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Full Length Research Paper

The negative impacts of adolescent sexuality problems among secondary school students in Oworonshoki Lagos

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This study was conducted to focus on the negative health outcomes related to sexual behaviour in adolescents and young adults attending public school in the Oworonshoki region of Lagos, Nigeria, Africa. Since, there is a relative dearth of knowledge on adolescents who face unique and challenging economics, health and education problems in our society. Data on the socio-demographic characteristics, prevalence and knowledge towards STD including HIV/AIDS, prevalence of sexual abuse practice/sexual behaviour, family planning awareness and acceptance including abortion practice were sorted out using self structured questionnaires and administered to 60% of student's population using a stratified random sampling technique. 55.8% lived with both parents. While, 50.3% of the mothers had basic secondary school qualifications, 72.4% of them are traders. 61.5% had sex education were from misinformed friends/peers while 51% had no basic knowledge about sexual behavioral practice and attitude towards STDs/AIDS (HIV). STD has a prevalence of 34 and 41% of boys used condoms for preventing STI/HIV transmission and unwanted pregnancies. One out of every five sexually active teenagers has experienced forced sex, especially among the circumcised girls who were more sexually active than the uncircumcised girls. 60% of girls between ages of 12 and 18 years had more than one unsafe abortion with severe vaginal bleeding (haemorrhage) as the chief complication. However, 65% of the girls did abortion for fear of leaving school and financial hardship as the reasons.

Key words: Adolescent, sexuality, attitude, knowledge, Lagos, legislation.

INTRODUCTION

Sexuality issues have been one of the most fundamental aspects of human existence, which is directly related to both the physical and psychosocial well-being of an individual. Psychologists have always believed that boys and girls achieved sexual maturity early in adolescence and physical maturity by the end of it (Abraham, 1980). However, adolescence is defined as that period of psychosexual developments between the onset of sexual maturity (puberty) and early adulthood, during which self-identity, sex roles and relationship with other persons are defined by the young peoples; this includes period between the ages of 10 and 19 years (Action health Incorporated, 1996).

Sexual health is seen as the integration of the physical, emotional, intellectual and social aspect of one's sexual beings in such a way that are positively enriching and enhancing personality, communication and love (WHO, 1989). Although, sexuality reflects the integral joyful part of humans with biological, social, physiological, spiritual, ethical, and cultural dimensions, it also encompasses growth and development, human reproduction, anatomy, physiology, masturbation, family life, pregnancies, childbirth, parenthood, sexual response, sexual orientation, contraception, abortion, sexual abuse, HIV/AIDS, and other sexually transmitted diseases (STD) (Action health

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Incorporated, 1996). In a pluralistic society like ours, attitude about adolescent sexuality differ not only by ethnicity, socio-economic status, religion and geographic regions, but, also vary widely within individual families and communities.

A recent Nigerian's survey had shown that the parents that ought to be the primary educators/communicator to their children on specific sexuality values had played the least role in this regards (Action health Incorporated, 1996). Also, our schooling systems provide little or no sexuality education for young people. One of the communiqués at the International Conference on Population and Development (ICPD, 1994), had stated that supports should be given by parents to promote integrated sexuallity education and services to the young people. (ICPD, 1994).

Focus group discussion with young people in Nigeria carried out by the Federal Ministry of Health and Social Services (1992) have shown that high percentage of young people do not support premarital sex. However, 24 to 40% of them were found to be sexually active and 22% had their first sexual experience through rape or coerced sex. In a study conducted by Action health Incorporated (1996), it was found that 56% of Nigerians are below 20 years and the median age at first sexual intercourse for the girls was 16 years. However, 60% of the youths do not know that pregnancy is possible at first sexual intercourse and teenagers accounted for 80% of unsafe abortion complication. Ogedengbe (1997) stated that in Nigeria, maternal deaths accounted for 758,000 of all annual deaths and that 20,000 of maternal deaths are abortion-related incidents in which 80% of the cases involved adolescents between ages of 10 and 19 years.

