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TRENDS IN QUALITY LIVING AND ADOLESCENT SAFETY CHALLANGES IN NIGERIAN

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Abstract

Any community large or small, urban or rural has social dimensions that will affect the health status of its adolescents. Such dimension includes fundamental changes in the political, social and economic structure of such community or society. These have changed many entrenched cultures, values and beliefs, engendering feelings of personal insecurity among Nigerians and most especially adolescent. These changes have been additionally fuelled by an increase in adolescent population, the proliferation of varying forms of personal lifestyle and domestic arrangement, and the growing dominance of unexamined subjectivity in response to moral issues. All sections and age groups of the Nigerian society are likely to be affected by safety hazards but perhaps the most vulnerable are adolescents because of society's increasing emphasis on instrumental values to the detriment of expressive ones. This article looked at the increasing vulnerability of adolescents and established the safety challenges' that adolescents encounter. It also highlighted the need for adolescents to have easy access to safety education and it should be accorded a high priority in school and educational policy.

Introduction

Quality of life, a term used to evaluate the general wellbeing of individuals and societies, is the degree to which a person enjoys the important possibilities of his/her life which results from opportunities and limitations experienced in life (Wikipedia, 2011; Quality of life Research Unit, 2011). It is also the product of interplay among social, health, economic and environmental conditions which affect human and social development.

One of the approaches that can be used to describe quality of life is the wellness approach. Wellness is a state of complete physical, mental and social wellbeing and not merely the absence of disease. It is a multidimensional state of being, describing the existence of positive health in an individual and an active process of becoming aware of and making choices toward a more successful existence. It is also a mindset, a

predisposition to adopt a series of key principles in varied life areas that lead to high levels of wellbeing and life satisfaction.

The six important components of wellness as highlighted by McKinley Health Centre (2011) includes: emotional, physical, social, environmental, mental and spiritual wellness. According to Centre for Disease Control (2011), the physical dimension of wellness is critical to overall wellbeing. Physical wellness is the ability to apply ones knowledge, motivation, commitment, behaviour, self-management, attitude, and skills toward achieving personal fitness and health goals. It encourages consumption and activities which contribute to high level wellness such as eating a variety of healthy foods, engaging in well planned physical activities, not engaging in pre marital sex or practicing safe sex, avoiding the use of alcohol and drugs among others.

The group of people mostly affected by health related behaviour which have influence on their wellness are the adolescents. Adolescents include persons aged 10-19 years and they constitute about 43% of the Nigerian population (Bamgbose, 2002). During the transition from childhood to adulthood, adolescents establish patterns of behaviour and make lifestyle choices that affect both their current and future health. Child.net (2012) asserted that most teens do not have a healthy lifestyle. They are deprived of sleep, eat the wrong foods and are inactive affecting overall health and wellness. While some adolescents struggle to adapt behaviours that could decrease their risk of developing chronic diseases in adulthood, such as eating nutritiously, engaging in physical activity, and choosing not to use tobacco, some engage in behaviours that contribute negatively to their health status.

Who is an Adolescent?

The word adolescence conjures up all kinds of images, both positive and negative. Indeed it is a time that is filled with potential possibilities, hopes, fantasies, stresses, uncertainties and high drama. The term adolescent is defined by the World Health Organization [WHO] (2005) as young people between the ages of 10 and 19 years. They explain further that this group is often thought of as a healthy group, nevertheless many adolescents do die prematurely due to accidents, suicide, violence, and pregnancy related complications and other illnesses that are either preventable or treatable and many more suffer chronic ill-health and disability. In addition, many serious diseases in adulthood have their roots in adolescence. For example tobacco use, sexually transmitted infections including HIV, poor eating and exercise habits could lead to illness or premature death later in life.

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Adolescence is the transitional stage of development between childhood and adulthood with the chief purpose of preparing children for adult roles (Wikipedia, 2011). It is a

period of time during which a person experiences a variety of physical changes and encounters a number of emotional and social issues. The Centre for Disease Control (2008) defined adolescence as a period of accelerated growth that bridges the complex transition from childhood to adulthood. Adolescence is also defined biologically, as the physical transition marked by the onset of puberty and the termination of physical growth. Cognitively, it is also explained as the changes in the ability to think abstractly, multi-dimensional and socially. It is also defined as a period of preparation for adult roles (King, 2004). The most widely accepted age range for adolescence is 10-19 years as defined by WHO (2005).

