The Performance of Reproductive Health Education among Female Adolescents: A Case of Chamwino District, Dodoma Region

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Abstract

This study was conducted in Chamwino District, in the four selected villages namely; Nzari, Mahamha, MvumiMakulu and Mvumi Mission. The objectives of the study were to identify methodologies used in delivering of reproductive health education to adolescents;examine adolescent's perception on the adequacy of reproductive health education offered to them; identify achievements of the reproductive health education offered to adolescents and identify challenges in delivering reproductive health education among adolescents. Data were collected using questionnaires and checklists. A total of 96 respondents and thirteen key respondents were involved in the study. Data were analyzed using Statistical Package for Social Science (SPSS). Content analysis was used for qualitative information. The findings from this study have revealed that a school was the major institution for delivering reproductive health education and the discussion was the method used. RHE Though adequate in increasing level of awareness on the consequences of early pregnancy, illegal abortion and STI's has not reduced the occurrence of the cases of early pregnancy, illegal abortion and STI's. The challenges encountered during the provision of reproductive health education were opposition fromcultural and religious factors, limited reach to non-schooling adolescents and lack of teachers who possess the necessary knowledge and training, to teach appropriate and correct information on sexual and reproductive health matters. It is recommended to equip teachers with skills and techniques in delivering reproductive health education; address social and cultural barriers

Keywords: Female adolescents, reproductive health, education

1.0 Introduction

The increased rate of unplanned pregnancy, illegal abortion, HIV/AIDS and sexual transmitted infections among the adolescents has made policy makers to look for an alternative structure to prevent the increasing rate of the mentioned health problems (Mbonile, 2004). One of the strategies was the introduction of sex and reproductive health education with the aim of promoting a broader definition of safer sex which is pleasurable, safer from unwanted pregnancy, infections and abuse (Ngalinda, 2005). In this way it was helping young people talk about sexual activities, sexuality and safer sex including the use of condoms (Mwambete *et al*., 2006). However, Records show that the majority of adolescents in Tanzania, especially school girls still experience early pregnancy, childbirth and enter motherhood without adequate information about maternal health issues (Mbonile and Kayombo, 2008). According to TDHS report, (2010), nearly 45% of Tanzania adolescents engage in sexual practices early before they are 15 years. Most of them start sexual intercourse, get married and have their first birth between age 15 and 17 years (Ngalinda, 2005). Studies on rural adolescents in Tanzania, have reported that school children in the rural areas lack credible knowledge about safe sex (Mwambete and Mtaturu, 2006; Muhondwa and Nyamhanga, 2007). They further argue that more than 32% of adolescents are sexually active, indicating the importance of reproductive health education for girls and boys in the school environment.

In the study area, efforts have been made to introduce several centres for provision of reproductive health education among adolescents however, despite the existence of such interventions; there are still problems of pregnancies, STI's and abortion among adolescents (DMO report, 2011).In this case the study to identify methodologies used in delivering of reproductive health education to adolescents; examine adolescent's perception on the adequacy of reproductive health education offered to them; identify achievements of the reproductive health education offered to adolescents and identify challenges in delivering reproductive health education among adolescents. It is hoped that this study will help policy and decision makers to improve the modalities of providing reproductive health education.

2.0 Methodology

2.1 Study area

This study was conducted in Chamwino District, Dodoma region. The district was selected due to the presence of youth centers for provision of reproductive health education, and high rate of girl's dropout estimated to be 24% due to pregnancy (TAMWA, 2012). Four villages namely Mahamah, Nzari, Mvumi Mission and Mvumi Makulu were selected to represent the district

2.2 Study methods

The study involved a cross sectional study design. Both quantitative and qualitative data were collected from both primary and secondary sources. Primary data were collected using questionnaires. A total of 109 respondents including science teachers, household heads and students were involved in the study. A simple random probabilities sampling technique was employed to obtain a representative sample from school female adolescents aged 14-24 years and households..A purposive sampling was also employed for some key informants. Data were analysed using a Statistical Package for Social Science (SPSS).