Research in several countries has shown that high percentage of young girls were coerced or forced during their first sexual contact. Married young women are especially unable to negotiate sex or condom use with their husbands who may have extramarital partners, such that the young women are several times more disposed than young men to contract the HIV/AIDS disease through heterosexual contact. Also, worldwide the percentage of infected young girls has increased from 62% to 77% in sub-Saharan Africa (Nigeria). This high prevalence of AIDS in Africa is having a dreadful social and economical impact on the countries in the continent (Global Health Council, 2006). A woman's vulnerability to the virus is attributable not only to biological differences, but also to the deeply entrenched socio-economic inequalities that further compound her risk (Global Health Council, 2006).

About 37% of the sexually active secondary school teenagers had adequate basic knowledge of STIs/AIDS but a much better knowledge was found among those especially 18 years who recently received AIDS education. More males were disposed to the use of condoms in preventing STD/HIV transmission. A 10 year report (1991 - 2001) released by the Communicable Disease Control Centre (CDC, 2002) has revealed that percentage of students who has had sexual intercourse has dropped from 54 to 46% and the condom usage has increased from 46 to 58%.

This research focuses on the negative health outcomes related to sexual behaviours in adolescents and young adults attending public mixed secondary schools in the Oworonshoki area of Lagos, Nigeria, Africa. Little current data exist on this population who faces unique and challenging economic, health and education problems that increase their risk for and acquisition of numerous health outcomes, including sexual abuse, health problem related to abortions, sexually transmitted infection (STI) as well as the human immunodeficiency virus (HIV). It is hope that the findings in this study will provide basis for development of health promotion and preventive health interventions.

MATERIALS AND METHODS

Study participants /subjects

The selection criteria for this study included students in the senior classes only irrespective of their ages and socio-economic backgrounds. A sample size of 600 students was chosen out of 1000 students in the School.

Sampling plan

Six senior classes which comprised of two Senior School SS-3 classes; two SS-2 classes and two SS-1 classes were chosen by stratified random method using the random table.

Procedure

For this study, highly structured self administered questionnaires were used to obtain data from the sample population. The questionnaires were anonymous to ensure confidentiality and honest results. Adequate explanations were given to the students at the beginning of the exercise to clarify issues that may raised in the questionnaires and the questionnaire were administered in-class after prior consent was obtained from the Principal and the respective class teachers by Dr Shittu. The students were told to also ask any question as the case may arise directly from the researchers and not their colleagues. Moreso, they were told to feel free when filling the form and to treat the exercise with much confidence as possible.

Measured outcome

The first section of the questionnaire contained questions on the socio-demographic data of the respondents, while the second section contained questions which test their sexual behaviour and activity; knowledge on sexually transmitted diseases (STD) and AIDS/HIV, abortion and family planning awareness and acceptance. 600 questionnaires were given out to cover the entire students in all the selected classes such that 60% of the total students' population was sampled.

Table 1. Bio-data of the respondents.

Age of respondent	**Frequency**	**%**
12 – 18	532	91.7
19 – 25	48	8.3
26 – 32	nil	0
>32	nil	0
Tribe of respondent	**Frequency**	**%**
Yoruba	480	82.7
Hausa	8	1.3
Igbo	80	13.8
Others	12	2.1
Religion of respondents	**Frequency**	**%**
Christianity	488	87.1
Islam	72	12.4
Traditional	20	3.45
Others	0	0
Family type of respondents	**Frequency**	**%**
Monogamous	440	75.6
Polygamous	140	24.1
Mother`s educational level	**Frequency**	**%**
No Formal Education	88	15.1
Primary Education	112	19.3
Secondary Education	292	50.3
Post Secondary	88	15.1
Respondent mother`s occupation	**Frequency**	**%**
Trader	420	72.4
Civil servant	76	13.16
Self employed	52	9.0
Private company	22	3.8
House wife	10	1.7
Nature of people living with respondent	**Frequency**	**%**
Grand parents	32	5.5
Parents (Both)	324	55.8
Uncle	44	7.6
Aunty	64	11.0
Others (cousin's etc)	24	4.1

Ethical consideration

The research was reviewed and approved by the College Ethic and Research committee.

Data analysis

Percentage computerized analysis and student's t-test of the data collected were done using SPSS software (SPSS, Inc., Chicago, Illinois).