While the definition of Adolescent can differ from culture to culture, it is generally accepted that the time referred to as adolescence is a time in a young person's life where they move from dependency to independence, autonomy and maturity. They begin to move from the family group which is their major social system to (the family now assuming a lesser role) being part of a peer group which becomes a greater attraction and eventually lead to the young person standing alone as an adult. This period extends over a substantial part of a person's life and each adolescent experiences individual change and growth at different rates. While some grow through the adolescent phase quicker and more smoothly, it may not be same for others. Indeed some adolescents have supportive families; others go through this daunting period of their lives alone.

During the transition from childhood to adulthood, adolescents establish patterns of behaviour and make lifestyle choices that affect both their current and future health. During this period, some adolescents struggle to adopt behaviours that could decrease their risk of developing chronic diseases in adulthood, such as eating nutritiously, engaging in physical activity, and choosing not to use harmful substances. On the other hand, serious health and safety issues such as motor vehicle crashes, violence, harmful substance use, and risky sexual behaviours have also been shown to adversely affect adolescent (Olusola, 2014). While this is true, Environmental factors such as family, peer group, school, and community characteristics also contribute to adolescents' health and risk behaviours.

What are the Safety challenges that could affect adolescents' quality of life?

Safety according to Adio-Moses (2013), extends the scope of human experience by anticipating and preventing conditions that would otherwise be injurious and even fatal. Adolescents in Nigeria are faced with a lot of safety challenges that could affect the satisfaction derived from various life domains which may directly or indirectly affect individual adolescent quality of life. The domains that are selected in this write up as indicators of adolescents' safety challenges are: Unintentional and Self-inflected Injury, Substance use, alcohol consumption and abuse, Nutritional problems, Risky Sexual Behaviour, Digital/internet addiction.

Unintentional/ self-inflected injuries.

It is very disturbing to know that the leading causes of morbidity and mortality among adolescents/young people are usually preventable. While most teenagers escape a close brush with death, each year thousands adolescent/ youths are not as fortunate. Azubuike and Onyemaka (2012) reported that injuries affect the lives of 10 – 30 million children and adolescents each year and have been acknowledged as the leading cause of mortality among young people in the age range of 15 – 19 years. Injury, as a research problem has been largely ignored in developing countries like Nigeria.

Nmor, Nwaka, Kensuke,Toyosawa and Fujita (2013) provided a vivid picture in relation to adolescents in Nigeria. Their study sample 585 students (60.9% male, 39.2% female with overall mean age of 15 years). They inquired about participants self-reported injuries in the past one year (all injury inclusive). When reported, injuries were further assessed according to cause, intent, nature, type, place, and number of days absent from school due to injury. Overall, there were 549 self-reported injuries in the past one year (93.8%) among the respondents (95.5% for males and 90.8% for females, $p = 0.6696$). Sex wise, prevalence of injury differ by age, school setting and parents' occupation ($p < 0.05$). Falls 293 (53.4%) was the leading cause of injury. Falls and animal bites were significantly higher in males compared to females [206 (60.4%) vs 87 (41.8%) $p = 0.002$, and 10 (2.9%) vs 0 (0.0) $p = 0.016$] respectively. Traffic injuries and falls decrease progressively with age. Homes and schools were settings injuries occurred mostly. Over 68% of the reported injuries were unintentional. On the average, 2 days of normal school activity were lost per injured persons because of an injury.

Effect of Unintentional/ self-inflected injuries among adolescents

Injuries have physical, psychosocial, and financial consequences that extend well beyond the injury victim. Physical consequences affect the victim directly and can be short-term, such as broken bones or minor burns or long term, such as traumatic brain and spinal cord injuries and severe burns that result in permanent disabilities. Psychosocial consequences of injury include depression and post-traumatic stress disorder and can affect not only the injured adolescents but also their families and larger social circles.(children safety network, 2014)

Chandran,Hyder and Peek-Asa (2010) stressed that deaths represent just a small proportion of the injury burden; nonfatal health outcomes represent a large component of the injury burden. A substantially higher number of injuries result in potentially life-long disability, significant psychological trauma, and subsequent financial loss. Because injuries usually occur in young healthy individuals, the number of years lived with disability as the result of an injury is usually very large. According to the WHO, (2008), up to 50% of young children with unintentional injuries that present to a hospital are left with some form of disability. Unintentional injuries accounted for over

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7% of total deaths and over 9% of total disability-adjusted life-years in low income countries. The burden of injuries is high in Nigeria due to the weak evidence to guide intervention strategies.

