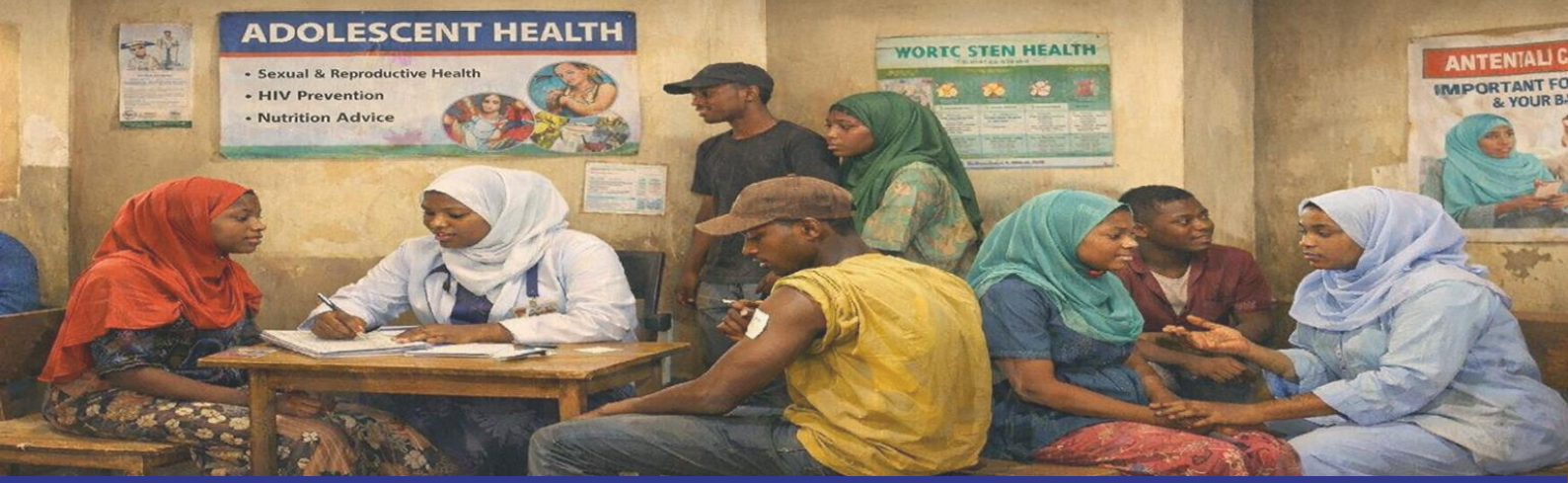

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Adolescent Sexual Initiation, Pressure, Safer-Sex Negotiation, and Access to Reproductive Health Services in Rural Bauchi State, North-East Nigeria

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PREFACE

This policy brief is the second in the series of communication to policy and decision makers as well as other stakeholders on the on-going implementation research project of the Centre for Population and Environmental Development (CPED) and its partners titled **'Gender-transformative approaches to address unmet adolescent sexual and reproductive health needs in rural Nigeria'** funded by IDRC under its program **"Addressing neglected areas of sexual and reproductive health and rights in sub-Saharan Africa (ANeSA)"**. CPED's policy brief series is designed to draw attention to key findings and their policy implications as projects are being executed. This edition presents how adolescents at young age are pressured into sex and how access to reproductive health services was low with some citing confidentiality fears when utilizing the facilities in the Northeastern part of Nigeria. We are very grateful to IDRC for the support in implementing this project so far. We also appreciate the cooperation of policymakers in Bauchi and Gombe States for their enthusiastic collaboration with CPED in the on-going implementation of the project.

