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Landscaping the behaviours, drivers and norms influencing the wellbeing of very young adolescents: an exploration of stakeholders' perspectives in Nigeria

Emmanuel Nwala^{1*}, Isaac Oritogun¹, Jane Ohioghome¹, Akinwumi Akinola¹, Oladunni Adenuga¹, Oluwabusola Oni¹, Bukola George¹, Niyi Adekanla¹, Manasseh Ibrahim¹, Seyi Anwo¹ and Osasuyi Dirisu¹

Abstract

Background In Nigeria, very young adolescents face overlapping risks (early marriage, GBV, poor SRH knowledge, low HPV vaccination, and limited opportunities for girls) driven by social, economic, and institutional barriers. Understanding these determinants is crucial for targeted interventions. This study explored behaviours and norms shaping VYAs in Nigeria.

Methods We used a qualitative, multi-state design with social-ecological and norms frameworks plus Five Whys analysis to map behaviours and drivers. Our research in 12 states examined early marriage, gender-based violence, HPV vaccination, SRH gaps, and barriers to girls' economic empowerment.

We purposively sampled diverse stakeholders. About 35 participants per state participated in workshops using discussion guides, mapping, and dot voting to prioritize behaviours and drivers. We included participants from urban, rural, and conflict-affected settings. We used thematic analysis with deductive and inductive coding, guided by a codebook aligned to the Social Ecological Model and Social Norms Framework. We applied cross-case synthesis and triangulation to link behaviours with drivers and norms, and prioritized findings by prevalence, impact, feasibility, and intersectional vulnerabilities.

Results Stakeholders indicated that behaviours, underlying drivers, and social norms strongly affect the well-being of very young adolescents in Nigeria. Harmful practices, such as early sexual initiation, transactional relationships, child, early and forced marriage, and limited use of health services, are widespread. Protective behaviours, including school participation and community engagement, are present but differ by location and population group. Key drivers include poverty, parental expectations, peer influence, gender norms, inadequate services, and media exposure. Norms that tie girls' value to marriageability, discourage discussion of sexuality and abuse, and promote scepticism toward vaccination continue to increase risk.

*Correspondence:
Emmanuel Nwala
Emmanuel.nwala@policycentre.org

Full list of author information is available at the end of the article



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Intersectional vulnerabilities worsen these challenges. Stakeholders observed that girls in rural and conflict-affected areas face higher risks of child marriage, gender-based violence, and limited access to services. Urban and peri-urban girls are more exposed to sexualized media, economic instability, and transactional risks. Economic constraints, restrictive inheritance practices, and limited financial skills further limit girls' economic opportunities. HPV vaccine uptake is hindered by misinformation, concerns about side effects or infertility, religious beliefs, and gender norms that shape decision-making. Stakeholders identified priority behaviours and drivers that can be addressed through multi-level interventions.

Conclusion Very young adolescents in Nigeria face interconnected risks stemming from social norms, economic constraints, and gaps in service delivery. Persistent harmful practices and structural inequities restrict protective behaviours and limit access to opportunities. Addressing these challenges requires targeted, multi-level interventions to change harmful norms, improve adolescent-friendly services, and increase protective and economic opportunities for girls.

Keywords Social and gender norms, Child early and forced marriage, Gender-based violence, Very young adolescents, Drivers, Norms, Behaviours, Stakeholder perspectives, Vulnerabilities, Sanctions, Harmful practices, Girls economic empowerment, Vaccination, Social determinants of health

Background

It is well known that very young adolescents (VYAs), aged 10 to 14, are at a crucial developmental phase in their lives where they undergo significant changes that impact their health and well-being [1]. They encounter physiological and developmental transitions, which are often accompanied by unique challenges, and are exacerbated by social determinants of health (SDH) that influence health and well-being [2]. These challenges include the social and physical conditions and systems due to which people are born, grow, live, and spend the rest of their lives [3, 4]. Studies have shown that gender norms, which are rigidly defined for any society, play a key and often negative role in determining the behaviours, opportunities, and risks available to VYAs as well as their access to fundamental resources such as education and health services [5–8]. Sadly, these norms can also act as a key social determinant, having a long-lasting negative impact on inequalities and multiple vulnerabilities across domains [9–11].

