago (1994) waiting to be signed, a jail term of seven years awaits parents who circumcise their female children or deface children with cultural mark [90]. Also indecent assaults of women are liable to a life jail under the reviewed children's decree awaiting promulgation, as the Federal Government considers measures to enhance children's welfare.

Anybody who attempts to sexually assault a woman will, on conviction, be sent to prison for 14 years.

Attempts by anyone to procure abortion will attract 14 years' on conviction, but any person "who attempts to procure abortion in good faith, shall not be criminally responsible."

A 10 years imprisonment is recommended for whoever "imports to Nigeria, any person under 18 years with intent that he or she will be forced or seduced to illicit sexual intercourse."

It is an offence punishable with two years jail if parents fail to immunise their children or if children do not have minimum of primary school education [90].

Child theft attracts 14 years' jail, while any man convicted of incest will be jailed for seven years. Anyone who compels child labour risks a one-year jail term.

The constitution of the Federal Republic of Nigeria 1979. while guaranteeing the Freedom, Equality and Justice including the welfare of all persons male or female, categorically states in section 15 (2) of its **'Political objectives' "**Accordingly, national integration shall be actively encouraged, whilst discrimination on the grounds of place of origin, sex, religion, status, ethnic or linguistic association or ties shall be prohibited."

Section 16: **"Economic objectives"**

(1) The state shall, within the context of the ideals and objectives for which provisions are made in this Constitution: -

(a) control the national economy in such manner as to secure the maximum welfare, freedom and happiness of every citizen on the basis of social justice and equality of status and opportunity;

(b) without prejudice to its right to operate or participate in areas of the economy other than the major sectors of the economy, manage and operate the major sectors of the economy;

(c) without prejudice to the right of any person to participate in areas of the economy within the major sector of the economy, protect the right of every citizen to engage in any economic activities outside the major sectors of the economy.

(2) The state shall direct its policy towards ensuring: -

(a) the promotion of a planned and balanced economic development;

(b) that the material resources of the community are harnessed and distributed as best as possible to serve the common good;

(c) that the economic system is not operated in such a manner as to permit the concentration of wealth or the means of production and exchange in the hands of few individuals or of a group; and

(d) that suitable and adequate shelter, suitable and adequate food, reasonable national minimum living wage, old age care and pensions, and unemployment and sick benefits are provided for all citizens.

Sections 17 **"Social objectives"** specifically stressed that: -

(1) The State social order is founded on ideals of Freedom, Equality and Justice.

(2) In furtherance of the social order: -

(a) every citizen shall have equality of rights, obligations and opportunities before the law;

(b) the sanctity of the human person shall be recognised and human dignity shall be maintained and enhanced;

(c) governmental actions shall be humane;

(d) exploitation of human or natural resources in any form whatsoever for reasons other than the good of the community shall be prevented; and

(e) the independence, impartiality and integrity of courts of laws, and easy accessibility thereto shall be secured and maintained.

(3) The State shall direct its policy towards ensuring that:-

(a) all citizens without discrimination on any ground whatsoever have the opportunity for securing adequate means of livelihood as well as adequate opportunities to secure suitable employment;

(b) conditions of work are just and humane, and that there are adequate facilities for leisure and for social, religious and cultural life;

(c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;

(d) there are adequate medical and health facilities for all persons;

(e) there is equal pay for work without discrimination on account of sex, or on any other ground whatsoever;

(f) children, young persons and the aged are protected against any exploitation whatsoever, and against moral and material neglect; and

(g) provision is made for public assistance in deserving cases or other conditions of need.

While Section 18 **"Education objectives"** says: -

(1) Government shall direct its policy towards ensuring that there are equal and adequate education opportunities at all levels.

(2) Government shall promote science and technology.

(3) Government shall strive to eradicate illiteracy; and to this end Government shall as and when practicable provide: -

(a) free, compulsory and universal primary education;

(b) free secondary education;

(c) free university education' and
(d) free adult literacy programme.

Sections 30-40 of the 1979 Constitution guarantee to every Nigerian citizen 'male and female' their **"Fundamental Rights"** - to life; to dignity; to personal liberty and to fair hearing. They also guarantee the rights to private and family life; to freedom of thought, conscience, and religion; to freedom of expression; peaceful assembly and association; to freedom of movement; to freedom from discrimination and to freedom from compulsory acquisition of property without compensation.

Sections 31 **"Rights to dignity of human person"** stressed: -

(1) Every individual is entitled to respect for the dignity of his person, and accordingly: -

(a) no person shall be subjected to torture or to inhuman or degrading treatment;

(b) no person shall be held in slavery or servitude; and

(c) no person shall be required to perform forced or compulsory labour.

Sections 39 **"Right to freedom from discrimination"**

(1) A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person: -

(a) be subjected either expressly by, or in the practical application of, any law in force in Nigeria or any executive or administrative action of the government to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religions, or political opinions are not made subject; or

(b) be accorded either expressly by, or in the practical application of, any law in force in Nigeria or any such executive or administrative action, any privilege or advantage that is not accorded to citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religions or political opinions.

(2) No citizen of Nigeria shall be subjected to any disability or deprivation merely by reason of the circumstances of his birth.

Dr Jadesola O. Akande in her Book - **'INTRODUCTION TO THE NIGERIAN CONSTITUTION'** [42], PP.39, commented as follows: -

"Discriminatory treatment is defined as, "affording treatment to different persons attributable wholly or in part to their respective descriptions by race, tribe, place of origin, political opinion, sex . . . whereby persons of such description are not made subject or accorded privileges which are accorded to persons of another such descriptions." The constitutional prohibition of irrational discrimination constitutes an important expression in the area of the legal protection of human rights.

Of particular significance is the provision - section 39 (2) prohibiting discrimination based on the circumstances of one's birth. This provision is generally believed to be an attempt to remove any disability attached to illegitimacy. Indeed the original draft of the Committee specifically stated that no citizen of Nigeria shall be the subject of discrimination merely on the ground "that he was born out of wedlock." The objection of this provision and which was expressed by many of members of the Drafting Committee as well as of the Constituent Assembly is that it is repugnant to morality. They argued that, for example, under the Islamic Law, a bastard has no right to the estate of his deceased putative father and a constitutional provision which presumably nullifies this would be contrary to the way of life of a large majority of the population. It would appear that any law or act, whatsoever which encourages such discrimination, may not even now be inconsistent with the constitution.

The Supreme Court of the United States has struck down a whole host of laws treating illegitimate children differently from those born in lawful wedlock, for example, regulations preventing illegitimate children from suing to recover for the wrongful death of a parent or for benefits under the Workmen's Compensation. But recently, a closely divided court upheld a statute making illegitimate children ineligible to share in a father's estate when the father died without a will. This decision would seem to support the contention in Nigeria that the provision

in the Constitution cannot overrule the Sharia Law and injunction on the sharing of the estate of a deceased who dies intestate as a Moslem.

What about discrimination based on sex? In Nigeria, this provision represents an important expansion in the area of legal protection for human rights. Previously, the Constitution did not include sex as one of the classification and therefore it was possible for some of the States to deny women the right to vote. Under the present Constitution such discrimination would be invalid. In the United States, it was late as 1971 before any classification based on sex was declared to violate the equal protection clause. Prior to that time, state laws excluding or restricting women's participation on juries had been sustained, as well as many laws purporting to provide special protection for women. Since the adoption of the Civil Rights Act of 1964, such laws of regulations of companies affecting interstate commerce that discriminate against persons because of sex are illegal, for example, a company regulation denying employment to women with preschool age children. The first time the Supreme Court of the United States ever declared a state law unconstitutional because of discrimination based on sex was when an unanimous Court in Reed v. Reed stated that the arbitrary preference Idaho gave to fathers over mothers in the administration of their children's estates "cannot stand in the face of the Fourteenth Amendments Command."

Then a year later, in Frontiero v. Richardson the Court invalidated a Federal law that permitted a serviceman to claim as his dependent his wife but allowed a service woman to claim her husband as a dependent only if in fact he was dependent on her for over half of his support. Justice Brennan said, "There can be no doubt that our Nation has had a long and unfortunate history of sex discrimination. Traditionally such discrimination was rationalised by an attitude of 'romantic paternalism' which, in practical effect put women not on a pedestal, but in a cage."

Justice Brennan could have been speaking of present day Nigeria, where women are still excluded from serving on the jury, they are regarded as chattels to be inherited by men under customary family law; they require their husband's consent to obtain passport. However, they are now allowed to vote.

The guarantee against discrimination does not, however, prevent government from implementing special programmes and measures for the assistance of specific classes of persons who may suffer from particular disabilities or disadvantages. In Nigeria, ethnic differences are acute and the minorities must be involved in the total development of a united country, it may well be that unless special privileges are conferred on the less advanced communities to enable them to catch up with others, social harmony, which is the end sought by these non-discriminatory provisions may be unattainable. In the United States of America, this reasoning has been the basis of de-segregation laws and judicial decisions interpreting them. The fourteenth Amendment guarantees to all United States citizens the "equal protection of the laws." This was used by the Supreme Court to invalidate the Civil Rights Act 1875 enacted by Congress to encourage social discrimination. Equality before the law is achieved where persons in similar circumstances are treated similarly, but is not violated where special reasons appertaining to particular groups form the basis for the distinctive treatment. Thus legislation designed to confer special maternity benefits on women while at the same time restricting other generally enjoyed benefits do not offend these principles. Besides, the government is allowed to improve restrictions on appointments.

Women's Legal Status

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding age of first marriage can also have a significant impact on a young woman's reproductive health. Furthermore, rape and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health [10,67,93,94,95,102,108,114].

RIGHTS WITHIN MARRIAGE

Marriage law: Three types of marriage - customary, Islamic and civil are recognized in Nigeria. Marriage adhering to customary or civil law are legally valid throughout the country. In the Northern states, marriages under Islamic law are also legally recognized. Pursuant to customary and Islamic law, marriages may be polygamous; Islamic law in Nigeria permits a man to have up to four wives.

Under customary law, marriages are arranged between families, and the prospective suitor is often required to pay a bride price to the bride's family. Within customary marriages, traditions requiring women to undergo harsh and burdensome rites at widowhood, and the periodic ritual seclusion of women, are prevalent. Under Islamic law in Northern Nigeria, the father of a woman retain the "right" (ijbar) to arrange the marriage for his virgin daughter, regardless of her age and without her consent. Islamic law marriage involves a dowry paid directly to the woman to be married. In the Northern states, the customary seclusion of women is particularly rigorous and may restrict women's movement outside of their homes even in emergency situations [49,70,114].

Under civil law, marriage must be monogamous, and, unlike the other two types of marriage, it must be registered. In a civil or customary marriage, the spouses have a reciprocal duty to maintain each other as well as any children of the union. In Southern Nigeria, forced marriage under any system of laws is formally prohibited by law as a criminal offence, punishable by imprisonment for up to seven years. Despite this prohibition, women in the southwestern regions may be compelled to marry the local Chief or **Oba** (king). Arranged marriages are also common in rural areas of the South [114].

ECONOMIC AND SOCIAL RIGHTS

Property: - There are no formal laws restricting women's rights to own property in Nigeria. An 1882 law in force in many Nigerian states affirms the capacity of a married woman to hold, acquire, and dispose of property. Because property acquired during a marriage is often presumed to belong to the husband or male head of the household, a woman often cannot demonstrate her rights in property without documentation of ownership or proof of her contribution to the purchase of the property [70,72,114].

State laws and common law provisions governing intestate inheritance rights do not discriminate against women. Moreover, under customary laws, daughters may inherit from their parents' estates. However, most systems of Nigeria customary law exclude widows from inheriting property in their owns right, and widows often must enter into leviratic arrangements (in which the widow marries a member of her husband's family, such as a brother) to ensure the continuing support of their husband's family. Under Islamic inheritance laws as practiced in Northern Nigeria, one eighth of a man's estate is allocated to his surviving wife or wives. The remainder of the estate is distributed so that male heirs receive twice the share of any female heirs.

Labour: - The Constitution recognizes the principle of "equal pay for work without discrimination on account of sex" and seeks to eliminate discrimination "on any ground" in employment matters. However, Nigerian women encounter informal discrimination in employment and often do not receive wages commensurate with those received by male coworkers. Moreover, the Labour Act contains some provisions that - although designed to protect women, prohibit women from engaging in certain areas of employment, such as working at night or underground. The Constitution also seeks to ensure working conditions that are "just and humane" and do not endanger workers' health, safety, or welfare. By law, all women are entitled to 12 weeks' maternity leave, during which period they must receive, at minimum, 50 per cent of their regular wages. In addition, the labour laws require employers to provide women workers with at least one hour each day to nurse their children [44,45,144].

Access to Credit: - No specific laws limit women's access to credit. However, several obstacles exist for women who attempt to obtain credit, in Nigeria that are attributable to discriminatory customary laws relating both to women's right to own property and the prevailing attitudes of major financial institutions and investors toward female applicants. Women tend not to own real property that could serve as collateral for their loan applications. Moreover, financial houses currently require married women to obtain their husband's support for their credit applications [114].

Access to Education: - The Constitution states that a fundamental objective of state policy is the provision of educational opportunity at all levels of schooling. In its 1981 revised National Policy on Education, the government of Nigeria perceived an "imbalance" in female enrollment levels, and committed state and local governmental authorities to programming intended to encourage female attendance, particularly in primary, secondary, and technical schools. The federal government has allocated funds to establish women's education centres in each local governmental area to promote educational opportunities for women [114].

RIGHTS TO PHYSICAL INTEGRITY

Rape: - Both Nigerian criminal codes define rape in similar terms. In Southern Nigeria, the criminal code defines rape as "unlawful carnal knowledge of a woman or girl, without her consent." Unlawful intercourse with a woman's' consent also constitutes rape if the consent is

obtained by force, fraud, threats, or "intimidation of any kind." The laws in Southern Nigeria also proscribe attempted rape as an offense. In Northern Nigeria, the Penal Code defines rape to be sexual intercourse with a woman against her will or without her consent or sexual intercourse with a girl under the age of 14. Furthermore, the Penal Code criminalizes consensual intercourse if the woman's consent was obtained through the use of threats to her life or threats of physical harm. The punishment for rape under both codes is imprisonment for life. "Carnal knowledge" and sexual intercourse are defined for the purposes of both codes as acts of penetration. This definition excludes other sexual offenses, such as sodomy or the insertion of foreign objects into a woman's vagina, from the definition of rape. Such acts may be prosecuted under the laws prohibiting "unnatural" sexual offenses, assault, "indecent assault," or acts of "gross indecency" [70,114].

In general, both criminal codes in Nigeria provide little protection against marital rape. Under the Criminal Code in Southern Nigeria, intercourse between a husband and wife can never constitute rape. Pursuant to the Penal Code in Northern Nigeria, the definition of rape explicitly excludes the marital rape of a woman who has attained the age of puberty. Women may receive limited protection from marital rape under the prohibitions against assault. In addition, the above provisions that preclude prosecution of marital rape do not apply to the rape of an estranged spouse.

Domestic Violence: - Incidents of domestic violence may be prosecuted under general criminal code provisions penalizing assault. In Northern Nigeria, it is permissible for husbands to "correct their wives" with physical punishment if it is lawful under the system of customary law to which the spouses adhere, and if the punishment is not "unreasonable in kind or in degree" or "does not amount to the infliction of grievous hurt." In all states in Nigeria, a woman may use domestic violence as a ground for divorce if her husband has been convicted of grievously injuring her or attempting to seriously injure or kill her [70,114].

Sexual Harassment: - No laws deal explicitly with sexual harassment in Nigeria. However, criminal law in Nigeria prohibits "indecent assault," which is defined as an act of "gross indecency" committed against a person, without consent or by use of force or threats. But pursuant to the Criminal Code, indecent assault committed against a woman is a lesser offense than indecent assault of a man, and the crime carries lower penalties [70,114].

ADOLESCENTS

The needs of adolescents are often unrecognized or neglected. Given that approximately 22 per cent of Nigeria population are between the ages of 10 and 19, it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights, including those related to reproductive health, is important for women's right to self-determination as well as for their health [31,33-36,114].

Adolescent Reproductive Health: - Adolescents are not legally restricted from access to contraceptives, but informal restrictions operate to limit contraceptive use.

Marriage and Adolescents: - The average age at first marriage in Nigeria is 16. Child marriage is particularly common in the North, where the majority of girls are married between the ages of 12 and 15.

A variety of conflicting laws relate to the age at first marriage. The Eastern states of Nigeria have enacted legislation that prohibits marriage contracts between parties under the age of 16 and declares such marriage legally unrecognizable. In addition, for the remainder of the states, the civil law provides that parties to a valid civil marriage be "of marriageable age." Although the term "marriageable age" is not defined, adolescents under the age of 21 cannot marry without parental consent under the civil law. Yet customary law provides that children can marry when they have attained puberty, usually at age 14 for boys and 12 for girls. Under Islamic law as practiced in Northern Nigeria, on the other hand, there is no minimum age for marriage.

Education And Adolescents: - State and local governmental authorities are responsible for the provision and maintenance of primary educational facilities. Some Nigerian states have established scholarship funds for female students and made school attendance mandatory, prohibiting the withdrawal of female students for the purpose of marriage [9,36].

Sexual Offenses Against Minors: - Under the Penal Code in Northern Nigeria, Children under the age of 14 are incapable of providing consent, including consent to sexual acts. In addition, a child under the age of 16 is presumed incapable of consent to any act of "gross indecency" with an adult in a position of authority, such as a teacher or guardian.

In Southern Nigeria, the Criminal Code prohibits statutory rape. Sexual intercourse with a girl under the age of 13 is punishable by life imprisonment, with or without caning and sexual assault of a girl under the age of 13 and 16, including statutory rape, are punishable by imprisonment for up to two years.

In both Southern and Northern Nigeria, the criminal laws also contain specific prohibitions against the "procuration" or employment of a minor child in prostitution [114].

ABORTION

Abortion is generally illegal under the various criminal codes.[1] Generally, those who perform abortion are subject to imprisonment for up to fourteen years.[2] For women who induce their own miscarriage, the general sentence is between seven and fourteen years.[3] Suppliers of instruments for performing an abortion are subject to imprisonment for up to three years,[4] except in the northern states where the penalty is not specified [10,64,68,70,100,108,114].

2. THE LEGAL FRAMEWORK

Although the Nigerian constitution says nobody should be discriminated against on the basis of sex, our laws are still replete with biases against women as research findings by the Women's Right Project of the Civil Liberties Organisations (CLO) have shown.

The country has a compound legal system composed of three subsystems: the statutory law, Islamic law, and customary law. As such, there does not exists any uniform civil code. This makes sweeping assumptions on the state of women's legal status in Nigeria imprudent.

Magistrate and customary courts have jurisdiction to enforce customary law; in the case of Northern Nigeria, Sharia and area courts have jurisdiction. Customary law is defined by the Evidence as "a rule which in a particular district has from long usage, obtained the force of law." With these definitions, it is often difficult to determine the appropriate customary law for a given case in a situation where the parties to the case, come from two or more different cultural backgrounds. In such instances, the law binding between the parties or the law of the area of jurisdiction is applicable.

The three main legal frameworks are often juxtaposed or applied in isolation, depending on the culture and religion of the people involved, and the area of jurisdiction within which a case originates. For this reason, it is difficult to determine who is using what law, where, when and how, especially with regards to women. Thus, there is much confusion regarding the legal status of women in Nigeria [12,70,114].

Customary laws are subject to the 1979 constitution as amended. However, instead of statutes over-riding customary laws where the latter are found to be obnoxious, they have been used to entrench objectionable customary laws. Such statutes simply define customary law and practices only with the aim of giving them legitimacy. Examples of this abound, as revealed by the CLO findings. One concerns the minimum age of marriage. The Age of Marriage Law in Eastern Nigeria legitimises 16 years of age as the minimum age of marriage - as already stipulated by customary law in consonance with what is traditionally approved. In such a case, the law is not of much help.

MARITAL LAWS

Early and forced marriage

The minimum age of marriage is a matter of conjecture and speculation as evident in various official documents in Nigeria.

Early and forced marriage enjoy legal backing in Sharia law as practiced in Northern Nigeria and among some Muslim communities of South-western Nigeria [7,54,70].

Prosecuting cases of early marriage is fraught with obstacles arising from existing legal stipulations and the lack of a unifying legislation to over-ride the conflicts. The result is that the customary law of each locality takes precedence. Even in such instances, it is difficult to differentiate between what is customary and what is religious. In parts of Northern Nigeria, where child marriage is rampant, it is done with full religious backing, as exemplified in the case of Karimatu Yakubu and Alhaji Umaru Udatsu (appellants) vs Alhaji Yakubu Tafida Paiko and Alhaji Umaru Gwagwada (respondents). This is also made clear in the decision on the

case by Uthman Mohammed JCA of the Court of Appeal, Kaduna Judicial Division on December 11, 1985.

In this case, Karimatu, a 19-year old girl, had three suitors. Her father talked her into refusing the first suitor and allowed her a choice between the second and the third suitors. Initially she chose the second suitor, Alhaji Gwagwada. After the betrothal ceremony had been performed, she changed her mind in favour of Alhaji Ndatsu, the third suitor. Her reason for the change of mind about Alhaji Gwagwada is that after the betrothal he did not come to see her personally; he sent relatives to her rather than come himself. She developed the opinion, therefore, that he was negligent and would not make a good husband. She prayed her father not to go ahead with the solemnisation of the marriage, enlisting several people into her service, among these was the Grand Kadi of Niger State. While she was still in the process of getting intermediaries to mediate on her behalf, her father concluded the marriage in her absence. Karimatu filed a petition at the Area Court seeking the dissolution of the marriage. Her petition was granted and the marriage was dissolved. Alhaji Gwagwada appealed to the Upper Area Court; Minna but was not successful. Her father then appealed to the Sharia Court of Appeal, Minna. Among the Kadis of the court who heard the case was the Grand Kadi who Karimatu had earlier met to mediate on her behalf. The Sharia Court refused Karimatu's counsel appearance in the court on the excuse that he was not knowledgeable in the rules governing legal representation in a Sharia Court. The proceeding continued without Karimatu being represented by counsel and the court ruled in favour of Karimatu's father and Alhaji Gwagwada and dissolved her marriage to Alhaji Ndatsu, her chosen husband, arguing that:

" . . . under the strict interpretation of the law under the Maliki School, a father has the right to marry his virgin daughter out without seeking her consent, irrespective of her age; but if he wishes, may consult her."

The court then ruled that Karimatu's father had rightly exercised his power of compulsion, his power of **Ijbar.** She was ordered to return to her father's house to observe the **Istibra,** after which she would be given to Alhaji Gwagwada.

Karimatu filed an appeal before the Court of Appeal, Kaduna. In his ruling the leading Judge, Justice Uthman Mohammed JCA, noted that even though,

"One conclusion on which there is a consensus of opinion in the Maliki School of law is that a father has a right to compel his virgin daughter in without her consent and even if she has attained puberty, . . . if he consults her that would be most desirable."

Moreover, he noted that this is the view of the **Risalah.** [70].

A precedent was also found in an earlier judgement involving a similar case, decided at the Sharia Court of Appeal where it was held among other consideration that:

*"There can be no right of **Ijbar** after the father, having considered his daughter to be mature enough to decide things for herself, allowed the daughter to choose a husband in the first place. And that a father has a right not to complicate matters where his daughter is trying to get married."*

On this ground and on the ground that Karimatu was not allowed legal representation at the Sharia Court of Appeal, Justice Uthman Mohammed set aside the judgement of that court and upheld the judgement of the Area Court and the Upper Area Court. He ruled that the father lost his right of Ijbar when he allowed Karimatu to make a choice in the first instance. The marriage of Karimatu to Alhaji Gwagwada remained nullified and her marriage to Alhaji Ndatsu was upheld [70].

Although Karimatu eventually won the case against forced marriage after a hard run through the courts, one fact that remains is the position of the Maliki School of law on force marriages, which gives it legal backing and many girls continue to suffer from its insensitivity.

The Marriage Act by Section 18 [72,109] permits that if either party to an intended marriage is less than 21 years of age, a marriage license could be granted or a certificate issued. All that is required is the written consent of the father or, in his absence, the consent of the mother or guardian of such party is produced. With these loopholes, many parents give out their children in marriage without hindrance whatsoever. Again, the consent required primarily is that of the father and only in his absence is that of the mother necessary. However, the Matrimonial Causes Act (MCA) provides grounds upon which a marriage shall be void, one of which is either of the parties being below the marriageable age. Nevertheless, the MCA nowhere defines the term "marriageable age". In the absence of a statutory definition, it is a matter of conjection. In interpreting this provision, recourse is had either to the stipulates of the National Policy on Population [47], which Section 18 5.1.3. aspires to make 18 the age at first marriage (see also Section 4.3.1.1.; 5.3.6.; 5.3.7.; 5.5.7).

Recourse could also be had to the common law position that makes it the age of puberty - 14 for boys and 12 for girls.

In the Eastern states, the Age of Marriage Law 1956, which applies solely to marriages under customary law, in Section 3 (1) provides as follows: "A promise or offer of marriage between or in respect of persons either of whom is under the age of 16 shall be void." Under Islamic law, marriages can be concluded for infants and virgin daughters (Ijbar) by their parents [7,70].

DIVORCE

The rate of divorce is rapidly on the increase in most parts of the country, and is put at 49.5 per cent.

A good number of reasons were advanced for the increasing rate of divorce and chief among them was economic reasons and personality. Others include childlessness, negligence, forced marriage, constant quarreling, wife battering, infidelity, sexual incompatibility, and polygamy. With the biting inflation and rising cost of living coupled with unemployment, most families have had to make very uncomfortable adjustments that often put a great deal of pressure on the marital relationship [70].

Section 15 of the Matrimonial Causes Act (MCA) [109], allows "irretrievable breakdown of marriage" as sufficient ground for dissolution of marriage. Other grounds include willful and persistent refusal to consummate the marriage, adultery, or conduct which the petitioner cannot be reasonably expected to bear (such as attempt to murder or the commission of an offence with an intent to inflict grievous harm or hurt on the petitioner). Others are desertion, separation and respondent's consent to divorce, three years separation, failure to comply with a decree of

restitution of conjugal rights and the presumption of death. Either party to the marriage can seek divorce [70,72].

Under the customary law, divorce is allowed but it is men mostly who have recourse to it. Although either party can initiate divorce proceedings under customary law, there are no standard grounds for divorce as under statutory law. This is because there are other non-judicial methods of dissolution of marriage. While customary courts are expected to follow the same rules as under statutory law, the application and outcome of such procedures differ from place to place according to the customs of the people. For example under Sharia, law, which is applied in many area courts in the Northern part of Nigeria, a man can divorce his wife simply by shouting the **talag** - three shouts of **"I divorce you."** Simply by this means divorce is made effective - unless it can be shown that it was used in the heat of anger without the intent of ending the marriage. Although the woman is entitled to use the **'Khul'** to obtain the dissolution of her marriage, this is only with the consent of her husband and upon the payment of compensation to him [49,70,114].

CHILD CUSTODY

It is perhaps in the area of child custody that women are most deprived under the customary law. Under customary law, the father has the sole right of custody. A woman begets children for the man. However, various Children and Young Persons laws that make the interest of the child paramount have modified this position. The decision is left to the discretion of the presiding judge. Among the factors taken into consideration in determining the best interest of the child is the conduct of each party, their ability to provide the child with good upbringing and the expressed wishes of the child (where she is able to express her wishes). Others are the age and sex of the child, and the character and personality of the parties. Most often, however, exercise of this discretion is governed more by cultural dictates than by what is in the best interest of the child. Fathers usually get child custody to the detriment of the wife and the child in question save in situations where it is proved beyond doubts that he is incapable of that responsibility. That is in consonance with the patriarchal customary law position that sees children as belonging to their father. Even where custody is granted to the mother, she is understood to only be looking after the children in trust for their father. Thus under customary law, the father has the sole right of custody. The tradition-informed tendency is reinforced on their husbands, women are often less able to provide adequately for the child's upkeep. Thus, they are often denied child custody on this ground [49,70].

PROPERTY RIGHTS

Under statutory law, women can hold, transfer, and inherit property. Where the deceased left a will the inheritance rights of the woman is respected. Less than 5 per cent of Nigerians dispose of their property by will, however. Custom and tradition therefore determine inheritance practices, and among the Yoruba and Efik, for instance, the right of daughters to share in their father's estate is recognised. In Islamic law, daughters take one half of what sons are entitled to, including real estate. In other areas of the country, they are not entitled to a share [70].

The Married Women's Property Act of 1882, a statute of general application in the whole of Nigeria except Oyo, Ondo, Ogun, Osun, Edo, and Delta states, recognises a married woman's contractual capacity to the extent of her separate property. Unduly, the courts assume that the

man is the owner of all family property unless the wife brings documentary evidence to prove her contribution.

Where a deceased dies intestate and was married under the Marriage Act, the Administration of Estates Law of the former western Region, applies in Oyo, Ogun, Ondo, Osun, Edo, and Delta states. In Lagos State, the relevant law is Section 36 of the Marriage Act [72]. In the Eastern states of Imo, Abia, Enugu, Anambra, Rivers, Cross River and Akwa Ibom, common law applies. The same is true in the northern states of the Federation. Islamic law entitles a wife to 8 per cent of the late husband's property while a man is entitled to half of a wife's.

With regard to property inheritance, wives have no such rights by tradition [7]. Among the customary practices, which infringe on women's right is the practice whereby a woman is inherited by her brother-in-law upon the death of her husband. This is especially so with the Igbo of Southeastern Nigeria amongst whom tradition forbids a woman from freely disposing of her self-acquired property without her husband's consent. In this instance, the recent case of **'Oli-Ekpe'** brought by Augustine against Caroline seeking a declaration that he was entitled to the property in accordance with Nnewi native law and custom of some Igbo land precluding female children from inheriting their father's estate was stripped of its legal cloak. The Court of Appeal in its ruling described it as "repugnant to natural justice, equity and good conscience" [96,98,99].

The landmark judgement was delivered on September 19th, 1997, by Justice Niki Tobi of the Appeal Court in Enugu, in a case of 'widow inheritance', namely: **Nwafor Mojekwu v. Caroline Mgbafor Mojekwu.** The appellant, Augustine, had asked the court to set aside the decision of the High Court permitting the respondent, Caroline, to inherit her husband's property situated at 61, Venn Road, Onitsha.

Augustine's defence was that the customary law of Nnewi, the homeland of both parties to the suit, forbids female inheritance. He, as present head of Mojekwu family, and the next male heir of his uncle, who is Caroline's husband, should be the one to inherit his estate. Mr. Justice Tobi, in his judgement, declared that his plea is "repugnant to natural justice, equity and good conscience." The learned Judge and his colleagues held that it is unthinkable in a contemporary society such as ours, which preaches democracy and equity for anyone, to discriminate against women on the basis of their sex. As a legal event, the appellate court's judgement upholds the respondent's fundamental right to dignity and the right to freedom from discrimination as enshrined in Sections **31** (1) and **39** (1) of the 1979 Constitution [71].

The Oli-Ekpe custom of Nnewi, Anambra State, accords the right of inheritance only to male issues such that a man's estate could pass to his brother, and subsequently his nephew, if he had no male issue, regardless of whether he had female ones.

The customary code specifically states that "under the Nnewi native law and custom, if a man dies leaving a male issue, the property belongs to the male child. If on the other hand, the deceased has no male child, his brother will inherit his property. If on the male issue who survives the father dies leaving no male issue, the father's brother will inherit the property. In on the other hand the deceased's brother dies leaving sons, the sons will inherit the property of the dead cousin. In particular, the **'diokpala',** that is the eldest son of the uncle, will inherit the property.

If the man dies and subsequently his only son and brother die, if the late brother has sons, the first son of the late brother will inherit all the property. The son of the late brother is called **'Oli-Ekpe',** i.e.; he inherited the property of his relation.

The Oli-Ekpe inherits the land, the wives of the deceased, and if the deceased had daughters he will give them in marriage. In other words, the Oli-Ekpe inherits the assets and liabilities of the deceased.

But in his lead judgement in the case of Augustine Nwofor Mojekwu and Caroline Mgbafor Mojekwu, Justice Nike Tobi said: "We need not travel all the way to Beijing to know that some of our customs, including the Nnewi Oli-Ekpe custom relied upon by the appellant are nor consistent with our civilised world in which we live today, including the appellant." He dismissed the appeal, saying: I am unable to come to the conclusion that this appeal has merit. On the contrary, I come to the conclusion that the appeal has no merit and it is hereby dismissed . . ."

Both Justice Ejiwunmi and Justice Eugene Chukwuemeka Ubaexonu present agreed with the judgement, which is known in legal circle as: 1997, 7 NWLR Part 512.

In the past, the court has also jettisoned traditions such as the one stipulating that a woman who divorced her husband and married another must return the dowry to her former husband, else the second marriage would be invalid. The issue was the contention in the case of **Edet v. Essien** where it was argued that the children had by the woman concerned for her second husband should be vested in the first husband.

The court rejected the tradition as being repugnant to natural justice, equity and good conscience, particularly as the biological father was alive.

Also, in the case of **Mariyam v. Sadiku Ejo,** the court debunked the tradition that a child born by a woman within 10 months of the collapse of an earlier marriage belonged to the first husband [96].