KEY MESSAGES

- Sexual initiation was described as starting as early as age 10; many participants placed onset in the mid-teens. Pooled adolescent responses suggested an approximate perceived average around 17 years (wide variation).
- Pressure to have sex was described as gendered and linked to economic vulnerability; confidentiality fears and stigma strongly reduced service-seeking.
- Safer-sex negotiation often focused on relationship commitments (e.g., insisting on marriage if pregnancy occurs). Condom knowledge was common, while some adolescents rely on phones/hotlines for SRH information.
- Utilization of facility-based adolescent SRH services was low; many adolescents prefer chemists or informal channels due to shame, fear, and provider/community proximity.

Background and brief literature review (North-East Nigeria)

Adolescents (10–19 years) in Nigeria's North-East face intersecting risks: early marriage, low modern contraception, and limited access to confidential, respectful services. National survey evidence shows persistent geographic inequality in adolescent childbearing and contraceptive use, with the North-East among the poorest performing zones (NPC & ICF, 2019). Early sexual debut increases exposure to unintended pregnancy and STIs, and is shaped by education, household conditions, and social norms (Yaya et al., 2018).

Peer pressure, economic stress, and gender power dynamics can make it difficult for adolescents—especially girls—to refuse sex or negotiate protection. Qualitative work in northern Nigeria highlights barriers such as stigma, fear of exposure, and provider attitudes that discourage adolescents from seeking reproductive health services (Ajuwon et al., 2006; Nmadu et al., 2020). Nigeria's national standards on Adolescent- and Youth-Friendly Health Services (AYFHS) call for accessible, acceptable, confidential, and quality services delivered by trained, non-judgmental providers (Federal Ministry of Health, 2018).

FGD Evidence Base

This brief synthesizes perceptions and experiences from FGDs with adolescents (male and female) and adult men and women in rural communities of Bauchi State. Three Local Government Areas (LGAs) were purposively selected for the qualitative component of the study in Bauchi State—Darazo, Tafawa Balewa, and Katagum. In each LGA, four Focus Group Discussions (FGDs) were conducted to capture perspectives across age and sex groups: two adult FGDs (male-only and female-only) and two adolescent/young people FGDs (male-only and female-only). Each FGD comprised approximately 6–8 participants. Participants in the adolescent/young people groups were aged 16–24 years, while participants in the adult groups were aged 25 years and above. The FGD is led by a facilitator who introduces the topics of discussion and helps to ensure that all members participate evenly in the discussions Findings reflect community narratives and perceived patterns; they should be interpreted as qualitative evidence of norms, constraints, and service gaps.

Emerging results from FGDs (Bauchi State)

1. When do adolescents start engaging in sexual activity?

Across adolescent FGDs, participants described initiation starting as early as age 10, with many placing onset at 15 years and above. Pooling the ages explicitly mentioned by adolescent groups yielded an approximate perceived average around 17 years, but with wide variation (from early adolescence to the mid-20s in narratives tied to marriage expectations).

Illustrative quotes

- "At what age do young people start having sex? … 10 years above … 15 yrs above." (Adolescent males, guide summary)
- "At what age do young people start having sex? … 15yrs above … 10 yrs above." (Adolescent females, guide summary)
- "At the age of 19 years … from 23 to 24 years … at the age of 25 when they are married." (Adolescent males, Katagum LGA)

2. Pressure to have sex from peers and parents/guardians

FGDs suggested that pressure is gendered and often connected to economic vulnerability. Adolescent girls were described as facing stronger pressure from peers and, in some cases, from guardians when basic needs cannot be met. Some participants also discussed pressure involving older men. Male adolescents were more likely to describe peer influence as indirect, though coercion was acknowledged

Illustrative quotes

- "Some guardians do pressure their children… because they cannot provide their basic need." (Adolescent females, guide summary)
- "There are a lot of pressure from friends and peers." (Adolescent females, guide summary)
- "The girls are more pressured than the male because of the economic situation…" (Adolescent females, guide summary)
- "Mostly it is unavoidable… your parents will be showing concern about not having child…" (Adolescent males, Katagum LGA)

3. Negotiating safer sex and protective practice

Negotiations described before sex were often relational rather than explicitly about protection. A common theme was a girl insisting on marriage if pregnancy occurs. Condom awareness was high and frequently cited as the main protection method. Adults and some adolescents described pills and injectables often obtained from chemists, alongside harmful misconceptions. A few participants highlighted phone-based SRH information.