In Nigeria, these challenges are reinforced by entrenched social and gender norms that shape adolescents' lived realities and contribute to persistent disparities in wellbeing [9]. Despite national efforts to promote gender equality and adolescent well-being, profound disparities persist, particularly in areas critical to holistic development. These challenges are often compounded by deep-seated cultural beliefs, traditional practices, and structural factors (e.g., poverty, limited access to quality services, and weak social protection systems) that dictate acceptable behaviours, roles, and expectations from an early age [2]. The resultant effects of these SDH elements are profoundly felt in communities, manifesting in specific behaviours and practices that can either support or undermine adolescents' holistic development and well-being.

This study focuses on five thematic areas where the impact of social and gender norms on adolescent well-being is most visible: child, early, and forced marriage (CEFM); gender-based violence (GBV); girls' economic empowerment (GEE); sexual and reproductive health (SRH); and Human Papillomavirus (HPV) vaccination. These themes reflect the critical intersections between sociocultural norms and health outcomes and serve as practical indicators of adolescent well-being in Nigeria. The impact of social and gender norms as critical social determinants of health is most pronounced in areas that affect adolescent health. These influences can be broadly understood as two interconnected clusters.

First, structural and systemic barriers, including CEFM, GBV, and GEE, directly shape adolescents' life trajectories. Harmful gender norms, for example, intensify the problem of CEFM, depriving adolescent girls of basic rights, educational opportunities, and lifelong health prospects. Similarly, GBV remains an ever-present threat. The widespread prevalence and cultural acceptance of violence, reinforced through everyday language, social practices, and the glorification of violent lifestyles by celebrities and elites, make GBV more pervasive and further obstructs access to reliable healthcare and wellness services. An illustration of this is the local ideal of toughness and dominance associated with masculinity, which often justifies aggressive behaviours among young men. This hegemonic masculinity not only normalizes violent actions but also restricts adolescents, especially females, from making autonomous life choices [10]. In the same way, approaches to GEE are constrained by socio-cultural constructs that limit girls' access to education, skills, and economic resources, thereby undermining their ability to make future-oriented health decisions.

Second, health service-related barriers (including access to SRH services and the uptake of preventive

interventions such as the HPV vaccination) are also strongly shaped by social and gender norms. Entrenched taboos and restrictive attitudes surrounding sexuality often hinder adolescents from seeking SRH information or care, resulting in avoidable health complications [6, 12, 13]. Likewise, despite its proven protective value, HPV vaccination remains subject to gendered attitudes, misconceptions, and community sentiments that discourage health-promoting behaviours [14–16].

These five thematic areas (CEFM, GBV, GEE, SRH, and HPV vaccination) represent critical and interlinked domains through which social and gender norms directly influence adolescent well-being. By systematically examining the behaviours, drivers, and norms across these domains from diverse stakeholder perspectives, this study adopts them as practical indicators of adolescent well-being in Nigeria, capturing both the systemic constraints on adolescents' life chances and the social determinants of their health-seeking behaviours. This framing directly informs the study objectives, which seek to explore these domains as entry points for understanding and addressing the social determinants of adolescent well-being.

Recognizing the urgent need for a nuanced, context-specific understanding of these interconnected dynamics and their roots in the SDH, a comprehensive multistate behavioural mapping exercise was conducted. This foundational exploration was critical not only for informing targeted interventions but also for prioritizing specific behaviours and norms that warranted deeper investigation through subsequent social norms exploration phases and baseline studies. This systematic approach was essential to identify and understand the intricate web of social and gender norms, their underlying drivers, and the prevailing behaviours affecting very young adolescents across Nigeria's diverse sociocultural landscapes and multisectoral challenges.

Therefore, this study presents findings from foundational work that involved extensive stakeholder engagement across 12 states in Nigeria. While existing empirical studies have examined how social and gender norms shape outcomes for older adolescents, there is scant evidence on the experiences of VYAs, despite their critical importance as a group. VYAs represent a formative life stage where identities, aspirations, and health behaviours begin to take shape. They are uniquely vulnerable to harmful norms yet hold strong potential for early interventions that can yield lifelong benefits. By systematically landscaping behaviours, drivers, and norms across diverse stakeholder perspectives on CEFM, GBV, GEE, HPV vaccination, and SRH, this study fills a key evidence gap in the literature. It provides formative insights into the social determinants influencing adolescent well-being in Nigeria and illuminates the complex realities

faced by VYAs. This not only lays the foundation for subsequent in-depth research but also informs the design of contextually relevant interventions that address root social causes, foster positive gender norms, and advance comprehensive adolescent well-being.

