

The Liminality of Adolescent Sexual and Reproductive Behaviour in Ibadan, Southern Nigeria

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Abstract

Most investigations and programmes addressing adolescent sexual and reproductive health in Nigeria tend to concentrate on the untenable dichotomy between in-school and out-of-school adolescents, as though there were no intermediary phase between these cohorts. The studies proceed as though the identities and behaviour of adolescents can be understood exclusively in terms of the formal structures of modern education. The present paper examines adolescent sexual and reproductive health among 1,458 in-school, out-of-school and between-school respondents in Ibadan metropolis. It concludes that this latter liminal phase in the educational lives of adolescents – the between-school phase – is distinct enough to generate its own special vulnerabilities. Focus group discussions were held with discussants from the three groups. They show that between-school male adolescents (i.e. those seeking entry into higher educational institutions or who aspire to do so) are more sexually active than the other two groups. Condom use and contraceptive knowledge are also lowest among this cohort. Between-school adolescents have poorer health seeking behaviour and partner communication patterns than in-school and out-of-school adolescents. Results like these point to disturbances in social structure, the emergence of an anti-structure, and the dynamics of vulnerability associated with liminal lives in a predominantly indigenous metropolis. They provide evidence of the need to expand programme focus in adolescent health research, advocacy and intervention and to direct policy attention to adolescents living in a phase further complicated by difficult choices.

Keywords: *adolescent sexuality, reproductive behaviour, liminality, Ibadan*

Introduction

As a creation of industrial society, adolescence is a liminal phase. It is a period of critical physiological, psychological and social changes compounded by adult dominance and the crises of heteronormativity. Its notoriously riotous character is not biologically fixed as such. Rather, it results from social ambiguities imposed upon this cohort by the requirements and exigencies of an industrial class society.

As it stands, therefore, the social period known as adolescence came into existence with the Industrial Revolution, which had its beginnings in the late 18th century. Adolescence's functional dormancy is not akin to a biological

pupal stage, as it were, in human development because, prior to the revolution, the ambiguities currently identified with adolescence were unknown to human society. All roles across the social strata were usually defined quite clearly. The period now known as “adolescence” was not accompanied by the tensions and notions of irresponsibility now associated with it until the demands of industrial society for a period of formal training and apprenticeship cast that cohort into its present liminal mould. These tensions arise from its contemporary liminality.

The early work of American cultural anthropologist Margaret Mead (1901-1978) clarifies this point substantially. Mead’s work had led to the publication of *Coming of Age in Samoa* in which she posed two crucial and interrelated questions:

Are the disturbances which vex our adolescents due to the nature of adolescence itself or to the civilization? Under different conditions does adolescence present a different picture? (Mead, 1928).

The answer to the first question is that “the disturbances which vex our adolescents” are due not to the nature of adolescence itself but to the civilization, its socialization patterns and systems of norms, values and expectations; if anything, these disturbances reflect a distortion of nature. The answer to the second question is: Yes.

Working in the small Samoan village of Ta’u (pop. 600), Mead examined the sexual behaviour of women aged 9-20 and found a fairly free and licentious sexual morality. She concluded from it that the passage from childhood to adulthood was accomplished with minimal anxiety. This heterodox finding did not conform to the hysteria linked with adolescence in her native America, and other societies that have followed in its developmental footsteps.

Mead’s *Coming of Age in Samoa* generated an unprecedented media frenzy and academic furore. Its provocative discussions attracted criticism from right wing academia but the study did succeed in showing that the notion of adolescence was a function of social structure and norms of the imperatives of social mobility. Accordingly, Schlegel and Barry (1991) have observed that adolescents experience harmonious relationships in their families in non-industrialised societies around the world and that adolescents are likely to be rebellious only in industrialised societies practising neolocal residence – unlike the patrilocal residence patterns common in much of the sedentary Nigerian countryside.

It is clear from this that modern market conditions have shaped how adolescents are defined in industrial society and established a marginal life course that they follow in adopting skills and embracing strategies that prepare them for future labour force participation. Those strategies include, but are not limited to, continuous attendance at a school that enables them acquire skills for the labour market. The schools exist as custodial institutions because the

skills they require for that participation ought not to take that long to acquire. Adolescents become the sidelined sacrifice for industrial development.

The mismatch between length of training and available potential reflects distortions in social structure and the creation of an anti-structure – age-specific patterns of growth in the population do not conduce with adolescent participation in the workforce. Should compulsory early retirement (at say age 50) be introduced as a policy measure, educational training periods would be progressively shortened worldwide. Adolescents would enter en masse into the labour force, if the size of that force remained constant. It follows from this that adolescence as we know it represents the complication of industrial class struggle by nascent age factors. This occurs when an emergent spirit of capitalism combines with age-long gerontocracy to take advantage of new forms of economic and social opportunities. It suspends social responsibility for adolescents. It deprives adolescents of clearly-defined roles. All opportunities are replaced by numerous liminoid encounters, including experimentation in the use of psychotropic substances, alcohol abuse, pronounced sexual networking, and a spirit of untrammelled adventure that is often prone to disaster. They do not benefit from the concrete expectations available to other population groups.

Against this background, the present paper argues that the scholarly tendency to confine “adolescence” to the dichotomy between “in-school” and “out-of-school” adolescents is delimiting for analysis and misleading from an empirical point of view. This tangential dichotomy, while very convenient for the academic pragmatist, is sadly guilty of what Victor Turner (1920-1983) described as “an obdurate evasion of the rich complexities of cultural creation” (Turner 1969: viii). The paper argues for the obdurate reinstatement of these complexities in studies of adolescent sexual and reproductive behaviour in Ibadan society.

Adolescence and Liminality

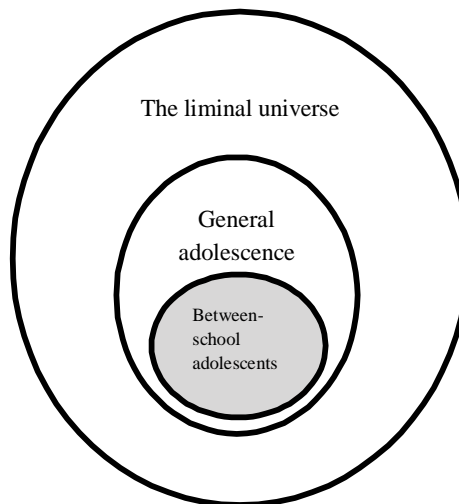
Adolescents, who occupy a betwixt-and-between position in the normal social categories of in-school and out-of-school adolescents, i.e. between-school adolescents, comprise a liminal class within a liminal class. The implications of this concentric anti-structure¹ for adolescent sexual behaviour and reproductive risk are the main issues dealt with in this paper (see Figure 1). Anti-structural status is characterized by liminality, marginality and structural inferiority, and these attributes apply soundly to adolescents who might have dropped out of school but later rallied themselves to return. As the concentric circles shrink, the experience of liminality becomes more intense while marginality expands

¹ A term coined by Victor Turner (1969) to describe the “transitional topsy-turveydom of the liminal phase of ritual” (Whitehead, 2004: 5), although the term has a wide variety of latter day applications.

at the defining core. Thus, while “the normative structure represents the working equilibrium, the ‘anti-structure’ represents the latent system of potential alternatives from which novelty will arise when contingencies in the normative system require it” (Whitehead, 2004: 6).

