Original Article

# Premarital Sexual Experience and Preferred Sources of Reproductive Health Information among Young men in Kumbotso, Northern Nigeria

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## ABSTRACT

**BACKGROUND**: Despite well known risks associated with unprotected premarital sex, this phenomenon has not been well explored among young men in rural northern Nigeria. We studied the predictors of premarital sex and preferred sources of sexual and reproductive health information among young unmarried men in Kumbotso, northern Nigeria.

**METHOD**: A cross section of 400 young men were interviewed using structured questionnaires with mostly closed ended questions.

**RESULTS**: Of the 385 respondents, 39 (10.1%) were sexually experienced. Less than half of respondents (48.7%) used a condom at sexual debut, and an equal proportion reported having multiple sex partners. Only 41.0% of sexually experienced respondents reported subsequent consistent condom use Age (adjusted odds ratio [AOR] = 4.12; 95% confidence interval (CI): 2.24-5.20) and educational attainment [AOR=3.57; 95%CI (1.49-9.10)] were significant predictors of sexual experience. The current versus preferred sources of sexual and reproductive health information included friends (51.3% vs. 93.3%), Islamic school teachers (41.0% vs. 72.7%) and school teachers (8.8% vs. 15.1%).

**CONCLUSION**: Although the prevalence of premarital sex among young men in this community in northern Nigeria was low, those that did engage in such activity were likely to not use condoms and to have multiple partners. Preferred and trusted sources of information included peers and religious leaders. The findings in this study could be used to develop innovative strategies for reaching young men with accurate sexual and reproductive health information.

**KEY WORDS**: Premarital sex, Young men, Sources, Information, Nigeria

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## INTRODUCTION

According to the United Nations, the world's population reached seven billion on the 31st of October 2011 and, if the current trend continues, it will rise to more than nine billion by the middle of this century.[1] This new population milestone ushers in a world populated by the largest generation of youth in human history. Eighty five percent of these youths live in developing countries, including Nigeria.[1] With an estimated population of 167 million, Nigeria is now the sixth in the world and the most populous country in Africa.[2] Persons under the age of 24 comprise 60% of Nigeria's population. By 2025, the number of young people aged 10-24 years in Nigeria is expected to reach 57 million.[3] The world in which young people grow up today is very different from that of their parents or grandparents. Compared with the youth of past generations, young people today have more opportunities and challenges. They are more likely to be independent from their parents and spend more time in school or on the streets. They are also more likely to have access to radio and television and, increasingly, to the internet and mobile phones. They are also entering adolescence earlier and healthier, postponing marriage until later, and are more likely to have sex before marriage.[4] Therefore the sexual and reproductive behavior of this large cohort of youths continue to raise serious concerns in view of the several health consequences associated with such behavior, including greater risk of acquisition of sexually transmitted infections.

Available evidence suggests that the number of young people aged 15-24 years who commenced premarital sexual relations has increased in the past few years. The Nigerian Demographic and Health Survey (NDHS)[5] reports that by age 20 years, 42% of boys are sexually experienced. The same survey reports an average age at marriage for men to be 24.3 years. NDHS also reports that young people in Nigeria have almost universal basic knowledge of HIV/AIDS regarding the major routes of transmission and of the protective effects of abstinence and condoms. Despite the knowledge of these protective measures, young people rarely subscribe to them, thus resulting in an escalation of negative sexual health outcomes.[5] This phenomenon has been attributed to peer pressure and inaccurate knowledge about sexuality and reproductive health among youth.[6]

In Africa, communication about sexual and reproductive health issues among boys tends to be left to their peers with little or no instruction coming from the parents. Moreover, when parents do communicate with these teenagers about sex and sexuality, the topics are generally limited to developmental changes and impersonal facets of sexuality, such as morality and dangers associated with pre-marital sex.[6] This may even be more pronounced in

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northern Nigeria, a culturally distinct and conservative region of the country. Additionally, rural youths even face more disadvantages such as limited opportunities for schooling and lack of access to electronic media. The in-roads made by drug and substance abuse and delinquency have increased the risks faced by these young men. Few studies have been conducted in northern Nigeria regarding sexual and reproductive health of young men. Even these have been conducted in urban areas focusing on in-school youth.[7] It is therefore important to investigate the sexual behavior and preferred sources of sexual and reproductive health information among young men in rural northern Nigeria. This could inform the development of culturally acceptable information, education and communication strategies for youth in this and similar settings.