3.0 Results and Discussion

3.1 General characteristics of respondents

Majority of respondents (58.3%) were in the age group of 14-17 years old (See Table 1). Age across villages varied except in Nzari. For example, in Mahamah and Mvumi Mission the majority were between 14 and 17 years, while in MvumiMakulu the majority were between 18 and 24 years old. In terms of education, two groups that is in-school and out-school were considered. Majority of the respondents (78.5%) had secondary school education. The same trend was observed across the villages except in Nzari where the majority had primary education. As for the out-school adolescents, an overall of the majority (83.9%) had primary education. Across villages the same trend was observed (Table1).

Table 1: General characteristics of respondents

	Residence in terms of Village (s) (%)				Average
Variable	MMK (N=24)	MM (N=24)	Nzari (N=24)	Mahamah (N=24)	(N=96)
Age					
14-17 years	45.8	58.3	50.0	79.2	58.3
18-24 years	54.2	41.7	50.0	20.8	41.7
Education level for in-school adolescents					
Primary	5.9	31.6	57.1	13.6	21.5
Secondary	94.1	68.4	42.9	86.4	78.5
Education level for out of school adolescents					
Informal	14.3	0	0	50	6.4
Primary	57.1	80	100.0	50	83.9
Secondary	28.6	20	0	0	9.7

MMK = MvumiMakulu, MM =Mvumi Mission,

Commented [u1]: "N" doesn't have to be interpreted. It is a known abbreviation in any scientific writing

3.2 Methodologies for delivering reproductive health education

The study investigated the methodologies used in delivering reproductive health education. In achieving this objective, institutions involved in RHE were identified and within these institutions, reproductive health topics/issues taught to adolescents were further identified. Finally, the ways used to deliver RHE issues were also identified. The results indicated that schools (62.4%) and hospitals (34.4%) were the institutions providing RHE (See Table 2). The other institutions were families. Contribution of schools and/or hospitals seem to be more important compared to a family, probably due to the fact that these institutions had trained people on reproductive health issue unlike families. According to Ngalinda (2005), the school provides a natural entry point for reaching young people with health education and services. At the village level, schools were the main delivering mode of RHE except in Nzari where the majority (54.2%) their main mode was hospitals. The possible reasons for the scenario could be an easy accessibility of health services and availability of health correspondents, who have experience and trained on reproductive health issues, thus, giving guidance and counselling on the consequences of early pregnancies and illegal abortion among adolescents. Maria (2007) argues that although the school provide a unique opportunity for education and discussion of issues related to reproductive health, hospitals/and or health centers should be given priority for RHE since hospitals are full of trained experts on health issues.

Table2: Institution (s) providing reproductive health education

Institution	Residence in terms of Village(s) (%)				Average
	MMK (N= 24)	MM (N =24)	Nzari (N =24)	Mahamah (N=24)	(N =96)
School	68.2	66.7	45.8	69.6	62.4
Hospital	31.8	33.3	54.2	17.4	34.4
Family (mother/father)	0	0	0	13	3.2
Total	100	100	100	100	100

MMK=Mvumi Makulu. MM =Mvumi MissionAs for the issues taught during reproductive health education, the field data showed that main topics in order of importance, were the control of sexual transmitted diseases (STIs) (37.7%) and family planning (31.1%)(See Tab 3). Other topics included were the use of contraceptives, early pregnancies, puberty, and transmission of STI's. The possible explanation for it could be the greater effort which was done by the Government to integrate STI's including HIV/AIDS in school curriculum, due to its greater impact on the health of human being. According to Mbonile and Kayombo (2008), STIs including HIV/AIDS questions were added to national exams; further providing support for the RHE programmes in a way of increasing knowledge of STI's including

HIV/AIDS to adolescents. Due to the impact of early pregnancies such as school drop-out and risky of death, people are considering this as an important issue to be taught at schools. Adolescents specifically girls do engage themselves in multiple sexual partners which in turn they undergo unprotected sexual practices leading to unintended pregnancies, acquiring HIV/AIDS, STIs and even termination from schooling (Seifu *et al.,* 2006; Maria, 2007; Moore *et al*., 2007).

