

Adolescent Reproductive Health Issues and Sexual Behaviours in Coastal Communities: A Case of Biriwa, Ghana

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Abstract

Adolescence is a vital stage of human development because it is characterized by physical, mental, emotional, and psychological changes and sexual experimentation as an individual transitions from childhood to adulthood. This study investigated adolescent reproductive health issues and sexual behaviors in Biriwa, Ghana. The study draws on the health belief model and social learning theory components to analyze the motivations and responses toward reproductive health issues. The study employed a descriptive survey design, and a questionnaire was used to gather data from 200 adolescents. The study discovered the prevalence of unhealthy premarital sexual intercourse and consequent abortion of pregnancies. Peer pressure and lack of financial support from parents or guardians were the main factors that motivated adolescents to engage in unhealthy premarital sex. Therefore, it is recommended that the health center provide regular reproductive health education for adolescents in the community.

Keywords: Adolescent, Sexual Behaviour, Sex, Reproductive Health

Abstrak

Masa remaja merupakan tahap vital perkembangan manusia karena ditandai dengan perubahan fisik, mental, emosional, dan psikologis serta eksperimentasi seksual sebagai transisi individu dari masa kanak-kanak menuju dewasa. Penelitian ini menyelidiki masalah kesehatan reproduksi remaja dan perilaku seksual di Biriwa, Ghana. Studi ini mengacu pada komponen model keyakinan kesehatan dan teori pembelajaran sosial untuk menganalisis motivasi dan tanggapan terhadap masalah kesehatan reproduksi. Penelitian ini menggunakan desain survei deskriptif, dan kuesioner digunakan untuk mengumpulkan data dari 200 remaja. Studi ini menemukan prevalensi hubungan seksual pranikah yang tidak sehat dan aborsi kehamilan. Tekanan teman sebaya dan kurangnya dukungan finansial dari orang tua atau wali menjadi faktor utama yang memotivasi remaja untuk melakukan hubungan seks pranikah yang tidak sehat. Oleh karena itu, disarankan agar Puskesmas memberikan pendidikan kesehatan reproduksi secara berkala kepada remaja di masyarakat.

Kata Kunci: Remaja, Perilaku Seksual, Jenis Kelamin, Kesehatan Reproduksi

Introduction

Adolescence is a vital stage of human development. It is the stage between the ages of 10 to 19 years where individuals transit from childhood to adulthood. Adolescence is characterized by physical, mental, emotional, and psychological changes and sexual experimentation (Waller, 2010 ; Langton & Berger, 2011 ; Esere, 2008). The changes at the adolescent stage present young individuals with risks and opportunities that can influence their prospects in life (Resnick, Catalano, Sawyer, Viner, & Patton, 2012). For this reason, adolescents require the utmost parental and guardian attention, direction, control, care, and understanding to ensure that they are raised to be healthy adults (Langton & Berger, 2011). Also, there is a need to pay attention to issues that

affect adolescents because of their social and health implications (Orben et al., 2020).

Adolescents constitute 16 percent (1.3 billion) of the world's population (UNICEF, 2022). The adolescent population keeps increasing, with Sub-Saharan Africa recording the most significant population increase. In Sub-Saharan Africa, the teenage population in 2019 was 247 million (Liang et al., 2019). This population of adolescents is expected to rise within the next 35 years (Kyilleh et al., 2018; Kabiru et al., 2013). All things being equal, an increase in the adolescent population implies increased opportunities and increased risks that are capable of influencing the total growth and development of young individuals. It explains why adolescent well-being has been a significant focus for governments, policymakers, and

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service providers since 1994 (Awusabo-Asare et al., 2004; Liang et al., 2019).

