Serial No	
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Title	The Erage Nigerian Adolescent and Sexual Life- a Challenge
Keywords	Nigerian Adolescent, Sexual Life, Preventive Services
Description	The Erage Nigerian Adolescent and Sexual Life- a Challenge
Category	Medicine
Publisher	
Publication Date	
Signature	

The Average Nigerian Adolescent and Sexual Life- A Challenge

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The earliest feature and hallmark of adolescence is sexual maturation which is seen as the development of secondary sexual characteristics, general increase in body size, change in body configuration and progressive sexual urge. Innate hormonal template in these adolescents and environmental influences predispose them to and encourage sexual activities. This calls for deliberate effort to forestall the numerous deleterious consequences of careless or illicit sexual activities. The ease at obtaining criminal abortion with its numerous complications in developing countries like Nigeria, despite the restrictive abortion law, at best compounds the picture rather than solve the problem. Poor value system, goal-setting, decision-making, parental supervision, and quite importantly, poor knowledge (ignorance in sexual issues) ill-equip them.

A typical case of today's adolescent in Nigeria is reported, illustrating the plight of these young adolescents in their state of unpreparedness for this cardinal milestone; little or absent supervision, inadequate informed decision-making capability for both parents/guardians and the adolescents themselves. Deliberate effort to provide preventive services for these adolescents to forestall avoidable self damage, vicious cycle of poverty and provide appropriate intervention measures is recommended.

Keywords: Nigerian Adolescent, sexual life, preventive services

INTRODUCTION

Adolescence is that dynamic period in a person's life, which commences with puberty and ends at maturity[1]; it is a milestone. The earliest feature and hallmark of this period is sexual maturation which starts with the development of secondary sexual characteristics and general increase in body size[1, 2] as well as progressive association with sexual urge. Administratively it falls between 10 – 24 years. It is a period that is dominantly under the sexual hormonal control but with strong environmental influence[3]. It therefore requires adequate preparation with graded sex education[4] that should help the adolescent develop the necessary 'ballast' to aid him/her navigate through the commonly described stormy period. Unfortunately, the latter is not easily/readily available in Nigeria as in most developing countries. Discussing sexual issues with young people is often regarded as a taboo but thankfully this is beginning to change especially while addressing the scourge of HIV/AIDS pandemic that is taking its highest toll in these developing countries particularly those in the sub-Saharan Africa where Nigeria belongs. Parents are yet to fully take their rightful place as the primary sex educators[4] in this matter; neither is the school fulfilling its responsibility in providing formal sex education as expected. The religious bodies are only beginning to give up their ostrich life-style as they have now started addressing the issue in these days of HIV and AIDS. Besides the innate hormonal template in these adolescents, environmental influences that encourage sexual activities, abound. These include the media, pornography due to uncensored video and internet movies, peer pressure, poverty, the society as a whole and e.t.c. The ease at obtaining clandestine / criminal abortion with its numerous complications in this country despite the restrictive abortion law, compound the picture. Other factors include poor parental supervision, poor value system, poor goal setting and decision-making, and quite importantly, poor knowledge (ignorance in sexual issues), agreeing with the statement that "my people perish for lack of knowledge"[5].

Of the many complications of early heterosexual intercourse which include STI/HIV/AIDS, cancer of the cervix and pregnancy out of wedlock; the later is the

most disturbing to most parents, at least on the short run. This is not only because of the associated stigma, sense of failure as a parent but mainly the fear that the girl, especially when very young, may not be able to go through the pregnancy successfully without damaging her 'immature' self. This has led to the mismanagement of a number of cases, often with far-reaching consequences. Megafu and Ozumba[7] had reported in addition, disturbance in education, abortion with its complications like infertility from bilateral tubal occlusion, anaemia, with the associated risks of blood transfusion and even death. Izuora[8] cited the case of a 13 year-old girl who was picked up while suffering from complications of her third abortion! A typical case of today's adolescent in a medium density area in Nigeria is here cited. This is to illustrate the plight of the young adolescents in their state of unprepared ness for such a cardinal milestone in one's life at adolescence, little or absent care / supervision necessary for this age group, inadequate informed decision-making capability for parents / guardians and the adolescents themselves.