Table 3: Issues taught in reproductive health education

Issue taught	Residence in terms of Village(s) (%)				Average
	MMK (N= 43)	MM (N =40)	Nzari (N =56)	Mahamah (N=23)	(N= 40)
Family planning	32.6	20	28.6	43.5	31.1
Early pregnancies	7	32.5	5	26.1	17.7
Puberty	4.7	10	17.9	30.4	15.8
Control of STI's/HIV/AIDS	18.6	37.5	33.9	60.9	37.7
Use of contraceptives	28	0	10.7	17.4	14
Transmission of STI's	9.3	0	0	0	2.3

Data based on multiple responses

MMK =MvumiMakulu, MM= Mvumi Mission

Ways for delivering RHE were also explored (Table 4). The overall majority (59.6%) of the respondents had the opinion that discussion method was the most frequently used mode for RHE (Table 4). Discussion methods involved the interaction between teachers and students in the process of learning, that is, teachers could discuss reproductive health issues with students.

Table 4: Ways for delivering reproductive health education

Ways	Residence in terms of village (s) (%)				Average
	MMK (N=30)	MM (N=30)	Nzari (N=40)	Mahamah (N=36)	(N = 34)
Discussion	66.7	76.7	47.5	52.8	59.6
Lecturing method	3.3	3.3	27.5	13.9	13.2
Reading books	30.0	20	17.5	19.4	21.3
Use of pictures and posters	0	0	5	8.3	3.7
Drama	0	0	2.5	5.6	2.2

Data based on multiple responses, MMK =MvumiMakulu, MM= Mvumi Mission

At the village level, variations of responses were also observed. In Mvumi Mission, MvumiMakulu and Mahamah main ways of delivering RHE were discussions between teachers, students and reading books. This means books which were used by students were biology books which contained RH issues. In Nzari village, discussion and lecturing methods was the main way for delivering RHE. The lecture method used was to involve a teacher as the main facilitator in the learning process, while students were observing and taking notes. The dominant of discussion and lectures over other methods could be attributed by the fact that they were simple to apply by teachers and do not require any expenses in their application, hence it was preferred by many teachers in delivering RHE. During focus group discussion one member had the following to say related to ways of delivering RHE:

"If teachers could use pictures or video to show people affected with sexual transmitted diseases it could be easy for young adolescents to fear and change their sexual behaviour but using only discussion or reading books could make them forget immediately after leaving the school."

In regard to this opinion, it means that the use of visual aids was considered to be the most effective way for delivering RHE. This is a challenge for institutions dealing with RHE. Such institutions should have different mechanisms in place of ensuring proper delivery of RHE. The possible strategies could be the use of visual aids such as posters, video and pictures. According to MoH (2011), it was noted that schools are for health and hygiene education, hence visual aids such as posters, video and pictures should be available all the time in order to facilitate the learning processes.

3.3 The adequacy of reproductive health education

Respondents were asked to indicate whether RHE was adequate or inadequate. The topics in RHE were STI's including HIV/AIDS, early pregnancies and illegal abortion (See Table 5). Respondents were further asked to give their opinion on whether RHE was helpful or not in reducing cases of STIs including HIV/AIDS, early pregnancies and illegal abortion.

Table 5: Adequacy of RHE on preventing of STIs, early pregnancies and illegal abortion

Adequacy	Topics			Average
	STIs/HIV/AIDs (N= 96)	Early pregnancies (N=96)	Illegal abortion (N=96)	(N=96)
Adequate	95.8	90.5	89.5	91.9
Inadequate	4.2	9.5	10.5	8.1
Total	100	100	100	100

On adequacy or inadequacy, the overall majority of respondents (91.9%) had the opinion that RHE topics provided have increased their level of awareness (See Table 5). The possible explanation could be the exposure of many adolescents in schools where this education was provided and the use of audio-visuals such as Radio and Television. In showing the importance of audio-visual one participant during focus group discussion had this to say:

"*Radio and Televisions play a great role in providing information related to STIs including HIV/AIDS, early pregnancies and illegal abortion to community members including adolescents by advocating their consequences enabling us to be aware on the ill-health effects."*

From the FGD it was also learnt that adolescents receive their information on sexual and reproductive health from the media and probably mostly the radio which is easily accessed in villages. Manzin (2001) revealed that radio, television and other mass media play an important role in disseminating health information throughout the country. He further argued that, adolescents do get much of their information on HIV prevention, treatment and testing, and other sexual and reproductive health issues, from mass media sources. Therefore, investing in mass media for insemination of reproductive health issues is important for the creation of awareness on the consequences of HIV, early pregnancies and illegal abortion among adolescents and particularly female. On whether RHE was helpful or not in reducing ill-effects of STIs including HIV/AIDS, early pregnancies and illegal abortion, field results have indicated that overall majority of respondents (67.7%) had the opinion that reproductive health education was helpful (See Table 6).

