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Socio-Cultural Determinants Influencing Adolescent Sexual And Reproductive Health In Bomet East Sub-County, Kenya

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Abstract: ***Sexual and reproductive health among adolescent is a fundamental human right and a human development issue that every government including Kenya must fulfill. However, studies have documented poor sexual and reproductive health outcomes among adolescents ages 10 to 19 in many developing countries and to the worst in rural settings. Although estimates from the 2014 Kenya Demographic and Health Survey indicate that the country registered improvements in maternal and child health outcomes, adolescent outcomes remained poor due to socio-cultural challenges associated with sexual and reproductive health information sharing. This study examined the Socio-cultural determinants influencing adolescent sexual and reproductive health in Bomet East Sub-County in Kenya and adopted a survey research design. Interview schedule and questionnaire constituted key instruments in collection of data. Data analysis utilized Statistical Package for Social Sciences (SPSS) in the organization and analysis of quantitative data collected and the findings presented using frequency and percentage tables. The qualitative data from the open ended questions and further probing were also integrated in presentation of findings. The researchers established that the major socio-cultural determinants influencing adolescent sexual and reproductive health included ingrained culture, poor parenting, negative peer influence and religious factors. The researchers therefore recommended that the county and the national governments should conduct intensive sensitization programmes to both parents and adolescents on sexual and reproductive health issues and in consultation with other stakeholders, develop mutually agreed training manuals for adolescents especially during the various religious forums and in secondary schools.***

Keywords: Adolescent; Determinants; Reproductive sexual health.

I. BACKGROUND TO THE STUDY

An adolescent is defined by the World Health Organization as a person aged 10 to 19 years-while young people are those aged 10-24 years (WHO, 2010). Adolescence is a progression from appearance of sexual characteristics to sexual and reproductive maturity; development of adult mental processes and adult identity and a period of transition from total socio-economic dependence to relative independence (UNESCO, 2008). One in every five people in the world is an adolescent and current estimates put the population of adolescents worldwide at 1.2 billion and 85% of them live in developing countries (WHO, 2010). In sub-Saharan Africa, young people age 10–24 account for approximately 33 percent of their countries' populations (NCPD, 2013). Studies by Zabin and Kiragu, (1998) and Susan &Wilson (2006) have documented poor sexual and reproductive health outcomes among adolescents ages 10 to 19 in many developing countries and to the worst in Africa. This has led to high level of sexual activity among unmarried adolescents of both sexes with progressively decreasing age of debut, risky sexual practices, including unprotected sexual intercourse with multiple partners (Ugoji, 2014). According to Linbee, Valencia, & Cromer (2000) practices such as homosexuality, lesbianism, and sexual orgies are indulged by the adolescents as experimentation and peer influences, owing to a wealth of uncensored information they are exposed to, through an

intensifying wave of westernization, the internet, and electronic media (Susan &Wilson, 2006).

Findings by WHO (2016) established that the timing of first sex and sexual behaviors of the young people today is not only affected by socio-cultural factors but also by a multitude of factors acting upon the vulnerable adolescents undergoing development physically, biologically, psychosocially and mentally. Studies in USA and Chile found on effect of socio-economic background on sexual behavior and differences in gender showed adolescents living with both biological parents report a later median age at first intercourse compared to adolescents living in other family settings (UNFPA, 2012). In Sub-saharan Africa, Family Care International (2008) finds that by the age of 20, at least 80% percent of Sub-Saharan African youth are sexually active. As per the Kenya Demographics Profile 2016, 18% of the 42 million population account for adolescents in the country. In Kenya, for instance, the study observes that about 64% of youths have various reproductive health related problems varying from unwanted pregnancies to HIV/AIDs and Sexually Transmitted Infections (Thumbi, 2003). Lack of access to sexual and reproductive health services and information contributes to high levels of morbidity and mortality for largely preventable reproductive health problems in the country (Omweno, Ondigi, Ogolla, 2015). These may be attributed to lack of adequate information and knowledge on reproductive health service due to harsh socio-cultural and or religious practices that may in one way or the other discourage access to sexual and reproductive health information (Thumbi, 2003).