But this intermediate period is not altogether exclusive. The norms can be those promoting normlessness in that phase and, for Turner, the existence of pregnant margins and cracks in society are predictors of the indeterminacy that is the hallmark of human transitions and mobility. It is very much like a global transit passenger during a layover in an airport, or a long-distance telephone conversationalist placed on hold by a dilly-dallying operator. Retreat is not advisable even as progress is not certain. They both are in a limbo. They are travelling without travelling, having a conversation without conversing. Like a member of the Nigerian National Youth Service Corps (NYSC), who is neither a worker *per se* nor any longer a student as such, the non-travelling traveller (i.e. the passenger on a layover) and non-conversing conversationalist (the caller on hold), or the worker on furlough, exist momentarily in a liminal state. They are neither here nor there. Their “there” is at best mostly notional, never concrete. These are the routine interstices of everyday social experience and structure, which are lacking in the anomalous “in-school”/“out-of-school” dichotomies of adolescence in the explanation of sexual and reproductive behaviour. Figure 1 displays the existential transience of all human beings with a focus on the triple liminality of life as lived by adolescents who are between schools.

Figure 1: The Triply Liminal State



While liminality might have been revolutionary in Turner's time, it did not go far enough in its applications. Its seminal philosophical influences lie deeper in the neo-Nietzschean discourse of a "slave morality", which abandons human beings to a primitive determinism that could render human initiatives futile and curtail human freedom by limitations that could, at any moment, render it empty. In light of such futilities, one can suggest that human existence itself is the most primary liminality. The Judaeo-Christian notion of sojourn and Shakespearean ideas of an existential stage reinforce this sense of transience. Human material existence is liminal. This is depicted in the outermost circle of Figure 1.

Things come and go. Fashions fade. Cultures are created, recreated, constructed, reconstructed, shaped, reshaped, and then abandoned and denied. There is much flux. The death of memory and its inability to survive consciousness is additional proof that human existence is a liminal interlude in a meaningless creative orchestra. Accordingly, for Craib (1976:125)

All existing beings are born for no reason, continue through weakness, and die by accident...Man is a useless passion. It is meaningless that we are born; it is meaningless that we die.

Such pessimistic existentialist pronouncements appear to be borne out by propositions of Greek cosmology, which indicate that the aboriginal state of the universe is chaotic. Order is always an imposition because nature can never order itself, or maintain its order, outside external intervention. Things tend to chaos. Accordingly, while Turner's ideas were powerful in their time, it can be said that they did not attribute to the material condition its primary value, namely futility. They shied away from the nihilistic conclusions which, in their critique of *Dasein*, Ludwig Feuerbach (1804-1872), Friedrich Nietzsche (1844-1900) and Martin Heidegger (1889-1976) had earlier embraced.

Against this background, we construct adolescence in this paper as a liminal phase within a liminal existence. By extension, as Figure 1 shows, between-school adolescents – and, to a degree, their in-school counterparts – are triply liminal. General industrial adolescence is problematic only because, as noted, it is an artifice foisted on the world by the demands of industrial society for formal education. Under these conditions, between-school adolescents are vulnerable. They make wrong choices. At precisely the point in their lives where they are full of energy, creativity and vision, the social system ignores the potential contributions they can make. They become subject to the allurements of a modern sexual society, marginalised in the social and economic marketplace. Debarred from producing wealth, they are also regulated in spending it. Within this scenario, young people must deal with rapid physical and physiological changes within their bodies and a bewildering mass of transformations in the external

environment, which complicate their passage through this developmental phase and reconstitutes that adolescence into an uneasy quest for relevance and self-identity.

Adolescent Sexual and Reproductive Health in Nigeria

One quarter of all Africans and one-third of the continent's adolescent population live in Nigeria. In Nigeria, where young people aged under 20 years constitute half the population, there is minimal access to proven sexuality, family life or HIV and AIDS education that would "help them become sexually healthy adults, practice safer sexual behaviours, and reduce unintended pregnancy and Sexually Transmitted Diseases (STDs), including HIV" (Brocato, *n.d.*: n.p.). Projections show that by 2025, this cohort will exceed 57 million and continue to grow as a result of past age-specific fertility rates.

Many adolescents experience life defining events such as first sexual intercourse and parenthood during this phase. Beginning sex at an earlier age increases the risk of Sexually Transmitted Infections (STIs) for adolescents because the longer a person is sexually active before marriage, the more partners that person she is likely to have (Orji and Esimai, 2005). By age 18, more than 60% of African adolescents have had sexual intercourse. This high rate of sexual activity is associated with the continued increase in the incidence of unsafe abortion, unintended pregnancy and STIs, including HIV/AIDS, in the adolescent population. Recent reports show that more than 60% of all new sexually transmitted infections are among this group (AIDS in Nigeria, 2006; Orji and Esimai, 2005). HIV prevalence rates for both youths and adolescents was 5% in 2003 (FMOH, 2003), higher than for any other group.

Despite efforts by government and non-governmental organizations to minimize sex-related problems among this cohort, adolescents are still often confronted with conflicting and at, times, contradictory social expectations (Smith, 2004a). They may be misdirected and become vulnerable to early drug abuse, rape, unplanned and unwanted pregnancy, unsafe abortion, STIs, including HIV/AIDS, (Morhason-Bello *et al.*, 2008; PATH, 2005; Smith, 2004b). At a time of tremendous economic growth and industrial opportunities on the continent, the persistent view of adolescents as a monolithic segment of the human population makes it difficult to appreciate the diversity of that group's reproductive health challenges (WHO, 2007). As noted, the period itself is a liminal stage in human development, and is less a biological category than a sociological construct. As a result of religious and cultural factors, issues associated with sexuality of adolescents in Nigeria are often shrouded in secrecy (Smith 2004a). Therefore adolescents do not openly use reproductive health services neither are these services adaptable to them.

The sexual and reproductive behaviour of these groups involves a complex system of sexual networking that could complicate interventions for behavioral change. The dynamics of social relationships ensures interaction within, between and across the in-school, out-of-school and the more liminal between-

schools groups. Because, as this study finds, between-school adolescents are subject to higher risky sexual and reproductive behaviours, they may serve as agents of sexual risk to other groups.