Table 6: Overall perception on the adequacy of reproductive health education by age of respondents

Variable	Age of respondents (years)		Average
	14-17 (N=56)	18-24 (N=30)	(N=96)
Helpful	72.5	64.3	67.7
Not helpful	35.7	28.5	32.3
Total	100	100	100

Results also have indicated that respondents with the age group 14-17 years old were more conversant with RHE than the other age group (Table 6). The possible reason for this scenario is that most adolescents in this age group still in schools where RHE is mostly provided. According to the Tanzania education policy, reproductive health education is provided in primary and secondary schools, therefore, it is possible that this age group receives such education while at school and observes the importance of it. On the other hand, most adolescents in the age of 18 years and above consider RHE not helpful in increasing their level of awareness. The possible explanation for this could be due to the fact that most adolescents in this age group have completed their primary and/or secondary education (regarded as out of school adolescents). Out of school adolescents in Tanzania do miss RHE services due to a poor structure of RHE programmes. According to Asheford *et al*. (2000) out of school adolescents often lack access to health information, counselling, legal protection as well as health care and other services as a result of poor structure of RHE programmes. Such situation leads to ineffective of RHE among out of school adolescents.

3.4 Achievements of reproductive health education

The study further focused on achievements reproductive health education in addressing a number of challenges such as early pregnancies, illegal abortion and STIs including HIV/AIDS.

3.4.1 Achievement of RHE in reducing early pregnancy

on the achievement of RHE in reducing early pregnancy, the results revealed that the majority 61.5% of the respondents gave the opinion that reproductive health education has not reduced cases of early pregnancies (See Figure 1). This indicated that RHE provided has failed to reduce cases of early pregnancies among female adolescents. The reasons for failure have also been probed.

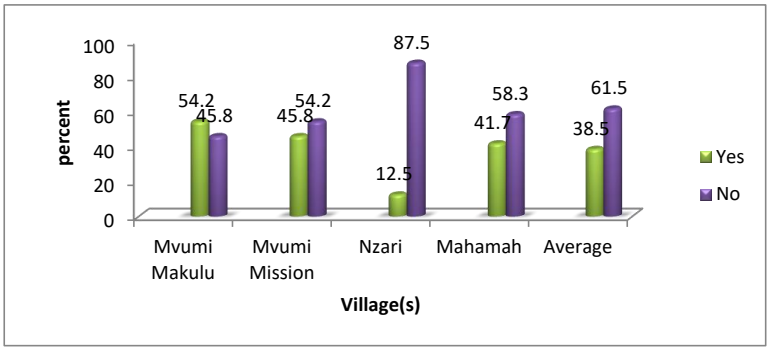

Figure 3: Achievement of RHE on early pregnancies

At a specific village level, there was variation in perception, for instance, Nzari village had high proportion of respondents (87.5%) who had the opinion that, RHE has not reduced cases of early pregnancies compared to other villages. This variation of responses may partly be attributed by different percentages of prevalence of early pregnancies among villages. During an interview with key informant one health correspondent in Nzari village narrated that most female adolescents attend at the village dispensary for maternal services. the results was also supported by statement from the Mvumi secondary school biology teacher who said:

"This reproductive health education has been provided in schools and other places from different sources but the outcome expected are not yet observed because girls have been leaving school every year due to pregnancies" (biology teacher, Mvumi mission secondary school, 2013)

Data from Chamwino District Education Office show that the increase of school adolescents' pregnancies between 2008 and 2011 (Table 7). Cases of early pregnancies dropped in 2009, thereafter, the cases continued to rise.