The Kenyan Government has in place, a Youth Reproductive Health and Development Policy Plan 2005-2015. The policy notes that the sexual and reproductive health needs and rights of the youth have received relatively little attention and it aims at improving the quality of life and wellbeing of the Kenya's young people by integrating their sexual and reproductive health concerns into the national development process and enhancing their participation in the process (NCPD, 2013). The same policy does not even mention socio-cultural factors and their influence on adolescents' sexual and reproductive behavior. It is on this basis that the adolescents have continued to have problems accessing information on sexual and reproductive health issues. Access to reproductive health services information that would help the youth to make responsible health decisions is further hampered by social norms and cultural taboos against discussing reproductive health issues (Tavadze, Bartel and Rubardt, 2009). In Kenya, very few studies have been researched on sexual and reproductive health (APHRC, 2010), leaving adolescents with an array of sexual and reproductive health challenges, including avoidance of unwanted, coerced, or forced sex; unintended pregnancies; unsafe abortions; and sexually transmitted infections, including human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) (NCPD, 2013).

A. STATEMENT OF THE PROBLEM

Globally, sexual health and reproductive health among the adolescents is gaining more and more attention from public health practitioners and health service providers because of its contribution towards overall health and well-being of adolescents (Chen et al. 2007). Although, adolescence can be considered as a 'stage' in the life-course, it is characterized by a series of inter-connected processes that underlie the physical, social, and emotional changes of puberty (Reynolds et al. 2006; Conde-Agudelo et al. 2005). The health risks arising from unsafe sexual practices and sexuality-related human rights abuses such as sexual coercion, together contribute to the global burden of disease. In Kenya, poor sexual and reproductive health especially among adolescents ages 10 to 19 is prevalent. Adolescent face health risks such as unintended pregnancy, unsafe abortion, miscarriage, pre-term delivery, low birth weight, neonatal mortality, and sexually transmitted infections (STIs) as well as HIV and AIDS (Abou-Zahr and Wardlaw, 2003, Alam 2000, Jolly et al. 2000, Magadi et al. 2007, Magadi, 2006; Reynolds et al. 2006). The negative outcomes are largely common in Kenya due to low access of sexual and reproductive health information by adolescents. To mitigate the health risks, international agreements such as the International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995 and the World Summit on Children in 2002 have extended the scope of the Convention of the Rights of the Child by affirming the right of all adolescents to receive sexual and reproductive health information, education and services in accordance with their needs (International Planned Parenthood Federation, 2000 and The United Nations Committee on the Rights of the Child 2003.

Evidence available from various studies indicates numerous interventions in place to generally address the menace. However, it is a dozen of studies that have identified socio-cultural factors as a major barrier to sexual and reproductive health education among adolescents (Katz and Naré 2002, Warenius et al. 2006, Wood and Jakes 2006). However, these studies do not give adequate evidence on how and to what extent socio-cultural factors affect sexual and reproductive behavior among adolescents. Despite the implementation of the 2015 Kenya National Adolescent Sexual and Reproductive Health Policy, which recognizes the importance of addressing adolescent sexual and reproductive health needs, adolescents in most part of the country still face enormous challenges in addressing their sexual and reproductive needs. Furthermore, the policy does not give a consideration of socio-cultural determinants of sexual and reproductive health among the adolescents. It's on this background therefore, that this research sought to find out the socio-cultural determinants of adolescent sexual and reproductive behavior in Bomet East Sub-County, Kenya. Understanding socio-cultural determinants and how they influence adolescents' sexual and reproductive behavior is essential for designing effective programmatic interventions to achieving the diverse sexual and reproductive health needs of younger adolescents and protecting their rights.

B. SIGNIFICANCE OF THE STUDY

This research is of great importance to the adolescent as it highlight how best to provide them with friendly services information on sexual and reproductive health. This is a step

towards universal access to sexual and reproductive health education (Senderowitz, 1999). Understanding socio-cultural determinants and how they influence adolescents' sexual and reproductive behavior is essential for designing effective programmatic interventions to achieving the diverse sexual and reproductive health needs of younger adolescents and protecting their rights. The findings of this study provides a concrete base to policy makers of reproductive health to redevelop and redesign programmes that adequately address the pertinent issues affective adolescents' sexual and reproductive health. The generations of new knowledge and information on accessibility to reproductive health services, also help policy makers in establishing new programs to enhance reproductive health services information among the youths. The findings of this study also form the basis for future research on issues that relates to adolescent reproductive health.