Alcohol abuse and Substance use among Nigerian adolescents

The use of alcohol, tobacco and other substances is one of the most important risk-taking behaviour among adolescents in Nigeria. Omigbodun and Babalola (2004) asserted that psychoactive substance misuse has increased in Nigeria especially among the adolescents. They affirmed that the studies carried out in the last two decades in Nigeria have identified adolescents as a major group involved in the use of psychoactive substances. They identified psychological dynamics of substance abuse to include peer pressure, experimentation and conduct problems and social factors such as poverty, family problems, and social acceptability of local alcoholic drinks like palm-wine.

Drugs that are commonly abused may be grouped into a number of categories: Narcotics, Stimulants, Depressants, Hallucinogens and Inhalants. Eneh and Stanley (2004) reported the pattern of substance use among Nigerian adolescents. The substances commonly used included alcohol 65%, kolanut 63.1%, cigarettes 61%, paracetamol 41.5%, butazolidine 39.3%, pemoline 28% and cannabis 26%. Others include tetracycline 25.7% and ampicillin 24.3% and valium 24%. Those that were least used included, heroin, cocaine, latex, petrol, pethidine and Ativan. The mean age of onset for alcohol was 4 years, kolanut 8 years, cigarettes 11 years, paracetamol, tetracycline, velum, cannabis was, 12 years, lexotan and Ativan, was 12.5 years and, latex inhalation, petrol, pethidine, Ativan, cocaine and heroin was 13.17 years. Males predominated in all the substances used.

The types and frequency of drug use among adolescents was reported by Abdukarim, Mokuolu and Adeniyi (2005). A prevalence rate of 40.1% found; currently used drugs included mild stimulants such as kolanut and coffee 294 (26.2%), alcoholl64 (14.5%), sniffing agents 80 (7.2%), amphetamine and ephedrine 66 (6.7%), cigarette 54 (4.8%), heroin 45 (4%) cocaine 40 (3.6%) and cannabis 38 (3.4%).The report of the findings of Igwe, Ojinnaka, Ehijiofor, Emechebe and Ibe (2009), also corroborate previous findings on substance use among secondary school students in Nigeria. 37% of the respondents were substance abusers with alcohol (31.6%) and cannabis (4.1%) being among the identified substances used among these adolescents.

Effects of Alcohol abuse and Substance use on Nigerian adolescents

Alcohol is an extremely powerful drug which is found in beer, wines and spirits such as whisky. It acts primarily to slow down the brain's activities. In low quantities alcohol is

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a stimulant. It has also been proven that alcohol consumption can reduce the risk of developing hypertension as well as heart attack. However taken in large quantities alcohol can damage or even kill biological tissues including muscle and brain cells. The major mental and behavioural effect of alcohol on adolescents is reduced skilled performance. Alcohol use by adolescents can interfere with school attendance, disrupt concentration and hurt academic performance.

Mba (2008) identified numerous negative effects of drug abuse on the body chemistry as follows: Physical problems associated with alcohol use include liver cirrhosis, pancreatic, peptic ulcer, tuberculosis, hypertension, neurological disorder, mental retardation for the foetus in the womb, growth, deficiency, delayed motor development, craniofacial abnormalities, limbs abnormalities and cardiac deficits, psychiatric e.g. pathological drunkenness, suicidal behaviour, socially-broken homes, increased crime rate, sexual offences, homicide and sexually transmitted diseases. Tobacco causes stimulation of heart and narrowing of blood vessels, producing hypertension, headache, loss of appetite, nausea and delayed growth of the foetus. It also aggravates or causes sinusitis, bronchitis, cancer, strokes, and heart attack. Stimulants: Lethargy, irritability exaggerates self confidence, damage nose linings, sleeplessness, and psychiatric complications. Inhalants causes anaemia, damage kidney and stomach bleeding. Narcotics cause poor perception, constipation, cough, suppression, vomiting, drowsiness and sleep, unconsciousness and death. Needless to say drug and alcohol abuse stand as a high correlate in other risky behaviours like delinquency and promiscuity. Drugs become a means of finding relief, comfort, or security.

Risky Sexual Behaviours among Adolescents

Sexuality is a vital aspect of human life. It refers to sexual feelings, behavior and development (Wikipedia, 2011). Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. The Planned Parenthood Federation (2014) explained that our sexuality affects who we are and how we express ourselves. There's a wide range of how people experience their sexuality. Some people are very sexual, while others experience no feelings of sexual attraction at all. They stressed further that sexuality may be influenced by family, culture, religion, media, friends, and experiences. No matter how important sexuality is, individual thoughts, desires, attractions, and values personal and unique.