In Nigeria, more than 60% of new HIV infections occur in youths ages 15 to 25. This takes place against a background in which one-third of the country's population of about 160 million are aged 10-24 years (NPC, 2007). Adolescent sexual and reproductive health behaviour is changing in ways that potentially undermines their physical health and social well being. Because the environment in which adolescents are currently growing places a greater premium on the acquisition of skills, the consequences of early sex and pregnancy may be more severe than they were in the past (Mensch *et al*, 2001).

Poverty and HIV transmission are connected in a variety of ways. Recent findings from a semi-longitudinal study of the social dimensions of HIV and AIDS prevention show that poverty provides an enabling context for transactional sex (REACH, 2010). Young women may be especially vulnerable due to societal practices that deny them education and work opportunities. Poverty also leads to poor nutrition and a weakened immune system, making poor people more susceptible to tuberculosis and to sexually transmitted diseases. Thus, adolescents who are between schools may find their health seeking and health protecting behaviour compromised by a range of choices they make just to stay adjusted in the society.

While informal channels of sex education are common, information about sex and reproduction received from friends and in the home are likely to be incorrect (Obono, 2008). More recent finding show that condom use is likely to occur within relationships where opportunity exists for discussion on sexual matters (Adebiyi and Asuzu, 2009) – a situation not likely to exist in frictional or opportunistic relationships characterized by the kinds of personal frustration prevailing among adolescents who are between schools. While recent government activities indicate that reproductive health education programmes are being developed, adolescents are at the moment faced with an almost complete lack of family life education and counselling services (Adeokun *et al*, 2009). Current educational programmes provided by the Nigerian Planned Parenthood Federation and organizations like the Association for Family and Reproductive Health based in Oyo State only reach a tiny proportion of the adolescent population. Their reach is tokenistic in comparison to the expected targets.

The behaviour of young people can have both short and long term consequences. Unprotected sexual relations are at the heart of problems associated with unwanted pregnancy or too early pregnancy and childbirth induced abortion and sexually transmitted diseases including HIV infection leading to AIDS. These actions may also result in maternal and child morbidity, mortality and infertility, not to mention thwarting of the social and economic development of young people (Olukoya and Ferguson, 2002;

Friedman, 1993). In an effort to reduce the high maternal, infant mortality and high rates of sexually transmitted infections and to minimize the drop-out rate, Nigeria developed a national reproductive health policy in 2000 that focuses on preventing risky sexual behaviours during adolescence. The programme was hampered by outdated and incomplete information on sexual knowledge, attitudes, and behaviors of adolescents in Nigeria (Slap *et al*, 2003).

The result is that a culture of silence still surrounds most reproductive health issues and many adults are uncomfortable talking about sexuality with their children (Smith, 2004a). Some lack accurate sexual health knowledge (Obono, 2008) and many Africans feel unable to discuss sexuality across perceived barriers of gender and age differences. Young people tend to absorb their knowledge about reproductive health haphazardly from a variety of sources (Barker, 2006). The result is the perpetuation of widespread ignorance. As many as 80% of patients at Nigerian hospitals with abortion-related complications are adolescent girls. The reasons young girls procure abortions include lack of accurate and comprehensive information about sexual and reproductive health, lack of appropriate reproductive health counseling and clinical services, non-use or ineffective use of contraceptives by sexually active young people, fear of partner rejection, parents, peer group, religious and community leaders, once they find out about the pregnancy and financial and emotional inability to take care of baby (Young Women, Population Reports, 2003).

Contraceptive use among adolescents is low at 30% and considerably lower than the rates reported for developed countries. This reflects inadequate contraceptive knowledge and access, as well as spontaneity of adolescent sexual activities (Orji and Esimai, 2005; Aziken *et al.*, 2003). This may also reflect the notion among youths that it is easier and safer to obtain an abortion than to practice regular contraception. According to Arowojolu *et al.* (2004), the poor use of contraceptives among Nigerian youth is due to the fear of side effects and the negative cultural attitudes of parents/guardians to contraceptive use.

Contrary to this view, however, Smith (2004a) seems to infer that the few adolescents, who do make use of contraceptives do so principally to prevent pregnancy and not for disease prevention. This shows that while a degree of success could be attained at preventing unwanted pregnancy, the risks of contracting STDs are high among them. Many young women do not have accurate or adequate information about effective contraceptives. Those who have do cannot obtain services and supplies they need. Sexual relations among young people who are unmarried may be sporadic and unplanned, making experience and lack of preparation additional barriers to contraceptive use, as well as rendering many contraceptive methods unsuitable for their needs (Barker 2006). Adolescents' lack of information and access to services is compounded by norms of disapproval targeting premarital sex and contraceptive use (Orji and Esimai, 2005).

A combination of limited budgets, problems imposed by the AIDS pandemic, and an inadequate supply of health care providers mean that improving reproductive health services is a challenge for most sub-Saharan countries. Adolescents should be able to protect themselves from unwanted sex, unplanned pregnancy, early childbearing, unsafe abortion and sexually transmitted infections. They form one of the largest groups with unmet need for reproductive health services. There are differences in the way these needs are met for adolescents from different socioeconomic strata of society, as well as for those living in urban and rural areas. One of the most important challenges facing reproductive health programs is how to address the needs of adolescents as they initiate sexual activity and are exposed to risk of unwanted pregnancy and infection especially for adolescents who form a more vulnerable segment of an already vulnerable population. Health promotion needs to be linked with service promotion, so that those adolescents who are sexually active can take necessary measures to protect their health. This is a major insight derived from findings of the present study.

Study Methodology

The empirical investigation on which this report was based took place at various intervals spanning 2003-2006 and involved participants from different schools and communities. The selection of schools for the in-school component followed a multistage sampling procedure in which a list of schools was obtained from the Oyo State Ministry of Education (OSME) as a sampling frame for in-school adolescents. The alternative household survey strategy was considered, but abandoned because a school-based strategy enabled numerous curricular intervening variables to be held constant. This was a more efficient approach as it provided access to a self-selected population for the research.

The list of schools was rearranged in alphabetical order and five schools were systematically chosen using a random start. Classes within the schools were randomly sampled and a total of 100 adolescent boys and girls randomly selected from the chosen classes in each school. In addition, a list of the extramural schools in Ibadan North Local Government Area (LGA) was retrieved from the OSME. The list was similarly rearranged in alphabetical order and five extramural schools were systematically picked using a random start. The random procedures for the selection of classes and 100 adolescents were identical to those used for the formal school settings.

A multistage sampling approach was also used to select out-of-school adolescents, but the procedure diverged from the in-school process owing to the absence of a sampling frame for out-of-school adolescents. As a way around this, a list of localities used during the 1991 census was retrieved from

the National Population Commission (NPC)² due to the fact that there was no list of enumeration areas (EAs) for Ibadan North LGA. The list of localities was rearranged in alphabetical order and five localities were systematically selected using a random start.