Globally, target 3.7 of the Sustainable Development Goals (SDGs) focuses on ensuring universal access to sexual and reproductive healthcare services and incorporating reproductive health into national strategies and programs (Warren et al., 2017). In Ghana, the well-being of adolescents, especially sexual and reproductive issues, has featured strongly on the government's developmental agenda due to factors such as early childbearing and the prevalence of HIV/AIDS (Esantsi. et al., 2015). Because of this, there have been many studies on adolescent reproductive and related issues. However, these studies have not focused on adolescents' health issues and sexual behaviors in coastal communities hence the study area. According to the Mfantseman District Ghana Health Service Report 2007 - 2008, there was a steady increase in the number of young people who visited clinics for reproductive health services. The clinics aimed to improve the sexual and reproductive health behavior and safety of adolescents and young people. However, data from the Boabab Medical Centre indicated that teenage pregnancy and abortion increased by four percent (4%) and two-point three percent (2.3%), respectively, from 2007 to 2009 in Biriwa. It remains unclear why such increases should be recorded in a district where there has been a remarkable improvement in the patronage of youth-friendly services. In addition, based on the general trends in promoting sexual and reproductive health services among marginalized communities, most adolescents within vulnerable subgroups are likely not to access these services at orthodox medical facilities such as the Boabab Medical Centre. Data from the health facility alone may not represent the actual state of affairs in Biriwa. Hence, this study sought to fill the knowledge gap concerning addressing adolescents' sexual and reproductive health issues and behavior in Biriwa. This study explores the dimensions of adolescent reproductive health behaviors and the determinants of these behaviors. Specifically, the study examines the predominant reproductive health issues among adolescents aged 13 - 19 at Biriwa. It also investigates the factors that influence their sexual behaviors.

Theoretical Framework

Examining adolescents' dimensions and health-seeking capabilities will require

measurements of knowledge and practices of certain behaviors. The measurements, however, need to be looked at within a given context. Therefore, given the phenomenon under study, the context-specific issues include the age at which adolescents start experimenting with sex, the age at which they get married, and selected adolescent reproductive health behaviors. Behavioral theories provide a framework that helps to understand better the actions people take when it comes to their health. Behaviour is not constant. Thus, behavior can be altered when there is a perception or susceptibility to risks. Primarily, what will motivate adolescents to alter their behavior in terms of reducing risky behaviors likely to result in detrimental reproductive health issues largely depend on their capabilities and skills to apply reproductive health knowledge they may be privy to (Auerbach, Wypijewska, and Brodie, 1994).

Underlying changing behaviors are expectancies and incentives. They could include environmental cues (the consequences of one's actions, referred to as outcome expectation, and yearnings about one's competence to perform the behavior required to influence outcomes, known as efficacy expectation). In this regard, adolescent behaviors are likely to be influenced or changed by what they value or consider as incentives or expectations for putting up a particular behavior (Bandura, 1997). These could be witnessed as improved health, physical appearance, approval from others, financial gain, or other consequences. Notably, one must be well aware of how their behavior is altered or influenced by their expectations or motivations. In this case, adolescent reproductive health behaviors can be altered by what the adolescent constitutes as expectations or incentives to experiment with sex, get married, or have an abortion, among others.

Becker (1974) stipulates that health-related actions depend on the presence of sufficient motivation to make health issues salient or relevant. Thus, the belief that one is susceptible to a severe health problem or the "sequelae" of that illness or condition and the belief that a specific health recommendation would be beneficial in reducing the perceived threat at a subjectively acceptable cost. Berker's model implies that a perceived threat or vulnerability should influence adolescents' health-related

actions in addition to the benefits of health recommendations.

Dimensions and Determinants of Adolescent Reproductive Health in Ghana

Adolescent reproductive health behaviour is affected by various issues. These issues relate to cultural, economic as well as demographic dimensions. They influence the extent to which young people transitioning into adulthood alter their behaviour in making reproductive health choices. They include:

Social Perspective of Ghana's Adolescent

The traditional duties, status, obligations, and socialization processes for adolescents have certain similarities despite Ghana's diversity of ethnic groups. For instance, among the Krobo of the Ga-Adangbe and the Akans, puberty rites were carried out for females after menarche. Although these rites are christened differently (Dipo among the Krobo and Bragro among the Akan), this initiation rite signifies their maturity and transition into adulthood. In the past, girls who missed this initiation because they were pregnant were shunned and, in some cases, expelled from their communities. This served as a check against teenage pregnancy. Boys, on the other hand, at the onset of puberty, were taught to be farmers, hunters, fishers, and artisans, while girls, in addition to the puberty rites, were taught personal hygiene, domestic activities, child care, vocational skills, and the art of trading (Awusabo-Asare et al., 2004).