II. RESEARCH METHODOLOGY

This research was done in Bomet East Sub-County using a survey research design. Surveys provide a way of gathering information from relatively large cases by adopting the use of samples (Kothari, 2004). The target population was all 3,348 adolescents of (12-19) years in selected secondary schools in all the wards in Bomet East Sub-County consisting of a boarding and a day secondary school respectively. A sample size of 346 respondents was determined in line with Krenjie and Morgan (1970) thus assuring 95% confidence level and 5% margin of error (see Table 3.1). The researcher adopted proportionate samples of students of (12-19) years from selected secondary schools, and was determined through simple random sampling technique. A total of 19 key informants were picked through purposive sampling based on the key information they had related to the objectives of the study and included 3 chiefs, 10 school principals and deputies, 4 village elders and 2 religious leaders.

Sub-County	Wards in the Sub County	Selected Secondary Schools	Target Population	Sample Size
Bomet East	Kembu	1.Kaporuso sec	482	50
		2.Mogoma sec	341	35
	Longisa	1.Koibeiyon sec	438	45
		2.Kiptulwa sec	278	29
	Kipreres	1.Kipreres sec	312	32
		2.Olbobo sec	281	29
	Merigi	1.Merigi sec	324	33
		2.Kapsimbiri sec	268	28
	Chemaner	1.Chemaner sec	338	35
		2.Kimuchul sec	286	30
Total	**5**	**10**	**3,348**	**346**

Source: Field Survey, 2019

Table 3.1: Sample Size

Interview schedule and questionnaire were adopted as key instruments in collection of both qualitative and quantitative data. Both research instruments had both open and closed-ended question items to ensure exhaustive collection of relevant data to the study. This study utilized Statistical Package for Social Sciences (SPSS) in the organization and analysis of quantitative data collected from the closed ended question and the analyzed data presented using frequency and percentage tables. The qualitative data from the open ended questions and further probing have been classified into various themes on the basis of their central focus for the purpose of presentation and analysis. Qualitative analysis includes presentation of quotes from different respondents. In this study, the data gathered from the field have been integrated with available secondary data for the purpose of interpretation.

III. ETHICAL CONSIDERATION AND INSTITUTIONAL AFFILIATION

The researchers followed all codes of research ethics: beneficence, respect and justice as prescribed in the Belmont Report. The two researchers are affiliated to Maasai Mara University. Research permits was sought prior to engagement in data collection. All research tools had a consent form and prior to administration of each method of data collection; voluntary informed consent was sought from each respondent. Confidentiality principle was adopted throughout the entire research process and the collected data was only used for academic research and not for any other purpose.

IV. FINDINGS AND DISCUSSIONS

Subsequent section highlights on the demographic characteristics of the respondents.

A. DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

The researchers sought to find out the various demographic variables such as age, respondent family status, and place of residence and the findings are as indicated.

a. SEX OF THE RESPONDENTS

When the researcher sought to find out the sex of the respondents, the findings were as indicated in table 4.1.

Sex of the respondents	Frequency	Percentage (%)
Male	194	56.1
Female	152	43.9
Total	**346**	**100**

Source: Field Survey, 2019

Table 4.1: Sex of the Respondents

The finding indicated that 194(56.1%) of the respondents were male while 152(43.9%) were female. It is evident from this finding that there is a gap in access to education between the boy and the girl child in the study area. As noted by key informants during Focus Group Discussion (FDGs), most parents in the study area still give preference to boy child education to the girl child.

b. AGE OF THE RESPONDENTS

Regarding the age bracket of the respondents, the findings is as indicated in table 4.2

Age Bracket (in Years)	Frequency	Percentage (%)
12-13	46	13.3
14-15	148	42.7
16-17	102	29.5
18-19	50	14.5
Total	146	100

Source: Field Survey, 2019

Table 4.2: Age of the Respondents

From the findings, the researcher noted that 46(13.3%) of the respondents were aged 12-13 years, 148(42.7%) were aged 14-15 years, 102(29.5%) were 16-17 years while 50(14.5%) were aged 18-19 years. It is apparent from the study that most of the respondents-250(72.2%) were between 14-17 years. As noted by WHO (2010), this is the age bracket that is largely characterized by physical, cognitive, moral, psychological, social-emotional, as well as spiritual development (WHO, 2010). At this stage adolescent development may be influenced by factors such race, ethnicity, gender, culture, family and the community environment and abundant of caution must be put towards proper guidance of the adolescents.

c. RESPONDENTS' FAMILY STATUS

When the researcher sought to establish the respondent status in relation to their parental background, the finding was as noted in table 4.3.