## METHODS SETTING

Kumbotso local government area (LGA) is one of the 44 LGAs in Kano state. Kumbotso LGA has a land area of 161 kilometers$^2$ and estimated 2006 population of 232,797. The population is made up of 118,274 males and 114,523 females with 51,215 women within the reproductive age group of 15 44 years.[2] Majority of the people are Hausas and Fulanis with few other tribes such as Yorubas, Igbos, Kanuri, Igalas and Igbiras as settlers. Most of the inhabitants are subsistence farmers. Other occupations in the area include petty trading, cattle rearing and civil service. There are 22 primary health care facilities in the LGA, 6 private clinics and several patent medicine stores.

### Study design and sample

This study was descriptive and cross-sectional in design. A sample size of 400 was obtained using the hypothesis method [8] and based on the proportion of sexually experienced young men in a previous study.[5] Our assumptions included a 95% confidence limit, a 5% margin of error and allowance made for 10% attrition rate. A multistage sampling technique was used for the selection of respondents. In the first stage, 5 wards were randomly selected from the existing 10. Thereafter, the houses in the sampled wards were numbered. A total of 400 houses were selected from the 5 wards using probability proportionate to size and systematic sampling technique.

The starting point in each ward was obtained using a random number table. Where >1 households were found in a house, one was selected by a single one-time ballot. Finally, eligible young men (age range 15 to 24 years) who were de facto residents in the sampled household were approached to participate in the study. Consent from a parent or caretaker was obtained for adolescents aged 15-17 years before the eligible adolescent was approached to participate in the survey. Once the parent or caretaker gave consent, separate informed consent was then sought from the eligible under-age adolescent. For those aged 18-24, consent was obtained directly. Ethical approval for this study was obtained from the Institutional Review Board at Aminu Kano Teaching Hospital.

### Study Instrument

Data were collected using a structured interviewer-administered questionnaire with mostly close-ended questions adapted from an earlier survey questionnaire.[5] The questionnaire was pretested among young men in nearby Fanshekara village and necessary changes then effected. The questionnaire consisted of four parts. The first section inquired about socio-demographic characteristics, the second assessed media exposure, current and preferred sources of information about sexual and reproductive health. The third section elicited information about sexual behaviour and risk taking.

### Data Analysis

The data from the questionnaires were entered and analyzed using SPSS version 16 software.[9] Odds ratios (95% confidence intervals) were used to determine the association of different factors with pre-marital sexual experience. Logistic regression analysis was used to assess the relative effect of determinants. Adjustment was made for predictor variables that were significantly related to the outcome variable at the bivariate level. A $P<0.05$ was considered statistically significant in all tests of significance.

## RESULTS

### Socio-demographic Characteristics

Out of 400 respondents approached for the study, 385 agreed to participate, giving a response rate of 96.3%. The age range of the respondents was 15 to 24 years with a mean age (±SD) of 19.2 (±2.7) years. Table I shows that the majority of the respondents (95.8%, n=369) were Muslims, most (94.9%) of whom belong to the Hausa/Fulani ethnic group. Students comprised 29% of sample respondents. One fifth of respondents were petty traders/hawkers while 21% were unemployed. A substantial proportion of respondents (41.80%) had no formal education. Forty participants (10.4%) had primary school education; nearly 45% had secondary school education while the rest (2.9%) had post-secondary education.

### Sexual Experience

Of the 385 respondents, 39 (10.1%) were sexually experienced. Ninety seven percent of the remaining uninitiated students (n=334) indicated planning to defer sexual debut till after marriage. Of the sexually experienced respondents, 48.7% reported using a condom at sexual debut while 16 (41.0%) reported subsequent consistent condom use. Up to 48.7% of sexually active respondents had multiple sexual partners

(range: 2 to 6), as depicted in Table V. Approximately 35.9% of respondents (*n*=14) reported having had sexual intercourse under the influence of influence of alcohol, marijuana or other locally sourced intoxicating substances (*Gadagi, Solvents and Glue)*. The sexual partners include prostitutes (43.6%), girl friends (23.1%) and divorced women (33.3%). No respondent admitted to engaging in homosexual activity.