Case Report

OA is a 12-year old JSS1 Igbo school girl, last of 3 children of her widowed mother who presented at the Adolescent Clinic, University of Nigeria Teaching Hospital (UNTH), Enugu, Nigeria in 2005. She was brought by her mother after her neighbour, an experienced mother, drew her attention to the fact that OA was pregnant. OA's mother and her elder brother, who had just graduated from the university, decided on an abortion but OA herself suggested they came to the Adolescent Clinic, refusing to identify the father of the baby.

At the clinic, the pregnancy was confirmed and her gestational age was found to be 14 weeks. Her menarche was at 9 years of age and she was able to name her sex partner, a 15 year-old SSS1 student living next door with his parents and siblings. Both belong to low socioeconomic class (SEC) and are from families that live in a 1-room apartment each. It was a first coital experience which directly followed the viewing of a pornographic film on video CD, in the boy's 1-room family apartment, at about 7.30 p.m. on the fateful day. This was before the family members, business people, returned from the day's job. Incidentally, there was a breakdown in electric power source and immediately, they put to practice their recently learnt lesson from the pornographic film. The boy denied paternity on the grounds that coitus was only once and that he considered himself too young to father a baby. The girl did not understand initially that she was pregnant until her attention was drawn to that fact, and she resented the boy. The dilemma arose as to what the nature of further management was to be. Various options were considered when the family was counseled as OA's mother and her brother immediately opted for abortion to avoid stigma also because of the fear that young OA was unlikely to successfully go through the pregnancy and deliver safely. The brother did entertain the fear of complications of abortion but immediately canceled the idea of marriage between the two because he 'could not imagine having that "rascal" as a brother in-law.' To the option of going to a hiding place, in a home where she could stay for the duration of the pregnancy, which usually ends up with giving up the baby for adoption, OA said she would need to go with the mother. They all agreed that if the baby would be delivered, it would not be given up for adoption. Once convinced that OA had a good chance of successful delivery, the family, with the brother as the spokesman, chose that OA would stay at home with her mother to have and keep her baby. The boy (father of the baby) and his family chose the ostrich approach and continued in the denial cover. They never got involved subsequently. OA eventually had a 3.5kg baby girl at term by SVD with no complication at all. This was 3weeks after her 13th birthday.

DISCUSSION

The major fear associated with pregnancy out of wedlock in these young adolescents is the fear that the young adolescent may not be able to go through the pregnancy following assumed immature/inadequate pelvis. Sahler and McAnarney[9] had stated that 1 year after menarche; a girl's pelvis is adequate for parturition. OA's case supports this. As at

usually ahead of cognitive development which limits their ability for abstract thinking of possible consequences of their actions. They get to know enough to land them into trouble but do not know enough to get them out of the trouble. Preventive service therefore is the hallmark. This is in the form of sex education, parenting courses, establishment of youth centres and Adolescent Clinics with counseling facilities at many centres within the reach of these young people for use as is required. Kulin[18] had already observed the need to provide an avenue like Adolescent Clinics in medical schools. This is for both prophylactic and therapeutic purposes as well as for exposure of medical students to Adolescent Health. Already this is operational in the advanced countries but only just trickling into the developing countries like Nigeria.

In conclusion, this case highlights the gaping need for appropriate sexual orientation of our children and young people, with parental involvement, and at quite an early age, to forestall such an early sexual exposure with its numerous and far-reaching complications. Parents/guardians need to take up their rightful position of primary sex educators of their children and wards with support from schools and religious bodies, even including a refocused media. It is the secrecy which has shrouded sexual issues that as, for so long, propagated most of the ills sociated with it as the young searching minds of adolescents are left to grope in the dark, waiting for the most likely fall. Adults, who had passed by similar pathways should rise up and help direct these young travelers the correct way, preventing them from making the same mistakes as they had made. Incidentally, because most parents did not receive this necessary guidance, the methodology might be difficult. Parenting should no longer be assumed; deliberate effort should be made to teach parents to learn the art, for the betterment of the society. The government of the land should support and encourage these measures in every way specially by establishing or supporting the establishment of well structured Youth Centres to address Adolescent Health issues practical and effective ways. This should form a political priority. There is need for the government to censor video (VHS) tapes including VCD and DVDs as well as put some form of control over certain internet sites. This is because these open the gateway to pornographic films for these immature and unprepared minds. The media with their innumerable advertisements which tend to institutionalize sex should also be addressed. A refocused media is an invaluable tool for re-orientating the society especially the adolescents who get most of their information from them and believe same. Prevention has remained better than cure but when the need for a cure arises, the need for the appropriate choice can not be over emphasized. This is more so as the adolescents – the heartthrob and the future of any society – is concerned.