Respondent's Family Status	Frequency	Percentage (%)
Total Orphan	21	6.1
Partial Orphan	30	8.7
Single Parent (Alive)	59	17.1
Both Parent (Are alive)	236	68.1
Total	**346**	**100**

Source: Field Survey, 2019

Table 4.3: Respondents' Family Status.

It is evident from the findings that 21(6.1%) of the respondents were total orphans, 30(8.7%) were partial orphans, 59(17.1%) had a single parent while 236(68.1%) had both parents. Where else the majority 236(68.1%) of the respondents had both parents, it was apparently clear that 110(31.9%) were either orphans (total or partial) or had a single parent. Miller, (2001) posit that both parents have complementary roles in the socio-psychological, cognitive and emotional development of adolescents. Based on this finding therefore, absence of all or one of the parents predisposes the adolescent to alternative sources of sexual and reproductive health knowledge such as peers.

d. RELIGIOUS AFFILIATION OF THE RESPONDENTS

The researcher sought to establish the respondent religious affiliation and the response are as indicated in table 4.4

Religious Affiliation	Frequency	Percentage (%)
Muslim	5	1.4
Protestant	231	66.8
Catholic	110	31.8
Total	**346**	**100**

Source: Field Survey, 2019

Table 4.4: Religious Affiliation of the Respondents

The findings revealed that 5(1.4%) of the respondents were Muslims, 231(66.8%) were Protestants while 110(31.8%) were Catholics. It is evident that 341(98.6%) of the respondents subscribed to Christianity while 5(1.4%) subscribed to Islam. As noted by Omweno, (2015) religious organizations are social institutions that also shape adolescents sexual and reproductive health.

e. PLACE OF PERMANENT RESIDENCE OF THE RESPONDENTS

Place of permanent residence of the respondents was sought and the finding was as indicated in table 4.5.

Permanent place of residence	Frequency	Percentage (%)
Within Bomet East Sub-County	332	96
Outside Bomet East Sub-County	34	4
Total	34	100

Source: Field Survey, 2019

Table 4.5: Place of Permanent Residence of the Respondents

It was found out that 332(96%) of the respondents were permanent residents of the study area while 34(4%) were not (outside Bomet East Sub-county). This demographic variable was important to the researchers in making inferences on the findings of the research. Conclusions made were therefore valid since the respondents are permanent residents of the study area.

B. THE SOCIO-CULTURAL DETERMINANTS OF ADOLESCENT SEXUAL AND REPRODUCTIVE BEHAVIOR IN BOMET EAST SUB-COUNTY, KENYA

In reference to the core objective of this study, the following sub themes were investigated

a. RESPONDENTS' KNOWLEDGE ON SEXUAL AND REPRODUCTIVE HEALTH IN BOMET EAST SUB-COUNTY

The researcher sought to assess whether the student had any knowledge on the various sexual and reproductive health issues and the findings were as indicated in table 4.6

Sexual and Reproductive Health Issues	Frequency	Percentage (%)
Use of contraceptives	46	13.3
STI and HIV/AIDs	272	78.6
Reproductive physiology	28	8.1
Total	**346**	**100**

Source: Field Survey, 2019

Table 4.6: Knowledge on Sexual and Reproductive Health Issues in Bomet East Sub-County

The findings indicated that 46(13.3%) of the respondents had knowledge on use of contraceptives, 272(78.6%) on Sexually Transmitted Infection and HIV/AIDs, while 28(8.1%) had knowledge on reproductive physiology. It is apparent from this finding that although most respondents had knowledge on STI and HIV/AIDs, most respondents had little knowledge on use of contraceptives and reproductive physiology. During the Focus Group Discussion (FGD), the researcher established that parents mostly refrain from discussing use of contraceptives with their adolescents. One key informant mentioned that;

"..Most parents in this area have no knowledge on contraceptive measures and if they had, they would not discuss such issues with their children because it is a taboo, and doing so is encouraging promiscuity amongst our children…." (FGD, 2/5/2019, Bomet East-Kenya).

Evidently, a part from being considered a taboo, most parents does not have knowledge on use of contraceptives and thus cannot advise their adolescents. It was however noted that those respondents who had knowledge on contraceptive use such as use of condoms and contraceptive pill learnt from their friends and had used them in their sexual encounters.