Domestic Violence, Rape and Female Genital Mutilation

DOMESTIC VIOLENCE

Section 55 of the Penal Code entitles husbands to beat up their wives as a form of chastisement in so far as grievous harm is not inflicted [7,70,109]:

Nothing is an offence which does not amount to infliction of grievous hurt upon any person and which is done by a husband for the purpose of correcting his wife, such husband of wife being subject to native law or custom in which such correction is recognised as lawful.

Grievous harm is defined by Section 241 of that Code to include emasculation; permanent loss of sight, hearing or speech; facial disfigurement; deprivation of any limb or joint; bone fracture or tooth dislocation, and other life-endangering harm.

For domestic violence to amount to a ground for divorce the respondent must, according to Section 15 (1c) and 16 (1e) of the MCA, have been convicted of:

(i) Having attempted to murder or unlawfully to kill the petitioner, or

(ii) Having committed an offence involving the intentional infliction of grievous harm or grievous hurt on the petitioner or the intent to inflict grievous harm or grievous hurt on the petitioner.

RAPE

Sections 357 of the Criminal Code states that [70,109]:

Any person who has unlawful carnal knowledge of a woman or girl, without her consent or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act, or in the case of a married woman, by impersonating her husband, is quilty of an offence which is called rape.

SEXUAL HARASSMENT

While many organisations and establishments have codes of conduct which forbid sexual harassment. Such codes often lack a clear conception of the problem. More importantly, there is no statutory provision addressing it. The provision in the Penal laws that comes closest to doing this is Section 353 which is on indecent assault of females. Such assault is classified as a misdemeanor punishable by two years imprisonment. In contrast, indecent assault on males is treated as a felony punishable by three years imprisonment as contained in Section 360 of the Criminal Code.

FEMALE GENITAL MUTILATION

Although Section 31 of the Constitution of the Federal Republic of Nigeria 1979, bars torture, inhuman and degrading treatment, there are no explicit laws against female genital mutilation. Perhaps for this reason, the practice has not been challenged in the courts.

Prior to 1987, Federal and State governments did not even address the issue of FGM, yet several different forms of FGM are prevalent in Nigeria.

LEGAL STATUS OF ABORTION

A. Legality:

The performance of an abortion in Nigeria is a criminal offence unless it is performed to save a pregnant woman's life. The Criminal Code and the Penal Code provisions treating the subject of abortion are similar and refer to the inducement or procuration of a 'miscarriage.' Abortions are illegal regardless of duration of pregnancy; the laws prohibit abortions performed at all stages of fetal or embryonic development from the time of fertilization [10,64,68,70,100,108,114].

The Penal Code regards the performance of most abortion as a criminal act. It states that any person who "voluntarily causes a woman with child to miscarry" may be punished by imprisonment. A woman who causes herself to miscarry is considered to be within the meaning of the provision. Under the Penal Code, a woman must actually be pregnant for the crime of abortion to have occurred. In contrast, under the Criminal Code the crime of abortion only requires intent to commit the act.

B. Grounds for Termination of Pregnancy

a. Mother's life of health: Nigerian law permits the performance of an abortion only if it is necessary to save a woman's life. The Criminal Code stipulates that a person "is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation . . . upon an unborn child for the preservation of the mother's life." Similarly, the Penal Code permits an abortion to save the life of a woman [68,114].

b. Eugenic: Not permitted

c. Juridical: Not permitted

d. Socio-economic: Not permitted

e. On request: Not permitted

f. Other: None

C. Procedural Requirements

a. Committee Approval: No special committee. However, in practice, two medical practitioner approval is sought.

b. Consent: No provision

c. Facility: No provision

d. Special payment provisions: No provision, however, Lower rates are charged for abortion treatments.

Labour Rights

Generally, women suffer much discrimination in this regard; some of which is statutory in origin and others traditional.

Though Section 24 (3e) of the Income Tax Act grants tax payers relief "for each unmarried child who was maintained by the individual during the year preceding the year of assessment . . ." the word "individual" in this clause is always interpreted by society to mean "men", thereby denying women such benefit. A married woman seeking tax relief in respect of a child is compulsorily required to prove that the father is not responsible for his/her upkeep [7]. In other words, it is assumed by society that men are heads of households whereas statistics show that more and more women are becoming the breadwinners in many families as a result of growing unemployment and spate of retrenchments affecting men [7,69,70,104,109].

Section 54 of the Labour Act guarantees to every woman maternity leave with pay that is not less than 50 per cent of the wages she would have earned but for her absence. This protection is guaranteed by Section 54 (5) to both "a legitimate and an illegitimate child." In some states, a female civil servant who becomes pregnant without being married is denied pay

during her maternity. In other places a single woman who becomes pregnant is "disciplined" with action which may "vary from termination of her appointment to outright dismissal." Women civil servants lose their housing which they had when single because of society's assumption that a woman should move into her husband's house after marriage and not vice-versa. Rule 03303 of the Kano state civil service states that any woman civil servant about to undertake a course of training of not more than six months duration, shall be called upon to enter into an agreement to refund the whole or part of the cost of the course should it be interrupted on account of pregnancy [7]. Women seeking employment are obliged to produce written permission to work from their husbands. For a married woman to obtain a Passport, the Immigration Department requires that her application be supported with a letter of consent written by her husband [104].

Section 55 and 56 of the Labour Act seeks to "protect" women from night and underground work and the Minister for Labour is further empowered by Section 57 to make regulations restricting or prohibiting women from undertaking designated jobs.

In the Police Force, the following Police regulations affect women negatively, Police Regulation 124 requires that [69,70]:

A woman police officer who is desirous of marrying must first apply in writing to the Commissioner of Police for the state police command in which she is serving requesting permission to marry and giving the name, address and occupation of the person she intends to marry. Permission will be granted for the marriage if the intended husband is of good character and the woman police officer has served in the force for a period of not less than three years.

Police Regulation 127:

An unmarried woman police officer that becomes pregnant, shall be discharged from the force, and shall not be re-enlisted except with the approval of the Inspector General.

At a seminar held recently, Rose Abang Wushishi, retired Inspector General of Police gave a list of myriad of regulations and requirements, which have a gender bias against women. Among the enlistment requirements for female is the tag *"must not be married"* which does not apply to men [104].

In enunciating the duties of women police officers, the restrictive nature of the job allocation tends towards obvious discrimination and marginalisation based on gender consideration. The Police regulation on the duties of women expressly states that "women police officers shall as a general rule be employed on duties which are connected with women and children." It also asserts that they would occasionally be involved in clerical duties, telephone duties and office orderly duties.

Ngozi Ikeano - Times Columnist in an article in the Daily Times, March 18, 1997, pp.11 [7], stressed - "It is about time Nigeria and its people do away with archaic traditions and customs as well as rules, regulations, policies, edicts and laws which are inherently discriminatory against women and infringe upon their reproductive rights. This is especially so since Nigeria has ratified the United Nations Convention on the Elimination of all forms of

Discrimination Against Women, the Rights of the Child as well as the African Charter of Human and Peoples' Rights. Women's rights are after all, human rights too [7,8]."

Women Reproductive Rights

The state of world population report [26], released by the United Nations Population Fund for Action (UNFPA) states that any culture which permits male supremacy over women amounts to violation of human rights and should be discarded. It blames cultures, which give men dominant roles in the society for the widespread discrimination suffered by women [21,86,113].

The report which is titled: **"The Right to choose, reproductive rights and reproductive health"** was presented at the United Nations Information Centre in Lagos by Mr. Roger Kazafinanja, the deputy representative of the UNFPA in Nigeria. The report reveals that the "denial of sexual and reproductive rights including free choice with regard to pregnancy and childbearing causes millions of deaths every year, and much more illness and disability. Most of those affected are women, the vast majority in developing countries [23,26,39,54,113].

It highlights the advantages in allowing people to exercise their rights of choice in order to enhance their reproductive and sexual health. These he says, were part of the agreements reached by nations in international conferences and which constitute the international framework for human rights founded on the notion that all human beings are equal [1,2,3].

Specifically, the International Conference on Population and Development (ICPD) held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995, the UNFPA report notes outlined all the items that make-up reproductive rights and their implications [23,53]. These rights, it continues, include voluntary choice in marriage, responsible sexual relations, determination of size and spacing of the family [113].

Building on human right treaties, the ICPD recognised a core set of sexual and reproductive rights; the right to reproductive self-determination, including the right to voluntary choice of marriage, and to have the information and means to determine the number, timing and spacing of one's children, equality and equity for men and women in all sphere of life; and sexual reproductive security, including freedom from sexual violence and coercion [26,39,53].

According to the report, widespread in observing these recommendations have had adverse implications on the welfare of women in particular across the world. For instance, 585,000 women (One every minute) die each year from pregnancy related causes, nearly all in developing countries. Many times this numbers are disabled as result of childbirth. The reports states that such death and suffering could be averted with relatively low-cost improvements in health care systems [23.26].

Sexual and reproductive rights, the report emphasis, are key issue in the empowerment of women and gender equality, and are equally critical to the economic and social well being of the global population [21,23].

The report observes that most women in a greater number of communities are poor and their economic activities are determined merely by the fact that they are women. It therefore, calls for actions to combat poverty, which helps to deny women their sexual and reproductive rights. It advocates giving women more access to credit and economic resources, and education to broaden their knowledge on sexual and reproductive health [1,3,26,27].

The UNFPA also want countries to invest more in primary health care. It recommends that: "Health services should be restructured to focus on the reproductive and sexual health

needs of clients, including under serve groups, using new guidelines, standards of conduct and evaluation methods. Non governmental organisations and the private sector must help design and implement and monitor programmes.

Relating the report to Nigeria the director of community development and population activities in the Federal Ministry of Health, Dr. Orjioke observed that it aptly depicts the situation prevailing in the country. He said that the bulk of Nigerian women are denied reproductive and sexual rights and are subjected to various forms of repression just because of their gender.

According to him, the report rightly describes the afflictions of more than 65 per cent of the teeming masses that are out of focus and who dwell in the rural areas of the country. They are mainly women that suffer gender discrimination, nutritional deficiencies, unequal access to health care and education merely because they are women. Many of them are denied all the rights to choose in our society. He attributed the prevalent violation of women's rights to reproductive and sexual health to poor response to education.

Under the Penal Code applicable to Northern Nigeria a husband is permitted to chastise his wife for various offences, including refusal of conjugal advances as long as the chastisement does not amount to grievous bodily harm [70,72,114].

The Penal Code defines grievous bodily harm as permanent deprivation of the power of sight, hearing or speech, disfiguration of the head or face, or hurt which causes the woman to be within or during a space of 21 days in severe bodily pain or unable to follow her ordinary pursuit.

The case of Mrs. Hayishat B. illustrates the implications of this law. This 24-year old housewife and mother of two told her husband, Haruna, on December 15, 1992, that she was not in a position to respond to his sexual advances due to ill health. Hayishat was beaten up by her husband, who the following day filed a charge against her in the Customary Court. When the case came up for hearing, the presiding lay magistrate blamed Hayishat for not telling her husband of her ill health during the earlier part of the day, thus failing to prepare him for the possibility that his sexual urges will not be satisfied later. The lay magistrate appealed to Haruna not to divorce Hayishat, but to give her a second chance. He then asked Hayishat to beg her husband, and fined her some amount [51,54,70].

Research carried out by the Women's Rights Project (WRP) on the legal status of women and their reproductive rights showed that 63 per cent of women were not aware of their rights and, therefore, could not recognise rights violation whenever it occurs. Women, according to the report presented by the Head of Women's Right Project of the CLO, Mrs. Theresa Akumadu, accept these negative socio-cultural dictates as a necessary part of their lives. This is mainly due to the low level of their education [51,93].

Dr Mrs. Adenike Emeke, a lecturer at the University of Ibadan spoke on the "Women's Reproductive Health and Rights; Customary Law Practice in Nigeria." She examined women's reproductive health problems and noted that "The problems related to women reproductive health have taken a serious turn for the worse in Nigeria and many other African countries due to socio-economic reason."

According to Dr. Emeke, the reality is that customary law in Nigeria does not "recognise an interest" called women's reproductive rights and this has no respect for it as a duty or sees the disregard of it as a wrong. It is at the customary law level in that the most intense exploitation of women's reproductive rights takes place [57].

For instance, under the customary law in Nigeria, a woman must not be found to say 'NO' to her husband's sexual advances no matter her reasons. If she is reported by her husband to his family, she is in trouble, and the same fate awaits her if the husband decides to report her to her own family. Most of the time, nobody bothers to listen to her reason for refusal, rather she is subjected to a long sermon and reprimanded by either her own mother, her mother-in-law, elderly relations etc [52,70].

Whether the woman's reason for refusal is hinged on health problem is not their concern, and the woman may be seen as the one who wants to break her own marriage.

It was discovered that an average Nigerian woman cherishes the family and would suffer, endure and undergo great torture - physical, physiological and sexual to keep the family ties. Again, when one looks at the customary court, the presiding judges are themselves men, old men, who want to maintain the status quo, thereby worsening the situation for women.

In far away Côte d'Ivoire, a 14 years old girl has been jailed since May, 1996 for killing her husband of an arranged marriage, who forced her to have sex with him. The teenage girl, Panta Keita, born of Guinean parents was forced to marry a cousin more than twice her age by her parents against her wish [52].

The daddy' husband, was said to have beaten and raped her when she refused to consummate the marriage. Panta escaped from the man, but her family took her back to him. But when she could no longer stand the agony she was being subjected to by her husband, she picked a knife and slashed her husband's throat while he was asleep. She was later charged with murder and detained in Abidjan.

But some time in the year the Ivorian President, Henri Konan Bedie however, ordered her released, following pressures from women's group, as part of a campaign against premature and forced marriages. The president might have ordered her release for recognising the fact that the girl has a right to choose whom to marry.

Unfortunately, many women do not know their fundamental and reproductive rights; and even those who know find it difficult claiming them. That is why their rights are being violated by the men and even women themselves who are supposed to protect those rights.

Dr Emeke concluded that women are major reproductive agents, and thus their reproductive needs, which have physical, medical, economic and legal dimensions must not be pushed aside.

Women must be accorded their reproductive rights and the customary law must see the respect for these rights as a duty and their disregard as a wrong done to the women [52,93].

3. STRATEGIES FOR THE ADVANCEMENT OF WOMEN

The International Women's Day (March 8) has come and gone, but women's concerns will continue to generate interest for as long as they remain a stumbling block to their advancement [6,22,31-35].

Series of International conferences have attempted to address some, if not all, of these issues with a view to improving the lot of women. Each conference had included a gender perspective.

These include the 1979 Convention of Elimination of All Forms of Discrimination Against Women and The 1985 Nairobi - Forward Looking Strategies for the Advancement of Women (FLS) [6,22,46,51,74].

The economic recession and the deteriorating situation of the African region in the 1980s was the subject of several regional strategies which were policy-oriented; these included the Lagos Plan of Action (LPA) and the African Priority Programme for Economic Recovery (APPER). During the same period African women drafted their own region - wide strategies at conferences held in Arusha (1984) and Abuja (1989). When they attended the World Conference in Nairobi, in 1985, women found that their issues, harmonized with global concerns [24,35,37,46,51].

The life of an African woman in the 1980s was characterized by hard manual work, using traditional and in-efficient implements and methods, frequent births, high mortality rates, rampant malnutrition coupled with poor health, low literacy rates, lack of professional and technical skills, widespread and entrenched animalistic beliefs and subservience to men. Reflecting on the situation, influencing government policy was one of the most strategies to adopt for the advancement of African women (Green). Any effort was worthwhile if it convinced decision-makers of the following statements [37,46,55,80]: -

"Concern about gender division of labour, women's exclusion from decision making and unequal access to land/skill is not simply egalitarian, humanitarian, nor in a narrow sense feminist. It is central to the reduction of national household poverty and in a number of cases to substantial increases in the rate of growth of production."

In designing the Lagos Plan of Action the heads of states and governments acknowledged that women were the critical factor for accelerating economic development. At last 'the primordial role of women in socio-economic life was being increasingly recognised. As Salim Ahmed Salim, Secretary-General of the OAU, said: "The Lagos Plan of Action and the Arusha Strategies do emphasize the imperative need to move the African women from the periphery of our decision making process to the main stream of our socio-economic planning." The LPA also played an important role in promoting gender concerns in Africa; this was acknowledged by government delegations, which came to Arusha in 1984. Tanzanian president Julius Nyerere opened the Arusha Conference by reminding delegations of the African position on women and development [46]:

The history of the world shows that the oppressed can get allies - and need to get allies - from the dominant group as they wage their struggle for equality, and progress. But no one, and no group, can be liberated by others. The struggle for women's development has to be

conducted by women, not in opposition to men, but as part of the social development of the whole people.

The conference itself was chaired by Gertrude Mongella, Minister of State of the United Republic of Tanzania, now Secretary-General of the World Conference in Beijing, 1995.

It adopted 'The Arusha Strategies for the Advancement of Women in Africa beyond the UN Decade for Women.' The strategies were policy-oriented and were meant to be guidelines for planning the full integration of women in development by sector and at every level to the end of the twentieth century. The thirty-nine member governments of the OAU and ECA present in Arusha requested all African governments to take appropriate steps to harmonize their national development plans with the objectives and integrated approach to the Arusha Strategies, which later became part of the women's brief presented to the world conference in Nairobi, Kenya.

The Abuja Conference which took place in November 1989, was described thus: *"In the largest such gathering ever of African women . . . the set of goals they came up with was remarkable for its pragmatism* [46].

The tone for this pragmatism was set by the opening speech of General Ibrahim B. Babangida, President of the Federal Republic of Nigeria:

"I want you to arrive at a declaration through what I would call the Abuja scale. You are to weigh the Arusha strategies and subject them to in-depth scrutiny . . . Despite the adverse effects of the world economic system on the developing countries, our economies are beginning to show signs of growth once more. Nigeria has made giant strides with regard to the advancement of women. Women were being highly placed both in the public and private sectors.

Nigeria has both signed and ratified the UN Convention on the Elimination of All Forms of Discrimination against Women, a Women Commission and the Better Life Programme for Women have all been established.

It was noted at the conference that there were indications that an increasing number of women were participating in family planning services, pre-natal and post-natal programmes; their nutritional status had also improved. Nevertheless, the conference classified health in general as an area in which little progress had been made. While overall mortality rates had declined, maternal mortality rates were still among the highest in the world; 1 out of 21 African women die as a result of pregnancy or childbirth. Fertility levels were above six children per woman. Furthermore, hazardous practices were current in the region such as early marriage and pregnancy, female circumcision and food taboos. The importance of education was re-emphasized by Susan Mubarak, First Lady of the Arab Republic of Egypt [46]:

"Education is a basic tool which equips women to fulfil their duties as wives, mothers, and partners in development. Education mobilizes the untapped resourcefulness of women in order for them to contribute most effectively to their surroundings. Schooling imparts knowledge and skills and brings about new, positive attitudes towards the welfare of the society."

J. Maud Kordyias, in her paper at the Abuja conference, supported the view that the agrarian crisis in Africa was due to the lack of historical perspective and to a blatant disregard for local knowledge. She argued that successful maintenance of a high population density depends on a production system in which environmental management, social institutions and

agrarian practices are intimately linked. African traditional agriculture had once included all these elements, but the fact had been ignored [46].

The delegates in Abuja noted that numerous non-governmental organisations (NGOs) UN agencies and regional institutions were making invaluable contributions towards realizing the Arusha and Nairobi objectives. To further accelerate progress towards the socio-economic transformation and recovery of Africa, a major shift in policy was required. With that in mind, the Abuja conference put together a declaration entitled the "Abuja Declaration on Participatory Development: the role of Women in Africa in the 1990s." The Drafting Committee chaired by Elise Therese Gamassa of Congo used a pragmatic approach and substantially revised the draft written by the secretariat. As a result the Abuja Declaration is unique; its objectives touch upon all pertinent issues and are clearly defined [46].

On a broader scale the Abuja Declaration deplored Africa's internal strife and urged governments to put an end to civil wars and the abuse of human rights. It also appealed for greater co-operation between government-sponsored organisation on the one hand the NGOs on the other.

Two important subsequent documents issued by African leaders endorsed the Abuja Declaration.

(a). The African Charter for Popular Participation in Development and Transformation (Arusha 1990). It stated that in monitoring popular participation: "We proclaim the urgent necessity to involve the people in Africa on the basis of agreed indicators." One of the indicators would be the 'extent of implementation of the Abuja Declaration on Women (1989) in each country.'

(b). The Kampala Document Towards a Conference on Security, Stability, Development and Co-operation in Africa (May 1991):
Africa's development in all aspects cannot be assured without the full involvement of women in decision-making processes at all levels and their full access to all factors of production (land, labour, capital). This calls for appropriate policies and implementation of strategies at the national, institutional and regional levels. Specifically, we call for the early implementation of the African Declaration on the Advancement of African Women, notably the Abuja Declaration, and the Arusha and Nairobi Forward-Looking Strategies.

Other recent conferences held to promote women's development include the Earth Summit in Rio De Janeiro in 1993, the International Conference on Population and Development (ICDP) in Cairo in 1994, the Social Summit in Copenhagen in 1995 and the epoch-making 4th World Conference on Women in Beijing, China also in 1995, which marked 20 years of the women's decade. Out of that conference came the Beijing Declaration and the Platform for Action (PFA) - an all important blue print endorsed by most countries present as strategies to be adopted for women's advancement [46,85].

Back home in Nigeria, efforts are being made for the implementation of the PFA by both government and non-governmental organisations (NGOs). For government, the Ministry of Women Affairs and Social Development as well as the Family Support Programme (FSP) serves as focal points. Women activists feel that action on the part of government regarding women's empowerment is very slow and still lacks tokenism, particularly in the area of public life and governance [46].

They have at various times called on government to be more alive to its responsibilities as regards its commitment to the PFA to which it is a signatory. It is believed that not until women find themselves in strategic positions can they begin a gradual policy change that would improve their status. Some NGOs have been effective in the PFA implementation. They have been working mostly in the area of gender sensitisation and enlightenment, which has helped to motivate women to challenge the age-long discrimination, that has held them back.

The struggle is still on, with society gradually shifting from the position where women are expected to "listen and obey" to where they can foresee, deliberate and decide."

Role Of The Nigerian Women

Examining how far the Nigerian women had come in respect of their empowerment, Mrs. Agbeke Ogunsanwo, Director General, cabinet office, Lagos states says: "Nigerian women have indeed come a long way, but I believe the sky is the limit for them. The International Women's Day, shall be a day for sober reflection - a brain storming session where we should be asking ourselves the questions: Where do we go from here?" [6,7,24].

"When we look back or even look at the present, we should give ourselves a pat on the back, to see how far we have fared in positions of authority. We have women breaking through in nearly all professions. We have more enrolment of girls in schools than boys in certain states. As I was looking through the register of those who have finished the National Youth Service Corp (NYSC) in Lagos State, I noticed the number of females almost tripled that of men. This shows that women are getting educated."

Ogunsanwo noted however, that women are still to make a break through in the area of politics. This is where women have to work harder she said. "Women just have to cultivate the habit of supporting women in politics. There should be a re-orientation and re-awakening in women as to the need to have that family support for their fellow women rather than being envious of them."

For Chief (Mrs.) Funke Akinkugbe, a lawyer and president of the Women's Network Caucus, (WNC), education is a tool for Nigerian women's empowerment. She expatiated that "We in WNC believe nothing much can be achieved if we still lag behind in education. Nigerians boys and girls should be educated up to the highest level and Nigerians who have missed out on early education should have access to adult literacy education and skills" [51,92,95].

She continues "It should be a crime not to send your child to school. Education should be compulsory and affordable and this will no doubt assist in the eradication of child labour, child marriage and arrest juvenile delinquency. Education will help to eradicate many obnoxious customs and practice e.g. widow-hood rites. Education will assist the people in improving their awareness towards good health and better family life" [6,7,80,89,92,94,95,105,106].

Akinkugbe said that would give women an option, a choice in life. Option as to values and skills, which will assist in lessening number of women in drug, related crimes. Education will assist in introducing flexible working hours for women, which would assist in achieving a better home life.

"Nursery schools should be attached to all public places, markets, factories, hospitals, schools, offices, churches, mosques, etc., as this would enhance the productivity of employees and lessen the stress in the life of everyone."

Mrs. Obiageli Obiora is of the opinion that for the future to hold any meaning for women's empowerment, sensitisation and reorientation have to begin at the home. "We need to do away with stereotyping. And lastly, women themselves need re-orientation in not seeing themselves as second class citizens" [6].

"We need attitudinal change to eradicate some of these cultural practices that are perpetrated by the women themselves."

Miss Patricia Kanebi, a senior matron at Eko Hospital Lagos, sums up women's empowerment so far as "a gradual process that would need to break down all those barriers that prevent women from actualising themselves. "We have just moved a step forward. We should work harder at removing socio-cultural barriers in order to forge ahead."

"Women need education and economic empowerment in order to be able to make choice" [6,24].

Belinda Bobby Diei Vice President of Federation of International Women Lawyers International (FIDA), and Executive Director of Women Justice Programme (WJP), spoke with Igho Akenegha and Bunmi Dan-Ekhator in a recent article in the PM NEWS. Speaking on the rights of women, the Vice President of FIDA said: "Our position is that we are not trying to condemn Nigeria in terms of human rights violation because I know that even in the developed countries, there are human rights violations. But what we are saying is that my association is mainly focused on the rights of women and children. We are focussing on this area because the rights of men are protected in Nigeria. We believe that women have less protection and as such, we have to try our best to protect and promote the rights children and women [50,82].

What advice do you have for Nigeria Women?

Belinda Bobby Diei: The advice I have for Nigerian women is to try and support one another because one can easily see that women are their own enemy . . . I believe that if women work together given their large population, they will be able to make it. I also advice women to be more involved in decision making because if they are not involved, they won't participate in decisions that concern them and their children. If women were there when all these cultural laws and beliefs started, of course we would not allow issues like widowhood practices and all that. Women were not there when these decisions were taken. If they try to find their way to the highest decision making body, of course they will be there when laws are passed and if such laws are detrimental to the women, they will oppose it and do something about it. That is why it is important for women to participate in politics.

How will you describe the Nigerian woman of today?

Belinda Bobby Diei: The Nigerian woman of today is now aware of the fact she is a human being just like the man. The Nigerian woman of today has come to realise that she has potentials and could attain some very high positions quite unlike before. I can say that I'm impressed by the Nigeria woman of today. It's just that we still have some little hurdles to cross.

Feminist Movements

What then can women do to break away from the shackles of societal discrimination and traditional morality?

Mrs. Adenike Adeniran, Past President, Institute of Chartered Accountants of Nigeria (ICAN) says: "Solidarity among the women folk is the best way to dealing with the situation" [87].

When you find another woman in distress, whether you know her or not, you do what you can do to help. You encourage her, support her. It is like you are riding a bicycle and you fall. If you find someone to shake off the dust, you are able to bounce back and continue" [66,87].

"The days of women being a stumbling blocks to each other, or running themselves down should really be put behind us. The idea now must be collective struggle. Women must come together to support each other and propagate the ideals of womanhood [66,81,87,103].

The drive for equality and female empowerment has been a slow, sometimes frustrating, but nevertheless worthwhile journey. The experiences of womanhood in the process are rooted in a past that sometimes appears lost in history. It is in fact the story of the International Women's Day. In ancient Greece, Cysistrata was said to have initiated a sexual strike against men in order to end war. But the modern history of the Women's Day, which is marked worldwide on March 8, is traceable to Russia, again in circumstances of war. By 1917, two million Russian soldiers have been killed in World War I, and Russian women, brushing aside opposition by political leaders, choose the last Sunday in February to strike for "bread and peace." Four days later, the Czar abdicated and the provisional government granted women the right to vote [85,102,103]. The Sunday of the Russian Women's strike was February 23 on the Julian Calender, then in use in Russia, but was March 8 on the Gregorian calendar in use elsewhere. Indeed, as warmongers beat their drums on the eve of World War I, Russian women had, as part of the peace campaign, observed their first International Women's Day on the last Sunday in February 1913. By the following year, women held rallies on or about March 8 in Europe and elsewhere to protest the war and sue for peace. A chronology of antecedent events shows that the first National Women's Day was observed throughout the United States on February 28, 1909, following a declaration by the Socialist Party of America. In 1920, AMENDMENT 19 gave all women the right to vote. By 1910, over 100 women from 17 countries were among members of Socialist International who met in Copenhagen to establish a Women's Day to honour the movement for women's rights and press for Universal suffrage for women. On March 19, 1911, over one million women and men attended rallies in Austria, Denmark, Germany and Switzerland to mark International Women's Day. Among the demands on these historic occasions were the rights to vote and to hold public office, the right to work, the right to vocational training and an end to job discrimination. Six days later, the Triangle Fire ravaged New York City, killing more than 140 working girls, most of them Italian and Jewish. "This even," says a UNIFEM document, "had a significant impact on labour legislation in the United States, and the working conditions leading up to the disaster were invoked during subsequent observances of International Women's Day" [85].

The First Lady Mrs. Maryam Abacha hosted a Peace Summit of ECOWAS First Ladies sometimes in 1996, in Abuja [11,14,17,28,111].

In her words at the opening ceremony: "I am confident that our deliberations at this historic meeting will proffer useful recommendations on the issues of prevention of war and

conflict resolution as well as the management and alleviation of the sufferings of the victims of war and conflict in
Africa"

"As you are aware, our Continent has been ravaged by series of armed conflicts and wars since the 1960s. These wars have had a devastating effect on our populations particularly our women and children, who are the most vulnerable groups in situation of armed conflicts" [17,38,40,41,56].

"It is to address this situation that some of us who were in Beijing last September at the Fourth World Conference of Women, called for the establishment of an African Peace Mission with the objective of contributing to on-going efforts to bring peace to the region. Indeed, the formation of a Peace Mission in Africa is a practical demonstration of our commitment to the implementation of the Dakar and Beijing Declarations and Platform of Action (PFA) which had as their themes "Action for Equality, Development and Peace" [111].

" . . . As women, mothers, and wives, we have a compelling moral responsibility to bring about peace to our people and our land."

" . . . As women, we have a role to play and as First Ladies, we have more opportunities and greater responsibilities for hope peace, stability and progress in our continent. Let us use our position of influence and authority to work for peace in our land. Yes, we have a stake!"

"A stake in the future of our loved one. A stake in the future of our communities. A stake in the future of our countries and stake in the future of our continent" [111].

The Beijing Conference

Like other international conference of this nature, the Beijing Conference was an inter-governmental meeting convened by the UN. In addition to UN member states participants and observers included UN Agencies, inter-governmental organisations, NGOs in Consultative status with Ecosoc and those NGOs accredited by the Commission on the status of women [2]. It was held from August 30 to September 15 1995.

The Platform for Action (PFA), a blue print for women's advancement every where around the world was the main document considered and adopted at the World Conference on Women. The 362-paragraph draft document reflected the reviewed progress made by women since 1985 and lists 12 critical areas of concern. These were considered as constraints to the advancement of women. The draft PFA offered corresponding strategic objectives and actions to be taken by governments, the international community, NGOs and the private sectors for the removal of the constraints. The twelve critical areas of concerns were:

* The Persistent and increasing burden of poverty on women.
* Unequal access to or inadequate educational and training opportunities of good quality at all levels.
* Inequalities in health care and related services.
* All forms of violence against women (and the girl child).
* Effects of persecution and armed or other kinds conflict on women (in particular those living under foreign occupation on alien domination).
* Inequality in women's access to and participation in the definition of economic structures and policies and the productive process itself.

* Inequality between men and women in the sharing of power and decision-making at all levels.
* Insufficient mechanisms at all level to promote the advancement of women.
* Promotion and protection of all (universal) human rights of women.
* Women and the media.
* Women and the environment.
* Persistent discrimination against and violation of the rights of (survival, protection and development of) the girl child.

The issues for discussion during the conference were however, narrowed down to new or unfamiliar contentious issues such as sexual orientation and sexual rights, parental responsibilities and the burden of sharing the cost of implementation of the PFA.

The Final Platform For Action

The Beijing Declaration summed up the adopted Platform of Action which is a step forward in the spirit of the consensus developed in Cairo, and provides a tool for the implementation of the ICPD programme of Action and indeed other unfinished agreements. Highlights of the document include:

Strengthening The Rights Of The Girl Child

The human rights of the girl child are recognised as an inalienable, integral and indivisible part of all human rights and fundamental freedoms in the Beijing Declaration and Platform for Action. The document pays attention to both the current and future well being of girls by addressing their need for education and health care. This includes their right to access of information and services to enable them to develop positive, responsible attitudes to their sexuality and attain the highest standard of reproductive health. The rights of the child to privacy and confidentiality in this regard are recognised [4,5,31]. So also are the rights of parents and legal guardians to provide appropriate direction and guidance, which it is stressed should be consistent with the evolving capacity of the child and oriented to the best interest of the child. Harmful practices and attitudes which represent or lead to discrimination and violence against girls, such as son preference and female genital mutilation, are singled out for particular attention by governments, and international and non-governmental organisations. The general need for action to promote gender equality and shared responsibility between girls and boys in the family, also recognised is the Cairo document, is reinforced in the Platform. A significant breakthrough for the economic security of girls and women was achieved when governments agreed, for the first time in an international document of this nature, to enact and enforce legislation that guarantees an “equal right to succession and ensure equal right to inherit, regardless of the sex of the child.”