Sexuality is about much more than just sex. It includes sexual and reproductive anatomy and body image, biological sex, gender, gender identity, sexual orientation, desires, thoughts, fantasies, and sexual preferences, values, attitudes, and ideals about life, love, and sexual relationships, sexual behaviors and masturbation.

Adolescence is a developmental period characterized by sexual initiation, experimentation and establishment of sexual behaviours which may pose health problems to the adolescents. Rates of sexual initiation during adolescent are either rising or remaining unchanged in Nigeria. Physiologically, the changes in reproductive organs that occur in the life of adolescents often serve as a motivating force in their quest to experiment with sex. Some naturally explore and take risks in many aspects of their lives, including sexual relationships. Those who have sex may change partners frequently and have more than one partner in the same time period or engage in unprotected sex. Many empirical studies have documented the trends and patterns of sexuality among Nigerian adolescents. In Ibadan, Olaseha and Alao (2011) reported that 28% of the adolescents who constituted their study participants had 2-5 partners and only few used a condom at recent sex. In Ibadan, Iwuagwu, Olaseha and Ajuwon (2000) reported among female undergraduate students that 55% had sex while number of sexual partners ranged from 10-23. Slap et al, (2003) in Plateau State reported that 57% of males and 48% of females reported history of sex with multiple partners. Ajuwon, Olaleye, Faromoju and Ladipo (2006) reported that 9% of adolescents in Gombe and Yobe states had sexual experience while only 3% used a condom.

A study by Eniola and Owoaje (2010) reported that only (26.7%) of the sexually active adolescent respondents used a contraceptive at their last sexual encounter and contraceptive use was significantly higher among the older females. In another study by Abduraheem and Fawole (2012) it was noted that 74.6% of the adolescents studied were sexually active, of which 66.4% had multiple partners and only 38.1% used condoms always during sexual intercourse.

Ajuwon (2005) submitted that many young people have poor understanding of the reproductive process while others harbour misconceptions such as the belief that pregnancy cannot occur at first sexual contact, and that use of contraceptives can cause infertility (Amazigo Kaufman & Obikeze, 1998). Research also confirms that many young person's participate in risky sexual activities including early debut of sexual activities (Olaseha, Ajuwon & Onyejekwe, 2004), multiple sexual partners, low and inconsistent use of condoms (Iwuagwu , Olaseha & Ajuwon, 2000). The explanations offered for increasing proportion of young persons involved in pre-marital sexual activities include earlier menarche, effects of mass media that glamorize sex, and increasing weakness of traditional control of the family system in Nigeria.

Effect of Risky Sexual Behaviour on adolescent health

The risks related to sexual activity among young people includes; Sexually transmitted diseases (STDs), unintended pregnancy often leading to unsafe abortion and its complications to become a parent, at any given age have the capacity of generating a life – altering experience. Irrespective of race, education and socio-economic status

motherhood and fatherhood both places high demands on one's life that were not there before the birth of a child. Indeed, becoming a parent comes with several responsibilities, and when people of school ages (students) become parents, the new responsibilities can be very over-helming and daunting. And for teenage parents that lack the support of their own parent, this experience can be more challenging and horrifying as they crave and seek support in adult –oriented systems in which even the older parents may find rather difficult to cope (Ekefre, Ekanem, Esien & Ekpenyong, 2014). Ajuwon, Olaleye, Faromoju and Ladipo (2006) submitted that adolescents account for a significant proportion of unsafe abortions globally and the Jones and Jerman(2014) reported that at least one-third of all women seeking hospital-care for abortion complications are under the age of 20 years. The physical, econom c, and social hazards that face young mothers and their babies are numerous and they range from deficiency in calcium and phosphorus during breast feeding to pregnancy induced hypertension, fistula, anaemia, vulnerability to HIV/AIDS and other STIs.

Piot (2005) submitted that adolescents are one of the groups hard hit by HIV/AIDS with over half of all new HIV infections in Africa in 2005 found among young persons aged 14-25 years especially young women. Weinstock, Berman and Cates (2004) reported that nearly half of the 19 million new STDs each year are among young people aged 15-24 years. Adio-Moses (2008) affirms that adolescents who are sexually active are susceptible or exposed to sexually transmitted disease including HIV/AIDS. STD's may include; Gonorrhoea, Chlamydia, trachomatis, Urethritis, Cancroid, Herpes, Syphilis, cervical cancer and many more

Contrary to what many adults may believe, the majority of adolescents who are sexually experienced use some method of contraception to protect themselves and their partners from unintended pregnancy and sexually transmitted diseases (STDs). But for adolescents who do not use contraceptives, or don't use them effectively or consistently, the consequences can be serious, especially for teenage girls.