The theoretical model

This study deliberately combined the Social Ecological Model (SEM) with a Social Norms Analytical Framework, further strengthened by the "Five Whys" approach for root cause probing. The helped to map adolescent behaviours and their drivers in a layered, nuanced way, while still digging into the real forces and actors that uphold these patterns [17].

At the heart of this approach is SEM, which situates adolescents at the center of a web of influences [18, 19]. The individual-level homes in on young people's knowledge, aspirations, and ability to make decisions. The interpersonal layer includes family, peers, and caregivers, highlighting their roles in shaping expectations and boundaries. Institutions (schools, government structures, NGOs, and faith-based groups) come next, acting as both facilitators and gatekeepers. At the broadest level, policies and national initiatives create a structural backdrop that can either build bridges or erect barriers to adolescent well-being. Notably, the framework introduces an uptake factor dimension, a methodological twist that examines whether adolescents are aware of, able to access, or incentivized to adopt various behaviours.

The addition of a social norms model [20, 21] within SEM allows for a more detailed examination of the societal pressures and expectations at play. It distinguishes between descriptive norms (what people believe others do) and injunctive norms (what people think others expect of them) and focuses on the sanctions (rewards or punishments) that maintain these norms. The framework also identifies the key norm enforcers (whether individuals or institutions) who actively maintain or police these expectations, making it possible to see not only the abstract existence of norms but also their real-world guardians.

To prevent the analysis from stopping at surface-level explanations, the "Five Whys" technique is woven throughout, iteratively drilling down to the foundational causes behind observable behaviours. This way, the study does not just catalogue what young people do; it uncovers why those behaviours persist and how the different layers of the ecological model interact to sustain them.

Overall, this hybrid model is methodologically robust in three major ways. First, it anchors adolescent practices in a complex ecological system, emphasizing the importance of social norms. Second, it elevates social norms analysis by explicitly connecting expectations to the people and structures that enforce them, illuminating

underlying power dynamics. Third, by employing causal tracing, it goes beyond superficial explanations to reveal the root causes across individual, social, institutional, and policy domains. This approach equips researchers and practitioners with a rigorous, context-sensitive framework for understanding adolescent behaviours in Nigeria that may be relevant for designing interventions to transform harmful gender norms.

Methods

Study design

A qualitative exploratory design was utilized, incorporating structured stakeholder dialogues to capture a range of perspectives from government actors, civil society organizations, service providers, community leaders, and organizations focused on adolescents. These dialogues enabled comprehensive discussions through guided prompts, targeted questions, and collective reflection on social norms, behavioral drivers, and structural factors influencing VYAs. Thematic analysis was conducted to synthesize data and identify recurring patterns and key insights.

Study setting

The study was conducted in 12 selected states in Nigeria: Benue, Nasarawa, FCT, Kano, Kaduna, Adamawa, Enugu, Ebonyi, Cross River, Edo, Lagos, and Oyo. These states were chosen using a rigorous multi-criteria framework to ensure their contextual relevance and national representativeness. This framework combines demographic, epidemiological, geographic, socio-cultural, and programmatic indicators to capture Nigeria's complexity. State selection prioritized areas with high burdens and clear opportunities for impact within the five core thematic areas central to adolescent well-being and gender equality. For instance, states were included where the prevalence of CEFM remains above Nigeria's 43% national average, GBV rates for physical, emotional, and sexual violence continue to be high, and HPV vaccination coverage is low. Gaps in adolescent-friendly SRH services and persistent barriers to girls' economic agency also justified their inclusion. The selection also ensured representation across all six geopolitical zones and Nigeria's rich religious, cultural, and linguistic diversity, including conflict-affected and rapidly urbanizing areas of the country. This stratified, theory-driven approach ensured robust, disaggregated data capable of informing national policy while remaining grounded in diverse local realities, consistent with best practices in social norm and behavioural research.