The NPC had demarcated 40 localities in Ibadan North LGA with an estimated average of 1,712 households per locality and an average of five persons per household. This yielded an estimated population of 8,560 persons per locality, or an overall estimate of 342,400 persons for all localities in the LGA. A frame of households was prepared and 100 households were systematically selected in each of the chosen localities following an initial survey round during which eligible households (i.e. those with at least one out-of-school adolescent) were flagged. In each selected household, two out-of-school adolescents were selected, where applicable. Where there were more than two, the Kish Grid was used to select the required respondents. Complementary items in the questionnaire enabled us sieve or distil the category of adolescents that we characterized as “between-school adolescents” or “liminal adolescents.”

In other words, this component of the study was conducted using a descriptive household survey design that was complemented by the use of in-depth interviews (IDIs) and focus group discussions (FGDs). While the principal instrument was the structured questionnaire, which was used to generate data on various characteristics of the adolescents, the qualitative methods proved essential for enhancing the explanatory significance of the survey results. Moreover, it was by this means that insights were gained into the existence of the liminal group of adolescents (those between schools) who constituted the third level of our analysis.

The questionnaire was self-administered among in-school adolescents in a typical class setting, for out-of-school and between-school respondents, however, it was administered as an interview schedule by trained assistants because illiteracy and semi-literacy increase with social distance from the educational system. Yoruba or Pidgin English versions of the instruments were used for the interviews. The questionnaire consisted of three sections, which were structured to elicit information on the socio-demographic background of respondents, their sexual and reproductive behaviour, and questions pertaining to their sexual knowledge, attitudes and contraceptive practices.

The FGD was the main qualitative method. Focus group discussions helped us investigate forms of sexual activity in each of the adolescent cohorts and the factors responsible for observed behaviour. It helped to foster better understanding of the topic and provided insights into the type of partner

² At the time of investigation, the 2006 Nigerian Population and Housing Census had not been conducted and the enumeration areas demarcated for the 1991 census were the most recent in the country. However, the EA maps for Ibadan North LGA were not available at the NPC office at the time of study, hence the recourse to the list of localities, which it provided.

communication that occurs in adolescent relationships, their fears about contraceptive use and barriers in acquiring contraception.

Results

Table 1 shows that 36.9% of study adolescents were sexually active. These results are interesting not only because of the high numbers of sexually active adolescents in the study area, but also because of the patterns in which they occur. Half of out-of-school adolescents had ever had sex relative to just over a quarter (27.1%) of between-school adolescents and 36.6% of in-school adolescents. While the findings do not show consistent discursive patterns in this preliminary exploration, they are significant for indicating differences in sexual profiles of a cohort that is sometimes mistaken to be homogenous.

Table 1: Sexual Profile of Adolescents

Variables	In-School % (N=480)	Out-of-School % (N=480)	Between-Schools % N=498	Total % N=1,458
Have partner of opposite sex				
Yes	75.0	65.7	34.3	58.3
No	25.0	26.9	65.7	39.2
Ever had sex				
Yes	36.6	50.0	27.1	37.9
No	63.7	50.0	72.9	62.2
Age at first sexual intercourse				
10-14	27.6	22.9	17.7	22.7
15-19	72.4	77.1	77	75.5
First sexual partner				
Boyfriend/girlfriend	63.2	72.5	47.4	61.0
Classmate	16.1	16.3	28.1	20.2
Brother's/sister's friend	8.0	3.8	11.9	7.9
Lesson mate	12.6	3.8	1.5	5.9
Tenant/Neighbour	0	0	11.1	11.1

Sexual debut is earliest among in-school adolescents (72.4%). Most between-school adolescents had sex for the first time at age 15-19, an indication that a drop-out status might increase the chances of sexual predation among this class or make transactional sex a more acceptable mode of coping in society. It is for this reason significant that while no in-school or out-of-school respondent had ever had sex with a tenant or neighbour, as many as 11.1% of adolescents classified as between-schools had done so.

These results are not as surprising as they might seem. They are useful for the insights they generate into the relationship between vulnerability and time use. The qualitative results and observation indicate that out-of-school adolescents occupy a less liminal status than their between-school counterparts. They have made their decisions and become adjusted to them. They may be terminal school drop-outs who have taken up trading or other work through

time. While they may not be in school, they certainly are not likely to be found at home either during the day. They are on the streets or in market stalls in the daytime. With in-school adolescents, the situation is straightforward. They are in school during the day. But this is not case with between-school adolescents. Their situation is more topsy-turvy. They spend the daytime alternating between homes. It is this implication of their liminality that makes them targets for neighbours and tenants in a way that does not exist for in-school or out-of-school adolescents. This explanation is even more plausible when taken together with the age at first intercourse among this cohort, which occurs at age 15-19 by which time their liminal status has begun.

Table 2 indicates that adolescent girls are more prone to having a partner of the opposite sex than their male counterparts. This tendency is more striking among out-of-school adolescent girls (53.8%) relative to between-schools adolescents (52.6%). As many as 75.6% of the between-schools adolescents who had had sex were boys relative to 58.6% for the in-school male group and 56.3% for the female out-of school adolescents. In-school and between-schools boys are more sexually active than their out-of-school counterparts. A focus group discussion with out-of-school boys shows that the mixed school environment provides opportunity for sexual contact among peers, which can take place outside the supervision of teachers. As discussants observed,

They normally put them together in a class, on the assembly ground and they move around the school premises together. Unlike us that don't come in contact with girls except when they pass by our workshop and we can't abandon work and follow them. Hence it just like putting a cock and a hen in the same place. Such an activity is bound to take place.

An in-school male adolescent agreed with this submission: "We walk with girls. We play with girls. We sit in class with girls. So, how do you expect us not to be sexually active?" This indicates that the structures of an industrial society could help account for risk factors of infection among adolescents. Rather than the familiar tendency to ascribe responsibility for high levels of reproductive mishaps among this group, it emerges from this that structural factors could be more germane to understanding these patterns and prevalence of adolescent sexual and reproductive problems.

Table 2: Distribution of respondents by ever had sex and their sexes

VARIABLES	In-School %	Out-of-School %	Between-Schools %	Total %
Have partner of opposite sex	N=480	N=480	N=498	N=1,458
Male	51.7	46.2	47.4	48.6
Female	48.3	53.8	52.6	51.4
Ever had sex	N=174	N=240	N=135	N=549
Male	58.6	43.8	75.6	56.3
Female	41.4	56.3	24.4	43.7

Table 2 shows in-school adolescent males are more likely than their out-of-school and between-schools counterparts to have sexual partners of the opposite. In this respect, there is consistency between the qualitative and the quantitative data. Table 3 indicates an expected gradient for the girls' groups: Their first sex partners are older. This is due to a combination of pubertal and financial factors. The out-of-school female respondents had older first sex partners than the other two groups. More than 11% had sexual partners aged 25 and above, with 2.2% having first sex with men as old as 30-35.