Table 7: Trends of school adolescent's pregnancies

Year	Number of pregnancy cases	Percentage
2008	52	20
2009	45	19
2010	57	22
2011	74	24

Source: DEO Chamwino, 2012

The reasons for the failure of RHE in reducing cases of early pregnancies among others were mainly peer pressure, personal behaviours and shortage of experts. Others were limited reach to out of school adolescents and lack of seminars (Table 8). Peer pressure accounted for about 39% of the respondents. This means that adolescents of the same age cohort tend to interact and influence each other on issues related to sexual matters. This tendency probably might change negatively or positively the behaviour of individual person. Maria (2007) argues that although some adolescents say they got information from peers that helped them abstain from sex and use condoms, information from friends was, in fact, frequently inaccurate. Personal behavior accounted for about 30.2%of the respondents.

Table 8: Reasons for the failure of RHE on early pregnancies

Reasons	Village(s)				Average
	MMK (N=18)	MM (N=23)	Nzari (N=38)	Mahamah (N=18)	(N =96)
Personal behavior	33.3	45.5	30.3	11.1	30.2
RHE not reaching many out school adolescents	0	7.2	8.6	19.2	8.8
Peer pressure	61.1	30.4	28.1	36.3	39
Shortage of RHE experts	5.6	4.3	26.3	18.7	13.7
Lack of seminars	0	11.6	6.7	14.7	8.3

Data based on multiple responses, N=Sample size

In specific villages, the same results were observed. That is personal behaviour and peer pressure counted high almost in all villages (Table 8).Therefore, regardless to the provision of RHE in various institutions, still personal behaviour and peer pressure remains an obstacle in reducing early pregnancies among female adolescents. Reasons which counted least were lack of seminars and limited reach to out-school adolescents. These counted for about 8.3% and 8.8% of the respondents respectively. This implies that seminars and limited reach to out-school adolescents are considered less in the performance of reproductive health education on early pregnancies.

3.4.2 Achievement of RHE in reducing illegal abortion

In this part responses were also bounded to yes or no. answers have revealed that majority (64.6%; N=96) of the respondents argued thatRHE has failed to reduce cases of illegal abortion (Figure 2). This means that a significant number of respondents did not value reproductive health education in reducing cases of illegal abortion.

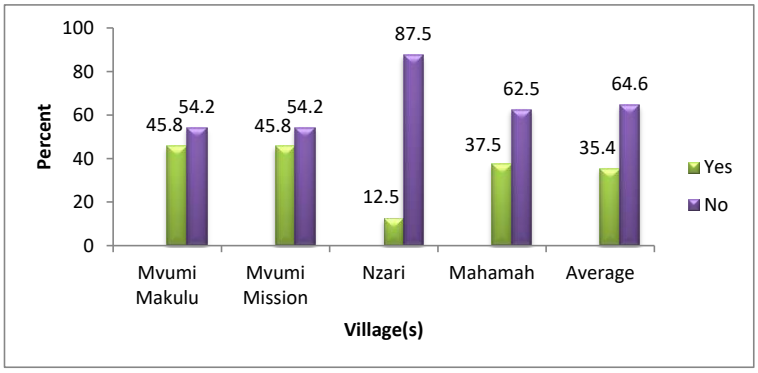

Figure 4: Achievement of RHE on illegal abortion

These results also varied among villages. For instance, Nzari and Mahamah villages had higher proportion (more than 60%) of the respondents who perceived that reproductive health education has failed to reduce cases of illegal abortion compared to other villages (Figure 6). During an interview in these villages with one of the adolescent aged 18 years old narrated

"*I had an affair with a boy of my age a year ago. We had sex on several occasions. After discovering that I was pregnant, my boyfriend deserted me. I went ahead and terminated the pregnancy with the help of a girlfriend."* This narration indicates how illegal abortion persists in these villages.

On the reasons for the failure of RHE in reducing cases of illegal abortion the findings revealed that the mostly given reason was school curriculum insufficiency. This accounted for about 28.1% of respondents (Table 9). The insufficiency of school curriculum is exhibited in lack of teaching and learning resources, qualified teachers and unsupportive environment. The same findings were observed by Lwihula *et al.*(1996).The authors concluded that school health programs are weak and the existing reproductive health education often excludes an aspect of premarital sexuality.