Reproductive And Sexual Health

The ICPD programme of Action was a ground breaking international consensus on the importance of reproductive health for the well being of women and population, as well as for

equitable and sustainable development. In Cairo, reproductive health was defined as including sexual health. The Beijing Platform for Action, while reinforcing and reaffirming the Cairo agreements, also managed to move forward the understanding of this central issue by recognising that women's rights and needs in relation to their sexuality can be separate and distinct from those which relate to reproduction. It also recognised that women's right to make decisions about their sexuality free from coercion, discrimination and violence, must be protected and respected.

Human Rights And Violence Against Women

One of the strongest messages of the Fourth World Conference on Women is that all women's right, including reproductive and sexual rights, are human rights. Governments declared their determination to ensure the full enjoyment of all human rights and fundamental freedoms by women and girls, and to take effective action against violations of these rights and freedoms. The Platform reaffirms that reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and includes the rights to make such decisions free from coercion, discrimination and violence. The document classifies female genital mutilation as violence against women and therefore a violation of their human rights. Strong condemnation is offered of violence against women in all contexts, including the situations of armed or other conflict. The document calls for education, sensitisation and preventive strategies among all sectors of the population, including adolescents, women and men, media personnel, and particularly all persons who may come into contact with victims of violence. Governments and local institutions are urged to support the potential role intermediate institutions such as health care or family planning centres in the field of information and education related to abuse.

Unsafe Abortion

The recognition of unsafe abortion as a public health concern in need of urgent attention was the focus of much controversy during ICPD. Governments negotiating in Beijing were able to use the language from Cairo as their starting point and, as a result, the issue did not take on a disproportional significance, which had been a grave concern of many observers. Further more, the language of the Platform for Action makes clear the connection between illegal and unsafe abortion. Recognising the role of national legislative processes in protecting the health and well being of women, governments are urged to "consider reviewing laws containing punitive measures against women who have undergone illegal abortion." It is hoped that this could lead to the removal of such statute [102].

Empowerment Of Women

The Beijing Platform For Action "an agenda for women's empowerment." While the Cairo Conference drew attention to the connection between women's empowerment and sustainable growth and development, it carefully framed references to reproductive rights in terms of "couples and individuals." It is appropriate that the Fourth World Conference on Women took a bolder stand in support of women's rights. The Beijing Declaration and the Platform For Action

both assert that "the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment."

Implementing The Beijing Platform For Action (PFA)

"It is strife that the relative disadvantaged position of women is the basis of the global movement aimed at securing an enhanced status and role for the women. The idea of the burgeoning movement assumes a deserving urgency in the face of conditions that are hardly conducive to female empowerment," says Noeleen Heyzer, Director of the United Nations Fund for Women (UNIFEM) [3,27,65,85].

According to Heyzer, "any development process that ignores the life chances of half the population cannot address the problem of poverty and the crisis of sustainability. It is a necessity that development fully incorporate an agenda for women's empowerment by including women's realities in the fullest sense."

Recently, in Abuja, women had cause to do some stocktaking on activities towards the implementation of the Beijing Platform For Action [11,57].

The workshop which was organised by the UNDP in collaboration with the Federal Ministry of Women and Social Development brought together the government NGOs and women leaders from across the country to among other things; facilitate, exchange and analysis of efforts by a wide spectrum of women to implement the PFA with respect to the 12 critical areas of concern, identify and refocus on areas that need more concerted action in future, assess impact of implementation at different levels with regard to publicity and advocacy; grassroots level and action - oriented implementation with respect to poverty alleviation, increase cost-effective use of scarce resources by reducing/eliminating duplication of efforts and or excessive focus on one area to the neglect of other areas and also to provide comprehensive data on the progress of implementation.

This data bank is to facilitate more effective co-ordination and refocusing of efforts by the Federal Ministry of Women Affairs and Social Development as well as future compilations of country reports and more effective country imputes at future regional and global reviews of the status of advancement of women through the PFA implementation.

Dr Babasola Chinsman, UNDP's resident representative was happy to note the concerted efforts by all women's groups, government and international agencies to ensure the successful implementation of the PFA. He said the UNDP had set aside 54 million dollars for women related projects as a mark of its commitment to women's empowerment [11].

The director of the Family Support Programme in the Women Affairs Ministry, Dr. Safiya Mohammed urge the women to come up with a national document on how far they had gone with the PFA, identify the gaps and come with strategies on which way forward.

Participants took up the challenge and broke into groups to compile actions taken so far in implementing the PFA. Gaps in implementation were identified. At the end of the two days workshop, group reports covering the following critical areas of concern were presented.

**** Women in decision-making and Public life: -**

It was observed that the transition to democracy was on and would be an opportunity to monitor women's progress in politics. It was noted that there had been an unequal representation of women in public life, which needs to be redressed.

Although prior to Beijing, only three per cent of women were represented in decision-making positions, which had now increased, to seven per cent, women insist that 40 per cent of women as stipulated in the PFA should be the target.

Actions taken so far have been geared towards mobilisations through awareness creation and sensitisation. These include production of radio jingles, rallies and public enlightenment workshops to encourage women's participation in politics, formation of a coalition of NGOs whose ideas culminated in the production of "A political Agenda For Nigerian Women by an NGO, Gender and Development Action (GADA)." The document serves as a blueprint for women's political empowerment.

Gaps in implementation include financial constraints for women interested in politics and the need for more male involvement in future endeavours. It was also agreed that there was a need to lobby government to be more alive to its responsibilities to women.

**** Women and Health/Girl Child: -**

It was noted that the available health structures leave much to be desired. There are mal-distributed and ill-equipped health facilities, poor staffing, no drugs and poor accessibility due to bad roads.

The problems are quite similar both in urban and rural areas with private hospitals being too expensive. Health personnel tend also to concentrate more in the urban areas whereas the rural populations are more in need of the health centres. Efforts so far are being made to train more health personnel for the rural areas and to provide incentives to attract them to such areas [18,19,20].

A slight decrease in maternal mortality had been recorded. But more needs to be done to further improve the situation. The problem of the girl child had always been that of low status, discrimination from birth as well as poor nutrition. Concerted efforts have been made to address these problems. Among these is a national research being undertaken by UNDP and the Women Affairs Ministry in 31 states of the Federation on harmful traditional practices on the girl child.

There is also a need for mass education for both men and women in sensitising them that health is wealth.

**** Women and Poverty Alleviation: -**

Feminised poverty has always been the bane of womanhood. Women, particularly the rural poor, have no access to credit facilities or income of their own. Efforts have been geared towards women's economic empowerment - such as provision of access to economic resources e.g. credit facilities and establishment of cottage industries. Government's provision of #54 billion to a new poverty alleviation programme - Family Economic Advancement Programme (FEAP) was commendable.

It was noted that there's need for government to review laws that militate against women's advancement and international conventions signed by government should be incorporated into our local laws.

** **Violence against women and human rights: -**

Domestic violence, rape, sexual harassment, abuse and forced prostitution have been identified as forms of violence against women in Nigeria. It was noted that there is a need to re-orientate society towards the issue of violence against women and to recognise that women's rights are human rights. Efforts are on to collate and document incidences of violence against women, review of customary laws, and pegging of marriageable age of girls to 18.

** **Women and the media: -**

Negative portrays of women in the media and their lack of access to information was identified. It was also recognised that not many women are in decision making positions in the media and where they are, they are not too gender sensitive. **What needs to be done to address these?** It was agreed that women journalists should be encouraged to go into mainstream journalism and more of them should go into media ownership business where they can influence positive reportage of women.

There is a need for gender sensitisation of men in the media and gender-sensitised men should be identified and encouraged. The National Broadcasting Commission (NBC) should be more alive to its responsibilities in censoring videos that portray women in negative light.

** **Women and Armed Conflict: -**

The important role of women in conflict resolution was acknowledged. In respect of this, government has appointed women into the National Implementation Committee. It also observed that 22 women were appointed into the Tiv Traditional Council to assist in conflict resolution. First Lady, Mrs. Maryam Abacha hosted a peace summit of African First Ladies as part of her programme as Chairperson of African First Ladies Peace Commission to which she was elected in Beijing.

** **Education: -**

Emphasis is being put on the education of the girl child. Lobbying is on to prohibit the withdrawal of girls from schools for marriage. Some states like Adamawa are already implementing this. It was also agreed that there should be a curriculum on gender studies in institutions and local scholarships should be awarded to females to encourage women.

** **Women and the Environment: -**

It was noted that not many NGOs are involved in this area and government has done poorly too in the area. It was agreed that more resources need to be pumped in this area and people need to be enlightened on waste management.

Summit Of African First Ladies

The three days African First Ladies Summit on Peace ended on the 7th of May 1997, with a call on African countries to establish a political quota system which allocate specific percentage of seats in civil and government structures to women [13,14,15,17,28,29,30,31,55,58,59,61, 62,63,65,81, 88,89].

In one of its documents titled: "The Political, Economic and Social Empowerment of Women," the Summit called for repeal of laws which discriminate against women such as inheritance, family and work related matters.

They also advocated the enforcement of laws, which could be favourable to women if implemented, as well as institutionalising legal awareness programmes so as to empower women with knowledge of their rights under existing laws.

By being provocative, the first ladies said government structures could identify employment and income generating opportunities to assist women to gain equal access to essential information and resources.

In a document titled: "Draft Abuja Declaration", the summit also agreed to initiate and promote programmes for the economic empowerment of women, encourage the introduction of peace education in primary and secondary school curricula.

It was observed at the conference that the North African First Ladies were absent from the summit. There were no explanations on the absence of the Afro-Arab First Ladies. But agency reports indicated that their absence might be as a result of the non-involvement of the First Ladies from the Arab part of Africa in politics [110].

Observers disclosed that their non-involvement in similar summits in future might be a cultural problem which participants in the conference may have to face.

Note:

1. Criminal Code Act of 1 June 1916 (The Laws of the Federation of Nigeria and Lagos Rev. 1958, Vol. 2, Cap. 42), Sections 227-229. Northern Nigeria: Sections 241 and 247.

2. The law of Northern Nigeria, Section 232, also provides that a fine may be substituted for the sentence or added to one. Lagos, Eastern and Western Nigeria: Sections 228.

3. Northern: Section 232, which provides that a fine may be substituted for or added to the term, Lagos, Western, Eastern: 229, seven years.

4. Lagos, Western, Eastern: Section 230.

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METHODOLOGY (Data and Operationalisations)

The purpose of this chapter which represents the final output of this project, is to further the understanding of conditions affecting women and the quality of life of childhood marriage and teenage pregnancy and fertility behaviour through a systematic analysis of its determinant, using roughly comparable data available from the World Fertility Survey (WFS) programme, the Nigeria Demographic Health Survey (NDHS) and data from other sources.

In the decade between the two major population conferences, held at Bucharest in 1974 and at Mexico city in 1984, there was an explosion of information on fertility from every region of the world, largely generated through the special surveys conducted under the auspices of the World Fertility Survey (WFS) programme. This international survey programme was developed in collaboration with the United Nations and in co-operation with the International Union for the Scientific Study of Population and was run under the aegis of the International Statistical Institute. Its objectives was defined as being "to assist a large number interested countries, particularly the developing countries, in carrying out nationally representative, internationally comparable, and scientifically designed and conducted surveys of human fertility behaviour" [5].

Most of the study of the WFS on 38 developing countries fairly evenly divided between Africa, Latin America the Caribbean, Asia and Oceania including the NDHS, were aimed at gathering reliable information on fertility, family planning, infant and child mortality, maternal care, vaccination status, breast feeding, nutrition, women employment and fertility, level of education, marital status, socio-economic characteristics and patterns of teenage marriage and maternal mortality and morbidity etc [5,7].

The 13 African countries that participated in the WFS programme were Benin, Cameroon, Côte d'Ivoire, Egypt, Ghana, Kenya, Lesotho, Mauritania, Morocco, Nigeria, Senegal, Sudan and Tunisia. In the case of Sudan, the survey was conducted only in the northern part of the country. Although the WFS programme began in 1973 and ended in 1984, African countries joined the programme rather late, with the result that most of the analytical reports were not completed by the end of the programme. This limited the number of comprehensive studies on the African countries that participated [5]. However, certain organizational constraints as well as timing considerations prevented the inclusion of data from all countries. In the African region, data from Nigeria had to be excluded because they were not available at the time of tabulations. Data from the Nigeria Demographic Health Survey (NDHS) were adopted and used in this case.

The Nigeria Demographic Health Survey (NDHS) [7]

The 1990 Nigeria Demographic and Health Survey (NDHS) is a nationally representative survey conducted by the Federal Government of Nigeria, represented by the Federal Office of Statistics (FOS), and U.S. Agency for International Development (USAID). The survey was funded by USAID and the Nigerian Government; it was carried out by the FOS with technical support from IRD/MACRO International Inc. Located in Columbia, Maryland. According to the NDHS, fertility remains high in Nigeria; at current fertility levels, Nigerian women will have an average of 6 children by the end of their reproductive years. The total fertility rate may actually be higher than 6.0, due to under-estimation of births [7]. In a 1981/82 survey, the total fertility rate was estimated to be 5.9 children per woman.

One reason for the high level of fertility according to the survey is that use of contraception is limited. Only 6 per cent of married women currently use a contraceptive method (3.5 per cent use a modern method, and 2.5 per cent use a traditional method). Knowledge of contraception remains low, with less than half of all women age 15-49 knowing any method.

Another factor leading to high fertility is the early age at marriage and childbearing in Nigeria. Half of all women are married by age 17 and half have become mothers by age 20. More than a quarter of teenagers (women age 15-19 years) either are pregnant or already have children.

Women who are from urban areas or live in the South and those who are better educated want and have fewer children than other women, are more likely to know of and use modern contraception. For example, women begin child bearing several years later than women in the North. In the North, women continue to follow the traditional pattern and marry early, at a median age of 15, while in the South, women are marrying at a median age of 19 or 20. Teenagers in the North have births at twice the rate of those in the South. Twenty births per 100 women age 15-19 in the North compared to 10 births per 100 women in the South. Nearly half of teens in the North have already begun child bearing, versus 14 per cent in the South. This results in substantial lower total fertility rates in the South. Women in the South have, on average, one child less than women in the North (5.5 versus 6.6). The survey also provides information related to maternal and child health. The data indicate that nearly 1 in 5 children dies before their fifth birthday. Of every 1,000 babies born 87 die during their first year of life (infant mortality rate). Mortality is higher in rural than urban areas and higher in the North than in the South.

Preventive and curative health services have yet to reach many women and children. Mothers receive no antenatal care for one third of births and over 60 per cent of all babies are born at home. Only one third of births are assisted by doctors, trained nurses or midwives.

Women and children living in rural areas and in the North are much less likely than others to benefit from health services. Almost four times as many births in the North are unassisted as in the South.

Age at Marriage and First Child Birth

There was no consensus in the study communities on the ideal age at marriage. The common feature among the response is that a woman is old enough for marriage when she is old enough to bear children. The practice of child marriage in the past rendered this conclusion incorrect [11]. With child marriage, the young wife was expected to stay with the mother-in-law for grooming and until she was fully matured for child bearing although this may not be the case in many areas.

Men were traditionally more mature than the women at marriage and were expected to have proven financial capability before taking a wife. While urban respondents emphasized the completion of higher education before getting married nowadays, in the villages and rural areas, the respondents considered ones' financial capability as a sufficient factor for marriage [11]. The conclusion is that it is difficult to fix the age at which people should marry now since marriage processes are changing. . .children these days bring their future partners to parents as

against the traditional practice of having mates selected by the parents. The girls, on their part are said to be involved in earlier sex these days than in the past.

It was noted that in the past women married early and begets children to avoid being exposed to immoral values. The respondents suggested that in the modern day Nigeria, women should start procreation at about 21-23 years. In spite of this suggestion, they contended that a women who at the age of 25 years and has not put to bed attracts uncomplimentary comments [11]. There are no upper age limits for procreation although respondents suggested 45-65 for women and 50-85 for men. It was noted that a man normally stops procreation whenever he feels weak to perform. Educated respondents, however, agreed that women who have reached 45 years of age should stop procreation to avoid birth complications. A woman remarked, for instance, that:

"If a woman notices that her children have started child bearing, she should stop so that her grandchildren might enjoy her as a grandmother."

Family Sizes Desires and Sex Preference

There appears to be no limit to the number of children a man can have as this is mostly determined by wealth and financial capabilities. The Efiks' would say *"Eyen ikemke owo"* (children are never enough for a man), while a Yoruba adage says 'one do not count children'.

The desire to have large family sizes is gradually declining among several segments of the population and this is mostly due to the present economic situation in the country and unless adequate steps are taken, there is the possibility of a reversal once the economy picks up again.

The new feelings in favour of the small family norm are threatened by some fears about child survival. The Efik believe that it is a great risk to have few children in the face of high child morbidity and mortality [11].

Although people indicated their preference for small families, a woman with one or no child, or who is known to be practicing family planning is also not appreciated and single parenthood are discriminated against and children born out of wedlock are also called derogatory names.

The preference for the male child is still very strong. In some communities the male child is described as the "tap root" in the family, while some described the male child as the "corner stone" of the family since he carries on the reproductive activities that help to increase the family lineage. The female child is described as *"ukana"* (oil bean seed) which can be scattered to any direction of the globe. The preference for male children as well as the other values and beliefs about children help to sustain the large family norms among the populace.

1. LEVELS AND TRENDS IN FERTILITY

A. Fertility

In the fertility measures based on the reported reproductive histories of women aged 15-49 interviewed in the NDHS, each woman was asked the number of sons and daughters living with her, the number living elsewhere, and the number who had died. She was then asked for a history of all her births, including the month and year each was born, the name, the sex, and if deceased, the age at death, and if alive, the current age and whether he/she was living with the mother. Based on this information, measures of completed fertility (number of children ever born) and current fertility (age specific rates) was examined [7].

Current Fertility

The current level of fertility is important because of its direct relevance to population policies and programme. Three-year age-specific fertility rates are presented in Table 9.1. Three year rates are calculated as a compromise between three criteria: to provide the most current information, to reduce sampling error, and to avoid problems noted in previous surveys of the displacement of birth from five years preceding the survey to six years (NDHS).

TABLE 9.1 Current Fertility

Age-specific and cumulative fertility rates sand the crude birth rate for the three years preceding the survey, by urban-rural residence and region, Nigeria 1990.

	Residence		Region		
Age group	Urban	Rural	Northeast	Northwest	Southeast
Southwest	Total				
15-19	0.093	0.166	0.224	0.194	0.106
0.074	0.146				
20-24	0.199	0.280	0.280	0.281	0.256
0.210	0.258				
25-29	0.255	0.265	0.237	0.274	0.268
0.270	0.263				
30-34	0.233	0.219	0.221	0.229	0.220
0.211	0.220				
35-39	0.145	0.164	0.140	0.156	0.162
0.176	0.159				
40-44	0.057	0.100	0.129	0.134	0.053
0.078	0.092				

45-49		0.034	0.071	0.075	0.061	0.050
	0.073	0.064				
TFR	**15-49**	**5.033**	**6.326**	**6.532**	**6.645**	**5.573**
	5.461	**6.011**				
TFR	**15-44**	**4.865**	**5.970**	**6.155**	**6.339**	**5.322**
	5.095	**5.691**				
GFR		**0.172**	**0.213**	**0.223**	**0.229**	**0.188**
	0.173	**0.203**				
CBR		**34**	**40**	**39**	**46**	**37**
32		**39**				

TFR: Total Fertility rate expressed per woman
GFR: General fertility rate (births divided by number of women 15-44), expressed per 1,000 women
CBR: Crude birth rate, expressed per 1,000 population
Note: Rates are for the period 1-36 months preceding the survey. Rates for age group 45-49 may be slightly due to truncation.

Source: NDH

Numerators of the age-specific fertility rates in Table 9.1 were calculated by isolating live births which occurred in the 1-36 months preceding the survey, (determined from the date of interview and date of birth of the child), and classifying them by the age (in five-year age groups) of the mother at the time of birth (determined from the date of birth of the mother). The denominators of the rates are the number of woman-years lived in each of the specified five-year age groups during the 1-36 months preceding the survey.

There are two regionally distinct patterns of fertility: that of the North and that of the South. During the central childbearing years (25-39), women tend to bear children at about the same rates in the North and the South. It is during the early and late childbearing years that differences are evident. In the teenage years, women in the North have children at twice the rate of women in the South (on average, each, 1,000 women age 15-19 in the South will give birth to 100 babies, while 1,000 women age 15-19 in the North will give birth to 200 babies). Women in the North achieve their peak fertility in their early twenties, while women in the South reach their highest fertility in their late twenties. In their early 40s, women in the North continue bearing children at twice the rate of women in the South [7].

The sum of the age-specific fertility rates, i.e., the total fertility rate (TFR), was used to summarise the current level of fertility. It can be interpreted as at the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the currently observed rates. If fertility were to remain constant at current levels, a Nigerian woman would give birth to an average of six children. The higher fertility of women in the North results in a total fertility rate, which is one child greater than that of women in the South (6.6 versus 5.5).

The Crude birth rate (CBR) was estimated from the history data and the age-sex distribution of the household population. Overall, there were about 39 births per thousand populations over the last three years, according to the NDHS.

Fertility trends were analysed in two ways. One was to compare the NDHS data with previous surveys.

Table 9.2 compares three-year total fertility rates as estimated by NDHS and NFS. The two surveys, nearly a decade apart, yielded almost the same total fertility rates. (5.9 for the NFS and 6.0 for NDHS); however, estimates vary greatly for subgroups of the population.

TABLE 9.2 Fertility by background characteristics

Total fertility rate for the three years preceding the survey and mean number of children ever born to women age 40-49, by selected background characteristics.

Background characteristic	NDHS Total fertility rate[1]	NDHS Mean number of children ever born to women age 40-49	NFS Total fertility rate[1]	NFS Mean number of children ever born to women age 40-49
Residence				
Urban	5.03	6.01	5.79	4.81
Rural	6.33	6.61	5.98	5.56
Region				

Northeast		6.53	5.75	5.95
4.34				
Northwest		6.64	6.21	6.38
6.53				
Southeast		5.57	6.99	5.72
6.53				
Southwest		5.46	6.84	6.25
5.30				
Education				
No education	6.50	6.41	6.14	
5.45				
Some primary	7.17	7.38	6.81	
5.99				
Completed primary	5.57	6.54	7.59	
5.71				
Some secondary		5.07	6.44	3.90
4.31				
Completed secondary/higher		4.18	5.82	NA
NA				
Total		6.01	6.49	5.94
5.41				

NA = Not applicable
1. Rate for women age 15-49 years

Both surveys indicated that the fertility of uneducated women is fifty per cent higher than the fertility of the most educated women.

Fertility trends were also estimated based on NDHS data alone. Table 9.3 shows the age-specific fertility rates for four-year periods preceding the survey

TABLE 9..3 Age-specific fertility rates

Age-specific fertility rates (per thousand women) for four-year periods preceding the survey, by mother's age at the time of birth, Nigeria 1990.

	Number of years preceding the survey				
Mother's age	0-3	4-7	8-11	12-15	16-19
15-19	144	178	166	179	168
20-24	267	297	321	288	250
25-29	274	316	326	309	[286]
30-34	228	261	287	284	[280]
35-39	162	210	[237]	[253]	--
40-44	95	[119]	[188]	--	--
45-49	[67]	[110]	--	--	--

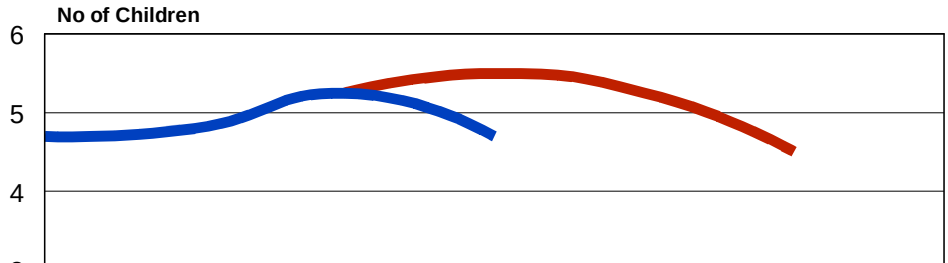
Note: Age-specific fertility rates are per 1,000 women. Estimates enclosed in brackets are truncated

Source: NDHS

The data in Table 9.3 along with similar data from the NFS were plotted in Figure 9.1. Figure 9.1 shows the trends in the total fertility rate based on estimates from the NFS and the NDHS.

Figure 9.1

Trends in the Total Fertility Rate Women 15-34, NFS NDHS Surveys



Children Ever Born and Living

The distribution of women by number of children ever born is presented in Table 9.4 for all women and for currently married women. The mean number of children ever born for all women increases rapidly with age so that by the end of her childbearing years, a woman has given birth to almost seven children. The distribution of women by number of births indicates that almost one quarter of teens have already borne a child, and nearly one-third of women age 45 and over have borne nine or more children.

Birth Intervals

There had been a fair amount of research to indicate that short birth intervals are deleterious to the health of babies. This is particularly true for babies born at intervals of less than 24 months. Table 9.5 shows the per cent distribution of births in the five years preceding the survey by the number of months since the previous births. Over one-quarter of births were born after an interval of less than 24 months. The median birth length (30 months) in only six months longer than the minimum considered safe.

TABLE 9.4 Children ever born and living

Percent distribution of all women and of currently married women by number of children ever born (CEB) and mean number ever born and living, according to five-year age groups and regions, Nigeria 1990.

	Number of children ever born (CEB)												
	Number of women	Mean CEB	Mean no of living children	0	1	2	3	4	5	6	7	8	9	10+	Total
ALL WOMEN															
Age															
15-19	1,612	0.3	0.3	76.5	17.3	5.0	0.8	0.3	0.0	0.0	0.0	0.0	0.0	0.0	100.0
20-24	1,676	1.4	1.2	32.3	24.7	21.9	11.4	7.9	1.1	0.6	0.2	0.0	0.0	0.0	100.0
25-29	1,669	3.0	2.4	11.3	12.9	17.8	20.3	15.3	13.1	6.5	1.8	0.6	0.2	0.3	100.0
30-34	1,410	4.6	3.7	4.1	5.2	9.7	12.6	16.6	16.9	14.4	10.7	6.2	2.8	0.8	100.0
35-39	954	5.5	4.3	4.5	2.7	6.7	7.2	14.0	12.5	14.5	13.9	11.3	6.1	6.5	100.0
40-44	836	6.3	4.8	4.6	3.9	4.2	7.7	7.9	9.5	11.3	13.0	14.9	9.4	13.6	100.0
45-49	624	6.8	5.1	4.0	3.9	3.9	6.1	5.9	8.9	9.4	12.4	14.0	10.8	20.6	100.0
Region															
Northeast	2,000	3.3	2.5	18.6	14.9	13.9	12.5	10.4	7.5	6.2	5.0	4.0	3.1	4.0	100.0
Noorthwest	2,098	3.4	2.6	16.4	14.6	13.5	12.5	11.2	8.5	6.3	7.7	4.6	1.9	3.1	100.0
Southeast	2,769	3.3	2.8	29.0	9.2	10.0	8.4	8.4	8.7	7.9	5.7	5.0	3.7	3.9	100.0
Southwest	1,915	3.1	2.5	31.9	10.8	8.6	7.7	9.8	8.6	7.1	4.3	5.5	2.1	3.6	100.0

Total	**24.2**	**12.1**	**11.4**	**10.2**	**9.8**	**8.3**	**7.0**	**5.7**	**4.8**	**2.8**	**3.6**	**100.0**
8,781	**3.3**	**2.6**										

CURRENTLY MARRIED WOMEN

Age

15-19	41.4	42.1	13.4	2.3	0.8	0.0	0.0	0.0	0.0	0.0	0.0	100.0
597	0.8	0.7										
20-24	15.6	29.6	27.8	14.7	10.1	1.3	0.8	0.2	0.0	0.0	0.0	100.0
1,279	1.8	1.5										
25-29	5.3	12.7	19.0	22.3	16.3	14.2	7.2	2.0	0.7	0.2	0.2	100.0
1,492	3.2	2.6										
30-34	3.5	5.1	9.8	12.4	16.5	16.7	14.6	11.2	6.4	2.9	0.8	100.0
1,348	4.6	3.8										
35-39	3.9	2.5	7.0	7.6	14.0	12.0	14.8	14.1	11.3	6.3	6.5	100.0
892	5.6	4.4										
40-44	4.7	4.2	3.9	7.9	7.8	8.7	11.1	13.6	14.7	9.4	14.0	100.0
731	6.3	4.8										
45-49	4.4	3.9	3.7	5.9	6.0	8.7	8.2	13.2	14.2	9.9	21.9	100.0
543	6.8	5.1										

Region

Northeast	13.9	15.6	14.8	13.2	11.2	8.0	6.5	5.2	4.2	3.1	4.1	100.0
1,849	3.5	2.7										
Northwest	11.1	15.6	14.0	13.3	11.9	8.8	6.8	8.3	4.9	2.1	3.4	100.0
1,944	3.7	2.8										
Southeast	6.4	10.7	14.6	12.0	10.9	11.2	10.6	7.9	6.3	4.7	4.9	100.0
1,801	4.4	3.7										
Southwest	5.8	13.9	12.0	10.9	14.0	11.9	10.0	6.2	7.7	3.0	4.8	100.0
1,287	4.3	3.5										

Total	**9.7**	**14.0**	**14.0**	**12.5**	**11.8**	**9.8**	**8.3**	**7.0**	**5.6**	**3.2**	4.2	100.0
6,880	3.9	3.1										

Source: NDHS

TABLE 9.5 Birth intervals

Percent distribution of births in the five years preceding the survey by number of months since previous birth, according to demographic and socio-economic characteristics, Nigeria 1990.

Characteristic	Numbers of months since previous birth 7-17	18-23	24-35	36-47	48+	Total	Number of births	Median number of months since previous birth

Age of mother								
15-19	16.8	28.4	38.4	10.4	6.1	100.0		25.2
120								
20-29	11.5	19.9	42.0	15.1	11.5	100.0		28.6
3,031								
30-39	8.2	16.3	42.0	16.3	17.3	100.0		30.9
2,761								
40+	6.8	12.7	32.0	17.6	30.9	100.0		36.4
813								
Birth order								
2-3	9.5	18.9	41.6	15.1	14.9	100.0		29.4
2,534								
4-6	9.5	17.5	40.0	16.5	16.6	100.0		30.7
2,709								
7+	10.3	16.1	40.5	15.8	17.4	100.0		30.7
1,481								
Sex of prior birth								
Male	9.6	18.1	41.1	15.6	15.8	100.0		29.7
3,332								
Female	9.7	17.4	40.4	16.0	16.5	100.0		30.6
3,393								
Survival of prior birth								
Living	8.7	16.9	40.8	16.6	17.1	100.0		30.9
5,808								
Dead	15.8	22.6	40.4	10.9	10.2	100.0		26.9
916								
Residence								
Urban	8.8	16.9	42.3	16.5	15.4	100.0		30.4
1,392								
Rural	9.9	17.9	40.3	15.6	16.3	100.0		30.1
5,333								
Region								
Northeast	9.4	17.2	37.4	17.0	19.0	100.0		31.1
1,576								
Northwest	9.5	17.5	40.7	16.8	15.5	100.0		30.8
1,847								
Southeast	11.7	18.7	43.9	12.9	12.8	100.0		28.6
2,049								
Southwest	6.8	17.0	39.6	17.7	18.9	100.0		31.5
1,252								
Education								
No education	9.1	16.9	38.8	16.6	18.6	100.0		31.2
4,445								

Some primary	10.3	18.1	45.6	15.8	10.1	100.0	29.0 692
Completed primary	9.4	19.1	44.7	15.2	11.7	100.0	29.1 941
Some secondary	14.5	18.7	45.6	9.3	12.0	100.0	27.2 319
Completed secondary/ higher	11.9	21.8	40.8	13.2	12.3	100.0	29.2 322
Total	**9.6**	**17.7**	**40.7**	**15.8**	**16.1**	**100.0**	**30.2 6,724**

Note: First-order births are excluded. The interval for multiple births is the number of months since the preceding pregnancy that ended in a live birth.

Age at First Birth

The age at which childbearing begins has demographic consequences as well as important consequences for the mother and child. In many countries, postponement of first births, reflecting an increase in the age at marriage, contributed greatly to overall fertility decline. Table 9.6 presents the distribution of Nigerian by age at first birth, according to their current age. One half of women became mothers before the age of 20, of which 10 to 12 per cent gave birth before age 15, and 21 to 28 per cent gave birth between age 15 and 17.

TABLE 9.6 Age at first birth

Percent distribution of women 15-49 by age at first birth, according to current age, Nigeria 1990.