**Predictors of Sexual Behaviour**

At univariate level, socio-demographic characteristics had significant effects on sexual behaviour. For instance, older respondents (20-24 year olds) were more likely to be sexually experienced compared to teenagers (P<0.05). Similarly, respondents with formal education were more likely to have been sexually initiated compared to their less well educated counterparts. Furthermore, non-Muslim and non-Hausa Fulani respondents were more likely to be sexually experienced (P<0.05). Age and educational attainment remained significant predictors of sexual experience after adjusting for confounding using multivariate analysis. Respondents in the 21-24 age brackets had more than four times the risk of being sexually experienced compared to younger respondents (15-20 years). The effect of educational status was varied. Respondents who primary school education had only had a more than three-fold risk of being sexually experienced compared to those with no formal education. In contrast, those who attained at least secondary school education had one and a half times the risk of pre-marital sexual activity (Table III).

**Media Exposure and Sources of Sexual and Reproductive Health Information**

Most respondents listened to the radio everyday (35.8%) or once a week (45.7%). They watched television, once a week (52.5%) or less frequently (39.5%). Only 17.1% of respondents have ever used the internet. Nearly one fifth of respondents (19%) had personal mobile phones, but all had access to commercial mobile phones. The main current sources of sexual and reproductive health information included friends (51.3%), Islamic school teachers (41.0%) and "western" school teacher (8.8%). Others were health workers (8.1%), home videos (6.8%) and books/magazines (4.4%). It is noteworthy that parents and other family members were minor current sources (2.1% and 0.52% for fathers and mothers, respectively) (Table IV).

Respondents preferred to obtain information regarding sexual and reproductive health from friends (93.3%), Islamic school tutors (72.7%), home videos (15.3%), school teachers (15.1%), health workers (10.1%), books/magazines (10.1%) and internet/mobile phones (9.4%). Parents and other family members were not mentioned as a preferred source by the respondents. Furthermore, when asked about those they would like to discuss specific topics with (e.g., information on signs of puberty) most respondents (73.8%) chose the Islamic school teacher. In contrast, for subjects such as pre-marital sexual experimentation and condom use the majority of respondents (91.3%) preferred to discuss with their peers/friends. Health workers/chemist owners (67.3%) and friends (29.4%) were the preferred advisers on sexually transmitted infections/HIV/AIDS, risk of pregnancy among sexual partners and contraception. Parents and other family members were not mentioned as preferred sources for any of these issues.

**Table I: Socio-demographic characteristics of respondents, Kumbotso, Nigeria, 2011**

| Characteristics | Frequency No. (%) |
|---|---|
| **Age group** | |
| 15-17 | 123(31.9) |
| 18-20 | 150(39.0) |
| 21-24 | 112(29.1) |
| Total | 385(100.0) |
| **Religion** | |
| Islam | 369(95.8) |
| Christianity | 16(4.2) |
| Total | 385(100.0) |
| **Education** | |
| No formal | 161(41.8) |
| Primary | 40(10.4) |
| Secondary | 173(44.9) |
| Tertiary | 11(2.9) |
| Total | 385(100.0) |
| **Ethnicity** | |
| Hausa/Fulani | 365(94.9) |
| Yoruba | 9(2.3) |
| Igbo | 6(1.6) |
| Others | 5(1.3) |
| Total | 385(100.0) |
| **Occupation** | |
| Students | 112(29.1) |
| Petty trading/hawking | 79(20.5) |
| Farming | 52(13.5) |
| Commercial motorcyclist | 43(11.2) |
| Unemployed | 81(21.0) |
| Others | 18(4.7) |
| Total | 385(100.0) |

**Table II: Sexual experience by socio-demographic characteristics**

| Characteristics | Sexually experienced Yes | No | Total | $\chi^2$ | P-value |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-17 | - | 76(100.0) | 76(100.0) | | |
| 18-20 | 1(0.78) | 127(99.2) | 128(100.0) | | |
| 21-24 | 38(20.9) | 143(79.1) | 181(100.0) | | |
| Total | 39(10.1) | 346(89.9) | 385(100.0) | 42.1 | <0.001 |
| **Education** | | | | | |
| Non-formal | 13(8.1) | 148(91.9) | 161(100.0) | | |
| Primary | 12(30.0) | 28(70.0) | 40(100.0) | | |
| Secondary | 12(6.9) | 161(93.1) | 173(100.0) | | |
| Tertiary | 2(18.2) | 9(81.8) | 11(100.0) | | |
| Total | 39(10.1) | 346(89.9) | 385(100.0) | 19.4 | <0.0001 |
| **Religion** | | | | | |
| Islam | 33(8.9) | 336(91.1) | 369 (100.0) | | |
| Christianity | 6(37.5) | 10(62.5) | 16(100.0) | | |
| Total | 39(10.1) | 346(89.9) | 385(100.0) | Fisher exact | 0.0003 |
| **Ethnicity** | | | | | |
| Hausa/Fulani | 31(8.5) | 334(91.5) | 365(100.0) | | |
| Yoruba | 3(33.3) | 6(66.7) | 11(100.0) | | |
| Igbo | 5(83.3) | 1(16.7) | 6(100.0) | | |
| Others | - | 5(100.0) | 5(100.0) | | |
| Total | 39(10.1) | 346(89.9) | 385(100.0) | Fisher exact | 0.003 |