However, these rites and initiations are no longer practised in many Ghanaian communities. Human rights arguments have been advanced towards the punishments that were levelled against girls who got pregnant without being initiated. Hence it is no longer mandatory for adolescent girls to participate in the initiation. Again, urbanization and migration have made celebrating such rites almost insignificant. While some people see it as a sheer waste of time, costly and risky to travel to their home towns merely to initiate their adolescent children, others also see it as uncivilized and a practice that is outmoded and has no significance for the development and well-being of the individual.

Age at a first sexual encounter

A substantial number of people experience their first sexual encounter before 18 (Population

Reference Bureau, 2001). A study of sexual activity among 15 to 19-year-olds in Ghana revealed a significant decline in the age at which people experience their first sexual encounter. In 1993, 33% of teenage males who had ever engaged in sexual activity made up 19% of the population. Female adolescents, on the other hand, tend to begin sexual intercourse earlier than males (Ghana Statistical Service [GSS], 2000, Ghana Social Marketing Foundation [GSMF], 1998; 2000).

According to Awusabo-Asare et al. (2004), the average age at which people start having sex is before 17. In their study, it was evident that 50% of 1,038 adolescents (471 females and 567 males) had their debut sex between the ages of 14 and 17, while twenty-five percent of the sexually active students had their break at sexual experience by age 13 or younger. Peer pressure, deception by partners, experimentation, and satisfaction of sexual desires were all reasons for engaging in sexual intercourse. Even though recent studies suggest that the age at first sexual encounter has fallen, most adolescents believe that maintaining chastity is still a worthwhile goal.

Premarital sexual behavior among adolescents

Studies conducted on adolescent sexual and reproductive health in some countries of Asia have revealed that premarital sex is clearly on the rise. In Korea, for example, 24% of male secondary school students and 11% of female secondary school students reported having had premarital sexual relations (Gubhaju, 2002). In addition, numerous young men who have had sexual experience have also admitted to having multiple lovers; in the Republic of Korea and Thailand, close to 70% of male students, and about 30% of young men, respectively, claimed to have more than two partners (Brown et al., 2001).

Premarital sex is prohibited by Indian custom; however, careful research shows it is becoming more popular among youths (Sharma, 2000). For example, data from Bangladesh by Uddin (1999) revealed a very high incidence of premarital sex; 61 percent, compared with 24 percent of females, had had premarital sexual activity among adolescents, and this percentage was much higher in urban than in rural areas. In addition, a 1991 study conducted in nine districts of Nepal also found that 20 percent of

young people were engaged in premarital sex (Rai, 2001).

Adolescent women frequently experience negative consequences of premarital sexual relations. For example, in Sri Lankan Free Trade Zone communities, Hettiarachchy and Schensul (2001) reported cases of young single women becoming pregnant after unprotected premarital sexual intercourse. These women began having sexual relations with men who promised to marry them in exchange for sexual relations. However, after learning of his partner's pregnancy, the man either disappeared or moved on to another woman. As a result, these young abandoned women faced the consequences of unwanted pregnancy, unsafe abortions, and the stigma of being a single mother.

Likewise, over time, studies conducted in Ghana have revealed increased premarital sex among adolescents. In a nutshell, 66.8% of males and 78.4% of females in a study conducted by Agyei et al. (2000) showed that most adolescents in the Eastern and Greater Accra regions had engaged in premarital sexual activities. Surprisingly, 20 and 30% of the respondents, thus, males and females, did not know that an adolescent girl could get pregnant before engaging in sexual activity.