Respondents who had knowledge on STI and HIV/AIDs totaling to 272(78.6%) noted that such information had been received during their religious camps, class sessions, media (radio and television programs) and from Sub County health officers. During the FGDs, one of the school principals noted that there were HIV/AIDs club programs in the school to sensitize the students on the STI and HIV/AIDs. One principal noted that;

"...we have HIV/AIDs club with a patron in our school which allows most of our students to get knowledge on HIV/AIDs related issues. We intend to develop compulsory educational programme in our school to equip all our students with information they need because most parents hardly discuss such matters with our student…."(FGD, 2/5/2019, Bomet East-Kenya).

Regarding reproductive physiology, only 28(8.1%) acknowledged having knowledge on such matters as safe and unsafe sex, abortion, pregnancy and reproductive health complications. The researcher noted that most of those who had such knowledge were mostly between 18-19 years. This confirms WHO, 2010 report that adolescents develops more interests on knowledge regarding sexual and reproductive health with increase in age towards early adulthood (WHO, 2010). Respondents noted knowledge on reproductive physiology had been obtained through their class lessons, parents, and the media.

b. KEY ACTORS IN DISSEMINATION OF SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE IN BOMET EAST SUB COUNTY

Regarding the major actors that the respondents found reliable and confident to discuss sexual and reproductive health issues with, the findings were as indicated in table 4.7

Key actors in SRHI	Frequency	Percentage (%)
Peers	172	49.7
Parent	86	24.9
Religious leaders	20	5.8
Health officers	12	3.5
Teachers and school administrators	56	16.1
Total	**346**	**100**

Source: Field Survey, 2019

Table 4.7: Key Actors in Dissemination of Sexual and Reproductive Health Knowledge in Bomet East Sub County

The finding revealed that 172(49.7%) of the respondents emphasized on their peers, 86(24.9%) on their parents, 20(5.8%) on their religious leaders, 12(3.5%) on health officers while 56(16.1%) preferred their teachers and school administrators. Apparent from this finding was that although, parents are often considered as the primary agents in dissemination of first knowledge (noted by Omweno, 2015), this study revealed that adolescent confide more on their peers-172(49.7%) than their parents-86(24.9%) and that their religious leaders-20(5.8%) on sexual and reproductive health issues. It was further noted that the respondents confides more on their teachers and school administrators -56(16.1%), than religious leaders and health officers.

This study confirms Adegbenga, et.al, 2003, that although social institutions such as the family, religious organizations and learning institutions plays a significant role in the early childhood development, peer influence constitute the dorminant factor/determinant in adolescent development. As noted during FGDs, one of teachers noted that;

"…Most students seek help from their fellow students on sexual and reproductive health related issues because they all face the same challenges. They share their sexual experiences during their break time and come to us sometimes for fear of reprisal from their parents due to family values and culture…..we encourage them to do so to avoid wrong choices" (FGD, 2/5/2019, Bomet East-Kenya).

It was further noted during the FGDs with the village elders, chiefs and school administrators that most of the respondents from a single parent or orphan, would seek such information from the peers, teachers and religious leaders. Sexual and reproductive health issues would only be sought from the health officers by the respondents on matters related to early pregnancy and Sexually Transmitted Infection since it requires a specialized health officers such a gynecologist. Furthermore, most respondents avoided seeking sexual and reproductive health knowledge from their religious leaders for fear of being considered as deviants and 'sinners' in their religious gatherings. One respondent noted that;

"…My pastor would really be furious if I asked him about contraceptives, sex or abortion... He will think I am becoming a pervert in the church and should be excommunicated …."(FGD, 2/5/2019, Bomet East-Kenya).