**Table III: Predictors of sexual experience among young unmarried men in Kumbotso, northern Nigeria.**

| Predictor | Crude OR | Adjusted OR (95%CI) | P value |
|---|---|---|---|
| **Age group (years)** | | | |
| d20* | 1.0 | | |
| 21-24 | 5.3(3.94-7.82) | 4.12(2.24-5.2) | 0.002 |
| **Education** | | | |
| Non-Formal* | 1.0 | | |
| Primary | 4.88 (1.85-12.90) | 3.57(1.49-9.10) | 0.004 |
| Secondary/Tertiary | 2.10 (1.20-3.57) | 1.53(1.07-2.20) | 0.038 |
| **Religion** | | | |
| Islam* | 1.0 | | |
| Christians | 6.11 (1.84-19.8) | 2.13(0.07-3.15) | 0.44 |
| **Ethnicity** | | | |
| Hausa/Fulani* | 1 | | |
| Others | 3.18(1.26-4.28) | 1.61(0.86-2.77) | 0.09 |

*referent category

**Table IV: Media exposure and sources of sexual and reproductive health (SRH) information**

| Characteristics | Frequency No. (%) |
|---|---|
| **Media exposure** | |
| **Radio** | |
| Everyday | 138(35.8) |
| Once a week | 176(45.7) |
| Less than once a week | 67(17.4) |
| Not at all | 4(1.1) |
| Total | 385(100.0) |
| **Television** | |
| Everyday | 23(5.9) |
| Once a week | 202(52.5) |
| Less than once a week | 152(39.5) |
| Not at all | 8(2.1) |
| Total | 385(100.0) |
| **Internet** | |
| Everyday | 10(2.6) |
| Once a week | 42(10.9) |
| Less than once a week | 14(3.6) |
| Not at all | 319(82.9) |
| Total | 385(100.0) |
| **Current sources of SRH information* (n=385)** | |
| Friends | 213(51.3) |
| Islamic School | 158(41.0) |
| School teacher | 34(8.8) |
| Health worker | 31(8.1) |
| Films/Home videos | 26(6.8) |
| Internet/mobile phone | 18(4.7) |
| Books/magazine | 17(4.4) |
| Other family members | 9(2.3) |
| Father | 8(2.1) |
| Brother | 8(2.1) |
| Mother | 2(0.52) |
| **Preferred sources of SRH information* (n=385)** | |
| Friends | 359(93.3) |
| Islamic School | 280(72.7) |
| Films/Home videos | 59(15.3) |
| School teacher | 58(15.1) |
| Health workers | 39(10.1) |
| Books/Magazine | 39(10.1) |
| Internet/mobile phone | 36(9.4) |

*** Multiple responses allowed**

**Table V: Risky sexual behavior among young unmarried men Kumbotso, northern Nigeria, 2011**

| Behavior | Frequency No. (%) |
|---|---|
| **Ever had sexual intercourse (n=385)** | |
| Yes | 39(10.1) |
| No | 346(89.9) |
| Total | 385(100.0) |
| **Intention to defer sexual activity till marriage (n=346)** | |
| Yes | 334(96.5) |
| No | 12(3.5) |
| Total | 385(100.0) |
| **Condom use at first intercourse (n=39)** | |
| Yes | 19(48.7) |
| No | 20(51.3) |
| Total | 39(100.0) |
| **Consistent condom use (n=39)** | |
| Yes | 16(41.0) |
| No | 23(59.0) |
| Total | 39(100.0) |
| **Number of sexual partners (n=39)** | |
| 1 | 20(51.3) |
| 2-4 | 11(28.2) |
| e5 | 8(20.5) |
| Total | 39(100.0) |
| **Sexual intercourse under influence (n=39)** | |
| Yes | 14(35.9) |
| No | 25(64.1) |
| Total | 39(100.0) |

## DISCUSSION

The proportion of sexually experienced unmarried male adolescents in our study (10.1%) was higher than the reported figure for the North West zone (5.9%).[5] It was however lower than the national (36.3%) and corresponding figures from all other zones of the country. The highest zonal figure was from the South South (53.3%). It is noteworthy that the HIV prevalence among youths from the different zones fairly mirrors the proportion of young men that were sexually experienced before marriage in these zones.[10] This supports the reported predominance of heterosexual transmission of HIV in developing countries.