Age at	Women with no	Median	Age at first birth			Number of
first						

Current age	births	<15	15-17	18-19	20-21	22-24	25+	Total	Women
15-19	76.5	5.6	14.7	3.1	NA	NA	NA	100.0	1,612
20-24 a	32.3	12.1	22.8	18.6	10.3	3.9	NA	100.0	1,676
25-29 19.7	11.3	9.6	25.5	18.8	16.0	15.1	3.8	100.0	1,669
30-34 19.6	4.1	12.3	27.6	17.5	14.1	14.2	10.2	100.0	1,409
35-39 19.1	4.5	9.4	23.4	16.3	17.0	12.4	17.1	100.0	954
40-44 20.1	4.6	12.1	22.9	14.1	14.5	14.0	17.8	100.0	836
45-49 20.1	4.0	9.5	21.2	18.0	13.1	13.3	21.0	100.0	624

NA: Not applicable
a: Less than 50 per cent of the women in the age group x to x+4 have had a birth by age x

Table 9.7 summarizes the median age at first birth for different cohorts and compares the entry age into parenthood for different subgroups of the population.

B. Adolescent Fertility

Recently, there has been a growing concern over the fertility of women under age 20 - adolescent fertility. High adolescent fertility is seen to have adverse effects on the health of teenage mothers and their infants, whether childbearing is within or outside marriage. An early start to childbearing may mean an interruption in education, resulting in low future income through lesser labour force options and larger completed family size. Data for developing countries show that levels of adolescent fertility are high compared with developed countries, although fertility among women aged 15-19 years appears to be declining in some countries. In a majority of countries, especially in Africa and in Latin America and the Caribbean, more than 10 per cent of the total fertility rate is contributed by women age 15-19; thus, women below age 20 are important contributors to total childbearing among all women [5].

TABLE 9.7 Median age at first birth

Median age at first birth among women age 20-49 years, by current age and selected background characteristics, Nigeria 1990.

Background Characteristics	Current age						Ages 20-49	Ages 25-49
	20-24	25-29	30-34	35-39	40-44	45-49		
Residence								
Urban	a	20.8		19.9	20.4	20.8	20.4	a
Rural	19.1	19.3		19.8	20.0	19.8	20.0	19.3
Region								
Northeast	17.5	18.0		17.6	19.9	20.7	22.4	18.3
Northwest	18.5	19.2		19.6	29.1	20.4	19.4	19.3
Southeast	a	20.0		19.5	19.9	18.6	19.4	19.9
Southwest	a	21.3		19.6	20.4	20.6	20.6	a
Education								
No education	17.8	18.2		18.5	20.0	20.2	20.0	18.8
Some primary	19.0	19.3		18.9	19.1	19.8	19.8	19.3
Completed primary	19.7	20.2		20.2	20.6	19.6	20.8	a
Some secondary	a		20.6	20.6	22.4	20.4	21.4	a
Completed secondary/ higher	a	a	23.3	21.3	22.1	23.3	a	24.5
Total	19.7	19.6		19.1	20.1	20.1	20.1	19.7

Note: The median for cohort 15-19 could not be determined because half the women have not yet had a birth.

a Medians were not calculated for these cohorts because less than 50 per cent of women in the age group *x* to *x + 4* have had a birth by age *x*.

Fertility rates among adolescents, who are defined in this study as women age 15-19 years, rise steeply across the age range (Table 9.8).

TABLE 9.8

AGE-SPECIFIC FERTILITY RATES FOR WOMEN AGED 15-19 FOR THE PERIOD

0-4 YEARS PRIOR TO THE SURVEY DATE, BY REGION AND COUNTRY
(PER 1,000 WOMEN)

Region and Country	Age					Age group 15-19 as percentage of total fertility rate
	15	16	17	18	19	
Africa						
Benin	45	69	128	190	286	10.6
Cameroon	105	134	183	244	274	14.6
Côte d'Ivoire	104	172	226	277	311	14.6
Egypt	23	52	105	142	196	9.4
Ghana	39	76	148	203	227	10.5
Kenya	48	129	207	243	284	10.8
Lesotho	13	51	102	154	226	8.8
Mauritania	90	112	175	184	233	12.4
Morocco	14	55	96	142	181	7.9
Senegal	78	162	187	268	266	13.1
Sudan	29	89	106	152	188	9.1
Tunisia	3	4	21	48	109	2.9
Average	**49**	**92**	**140**	**187**	**232**	**10.4**
Latin America and the Caribbean						
Colombia	22	59	95	161	194	10.7
Dominican Republic	34	76	122	194	206	10.8
Ecuador	21	60	113	154	183	9.7
Guyana	32	72	122	189	220	11.6
Haiti	13	24	50	97	107	5.2
Jamaica	54	110	170	200	248	14.7
Mexico	109	146	199	196	247	9.2
Paraguay	25	49	94	128	147	8.7
Peru	23	52	78	127	159	7.5
Trinidad and Tobago	23	38	75	117	149	11.5
Venezuela	39	50	111	139	168	10.6
Average	**36**	**67**	**112**	**155**	**184**	**10.0**
Asia and Oceania						
Bangladesh	**140**	**211**	**230**	**272**	**259**	**18.0**
Fiji	3	15	44	110	157	7.2

Indonesia		50	83	130	171	215		13.1
Jordan	29	80	125	216	256		8.1	
Malaysia		11	25	59	94	145		6.8
Nepal	29	76	130	181	220		10.9	
Pakistan		39	140	147	172	229		12.1
Philippines		8	17	53	82	122		5.1
Republic of Korea		0	2	8	22	40		1.4
Sri Lanka		4	17	30	65	82		5.1
Syrian Arab Republic	49		85	122	174	218		8.2
Thailand		13	35	68	105	142		7.4
Yemen	70	134	188	244	270		10.3	
Average	**34**	**68**	**103**	**147**	**181**		**8.7**	

Source: WFS

Adolescent fertility rates among African women were, on average, higher than among those in Latin America and the Caribbean and in Asia and Oceania. However, as in the case of fertility rates in other age groups, there is much variation within regions. Cameroon and Côte d'Ivoire had exceptional high fertility among women aged 15 and 16 years; and in these two countries, fertility rates were as high as 274 and 311 per 1,000 women, respectively, by age 19 [7]. In Latin America and the Caribbean and in Asia and Oceania, only Bangladesh, Jamaica, Jordan, Mexico and Yemen had comparable high rates among women aged 15 and 16 years.

Childbearing among adolescents (ages 15-19) contributes a sizeable percentage of childbearing, on average, about 10 per cent of the fertility rate.

Teenage Pregnancy and Motherhood

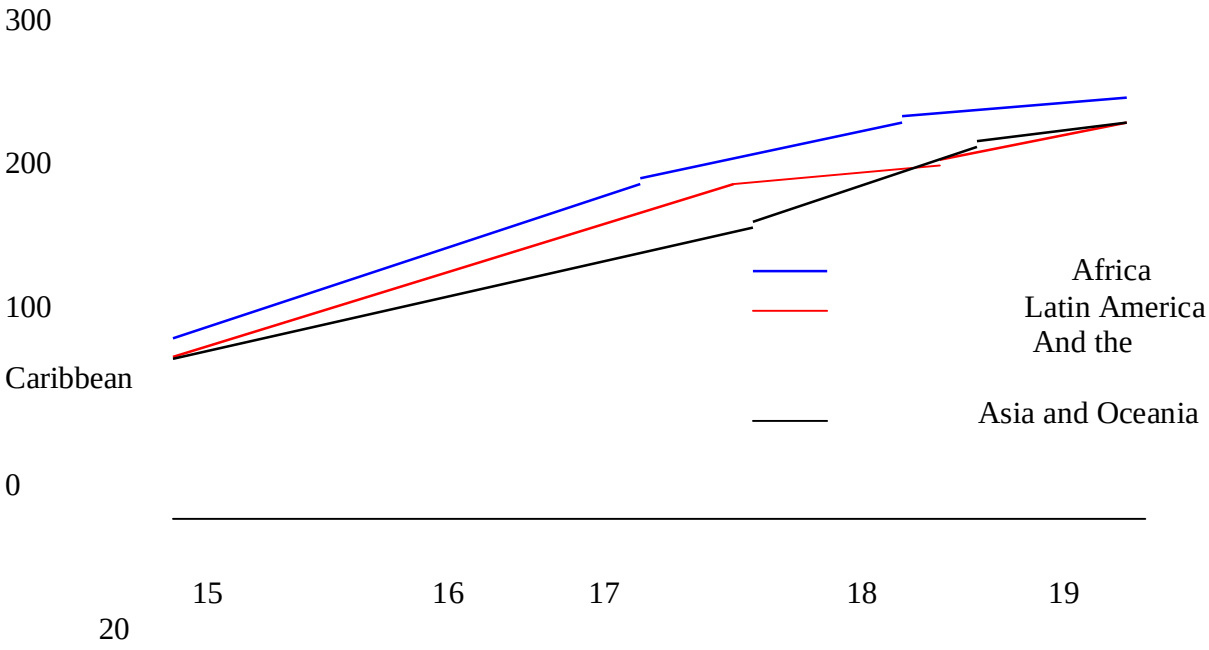
One of the targets outlined in the National Policy on Population is: "to reduce pregnancy to mothers below 18 years and above 35 years of age by 50 per cent by 1995 and by 90 per cent by the year 2000." Table 9.9 shows the percentage of women age 15-19 who are mothers or pregnant with their first child. About 40 per cent of teenagers 18 years of age have already begun childbearing (have already given birth, or are pregnant with their first child), and 30 per cent of teens 17 years of age. Attempts to reduce early childbearing need to target women in the North, where 48 per cent of teens have begun childbearing, compared with 14 per cent in the South.

FIGURE 9.2 Adolescent fertility rates, by age of woman and by region , level of development and strength of family planning programme effort.

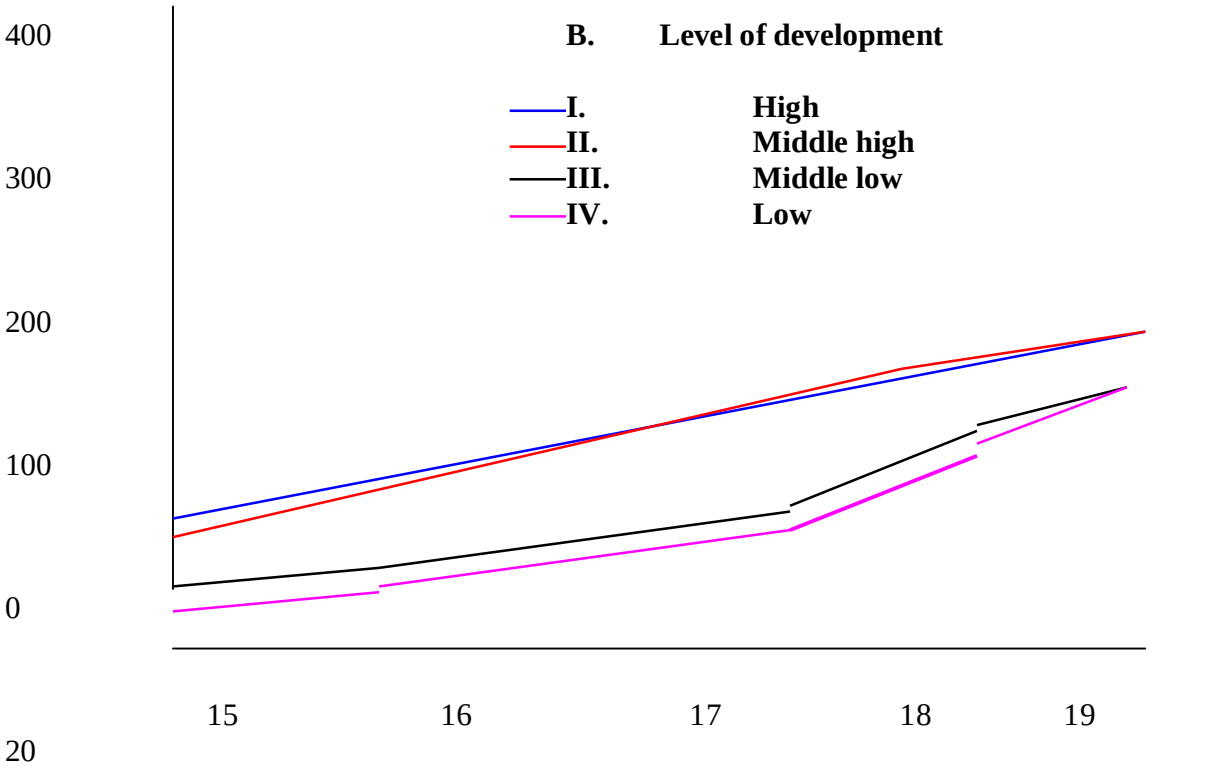
Rate per 1,000 women

400

A. Region



Rate per 1,000 women



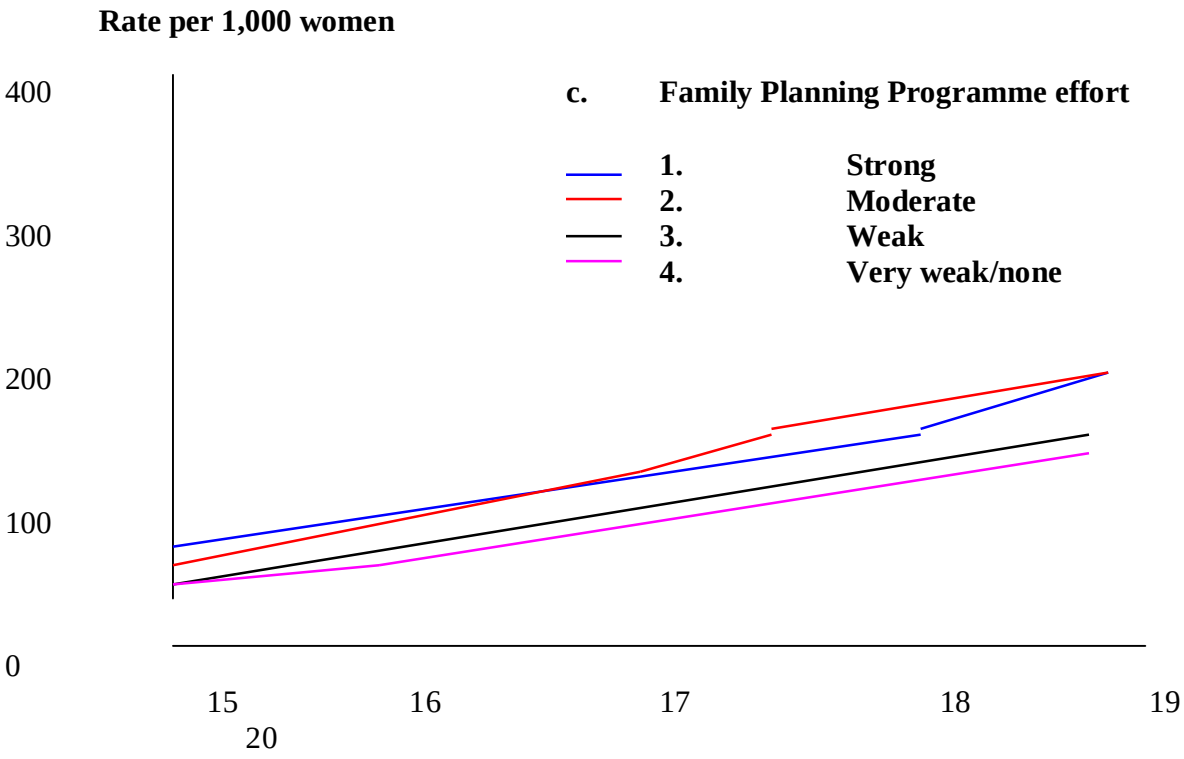


TABLE 9.9 Teenage pregnancy and mother

Percentage of teenagers 15-19 who are mothers or pregnant with their first child, by selected background characteristics, Nigeria 1990.

Background characteristics	Percentage who are Mothers	Percentage Pregnant with first child	Percentage who have begun child-bearing	Number of teenagers
Age				
15	9.3	3.9	13.1	373
16	14.9	5.9	20.8	322

17 326		24.7	5.5	30.2
18 333		34.4	5.0	39.3
19 259		39.0	3.8	42.8
Residence				
Urban 462		14.6	2.8	17.4
Rural 1,150		27.0	5.6	32.7
Education				
No education 545		43.4	8.6	52.1
Some primary 193		19.2	7.4	26.6
Completed primary 329	18.1		3.1	21.2
Some secondary 372	7.0		1.2	8.2
Completed secondary/higher 169	11.2		1.0	12.2
Region				
Northeast 352	39.5		10.7	50.2
Northwest 208	40.7		5.6	46.2
Southeast 570	13.9		2.9	16.7
Southwest 381	9.1		1.6	10.8
Total **1,612**	**23.5**		**4.8**	**28.3**

Source: NDHS

Figure 9.3 shows the percentage of teenagers who have begun childbearing (have already given birth, or are pregnant with their first child), by region. The differences between regions

are great: four times as many women age 17 in the Northeast have begun childbearing as in the Southeast.

Whereas most teens that have begun childbearing have given birth only once, small proportions have given birth twice. Table 9.10 shows the distribution of women are 15-19 by number of child ever born, excluding those who are currently pregnant. Eleven per cent of women age 18 have given birth to two children. By giving birth early and presumably with short birth intervals, these women and their children are at a higher risk of dying.

FIGURE 9.3
Percentage of Teenagers Who Have Begun Childbearing, by Region

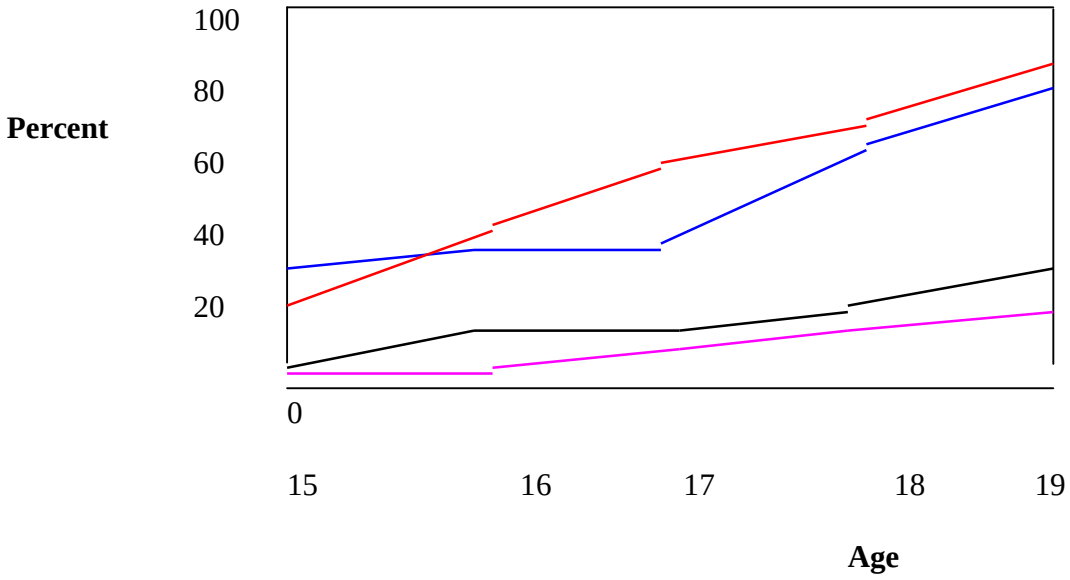


TABLE 9.10 Children born to teenagers

Per cent distribution of teenagers 15-19 by numbers of children even born (CEB), Nigeria 1990.

Age	Number of children ever born 0	1	2+	Total	Mean Number of CEB	Number of teenagers
15	90.8	8.4	0.9	100.0	0.1	373
16	85.1	13.6	1.3	100.0	0.2	322
17	75.3	17.7	7.0	100.0	0.3	326
18	65.6	23.8	10.6	100.0	0.5	333
19	61.0	25.8	13.2	100.0	0.6	259
Total	**76.5**	**17.3**	**6.2**	**100.0**	**0.3**	**1,612**

Source: NDHS

C. Fertility Preference

Preferred sex of next child

The question asked to obtain the respondent's preferences for the sex of her next child was, "Would you prefer your next child to be a boy or a girl?" Slight modifications in the wording were made if the respondent had no children or was pregnant at the time of the interview [5]. In all countries, this question was limited to currently married women who considered themselves fecund and who had expressed a desire for more children. Thus, women who did not want any more children were not asked about their preferences as to family composition. The findings with respect to this question are presented in Table 9.11. Responses to this question were grouped into three categories: "Prefer boy"; "Prefer girl"; and "Undecided". Included in this last category are women who said either sex were equally acceptable and women who could not (or did not) state a preference.

Son preference, as indicated by the much larger proportion of women who preferred sons over daughters, was found to be strongest in the Southern Asian countries Bangladesh, Nepal and Pakistan (in each country over 50 per cent of the women preferred son, compared with under 10 per cent who preferred a daughter) [5]; and in Jordan, Mauritania, the Republic of Korea and the Syrian Arab Republic (WFS). Daughter preference is evident only in Jamaica, where over 52 per cent expressed a desire for a daughter, compared with 31 per cent who wanted a son. Roughly equal preferences for sons and daughters can be found in several countries, most of which are in the Latin America and the Caribbean region. These countries include Colombia, Costa Rica, Panama, Paraguay and Ghana. From the regional point of view, son preference seems strongest in Asia and Oceania, where close to 50 per cent preferred son, compared with just 20 per cent who want a daughter.

A substantial proportions of women did not state a specific preference for the sex of the their next child and were coded as "undecided" in some of the regions. Among the families with more daughters, women tended to prefer a son. As in all-daughter families, this pattern appears universal.

TABLE 9.11

PREFERENCES FOR SEX OF NEXT CHILD AND PREFERENCE RATIO AMONG CURRENTLY MARRIED, FECUND WOMEN WHO WANTED ANOTHER CHILD.

Region and Country	Preference: Boy (percentage) (1)	Girl (Percentage) (2)	Undecided	Preference ratio (3)
Africa				
Benin	18.9	11.6	69.4	1.2
Cameroon	23.0	14.8	62.2	1.2
Côte d'Ivoire	23.6	17.2	59.2	1.1
Egypt	40.5	20.6	38.9	1.5
Ghana	32.9	34.4	32.7	1.0
Kenya	25.0	20.8	54.2	1.1
Lesotho	51.1	31.3	17.6	1.5
Mauritania	44.1	9.8	46.0	2.1

Morocco		26.1	17.7	56.1	
1.2					
Senegal		42.1	22.9	34.9	
1.5					
Sudan	41.8	22.3	35.9		1.5
Tunisia	29.0	17.5	53.5		1.3
Sub-Average	**34.1**	**20.6**	**45.3**		**1.4**
Latin America and the Caribbean					
Colombia		42.1	40.5	17.4	
1.0					
Costa Rica		31.6	32.5	35.8	
1.0					
Dominican Republic	46.8	39.4	13.8		1.2
Ecuador		41.9	32.8	25.2	
1.2					
Guyana		39.1	35.8	25.1	
1.1					
Haiti		24.8	28.8	46.3	
0.9					
Jamaica		31.1	52.2	16.6	
0.7					
Mexico		37.2	28.3	34.5	
1.2					
Panama		39.4	40.7	19.9	
1.0					
Paraguay		35.5	37.3	27.2	
1.0					
Peru		38.9	33.8	27.2	
1.1					
Trinidad and Tobago	42.4	35.5	22.1		1.1
Venezuela		33.0	42.8	24.2	
0.8					
Sub-Average		**36.7**	**37.5**	**25.8**	
1.0					
Asia and Oceania					
Bangladesh		59.9	8.3	31.8	
3.3					
Fiji		43.3	30.5	26.1	
1.3					
Indonesia		34.5	29.2	36.3	
1.1					
Jordan	40.8	12.0	47.2		1.9
Malaysia		36.1	28.5	35.4	
1.2					
Nepal		67.2	7.5	25.3	
4.0					

Pakistan		71.6	5.0	23.4	4.9
Philippines		33.7	36.9	29.4	0.9
Republic of Korea	67.1	13.7	19.3		3.3
Sri Lanka		52.2	30.6	17.2	1.5
Syrian Arab Republic	49.6	11.0	39.4		2.3
Thailand		49.0	34.5	16.5	1.4
Yemen	20.5	9.1	70.4		1.3
Sub-Average		**48.1**	**19.8**	**32.1**	**2.2**
Total		**39.9**	**26.3**	**33.8**	**1.5**

Source: WFS

Table 9.12 shows the average proportion of women who wanted a son, a daughter or either, and the average "preference ratio" for the countries grouped according to level of development.

TABLE 9.12
PREFERENCES FOR SEX OF NEXT CHILD AND PREFERENCE RATIO AMONG CURRENTLY MARRIED, FECUND WOMEN WHO WANTED ANOTHER CHILD, BY LEVEL OF DEVELOPMENT.

Level of Development		Preference: Boy (Percentage)	Girl (Percentage)	Undecided	Preference Ratio
I.	High	40.0	34.6	25.1	1.2
II.	Middle-high	41.0	29.0	29.7	1.4
III.	Middle-low	34.5	25.2	40.3	1.2
IV.	Low	46.5	14.2	39.2	2.4

The general expectation is that, as development increases, preferences for a particular sex become less strong. The data seem to indicate this tendency. The preference ratio indicates a strong son preference in the low development group and a moderate son preference in the other groups.

Table 9.13 presents the sex preferences for each type of family composition by level of development.

TABLE 9.13

PREFERENCES FOR SEX OF NEXT CHILD, BY LEVEL OF DEVELOPMENT AND FAMILY COMPOSITION

(Percentage)

	Level of Development and sex composition	Preference Boy	Girl	Undecided
I	**High**			
	All boys	7	76	16
	More boys	15	59	26
	Balance	34	28	38
	More girls	69	9	22
	All girls	79	6	15
II	**Middle-high**			
	All boys	8	69	23
	More boys	19	43	38
	Balance	35	19	46
	More girls	66	5	29
	All girls	78	3	19
III	**Middle-low**			
	All boys	7	54	39
	More boys	13	39	48
	Balance	29	16	56
	More girls	49	4	47
	All girls	63	2	35
IV	**Low**			
	All boys	20	39	41
	More boys	28	19	53
	Balance	44	7	50
	More girls	54	4	42
	All girls	66	2	33

Source: WFS

Two patterns were evident. In general, for each type of composition, the proportion of women coded as "undecided" declines with increasing levels of development. Among families with all boys, for example, the proportion undecided declines from 41 per cent in development group IV to 16 per cent in development group I. At the same time, there is evidence that, with development, respondents are more likely to desire for their next that sex which will help to balance the family.

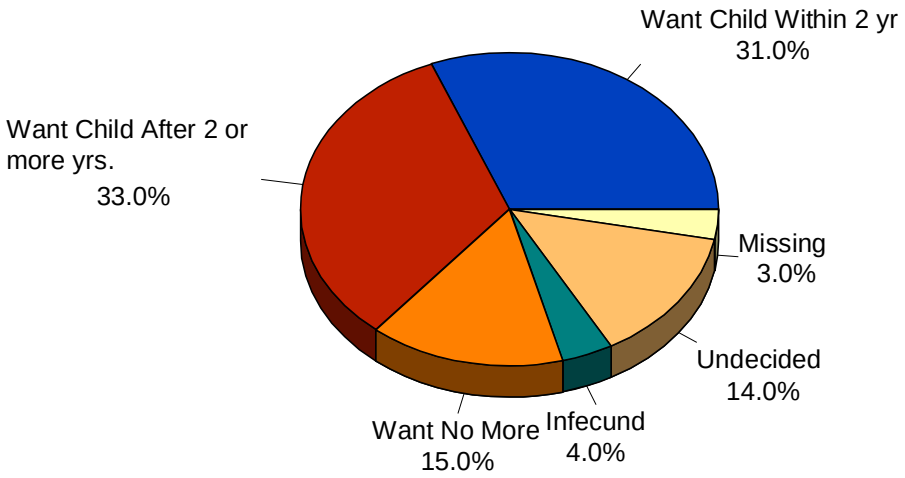
In the NDHS several questions were asked to ascertain women's fertility preferences: their desire to have another child, the length of time they wanted to wait before having that child, and the number of children they considered to be ideal. These questions were asked of non-sterilised, currently married women; and the question to ascertain ideal family sized was asked of all women.

Desire for More Children

Women were asked: "Would you like to have another child or would you prefer to not have any more children? If they did indeed want another child, they were asked: "How long would you like to wait from now before the birth of another child?" These questions were appropriately phrased if the woman had not yet had any children, and if the woman was pregnant, she was asked about her desire after the baby she was expecting. Figure 9.4 shows the per cent distribution of currently married women by their fertility preferences and Table 9.14 shows the distribution according to the number of living children.

Figure 9.4

Fertility Preferences among Currently Married Women



NDHS

TABLE 9.14 Fertility preference by number of living children

Percent distribution of currently married women by desire for more children, according to number of living children Nigeria 1990.

Desire for children	No of living children[1] 0	1	2	3	4	5	6+	Total
Have another soon[2]	60.4	38.9	37.9	30.1	23.5	21.1	15.2	31.2
Have another later[3]	8.3	45.1	40.1	39.5	35.2	30.5	19.3	32.8
Have another, undecided when	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Undecided	14.5	7.9	11.0	14.0	17.1	17.2	16.0	13.6
Wants no more	1.4	3.2	5.0	8.6	16.1	23.6	43.4	15.1
Sterilised	0.0	0.1	0.1	0.2	0.2	0.4	0.9	0.3
Declared Infecund	11.8	2.8	3.8	4.1	4.0	4.0	3.6	4.4
Missing	3.5	2.0	2.1	3.4	3.3	3.1	1.5	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	612	1,168	1,144	1,113	928	735	1,181	6,880

1. Includes current pregnancy
2. Wants next birth within 2 years
3. Wants to delay next birth for 2 or more years

Overall, 64 per cent of women want another child, but 33 per cent want to wait two or more years before having that child. Fifteen per cent do not want any more children at all. Not surprisingly, the desire for more children declines noticeably as the number of living children increases.

Thus, 60 per cent of women with no living children want to have a child soon (within the next two years), whereas only 15 per cent of women with 6 or more living children want a child soon. Conversely, among women with no living children, only one per cent declare not wanting any children, and 43 per cent of women who have six or more children no longer want any more. This indicates a considerable interest in controlling fertility, and therefore a potential demand for family planning services, among women with many children. In the category of women with six

or more children, those who either want to space or to limit their births total more than 60 per cent.

The per cent distribution of currently married women by desire for children, according to age is shown in Table 9.15. The desire to limit births increase rapidly with age; only one per cent of women age 15-19 want no more children, while 46 per cent of those age 45-49 years want to stop childbearing.

TABLE 9.15 Fertility preferences by age

Per cent distribution of currently married women by desire for more children, according to age, Nigeria 1990.

	Age of women							
Desire for children	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Have another soon[1]	38.3	39.6	32.8	30.0	29.4	23.1	15.7	31.2
Have another later[2]	47.7	43.9	42.9	31.7	23.8	12.5	7.5	32.8
Have another, undecided when		0.1	0.0	0.0	0.0	0.0	0.0	0.0
Undecided		10.3	9.8	12.6	17.6	15.4	17.6	11.0
13.6								
Wants no more		1.4	2.7	6.9	14.5	23.4	32.7	45.9
15.1								
Sterilised		0.0	0.0	0.1	0.1	0.4	1.4	0.5
0.3								
Declared Infecund	0.6	1.2	1.5	2.8	5.3	11.6	17.0	4.4
Missing		1.7	2.7	3.2	3.3	2.3	1.1	2.8
2.6								
Total		100.0	100.0	100.0	100.0	100.0	100.0	100.0
100.0								
Number		997	1,279	1,492	1,348	892	731	543
6,880								

1. Want next birth within 2 years
2. Wants to delay next birth for 2 or more years

The desire to stop childbearing varies greatly by background characteristics of the respondent (see Table 9.16). Overall, the percentage of women who want no more children is twice as high in the Southeast and Southwest (22 and 23 per cent) as it is in the Northeast and Northwest (9 and 10 per cent).

The percentage of women wanting no more children is positively associated with education. Among women with four children, the desire to stop having children is much more common for women with the highest level of education (37 per cent) than for women with no education (15 per cent).

TABLE 9.16 Desire to limit (stop) childbearing

Percentage of currently married women who want no more children, by number of living children and selected background characteristics, Nigeria 1990.

Background Characteristic	Number of living children 0	1	2	3	4	5	6+		Total
Residence									
Urban	0.0	2.7	5.5	11.4	27.5	32.8	51.8		20.5
Rural		1.8	3.4	4.9	8.1	13.6	21.4	42.1	
14.0									
Region									
Northeast		2.3	3.6	4.5	4.3	10.0	17.6	31.5	
9.2									
Northwest		1.2	2.8	5.8	11.0	11.5	21.0	24.1	
10.1									
Southeast		0.6	4.2	4.5	10.4	19.3	26.6	52.8	
21.8									
Southwest		0.0	2.4	5.5	9.6	27.8	29.6	60.1	
23.4									
Education									
No education	1.8	3.8	4.1	8.3	14.8	19.9	37.4		13.9
` Some primary	0.0	2.9	4.3	3.8	16.0	22.0	55.6		20.6
Complete primary	1.0	0.5	9.6	11.9	19.2	35.9	63.0		20.0
Some secondary		0.0	4.5	1.8	5.5	15.3	45.2	56.3	
11.9									
Completed secondary/higher	0.2	3.4	6.3	16.9	37.4	54.9	97.4		17.6

Total	**1.4**	**3.3**	**5.1**	**8.8**	**16.9**	**24.0**	**44.3**	**15.4**

Source: NDHS

Demand for Family Planning Services

Women who are currently married, and who declared either that they do not want to have any more children (they want to limit their childbearing) or that they want to wait two or more years before having another child (they want to space their births), but are not currently using contraception, have an *unmet need for family planning.* Women with unmet need and those currently using contraception constitute the total demand for family planning (see Table 9.17).