Eating Disorders/Unhealthful Eating Patterns

Eating disorder has also become very common or has become the order of the day. The desire and addiction with thinness has supersedes the desire to be healthy and teenagers often resort to desperate or even dangerous methods of weight control. As a result, it is common for adolescents to snack, and indeed parents do encourage snacking. The typical adolescent tends to eat a good deal of junk food, sweets or meals from fast-food restaurants that are high in fat and low in fibre, vitamins, and minerals. Parents can help by serving well-balanced home cooked meals and by stocking the kitchen with healthy snacks such as fruit and other natural low fat snacks. It's also important not to skip meals, since this can easily lead to snacking on junk foods consumption. Being thin

becomes an obsession and leads to eating disorders anorexia and bulimia. Combined, these conditions affect about 4 percent of adolescent and young women.

Eating disorders are serious, sometimes life- threatening, conditions that tend to be chronic. They usually arise in adolescence and disproportionately affect females. About 3 percent of young women have one of the three main eating disorders: anorexia nervosa, bulimia nervosa, or binge-eating disorder. Binge-eating disorder is a newly recognized condition featuring episodic uncontrolled consumption, without compensatory activities, such as vomiting or laxative abuse, to avert weight gain Bulimia, in contrast, is marked by both binge eating and by compensatory activities. Anorexia nervosa is characterized by low body weight (< 85 percent of expected weight), intense fear of weight gain, and an inaccurate perception of body weight or shape (Rockall, Logan, Devlin and Northfield, 2014). In other cases the eating disorder is a manifestation of underlying psychological issues, including low self-esteem, poor self-image, family problems, stress, or feelings of not being in control.

Signs of eating disorders: Constant adherence to increasingly strict diets, regardless of weight, Habitual trips to the bathroom immediately after eating, Secretly bingeing on large amounts of food, Hoarding large amounts of food, Increase in consumption of laxatives, diuretics or diet pills, Exercising compulsively, often several hours per day, Using prescription stimulant medications (like Adderall) and/or illicit stimulant drugs (like cocaine) to suppress appetite.

It is more difficult to spot someone with bulimia, compared to anorexia, since people with bulimia typically maintain a normal weight and tend to do their bingeing and purging in secret. Both anorexia and bulimia have serious consequences and in extreme cases cause death. About 20 percent of people with anorexia die because of complications related to the disorder (Kam, 2014). Other forms of nutritional problems found in adolescents are;

Under-nutrition: Is defined as the outcome of insufficient food intake (hunger) and repeated infectious diseases (United Nations International Children's Emergency Fund, 2006). Under nutrition includes being underweight for one's age, too short for one's age (stunted), dangerously thin (wasted), and deficient in vitamins and minerals (micronutrient malnutrition). This form of malnutrition often frequently goes unrecognized by young people or their families however it has been reported to have adverse effects on adolescents' ability to learn and work at maximum productivity. The study carried out by Ogechi, Akhakhia and Ugwunna (2007) among Nigerian adolescents revealed that Over 20% of the adolescents were thin (BMI<18.5kg/m2) and the prevalence of stunting is 67.3% and 57.8% for boys and girls, respectively. Ayoola, Ebersole, Omotade, Bamidele, Brieger, Salami, Dugas, Cooper and Luke (2009) also

reported that 37% of male and 23% of female adolescents were underweight. Another report by SenbanjoI, Oshikoya, Odusanya and Olisamedu (2011) showed the prevalence of stunting among Nigerian adolescents aged 10-14 years as 19.6% and those aged 15-19 years as 19.1%.

Over-nutrition: This is a form of malnutrition that involves excess dietary intake that shows up as accumulation of excess body fat. Over-nutrition is an emerging problem in the Nigerian society, particularly where lifestyles become urbanized and westernized. There are two forms of over-nutrition depending on severity: overweight and obesity. The increase in obesity prevalence has been observed among pre-school-children and adolescents in Nigeria. The study of Ogechi, Akhakhia & Ugwunna (2007) revealed that about 4% for boys and 2% of girls were at risk of becoming overweight Also, Akinpelu, Oyewole and Oritogun (2008) citing Akesode and Ajibode (1983) reported that in Nigeria, the prevalence of obesity among 457 school children in the age group 6-19 years was 3.2% for males and 5.1% for females based on weight for age while 3.7% males and 3.3% females were classified as obese when triceps skin fold thickness was used as the basis of obesity. Also, Akinpelu, Oyewole and Oritogun (2008) reported in their study that the prevalence of overweight seems high in both genders (0-8.1% and 1.3-8.1% in males and females respectively) while obesity prevalence was low (0-2.7% and 0-1.9% in males and females respectively).