When compared with reports from other countries, the proportion of sexually experienced unmarried males was much lower than that reported from Malawi[11] (63.2%), Tanzania[12] (54%), Zimbabwe[13] (36%), Vietnam[14] (31%), India[15] (21.7%) and the USA[16] (46%). However, our figure was similar to that reported from Bangladesh[17] (12.8%). These variations could be due to differences in socio-cultural characteristics, religiosity, and attitudes towards premarital sex. For instance, pre-marital sex is prohibited among Muslims and is culturally abhorred in the predominant Hausa culture in the study area. Although 97% of our sexually naïve respondents claimed they would delay engaging in sex till they marry, this is doubtful considering the fact that the proportion of

sexually experienced respondents doubled among 21-24 year olds whereas the average age at marriage for men was earlier reported to be 24.3 years in the study area.[5]

Although the prevalence of premarital sex was relatively low, the risky nature of sexual encounters is a source of concern. For instance, less than half of the sexually experienced respondents claimed to have used condoms at sexual debut. Being a self-reported study, the actual figure may be even less. Our finding is however higher than the figures reported among young men in the North West (6.4%) and nationally (22.2%).[5] It is also higher than the figures reported from Ibadan[18] (32.2%) in South West Nigeria. Similarly, the reported consistent use (41%) of condoms in this study was slightly higher than the North West figure (36.3%) but lower than the national figure (49.4%).[5] The concordance of our rate of condom use at debut with consistency is not surprising, as earlier reports indicate that individuals who use condoms at sexual debut are more likely to be consistent.[19] Elsewhere, consistent condom use was lower in Bangladesh (8.6%)[17] and India[15] (22.3%) but higher (48.1%) among unmarried men in Malawi.[11] The proportion of young men who had multiple sex partners in this study (48.7%) was also similar to the figure reported from Ibadan[18] (48%) but lower than reports from Enugu (62.3%),[20] both in Nigeria. Although the use of alcohol is unusual in this predominantly Muslim community, the occurrence of sexual relations under the influence of intoxicating substances could be due to the increasing use of drugs and substances among youths due to social stresses, peer pressure and unemployment. Higher use of alcohol and intoxicating substances were reported from other parts of Nigeria.[5] The variations in culture, religion and social acceptance of alcohol and other intoxicating substances may explain these differences.

The significant effect of age on sexual experience has been reported by other workers and could be explained by the maturation process and the intense sexual drive and strong peer influence in late adolescence. With puberty also starting earlier, largely because of better nutrition, the interval between childhood and assuming adult roles has lengthened. During this extended period of adolescence and young adulthood, young people may have sexual relations before marriage, putting them at risk of sexually transmitted infections. The risks associated with sexual relationships, especially among the unmarried, are heightened by young people's lack of access to information and services related to sexual and reproductive health. Programs that provide such information and services would benefit young people by preparing them to make more informed decisions about marriage, sexual relationships, and childbearing.

Although the likelihood of early sexual debut generally decreased with increasing education, the less-than-optimal protective effect of education on postponing sexual debut could be a reflection of the state of sexuality and reproductive health education in schools and at homes in the study area. The higher likelihood of premarital sex among those that had only primary education compared to their more educated counterparts could be due to the lack of opportunity for family life education among primary school pupils due to strong opposition from parents and religious leaders. The situation may even be worse among out of school youths where cultural taboos are major obstacles to informed discussions about sexual and reproductive health issues. Premarital sexual relationships are forbidden, and talking about them or about sexuality in general is often considered taboo and is abhorred. The silence stems in part from the belief that talking openly about sexual and reproductive health might encourage premarital sex and promiscuous behavior. But reviews of sex education programs worldwide have concluded that sex education does not encourage early sexual activity, and can delay sexual debut and lead to more consistent contraceptive use and safer sex practice.[21] Without doubt therefore, appropriate sexuality education from acceptable sources can result in young adults delaying first intercourse. There is a need to assure parents and religious leaders that providing age appropriate information to adolescents will not increase promiscuity but will actually promote responsible choices and sexual behaviour.