TABLE 9.17 Need for family planning services

Percentage of currently married with unmet need for family planning, met need for family planning, and the total demand for family planning services, by selected background characteristics, Nigeria 1990.

Background Characteristic	Unmet need for family planning			Met need for family planning			Total demand for family planning			Percentage of demand satisfied
	For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total	
Age										
15-19	15.7	0.3	16.0	1.3	0.0	1.3	17.0	0.3	17.3	7.7
20-24	13.6	1.0	14.6	4.7	0.4	5.1	18.3	1.4	19.7	26.0
25-29	13.2	2.9	16.1	5.3	0.7	6.0	18.5	3.6	22.1	27.3
30-34	12.1	6.0	18.1	3.7	2.8	6.5	15.8	8.8	24.6	26.5

35-39	11.2	12.7	23.9	2.9	5.8	8.7	14.1	18.4	32.6	26.8
40-44	6.1	23.7	29.7	0.8	7.6	8.4	6.9	31.2	38.1	22.0
45-49	4.1	39.3	43.4	0.4	4.2	4.6	4.5	43.4	47.9	9.6
Residence										
Urban	12.3	9.7	22.0	8.5	6.4	14.9	20.8	16.1	36.9	40.4
Rural	11.3	9.2	20.5	2.0	1.6	3.6	13.3	10.8	24.1	15.0
Region										
Northeast	14.4	6.5	20.9	1.0	1.0	2.0	15.4	7.5	22.9	8.8
Northwest	8.0	6.2	14.2	0.7	0.6	1.2	8.6	6.8	15.4	7.9
Southeast	13.1	13.2	26.3	5.1	3.8	9.0	18.2	17.0	35.3	25.4
Southwest	10.6	12.4	23.0	8.4	6.6	15.0	19.0	19.0	38.0	39.5
Education										
No education	10.0	9.8	19.8	1.0	1.0	2.0	11.0	10.7	21.8	9.1
Some primary	15.4	10.4	25.7	3.2	4.6	7.8	18.6	14.9	33.5	23.3
Completed primary	12.8	9.7	22.5	4.1	6.5	10.6	17.0	16.2	33.1	32.1
Some secondary	21.0	4.4	25.4	12.6	4.4	17.0	33.6	8.8	42.4	40.2
Completed secondary/higher	13.0	4.9	18.0	19.7	9.0	28.7	32.7	13.9	46.7	61.5
Total	**11.5**	**9.3**	**20.8**	**3.4**	**2.7**	**6.0 1**	**4.9**	**11.9**	**26.8**	**22.5**

Fertility desires are high in Nigeria, so the total demand for family planning is relatively low, 27 per cent of currently married women. Table 9.17 indicates that the demand for family planning is highest among the most educated women: 47 per cent of those who have completed secondary school have a demand for family planning. Demand is greater in urban areas (37 per

cent) than in rural areas (24 per cent); but only 40 per cent of the damand in urban areas are satisfied.

For the great majority of women, the need for family planning is not fulfilled (more than three-quarters of the total demand is unsatisfied). Although the unmet need for spacing and for limiting purposes is very low (12 and 9 per cent of currently married women), younger women are more likely to need family planning for spacing purposes (16 per cent), and older women for limiting purposes (39 per cent). The data show that even the moderate demand for family planning that currently exists in Nigeria remains mostly unfulfilled.

Large differences in need for family planning exist between regions. Even the low demand extant in the Northeast (23 per cent) and Northwest (15 per cent), is not fulfilled (less than 10 per cent of demand is satisfied). In the Southeast and Southwest, 35 and 38 per cent of demand is satisfied, respectively. The most educated women have the highest proportion of demand satisfied (62 per cent).

Ideal and Actual Number of Children

In order to ascertain what women consider to be the ideal number of children, they were asked: "If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole like, how many would that be?"

TABLE 9.18 Ideal number of children

Percent distribution of all women by ideal number of children and mean ideal number of children for all women and for currently married women, according to number of living children, Nigeria 1990

Ideal number of children	Number of living children											
	None	1	2	3	4	5	6+	Total				
0	0.0	0.1	0.0	0.1	0.0	0.0	0.1	0.0				
1	0.3	0.5	0.1	0.0	0.0	0.0	0.0	0.1				
2	1.4	0.5	1.1	0.2	0.4	0.6	0.5	0.8				
3	3.8	2.9	1.0	1.2	0.5	0.9	0.8	1.9				
4	18.6	10.3	11.4	5.6	9.6	3.0	2.9	10.0				
5	13.4	6.9	8.8	7.4	8.2	8.9	2.8	8.5				
6+	15.3	14.3	12.9	17.0	19.2	23.7	26.2	17.8				
Non-numeric response	47.2	64.6	64.7	68.5	61.9	62.8	66.8	60.8				

Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number of women	2,083	1,290	1,194	1,166	986	784	1,278	8,781
Mean ideal number	5.0	5.5	5.7	6.1	6.1	7.0	7.2	5.8
Number of women	1101	457	422	367	375	292	425	3438
Mean for women in union		5.5	5.6	5.7	6.1	6.0	7.1	7.2
Number of women in union		157	381	401	348	345	265	285 2,284

Table 9.18 indicates that the idea of conscious reproductive choice is largely unknown to a large proportion of women. Sixty-one per cent of women gave non-numeric responses. In most cases, women indicated that the number of children they would have is "up to God."

Table 9.19 presents the mean ideal number of children by age and selected background characteristics of the respondents.

TABLE 9.19 Mean ideal number of children by background characteristics

Mean ideal number of children for all women, by age and selected background characteristics, Nigeria 1990.

Background characteristics	Age of women							Total
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Residence								
Urban	4.7	4.6	4.9	5.7	5.4	6.2	6.2	5.0
Rural		5.6	5.8	6.2	6.8	6.5	7.3	7.3 6.3
Region								
Northeast		6.2	6.5	6.8	7.0	6.6	6.7	7.0 6.6
Northwest		5.5	6.5	6.8	7.4	5.6	7.0	10.1 6.7

	Southeast		5.3	5.3	5.7	6.3	6.5	7.6	6.8	5.9
	Southwest		4.7	4.6	4.6	5.9	5.5	6.2	6.0	5.0
Education										
	No education	6.0	7.1	6.9	7.1	6.5	7.4	7.3		6.9
	Some primary	5.9	5.5	5.4	6.5	6.1	7.2	5.8		6.1
	Completed primary	5.4	5.5	5.8	6.4	6.0	6.7	6.7		5.8
	Some secondary		4.9	4.8	5.5	5.3	4.9	5.8	5.5	5.0
	Completed secondary/higher	4.8	4.5	4.6	4.7	5.1	5.0	5.4		4.6
Total			**5.3**	**5.3**	**5.7**	**6.5**	**6.1**	**7.0**	**7.0**	**5.8**

Typically, urban and more educated women have a smaller ideal family size. Thus, among women with no education the mean ideal number of children is 6.9, and gradually decreases to 4.6 among the highest educated women. In urban areas, the mean ideal number of children is 5, compared to 6.3 in rural areas. The difference between regions is also significant, the ideal family size being about one child larger in the northern regions than in the southern regions.

2. RURAL OR URBAN RESIDENCE FERTILITY

The relationship between respondent's current and childhood residence and fertility was explored here. The relationship is seen to work through two channels: (a) characteristics and preferences of individuals according to where they live; and (b) characteristics of their residential locations.

Rural/urban differences are among the most widely studied socio-economic differentials in individual fertility. Prior research had established that variations in type of place of residence (whether rural or urban) are related to variations in fertility. This implies that changes in residence patterns of a population can lead to changes in fertility. In addition, knowledge of rural/urban differentials in fertility is valuable for policy purposes; the design and location of development projects, which indirectly have an impact on fertile as well as family planning programmes which directly affect contraceptive practice, can be chosen and when appropriate, adjusted to suit policy objectives.

A. Characteristics of the Household Population

The NDHS collected information on all usual residents and visitors who spent the previous night in the household. A household was defined as a person or group of persons living together and sharing a common source of food.

Age

The age distribution of the household population in the NDHS is shown in Table 9.20 and Figure 9.5 by five-year age groups.

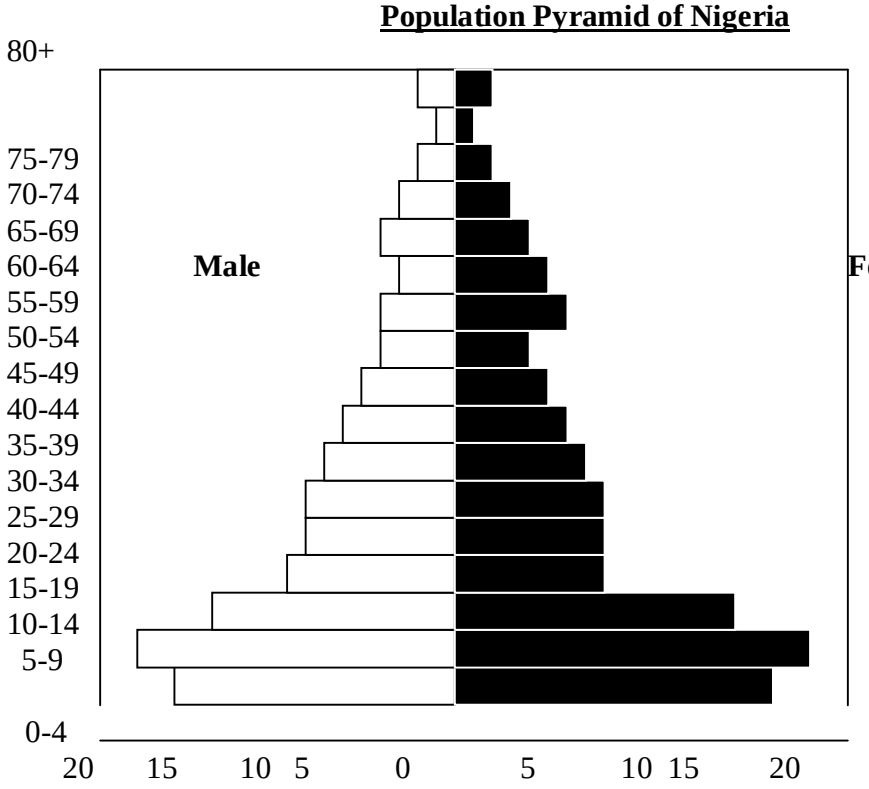


Figure 9.5

TABLE 9.20 Household population by age, residence and sex

Per cent distribution of the de facto household population by five-year age group, according to urban-rural residence and sex, Nigeria 1990.

	Urban			Rural			Total	
Age group	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	14.6	15.1	14.8	16.9	17.3	17.1	16.4	16.8	16.6
5-9	16.8	16.7	16.7	18.8	17.1	18.0	18.3	17.0	17.7
10-14	13,5	15.7	14.6	13.2	13.4	13.3	13.3	13.9	13.6

15-19	11.0	8.8	9.9	8.8	7.0	7.9	9.4	7.4	8.4
20-24	6.9	8.6	7.8	5.4	7.2	6.3	5.8	7.5	6.7
25-29	7.5	8.0	7.7	5.5	7.4	6.5	6.0	7.6	6.8
30-34	6.3	6.2	6.2	5.4	6.4	5.9	5.6	6.3	6.0
35-39	4.9	3.9	4.4	4.2	4.2	4.2	4.4	4.2	4.3
40-44	4.5	3.7	4.1	4.0	3.9	4.0	4.1	3.8	4.0
45-49	3.0	2.2	2.7	3.4	2.9	3.2	3.3	2.8	3.0
50-54	2.6	4.0	3.3	3.3	4.7	4.0	3.1	4.5	3.8
55-59	1.4	1.9	1.7	2.0	2.8	2.4	1.9	2.6	2.2
60-64	2.2	2.2	2.2	2.8	2.5	2.6	2.6	2.4	2.5
65-69	1.5	0.9	1.2	1.8	1.0	1.4	1.8	1.0	1.4
70-74	1.3	0.9	1.1	1.9	0.9	1.4	1.7	0.9	1.3
75-79	0.5	0.3	0.4	0.7	0.4	0.5	0.7	0.3	0.5
80+	1.1	0.9	1.0	1.5	0.7	1.1	1.4	0.7	1.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number	5,799	5,690	11,489	17,651	17,888	35,539	23,450	23,578	47,028

NDHS

The distribution conforms to the pattern characteristic of high fertility populations, i.e., a much higher proportion of the population in the younger than in the older age groups. However, the youngest age group (0-4) numbers fewer than the 5-9 years olds.

Table 9.21 compares the population age structure found in the 1990 Nigeria Demographic and Health Survey (NDHS) with that in the 1963 Census, the 1980 National Demographic Sample survey (NDSS 1980) (National Population Bureau and

IRD/Westinghouse, 1988), and the 1981/82 Nigeria Fertility Survey (NFS 1981/82), (National Population bureau and World Fertility survey, 1984); dependency ratios are also shown. The age dependency ratio is the ratio of the number of persons age 0 to 14 and 65 and over divided by the number of persons age 15 to 64. It is an indicator of the dependency responsibility of adults in their productive years.

The dependency ratios in Nigeria are typical of those found in other African countries. With approximately 47 per cent of the population under age 15 and 4 per cent over age 64, there is one dependent person for each adult in the population. As in many rapidly growing populations, the old age dependency is minimal compared to child dependency [5,7.].

Table 9.21 Population by age from selected sources

Per cent distribution of the population by age group selected sources, Nigeria 1963-1990.

Age group	Census 1963	NDHS 1990	NFS 1980	NDHS 1981/82
Less than 15	43.1	47.2	49.5	47.1
15-64	54.9	50.2	48.1	48.5
65+	2.0	2.8	2.3	4.3
Total	**100.0**	**100.0**	**100.0**	**100.0**
Median age	--	--	--	16.3
Dependency ratio	0.82	1.00	1.08	1.06

Sources: FOS, NDHS, WFS.

Household Composition

While the large majority of households in Nigeria are headed by males (86 per cent), there are regional differences (Table 9.22). About 20 per cent of households in the South are

headed by women, whereas it is unusual in the North for a household to be headed by women (5 per cent).

Female headed households are more common in Urban areas (18 per cent) than in rural areas (13 per cent); single person households are more common in urban areas (16 per cent) than in rural areas (9 per cent) and households of nine or more persons are more common in rural areas, 17 per cent compared to 11 per cent in urban areas. As a result, average households size is larger in rural (5.6) than in urban (4.8) areas.

Households are largest, on average, in the Northeast (5.8 persons per household), and smallest in the Southwest (4.9 persons per household). The overall average household size is 5.4 persons.

Seven per cent of households include one or more children under age 15 who have neither their natural mother nor natural father living with them.

TABLE 9.22 Household composition

Percent distribution of households by sex of head of household, household sizes, kinship structure, and presence of foster children, according to urban-rural residence and region, Nigeria 1990.

Characteristics	Residence		Region			
	Urban	Rural	Northeast	Northwest	Southeast	Southwest	Total
Household headship							
Male	82.0	87.1	94.3	94.9	77.3	81.2	85.7
Female	18.0	12.9	5.7	5.1	22.7	18.8	14.3
Number of usual members							
1	16.2	9.2	7.4	6.7	12.9	15.8	11.1
2	12.7	9.6	10.8	10.8	9.3	11.3	10.5
3	12.9	12.7	13.2	18.1	9.6	12.0	12.8

4			12.2	13.2	14.6	13.3	11.9
12.4		12.9					
5			11.1	11.9	11.7	11.7	11.6
11.8		11.7					
6			10.4	11.3	10.2	9.9	12.5
10.8		11.0					
7			8.1	8.8	7.7	8.9	9.0
8.5	8.6						
8			5.5	6.5	5.9	5.3	7.4
5.6	6.2						
9+			11.0	16.8	18.6	15.2	15.6
11.7		15.2					
Mean size			**4.8**	**5.6**	**5.8**	**5.4**	**5.5**
4.9	**5.4**						
Relationship structure							
One adult			22.2	13.5	9.7	8.8	19.9
22.0		15.8					
Two related adult of:							
opposite sex			34.8	37.1	40.9	46.6	29.8
32.8		36.5					
same sex			5.2	2.0	1.2	0.6	4.2
4.6	2.9						
Three or more related adults			34.6	45.5	45.8	43.3	43.5
37.9		42.6					
Other			3.3	1.8	2.4	0.7	2.5
2.7	2.2						
With foster children			7.1	6.8	6.2	3.8	8.1
8.6	6.9						

Note: Table is based on de jure members; i.e., usual residents.

Housing Characteristics

In order to assess the socioeconomic conditions under which respondents live, women were asked to give specific information about their household environment. Table 9.23 presents this information for all households.

TABLE 9.23 Housing characteristics

Per cent distribution of households with eligible women by housing characteristics, according to urban-rural residence and region, Nigeria 1990.

Characteristic	Residence		Region				Total
	Urban	Rural	Northeast	Northwest	Southeast	Southwest	
Electricity	82.4	8.6	11.0	13.0	22.4	65.4	27.3
Source of drinking water							
Piped into residence	17.3	1.5	4.8	5.1	2.7	10.3	5.5
Piped into yard	13.8	1.8	3.4	4.1	3.7	8.6	4.8
Public tap	32.2	8.4	11.3	4.1	17.3	24.5	14.4
Well with hand pump	7.4	6.8	15.3	4.8	2.4	7.2	7.0
Well without hand pump	14.8	28.1	31.9	49.1	9.5	13.2	24.7
River, spring. surface water	4.9	51.9	30.5	32.1	62.0	27.4	40.0
Tanker truck/ other vendor	8.9	0.7	1.6	0.5	1.5	8.1	2.8
Rainwater	0.3	0.7	1.2	0.1	0.8	0.3	0.6
Other	0.4	0.0	0.0	0.0	0.0	0.4	0.1

Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Sanitation facility							
Flush	29.9	2.1	0.5	1.7	7.7	27.7	9.1
Bucket	1.5	0.3	0.1	0.1	0.6	1.4	0.6
Pit	60.4	62.2	74.9	66.7	57.8	48.8	61.7
No facilities	8.1	35.5	24.5	31.5	33.9	22.1	28.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Flooring							
Parquet/ polished wood	2.0	0.2	0.2	0.3	0.2	2.0	0.6
Vinyl/asphalt strips	0.9	0.3	0.3	0.3	0.6	0.7	0.5
Ceramic tiles	3.3	0.7	0.2	0.9	0.9	3.8	1.4
Wood planks	0.5	0.1	0.4	0.2	0.0	0.4	0.2
Cement	72.6	46.9	32.4	54.5	58.8	66.0	53.4
Animal dung	0.5	1.1	1.5	0.4	0.5	1.4	0.9
Earth/sand	7.1	50.6	64.7	43.3	38.9	11.3	39.5
Other	12.9	0.1	0.3	0.2	0.0	14.3	3.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Persons per sleeping room							
1-2	43.4	50.2	54.9	47.0	50.0	41.5	48.5
3-4	35.6	33.6	31.8	38.0	31.2	36.2	34.1
5-6	14.7	10.3	7.8	11.0	11.9	14.8	11.4
7+	6.2	5.6	4.8	3.5	6.8	7.5	5.7

Missing/ Don't know	0.1	0.4	0.7	0.5	0.1	0.0
0.3						
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
100.0						
Mean persons per room	3.4	3.2	3.0	3.1	3.2	3.5
3.2						
Number of households	1,649	4,844	1,471	1,529	2,025	1,468
6,493						

Overall, 27 per cent of households in Nigeria have electricity. While electricity is available to the majority of eligible women in urban areas (82 per cent) it is only a small minority in rural areas (9 per cent). Two-thirds of households in the Southwest have electricity, compared to 11 per cent in the Northeast.

Sources used by households to obtain drinking water differ considerably by area of residence. In urban areas, piped water is the primary source of drinking water: 32 per cent obtain water from a public tap and another 31 per cent have water piped into their residence or yard. In rural areas, water from rivers and spring is the main source of drinking water (52 per cent) and another 28 per cent obtain water from a well without a hand pump.

Modern sanitation facilities are not available to large segments of the population. The use of pit toilet is common in both urban and rural areas (60 and 62 per cent respectively); in urban areas, most of the rest of the population use flush toilets (30 per cent), and in rural areas, most of the rest of the population have no facilities (36 per cent).

The flooring material of dwelling units is usually cement (53 per cent) or earth (40 per cent). Cement flooring is most common in urban areas (73 per cent). Of the remaining urban households, most have carpet or tile flooring (coded in the "other" category). Households in rural areas also have cement flooring (47 per cent) but are equally likely to have an earth or sand floor (51 per cent).

Information was collected on the number of rooms' households' use for sleeping (as measure of crowding). There was not much diversity according to residence and region. In about one-third of households three or four persons share a room for sleeping; however, in almost half of the households the average is one or two persons.

Household Durable Goods

Respondents were asked about ownership of particular household goods (radio, and television, to assess access to media; refrigerator, to assess food storage) and modes of transportation (bicycle, motorcycle, car). The results presented in Table 9.24 indicated that 55 per cent of households own a radio (80 per cent in urban areas, 47 per cent in rural areas) and 19 per cent own a television (54 per cent in urban areas, 7 per cent in rural areas). Televisions and refrigerators are mostly restricted to the urban areas due to lack of electricity in rural areas. Many rural households (37 per cent) own a bicycle whereas only 17 per cent of urban households have a bicycle. Seventeen per cent of urban households own an automobile.

TABLE 9.24 Household durable goods

Percentage of households with eligible women possessing various durable consumer goods, by urban-rural residence and region, Nigeria 1990.

	Residence		Region				
Possession	Urban	Rural	Northeast	Northwest	Southeast	Southwest	Total
Radio	79.6	46.6	39.1	53.1	55.9	71.5	54.9
Television	53.7	7.1	6.3	8.1	16.5	46.0	18.9
Refrigerator	32.9	3.1	4.1	4.6	8.9	26.0	10.7
Bicycle	16.6	36.9	26.4	30.8	46.4	17.7	31.7
Motorcycle	17.5	16.3	10.0	19.0	19.0	17.3	16.6
Auto	16.6	4.4	3.2	4.9	6.7	15.5	7.5
Number of households	1,649	4,844	1,471	1,529	2,025	1,468	6,493

Access to Media

Women were asked if they usually listen to a radio or watch television at least once a week. This information is important to programme planners seeking to reach women with family planning and health messages through the media. Overall, one-quarter or women watch television weekly and one-half listen to the radio weekly (Table 9.25). Media access is higher among younger women, one-third of who watch television at least once a week and over one-half listen to the radio once a week. Most media access is among the urban population, although 44 per cent of the rural population does listen to the radio. A much higher proportion of educated women, women in urban areas, and women in the Southwest watch television and listen to the radio.

TABLE 9.25 Access to mass media

Percentage of women who usually watch television once a week, or listen to radio once a week, by selected background characteristics, Nigeria 1990.

Background characteristic	Watch television weekly	Listen to radio weekly	Number of women
Age			
15-19	33.8	58.0	1,612
20-24	28.5	55.8	1,676
25-29	28.0	55.9	1,669
30-34	19.5	52.3	1,410
35-39	21.5	52.9	954
40-44	20.0	45.4	836
45-49	16.6	40.6	624
Education			
No education	9.3	39.7	5,020
Some primary	23.6	56.6	794
Completed primary	39.8	69.0	1,300

Some secondary		56.4		73.6
765				
Completed secondary/				
higher	71.3		86.3	
894				
Residence				
Urban	67.4		82.1	
2,187				
Rural		11.7		43.7
6,594				
Region				
Northeast		8.4		35.5
2,000				
Northwest		11.5		47.8
2,098				
Southeast		25.6		53.8
2,769				
Southwest		58.8		77.1
1,915				
Total		**25.5**		**53.3**
8,781				

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3. EDUCATION AND FERTILITY

A. Relevant of Education

Studies of fertility conditions and change have consistently pointed to education as an important factor in accounting for fertility differences within population. Education, therefore, have come to occupy an important place in investigative work, both as concerns differential fertility by socio-economic status and, more fundamentally, in the search for casual explanations of fertility levels and change. Knowledge of the education-fertility relationship is especially relevant for development planning because education can be directly influenced by government policy. Among national populations where high fertility is considered an obstacle to development, detailed knowledge of the education-fertility relationship would doubtlessly facilitate decisions concerning educational levels, curriculum content, the structure of the educational system and, ultimately, the division of resources between education and other competing programmes.

Quality of Education

It is profitable to examine the conceptual significance of education, considered as an influence on fertility [5]. Although attention has generally been focused on educational

attainment (its quantitative aspect), it is worth noting at the onset that education is by no means a homogeneous commodity whose only important attribute is "level-reached". While education content may not be as important as educational attainment hypothesized causal paths linking education with fertility (such as postponement of marriage), it clearly is so with regard to those effects on fertility which operate "through changes in attitude, self perception, and the productivity of human capital [5]. Education about population issues has been cited as one instance where educational content may affect fertility.

Besides the quantity (attainment) and content aspects of education, quality of schooling or what has been called the "hidden curriculum" has been pointed to as a likely influence on fertility and fertility ideals. Nevertheless, research in related areas have failed to find significant links between observed attitudes and features such as size or quality of school or teaching materials available. Other aspects of education of possible importance for fertility include areas of knowledge, cognitive skills, school environment and length of school day and year [5]. But the fact remains that studies on the topic have almost exclusively relied upon the quantity aspect of education, the aspect that is easiest to measure.

Education and fertility

The specific connections that have been theorized to exist between education and fertility can be classified in a variety of ways. To adopt the economist's terminology, individual - level effects of education can be divided into those which act on the demand for children, those which affect the supply of children and those which influence the cost, broadly defined, of fertility regulation.

Education may directly change attitudes, values and beliefs towards a small family norm and towards a style of child-rearing that is relatively costly to the parents in time and money (higher "child quality"). The potential for education to diffuse non-traditional values does not end in the class-room, since the educated are likely to continue to be exposed to modern or ideas through newspapers and books, and through ownership of radios and television sets, which they typically acquire earlier than couples of lower socio-economic status. Education also influences economic factors in ways that are thought to discourage high fertility: it reduces the economic utility of children; it creates aspirations for upward social mobility and the accumulation of wealth; and it increases the opportunity cost of women's time and enhances the likelihood of their employment outside the home. Education also increases earning ability, which might, other things being equal, lead couples to want more children. This "income effect", however is evidently usually of minor importance in relation to the fertility decreasing effects of the other influences.

Evidence from preceding surveys including those of this study and that of the WFS, and NDHS revealed a strong positive relationship between education and contraceptive use. Avenues through which education may affect fertility control include: (a) education facilitates the acquisition of information about family planning; (b) education increases husband - wife communication; (c) education impacts a sense of direction and control over one's destiny, which may encourage attempts to control childbearing as well; (d) the higher income of educated couples makes a wide sense of contraceptive methods affordable. The relationship

between education and abortion, though not well studied, may be another important effect of education on fertility.

Education also affects the supply of living children paths other than its influence on deliberate fertility control. The three most important of these influences are: (a) education delays entry into marital unions; (b) education is associated with lower prevalence and duration of breast-feeding; (c) education is associated with reduced child and adult mortality. In addition; in countries with a tradition of extended post-partum abstinence, educated couples tend to observe the customs less than others [7]. The breast-feeding, abstinence and mortality effects act to increase the supply of children, raising the possibility that the net effect of education on number of births or surviving children may not always be negative. Education may also be associated with increased fecundability, lower foetal loss and a longer reproductive span for women, through better nutrition and health and, in the case of fecundability, possibly through higher rates of sexual intercourse [7].

Another line of theoretical speculation concerns "spill-over effects", by which is meant the effect that others' education may have on an individual couple's fertility. One such connection involves the cost of childcare substitutes: "If women in general have very little education, an educated woman can afford massive child care substitutes and thus can combine the benefits of education with high fertility." Another spillover effect may occur when parents with little education foresee (because the environment strongly favours education) the necessity of giving much more education to their children than they themselves received. Indeed, in some ways the education given to children is probably more crucial than the parents own schooling (Cadwell, 1982): not only does school attendance cost money and decrease the amount of productive work from children while they are young, it may also undermine children's adherence to traditional filial obligations, leading parents to expect less help from children later on, thus decreasing the incentive to have a large family [5].

There are theoretical reasons to expect women's education to be more strongly negatively related to fertility than men's and earlier research tends to bear this out. At last in societies where well-paid jobs are open to educated women, time needed for child care has a higher opportunity cost for educated than uneducated women; this tends not to be true for men, because child care is usually the province of women, regardless of educational attainment. For men, a positive relation between education and fertility might be expected from the "income effect mentioned earlier, at least after statistical control for other variables. Another consideration is that in most developing countries the contraceptive methods in widest use are "female methods", principally hormonal pills, female sterilization and intra-uterine devices (IUD). Although the use of contraception undoubtedly depends in part upon the husband's characteristics, and upon those of other members of extended families as well, still it is the woman who must know how to obtain and use those methods, and be willing to do so. Her own education may in these respects be more important that that of her husband.

B. National Education Policy

In the three decades since independence, the education sector has recorded phenomenal growth in student enrollments and numbers of institutions, and has expanded to reach all parts of the federation. The national education policy has evolved over the years to meet the needs of the country. In 1976, Nigeria adopted a national policy of Universal Primary Education, which gave every child the right to free primary schooling. The emphasis in education shifted from the

standard liberal education to the new more practical 6-3-3-4 system. Under the new system, primary education is six years, and secondary education is six years rather than five years (three years junior secondary and three years senior secondary). A graduate of secondary school may then choose to further his or her education by attending a university or polytechnic for a 4-year course leading to a degree or to the Higher National Diploma. At this level, very few courses last more than four years. The goal is for the nation to meet its manpower requirements in various areas of social, economic and political growth, as well as achieving national development and modernization. A nationwide mass literacy programme was launched in June 1990, although it had been in existence at state and local levels for over 25 years. The National Commission on Nomadic Education was recently established to address the needs of children of migrant cattle herders and fishing peoples in the riverine areas [7].

In the NDHS, information on educational attainment was collected for every member of the household (see Table 9.26). One-half of the population has received no formal education; 43 per cent of males and 58 per cent of females have never been to school; 32 per cent of males and 26 per cent of females have attended only primary school; and 14 per cent of males and 9 per cent of females have attended secondary school. Only 3 per cent of males and 1 per cent of females have obtained higher education.

The proportion of persons with no education is much higher in the rural areas than in urban areas, and this difference is seen for both males and females. Rural residents are twice as likely to have never attended school (58 per cent) as urban residents (29 per cent).

There are major regional differences in the level of education. The Northwest has the highest proportion of persons with no education (73 per cent of males and 86 per cent of females); in the Southwest, those who have never been to school are in the minority (18 per cent of males and 30 per cent of females).

Table 9.26 Educational level of the household population

Per cent distribution of the de facto male and female household population age five and over by highest level of education attended, according to selected background characteristics, Nigeria 1990.