RESULTS

A total of 580 out of the 600 questionnaires distributed to the students were well filled and selected having met the selection criteria for this study. The male to female ratio was found to be 1:1.5 in which 91.7% of respondents were in the ages of 12 to 18 years range. 82.7% were of Yoruba background and mostly from the monogamous settings (75.6%). About 55.8% of the respondents lived with both of their parents, while 50.3% of the respondents' mothers had basic secondary school education. However, their mothers (72.4%) were mostly petty traders. About 87.1 % of respondents were from the Christian home (Table 1).

About 61.48% of their information on sex education was gotten from their equally misinformed friends/peers. 80% of students were not aware that pregnancy is possible through the first sexual intercourse. The median age in this study was found to be 15 years and girls were

more sexually active than boys. Despite their exposure, about 51% of respondents had no basic knowledge about behavioral practice and attitude about STDs/AIDS (HIV). One out of five every sexually active teenagers has experienced forced sex and majority of them were younger than 18 years of age. 52% of respondents reported alcohol and drug (cigarette smoking) abuse. 60% of the girls between 12 and 18 years had unsafe abortions in which about 11% had more two abortive procedures done and severe vaginal bleeding (haemorrhage) was the chief complication. 65% of the girls did abortion for fear of leaving school and financial hardship as the reasons. 20% of sexually abuse girls were present in the school. It was found out from this study that more females (46%) were circumcised and 58% of them were more sexually active than the uncircumcised females; hence encouraging sexual abuse practices among the adolescents.

STD has a prevalence of 34% among the students. 73% of respondents have used one form of contraceptives. However, condom was highly favoured due to its affordability and awareness campaign such that 41% of boys were disposed to condoms usage for preventing sexually transmitted infection (STI)/Human immunodeficiency virus (HIV) transmission and unwanted pregnancies.

DISCUSSION

The sexual behaviour of young people reflects attitude and behaviour in the society as a whole and this field is dynamic since attitude and behaviour change with time. In general, adolescents are faithful to one partner at a time but their time perspective are short and this combined with early coitus in a relationship result in each having a high number of partners and this creates condition for rapid spread of STDs and risks of HIV infection. From this study, it was observed that one out of every five sexually active teenagers has experienced forced sex and majority of them were younger than 18 years of age. This is alarming in view of the pluralistic nature of our society with increased risk for and acquisition of numerous health problems such as sexual abuse, sexually transmitted infection (STI) as well as the human immunodeficiency virus (HIV) among others. However, sexual abuse has become a culturally sensitive area that can only be addressed mainly by the psychiatric and medical professions in the management of the victimized teenagers who often times suffered a long effect of the sexual insults. The rate of sexual abuse among adolescents appears to be increasing although this may be consequence of more precise reporting (Feldman et al., 1991).

Other study has shown that the sexually abused girls and boys have significantly higher level of risky health behaviour and risky attitude, especially, if they were children of the adolescent mothers with a two times likelihood of abuse and neglect. Alcohol and other drugs have been found to impair decision-making and leads to development of assertiveness skills by those who indulged in them as seen in this present study where 52% of respondents were stimulant abusers coupled with high sexual behavioural incidences, that are 54% being sexually active and 11% of them abused sexually.

73% of respondents have atleast in the past used one form of contraceptive. This is contrary to Person and Jarlboro (1992) in Sweden who reported that contraceptive acceptance and practice were independent of respondent's educational level and age. However, Oni and McCarthy (1990) in Ilorin have reported that contraceptive acceptance rate were 15% for primary education, 20% for secondary education and 4.5% for the educated women. This high rate contraceptive acceptance did not correlate with high prevalence of STD (34%) and 60% abortive practice done to get rid of unwanted pregnancies especially among the girls who were more vulnerable to these health related problems.

About 51% of respondents had basic knowledge about behavioral practice and attitude about STDs/AIDS (HIV). Study by Wellings et al. (1995) suggested that having the school as the primary source of sex education might have increased the use of condoms at first sexual intercourse. Also, Kirby et al. (1994) have stated that sex education programme in general and that some specific programme especially, can increase the use of condoms and other forms of contraception when young people do have sex. In this study, condom use alone accounted for 41% in boys. This was relatively similar to other previous studies, 68% in males (WHO, 1991) and in sharp contrast to study by Ajuwon et al. (2001) where 16.1% of the male respondents used condom. Condoms are satisfactory contraceptives only in a stable relationship involving experienced people and since condom use is the only method available for protection against diseases, it should be recommenced to teenagers together with such oral contraceptives.