Micronutrient deficiency

Adolescents (both boys and girls) are at risk of developing iron deficiency and iron deficiency anaemia due to increased iron requirements for growth and possible Infectious diseases such as malaria, schistosomiasis, and hookworm which often reduces iron absorption or increases iron loss in both boys and girls. Anumudu, Afolami, Igwe and Keshinro (2009) reported that most of the children they studied were anemic, 87.1%, having PCV values below the 32% cut-off and 95% with hemoglobin levels lower than the 11g/dl.

Approaches to solving adolescents health and Safety challenges

A lot of parents would have had several talks with their children about basic safety issues by the time the child becomes an adolescent. However, talking to adolescents about safety can present new challenges for both parents and adolescents. The need to separate from parents to establishing their own identity and becoming more independent is a force that exposes adolescents to a lot of safety challenges. Adolescents are also influenced by peer pressure and can feel invincible which may lead them to participate in risky behaviour. Adopting different effective approaches could help in solving adolescent health and safety challenges.

Effective Communication and safety Education: between parents and teenagers has been recommended as a very important approach to ensure safety. Parents are advised to pay attention to their tone of voice when they are giving their adolescents advice or guidance and should be sure to show respect to the adolescent's intelligence and experience. Swierzewski (2008) submitted that parents should keep adolescents informed about current information regarding health and safety on a day to day basis. In many cases allowing them to read information is more effective than talking.

Appropriate Sexuality Education Intervention: to reduce sexual risk behaviours and related health problems among youth, schools and other youth-serving organizations can help adolescents adopt lifelong attitudes and behaviours that support their health and well-being including behaviours that reduce their risk to HIV, other STDs, and unintended pregnancy. Ajuwon, Olaleye, Faromoju and Ladipo (2006) stated that there is need to target adolescents with appropriate interventions that address not only the contextual factors such as gender roles and poverty that place them at risk, but also individual factors including access to knowledge on life skills, safe sex negotiation and efficient use of contraceptives (Centre for Disease Control, 2011). To ensure sexual health among adolescents, sexuality education intervention should emphasis on abstinence and promotes the knowledge of dangers inherent in sexual risk behaviour.

Nutrition Education: Nutrition education and health promotion programs that will foster healthy eating among adolescents should be put in place. Adolescents with eating disorder should be exposed to treatment focusing on helping them to cope with their disordered eating behaviors and establish new patterns of thinking about and approaching food. Kam, (2014) advised that kids and adolescents with eating disorder should have medical supervision, nutritional counselling, and therapy. Other professionals should help to address adolescents' perception about body size, shape, eating, and food. Additional therapy such as medications, including antidepressants and psychotherapy should also be suggested in severe cases.

Conclusion

Adolescents in Nigeria have all the characteristics of adolescents all over the world and they are faced with similar health and safety challenges ranging from alcohol, drug abuse, sexuality and nutrition. Additional teen safety issues are related to physical growth and increased strength and agility that usually develop before other skills such as decision making, common sense and good judgement. Young people's behaviours are influenced at the individual, peer, family, school, community, and societal levels. Effective communication between adolescents and their parent is an important component in solving most adolescent health and safety challenges. The net increase in premarital sexual intercourse accompanied by a lack of efficient use of contraceptives has resulted in an increase in the incidence of out of wedlock pregnancies and sexually

transmitted infection. Health education plays an important role in providing organised information concerning safety, sex, drug and nutritional issues.

Recommendation

All the sectors of the society that are directly and indirectly associated with children and adolescents should make it a point of duty to contribute to adolescent health, safety, and well-being through intervention and health educational programmes. A collaborative effort that engages multiple organisations is necessary to address every aspect of adolescent health and safety. Such joint efforts can also help to promote a more comprehensive approach to addressing adolescent health and safety challenges from a holistic point of view. Whatever approach is adopted should view each adolescent as a whole person, recognizing and drawing upon his or her assets and not just focusing on risks. Adolescent are intent on experimenting, but they should be guided by parents and guardians to adopt safe lifestyle habits. Indeed most of the habits that seem attractive to adolescent are also bad for their health.