Background Characteristic	None	Some pry	Compl. pry	Some sec.	Compl. Sec.	Higher	Missing	Total	persons of years
MALE									
Age									
5-9	51.0	29.7	0.9	0.0	0.0	0.0	19.1	100.0	4,293
10-14	21.7	49.9	8.9	7.0	0.0	0.0	12.4	100.0	3,115
15-19	20.6	15.4	21.3	24.8	10.0	0.5	7.5	100.0	2,194
20-24	23.0	5.0	22.4	12.5	27.9	4.8	4.5	100.0	1,362
25-29	31.8	3.9	21.7	6.8	23.9	9.0	2.8	100.0	1,409
30-34	41.1	5.5	22.3	3.1	15.4	8.3	4.2	100.0	1,320
35-39	46.1	5.0	21.5	2.8	13.2	7.5	3.9	100.0	1.034
40-44	53.6	5.6	22.3	2.8	9.3	4.1	2.4	100.0	971

	45-49		52.7	9.5	18.4	4.1	8.1	4.4	2.7		100.0	
771		0.9										
	50-54		72.6	7.3	8.5	1.8	5.3	3.1	1.4		100.0	
729		0.7										
	55-59		72.3	7.7	8.4	3.0	2.0	2.3	4.2		100.0	
443		0.7										
	60-64		80.1	5.0	6.8	1.1	2.2	1.5	3.2		100.0	
614		0.6										
	65+		84.4	5.8	4.7	1.0	1.1	0.9	2.1		100.0	
	1,320		0.6									
Residence												
	Urban		22.4	21.3	15.1	11.1	15.7	6.5	8.1		100.0	
	4,848		6.1									
	Rural		50.2	18.4	11.6	4.5	5.1	1.4	8.8		100.0	
14,765		0.9										
Region												
	Northeast	65.5	7.8	8.6	1.8	4.0	1.1	11.2		100.0		4,731
	0.7											
	Northwest	72.8	10.3	6.2	2.9	3.6	1.3	2.9		100.0		3,997
	0.7											
	Southeast	26.8	27.8	18.4	6.2	8.0	2.3	10.5		100.0		6,148
	3.6											
	Southwest	17.8	26.4	14.1	13.1	14.6	5.7	8.4		100.0		4,737
	6.0											
Total			**43.3**	**19.1**	**12.5**	**6.1**	**7.7**	**2.6**	**8.6**		**100.0**	
19,613		**1.2**										

FEMALE

Age												
	5-9		54.4	27.9	0.2	0.0	0.0	0.0	17.4		100.0	
	4,010		0.7									
	10-14		34.1	41.7	7.4	6.6	0.1	0.0	10.1		100.0	
	3,288		2.9									
	15-19		33.6	11.0	20.6	20.0	8.2	0.4	6.2		100.0	
	1,749		6.2									
	20-24		42.0	6.6	18.6	10.6	17.1	2.3	3.0		100.0	
	1,777		6.0									
	25-29		54.2	6.3	17.2	5.8	11.7	3.2	1.6		100.0	
	1,784		0.9									
	30-34		71.1	7.5	10.8	2.7	3.1	2.9	2.0		100.0	
	1,491		0.7									
	35-39		70.4	9.4	11.9	2.3	3.4	1.1	1.6		100.0	
982		0.7										
	40-44		78.9	7.8	8.0	1.9	1.1	0.8	1.6		100.0	
905		0.6										
	45-49		84.7	6.5	5.0	1.9	0.7	0.9	0.3		100.0	
654		0.6										
	50-54		90.9	3.8	3.2	0.4	0.5	0.3	0.9		100.0	
	1,072		0.5									
	55-59		95.8	1.6	1.1	0.7	0.1	0.2	0.5		100.0	
615		0.5										
	60-64		96.3	2.2	0.7	0.1	0.1	0.0	0.5		100.0	
567		0.5										
	65+		95.2	1.9	1.9	0.1	0.2	0.1	0.6		100.0	
711		0.5										

Residence									
Urban	36.3	21.4	12.1	10.8	9.9	2.5	7.0	100.0	
4,733	3.0								
Rural	65.2	15.4	7.5	3.0	2.0	0.4	6.5	100.0	
14,889	0.7								
Region									
Northeast	82.0	4.8	4.0	0.8	0.7	0.0	7.7	100.0	
4,638	0.6								
Northwest	86.2	6.6	3.1	1.4	1.1	0.1	1.5	100.0	
4,071	0.6								
Southeast	43.1	24.6	12.5	5.5	4.0	0.8	9.4	100.0	
6,476	1.0								
Southwest	29.7	27.5	12.8	11.6	9.5	2.7	6.3	100.0	
4,437	3.6								
Total	**58,2**	**16.9**	**8.6**	**4.9**	**3.9**	**0.9**	**6.7**	**100.0**	
19,622	**0.8**								

Table 9.27 presents enrollment rates by age, sex and residence. Fifty-five per cent of children age 6-15 years are enrolled in school. As shown in Figure 9.6, enrollment is higher in urban areas (about three-quarters of children are enrolled) than in rural areas (one-half are enrolled); and boys are more likely to be enrolled than girls (59 per cent versus 51 per cent). Enrollment after age 15 drops significantly; only one-quarter of older teens are still in school and only 11 per cent of those in their early twenties are still in school; the urban/rural differences are not as great at these ages, but male/female differences are greater because women are much less likely than men to go on for higher schooling.

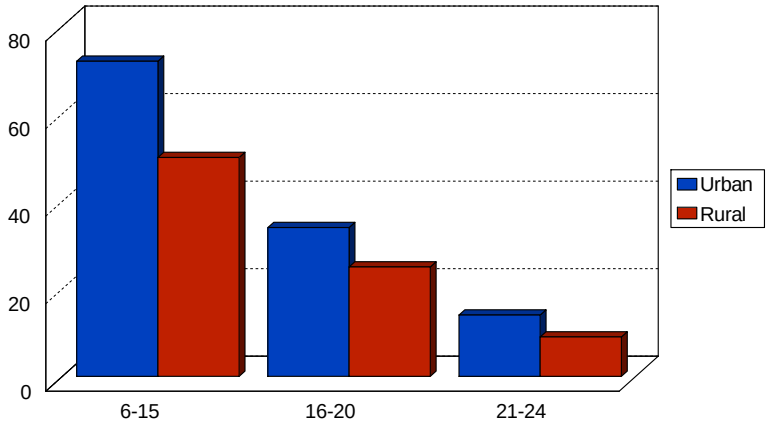
Table 9.27 School enrolment

Percentage of the de facto household population age 6-24 years enrolled in school, by age group, sex. And urban-rural residence, Nigeria 1990.

	Male			Female			Total		
Age group	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
6-10	74.1	49.9	55.4	69.4	43.0	49.4	71.7	46.6	52.5
11-15	75.8	60.9	64.9	70.2	48.0	54.0	73.0	54.6	59.5
6-15	74.8	54.1	59.1	69.7	45.0	51.2	72.3	49.7	55.3
16-20	37.6	32.4	33.9	30.0	16.9	20.5	33.9	24.6	27.2
21-24	18.0	16.6	17.1	10.1	4.1	6.0	13.6	9.4	10.0

Figure 9.6

School Enrollment by Age and Place of Residence



NDHS 1990

C. Differential in Education

Table 9.28, shows the distribution of the surveyed women by education, according to selected characteristics. Education is inversely related to age; that is, older women are generally less educated than younger women. For example, 85 per cent of women age 45-49 have had no formal education, whereas only 34 per cent of women age 15-19 have never been to school.

Table 9.28 Level of education

Per cent distribution of women by the highest level of education attended, according to selected characteristics, Nigeria 1990

Background Characteristic	Level of education: None	Some primary	Completed primary	Some secondary/ secondary	Completed of Higher	Total	Number of women
Age							
15-19	33.8	12.0	20.4	23.1	10.5	100.0	1,612
20-24	42.1	7.9	18.9	11.6	19.5	100.0	1,676
25-29	54.3	6.9	16.9	6.8	15.0	100.0	1,669

30-34	70.0	10.2	11.5	2.5	5.6	100.0
1,410						
35-39	72.6	9.6	10.6	2.6	4.7	100.0
954						
40-44	78.2	8.8	9.1	2.0	2.0	100.0
836						
45-49	84.9	7.2	5.1	1.4	1.4	100.0
624						
Residence						
Urban	31.2	7.3	19.4	16.6	25.5	100.0
2,187						
Rural	65.8	9.6	13.3	6.1	5.1	100.0
6,594						
Region						
Northeast	83.7	4.7	7.1	2.4	2.0	
100.0	2,000					
Northwest	87.8	2.9	5.0	2.1	2.2	
100.0	2,098					
Southeast	36.2	16.8	23.7	11.2	11.8	
100.0	2,769					
Southwest	26.1	9.1	20.7	18.9	25.1	
100.0	1,915					
Total	**57.2**	**9.0**	**14.8**	**8.7**	**10.2**	**100.0**
8,781						

Twice as many urban women have received some education as rural women (69 per cent versus 34 per cent). Only a small proportion of rural of women (11 per cent) go on for secondary schooling compared to urban residents (42 per cent).

Table 9.28, provides information on women's level of education by region. The northern regions have a much high proportion of uneducated women (86 per cent) than the southern regions (36 per cent in the Southeast, 26 per cent in the Southwest). The proportion of women who have had some secondary education is ten times higher in the Southwest than in either of the Northern regions.

4. NUPTIALITY

Although marital unions form the predominant context for childbearing and child-rearing throughout the world, the structure and associated customs, as well as the initial timing, prevalence and stability of unions, vary widely [11]. The date of entry into first union is an important milestone in a woman's life; it represents not only a major change in the composition of her family but usually the beginning of regular exposure to the risk of childbearing [7].

Within each country, later age at marriage is associated with lower completed family size. On average, among women aged 40-49, those who first married under age 17 had borne 0.8 child more than those marrying at 21-24 and 3.2 more than those marrying at 25 or over. However, elimination of early marriages would not itself produce low levels of fertility; even women who married after age 25 usually average at least four children. Many Governments regard early marriage with concern, not simply because it is associated with high fertility but because of health risks to adolescent mothers and their children and because early marriage and childbearing may foreclose opportunities for women's education, employment and involvement in the wider society. Despite recent increases in marriage, the World Fertility Survey [5] data show that large proportions of adolescent women in developing countries still marry and bear children. Of all women currently in their early twenties, an average of 22 per cent had entered a union before age 16, some 40 per cent before age 18 and 57 per cent before age 20. Twenty two per cent had borne a child before the age of 18. In the least developed countries, roughly one third had become mothers by this age.

A. Marital Status

Given the cultural diversity in marriage patterns, regional differences in the prevalence of informal unions and marital dissolution and remarriage are expected. In addition, the level of socio-economic development is expected to be related to the age of marriage and proportions married, since greater economic development is likely to result in better opportunities for women.

Table 9.29, presents the percentage of women never married in five-year current age groups and singulate mean age at marriage, by region, country and level of development. Of the three major regional groups, the highest proportions remaining single at each age are found in Latin America and the Caribbean, on average. The African region shows the greatest propensity for early marriage, with as many as 35 per cent of women aged 15-19, on average, having entered their first marriage at the time of the surveys. Asia and Oceania occupy the middle position between these two extremes. While almost universal marriage is found in all three regions, with 3-7 per cent remaining single by ages 30-34, moderate regional differences persist at ages 20-29. Only in Latin America and the Caribbean does celibacy remain significant, at 4-5 per cent, on average, at ages over 40. These regional differences are reflected in the summary measure, singulate mean age at marriage (SMAM), which is based on marital status distribution and can be interpreted as the average number of years filled before the first marriage, by women who eventually marry. These results show that a very young age at marriage characterizes the African region, which has an average SMAM of 19.8 years, compared with 21.0 in Asia and Oceania and 21.5 in Latin America and the Caribbean [5].

Table 9.29

Percentage of women never married in five-year current age groups and singulate mean age at marriage, by region, country and level of development.

	Current age group							Singulate mean age at marriage
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Africa								
Benin	56	10	1	0	0	0	0	18.2
Cameroon	47	10	4	2	1	1	2	17.5
Cote d' Ivoire	44	10	5	2	1	0	0	17.8
Egypt	78	36	14	4	2	2	2	21.3
Ghana	69	15	3	1	1	1	0	19.3
Kenya	72	21	4	2	1	1	1	19.9
Lesotho	68	16	7	5	3	2	2	19.6
Mauritania	61	24	9	5	2	2	2	19.2
Morocco	79	36	12	3	1	1	0	21.3
Senegal	41	14	4	0	0	0	0	17.7
Sudan	78	36	11	4	2	1	1	21.3
Tunisia	94	57	20	6	2	2	1	23.9
Average	**65**	**24**	**7**	**3**	**1**	**1**	**1**	**19.8**
Latin America and the Caribbean								
Colombia	85	44	22	11	12	9	9	22.1
Costa Rica	85	45	25	12	13	11	10	22.7
Dominican Republic	72	27	10	5	2	3	3	20.5
Ecuador	82	43	20	11	7	8	6	22.1
Guyana	72	26	7	2	3	2	2	20.0
Haiti	84	41	14	4	3	2	1	21.8
Jamaica	70	12	4	1	3	1	2	19.2

	Mexico	81		34	15	9	6	6	5
	21.7								
	Panama	80		35	12	7	5	3	3
	21.2								
	Paraguay		83		43	19	11	6	5
5	22.1								
	Peru		86		49	23	11	9	5
6	23.2								
	Trinidad and Tobago		80		32	10	5	3	2
2	20.9								
	Venezuela		80		41	18	8	4	3
3	21.8								
Average		**80**		**36**	**15**	**7**	**6**	**5**	**4**
	21.5								
Asia and Oceania									
	Bangladesh		30		5	1	0	1	0
0	16.3								
	Fiji		88		34	9	4	3	2
1	21.8								
	Indonesia		63		20	5	2	2	1
1	19.4								
	Jordan		81		37	12	4	2	3
2	21.6								
	Malaysia		89		47	17	7	4	2
1	23.1								
	Nepal		42		7	2	1	1	1
1	17.1								
	Pakistan	62		22	9	3	3	1	1
	19.8								
	Philippines		92		58	29	14	9	5
6	24.5								
	Republic of Korea		97		60	11	1	1	0
0	23.2								
	Sri Lanka		93		61	32	13	6	5
2	25.1								
	Syrian Arab Republic	77		40	17	8	6	3	2
	22.1								
	Thailand	85		42	19	10	6	4	3
	22.5								
	Yemen	39		7	3	2	0	2	1
	16.9								
Average		**72**		**34**	**12**	**5**	**3**	**2**	**1**
	21.0								
Level of development									
	I. High		82		37	13	6	5	3
3	21.6								
	II. Middle-high		84		45	20	9	6	4
3	22.7								
	III. Middle-low		64		20	6	2	1	1
1	19.5								
	IV. Low		55		18	6	2	1	1
1	18.7								

ALL COUNTRIES		**73**	**32**	**12**	**5**	**3**	**3**	
2	**20.8**							

Sources: Smith (1990), and Ebanks and Singh (1984). WFS.

Current marital status of the NDHS is shown in Table 9.30. The term "married" refers to legal or formal marriage, while "living together" refers to informal union. In subsequent tables, these two categories are combined and referred to collectively as "currently married" or "currently in union." Women who are widowed, divorced, and not living together (separated) make up the remainder of the "ever-married" or "ever in union" category.

Table 9.30. Current marital status
Per cent distribution of women by current status, according to age, Nigeria 1990.

Age	Number of women	Marital status: Never married	Married	Living together	Widowed	Divorced	Not living together	Total
15-19	1,612	61.4	34.0	3.0	0.3	0.7	0.6	100.0
20-24	1,676	21.7	70.8	5.5	0.5	0.7	0.8	100.0
25-29	1,669	7.9	81.5	7.9	1.0	0.7	0.9	100.0
30-34	1,410	0.9	84.9	10.8	1.4	1.4	0.7	100.0
35-39	954	1.2	83.7	9.8	3.7	0.5	1.1	100.0
40-44	836	0.3	77.7	9.8	7.8	2.8	1.7	100.0
45-49	624	0.1	78.7	8.2	10.3	1.8	0.8	100.0
Total	**8,781**	**17.2**	**70.9**	**7.4**	**2.4**	**1.1**	**0.9**	**100.0**

Most women are currently in a union (78 per cent). The NFS, which also defined marriage to include both formal and informal unions, reported a similar figure (80 per cent of women were in a union at the time of the survey). Although the great majority of women are in a union, a fair proportion enter their twenties having never being married (22 per cent of women age 20-24 years). As expected, the proportion of women who are widowed increase with age, reaching 10 per cent among those 45-49 years. Two per cent of women are divorced or separated.

Polygyny

Since polygyny is common Nigeria, married women were asked whether their husbands had other wives, and if so, how many. Overall, 41 per cent of currently married women are in a polygynous union.

Table 9.31, indicates that polygyny exists in all regions and among all socioeconomic groups, although prevalence varies. Rural women and women in the north are more likely than urban women and women in the south to be in such unions. Nearly one-half of women who have no education are in a polygynous union, compared to 17 per cent of those who have completed secondary school (NDHS).

Table 9.31 Polygyny

Percentage of currently married women in a polygynous union, by age and selected background characteristics, Nigeria 1990.

Background Characteristic	All ages	Age of women 15-19	20-24	25-29	30-34	35-39	40-44	45-49
Residence								
Urban	22.6	26.0	27.4	34.5	39.3	51.5	45.6	33.6
Rural	27.8	35.8	38.2	51.1	49.6	45.5	55.1	42.9
Region								
Northeast	43.6	25.8	34.5	46.5	51.1	50.8	52.5	54.3
Northwest	49.7	31.0	44.1	43.8	62.3	57.0	50.4	65.8
Southeast	30.4	24.3	26.0	21.7	34.0	36.1	38.8	37.6
Southwest	38.4	21.4	23.6	28.7	40.0	50.1	45.4	57.1
Education								
No education	47.8	32.0	42.0	43.8	54.0	53.0	48.8	56.3
Some primary	34.1	27.1	34.8	40.4	32.3	28.4	43.4	26.6
Completed primary	27.0	11.5	26.8	21.7	34.6	33.5	35.1	49.5
Some secondary	22.5	20.5	31.3	25.8	42.5	49.6	20.5	26.8

Completed Secondary/higher	0.6	15.0	11.9	23.7	26.6	33.8	36.3	16.9		
Total	**27.0**	**33.7**	**35.6**	**47.3**	**47.3**	**46.8**	**53.4**	**40.9**		

It is not uncommon for a woman to have two or more co-wives (see Table 9.32). In fact, in the Southeast, although most women are in a monogamous union (70 per cent), more women have two or more co-wives (20 per cent) than have one co-wife (10 per cent). The likelihood of having two or more co-wives increases with age, as more time passes in which the husband may acquire a younger wife. Women who are more educated are less likely to have a co-wife; 28 per cent of women with no education have one co-wife, compared to 8 per cent of those who have completed secondary or higher education.

Table 9.32. Number of co-wives

Per cent distribution of currently married women by number of co-wives, according to selected background characteristics, Nigeria 1990.

Background Characteristic	Number of co-wives			Total	Number of women
	0	1	2+		
Age					
15-19	73.0	15.7	11.3	100.0	597
29-24	66.3	22.5	11.1	100.0	1,279
25-29	64.4	21.4	14.1	100.0	1,492
30-34	52.7	28.5	18.8	100.0	1,348
35-39	52.7	22.0	25.3	100.0	892
40-44	53.2	23.1	23.3	100.0	731
45-49	46.6	26.3	27.1	100.0	543
Residence					

Urban		66.4	20.0	13.4	100.0
1,476					
Rural	57.1	24.0	18.9	100.0	
5,404					
Region					
Northeast	56.4	26.0	17.6	100.0	
1,849					
Northwest	50.3	33.3	16.3	100.0	
1,944					
Southeast		69.6	10.2	20.1	100.0
1,801					
Southwest	61.6	21.8	16.6	100.0	
1,287					
Education					
No education		52.2	28.0	19.8	100.0
4,610					
Some primary		65.9	16.0	18.0	100.0
594					
Completed primary	73.0	14.4	12.6	100.0	
911					
Some secondary	73.2	12.6	14.2	100.0	
322					
Completed secondary/higher	83.1	7.9	8.4	100.0	
438					
Total		**59.1**	**23.1**	**17.7**	**100.0**
6,880					

NDHS

Age at First Marriage

The National Policy on Population states that "Families shall be dissuaded from giving away their daughters in marriage before the age of 18 years." However, the NDHS indicated that half the women in Nigeria have married by age 17 (the median age nationally) and, except of younger cohorts, this pattern remained stable over time (Table 9.33).

Cohort trends in age at marriage can also be described by comparing the cumulative distribution for successive age groups, as shown in Table 9.33. For instance, for the cohort currently aged 20-24, accumulation stops with percentage married by exact age 20.

Table 9.33. Age at first marriage

Percentage of women who were first married by exact age 15, 18, 20,22, and 25, median age at first marriage, according to current age, Nigeria 1990.

Current age	Number of women	Median age at marriage	Percentage of women who were first married by exact age 15	18	20	22	Percentage who had never married by age 25	Percentage who had first married by a
15-19	1612	a	20.1	NA	NA	NA	NA	61.4
20-24	1676	17.8	26.7	51.9	67.6	NA	NA	21.7
25-29	1669	17.2	29.8	55.0	68.8	78.6	88.6	7.9
30-34	1410	16.3	29.8	62.5	76.0	85.7	93.7	0.9
35-39	954	17.3	25.4	56.4	70.1	82.8	90.3	1.2
40-44	836	16.8	29.9	57.6	70.6	85.9	92.7	0.3
45-49	624	17.3	24.0	56.5	71.9	83.5	91.6	0.1
20-49	7169	17.1	28.0	56.4	70.6	81.2	88.2	7.3
25-49	5493	16.9	28.4	57.7	71.5	82.8	91.2	2.9

NA = Not applicable
a = Omitted because less than 50 per cent of the women in the age group *x* to *x+4* were first married by a age *x*.

On a national scale, age at marriage has not changed appreciably over time. Only among the youngest women (15-24) has there been a slight shift from marrying during the mid-teen years to the later teen years. Whereas about 30 per cent of women have typically married by age 15, only 20 per cent of those currently age 15-19 years have married by age 15. Thus, the median age at marriage has increased by about one-half a year.

The national picture masks quite variable marriage behaviour patterns; Table 9.34, gives a more detailed picture of the trends in the median age at marriage. It can be seen that the slight change observed at the national level has been achieved primarily through changes in behaviour of women in the south. In the southeast, the median age at marriage has increased by two years between the cohorts of women age 20-29 and 40-49; a similar increase appears to be taking place in the southwest. There has been no clear change in behaviour among women in the North.

Education is closely related to age at first marriage. The median age at first marriage increases steadily with education, from 15.7 among women with no education to 20 for women with secondary schooling.

Table 9.34 Median age at first marriage

Median age at first marriage among women age 20-49 years, by current age and selected background characteristics, Nigeria 1990.

Women Background Characteristic	Current age 20-24	25-29	30-34	35-39	40-44	45-49	Women age 20-49	Women age 25-49
Residence								
Urban	a	19.9	18.1	18.7	18.9	19.1	19.4	19.0
Rural	16.7	16.3	15.9	16.8	16.4	16.9	16.4	16.3
Region								
Northeast	14.8	14.9	15.1	15.4	15.3	15.7	15.2	15.2
Northwest	15.7	15.4	15.4	15.2	15.2	15.7	15.4	15.4
Southeast	19.4	19.3	18.2	18.1	17.3	17.4	18.5	18.3
Southwest	a	20.5	18.6	19.7	20.1	19.5	a	19.7
Education								
No education	15.2	15.3	15.6	16.1	16.0	16.8	15.7	15.8
Some primary	17.3	16.7	17.3	18.2	18.9	18.8	17.8	18.0
Completed primary	18.0	18.8	19.1	19.5	19.2	20.1	18.7	19.1
Some secondary	19.8	20.3	19.6	20.5	19.2	20.6	20.0	20.2
Complete secondary/higher	a	24.9	22.9	21.1	22.2	23.4	a	23.9
Total	**17.8**	**17.2**	**16.3**	**17.3**	**16.8**	**17.3**	**17.1**	**16.9**

Note: Medians are not shown for women 15-19 because less than 50 per cent have married by age 15 in all subgroups shown in the table.

a: Omitted because less than 50 per cent of the women in the age group were first married by age 20.

NDHS

Age at First Sexual Intercourse

While age at first marriage is commonly used as a proxy for exposure to intercourse, the two events do not coincide exactly. Women may engage in sexual relations prior to marriage, especially if they are postponing the age at which they marry. The NDHS asked women to state the age which they first had sexual intercourse (Table 9.35 and 9.36).

In many cases sexual activity precedes marriage (Table 9.35). For example, by age 18, 63 per cent of women have had intercourse, while 72 per cent have married. Overall, the median age at first sexual intercourse is just over 16 years, which is about three-quarters of a year earlier than the median age at marriage. Comparing cohorts, there has been little change over time.

Table 9.35 Age at first sexual intercourse

Percentage of women who had first sexual intercourse by exact age 15, 18, 20, 22, and 25, and median age at first intercourse, according to current age, Nigeria 1990.

Current age	Number of women	Percentage of women who had First intercourse by exact age: 15	18	20	22	Percentage who never had intercourse 25	Median age at first intercourse
15-19	1,612	24.4	NA	NA	NA	NA	45.6 a
20-24	1,676	29.7	63.0	82.5	NA	NA	7.5 16.6
25-29	1,669	31.2	62.1	80.4	89.6	96.7	1.5 16.4
30-34	1,410	32.8	67.4	82.6	91.9	97.4	0.4 15.9
35-39	954	27.8	63.0	75.3	87.5	93.3	0.2 16.5
40-44	836	31.1	61.1	77.5	89.9	94.2	0.0 16.4
45-49	624	27.6	62.3	78.7	88.3	94.2	0.0 16.5
20-49	7,169	30.4	63.4	80.2	89.9	94.8	2.2 16.3
25-49	5,493	30.6	63.5	79.4	89.7	95.6	0.6 16.2

NA = Not applicable
a: Omitted because less then 50 per cent of the women in the age group *x* to *x+4* had had intercourse by age *x*.

If women do not wait for marriage to become sexually active, has the increasing age at marriage in the Southeast and Southwest and among women with increasing education had any effect on reducing exposure to intercourse? Table 9.36, shows that while women in the Southeast and Southwest do indeed initiate sexual activity two to three years later than women in the Northeast and Northwest, they have been doing so for several decades. While age at marriage has been increasing, the age of initiating sexual relations has remained unchanged in the Southeast and Southwest.

However, women with more education to tend to marry later (the median age at first marriage for the most educated women is eight years later than that of women with no education); but they do not delay sexual relations to the same degree that they delay marriage (the median among the most educated is 3. 5 years later than for the least educated women). An urban-rural comparison shows similar results: while urban women have a median age at marriage three years later than rural women, their median age at first intercourse is only two years later.

Table 9.36 Median age at first intercourse

Median age at first sexual intercourse among women age 20-49 years, by current age and selected background characteristics, Nigeria 1990.

Women Background Characteristic	Current age 20-24	25-29	30-34	35-39	40-44	45-49	Women age 20-49	Women age 25-49
Residence								
Urban	17.9	17.8	17.4	17.6	17.8	18.3	17.8	17.7
Rural	16.0	15.9	15.7	16.1	16.1	16.0	15.9	15.9
Region								
Northeast	14.7	15.0	15.0	15.4	15.3	15.5	15.1	15.2
Northwest	15.5	15.3	15.3	15.1	15.3	14.9	15.3	15.2
Southeast	17.8	17.9	17.6	17.4	16.3	17.1	17.6	17.5
Southwest	18.4	18.5	17.9	18.7	18.9	18.4	18.4	18.5
Education								
No education	15.0	15.2	15.4	15.8	15.9	15.9	15.5	15.6
Some primary	16.6	16.3	16.8	17.8	18.3	18.3	17.1	17.3

Completed primary	17.3	18.2	18.3	18.5	17.9	18.9	18.0
18.2							
Some secondary	18.1	18.1	19.1	18.5	17.8	20.1	18.3
18.4							
Complete secondary/higher	18.9	19.0	20.0	19.2	18.5	20.0	19.0
19.2							
Total	**16.6**	**16.4**	**15.9**	**16.5**	**16.4**	**16.5**	**16.3**
16.2							

Note: Medians were not shown for women 15-19 because less than 50 per cent had had intercourse by age 15 in all subgroups shown in the table.

Recent Sexual Activity

In the absence of contraception, the probability of pregnancy is related to frequency of intercourse. Thus, information on sexual activity can be used to refine measures of exposure to pregnancy. Only 10 per cent of women interviewed in the NDHS had never had sexual intercourse. But not all women who have ever had intercourse are currently sexually active. Table 9.37, presents data on sexual activity, by background characteristics; the distributions are shown for women who have ever had intercourse.

Table 9.37 Recent sexual activity

Per cent distribution of women who have ever had sexual activity in the four weeks preceding the survey and the duration of abstinence by whether or not postpartum, according to selected background characteristics, Nigeria 1990.

Background Characteristics	Ages of Total women	Not sexually active in last 4 years					
		sexually active in last 4 weeks	(postpartum) 0-1 years	(postpartum) 2+ years	(not postpartum) 0-1 years	(not postpartum) 2+ years	Missing
Age of mother							
15-19	100.0 877	66.3	16.7	1.7	13.8	0.8	0.7
20-24	100.0 1,551	65.8	19.8	1.0	12.4	0.8	0.2

25-29	58.7	25.7	3.0	10.9	1.3	0.4	100.0	1,646
30-34	61.1	21.2	4.2	12.1	1.2	0.2	100.0	1,404
35-39	57.7	20.4	4.7	13.7	3.3	0.1	100.0	952
40-44	56.8	10.8	6.4	17.2	8.6	0.2	100.0	836
45-49	52.5	8.1	1.6	22.0	15.9	0.0	100.0	654
Duration of union								
0-4	59.3	29.0	1.7	9.0	0.3	0.7	100.0	1,377
5-9	62.8	24.9	2.8	9.1	0.3	0.2	100.0	1,405
10-14	63.0	20.1	4.7	10.9	1.3	0.0	100.0	1,374
15-19	60.5	21.5	3.4	12.0	2.4	0.2	100.0	1,261
20-24	58.7	16.0	5.3	14.9	5.1	0.0	100.0	847
25+	58.9	5.6	2.7	18.9	13.5	0.3	100.0	1,003
Never in union	58.5	3.1	0.9	33.0	4.0	0.6	100.0	623
Residence								
Urban	58.0	18.2	2.5	17.6	3.5	0.2	100.0	1,881
Rural	61.4	19.4	3.3	12.4	3.2	0.3	100.0	6,010
Region								
Northeast	74.6	14.8	1.7	7.5	1.1	0.4	100.0	1,920
Northwest	66.3	20.1	3.1	8.5	2.1	0.2	100.0	1,990
Southeast	52.0	19.9	3.7	18.8	5.5	0.2	100.0	2,349
Southwest	49.4	21.9	4.1	20.0	4.2	0.4	100.0	1,632
Education								
No education	63.1	18.0	3.8	11.1	3.7	0.2	100.0	4,878
Some primary	52.4	27.0	3.7	13.3	3.4	0.1	100.0	680

Completed primary	55.6	22.4	2.9	16.4	2.5	0.3	100.0
1,093							
Some secondary	57.5	20.3	0.4	19.9	2.0	0.0	100.0
487							
Completed Secondary/higher	60.8	13.7	0.2	22.1	2.3	0.8	100.0
745							
Current contraceptive							
No method	59.0	20.6	3.4	13.3	3.5	0.2	100.0
7,228							
Pill	79.6	2.4	0.0	16.4	1.1	0.5	100.0
121							
IUD	85.1	0.7	1.6	11.2	1.4	0.0	100.0
65							
Injection	84.7	3.8	0.0	11.5	0.0	0.0	100.0
61							
Durex/Condom	(81.6)	(2.6)	(0.0)	(15.7)	(0.0)	(0.0)	100.0
46							
Other modern	(76.3)	(4.5)	(3.1)	(12.7)	(3.3)	(0.0)	100.0
37							
Other	74.1	3.8	0.2	20.4	0.4	1.1	100.0
331							
Total	**60.6**	**19.1**	**3.1**	13.6	3.3	0.3	100.0
7,891							

Women are considered to be sexually active if they had intercourse at least once in the four weeks prior to the survey. Women who are not sexually active may be abstaining in the period following a birth, or may be abstaining for various other reasons. Among women who have had sexual intercourse, 61 per cent were sexually active in the month prior to the survey. Women who have never been in a union are just as likely to be sexually active as those who are in a union; however, they are not as likely to be postpartum abstaining (the main reason women in a union may not be sexually active). Approximately one-fifth of women in the South who have ever had sexual intercourse are currently abstaining for reasons other than being postpartum; this double that for women in the North. Compared to the Northeast (where three-quarters of women who have had intercourse are currently sexually active), only half of the women in the South are currently sexually active. As expected, women who are using a method of family planning are more likely to be sexually active than those who are not.

Postpartum Amenorrhoea, Abstinence, and Insusceptibility

Postpartum protection from conception can be prolonged by breastfeeding, which can lengthen the duration of amenorrhoea (the period following a birth, but prior to be the return of menses). Protection can also be prolonged by delaying the resumption of sexual relations. Table 9.38, presents the percentage of births whose mothers are postpartum amenorrhoeic and abstaining, as well as the percentage of births whose mothers are defined as still postpartum insusceptible for either reason, by time since the last birth.

Three-quarters of Nigerian women remain amenorrhoeic for at least six months following a birth; most women abstain from sexual relations during this time. However, about 12 months later (about 18 months after birth), fewer than half the women are still amenorrhoeic (41 per cent), and fewer than one-third (31 per cent) are still abstaining. Overall, 50 per cent of women become susceptible to pregnancy within 19 months of giving birth.

Table 9.38 Postpartum amenorrhoea, abstinence and insusceptibility

Percentage of births whose mothers are postpartum amenorrhoeic, abstaining and insusceptible, by number of months since birth, and median and mean durations, Nigeria 1990.