Contraceptive use among adolescents

Numerous surveys have also reported the low level of contraceptive use among sexually active unmarried adolescents. For instance, among Vietnamese college students, just 32 percent of females and 28 percent of males used contraception when they first had sex (Brown et al., 2001). Of the 1,250 sexually experienced young people aged 15 to 25 years in the People's Democratic Republic of Laos, up to 79% did not use contraception for the first time (Sisouphanthong et al., 2000). Comparably, research conducted in a border town in Nepal indicated that fewer than 65 percent of unmarried men between the ages of 18 and 24 have never used condoms when having sex with their non-regular sex partners, including commercial sex workers. They asserted they had no sexually transmitted diseases since they believed they were paying attention to choosing a disease-free woman as their partner. However, many men became infected with sexually transmitted infections and became aware of the dangers of unprotected sex (Tamang et al., 2001).

The use of contraceptives among adolescents reveals issues of critical importance to this specific group, namely that adolescent girls may be aware of contraceptives but do not always use them. For example, Sharma (2000) discovered that contraceptive knowledge exceeds 90% among adolescent married girls in India in a study conducted in that country. However, contraception awareness among teenagers is less advanced than among women in their 20s and 30s and their 15s and 19s. Moreover, there is a slight variation in the understanding of contraception between women aged 15-19 and 20-24.

However, increased contraceptive knowledge does not always translate into increased contraceptive use. For example, according to Ajzen and Fishbein (1980), less than 10 percent of adolescent girls were found to be using any form of contraceptive in India, the Lao Peoples' Democratic Republic, Nepal, and Pakistan, while contraceptive use among adolescents was reasonably high (at least 30 percent) in such countries as Bangladesh, Indonesia, Kazakhstan, Sri Lanka, Thailand, and Turkey. He also stated that adolescent contraception use is significantly lower than women aged 20-24.

The above findings coincide with a survey by the United States Census Bureau, which found that teenage females in developing nations utilize contraception far less frequently than older women (McDevitt et al., 1996). The survey also found that roughly 13 million adolescent girls in underdeveloped nations have unmet family planning needs. The study also showed that in several Asian nations, more than 30% percent of married adolescent girls intended to put off or limit childbirth but are not currently using contraception. Unmet needs among adolescents can be significantly more prominent if they include sexually active unmarried teens who are not currently using contraception.

Research done in Ghana demonstrates that young people have a good level of knowledge about contraceptives and where to get them. For example, the GSS (2000) findings show that 76% of women aged 15-19 years and 88% of men of this age knew at least one contemporary form of family planning. On the other hand, 33% of women and 6% of men between 12 and 14 were familiar with at least one current form of family planning. Condoms were the most frequently reported technique (77% of men and 66% of

women knew this method). The percentage of males and females aged 15 to 19 who knew at least one current approach was over 80%, according to the GSMF (1998) survey. However, teenagers only have a cursory understanding of some particular techniques. For instance, according to GSMF (2000) data, while 25% of men and 49% of women aged 12 to 24 years were aware of the pill, only 21% of women and 46% of men who were mindful of the method were aware that it must be taken consistently to be effective.

Although adolescents are highly conscious of contemporary ways of contraception and that it is imperative to satisfy their needs in terms of reproductive health, they rarely utilize contraception as a rule. According to the GSMF (1998), 35% of married females and 13% of all 15 to 19-year-olds utilized modern family planning techniques in 1998. However, the effective use of contraceptives is still surprisingly low. Only 20% and 37% of sexually active females and boys aged 15 to 19 in 1998 used a modern type of contraception. Reportedly, 77% of sexually active adolescent women and 85% of sexually active adolescent men have used contraceptives, and 64% and 74% of the same have used any modern contraception. Male condoms are the most popular contraceptive method ever used (58% of females and 71% of male respondents, respectively), and IUDs and pessaries are the least used contraceptive methods among females (about 1% for each method).