Sample and sample size

This study employed a purposive sampling strategy for participant identification, consistent with its qualitative,

exploratory design aimed at generating rich, context-specific insights rather than statistical generalizability. A total of 12 states (Benue, Nasarawa, FCT, Kano, Kaduna, Adamawa, Enugu, Ebonyi, Cross River, Edo, Lagos, and Oyo) were selected randomly, as detailed in the study setting section, to ensure broad contextual relevance and national representativeness.

Within each selected state, participants for the multi-sectoral consultative workshops were identified through systematic stakeholder-driven landscape mapping and profiling [22] during the preparatory stage. This ensured broad and representative participation, including government officials, traditional rulers, faith leaders, civil society organizations, community leaders, educators, healthcare workers, parents/caregivers, social workers, law enforcement officials, representatives of adolescent-focused organizations, and media professionals. An average of 35 participants engaged in the consultative workshops in each state. The participant sample size was thus determined by this inclusive, multi-stakeholder engagement approach across the 12 states, aiming for depth and breadth of perspectives on the issue.

Data collection

This study employed a robust, multi-phase qualitative methodological framework grounded in participatory principles to generate nuanced, context-specific insights into adolescent behaviours, key drivers, and pervasive gender norms across the 12 selected states. The preparatory stage involved systematic state-level stakeholder landscape mapping and profiling to identify and prioritize key actors across the sectors. This analysis informed targeted engagement strategies and invitation protocols, ensuring broad-based and representative participation that included diverse voices, from community gatekeepers to government officials and frontline personnel. Concurrently, critical policy and strategic documents related to adolescent protection, gender equity, child rights, and health were reviewed to align local insights with the national frameworks.

Data were primarily collected through multisectoral participatory consultative workshops, complemented by extensive desk reviews, to generate harmonized, actionable evidence. These workshops utilized standardized participatory tools and structured discussion guides to facilitate the process (see supplementary materials attached – standardized participatory tool). The discussions systematically explored five key thematic areas: CEFM, GBV, GEE, HPV vaccination, and SRH. Within each theme, participants identified and mapped key behaviours, their enabling and hindering drivers, and the underpinning social and gender norms. To enhance diagnostic rigor, the "Five Whys" technique was used for root cause analyses, and dot voting enabled stakeholders

to prioritize critical issues for intervention. Facilitators guided discussions to ensure comprehensive input, with all data systematically captured through real-time notetaking, flip chart synthesis, and audio recordings, ensuring accuracy, triangulation, and data integrity. While the core methodology remained consistent, state-specific augmentations, such as institutional protocol reviews, enriched the contextual depth and utility.

Data analysis

The analysis aimed to provide a comprehensive landscape of the complex factors influencing the well-being of very young adolescents, ultimately serving as a robust evidence base for prioritizing areas for deeper social norms exploration and informing future interventions. The qualitative data collected from the workshop discussions were subjected to thematic analysis. Notes from all workshops were collated, transcribed, and systematically reviewed to identify recurring themes, patterns, and key insights related to behaviours, drivers, and norms across the five thematic areas. Data were analyzed to synthesize commonalities and highlight significant differences in perspectives across states and stakeholder groups.

Results

Participants’ characteristics

Overall, men accounted for 53.8% and women 46.2% of participants, with men dominating the Government (60.3% male; 39.7% female) and Traditional and Religious Leaders groups. This strong male representation offers a clear entry points to engage men in transforming harmful norms. Nonetheless, CSOs had higher female engagement (55.8% female versus 44.2% male), ensuring strong women’s voices. This disaggregation highlights how diverse stakeholder engagement supports norms shifting (see Fig. 1).

Key CEFM behavioural patterns, drivers and norms

Behaviours

Stakeholder evidence regarding behaviours associated with child, early, and forced marriage (CEFM) reveals

several recurring patterns in some states. A prominent behaviour is the arrangement or acceptance of marriage following adolescent pregnancy. In numerous contexts, marriage is regarded as a socially acceptable response to pregnancy, especially where stigma and concerns about family reputation are pronounced. These findings indicate that early marriage often serves as a mechanism for managing perceived social risk, rather than reflecting girls’ preferences or readiness for union.

“Teenage pregnancy... is sometimes used to justify child marriage.”--MSD, Benue.

“Families force unions to avoid shame associated with pregnancy.”--MSD, Enugu.

“Pregnancy often prompts families to arrange marriage to avoid stigma.” -- MSD, FCT.