Table 3: Forms of sexual activity among adolescents

VARIABLES	In-School		Between-Schools		Out-of-School	
	%		%		%	
	Male	Female	Male	Female	Male	Female
Age of first sex partner						
10-14	31.4	16.7	26.5	24.2	22.9	9.6
15-19	56.9	54.2	66.7	57.6	74.3	45.2
20-24	11.7	25.0	6.9	18.2	2.8	37.0
25-29	-	4.2	-	-	-	5.9
30-35	-	-	-	-	-	2.2
Number of sex partners since onset of sex						
1	33.3	52.8	57.8	42.4	36.2	53.3
2-4	52.9	41.7	30.4	39.4	57.1	37.0
5-7	13.7	5.5	11.8	18.2	6.7	9.7
Coital frequency in past 1 month						
0	31.4	22.2	57.8	45.5	12.4	19.3
1	18.6	27.8	11.8	9.1	23.0	41.5
2-4	32.4	41.7	25.5	36.4	51.4	32.6
5 and more	17.6	8.3	4.9	9.1	12.4	6.7

Table 3 shows that in the one month preceding the survey, at least 50% of the target respondents had at least one sexual encounter, which reflects that they were sexually active at the time of study. The mean age for engaging in sex for out-of-school adolescents in this study is 15.9 years, for between-schools adolescents 15.3 and for in-school adolescents 15.1. In other words, sexual debut is similar across the groups although in-school adolescents start having sex a little earlier, followed by between-schools adolescents, in a pattern that again suggests the implications of liminal status for adolescent sexual behaviour. Monthly coital frequency is highest among out-of-school males (64%) relative to in-school males (50%) and females (50%) and between-schools females (46%). Between-schools adolescents have the highest number of sexual partners with nearly 60% of between-schools adolescent girls having had at least two sex different partners since first sex, relative to 42% of between-schools males, and 47% for in-school and out-of-school adolescent

girls. This indicates that gender and liminality affect sexual networking for this class.

Table 4 shows that 50% of those noticing STI symptoms went on to seek treatment. Up to 68% reported that the infection occurred within the preceding 11 months. Up to 57% had the infection diagnosed by a Doctor and 35.7% was by self-diagnosis or peer diagnosis. Among the between-schools adolescents 50% also reported that they had had a STI and 54.2% said the infection was in the last 11 months. About 63% and 38% of these between-schools adolescents had the infection diagnosed themselves and their friends respectively. The out-of-school adolescents self-diagnose their infections (40.4%).

In addition, 9.4% of the female sexually active out-of-school adolescents had gotten pregnant and 71.1% of these girls that got pregnant terminated the pregnancy, while the rest delivered the baby. About 8% of the in-school female adolescents had also gotten pregnant and 83.3% of the pregnant girls terminated the pregnancy, while among their between-schools counterparts 1.8% had gotten pregnant and 66.7% of the pregnant girls had terminated the pregnancy. Fifty percent among the in-school and between-schools reported that they had gonorrhoea, while 80.7% was reported in the case of the out-of-school adolescents; other mentioned infections include syphilis and Candidiasis. These patterns are buttressed by FGDs with in-school adolescent girls. There was consensus that:

They [young persons] contract HIV/AIDS, some get pregnant, some die while trying to abort their pregnancies, in some cases they get addicted to sex, while some on going for abortion several times their wombs get damaged. Some people if they know the symptoms they just know they have a particular disease and some go for test in an hospital and some just [keep] passing excess urine; thus they just know that they are not well.

Table 4: Distribution of adolescent sexual and reproductive health problems

VARIABLES	In-School		Between-Schools		Out-of-School	
	Freq.	%	Freq.	%	Freq.	%
Noticed infection						
Rashes/bumps/pimples	42	50.0	21	43.7	45	50.0
Offensive odour/pus	18	21.3	3	6.3	27	30.0
Cut/wound	6	7.4	4	8.3	6	6.7
Burning sensation	18	21.3	20	41.7	12	13.3
Length of time since infection was noticed						
1 month-11 months	57	67.9	26	54.2	58	64.4
12 months-23 months	-	-	13	27.1	-	-
24 months-35 months	27	32.1	3	6.3	23	10.0
36 months and more	-	-	6	12.5	9	11.9
Ever had an STI	42	8.8	24	4.8	57	11.9
Type of STI						
Gonorrhoea	21	50.0	12	50.0	46	80.7
Syphilis	15	35.7	2	8.3	11	19.3
Candidiasis	6	14.3	10	41.7	-	-
How did you confirm the infection?						
Self-diagnosis	15	35.7	15	62.5	23	40.4
Friend	3	7.1	9	37.5	10	17.5
Chemist	-	-	-	-	4	7.0
Doctor	24	57.1	-	-	16	28.1
Traditional Healer	-	-	-	-	4	7.0
Ever pregnant	36	7.5	9	1.8	45	9.4
Outcome of preg						
Carried to term/ delivered	6	16.7	3	33.3	13	28.9
Terminated	30	83.3	6	66.7	32	71.1

Table 5 indicates where adolescents that reported a STI sought treatment; 79%, 62% and 61% for in-school, between-schools and out-of-school adolescents respectively reported going to a clinic, 38% and 21% of in-school and out-of-school adolescents reported using the chemist and a minor proportion of both groups said they used herbs while no adolescent reported using herbs among the between-schools adolescents. Half of the in-school adolescents (50%) reported that their partners referred them to the facility where they sought treatment for infection while 46% of the between-schools and 35% of the out-of-schools were referred by their friends. An equal

proportion of the in-school and out-of-school had obtained abortions from chemists and traditional doctors. About 43% of in-school adolescents reported that their friends referred them to these abortion centres, while 50% of the between-schools adolescents were referred by their partners/fathers. Out-of-school adolescents were referred by their friends 56% of the time and 25% by a sexual partner. Although a reasonable proportion of the adolescents go for abortion with a doctor, a large number seek alternatives sources of abortion. Sometimes, the use of these alternatives is a functional of scepticism and distrust of Western medicine although this could be the result of its alienating bureaucracy. For the out-of-school adolescents:

If you have such diseases, you go a traditional doctor because if you go the hospital the doctor will just prescribe injections for you and after a month it might reoccur. It happened to a friend who went to a hospital. It was when he started using herbs that he finally got cured.

The data reflect that between-schools adolescents are more likely to be referred by partners. While majority of the adolescents across the three groups still turn to doctors for termination of pregnancy, a quarter of them still turn to chemists and traditional doctors for this same purpose. Forty-three percent of in-school adolescents and 56% of out-of-schools adolescents reported that their friends referred them to where they got an abortion while half (50%) of the between-schools reported their sexual partners referring them. So it can be deduced that while in-school and out-of-schools preferred to be referred by their friends, their between-schools counterparts prefer their friends. Programmes need to be sensitive to how information circulates within teen and adolescent networks because, even if they are erroneous, they create perceptions that have consequences for teen action.