Coercive sexual relationships among adolescents

Women adolescents are particularly prone to forced sexual interactions. There are stories of “sugar daddy” relationships between young girls and older and more affluent older men, in which young girls have sex with older men in exchange for money (Afenyadu et al., 2003). In addition to men’s economic coercion, young women have been compelled to have sexual intercourse with someone controlling them. In South Korea, 9% of female industrial workers claimed they were coerced into having their first sexual contact with coworkers or bosses (Brown, 2001). In addition, young women are frequently forced into having sexual contact with their boyfriends, even when they are just starting to date. Due to pressure from their lovers, a quarter of young Thai women had their first sexual contact. To appease their lovers and maintain the

relationship, these women consented to their sex requests. Additionally, young women in Bangkok acknowledged that they had less negotiating power regarding sexual relations (Isarabhakdi, 2000; Soonthorndhada, 1996).

Methods

The descriptive cross-sectional survey design was employed in this study to garner information from adolescents about their reproductive health behaviors. The descriptive cross-sectional survey was considered appropriate for this study because the researcher sought to describe the reproductive health behavior of adolescents in Biriwa (Fraenkel et al., 2012). Biwa is a town in the Mfantseman Municipality in the Central region of Ghana. It is a coastal community situated 75 meters above sea level. It has a population of seven thousand seven hundred and thirty-seven (7,737) people (GSS, 2000). The people of Biriwa are generally Fantes. The principal occupation is fishing, as the community is within 5 kilometers of the Gulf of Guinea. The community is rural, and illiteracy is high (GSS, 2000). There are four schools in the community: two (2) Basic schools, one (1) Junior High, and one (1) Vocational school. Significant economic activities include fishing and petty trading.

The population for the study comprised adolescents aged thirteen to nineteen (13 – 19) years old in the primary and vocational schools in Biriwa. The researcher’s decision to include individuals aged 13-19 is based on the WHO (2018) assertion that adolescents are individuals between the ages of 13-19. The total population of adolescents (between 13-19 years) in the primary and vocational schools in Biriwa was 200. The total population sampling technique, which purposively involves the use of the entire population, was used in the study (Crossman, 2020). Hence, all 200 adolescents in the primary and vocational schools in Biriwa were involved in the study. It was because these individuals were between 13-19 years old and had the information relevant to the purpose of the study. The decision of the researcher was also in line with the position of Bernard and Bernard (2013), who emphasize that the purposive involvement of respondents or participants in a study means that the researcher determines what he or she needs to know and finds individuals who would provide the vital information based on informed consent. Data

were analyzed using frequency and percentages.

Results

This section presents the findings, interpretation, and discussions about the purpose of the study. The respondents' background information is presented first, followed by the primary findings.

Demographic Characteristics

Table 1 shows the results of the respondents concerning their gender, age, and educational level. Out of the 200 participants, the majority were males (n=102; 51%) and the remainder (n=98; 49%) were females. In addition, most respondents were in SHS (n=97) followed by those in JHS (n=76).

Table 1
Demographic Characteristics of Adolescent Respondents

Variables	Categories	Frequency (f)	Percentages (%)
Gender	Male	102	51
	Female	98	49
Age	13-16	56	28
	17-19	144	72
Education	Primary	27	13.5
	JHS	76	38
	SHS	97	48.5

Source: Field Data, 2022

Reproductive Health Issues among Adolescents

From Table 2, 33.5% of the adolescent respondents reported that a critical issue encountered as adolescents was teenage pregnancy, while 38% repo was abortion. Concerning abortion, the result could be

explained against the social stigma associated with premarital pregnancy. In Ghana, families are considered irresponsible if a member gets pregnant before marriage. Hence, some families support teenagers in aborting their pregnancy to avoid disgrace. On the other hand, some adolescents abort their pregnancies without knowing their parents or guardians due to the social stigma and punishment they would receive from their family or religious organization.