Furthermore, other reasons included fearing for drop out and shortage of reproductive health experts. These accounted 21.3% and 18% respectively. Findings also have revealed that education came at late stage of adolescents. This was accounted by 18.5% of respondents. This implies that most school children received insufficient information or skills on sexuality until it was too late. Interestingly, fear of being expelled by parents when pregnant and the education of not reaching many out-school adolescents, were also among the reasons for persistent cases of illegal abortion perceived by respondents (Table 10). With regards to this, during a focus group discussion one participant had to say;

"*At schools reproductive health education provided does not cover many issues, for instance, teachers are not talking about the consequences of abortion which in turn many adolescents are committing illegal abortion without an adequate information leading them to death*."

This observation indicates that more education concerning abortion and its consequences is still needed to all adolescents who are in school and out of schools.

Table 10: Reasons for the failure of RHE on cases of illegal abortion

Reasons	Residence in terms of village(s)				Average
	MMK (N=19)	MM (N=23)	Nzari (N=30)	Mahamah (N=17)	(N=96)
Fearing to be expelled by parents	26.3	4.3	13.3	11.8	13.5
Education not reach many adolescents	0	0	6.7	5.9	3.4
Fearing for drop out	21.1	21.7	10	41.2	21.3
Shortage of RHE experts	15.8	17.4	23.3	11.8	18.0
Education comes at late stage	0	34.8	20	0	15.7
Curriculum not sufficient	36.8	21.7	26.7	29.4	28.1

Data based on multiple responses

Key: MMK= MvumiMakulu, MM= Mvumi Mission

3.4.3 Achievement of RHE on STIs including HIV/AIDS

In regard to the achievement of reproductive health education on STIs, the findings have revealed that an overall majority (67.7%; N=96) of the respondents argued that RHE has not reduced cases of STIs including HIV/AIDS (Figure 5). These observations indicated that reproductive health education provided has failed to reduce cases of STIs including HIV/AIDS among female adolescents.

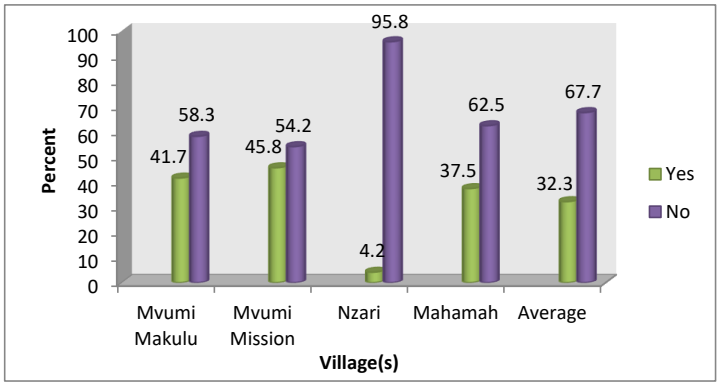

Figure 5: Achievement and /or failures of RHE on STIs/HIV/AIDS

However results from specific villages differed on the responses (Figure 5). For instance, Nzari village had higher proportion (96%) of respondents, than the average proportion of the respondents who reported that RHE has not reduced cases of STI's/HIV/AIDS, compared to the remaining villages. These variations may partly be attributed by different percentages of prevalence of consequences of risk sexual behaviors, such as STIs including HIV/AIDS in each village. The reasons for the failure of RHE in reducing cases of STI's including HIV/AIDs were also identified. The findings in Table 10 revealed that the mostly given reason was poverty accounting 37% of the respondents. The link between poverty and persistency of STIs is shared by Madise *et al*. (2007) who observed that sexual behaviors among adolescents are linked with poverty where by female adolescents were vulnerable to infections because of sexual practices and non-use of condoms.