Illustrative quotes

- "If she gets pregnant, you will have to marry her… if you say no, then she don't give sex." (Adolescent males, guide summary)
- "Which forms of protection…? … Condom." (Adolescent males, guide summary)
- "Majority of the young girls use pills while the Boys use condoms… they use to get them from the chemist." (Adult males, FGD)
- "If you dial 421, you will receive information…" (Adolescent males, Darazo)

4. Availability and accessibility of adolescent reproductive health services

Adolescent females reported not using community SRH services for advice on sex, contraception or STIs. Adolescent males reported that visits occur but are "very minimal," with many avoiding facilities due to fear or shame. Adult groups suggested adolescents often present only when pregnancy occurs or a problem becomes urgent. Participants highlighted the need for more facilities, trained personnel, and awareness-raising.

Illustrative quotes

- Have you ever been to any community services…? … NO." (Adolescent females, guide summary)
- "Yes, but is very minimal… majority don't use to go there because they are afraid." (Adolescent males, Darazo)
- "They don't use to go… until the need arise… or until they are pregnant." (Adult males, FGD)

5. What prevents adolescents and women from receiving SRH services?

Key barriers were lack of confidentiality and fear of gossip; shame and stigma (especially for unmarried adolescents); provider/community proximity; misconceptions about contraception; and limited awareness of services.

- Confidentiality concerns and fear of being talked about in the community.
- Shame/embarrassment and fear of stigma, especially for unmarried adolescents.
- Provider/community proximity (knowing the health worker personally) discourages use.
- Myths and fears about contraception (e.g., infertility).
- Limited youth-targeted outreach; reliance on chemists/phones/peers.

Illustrative quotes

- "Lack of confidentiality… Health workers tend to share all your problems…" (Adolescent females, guide summary)
- "Some are ashamed because of their relationship with the health personnel… within the community." (Adolescent males, Darazo)
- "Not always because, they are shy and they don't want people knowing…" (Adult females, Tafawa Balewa)

Call to action (Bauchi State and LGA stakeholders)

The FGDs point to an urgent need for culturally appropriate, confidential, and accessible adolescent SRH information and services. The actions below align with Nigeria's AYFHS standards and respond directly to the barriers raised:

Priority actions (next 6–12 months)

- Bauchi State Ministry of Health and SPHCDA: operationalize AYFHS in selected PHCs (confidential space, adolescent-friendly hours, trained staff).
- Facility managers: enforce confidentiality protocols (private counseling, client flow that avoids exposure, staff accountability).
- LGA health authorities and partners: scale community and school-based SRH education (including parent sessions) through trusted leaders and radio.
- Commodity/logistics teams: ensure steady condoms and modern contraception; strengthen referrals from chemists to PHCs for counseling and follow-up.
- CSOs/youth structures: peer educator networks to address pressure, consent, and safer-sex negotiation; publicize trusted phone-based SRH information.

Medium-term actions (12–24 months)

- Expand youth-friendly corners and mobile outreach for hard-to-reach settlements; monitor quality through routine supportive supervision.
- Strengthen adolescent service data review (age/sex disaggregated) to track uptake while protecting confidentiality.
- Link vulnerable adolescents to livelihood and social protection support to reduce transactional sex pressures.

Conclusion

Adolescents in rural Bauchi State were described as initiating sex from early adolescence, with pressures shaped by peers, economic vulnerability, and marriage and fertility expectations. Utilization of facility-based SRH services remains low due to confidentiality fears, stigma, and limited youth-tailored provision. Strengthening AYFHS implementation with community-led demand creation can improve uptake and reduce unintended pregnancy and STI risks.

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