Table 6 indicates that more than half of the targeted adolescents were aware of at least one modern method of contraception. Condom-related knowledge was high (77%, 76% and 82% for in-school, between-schools and out-of-school adolescents, respectively). By contrast, knowledge about implants was low at 41% for in-school, 29% for between-schools adolescents and 28% for out-of-school adolescents. Although the results show that 69%, 70% and 79% of in-school, between-schools and out-of-school adolescents, respectively, had ever used a condom, in-depth interviews and FGDs suggest that use is not consistent. Withdrawal method of preventing pregnancy had been used by 67% of between-schools adolescents and 19% of the out-of-school adolescents. The use of withdrawal method indicates that condom use among between-schools adolescents is low. Condoms are mostly used by out-of-school adolescents than any other group.

Table 6: Knowledge and use of contraceptives across adolescent groups

VARIABLE	In-School		Between-School		Out-of-School	
	Freq.	%	Freq.	%	Freq.	%
Ever heard of method	N=480		N=498		N=480	
Pill	261	54.4	278	55.8	282	58.8
IUD	231	48.1	223	44.2	186	38.8
Injectables	267	55.6	227	45.6	249	51.9
Implants	198	41.3	144	28.9	35	28.1
Diaphragm	210	43.8	204	41.0	237	49.4
Condom	369	76.9	376	75.5	396	82.5
Female sterilization	240	50.0	279	56.0	168	35.0
Male sterilization	192	40.0	240	48.2	168	35.0
Periodic abstinence	222	46.3	231	46.4	195	40.6
Ever used methods	N=174		N=135		N=240	
Pill	70	40.2	33	24.4	33	13.8
IUD	-	-	-	-	9	3.8
Injectables	-	-	-	-	-	-
Implants	-	-	-	-	-	-
Diaphragm	-	-	-	-	-	-
Condom	120	69.0	95	70.4	189	78.8
Female sterilization	-	-	-	-	-	-
Male sterilization	-	-	-	-	-	-
Periodic abstinence	63	36.2	29	21.5	39	16.5
Withdrawal	12	6.9	90	66.7	45	18.8

Table 7 indicates that 96.5% of in-school adolescents, 91.1% of between-schools and 77.5% of out-of-school adolescents used a method during their last sexual encounter indicating that contraceptive use is higher among in-school adolescents compared to other groups. With regard to the type of contraceptive used, result shows that 49.4% of in-school, 42.3% of between-schools and 72.6% of out-of-school adolescents reported using a condom; indicating a low condom usage among between-school adolescents. Similarly, 29.8% of in-school adolescents used pills during their last sexual intercourse and 41.5% of between-schools adolescents used withdrawal as a method during their last sexual encounter. 17.3% of in-school adolescents and 4.8% of out-of-school adolescents reported using periodic abstinence as a method. The reason for their choice of contraceptives, ranged from 60.2% of between-schools used the method to prevent both STDs and pregnancy, 48.3% used the method to prevent only pregnancy; i.e. they were not concerned about contracting a STD, 41.1% of in-school adolescents also used the method to prevent both pregnancy and STDs while only 21.4% of in-school, 7.3% of between-schools and 14.5% of out-of-school adolescents used the method for the sole purpose of preventing sexually transmitted infections. 3.4% of in-school, 8.9% of the

between- schools and 22.5% of the out-of-school adolescents did not use any method during their last sexual intercourse.

Table 7: Reasons for use and non-use of methods

VARIABLE	In-School		Between-School		Out-of-School	
	Freq.	%	Freq.	%	Freq.	%
Used method last sex	N=174		N=135		N=240	
Yes	168	96.5	123	91.1	186	77.5
No	6	3.4	12	8.9	54	22.5
Method used last sex*						
Pill	50	29.8	20	16.3	24	13.0
Condom	83	49.4	52	42.3	135	72.6
Withdrawal	6	3.6	51	41.5	18	9.7
Reason for method						
To prevent pregnancy	63	37.5	40	32.5	90	48.3
To prevent STIs	36	21.4	9	7.3	27	14.5
To prevent STIs/pregnancy	69	41.1	74	60.2	69	37.1
Reason for no method						
Did not feel like it	6	100.0	5	41.7	13	24.1
Sex was not planned	-	-	7	58.3	-	-
To feel more pleasure	-	-	-	-	11	20.4
Fear of side effects	-	-	-	-	11	20.4
Do not believe in it	-	-	-	-	6	11.1
Forgot	-	-	-	-	6	11.1
No reason	-	-	-	-	7	13.0

**Only methods used listed*

Respondents that didn't use any method were asked the reason for this; 100.0% of the in-school, 41.7% of between-schools and 24.1% of the out-of-school said they did not feel like using any method. Fifty-nine percent of the between-schools adolescents said that the sexual intercourse was not planned. 20.4% of the out-of-school reported they did not use any method so they could feel more pleasure and 20.4% of this same group reported fear of side effects as reason for not using method. Other reasons given include not believing in contraceptives, forgot all about it and some don't have any reason for not using contraceptives.

From the data, more out of adolescents use contraceptives as prevention against pregnancy and not necessarily as prevention from sexually transmitted infections unlike their in-school and between-schools counterparts where more adolescents reported prevention of STDs and pregnancy as a reason for using contraceptives. More out-of-school adolescents use condoms than any of the other two groups.

The study examined the communication and notification patterns between adolescents and their sexual partners (Table 8). Adolescents were asked if they informed their partners about their infection.

Table 8: Patterns of partner notification on issues about sexually transmitted infections

VARIABLE	In-School		Between-School		Out-of-School	
	Freq.	%	Freq.	%	Freq.	%
	N=42		N=24		N=57	
Did you tell your partner when you had an infection?						
Yes	33	78.6	13	54.2	39	68.4
No	9	21.4	11	45.2	18	31.6
Reasons for telling partner						
Trust and love	14	42.4	-	-	7	17.9
Could not cope alone	7	21.2	-	-	-	-
To let partner know he/she gave me	12	36.4	-	-	23	59.0
Did not wish to infect partner	-	-	13	100.0	9	23.1
Reasons for not telling partner						
Too embarrassed	9	100.0	-	-	-	-
Did not wish to discourage partner from having sex with me	-	-	11	100.0	-	-
Did not want partner to end relationship	-	-	-	-	11	61.1
Felt no need to disclose	-	-	-	-	7	38.9
Was it a good decision to notify your partner?						
Yes	30	90.9	3	100.0	32	82.1
No	3	9.1	-	-	7	17.9
Why was it a good decision?						
Was able to confirm if partner infected me	12	40.0	-	-	4	12.5
Able to protect self against pregnancy/STIs	18	60.0	5	38.5	-	-
Made partner aware of my health status	-	-	6	46.2	-	-
Confirmed partner's love for me	-	-	2	15	4	12.5
Made partner treat self	-	-	-	-	2	6.3
Produced advice about treatment	-	-	-	-	10	31.1
Ideal thing to do	3	100.0	-	-	7	100.0
Why was it a bad decision?						
We broke up	3	100.0	-	-	7	100.0