Table 11: Reasons for the failure of RHE on STIs

Reasons	Residence in terms of village(s) (%)				Average
	MMK (N= 27)	MM (N=22)	Nzari (N=44)	Mahamah (N=24)	(n=96)
Personal behaviour	48.2	18.2	31.8	34.2	33.1
Poverty	48.1	40.9	18.2	40.8	37
Shortage of RHE experts	3.7	13.7	41	20.8	19.8
Ignorant	0	13.6	4.5	0	4.5
Education comes at late stage	0	13.6	4.5	4.2	5.6

Data based on multiple responses, MMK= MvumiMakulu, MM= Mvumi Mission

As for village level, some reasons valued high than the other, for example, personal behaviors and poverty valued high in MvumiMakulu village than in Mvumi Mission, Nzari and Mahamah villages (Table 11). These reasons counted high in this village because they were regarded by the respondents contributing to the prevalence of STIs and HIV/AIDS among the adolescents. On the other hand, the ignorance of the people on RHE and education came at a late stage of adolescents were valued low, specifically in Nzari and Mahamah villages. The two reasons valued low in the given villages because they had no direct impact on STIs including HIV/AIDS among the population.

Observations from the result also indicated that there was a problem of delivering sufficient information on reproductive health issues due to lack of experts, although poverty contributed for an increase of HIV/AIDS prevalence in the study area. Similar view had been given during a focus group discussion (Plate 3) by one participant who had to say:

"In our villages there is a problem of an access to RH services for out-schooling adolescents, and the information for the youth affected adolescent reproductive health, at the same time there was no special programmes designed to help us on issues of RH which has resulted to many problems including HIV/AIDS and other STIs among adolescents." (An 18 years old girl, at Nzari Village, 2013)

3.5 Challenge towards the provision of RHE

Key informants namely teachers and health officials, were enquired on the challenges encountered in delivering the RHE were explored (Table 11).

Table 11: Perceived Challenges towards the provision of RHE

Challenges	Respondents (%)		Average (N=13)
	Health officials (N= 4)	Teachers (N= 9)	
Cultural and religious factors	42.4	55.4	48.9
Limited reach to out of school adolescents	24.4	15.6	20
Lack of teachers who possess necessary skills	33.2	29	31.1
Total	100	100	100

The results indicated identified cultural and religious factors(48.9%), limited reach to out of school adolescents (20%), and lack of teachers who possess the necessary skills (31.1%) as barriers towards the provision of reproductive health education among adolescents in Chamwino District. such results is supported by Mbonile and Kombo (2005), who argued

that despite the erosion of traditional and cultural values with an increasing modernization, there are some traditional and cultural values which seem to play a role in inhibiting the performance of sex and reproductive health education in schools. Also, MoH (2011),noted that schools are short of resources and teachers have neither the training nor the equipment to deliver health education on top of their existing workload. Following a quote from one of the respondent during an interview one key informant had the following to say:

"*Even teachers who are trained are often not willing to teach the most sensitive parts of the curriculum, such as information and skills related to condom use. Some teachers were reluctant to teach about condoms, because they felt this could lead to their dismissal, while others felt that part of the curriculum contradicted their personal values*." (Biology Teacher Chilonwa Secondary School, 2013).

4.0 Conclusion and Recommendations

From this study it can be concluded that, the school is the leading institution for delivering reproductive health education and majority of respondents reported control of sexual transmitted diseases, family planning, and early pregnancies as the major topics are taught during RHE and discussion method was a dominant method, used by instructors in delivering reproductive health education; RHE was adequate in increasing level of awareness on the consequences of early pregnancies, illegal abortion and STIs including HIV/AIDS among adolescents; RHE provided are insufficient to reduce cases of early pregnancies, illegal abortion and STIs including HIV/AIDS, regardless of the awareness on STIs, early pregnancies on three aspects. Challenges encountered towards reproductive health education were resistance from cultural and religious factors, Limited reach to out of school adolescents and lack of teachers who possess the necessary knowledge, training to teach appropriate and the correct information on sexual and reproductive health matters. Basing on findings of this study it is recommended that; Teachers who are mostly facilitators should be given priorities to attend various training which would enable them to provide sufficient knowledge on reproductive matters; The Central Government, Non-Government Organizations and Community in general should address social and cultural barriers that increase adolescents' vulnerability to sexual risk by addressing the stigma surrounding female sexuality, discouraging early marriage and encouraging responsible behaviors; There should be a friendly health services such as free information provision and accessible health services with trained facilitators, designed for young adolescents where they could express their feelings and emotional, especially in each dispensary in the rural areas; Reproductive health providers should employ several methods and techniques including seminars, conferences video and formation of different clubs among adolescents themselves.

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