Nevertheless, most adolescents sought sexual and reproductive health information from the peers, parents, teachers and school administrators, religious leaders and health officers respectively depending on their perceived need or help required.

c. SOCIO-CULTURAL FACTORS INFLUENCING ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN BOMET EAST SUB-COUNTY, KENYA

The researcher also sought to assess the various socio-cultural factors influencing adolescent sexual and reproductive health in Bomet East Sub County and the finding was as indicated in table 4.8

Socio-Cultural Factors	Frequency	Percentage (%)
Negative Peer Influence	64	18.5
Religious Beliefs	49	14.1
Poor Parenting	102	29.5
Deeply Ingrained Culture	131	37.9
Total	**346**	**100**

Source: Field Survey, 2019

Table 4.8: Socio-Cultural Factors Influencing Adolescent Sexual and Reproductive Health in Bomet East Sub-County, Kenya

The researcher noted that 64(18.5%) of the respondents cited negative peer influence, 49(14.1%) cited religious beliefs, 102(29.5%) cited poor parenting while 131(37.9%) cited deeply ingrained culture. It is evident from this finding that although there is no single major factor, a conglomerate of socio-cultural factors influences adolescent sexual and reproductive health led by family values and culture, poor parenting, negative peer influence and religious factors respectively.

Focused Group Discussion revealed that since most adolescents confide in their peers, most of them become victims on unhealthy sexual related issues such as abortion, early pregnancy, abortion and unsafe sex with multiple sexual partners. Additionally, negative peer influence lured most adolescents to sexual perversion such as lesbianism, homosexuality and masturbation and early unprotected sex. One key informant noted that;

"….cases of school drop-out and suspension has been common owing to early pregnancies as well as sex related cases…. Every stakeholder in the school should take responsibility and advice these kids…" (FGD, 2/5/2019, Bomet East-Kenya).

It was also noted during FGDs that due to deeply ingrained culture which prohibit public discussion of sexual and reproductive health issues by both adults and adolescent, it served as a constraining factor to adolescent access to sexual and reproductive health information. The concept of preserving "face" by not bringing shame onto oneself or one's family is critical in shaping sexual and reproductive health behaviour and outcomes. In the study area, the fear of being stigmatized as an individual who deviates from societal norms continues to be strong. Conformity to societal norms in this case has negative impact on dissemination of sexual and reproductive health knowledge. A chief during FGDs noted that;

"….it is a taboo in this community to discuss sexual and reproductive issues with young people. People believe that young boys are taught such matters in "Menjo' (Seclusion) after circumcision and mothers should either advice their daughters or take them to their grandmothers…" (FGD, 2/5/2019, Bomet East-Kenya).

Owing to such cultural believes, it becomes an impediment on adolescent access to sexual and reproductive health knowledge which leads them to confide in their peers for any information, which could be detrimental to their development. FGDs further revealed that poor parenting influenced adolescent sexual and reproductive health as a number of adolescents were orphans, from single parents or neglected by both parents. As noted by miller, (2001), proper parenting equips adolescents with relevant information to cope with developmental changes on sexual and reproductive health. With respect to this study, FGDs revealed that most parents engage in drugs and substance abuse, domestic violence, leaving their adolescent vulnerable to negative peer influence. Additionally, parents' occupation and extravagance allows adolescent access to internet connected mobile phones which enables them to access uncensored adult information such as pornography and western gothic horror pop culture.

During FGDs, it was further noted that although various religious leaders had youth programmes to disseminate knowledge on HIV/AIDs, hardly any programme existed to freely teach on matters such as abortion and the use of contraceptive measures. Religious leaders noted that teaching on sexual and reproductive health issues was not only a taboo in the community but also a way of encouraging adolescents to promiscuity. This is consisted with Omweno, (2015), that although religious institutions provide a platform for disseminating sexual and reproductive health knowledge, various religious groups do not approve of the content especially on matters of abortion and contraceptive use.

V. CONCLUSION AND RECOMMENDATIONS

Adolescence is 'stage' in the life-course, characterized by a series of inter-connected processes that underlie the physical, social, and emotional changes of puberty (Reynolds et al. 2006). In Bomet East Sub County, sexual and reproductive health knowledge is sourced by the adolescents from their peers, parents, teachers and school administrators, religious, and health officers. Various socio-cultural factors such as deeply ingrained culture, poor parenting, religious beliefs and negative peer influence, constrain access and dissemination of sexual and reproductive health information. The researchers therefore recommend that the county and the national government should conduct intensive sensitization programmes to both parents and adolescents on sexual and reproductive health. Both levels of governments and religious leaders should partner together in developing a mutually agreed curriculum for adolescents training in various religious forums. In addition, sexual and reproductive health education should be taught in the early secondary school levels (Form 1 and 2) to equip learners with skill to cope with challenges related to socio-psychological, physical emotional and cognitive development during adolescence. The findings of this study also form the basis for future research on issues that relates to adolescent reproductive health.

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