Another observable behaviour is girls’ compliance with their parents’ or guardians’ decisions about marriage. Stakeholder insights indicate that adolescents frequently possess limited agency in these decisions, particularly in settings where family authority and cultural expectations strongly influence life transitions. In certain contexts, girls may also enter relationships or unions in response to economic hardship, parental neglect, or the need to secure material support, reflecting adaptive strategies within constrained circumstances.

“Adolescents accept parental decisions regarding marriage.”-- MSD, Benue.

“Families view early marriage as a pathway to social security and economic relief” -- MSD, Kano.

“Girls enter relationships for economic survival in contexts of financial vulnerability.” -- MSD, Lagos.

Findings suggest that school disengagement may be attributable to these behaviours. Pregnancy, stigma, or impending marriage frequently precede school dropout, and in some cases, marriage is positioned as a practical alternative to continued education. This pattern indicates

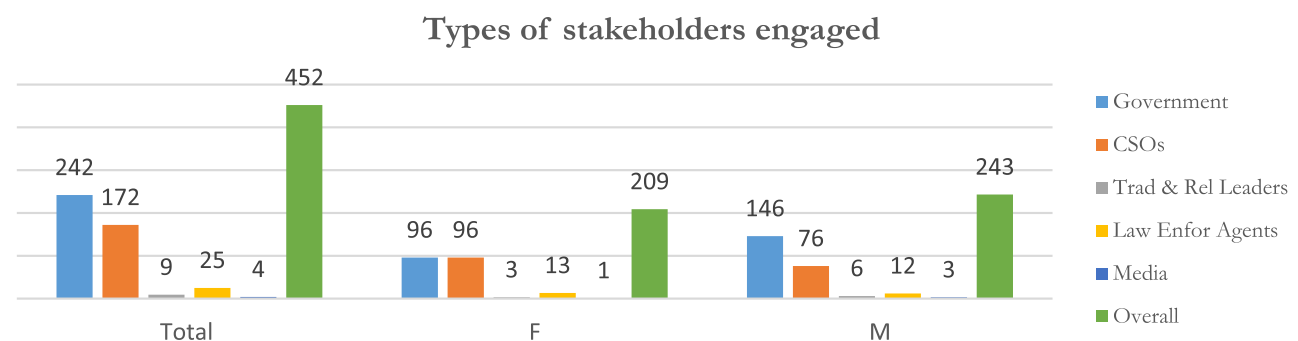


Fig. 1 Types of stakeholders engaged

a behavioural pathway in which educational exit and early union mutually reinforce each other.

“Early marriage disrupts education and contributes to school dropout.”-- MSD, Kano.

“School dropout and teenage pregnancy increase vulnerability to early marriage.” -- MSD, Edo.

“Marriage is used to manage social consequences associated with pregnancy and honour.”-- MSD, Enugu.

We found that normative pressures also influence behaviour. Community expectations, considerations of family honour, and social acceptance of early marriage shape decisions and responses to adolescent sexuality. In several states, peer and community norms reinforce the acceptability of early marriage. However, evidence from Benue indicates that structural pressures, including poverty and displacement, may play a more significant role than peer influence.

“Early marriage persists due to socio-cultural and economic pressures.” --MSD, Kano.

“Poverty and weak protection systems contribute to early marriage decisions.” -- MSD, Nasarawa.

“Early marriage is used as a coping mechanism in contexts of poverty and displacement.” -- MSD, Adamawa.

Drivers

In this study, economic hardship consistently emerged as a primary factor influencing decisions regarding CEFM in several contexts. Stakeholders reported that poverty, displacement, and household financial strain often compel families to consider marriage as a strategy to alleviate economic burdens or secure material support. In such circumstances, early marriage functions less as a cultural ideal and more as a survival mechanism within limited livelihood options.

“Early marriage is used as a strategy to reduce household burden.”--- MSD, Kano.

“Girls are married off to ease family financial pressure.”--- MSD, Nasarawa.

“In displacement settings, marriage becomes a coping mechanism for survival.” --- MSD, Adamawa.

Social norms related to honour, morality, and gender expectations were also identified as significant drivers. Stakeholders indicated that concerns regarding family reputation, cultural expectations of chastity, and the desire to avoid social shame following pregnancy

or sexual activity strongly influence decisions to marry girls early. These norms perpetuate the belief that marriage safeguards family honour and restores social respectability.