Abortion was more common (60%) especially among the age range of 12 - 18 years with about 11% of the girls having engaged in the practice more than twice and haemorrhage was the chief complication. 65% of the girls have reported fear of leaving school and financial hardship as the reasons for engaging in the abortion practice. It was observed that some of girls who aborted have used herbal concoction and detergent as means of inducing abortion, a practice which not only endangers their lives, but, threatened their future fertility potentials. Infection (PID) is one of the commonest causes of infertility due to tubal blockage in Nigerian women which are as a result of illegal abortion. (Shittu et al, 2005).

It has become a traditional practice to protect adolescents from receiving education on sexual matters on false pretence that ignorance will encourage chastity, yet the consequence of unprotected sexual practice among

our adolescents is glaring and devastating. The most visible result is the high rate of unwanted teenage pregnancies and abortions (Olikoye, 1996). However, available data have shown that there is no evidence to prove that sexuality education lead to earlier or increase sexual activity among young people (Olikoye, 1996). However, because the adolescent do not generally have adequate information of family planning and the methods available are not easily accessible to them, these also have further compounded the burden that unwanted pregnancies and its associated factors mainly infection and death posed. Hence, any social structures that permit such extensive destruction of young lives must be questioned, when there are safer human alternatives. Students from poverty situation especially should be targeted for these information campaigns with regards to support services and how to gain access to them. However, some of the causes of this problem apart from lack of access to information on sex education are the poor socioeconomic infrastructures as a result of the current economic depression (poverty) coupled with the unstable political climates that characterized a typical African setting. The problems associated with STD and AIDS (reproductive tract infections) affect all aspects of the life of young people especially the females who happen to bear the greatest brunt of the disease with its rapid spread among them. A woman's vulnerability to the virus is attributable not only to biological differences, but also to deeply entrenched socio-economic inequalities that further compound her risk.

As observed from our findings in this study that the abortion rate were higher among the girls from the polygamous settings and whose mothers were petty trader probably because the mother are usually engaged and seldom have the time to impact on their children.

It has been estimated that Lagos state with a population of over ten millions people will obviously, over stretched the limited available health facilities and adolescents, who happen to constitute a larger percentage of the populations will be at greater risk. Hence, the impacts of the present Non Governmental Organization (NGOs) need to be appraised as it relate to awareness level among this vulnerable group as far sexuality issues are concern. There is need for society to begin to consciously confront issues of sexual abuse among children and adolescents and has encouraged other helping professions to deal with children to become more familiar with the problem. Victims of childhood sexual abuse display a broad array of behaviours which include social isolation, chronic depression, poor self esteem, vague somatic complaints, substance abuse, self injurious behaviours and underlying resentments (Furnis, 1984; Shearer and Herbert, 1997; Beithchman et al., 1992). However, as abnormal these behaviours may seem, care must be taken not to misinterpret them as typical adolescents behaviours (Furnis, 1984). Fortunately, many more Nigerians are beginning to realize that if these adolescents' sexual problems are to be effectively addressed, it is important that all people develop accurate, rational and responsible attitude and behaviour towards issues around sexuality.

We therefore recommend that universal sex education especially on reproductive health should be inculcated into the family support programme in order to reorientate and change our role to-wards the building up of a healthy adolescent life. At a community level, health providers are in an excellent position to participate in the development and delivery of comprehensive sexuality curricular in the schools and other public institutions. Efforts must be taken to set up adolescent health centres and counseling units which will readily made available and provide accessible reproductive services in order to control the health related outcome problems being faced by adolescents. Parents should be re-orientated concerning the adolescent's reproductive life style and its dynamism. More so, the media should be mobilized to focus on campaign aimed at improving and promoting/preventive interventional strategies for the adolescents.

There is need to carry out other similar study using a pure single sex school setting rather than a co-educational settings in order to appreciate the health related factors observed in this present study.

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