To have the most positive impact on adolescent health, government agencies, community organizations, schools, and other community members must work together in a holistic and comprehensive approach. Providing safe and nurturing environments for our nation's youth can help ensure that adolescents will be healthy and productive members of society.

References

Abdulkarim, A. A., Mokuolu, O.A. & Adeniyi, A. (2005). Drug use among adolescents in Ilorin, Nigeria. *Tropical Doctor*; 35: 225—228

Abduraheem, A. A., & Fawole, O.A. (2012). Young People's Sexual Risk Behaviors in Nigeria. Retrieved 05/04/2014*http://jar.sagepub.com/content/24/4/505*

Adio-Moses, R.O. (2004) *Knowledge and Reported Symptoms of Selected Sexually Transmitted Infections among Female Secondary School Students in Oyo* State,Nigeria. In Igbanugo, V. C., Ogundele, B.O., Abass, A.O. & Adegbesan, O. A. Multi-disciplinary Approach To Human Kinetics And Health Education. A book of Reading in Honour of Professor Yomi Awosika. 183-192.

Adio-moses. R.O. (2013), Survey of Environmental Health Conditions In Relation to Safety in Public Primary Schools in Egbeda Local Government Area of Oyo State Nigeria. *Nigerian School Health Journal* 25(1) 72-79.

Ajuwon, A,J., Olaleye, A., Faromoju, B. & Ladipo, 0.0. (2006). Sexuality behaviour and experience of sexual coercion among secondary school students in three states in North Eastern Nigeria. *BMC Public health*, 6:310

Ajuwon, A.J. (2005). *Benefits of sexuality education for young people in Nigeria.* Africa Regional Sexuality Resource Centre.

Akinpelu, A.O., Oyewole, O.O. & Oritogun, K.S. (2008). Overweight and obesity: does it occur in Nigerian adolescents in an urban community? *International Journal of Biomedical and Health Science,* 4:11-17.

Amazigo, U. Kaufman, S.N. & Obikeze, D.S. (1998). Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria. *International Family Planning Perspective,* 23: 28-3 3.

Anumudu, C., Afolami, M., Igwe, C., Nwagwu,M. and Keshinro, 0. (2008). Nutritional anaemia and malaria in pre-school and school age children. *Annals of African Medicine,* 7:11-17.

Ayoola, 0., Ebersole, K., Omotade, O.O., Bamidele O. T., Brieger,W.R,, Salami, K., Dugas. L.R., Cooper, R.S. & Luke, A. (2009). Relative Height and Weight among Children and Adolescents of Rural Southwestern Nigeria. *Annals of Human Biology,* 36(4): 388-399.

Azubuike, S.O. & Onyemaka, E. O. (2012)Epidemiology of non–fatal injuries among adolescents in an urban Niger delta community of Nigeria. *International Journal of Critical Illness.* 2(3): 180–185.

Bamgbose, O. (2002). Revitalizing the Nigerian adolescents. A consideration of rights and attendant responsibilities. In l.A. Nwazuoke, Y. Bamgbose & Moronkola, O. A. (ed). Contemporary issues and researches on adolescents. 15-35.

King.C. (2004) Adolescent reproductive health in Nigeria. Retrieved on 01/05/2012 from *http ://www.advocatesforyouth.org/storage/advfy/documents/fsnigeria.*

Center for Disease Control, (2011). Dimension of wellness: Physical wellness.*http://www.defrnitionofwellness.com/dimensions-of-physical-wellness.html*

Chandran A,Hyder A.A and Peek-Asa C. (2010) The Global Burden of Unintentional Injuries and an Agenda for Progress *http://epirev.oxfordjournals.org/content/32/1/110.full?sid=96e32b36-5c96-4470-bd81-1566170c2023*

Child.net (2012). Health and Wellness *http://www.child.net/articles/healthJ* Retrieved 16/04/2012 Retrieved 16/04/20 12

Children safety network (2014) preventing adolescent injury: the role of health plans . *http://www.nihcm.org/pdf/InjuryIssueBrief.pdf*

Ekefre E. N., Ekanem S. A., Esien, O.&Ekpenyong E., (2014) Teenage Pregnancy and Education in Nigeria: A Philo-Sociological Management Strategy *Journal of Educational and Social Research 4.(3).*

Eneh, A.U. & Stanley, P.C. (2004). Pattern of Substance Use among Secondary School Students in Rivers State Nigerian. *Journal of Medicine,* 13: I,

Eniola, O.C. & Owoaje, E.T. (2010). Patterns of contraceptive use among female undergraduate in the University of Ibadan, Nigeria. *The Internet Journal of Health,* 10;

Igwe, W.C., Ojinnaka, N., Ejiofor, S.0., Emechebe, G.O. & Ibe, B. C. (2009).