Factors that Influence Adolescent Sexual Behaviour

To determine the causes of adolescent sexual behavior, adolescents were questioned about the factors influencing their sexual and reproductive health behavior. The adolescents (42.5%) identified peer pressure as the most important factor, and this was more pronounced among males (22.5%) than among females (20%). The need to feel a sense of belonging or acceptance reaches its peak during adolescence. Most boys form clicks (brothers code) early and look out for each other more often than girls. It influences how one behaves, as attested to by the research findings as more males indicated being peer-influenced than females. The second factor was lack of finance (32.5%), which was more predominant among girls (17.5%) than boys (15%). The biological and physical changes adolescent girls go through sometimes influence their behavior. This could lead some of them into sex for money, as shown by the findings with girls leading.

The figure indicates that most adolescents (79%) said the nurses sometimes provided health and sexual education, while 17% said

Table 2
Adolescent respondents' views on the most dominant ARH issues

Variables	Teenage Pregnancy		Abortion		Premarital sex		STI		Others		Total	
	f	%	f	%	f	%	f	%	f	%	f	%
Gender												
Male	34	17	40	20	14	7	8	4	6	3	102	51
Female	33	16.5	36	18	13	6.5	11	5.5	5	2.5	98	44
Total	67	33.5	76	38	27	13.5	19	9.5	11	5.5	200	100
<i>Education</i>												
Primary	7	3.5	7	3.5	4	2	3	1.5	2	1	23	11.5
JHS	36	18	30	15	3	1.5	3	1.5	4	2	76	38
SHS	23	11.5	40	20	18	9	11	5.5	5	2.5	97	48.5
None	1	0.5	1	0.5	2	1	0	0	0	0	4	2
Total	67	33.5	76	38	27	13.5	19	9.5	11	5.5	200	100

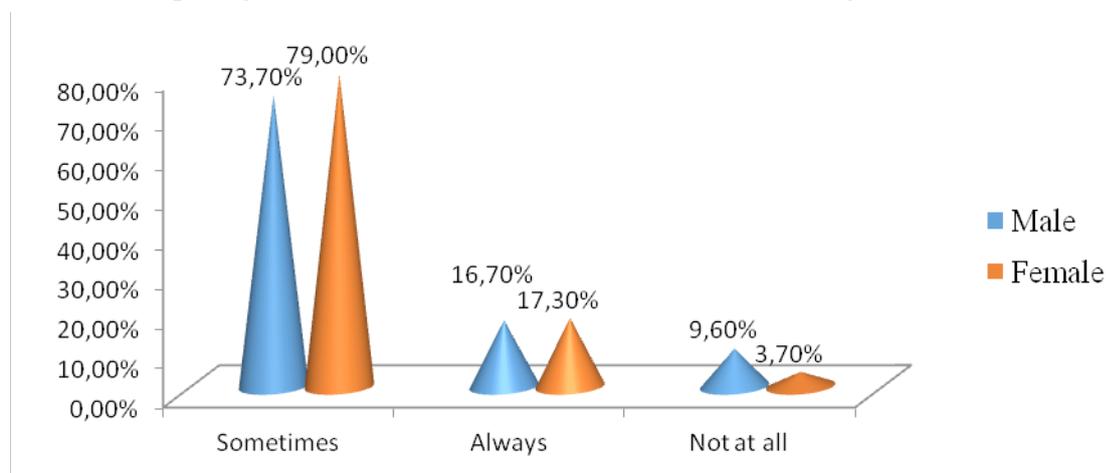
Source: Field Data, 2022

Table 3
Factors that Influence Sexual Behaviour of Adolescents

Variable	Peer Pressure No. %	Lack of Finance No. %	No parental support No. %	No Education on SRH No. %	Others No. %	Total No. %
Adolescent respondents						
Male	45 22.5	30 15	10 5	12 6	5 2.5	102 51
Female	40 20	35 17.5	5 2.5	1 0.5	17 8.5	98 49
Total	85 42.5	65 32.5	15 7.5	13 6.5	22 11.0	200 100

Source: Field Data, 2022

Figure 1
Frequency of Provision of Health and Sexual Education by Health Workers



Source: Field Data, 2022

they always educated them on health and sexual issues. Although some adolescents (36.5%) often discussed health and sexual issues with their friends, they sometimes consulted health workers for more information. The proportion of female adolescents (79%) who reported that nurses sometimes helped them get health and sexual education was higher than that of male adolescents (74%) who reported the same.