Months Since birth	Number of births	Amenorrhoeic	Abstaining	Insusceptible

<		93.7	95.9	98.5	
	267				
2-3		89.2	89.5	95.8	
	283				
4-5		82.8	74.7	93.3	
	307				
6-7		76.8	61.2	85.7	
	352				
8-9		72.6	58.4	84.6	
	303				
10-11		64.0	51.3	74.8	
	210				
12-13		57.4	44.4	73.0	
	317				
14-15		44.6	33.4	58.1	
	294				
16-17		48.9	40.7	59.8	
	295				
18-19		41.0	31.4	52.2	
	232				
20-21		27.0	30.0	45.2	
	216				
22-23		22.6	21.7	32.0	
	168				
24-25		12.1	17.9	26.0	
	315				
26-27		7.9	10.4	14.9	
	300				
28-29		8.6	9.3	13.0	
	265				
30-31		7.4	8.8	13.7	
	245				
32-33		4.2	10.8	12.8	
	212				
34-35		14.2	16.4	20.0	
	222				
Total		**45.3**	**40.9**	**55.2**	
4,802					
Median		**14.6**	**10.8**	**19.0**	
--					
Mean		**15.8**	**14.4**	**19.3**	
--					

CCXL

Prevalence/Incidence Mean --	**16.1**	**14,5**	**19.6**

NDHS

Table 9.39, shows the median duration of insusceptibility by background characteristics of the mothers. Duration of breastfeeding (which is linked to amenoorheoa) decreases as the education level of the mother increases. As a result, the duration of amenorrhoea for educated women is shorter too. Whereas the median for women with no education is one and a half years, it is less than nine months for women with secondary or more schooling. Women are more similar to each other in their duration of abstaining than their duration of amenorrhoea. The median duration of abstinence is between 10 and 11 months.

Table 9.39 Median duration of postpartum insusceptibility by background characteristics

Median number of months of postpartum amenorrhoea, postpartum abstinence, and postpartum insusceptibility, by selected background characteristics, Nigeria 1990.

Background characteristic	Postpartum amenorrhoea	Postpartum abstinence	Postpartum insusceptible	Number of births
Age				
<30		13.8	9.5	17.3
2,856				
30+		16.2	11.5	21.0
1,946				
Residence				
Urban		12.0	11.6	15.1
998				
Rural	16.4	10.6	19.9	
3,804				
Region				
Northeast		19.5	10.9	21.2
1,214				

Northwest		17.1	7.8	19.9
1,311				
Southeast		12.0	11.0	15.9
1,395				
Southwest		13.2	12.7	17.0
883				
Education				
No education	18.2	10.6	21.0	
2,972				
Some primary	15.1	12.7	20.0	
495				
Completed primary	21.1	10.9	15.2	
728				
Some secondary		7.9	8.5	16.3
279				
Completed secondary/higher	8.5	8.3	10.2	
323				
Total		**14.6**	**10.8**	**19.0**
4,802				

Note: Medians are based on current status.

Termination of Exposure to Pregnancy

Later in life, the risk of pregnancy begins to decline with age, typically beginning around age 30. While the onset of infecundity is difficult to determine for any individual women, there are ways of estimating it for a population. Table 9.40, presents indicators of decreasing exposure to the risk of pregnancy for women age 30 and above.

Table 9.40 Termination of exposure to the risk of pregnancy

Indicators of menopause, terminal infertility and long-term abstinence among currently married women age 30-49, by age, Nigeria 1990.

Age	Menopause[1]	Terminal infertility[2]	Long-term abstinence[3]
Age			

30-34	2.3	16.1	1.4
35-39	3.1	26.5	2.4
40-41	12.2	49.9	4.8
42-43	11.6	46.9	4.7
44-45	24.5	59.3	6.0
46-47	19.3	67.5	5.1
48-49	40.7	83.1	11.9
Women 30-49	10.6	33.7	3.4

1. Percentage of non-pregnant, non-amenorrhoeic currently married women whose last menstrual period occurred six or more months preceding the survey or who report that they are menopausal.
2. Percentage of currently married women in their first union of five or more years who have never have never used contraception and who did not have birth in the five years preceding the survey and who are not pregnant.
3. Percentage of currently married women who did not have intercourse in the three years preceding the survey.

NDHS

The first indicator, menopause, includes women who are neither pregnant nor postpartum amenorrhoeic, but have not had a menstrual period in the six months preceding the survey. Forty-one per cent of the oldest women interviewed are menopausal. The second indicator of infecundity was obtained from a demonstrated lack of fertility. If a woman has continuously married for the five years preceding the survey, did not use contraception, and did not give birth in that time (nor is currently pregnant), she is considered terminal infertile. By the early forties, about half the women appear to be terminally infertile. The last indicator is long-term abstinence, which is the percentage of currently married women who did not have intercourse in the last three years. This percentage is fairly low, except among the oldest women.

5. MATERNAL AND CHILDBIRTH

Findings in maternal and child health coupled with information on infant mortality rates, can be used to identify subgroups of women whose live births are "at risk" and to provide information to assist in the planning of appropriate improvements in services.

A. Antenatal Care and Delivery Assistance

Table 9.41, shows the per cent distribution of births in the five years preceding the survey by source of antenatal care received during pregnancy, according to maternal and background characteristics. For over half (57 per cent) of all births, mothers received antenatal care from a

doctor, trained nurse, or midwife. For one-third (35 per cent) of births, mothers received no antenatal care at all. Women received antenatal care from a Traditional birth attendant (TBA) for only 4 per cent of births.

Table 9.41 Antenatal care

Per cent distribution of births in the five years preceding the survey, by source of antenatal care during pregnancy according to selected background characteristics, Nigeria 1990.

Background Characteristic	Doctor	Trained nurse/ Midwife	Auxiliary midwife/ Assistant	Village health worker	Trained traditional birth attendant	Tradi-tional birth attendant	Other	No one	Total	Number of births
Mother's age at birth										
<20	30.7	17.5	0.9	1.8	0.9	3.6	1.5	43.2	100.0	1,344
20-34	38.5	20.8	1.3	1.5	0.9	3.7	1.5	31.8	100.0	5,649
35+	31.8	20.1	1.3	1.7	0.6	3.2	1.6	39.6	100.0	1,119
Birth order										
1	39.1	21.0	0.9	1.2	1.1	3.6	1.1	32.0	100.0	1,458
2-3	38.5	19.9	1.0	1.9	0.8	3.4	1.0	33.5	100.0	2,516
4-5	37.5	18.6	1.3	2.0	1.1	3.3	1.5	34.8	100.0	1,992
6+	30.7	21.4	1.7	1.1	0.6	4.0	2.3	38.2	100.0	2,147
Residence										
Urban	61.2	23.1	0.5	0.4	0.7	1.3	1.6	11.1	100.0	1,714
Rural	29.6	19.4	1.4	1.9	0.9	4.2	1.5	41.1	100.0	6,399
Region										
Northeast	26.5	9.9	0.3	1.3	0.2	3.7	3.5	54.7	100.0	1,924
Northwest	31.2	14.0	0.2	0.2	0.7	0.5	0.9	52.4	100.0	2,242

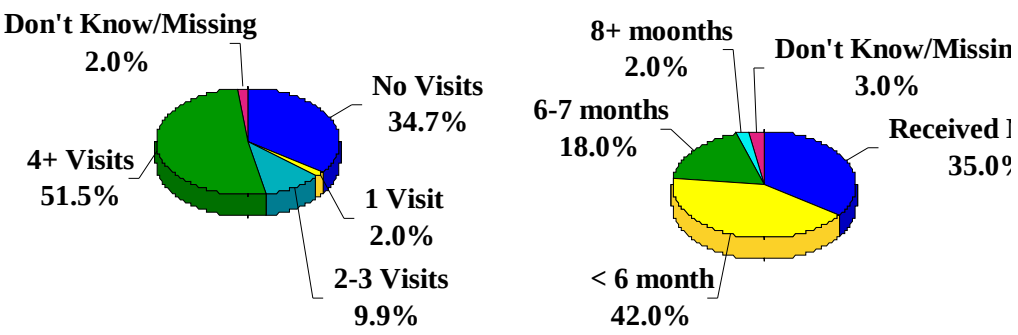
Southeast	35.0	29.5	2.7	3.8	1.7	7.6	0.1	19.6	100.0	2,422
Southwest	58.1	27.4	1.7	0.5	0.7	1.7	2.1	7.7	100.0	1,525
Mother's education										
No education	27.5	15.9	0.9	1.7	0.7	3.4	2.0	47.9	100.0	5,091
Some primary	35.0	32.4	4.2	1.3	1.3	6.7	1.2	17.9	100.0	824
Completed primary	47.8	28.3	1.0	1.9	1.2	4.0	0.9	15.0	100.0	1,212
Some secondary	60.6	26.4	0.4	1.4	0.9	1.5	0.2	8.6	100.0	459
Completed secondary/higher	76.4	18.2	0.9	0.6	0.6	0.4	0.3	2.6	100.0	521
All births	**36.3**	**20.2**	**1.2**	**1.6**	**0.9**	**3.6**	**1.5**	**34.8**	**100.0**	**8,113**

There are marked differences in the sources of antenatal care for births in urban and rural areas. The concentration of doctors in urban areas probably accounts for the fact that most births to urban women received antenatal care from a doctor (61 per cent), while only 30 per cent of births to rural women received such care. In fact, 41 per cent of rural births received no antenatal care, compared to 11 per cent of urban births.

There is a strong association between education and receiving antenatal care. Births to women with no education are about as likely to receive some kind of care as not; whereas it is unlikely that a birth to a woman who has had some education will receive no antenatal care. As the mother's level of education increases, so does the likelihood that she will be seen by a doctor during the pregnancy; 28 per cent of births to mothers with no education received antenatal care from a doctor compared to 76 per cent of women who completed secondary or higher schooling.

Information about the visits made by pregnant women is presented in Figure 9.7. In 52 per cent of births, mothers made four or more antenatal care visits. This constitutes 81 per cent of all births that received care, which suggests that those women who used the antenatal clinic were aware of the importance of regular attendance.

Figure 9.7
Distribution of Births by Number of Antenatal Care Visits and Stage of Pregnancy at First Visit



Only 42 per cent of all births received some antenatal care before the 6-month of gestation (Figure 9.7). However, for births to mothers who made antenatal visits, 67 per cent received attention before the six-month of pregnancy.

The median duration of gestation at which the first antenatal care visit was made was 5.3 months. This is rather late if mothers are to receive the maximum benefits of antenatal care. The advantage of starting antenatal care within the first three months of pregnancy is that a woman's baseline health can be assessed. Knowledge of a woman's baseline health will make early detection of any abnormalities easier; this, in turn, aids health workers in taking appropriate action to care for the mother.

Table 9.42 presents tetanus toxoid coverage during pregnancy for all births in the five years preceding the survey. Tetanus toxoid injections are given during pregnancy for the

prevention of neonatal tetanus, one of the principal causes of death among infants in many developing countries. For full protection, a pregnant woman should receive two doses of the toxoid. However, if a woman has been vaccinated during a previous pregnancy, she may only require one dose for a current pregnancy.

Table 9.42 Tetanus toxoid vaccination

Per cent distribution of births in the five years preceding the survey, by number of tetanus toxoid injections given to the mother during pregnancy and whether the respondent received an antenatal card, according to selected background characteristics, Nigeria 1990.

Background Characteristic	Number of births	Number of tetanus toxoid injections: None	One dose	Two or more doses	Don't know/ Missing	Total	Percentage given antenatal card
Mother's age at birth							
<20	1,344	54.5	11.2	32.2	2.1	100.0	48.6
20-34	5,649	43.4	11.9	43.4	1.3	100.0	60.6
35+	1,119	52.1	8.9	38.4	0.6	100.0	60.7
Birth order							
1	1,458	43.8	14.0	41.4	0.8	100.0	60.7
2-3	2,516	44.7	12.0	41.6	1.6	100.0	59.1
4-5	1,992	45.7	10.3	42.2	1.7	100.0	57.4
6+	2,147	50.9	9.8	38.4	0.9	100.0	54.1
Residence							
Urban	1,714	23.1	12.6	63.3	1.1	100.0	85.1
Rural	6,399	52.7	11.0	34.9	1.4	100.0	50.3
Region							
Northeast	1,924	65.2	10.6	24.1	0.2	100.0	35.8

Northwest		56.7	11.1	29.7	2.6	100.0
44.9	2,242					
Southeast		35.8	11.0	52.5	0.7	100.0
67.7	2,422					
Southwest		24.7	13.3	60.3	1.9	100.0
88.0	1,525					
Mother's education						
No education		58.0	11.2	29.3	1.5	100.0
44.9	5,091					
Some primary		34.6	11.8	53.2	0.4	100.0
69.1	824					
Completed primary		29.0	12.0	57.8	1.3	100.0
76.5	1,212					
Some secondary		20.0	12.7	66.5	0.8	100.0
85.6	459					
Completed secondary/higher		16.0	10.3	72.3	1.4	100.0
96.1	521					
All births		**46.4**	**11.4**	**40.9**	**1.3**	**100.0**
57.6	**8,113**					

Forty-one per cent of births received the protection of two or more doses of tetanus toxoid during gestation; 46 per cent were not protected by any tetanus toxoid vaccination. The mothers of births in the Southeast and Southwest were twice as likely to receive two or more doses during gestation (53 and 60 per cent) than were mothers in the Northeast and Northwest (24 and 30 per cent).

The relationship between education of mothers and vaccination status is striking; the proportion of live births in which two or more doses of tetanus toxoid were received increases steadily from 29 per cent among women with no education, to 72 per cent of births to women who completed secondary education. Educated women may have greater accessibility to modern medical care, or may have a greater understanding of the advantages of vaccinations, or may be more able to utilise the services provided.

Table 9.43 Place of delivery

Per cent distribution of births in the five years preceding the survey, by place of delivery, according to selected background characteristics, Nigeria 1990.

Background Characteristic	Health facility	At home	Home of health worker	Other	Don't know/ Missing	Total	Number of births

Mother's age at birth						
<20		23.8	70.1	4.3	0.4	1.4
	100.0	1,344				
20-34		32.8	59.9	4.5	0.6	2.1
	100.0	5,649				
35+		29.8	62.0	4.9	0.5	2.8
	100.0	1,119				
Birth order						
1		34.7	58.3	5.1	0.3	1.5
	100.0	1,458				
2-3		30.1	63.7	4.1	0.3	1.8
	100.0	2,516				
4-5		30.7	61.1	4.9	0.8	2.4
	100.0	1,992				
6+		29.5	62.9	4.3	0.8	2.5
	100.0	2,147				
Residence						
Urban		58,2	32.8	3.8	0.4	4.8
	100.0	1,714				
Rural		23.6	69.7	4.7	0.6	1.4
	100.0	6,399				
Region						
Northeast		10.4	88.6	0.1	0.3	0.7
	100.0	1,924				
Northwest		9.7	89.5	0.2	0.2	0.3
	100.0	2,242				
Southeast		46.3	38.4	11.4	0.9	3.0
	100.0	2,422				
Southwest		63.6	24.9	5.6	0.9	5.0
	100.0	1,525				
Mother's education						
No education		15.8	80.2	2.8	0.4	0.8
	100.0	5,091				
Some primary		44.7	40.3	10.8	1.3	3.0
	100.0	824				
Completed primary		48.1	37.7	8.7	0.8	4.7
	100.0	1,212				
Some secondary		71.2	17.6	4.2	0.8	6.2
	100.0	459				
Completed secondary/higher		81.7	12.6	3.0	0.2	2.6
	100.0	521				
Antenatal care visits						

None	1.6	94.6	2.4	0.3	1.0	100.0	2,805
1-3 Visits	25.7	69.1	3.8	0.8	0.7	100.0	963
4 or more visits	52.8	38.1	6.3	0.7	2.2	100.0	4,187
Don't know/Missing	4.6	64.9	2.6	0.0	27.8	100.0	157
All births	**30.9**	**61.9**	**4.6**	**0.6**	**2.1**	**100.0**	**8,113**

Fifty-eight per cent of births in the last five years preceding the survey were to mothers who received antenatal cards for their pregnancies. Those who were less likely to have cards were births to women under 20 years of age, births to rural women, births to women from the Northeast and Northwest, and births to women who had no education.

Women who had contact with health professionals during pregnancy were much more likely to deliver at a health facility than women who had no such contacts (Table 9.43). Fifty three per cent of births to women who made four or more antenatal visits were delivered in a health facility, compared to two per cent of births to women who made no antenatal care visits.

Table 9.43 shows the distribution of births by the place of delivery. The differences between the North and the South are substantial. While delivery births at home is not uncommon in the Southeast and Southwest (38 and 25 per cent), it is the norm in the Northeast

Table 9.44 Assistance during delivery

Per cent distribution of births in the five years preceding the survey, by type of assistance during delivery, according to selected background characteristics, Nigeria 1990.

Background Characteristic	Doctor	Trained Midwife	Auxiliary Nurse/ Assistant	Village midwife/ health worker	Trained traditional birth attendant	Tradi-tional birth attendant	Other	No one	Don't know/ Missing	Total	Number of births
Mother's age at birth											
<20	7.7	16.0	1.1	0.7	3.7	23.0	4.9	42.4	0.7	100.0	1,344
20-34	11.1	21.7	1.2	1.0	3.5	18.9	5.3	37.0	0.4	100.0	5,649
35+	9.6	19.7	1.9	1.1	3.5	16.6	4.6	41.9	1.1	100.0	1,119
Birth order											

1	13.0	21.9	1.1	0.9	4.1	19.8	4.3	34.5	0.3	100.0	1,458
2-3	10.1	19.8	1.4	0.8	3.6	18.7	4.5	40.6	0.4	100.0	2,516
4-5	10.2	20.9	0.8	1.2	3.5	20.4	5.2	37.4	0.5	100.0	1,992
6+	8.9	20.0	1.6	1.0	3.2	18.4	6.3	40.0	0.7	100.0	2,147
Residence											
Urban	21.3	38.1	1.2	0.2	2.6	9.6	4.5	21.6	0.8	100.0	1,714
Rural	7.4	15.8	1.3	1.2	3.8	21.8	5.3	43.1	0.4	100.0	6,399
Region											
Northeast	7.2	3.7	0.1	0.3	2.9	23.4	5.8	56.1	0.7	100.0	1,924
Northwest	5.2	5.0	0.2	0.1	2.2	21.0	2.6	63.5	0.2	100.0	2,242
Southeast	10.5	35.1	1.9	2.5	5.8	21.1	6.7	15.9	0.5	100.0	2,422
Southwest	21.5	41.4	3.3	0.7	2.7	8.3	5.5	15.7	0.8	100.0	1,525
Mother's education											
No education	6.2	9.4	0.7	1.0	3.4	21.8	5.7	51.4	0.3	100.0	5,091
Some primary	9.7	34.9	2.1	1.2	4.6	18.7	5.7	22.2	0.9	100.0	824
Completed primary	14.2	34.4	2.4	1.1	4.1	17.6	3.8	21.2	1.2	100.0	1,212
Some secondary	21.6	47.4	3.1	0.5	3.4	9.4	4.8	9.3	0.5	100.0	459
Completed secondary/higher	32.0	49.9	0.8	0.6	2.4	6.3	2.0	5.7	0.1	100.0	521
Antenatal care visits											
None	0.9	0.9	0.2	0.1	3.5	30.6	6.2	57.6	0.0	100.0	2,805
1-3 Visits	12.0	14.1	0.6	0.3	4.9	16.0	5.9	46.3	0.0	100.0	963
4 or more visits	16.5	35.8	2.1	1.7	3.3	11.4	4.4	24.7	0.0	100.0	4,187
Don't know/Missing	2.6	1.1	1.6	0.0	2.1	44.4	1.4	20.4	26.3	100.0	157
Total	**10.3**	**20.5**	**1.2**	**1.0**	**3.6**	**19.2**	**5.1**	**38.6**	**0.5**	**100.0**	**8,113**

and Northwest where nine of ten children are still delivered at home. The high proportion of births delivered at home in the North has serious consequences for both maternal and child health.

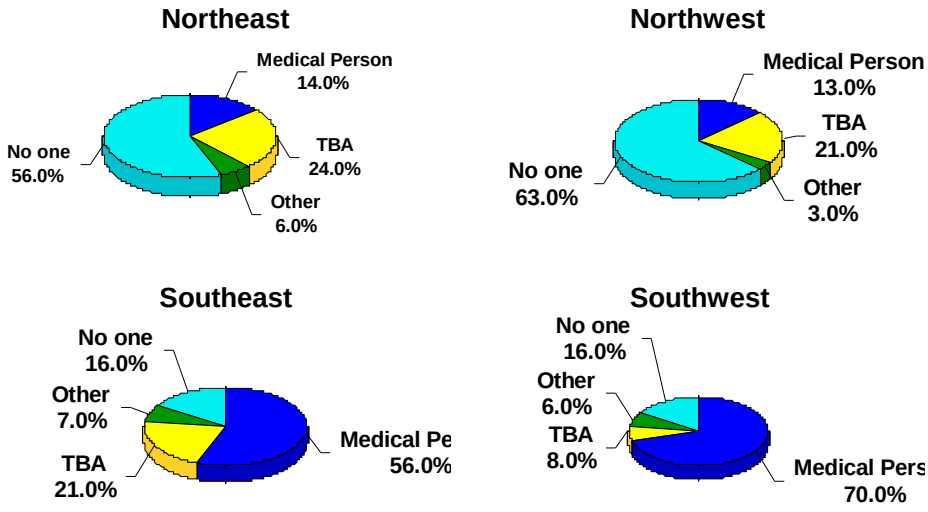
The expected pattern with regard to mother's education can be seen in Table 9.43:the proportion of births delivered in a health facility increases steadily from 16 per cent of births to mothers with no education to 82 per cent of births to mothers with completed secondary or higher education.

Overall, about 60 per cent of births in Nigeria are delivered at home, while 30 per cent are delivered in health facilities.

The type of assistance a woman receives during the birth of her child depends on the place of delivery. Births that are delivered at home are more likely to be delivered without assistance from anyone, whereas, births delivered at a health facility are more likely to be delivered by trained medical personnel (not shown).

Overall, more than half the births in the Northeast and Northwest are delivered without assistance while only 16 per cent of births in the Southeast and Southwest are delivered by without assistance (see Table 9.44 and Figure 9.8).

Figure 9.8
Assistance During Delivery by Region



Births to rural women, births to women in the Northeast and Northwest, births to women with no education, and births to women who make no antenatal visits, are more likely to be delivered without any type of assistance. These characteristics identify women who are at greater risk of dying due to complications occurring during pregnancy and delivery.

While doctors provided some antenatal care to 36 per cent of births (see Table 9.41), they assisted in delivering only 10 per cent (see Table 9.44). Trained nurses, midwives, and birth attendants delivered approximately 30 per cent of the births in the Northeast and Northwest, and 62 to 52 per cent of the births in the Southeast and Southwest. It is possible that many of the women who received antenatal care from doctor could not afford doctors' delivery fees; however, it is standard practice in Nigeria for normal deliveries to be performed by nurse-midwives rather than doctors [7].

If they are available to assist, doctors tend to do so in cases with complications.

Only 2. 5 per cent of babies born in the last five years preceding the survey were delivered by caesarean section. Less than 2 per cent of births were born prematurely (see Table 9.45). For 90 per cent of births, the birth weight was unknown, which is to be expected given that two-thirds of births were delivered at home.

Only 16 per cent of babies born in the five years preceding the survey were reported by the mother to be very small or smaller than average at birth; 30 per cent were reported to be larger than average or very large; the remaining half of births were reported to be average size at birth.

Table 9.45 Characteristics of delivery

Percentage distribution of birth in the five years preceding the survey by whether the delivery was by caesarean section, whether premature, and by birth weight and the mother's estimate of baby's size at birth, Nigeria 1990.

Caesarean
2.5

Premature birth
1.5

Birth weight
Less than 2.5 kg 0.7
2.5 kg or more
8.9
Don't know/missing 90.4
Total
100.0

Size at birth
Very small
6.3
Smaller than average
9.9
Average
52.3

B. Infant and Child Mortality

A demographic assessment of Nigeria's population would be incomplete without analysis of infant and child mortality rates [7]. Such analysis could form the basis for informed decisions on health, as well as population, policies and programmes. Information about infant and child mortality is also necessary for economic and health planning.

In the five years preceding the survey, nearly 1 in 5 children died before their fifth birthday. Neonatal, post-neonatal, infant, child and under-five mortality rates are shown in Table 9.46, for five-year periods in the 15 years preceding the survey. Under five mortality over this period has fallen slowly from 201 deaths to 192 deaths per thousand live

births [7]. The small decline is largely attributable to a drop in the neonatal rate from 52 to 42 deaths per thousand live births; mortality between 1 and 59 months of age has shown no improvement over the period. The latter finding may reflect the offsetting effects of improved health services on the one hand, and the deteriorating economic position of the average Nigerian household, on the other. Overall, 87 of every 1,000 children born die before their first birthday, and 115 of every 1,000 children alive at age one year die before their fifth birthday [7].

Table 9.46 Infant and child mortality

Infant and child mortality rates by five-year periods preceding the survey, Nigeria 1990.

Years Preceding Survey	Neonatal mortality	Post-neonatal mortality	**Infant mortality**	Child mortality	**Under-five mortality**
0-4	42.1	45.2	87.2	115.2	192.4
5-9	48.7	47.0	95.7	103.3	189.1
10-14	51.9	46.7	98.6	113.5	200.9

NDHS

An important finding of the NDHS involves the age pattern of under five mortality. In most countries of the world, mortality during the first year of life exceeds that during subsequent four years. However, this is not the case in Nigeria: child mortality (115/1000) is substantially higher than infant mortality (87/1000) in the 5-year preceding the survey. The higher level of child mortality, relative to infant mortality, is a pattern found in other West African countries such as Mali and Senegal.

Table 9.47 presents neonatal, post-neonatal, infant, child and under-five mortality rates by selected background characteristics for the 10-year period (1981-1990) preceding the survey. Figures 9.99 and 9.10 show infant and child mortality rates by selected characteristics.

The pattern of higher child mortality relative to infant mortality is most prominent in the Northeast and Northwest (Table 9.47). Particularly striking is the comparison of the Southeast

and Northeast. While the two regions have similar levels of infant mortality, child mortality in the Northeast (139/1000) is more than double that in the Southeast (67/1000).

The regional variation in the age pattern of under-five mortality may be explained by socioeconomic differentials. It could be seen that high child mortality (relative to infant mortality) is experienced by children born to mothers who are uneducated, who live in rural areas, and who have limited access to basic health services.

It would be expected that neonatal mortality would reflect the quality of care received during the antenatal and delivery period. Surprisingly, women who received the most care (both antenatal and delivery care) gave birth to babies who experienced higher neonatal mortality than babies born to women with less care. It may be that many of these women had complications which required medical attention at birth while uncomplicated pregnancies did not require medically assisted delivery [7].

Table 9.47 Infant and child mortality by background characteristics

Infant and child mortality rates for the ten-year period preceding the survey, by selected background characteristics, Nigeria 1990.

Background Characteristic	Neonatal mortality	Post-neonatal mortality	**Infant mortality**	Child mortality	**Under-five mortality**
Residence					
Urban	40.4	35.1	75.4	58.9	129.8
Rural	46.7	49.1	95.8	123.8	207.7
Region					
Northeast	39.2	48.5	87.7	151.2	214.6
Northwest	57.8	52.0	109.8	151.2	244.4
Southeast	38.6	44.1	82.7	66.5	143.7
Southwest	46.3	38.3	84.6	90.3	167.2
Education					
No education	48.4	47.5	95.9	126.4	210.1

Some primary		43.4	54.1	97.5	103.7
191.1					
Completed primary	38.5	41.2	79.8	63.0	
137.7					
Some secondary	42.7	50.2	92.9	62.9	
149.8					
Completed secondary/higher	30.0	18.7	48.6	30.2	
77.3					
Medical maternity care					
No antenatal/delivery care	43.2	58.0	101.2	184.7	
267.2					
Either antenatal or delivery	34.5	37.2	71.7	106.4	
170.4					
Both antenatal & delivery	46.5	34.5	81.0	68.4	
143.8					
Total		**45.3**	**46.1**	**91.4**	**109.6**
191.0					

Figure 9.9
Infant Mortality
by Selected Characteristics

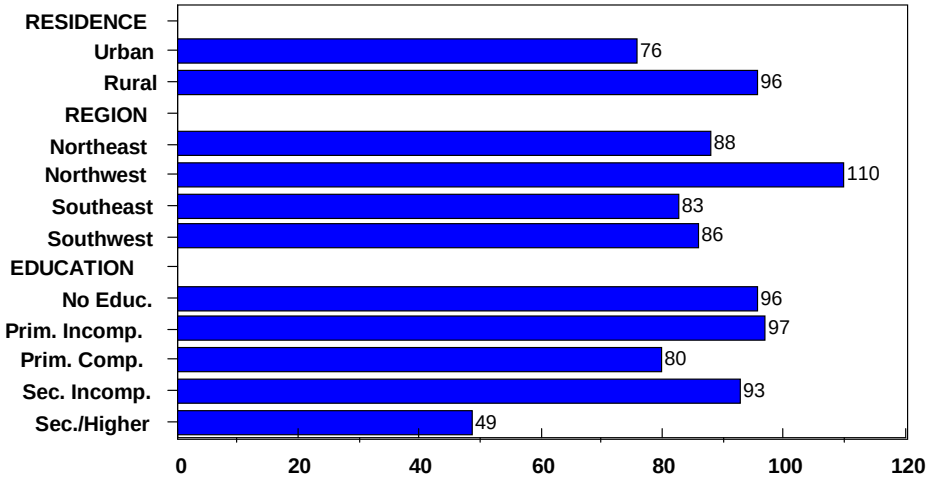


Table 9.48 present's mortality rates for the ten years preceding the survey by selected demographic characteristics. Children born to the youngest and oldest mothers have higher mortality rates than do children born to mothers age 20-39; first born and high parity children also have higher neonatal mortality than children of birth orders 2-6.

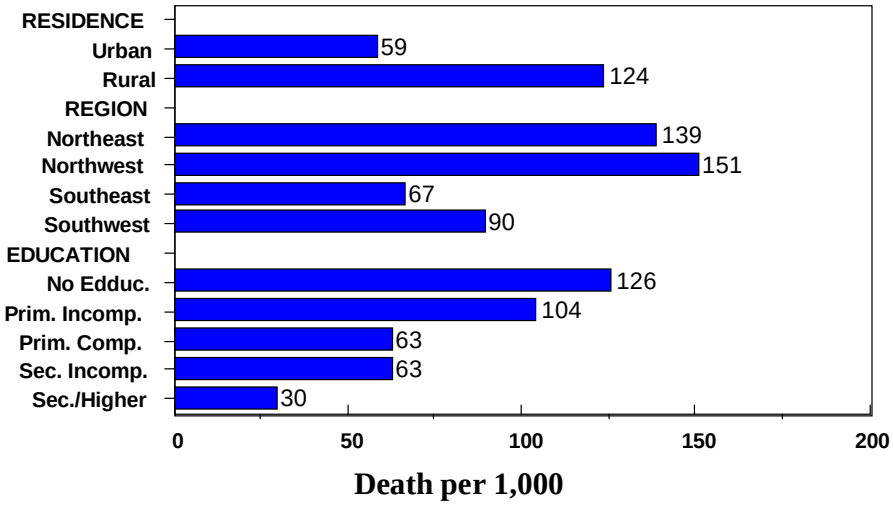
Table 9.48 Infant and child mortality by demographic characteristics

Infant and child mortality rates for the ten-year period preceding the survey, by selected demographic characteristics, Nigeria 1990.

Demographic Characteristic	Neonatal mortality	Post-neonatal mortality	**Infant mortality**	Child mortality	**Under-five mortality**
Sex of child					
Male	49.0	44.7	93.7	117.6	200.2
Female	41.6	47.5	89.1	101.5	181.6

Deaths per 1,000 births

Figure 9.10
Child Mortality (1-4yeasrs)
by Selected Characteristics



Age of mother at birth					
< 20	61.6	58.9	120.6	122.8	228.5
20-29	36.7	42.3	79.0	107.0	177.5
30-39	48.5	43.0	91.5	101.9	184.0
40-49	(68.5)	(57.5)	(126.0)	(138.6)	(247.2)
Birth order					
1	50.4	41.9	92.4	90.6	174.5
2-3	37.0	44.9	81.9	108.0	181.1
4-6	42.7	49.5	92.2	110.8	192.8
7+	61.1	46.6	107.7	136.7	229.6
Previous birth interval					
< 2 yrs	57.5	60.9	118.4	123.3	227.0
2-3 yrs	29.0	39.9	68.9	112.6	173.7
4 yrs +	16.9	21.8	38.7	54.9	91.5
Size at birth					
Very small	(93.2)	(95.0)	(188.2)	(122.3)	(287.4)
Smaller than average	63.0	59.0	122.0	(185.5)	(284.9)
Average	30.4	35.3	65.7	120.6	178.4
Larger than average	21.2	49.4	70.6	(102.6)	(166.0)
Very large	49.0	37.4	86.4	(111.5)	(188.2)

Shorter birth intervals are associated with higher mortality both during and after infancy. Children born less than two years after a previous birth are three times more likely to die during infancy than babies born four or more years after the previous birth are. The birth interval effect appears most pronounced during the neonatal period, a pattern which is consistent with an explanation involving maternal depletion, the term used to describe the physical weakness of

mothers associated with frequent childbearing. The NDHS findings support the importance of child spacing for child survival [7].