About 79% of in-school, 54.2% of between- schools and 68.4% of out-of-school adolescents that had an infection reported that they told their partners. The reason for telling their partners include avoid infecting partner; 100% of between-schools and 23.1% of out-of-school adolescents reported this. A significant proportion (42.4%) of in-school adolescents and 17.9% of out-of-school adolescents claimed that love for their partners made them tell their partners. Fifty-nine percent of out-of-school adolescents and 36.4% of in-

school adolescents told their partners to let their partners know they got the infection through them; 21.2% of in-school adolescents told their partners because they could not cope alone.

Whereas, all in-school adolescents that had an infection reported that they were too embarrassed to tell their partners, all of the between-schools said they did not so as not to discourage their partners from having sex with them. Similarly, 61.1% of the out-of-school adolescents were afraid their partners will leave them if informed of their infection while 38.9% of them felt no need to tell their partners. This result indicates that different sexual and behavioural patterns exist among the three groups. It strongly reaffirmed that the unique sexual drive of between-school-adolescent is a prominent determinant of their sexual behaviour compared to the other groups. In other words, the motives for not revealing their condition to partners clearly indicate that between-school-adolescents are more likely than any other groups to infect their sexually partners STDs.

Results also show that 90.9% of in-school adolescents, 100% of between-schools adolescents and 82.1% of out-of-school adolescents felt it was good decision if they tell their partners. Questions were further asked as to why it will be a good decision to tell their partners. Result reveals that 60.0% of in-school adolescents felt that by telling their partners they will be able protect their partners against sexually transmitted infections and 38.5% of between-schools adolescents also felt this way. This further reveals a disparity in the in the sexual behaviour of the groups involved. While all between-school adolescents felt it was good decision to tell their partners, only 38.5% of this group was concerned about the need to protect their partners against sexually transmitted infections.

The disparity continues as 37.5% of out-of-school adolescents thought it was a good decision because their partner will be able to treat self; 46.2% of between-schools feel it will serve as a way of informing partner of the status of their health. While 31.1% of out-of-school adolescents thought it was the ideal thing to do. Other reasons given include, that it serves to confirm my partners' love for them and it was an opportunity to ask for advice for treatment. Some adolescents thought it was a bad decision to tell their partners because such disclosure could lead to the end of the relationship.

On the discussion of contraceptive choice with partner 81.0% of in-school, 55.6% of between-schools and 63.8% of out-of-school adolescents reported that they discuss contraceptive choice with their partners (Table 9). This indicates that contraceptive choice is freely discussed among in-school adolescent than the other two groups. Structural constraint could be a factor for this. Being out of school imposes a level of freedom on adolescents which in-school adolescents may not be able to have. Again, the aspiration for educational pursuit and accomplishment is high when adolescents are in school. Thus, this shows that once a degree of freedom is attained and the aspiration for educational accomplishment becomes deemed in-school

adolescents may not be disposed to contraceptive discussions with their partners. More results show that 39% of in-school adolescents felt discussing contraceptives was the ideal thing to do; 32.7% of out-of-school and 30.7 between-schools adolescents felt it was a way to guide against getting pregnant. This finding aligned with Smith’s (2004) showing that contraceptive use among migrant youths in Northern Nigeria was primarily for pregnancy prevention and not against STDs. A quarter (26.1%) of the out-of-school adolescents felt that without discussing contraceptives, the method might be ineffective, 32% of out-of-school adolescents felt it was a way to avoid side effects. Other reasons reported include that it helps to achieve the best results and that it aids to choose an adequate method as well as being an out of love gesture for their partner.

Discussing contraceptive choice differs among the between-school adolescent as 100% felt that their partners might not like it if they discuss contraceptive choice with them. About 53% of between-schools and 77.0% of out-of-school adolescents felt it was not necessary to discuss their contraceptive choice with their partners; 26.7% of between-schools adolescents felt that partners already know. Other reasons given include don’t have a steady partner, fear of rejection by partner and too shy to discuss it with partner.

Table 9: Patterns of partner discussion about contraception

VARIABLE	In-School		Between-School		Out-of-School	
	Freq.	%	Freq.	%	Freq.	%
Do you discuss contraceptive choice with your partner?	N=174		N=135		N=240	
Yes	141	81.0	75	55.6	153	63.8
No	33	19.0	60	44.4	87	36.3
Reasons for discussing it with partner						
Avoid getting pregnant	28	19.9	23	30.7	50	32.7
Without discussion, method might be ineffective	13	9.2	-	-	40	26.1
Ideal thing to do	-	-	14	18.7	25	16.3
To be safe from diseases	55	39.0	-	-	13	8.5
To avoid side effects	45	-	24	32.0	5	3.3
To achieve best results	-	-	6	8.0	-	-
To choose an adequate method	-	-	8	10.7	-	-
Out of love for partner	-	-	-	-	20	13.1
Reasons for not discussing it with partner						
Partner might not like	33	100.	-	-	-	-
Not necessary	-	-	40	53.3	67	77.0
They already know	-	-	20	26.7	-	-
Do not have steady partner	-	-	-	-	5	5.7
Fear of rejection by partner	-	-	-	-	10	11.5
Too shy	-	-	-	-	5	5.7

Multiple regressions show predisposing factors of in-school adolescent sexual behaviour (Table 10). There is a significant linear relationship between the criterion variable of ever had sex and the following predictor variables: sex and age. Hence in-school adolescent's sex and age are predisposing factors that can influence their engaging in sexual activity. Age is the common denominator that predisposes the three groups to different sexual and reproductive behaviours and experiences. Given the disparity in the age of in-school adolescents and the other groups, sexual activity among in-school adolescent will be low compared to out-of-school and between-school adolescent. In other words, the out-of-school and between school adolescents are a group of sexually active population because of the sexual transition and sexual freedom that comes with age.