SocioDemographic Correlates of Psychoactive Substance Abuse among Secondary School Students in Enugu, Nigeria. *European Journal of Social Sciences*, 12; 2, 277

Iwuagwu, S.C., Olaseha, I.O. & Ajuwon, A.J. (2000). Sexual behaviour and negotiation of male condom by female students of University of Ibadan, Nigeria. *Journal of Obstetrics and Gynaecology,* 20:507-513.

Jones, R. K. & Jerman, J.(2014). Abortion Incidence and Service Availability in the United States. *Perspective on Sexual and Reproductive Health,*46(1)3-14.

Kam, K. (2014), Eating Disorders in Children and Teens*http://www.webmd.com/mental-health/eating-disorders/features/eating-disorders-children-teens*

Mba, A.I. (2000). Counselling techniques for the rehabilitation of drug addicts in Nigeria. *The Counsellor*, 18(1) 10-18.

Mckinley health centre (2011) What is wellness *Retrieved 06/08/2014 http://www.mckinley.il1inois.edu/units/health_ed/we1lness.htm,*

Mokhtar, N., Elati, J., Chabir, R., Bour, A., Elkari, K., Schlossman, N., & Caballero, P. (2011) National academy of sciences Challenges in adolescent health care : workshop report*http://www.nap.edu!cata1og.php?record_id 12031 Retrieved* 16/04/2012

Nmor, J.C., Nwaka, H.K., Kensuke, G.J., Toyosawa, J., & Fujita. D. (2014). High rate of injuries among students in Southern Nigeria: An urgent call to action*http://dx.doi.org/10.4236/health.5122665*, (12)1965-1975

Ogechi. U.P., Akhakhia, O.I. & Ugwunna, U.A. (2007). Nutritional status and energy intake of adolescents in Umuahia Urban, Nigeria. *Pakistan Journal of Nutrition,*

Olaseha I.O. & Alao. A., (2011). A Comprehensive Analysis of Condom Use among Unmarried Youths in Rural Community in Nigeria. *Public Health Research. 1(1) 8-16*

Olaseha, I.O., Ajuwon, A.J. & Onyejekwe, C. (2004). Reproductive health knowledge and use among mothers in sub-urban community. *African Journal of Medical Science*, 33:193-194

Olusola F.J. (2014). Socio-Personal factors as predictors of Health Seeking behaviours among inhabitants of Oyo state Nigeria. *Nigerian School Health journal.*26(2) 115-123.

Omigbodun O.O. & Babalola O. (2004). Psychoactive Substance Misuse among Nigerian Adolescents. *Annals of African Medicine* 3(3) 111-115

Piot, P. (2005). *Making money for the people on the ground. Speech presented at the opening ceremony of international conference on sexually transmitted diseases and AIDS.* (ICASA, 2005), Abuja, Nigeria.

Planned Parenthood (2014) Adolescent Sexuality *http://www.plannedparenthood.org/health-*

info/sexuality#sthash.oZa0tmQ0.dpuf

Rockall TA, Logan RF Devlin HB, Northfield TC. (2014) Risk assessment after acute upper gastrointestinal haemorrhage. http://www.ncbi.nlm.nih.gov/pubmed/8675081

Senbanjo, I.O., Oshikoya, K.A, Odusanya O.O. & Olisamedu, F.N. (2011). Prevalence of and risk factor for stunting among school children and adolescents in Abeokuta, South western Nigeria. *Journal of Health Population and Nutrition,* 29:364-370.

Sexual and Reproductive Health, 36(1):6-1 0.

Swierzewski S.J. (2008) Adolescent Safety .Overview of Teen Safety. Retrieved, 23/04/2014. http;//www.healthcommunities.com

United Nations International Children's Emergency Fund, (2006). Nutrition, Survival and Development: Progress for Children, A report Card on Nutrition number 4, http;//www.unicef.org/progressforchildren/2006/indexsurvivalanddevelopment.html

WHO, (2005). Adolescent health and development. *http://whqlibdoc.who.int/publications/2005/9241 593660 eng.pdf 16/04/20 12.*

Wikipedia 2011 quality of life Retrieved from http://en.wikipedia.org/wiki/Ouality of_life. 16/04/2012

World Health Organization. (2008). The Global Burden of Disease: 2004 Update. Geneva, Switzerland: World Health Organization