Children who are very small or smaller than average at births, experience higher mortality rates than children of average, larger than average, or very large. Since low birth weight is known to have a strong effect on early morbidity, it is not surprising that the most pronounced effects occurs during the neonatal period and diminishes with increasing age of the child.

c. High Risk Fertility Behaviour

Infants and children have greater probability of dying if they are born to mothers who are too young or too old, if they are born after a short birth interval, or if they are of high parity (Table 9.49). In this analysis, a mother is classified as "too young" if she is less than 18 years of age, and "too old" if she is over 34 years of age at the time of delivery. A "short birth interval" is defined by a birth occurring less than 24 months after the previous birth, and a child is of "high birth order" if the mother had previously given birth to three or more living children (i.e., if the child is of birth order 4 or higher). Children can be further cross-classified by combinations of these characteristics. First births, although often at increased risk, are not included in this analysis because they are not considered an avoidable risk.

Column 1 in Table 9.49 shows the percentage of children born in the five years preceding the survey who are included in specific risk categories (due to mother's age, time elapsed since previous birth, or number of previous births). Two-thirds of children (68 per cent) were at elevated risk as a result of the mother's fertility behaviour. Forty-two per cent of children were at elevated risk due to one high risk characteristic (i.e. they were in a *single risk* category); and additional 25 per cent had more than one high risk characteristic and were in a *multiple risk* category.

Fourteen per cent of births in the five years preceding the survey were to mothers who were over 34 years of age, and 8 per cent were to mothers who were less than 18 years of age; one-quarter of the births occurred after an interval of 24 months or less; and half of all children were of birth order 4 or higher.

In order to calculate the increase in risk attributable to fertility behaviour, risk ratios were calculated for each of the risk categories (see column 2, Table 9.49). A risk ratio is the ratio of the proportion of children in the category who have died, to the proportion who have died in the *not in any risk* category (children in the *not in any risk* category are born to mothers age 18-34, born at an interval of 24 months or more after the previous birth, and are parity 3 or less). Children in the multiple risk categories had nearly twice the risk of dying of children in the *not in any risk* category. Children born to mothers less than 18 years of age (and at no other risk) had a 30 per cent greater chance of dying than the children in the reference category.

Based on this brief analysis of high-risk fertility behaviour, the question can be asked: how many women currently have the potential for having a high-risk birth? This may be answered

Table 9.49 High risk fertility behaviour

Per cent distribution of children born in the five years preceding the survey who are at elevated risk of mortality, and the per cent distribution of currently married women at risk of conceiving a child with an elevated risk of mortality, by category of increased risk, Nigeria 1990.

Category	Births in the last 5 years Preceding the survey: Percentage of birth	Risk ratio	Percentage of currently married women[a]
Not in any risk category	32.3	1.00	20.9[b]
Single risk categories			
Mother's age < 18	7.8	1.31	2.7
Mother's age > 34	0.8	(0.26)	4.0
Birth interval < 24	7.6	1.07	9.3
Birth order > 3	26.9	1.05	19.0
Subtotal	42.3	1.08	35.0
Multiple risk categories			
Age < 18 & birth interval < 24[c]	1.4	(3.98)	0.9
Age > 34 & birth interval < 24	0.1	(2.77)	0.1
Age > 34 & birth order > 3	10.4	1.47	22.6
Age > 34 & birth interval < 24 & birth order > 3	2.6	1.67	5.9
Birth interval < 24 & birth order > 3	11.0	2.09	14.6
Subtotal	25.4	1.90	44.1
In any risk category	**67.7**	**1.39**	**79.1**

Total	**100.0**	**100.0**	**NA**
Number	**6,880**	**8,118**	**NA**

NA: Not applicable

Note: Risk ratio is the ratio of the proportion dead of births in a specific risk category to the proportion dead of births not in any risk category. Figures in parentheses are ratios based on fewer than 200 cases.

a: Women were assigned to risk categories according to the status they would have at the birth of a child, if the child were conceived at the time of the survey: age less than 17 years and 3 months, age older than 34 years and 2 months, latest birth less 15 months ago, and latest birth of order 3 or higher.

b: Includes sterilised women.

c: Includes the combined categories Age < 18 and birth order > 3.

NDHS

by simulating the distribution of currently married women by the risk category into which a currently conceived birth would fall. In other words, a woman's current age, time elapsed since last birth, and parity are used to determine into which category her next birth would fall, if she were to conceive at the time of the survey. For example, if a woman age 37, who has five children, and had her last birth three years ago were to become pregnant, she would fall into the multiple risk category of being too old (35 or older) and too high a parity (4 or more children). Women who have the potential for a high-risk birth can avoid experiencing the risk by using contraception to avoid the pregnancy (either to space or to limit the pregnancy, depending on which risk category she is in). To determine what proportion of women in the simulation have the potential for a high risk birth, it is assumed that all but sterilised women conceive.

Two points emerge from this discussion. First, the percentage of estimated high risk births (in any category) would increase without some fertility control among women who share a high risk profile. This can be seen by comparing the proportion of women who currently have the potential for a high risk birth (79 per cent) with the proportion of births in the five years preceding the survey that were classified as high risk (68 per cent). Second, this increase in high-risk births is linked to increases in the percentage of births in the multiple risk categories, from 25 to 44 per cent of births. These findings pose a challenge to policy makers and programme managers alike so that high-risk births can be avoided.

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1. NATIONAL POLICIES AND PROGRAMMES

Fifteen years ago, a Russian town hosted world experts desirous of protecting and promoting the health of all the people of the world. When they rose from the Alma- meeting, they had set a target year for the rest of the world. That target was the year 2000 AD, by which time the group projected that a level of health that would enable the entirety of the world's population lead a socially and economically productive life be attained. The result is what is now referred to as the **Alma Ata Declaration.**

It was in response to this global declaration that the government of Nigeria in 1988 adopted, for the first time, a National Policy on Health and Population [23], and strategy to achieve health for all.

Essentially, the policy described in details, the goals, structure, strategy, and policy direction for development and self-reliance in the country. Nigeria had joined the rest of the world and so the jingles hit the airwaves. Like housing, education and shelter, "health for all" was also added to the lot of the already over burdened magic year. "For eight years, these jingles have persisted, albeit at varying tempos" so says a Newspaper report [23]. The report further add: "But even at its crescendo, something did not just seem right and as the days drew nearer to the turn of the century, the jingles began to sound with more pronounced reluctance. By 1992, even the most stoic of optimists began to doubt the feasibility of the 12 years target as government continued to live the dream."

At the sitting of the National Council on Health in Maiduguri recently, Health Minister Dr Ikechukwu Madubuike (1995-1997), blamed the failure of most of our policies on weak political will, poor intersectorial collaboration, lack of relevant, accurate and reliable information [23,34]. He identified other problems as the lack of active participation by the private sector, poor management capacity and low community involvement and participation.

He insisted that the deterioration of the health status of Nigerian is an indication of the loopholes in the policy.

Professor Umaru Sheu, Pro-chancellor, University of Maiduguri and Chairman, Federal Task Force for National Immunisation, took a critical look at the infant mortality rate, child mortality rate, maternal mortality rate and life expectancy at birth in the country and notes that they have been deteriorating over the years [5,24].

Madubuike retorts: "How do we really justify whether a system is working well? Look at the profile! Take infant mortality rate, it is one of the worst in the whole world. Look at our life expectancy, it is only 50 years while other countries are clocking 75 years for men and 60 years for women. Our maternal mortality rate is still 800 per 100,000. These are clear indicators that we are not doing well and there is need to set up appropriate policies and instruments to prevent these worrisome trends."

Roles of Government

There is no doubt that government has played a vital role in bringing about the great advances in health over the past four decades.

In the 1960s and 1970s, developments at all level of the Nigerian economy and health systems were characterised by effective management before the rot set in. And the harvest of responsibilities not matched by adequate funding and the availability of trained manpower has been enervating.

Since the 1980s, there has been a systemic degeneration and it is clear that the country has become incapable of meeting the rising contemporary health challenges and needs of the populace [31,33-35,38,41].

This sorry state of affairs according to Professor Oladipo Akinkugbe is due to, among other things, poor planning, under-funding, mismanagement in administration and resource allocations [38].

According to Professor Adeoye Lambo, a former deputy director general of WHO, "The deteriorating state of the nation's health care service is the greatest failure of our contemporary society" [33,34]. Speaking in Abeokuta, at the 40th anniversary lunch of the Baptist Boys High School (BBHS) Independence Class, Lambo said mutual distrust among constituent parts of the country had negatively affected national development [35].

He said, "I look forward to the day in Nigeria when the fear of despairing miseries of the rejected and frustrated group of children is removed from houses, towns and cities because National Education Policy guarantees services that are accessible, of quality, affordable and acceptable to all Nigerians [35]."

Fertility And Nuptiality

The relationship between fertility and the different types of marital unions is not easy to untangle. There may be an element of selectivity in that women who are childless or at low parities may be more likely to have husbands who take on another wife. Achieved fertility may affect the timing and stability of marital unions. The timing of the first marriage may determine the occurrence of pregnancy, if sexual activity begins before marriage, as is the case among some ethnic groups [3,8,18,19,24,26].

The effect of polygamy on fertility is controversial. It is claimed that low fertility in polygamous unions may be the result of favouritism, in that some wives may be favoured by the husband over others, or may be due to low coital frequency (Lorimer, 1954, p.98 Musham, 1956; Romaniuk, 1968, p.214) [3,18,24].

It has been shown that age at marriage is generally low and marriage is almost universal for African women by age 20. Trends in age at marriage show that there is a rise in the age at marriage and decline in the proportion marrying. This is particularly true of more educated urban women.

Another aspect of marriage, the type of marital union, was also considered; and it was found that the incidence of polygamy is high - from 30 to 47 per cent. Remarriages are also very common. Further, it was found that there is a relationship between the type of marital union and education in that women with more years of education are more likely to remain in a monogamous union and less susceptible to the incidence of divorce and remarriage [1,13,24].

Under the traditional African family system, the survival and maintenance of the lineage takes priority over the conjugal bond. When they accept a bridewealth payment, the bride and her family agree to transfer reproductive rights to the husband and his lineage. If divorce or separation occurs, the wife is obliged to return the brideweath payment and leave her children with their father [1].

Findings from this study, as well as other studies including the NDHS and WFS indicated that large numbers of women failed to respond to the survey question on the number of children desired; this failure is consistent with a kinship system in which family sized decisions are made by the husband and his lineage. However, the costs of raising children are sustained not by the husband alone, but by the wife or by other women to whom the children are fostered out. Thus, husbands benefit from children's labour but bear few of the costs of their rearing, and so have little incentive to reduce fertility; women bear most of the costs of children, but do not see family-sized decisions as one of their basic rights [19].

Enhancing The Capacity Of The Female Child

One important indicator of women's status in the society is their access to education. Education can have a profound impact on the position of women, particularly in strongly patriarchal societies where it allows girls to have a wider social network, new reference groups and greater exposure to the modern world than they might otherwise experience. In addition, exposure to schooling allows girls to be free from parental control for several hours a day and gives them experience in interacting with boys, strangers, and authority figures other than their parents.

John Caldwell cites the role of mass education within a country or cultural group as a key factor in changing intergenerational attitudes and economic relationships within the family. He identified several mechanism through which changes take place: The labour that children contribute to the family decreases; the cost of children increases as the need to pay for school fees, clothing, books and other commodities rises; children shift from being producers to being dependents; and Western middle-class values are spread. He also argues that boys and girls often have differential access to educational opportunities; that the modernizing effects of education may be greater for girls than for boys; and that traditional families often fear schooling for girls, because they believe that educated women will be less likely than their uneducated counterparts to accept traditional relationships and certain *customs and beliefs* [1,2,14].

Knowing how to express ideas and how to ask questions are particularly important skills for girls to have (although they are discouraged from doing both under the traditional system). As educated girls mature, they can continue to use these social skills and to benefit from the social networks formed during school years. Such tools are important for improving health, because they give women the ability to decide whether a particular condition requires the attention of health personnel; they enable women to find out how and where to obtain information about health services; and they empower women to take action when necessary. A similar argument could be advanced in the case of fertility: If a woman wishes to limit her family size, at the very least she will need the skills necessary to know how to go about seeking information about birth control and family planning services. As their amount of education increases, women's views about many things change, including desired family size and the risk of female circumcision (FC).

Issues And Trends

There are many policy issues that the government and that of African countries need to consider if they want to reduce the high levels of fertility and maternal morality rate, in view of their overall socio-economic developments. Ensuring equitable access for the girl child to health,

nutrition, work parity, and education, demands the committed support and backing of the family, governmental and non-governmental organisations (NGOs) etc.

The girl's health vulnerability also stems from other social, cultural and traditional practices. In at least 25 countries in Africa, the Arab regions, and elsewhere, the practice of female circumcision places severe health risks, as well as emotional and psychological strains, on an estimated 75 millions girls as they enter adolescence and adulthood. This is clearly an area that calls for special advocacy and action in favour of the girl child.

Adolescent reproduction and early childbearing exact a heavy toll on young mothers and their children. The evidence points to the need to expand the coverage of health education, contraceptive knowledge and services, and the need to review age at marriage and pass legislation to increase the age at marriage.

Women's education should be improved. There should be more opportunities to continue with education for many years. This will lessen entry into marriage at an early age, as is the case at present. In addition, adequate education among women would act as a catalyst in changing their attitudes, which currently favour large family sizes. Furthermore, adequate education will prepare women to engage in gainful employment outside the home.

Existing programmes need to be strengthened and improved to achieve their desired objectives. Where there are no clear programmes and policy, formulation of relevant policies should be given full consideration and duly implemented.

2. WOMEN AND MANPOWER DEVELOPMENT

Manpower development is closely tied to the facilities available for education and training. In 1961, enrollment in the primary school was 2.8 million, but by the end of the period this has risen to about 4.0 million [27]. In 1976, Nigeria adopted a national policy of Universal Primary Education, which gave every child the right to free primary education [13,14,15,16,17,18]. The emphasis in education shifted from the standard Liberal education to the new more practical 6-3-3-4 system; however, the education facilities available and the curricula used do not take into full account the national manpower requirements [27]. The primary and secondary educational systems lack vocational and/or occupational orientation. The few technical and/or vocational schools have not attracted good students because of the low rating given their graduates. This calls for meaningful manpower development policy and for concerted effort at the provision of employment and training opportunities [10,16,43]. New approaches to primary, secondary, technical, teacher, higher, adult and non-formal and special education will be necessary to effectively address the issues affecting women and the manpower development. These include the structural imbalance in the country's educational system, low level of enrollment, shortage of all grades of teaching staff, the lopsided distribution and the low ratio of educational facilities, the low level of national literacy arising from inadequate non-formal-adult education facilities, the poor state of special education for the handicapped, the almost total neglect and poor funding of education, and the rather low enrollment in institutions of higher learning arising from financial incapacitation of most parents [8,9,11,14,15,16,20,21,27,29,38].

The economic records of the country in the 1980s have been dismal in respect to growth, external balance, poverty, and food security. From the onset of the decade, there were alarming signs, characterised by high population growth, and unemployment [20,21,36,37,44]. To make matters worse, even the prevalent low income was unequally distributed among the population and the young dominated the figure [44]. The continuing slump in the price of oil, policy errors, volatile exchange rates, weak incentive and structures, all combined with other circumstances to aggravate the situation further. In this circumstances women struggled to survive [15,22,32,39,44,46].

At the Nairobi Conference, there was a new and deeper understanding that broad economic and social factors - many of which are outside women's control - and issues of sex/gender impacted strongly on women's potential to contribute to their own progress and to the well-being of their families and nations. Paragraph 24 of The Forward - Looking Strategies for the Advancement of Women (FLS) is telling [22]:

"If the current trends continue, the prospects of the developing world, particularly the low - income and least developed countries, will be somber . . . In order to redress this outlook and thereby promote the advancement of women, policies should be re-oriented and reinforced to promote world trade, in particular so as to promote market access for the export of developing countries."

Lessons can be drawn from this experience. In recent studies carried out by the Harvard Institute for International Development (HIID), global patterns of growth during 1965-90 were shown to depend on four factors: initial conditions; physical geography; government policy and demographic change [30]. Initial conditions matter in the sense that; other things being equal,

poorer countries tend to grow faster than richer ones. Physical geography matters in several ways. Landlocked countries grew more slowly than coastal economies (being entirely landlocked was found to subtract roughly 0.7 percentage points from a country's annual growth. And tropical countries grew 1.3 percentage more slowly each year than those in the Temperate Zone, even after allowing for other differences. This seems to reflect the cost of poor health and unproductive farming [30] (TABLE 10.1).

Economic policies proved crucial in three different ways. First openness was decisive for rapid growth. Open economies grew 1.2-percentage points per year faster than those closed economies, controlling for everything else.

Second, prudent fiscal policy is crucial. Fast-growing countries tend to have government with high rates of saving and low spending relative to GDP. Each rise of ten percentage points of GDP in government saving was found to raise the overall GDP growth rate by one percentage point.

Third, the rule of law delivers growth. Good government is not just moral concern, or a basis for social stability and political legitimacy. Corruption, government breach of contract, expropriation of property, and inefficiency in public administration are found to harm growth (TABLE 10.1).

Demography is the fourth factor. All developing countries are moving from high birth and death rates to low ones. In most cases, death rates fall first, as medical advances reduce infant mortality and extend adult lives even before there is a change in fertility. The first phase, therefore, is faster growth of population. This followed by a fall in birth rates, as households adjust to longer life expectancy and lower infant mortality. (Fertility choices also interact with levels of development. As mothers' time in the labour force rises in value, families tend to have fewer children).

East Asia is passing through this transition earlier and faster than most developing regions. Its rapid population growth is already abating, and more of the population is now of working age.

In South Asia and sub-Saharan Africa, birth rates have been much slower to fall. The result has been a bulge in the population of dependent children: more mouths to feed, without a corresponding increase in the number of workers [30].

Table 10.1

Explaining failure

Contribution of selected factors to the difference between growth (per person per year) in the regions shown and growth in East and South-East Asia*****, 1965-90, %.

	South Asia	Sub-Saharan Africa	Latin America
Initial conditions	***0.3***	***0.7***	***-1.2***
Initial GDP per person	0.5	1.0	-1.2
Schooling	-0.2	-0.4	-0.1
Policy Variables	**-2.1**	**-1.7**	**-1.8**
Government saving rate	-0.4	-0.1	-0.3
Openness	-1.2	-1.2	-1.0
Institutional quality	-0.5	-0.4	-0.5
Demography	**-0.9**	**-1.9**	**-0.2**
Life expectancy	-0.5	-1.3	0.1
Growth in working age Population	-0.3	0.1	-0.2
Growth in total population	-0.2	-0.7	-0.1

Resources and geography

Poverty is closely linked to rapid population growth which tends to put pressure on available resources such as land, social and economic infrastructure and make the implementation of poverty reduction policies difficult.

Apart from the above indications, there are yet other startling revelations. For example, the adult literacy rate for Nigeria is 49 per cent with the northern states having the lowest,

ranging from ll per cent for Taraba and Yobe, Jigawa 12 per cent, Sokoto 16 per cent, Edo 79 per cent, Delta, Rivers, Abia and Akwa Ibom 78 per cent while Anambra has 77 per cent [47]. The average literacy rate follows the same plattern, 67 per cent of households are without electricity. Southwestern Nigeria has the lowest deprivation rates of 31 - 48 per cent, while only 7 per cent households in Jigawa, Kebbi and Sokoto enjoys electricity supply. Average household size was put at 4.8 with the highest figures in the north and the lowest in the south [47].

In the area of agriculture, the national average for households stood at 61 per cent with the north carrying the highest being 93 per cent in Kebbi State followed by Sokoto 92 per cent, Jigawa and Katsina 88 per cent. The lowest rate was recorded in Lagos with only two per cent of the households in agriculture. As can be expected, rural areas are engaged more in agriculture.

The Human Development Report 1994 of the United Nations Development Programme states: "Despite all our technology break through, we still live in a world where one fifth of the developing world's population goes hungry every night, a quarter lack access to even a basic necessity like drinking water and a third live in a state of abject despair at such a margin of human existence that words simply fail to describe it."

Let us imagine for a moment that our situation in Nigeria is worse than the averages being stated in the United Nations Development Programme Report [47].

The Vision 2010 committee puts the incidence of poverty i.e. those living below the poverty line at 50 per cent. Only 40 per cent of the population have access to safe drinking water. Eighty five per cent of urban populace lives in single rooms with average of eight occupants and most Nigerians consume less than the required protein intake [47].

Successive governments since independence have one way or the other addressed the issue of poverty alleviation in the country. Very little success was recorded due mainly to the uncoordinated policy enunciation and haphazard implementation strategies. Numerous programmes have been designed at one time or another directed at the under privileged segment of the Nigerian society addressing their various needs in the areas of provision of social services such as health, education, shelter, water, sanitation, agriculture, rural roads, etc., direct credit delivery and some macro economic policies directed at small scale industries and production yet most of the programmes fell short of expectations. Where the intention is to target the underprivileged, the programme is hijacked by the elite [47]. Additionally most of the programmes overlapped with various agencies doing the same thing. Terms of reference given to the agencies fell short of stipulating targets to be achieved resulting in laxity in performance and wastage of resources [47].

There were inadequate co-ordinating mechanisms. Agencies compete with one another rather than complement and co-operate with one another. Disjointed implementation resulted in efforts not achieving the desired results. Results achieved are hardly sustained due to the absence of follow up mechanism.

Political instability resulted in the abandonment of programmes before achieving maturity. In some instances, changes in government brought with them dissolution of boards and management changes as well as change in emphasis and focus. This sometimes resulted in retardation in progress made or outright confusion in roles.

Fraudulent activities and mis-management resulted in wastage of resources and failure to achieve cost effective results. Funds earmarked for programmes are not judiciously utilised to the extent that they are either misapplied with the programme or diverted to other use outside the programme. The people for whom programmes are designed are hardly involved either at policy design or implementation stage. The populace becomes on-lookers rather than participants. And

they reluctantly partake in what is handed over to them. The result is an uncommitted and interested target who, do not understand what is at stake for them [47].

In an article title: "Why poverty defies solution" written by Mrs. Hamra Imam, MD. People's Bank of Nigeria, and published by Business Times, she clearly summed it up in this way [47]: -

"Going by the various definitions of poverty, the outcomes of demographic studies in poverty and the attempts at poverty reduction through various government initiatives and interventions, the answer as to what needs to be done cannot be far-fetched. However, in view of the failures of various programmes to impact directly on the target populace, a more critical look at these solutions has become imperative. One is tempted to ask whether government has actually been paying lip service and not actually interested in drastic reduction of poverty through the ages. There is every reason for one to believe that Nigeria is very well endowed with abundant natural, human and material resources so much so that there is no excuse for the level of poverty in the land. We have already noted key issues that have contributed to this state of affairs. We know the causes and consequences of poverty but we are yet to grasp the implementation strategies of poverty alleviation. Perhaps as a nation, we lack the commitment, the sincerity, the will and the milk of human kindness that would enable our policy makers and implementators to sacrifice personal comforts in order that we become our brother's keeper. We know that the poor, the underprivileged members of the society are helpless not lacking in the ability for self actualisation mainly due to their inability to access social services, income and infrastructural facilities necessary for economic and social well being."

The Nigerian economy, despite the influx of petroleum money since the 1970s, remains one of the most inefficient and distorted in the world. Its major industries are hampered by a crumbling infrastructure in both utilities and transportation - a testimony to decades of mismanagement - which leads to supply bottlenecks. A distorted pricing system based on a wide swath of subsidies does little to improve the overall situation. Allied to these structural problems, a culture of bribery hinders foreign investment and slows decision making. Indeed, extrabudgetary spending, much of it wasteful, has been a perennial characteristic of Nigerian governance. The economy requires a major overhaul, from reducing its dependence on oil to major financial and exchange rate liberalisation.

The last two years have seen Nigeria's economy expand in excess of population growth. Recently, the regime of General Sani Abacha imposed extremely strict expenditure and monetary policy targets in a largely successful attempt to bring down inflation. Following Abacha's death in June 1998 and the change of leadership, economic policy has become more expansionary, including making outstanding payments to joint-venture partners in the oil industry, spending large amounts on a privatisation programme, and tabling a drastic review of the civil service minimum wage. Given the new policies, inflationary pressures are starting to build. In order to reduce those pressures, non-oil production will need to be stimulated and public infrastructure replaced, particularly as the fuel crisis that has engulfed the country since early 1997 has more than doubled the energy and transportation costs for households and manufacturers in the past year. The end result is going to be declining per capita income for Nigeria's estimated 110 million population, as growth was likely not more than two per cent in 1998 and will probably be less in 1999.

The drop in oil prices will also have a major impact on government finances and the current account balance. Since the 1998 budget assumed a $17-per-barrel price when an average of not more than $13 per barrel has been realised - and will probably be lower in 1999 - the original projections will be wildly optimistic. Yet Abubakar's expenditure commitments include raising civil servants' wages, rehabilitating the oil refineries and improving electric power supply. The crunch, which is coming, will undoubtedly be extremely serious. Simply put, the BBC quarterly publication 'FOCUS ON AFRICA', JANUARY - MARCH 1999, pp.37 explains:

. . . Because it has no access to IMF or bilateral credit at present, Nigeria has begun to run down its foreign exchange reserves to finance the deficit, but it cannot do this forever. Until oil prices recover, the administration will have only limited options to deal with its financing crisis, none of which is particularly positive individually, but collectively may allow Nigeria to avoid biting the bullet and making the really difficult economic decisions. However, all have serious negative consequences. Firstly, the government could cap debt repayments in the short term but his would militate against any future debt-rescheduling deals. An alternative would be to borrow against any future oil earnings at extremely costly commercial terms as it did in the 1980s. Thirdly, the money supply could be increased to meet domestic spending requirements, but this would further fuel inflationary pressures.

The government is also clearly hoping that its privatisation programme will be a success. Companies to be privatised include the hopelessly under-performing and mismanaged Nigeria Electric Power Authority (NEPA), Nigeria Telecommunications (NITEL), cement, sugar, fertiliser, steel and car factories and two Lagos hotels.

The government will sell a 40-per-cent stake in enterprises to foreign investors who will play an active role and a 20-per-cent stake to Nigerian investors through the stock exchange. The government will retain the remaining 40 per cent. Difficulties are bound to occur, however, such as assessing the valuation of many of the enterprises, and landing an agreement on protecting foreign investors with minority stakes. Critically, however, while Abubakar has stated that the Nigerian National Petroleum Corporation (NNPC) will be privatised eventually, no mention was made of its fate in the October announcements, further indicating that the government is not willing to deal with the root causes of Nigeria's economic malaise.

Given the size of the cash crunch, a major element along the way to economic recovery will be the need to open negotiations with the World Bank, the IMF and the Paris Club of official creditors in order to gain debt rescheduling and a less punitive payments schedule on the estimated $30 billion external debt. Nigeria has a poor record on debt repayment, and the international institutions have indicated that far-reaching economic reforms are needed before debt relief can be granted. The abolition of the dual exchange rate system, where a vastly differing official and unofficial rate co-exist, is a key priority. This will be the condition for negotiations with Paris Club creditors for a debt-relief initiative, and may open up the possibility of renewed concessional credit, which is currently unavailable. But the question remains whether Nigeria's new leaders will have the stomach to deal with a massive Naira depreciation, at a time when inflationary pressures are already high.

The oil price is likely to rise again in the future, perhaps just in time to save a Nigerian government from making the politically unpopular decisions which are required to overhaul its economy - namely full-scale privatisation, tackling corruption, liberalising prices and the exchange rate and instituting fundamental labour market and public service reform. The coming months will no doubt be unpleasant, economically speaking, for Nigerians, but the government

will manage to fudge a policy response long enough to escape the oil price recession until 2000. The lessons from the coming crunch should be clear, however, to both foreign partners and individual Nigerians. A democratically elected government must begin to build on Nigeria's productive base now, so as to ensure that when oil prices recover, the opportunity to deal with the structural deficiencies in infrastructure, education and health will not be wasted.

That Nigeria has abundance of natural and human resources is no longer news. The interesting and amazing fact is the paradox that a vast majority of Nigerians live in poverty. With an average output of about two million barrels of crude oil per day, the country earns almost 35 cents per capita per day. This translates to about #12,000 per capita per year.

According to Human Rights Africa (HRA), a human rights NGO, Nigeria made 1.3 million daily from oil in 1997. Other reports say that between 1972 and 1990, the country earned 200 billion dollars from oil alone. Yet, this made little impact on the welfare of the people. Reported average national per capita income stands at #1,014, while the average household income for 1992/93 stood at #1,250.

UNDP's Human Development Report on Nigeria said that in 1985, 43 per of the population lived below the poverty line, and government spending in the social sector declined from 13.1 per cent in 1985 to 9.3 per cent in 1992. For instance, per capital expenditure per annum on health in Nigeria stands at nine Dollars per person, much lower than the 14 Dollars spent by Ghana and the 16 Dollars spent by Kenya.

In 1990, spending on health, as a percentage of GDP was 2.7 per cent in Nigeria as against 3.5 in Ghana and 4.3 in Kenya, under-five mortality rate in Nigeria is 20 per cent.

In Ghana it is 15 per cent while in Kenya it is 9 per cent. In Nigeria, over 20 per cent of primary school-age children as well as 80 per cent of secondary school age children are not enrolled in schools.

On the whole, most Nigerian felt poorer in 1995 than they were in 1992 with incidences of individual poverty increasing, while the absolute poor increased from 35 million in 1992 to 44 million by 1995. According to FOS, 71 per cent of Nigerian households are poor, half of them very poor (living on below one dollar a day).

Nigeria's ranking in the global human development index remains low. It places 137 out of 174 countries in 1997 and 133 out of 163 countries in 1998. The country ranks behind such African countries as Cameroon, Kenya, Ghana and Sao Tome.

Also in Nigeria, more than 32 per cent of all households obtain their drinking water from streams, ponds and other unhygienic sources. Average calorie and protein intakes per capita stood at 2256 kilocalories in 1985 and only increased to 2259 in 1995. Protein intake increased only from 60 grams per capita per day in 1985 to 67 grams in 1995. Even as at 1995, the average food nutrient intake in Nigeria was still below the acceptable minimum international standards.

Nigeria's poor performances in the above mentioned socio-economic indices, the UNDP says, could be traced to poor policies as well as defective strategies employed in carrying out government programmes.

Most policies and programmes, it says, are not focused on the poor. They are hazy in most case with negligible benefits going to the people. Policy inconsistencies and lack of continuity have equally aborted planned progress. Most of the programmes it contends are either not well planned or are not people-oriented. In most cases, emphasis is on investments in the country's resources rather than in the people's welfare. There are large-scale and capital-

intensive projects that have no relevance to the people. But more importantly, the organisation argues that personal gains get more prominence over the larger interest of the people. Financial resources from local and external sources end up in the state and federal bureaucracies without reaching the people for whom they were intended.

Lack of accountability and transparency in the management of development programmes meant for the people are major obstacles affecting the projects. Also, the scope of the programmes are most often too large that resources for them are thinly spread to make any meaningful impact, and there is dearth of mechanisms to sustain the programmes.

Lowering Fertility Rates

The demographic transition towards a state of moderate or low fertility that has occurred in many parts of the developing world is associated not only with economic development, changes in the status of women and increased contraceptive prevalence, but also with the postponement of marriage and first birth and, in some cases, with the legalisation of abortion. China, South Korea, the Philippines, Sri-Lanka and Taiwan are noted examples where one or both of these changes have led to decreased fertility [1,2,19,28].

Fertility can be lowered in other ways: women who have completed their childbearing could become sterilized at younger ages and at lower parities*;* the prevalence of illegal abortion could rise; or contraceptive use could become more effective and more widespread. The first two of these solutions are undesirable for many reasons, and the third is extremely difficult to achieve. Earlier sterilization is a highly imperfect response, especially in *cities,* where consensual unions are on the rise and marital breakdown is common *and on the increase:* many women starting a new union in their late 20s or early 30s might regret an earlier decision to be sterilized. Only Cuba and a few other countries have legalized abortion; illegal abortion, with its attendant health risks, is an inadvisable practice. And, despite recent substantial increases in contraceptive use among all women of reproductive age, improved and more widespread contraceptive among young women has proved to be an elusive goal [56].

Because abortion is not likely to be legalized in *Nigeria and many other countries* for many years, postponing marriage and first birth appears to be the most viable avenue for achieving continuing fertility decline [1,3,4,28,42,45], if sexual activity continues to begin at relatively early ages, improved levels of contraceptive use will also be necessary if a delay in childbearing is to be achieved.

In addition to reducing family size, delaying the first birth has other benefits: other factors being equal, women who postpone marriage and motherhood until their 20s are more likely to stay in school and to obtain educational credentials that will allow them to find better paying jobs. As a result both their economic status and their standing in the community will be improved. For these and other reasons, women who give birth after their adolescent years, tend to be of higher socio-economic status than those who become teenage mothers, experience better birth outcomes and run lower risks of maternal morbidity and mortality [1.2.9,19,24,26].

Although the Nigeria government appears ready to arrest the poor situation, a lot still need to be done through an appropriate and effective working policy implementation programme. On the one hand there are still cases of Female genital mutilation (FGM) in certain

areas especially in the rural settlements with its attendant risks. At the other extreme are communities where marriages are arranged prior to puberty, and the sooner the girl becomes pregnant thereafter, the happier everyone is - except may be the girl!

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