The dominance of friends and Islamic school as major sources of sexuality and reproductive health information in our study contrasts with reports from other studies.[6,7] The preference of friends in areas related to intimacy, wet-dreams, romance and condom use could be due to their less judgmental attitude and similar life experiences. The choice of health workers for treatment of STIs is not surprising as this is a technical issue. So also in issues related to religion and morality respondents chose Islamic scholars as their main source of information. It is noteworthy that attendance at Islamic schools during childhood and adolescence is nearly universal in the study area. Islamic scholars take on roles of both parents and teachers in the *Almajiri* system, and apart from peers probably constitute the most important agents of socialization. They provide guidance on Islamic teachings regarding puberty, adolescence, prohibition of pre-marital sex etc. They are also trusted by parents and the community. They are therefore, a veritable entry point and a powerful channel of communicating with out of school youths or those who are not enrolled in western schools. Having said this, approaching religious tutors will require tack and patience. But, once they are convinced of the merits of the case, they may open a whole new window of opportunity for delivering culturally acceptable information to these teeming youths.

Generally, there is little disagreement on the need to protect young people against pre-marital unprotected sexual activity that may result in contracting sexually transmitted infections including HIV, unwanted teenage pregnancies and its consequences for both sexual partners. The controversy has always been around the age, content and channels of communication and condom use. Regardless of these shades of opinions, young men are likely to have their preferences when it comes to sourcing of sensitive information regarding sexuality. It is when their preferred sources are used that programs are more likely to succeed. The findings of this study should therefore be used to inform policy, program and practice in similar settings.

In this study we found that young people were generally reluctant to seek information about sexuality and reproduction from their parents, fearing their parents will conclude they are engaged in forbidden activities. The discrimination of sources for particular information is also noteworthy. Their preferred sources of reproductive health information must be taken into consideration when planning sexuality education programs. However the most competent and authoritative sources of information should also be considered. Unless trained and equipped with the right information, peers who provide reproductive health information are usually as uninformed themselves on issues such as safe periods, sexually transmitted infections and pregnancy prevention. If peers are to provide reproductive health information to their mates, they should be trained as peer educators who can serve as role models and sources of appropriate information to others. The low preference of teachers as a source of reproductive health information is an indictment of the education system as a source of information on life skills. The tactful introduction of family life education into schools should improve the capacity of teachers to handle a more authoritative education of adolescents on sexual and reproductive health information. This will enhance the acceptability of the messages and will increase the likelihood of achieving optimal results. The role of modern mobile communication systems needs to be considered. Social networks such as *Facebook* are quite popular among youths and can be utilized to provide accurate information on sexual and reproductive health

This study had several limitations. Firstly, our respondents were from one community in northern Nigeria. Although, Kumbotso is a typical rural northern setting, the region is by no means homogenous. There is therefore a need to exercise caution in extrapolating our findings to all of the North. Secondly, this study elicited very personal issues and was based on self-report, and could therefore be prone to social desirability bias. However, we assured respondents of confidentiality and questionnaires were administered by male students within the same age bracket to minimize these biases.

In conclusion, this study showed a relatively low prevalence of pre-marital sex among young men in this northern Nigerian community, but with risky sexual practices. It also identified age and educational attainment as main correlates of sexual experience before marriage. The preferences for peers and Islamic scholars and low ranking accorded school teachers, health workers and parents in giving reproductive health information were clearly enunciated by respondents. There should be concerted effort among programmers to creatively harness the contributions of these groups to ensure that adequate reproductive health information reaches this target population in the most appropriate and acceptable way.

Countries must ensure that the programs and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted infections and sexual abuse. In doing so, these services must safeguard the rights of adolescents to privacy, confidentiality, informed consent, and respect for cultural values and religious beliefs. Policymakers and program planners need to take into account the political, social, and economic context of the lives of young people and how this affects young people's sexual and reproductive health. Governments need to enact policies and programs that would provide comprehensive sexuality education in schools, particularly through working with parents and training teachers. In communities with low school enrollment, there is a need to explore ways to reach out-of-school youth such as through *Islamiyya* schools, as these unreached youths may be most vulnerable to sexual and reproductive health risks. The creative use of mass media, the internet/mobile phone and other emerging technologies should also be explored.

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