Table 10: Regression models on factors that predict adolescent sexual behaviour for in-school adolescents

Variable	T	B	P
Sex	2.209	0.100	0.028
Age	4.646	-0.211	0.000
Ethnicity	1.902	0.084	*0.058
Religion	-0.173	0.008	*0.863
Father's occupation	-0.397	0.018	*.692
Mother's occupation	1.058	0.048	*0.290
Live with	-1.773	-0.079	*0.077

∴ Were not significant predictors in this model (F_{8, 471} 5.073 P<0.05)

Multiple regressions were conducted to identify predisposing factors that predict between-schools adolescent behaviour (Table 11). There was a significant linear relationship between the criterion variable of ever had sex and the following predictor variables: sex and age. Hence between-schools adolescent's sex and age are predisposing factors that influence their engaging in sexual activity. This further reinforces the argument that the disturbance in the social structural creates a socio-sexual transition among adolescents as they experience a disrupted transition in their education. A socio-sexual transition occurs among adolescents as they grow physically, mentally and sexually and transit from secondary school without a corresponding enrolment into tertiary institution (Atere *et al.*, 2010). This transitional period becomes significant for adolescent in making difficult choices which are influenced by their sexual and reproductive behaviour with attendant consequences for their educational or life aspirations.

Table 11: Regression models on factors predicting adolescent sexual behaviour among between-schools adolescents

Variable	T	B	P
Sex	5.061	0.215	0.000
Age	-7.587	-0.322	0.000
Ethnicity	1.667	0.068	*0.096
Religion	-0.057	0.002	*0.955
Father's occupation	-1.407	0.058	*0.160
Mother's occupation	-0.019	-0.001	*0.985
Live with	-0.325	-0.013	*0.745

† Were not significant predictors in this model (F_{8, 489} 15.692 P<0.05)

Multiple regressions were conducted to identify predisposing factors that predict out-of-school adolescent behaviour (Table 12). There was a significant linear relationship between the criterion variable of ever had sex and the following predictor variables: sex, age, religion and father's occupation. Hence out-of-school adolescent's sex, age, religion and father's occupation are predisposing factors that influence their sexual and reproductive behaviour. The influence of religion on the sexual behavior of adolescents has been explained by Smith (2004). According to him, young people commonly situate their understandings and explain their behaviours in response to the HIV/AIDS epidemic in terms of religion. He affirms that popular religious interpretations of HIV risk pose real dangers, leading many young migrants to imagine themselves as at little or no risk, and contributing to inconsistent protective practices.

Table 12: Regression models for identifying predisposing factors that predict adolescent sexual behaviour for out-of school adolescents

Variable	T	B	P
Sex	-3.079	0.132	0.02
Age	-7.626	-0.339	0.00
Ethnicity	0.708	0.030	*0.479
Religion	-2.148	0.096	0.032
Father's occupation	0.490	0.025	0.00
Mother's occupation	-0.595	-0.029	*0.625
Live with	-1.322	-0.057	*0.552

* Were not significant predictors in this model (F_{9, 470} 10.344 P<0.05)

Recent findings suggest that the socio-economic status of households which is often determined by the occupation of household heads is very influential in determining the sexual behaviour of adolescents. Recent NDHS

indicate that adolescents who have access to the media and those of high socio-economic status are more sexually exposed than their counterparts who do not have access to media or have fewer household facilities. It also shows that exposure to premarital sex increases with access to newspapers, radio and television. Similar results emerged from a study of adolescents in a peri-urban settings showing that exposure to media has a way of shaping adolescents' reproductive behaviour across several generations. (Obono and Obono, 2009).

The P-value = 0.014 is less than 0.05. This means that there is a significant difference between sexual and reproductive problems in both between and in-school adolescents. This leads to a rejection of the null hypothesis and acceptance of the alternate hypothesis that there are significant differences between the sexual and reproductive health conditions of between-schools adolescents and in-school adolescents. They former category are also less likely to identify their sexual and reproductive health problems relative to their in-school and out-of-school counterparts.

Conclusion

This study has shown that distinctions among adolescents are critical for effective programme development and responsive policy formulation. Fundamentally, the data indicate that the tendency to subsume all adolescents within one broad category (in-school) or the other (out-of-school) is simplistic. It is also further proof of the marginalization of adolescents even within the context of scientific conceptualization and studies. Scientific understanding of adolescence and adolescents must shift to accommodate them as a group, which is as complex as any other.

Adults are not more complex in this regard than adolescents. Yet, they are grouped in accordance with educational status, occupation, ethnicity, sex, religion, migrant history, and so on. When it comes to adolescents, however, the grouping is simplified to the misleading dichotomy of "in-school" and "out-of-school". The categorization should be more nuanced than that because adolescents are not a single or homogenous group. They can be understood in as many complex ways as adults can. Even within the rubric of a school-based or school-oriented categorization, there is a liminal group of adolescents that is vulnerable to reproductive hazards and whose marginal status may hold numerous programme implications. This is a seminal contribution of this study.

The data show that between-schools adolescents are the most sexually active among all three groups. This is significant. When data were disaggregated by sex, between-schools male adolescents were found to be the most sexually active sub-group. Out-of-school girls were more sexually active than their female in-school or between-schools counterparts. Out-of-school adolescents had the highest number of sex partners. The qualitative data suggest this may be because, out of school, these adolescents find work and may be engaged in economic activities that enable them pay for sex or, otherwise, support a girlfriend financially. Hence, a combination of gender and

intra-group class distinctions can foster understanding of sexual behaviour, at least in term of the sexual networking and coital frequency.

Most respondents had their first sexual encounter with their boyfriend/girlfriend and at age 15-19. All adolescent groups commenced sexual activity at about this age but the in-school group commenced earlier than any other group for reasons, as noted, of opportunities provided by coeducational environments. Identification of sexually transmitted infections is still problematic because only 50% of adolescents who noticed symptoms of an infection linked them to a disease and sought treatment for it. Most infections reported were in the last 11 months, which shows sexually transmitted infections were still common among them. The in-school groups had better health seeking behaviour than any other group because they visited the clinic more than any other group. The most reported infection was gonorrhoea. Condom usage was higher among out-of-school adolescents during last sexual intercourse but doubts remain about overall consistency. Contraceptive knowledge and partner communication were highest among the in-school group. In other words, between-schools adolescents have poor health seeking behaviour and partner communication compared to other groups.

As a heuristic investigation of such an important cohort, the study does not have all the answers to necessary questions about these patterns of sexual and reproductive behaviour. Its main contribution has been to establish the need to develop approaches that agree with empirical reality on the ground. Its findings point in one direction: Adolescents do not constitute a homogenous group. They are complex and can be studied from a variety of viewpoints and categorizations. Where the school-based or school-oriented scheme is selected, it is necessary to re-categorize study participants in accordance with the full range of possibilities that exist for such school-oriented investigations. Such an approach will include the liminal cohort that exists between schools. Such adolescents were once in school but have left temporarily and have aspirations of return to school at some time. The circumstances leading to their exit from school may include unplanned pregnancy or the withdrawal of financial support, which could result from the death of a parent or benefactor. Subsequent studies should focus on how this liminality-within-a-liminality has implications for adolescent sexual behaviour and reproductive wellbeing in conditions of rapid social, demographic, economic, political and cultural change.

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