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1990, a survey revealed that the mean menarcheal age for Igbo girls is 13.23 +/- 1.27yr[10] but OA had her menarche at an equally early age of 9 years. This survey was obviously before OA was born and underscores the importance of periodic repeat of such surveys. The issue therefore is more of what to do to prevent pre-marital sex with its complications and how to ensure that one that does get pregnant is well looked after until she is delivered of her baby.

Like in many developing countries, Nigeria has a restrictive abortion law[11], but irrespective of this, the first option of OA's family was abortion. This seems to support the estimate[12] that over 610,000 abortions are done in Nigeria every year and that 60.1% are aged 10 – 24 years while 2/3 of those who die from abortion-related causes are youth aged 15 – 24 years. Often people make choices without thinking through and without clear understanding of the issues at stake or even without being well informed. This is one of the reasons why people undergo subsequent emotional and psychological instability later in life especially if fertility becomes a problem in later life. Many people do not understand that by 2 to 3 weeks of gestation, when a woman has not even known that she is pregnant, life has begun as the heart and the blood vessels are already developed and functional. Besides, OA was already 14 weeks pregnant – after the first trimester when the risk of complications following abortion increases. Following an effective counseling, the family was able to change their decision. Another source of strength was the involvement and support of the entire family ab initio. Even in countries without this restrictive abortion law, effective counseling is likely to produce a similar result.

Adolescents are known for sexual experimentation, especially at middle adolescence, with their usual lack of plan to have coitus, their invincibility (believing that they can neither get pregnant nor catch any of the STIs/HIV/AIDS) especially at their first exposure, and hence they rarely use contraceptives[13, 14]. Even though this annoys adults especially when these young people know these consequences and still indulge in pre-marital sex, such an attitude is consistent with normal adolescent psychology[14]. This is why there is a very strong need to start and heighten graded preventive services quite early in the lives of these young ones: there is need to inculcate in them ballast that is to keep them positively stable as they wade the storms of growth and development. They need factual information, proper supervision, appropriate value system, skills for decision-making, assertive behaviour etc as well as positive self-esteem, a conscience and the knowledge and fear of the deity among other things. The need for graded sex education as well as supervised exposure for normative social acculturation can not be over emphasized. In counseling, there is need to offer straightforward, non-judgmental information, and a willingness to assist in avoiding pregnancy and sexually transmitted diseases and so best results come from targeting younger adolescents, especially those not yet sexually exposed[14].

Secular trend for earlier sexual maturation had been noted among Nigerian Igbo Girls[3] but to have a drop of age at menarche from 13.23 years to 9 years is too drastic to be explained by secular trend. From 1950 when Ellis[15] recorded age at menarche as 14.3 years to 1962 when Tanner and O'Keeffe[16] published it as 14.1years onto 1990 when Nwokocha[10] found it to be 13.23 years, the age had dropped by barely 1 year. This is secular trend. A drop of 4 years in age at menarche over 15 years is an aberration from the average. The fact that OA has proved to be normal confirms her as a normal aberration from the average and highlights the need to commence preventive services / activities for appropriate reproductive and sexual health quite early in life. It also calls for extra effort in addressing sexual issues especially among the low and medium SEC where they end up with a vicious circle of poverty as earlier reported by Singh[17] and others. In addition, it calls for careful management and assistance for such young adolescents already suffering from the complications of illicit sexual life.

This case also demonstrates the fact that adolescents usually do not plan sexual intercourse and that they do not usually use contraceptives. Often, especially in the very young ones like OA, they are not able to even project and unable to handle the consequences of their actions. This is because the development of reproductive capability is

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