Discussion

The study examined the predominant reproductive health issues among adolescents at Biriwa and the factors influencing these sexual behaviors. The findings of this study are similar to that of Brown et al. (2001), who reported that 30 – 50% of adolescents in developing countries reported abortion as the main problem they encountered. The results further show that the proportion of female adolescents (18%) who reported abortion as the problem they encountered was lower than that of the males (20%). This difference in the male-to-female

ratio reporting that abortion was a problem they encountered could be attributed to the emerging empowerment of boys in reproductive health. These results contradict the report by GSMF (1998) that usually revealed boys between the ages of 12 and 24 years have a lower tendency to have sex as compared to girls in the same age cohort, hence the greater probability of girls engaging in abortion of pregnancy than boys within that group. These reproductive health issues identified by the study clearly indicate that the adolescents in the community are sexually active. Also, the results suggest that adolescents in the community are susceptible to premature sexual encounters, leading to teenage and unintended pregnancies, which can facilitate abortion tendencies. It further indicates that unprotected sex was rampant, as 73% of the adolescents reported either teenage pregnancy or abortion as one of the predominant reproductive and sexual health issues they faced in the Biriwa community. This is usually the case in most studies, with particular reference

to the Philippines, where unprotected sex is common and at an estimated rate of 85% among adolescents (Gray & Srisuman, 1999; Isarabhakdi, 2000).

The results of this study have revealed that the most important factor that influenced the sexual and reproductive health behavior of adolescents in the Biriwa community was peer pressure. According to the United Nations (1994), peer pressure has often been an essential issue for youths worldwide and, for that matter, an adolescent. It has also been reported that peer pressure is the most significant factor influencing adolescents to engage in risky behaviors (Maxwell, 2002). Afenyadu and Goparaju (2003) argue that peer pressure significantly determines sexual behavior among male and female adolescents in Dodowa, Ghana. Also, it was noted that peer pressure in sexually active adolescents emanates from the desire to raise their ego when dealing with friends of the same age. Studies by Podhisita et al. (1996) and Afenyadu and Goparaju (2003) opine that lack of finance is also a significant factor that could lead some adolescents to sex for money. Most vulnerable adolescent girls tend to encounter sexual exploitation compared to adult women due to financial challenges emanating from parental or caregiver neglect.

This result suggests that, even though adolescents at Biriwa did not always obtain help from nurses on health and sexual education, the majority (80%) sometimes received some help. On the contrary, Bhakta (2002) found that healthcare providers in Asian clinics seemed unprepared to discuss sexuality issues with adolescents, and many feared that the provision of contraceptives would condone premarital sexual activity. The low level of public discussions on adolescent sexual and reproductive health is exacerbated by inadequate national-level policies that provide information on referral services to young people. This assertion is supported by Erulkar et al. (2005) in their study conducted in Kenya and Zimbabwe on respondents whose characteristics are similar to this study. To ameliorate this, it has been noted that adopting innovative client-centered approaches in health care delivery that enhance confidentiality and reduce barriers such as out-of-pocket payment, short waiting time, and unfriendly staff behavior are *sin qua non*. (Erulkar et al., 2005).

Conclusion

The study revealed that the predominant adolescent problem at Biriwa was abortion, which indicates that adolescents were sexually active and engaged in premarital sexual intercourse. Further findings from the study showed that peer pressure was the major factor influencing adolescent reproductive health and sexual behavior in the community. This could strongly influence adolescent reproductive health-related decision-making either positively or negatively depending on the information being relayed from one adolescent. Adolescent respondents occasionally receive information about reproductive health from the Government Health Centre. An environment of household-level transparency and community-based support systems should be created to address the knowledge gaps in adolescent sexual relationships and healthcare needs. It is recommended that adolescents should be encouraged by their teachers to seek more assistance from the government health center. This will ensure that adolescents in the community stay out of premarital sex, thus, preventing unprotected sex, unwanted pregnancy, and abortion.

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