“Families marry girls early to protect honour and avoid shame.” -- MSD, Enugu.

“Pregnancy outside marriage is seen as a disgrace that must be corrected.” -- MSD, FCT.

“Marriage is used to preserve family dignity.” -- MSD, Kaduna.

Nevertheless, we found that limited access to sexual and reproductive health information and services constituted another recurring driver. Stakeholders observed that insufficient sexuality education, lack of open discussion about adolescent sexuality, and widespread misinformation contribute to early pregnancy, which subsequently precipitates marriage decisions. In contexts where adolescents lack accurate knowledge and support, families frequently regard marriage as the most socially acceptable solution.

“Lack of sexual health education contributes to teenage pregnancy and early marriage.” -- MSD, Oyo.

“Silence around sexuality leaves girls uninformed and vulnerable.” -- MSD, Cross River.

“Girls learn from peers and misinformation, leading to early pregnancy.” -- MSD, Lagos.

Gender norms and power dynamics further influence early marriage decisions. Stakeholders explained that patriarchal expectations position girls as dependents whose futures are determined by marriage, while restricting their involvement in decisions that affect their lives. In numerous contexts, girls are socialised to accept family decisions, thereby reinforcing early marriage as a normative life course transition.

“Girls are expected to be submissive and accept decisions made for them.”-- MSD, Benue.

“A girl’s value is tied to marriage and obedience.” -- MSD, Ebonyi.

“Families prioritise marriage over girls’ autonomy and aspirations.” -- MSD, Edo.

Norms

Findings show that social expectations regarding girls’ sexuality and chastity significantly influence norms that perpetuate child, early, and forced marriage. Stakeholders reported a widespread belief that a girl’s purity requires protection and that marriage is considered the

appropriate response to pregnancy or perceived sexual activity. These norms position early marriage as a moral corrective action rather than recognizing it as a violation of rights.

"Girls are married early to preserve purity." -- MSD, Kano.

"Pregnancy outside marriage brings shame to the family." -- MSD, Enugu.

"Marriage is seen as the proper response when a girl becomes sexually active." -- MSD, FCT.

Norms associated with family honour and social reputation further reinforce early marriage practices. Families often experience community pressure to conform to expectations that prioritize respectability over girls' autonomy. Within this context, early marriage is viewed as a means to maintain social standing and avoid stigma or gossip.

"Families act quickly to avoid community shame..." MSD, Kaduna.

"Honour is protected when a girl is married early."--- MSD, Nasarawa.

Community pressure pushes patriarchal norms that define girls primarily as dependents and future wives, also influencing expectations regarding early marriage. Stakeholders observed that girls are socialized to accept marriage as their primary life trajectory, whereas boys are encouraged to pursue education and leadership roles. These norms perpetuate unequal power relations and reinforce compliance with early unions.

"A girl is raised to become a wife." ---MSD, Ebonyi.

"Families invest more in boys because girls will marry out." --- MSD, Edo.

"Girls are expected to accept marriage as their destiny." --- MSD, Benue.

Cultural and religious interpretations also help legitimise early marriage norms. In some contexts, early marriage is framed as consistent with tradition or faith values, which can discourage questioning or reform. These interpretations may coexist with evolving views but continue to shape community acceptance.

"Early marriage is seen as part of our tradition." -- MSD, Adamawa.

"Religion is used to justify early marriage practices." -- MSD, Kano.

"Custom supports marriage once a girl reaches puberty." -- MSD, Cross River.

Key GBV Behavioural Patterns, Drivers and Norms Behaviours

Stakeholder discussions across multiple states reveal that GBV against adolescent girls frequently occurs in environments characterized by silence, normalization, and fear. Adolescent girls commonly experience verbal abuse, harassment, coercion, and sexual violence, yet often remain silent due to stigma, fear of retaliation, and the absence of safe reporting mechanisms. This pervasive silence enables the continuation of violence and perpetuates impunity within homes, schools, and communities.

"Girls keep quiet because they are blamed when they speak." -MSD, Nasarawa.

"Rape cases are hidden to protect family reputation." -MSD, Cross River.

"Victims fear reporting abuse due to stigma." - MSD, Kaduna.

Victim-blaming and the normalization of harmful male behaviour consistently emerged as key behavioural patterns. Girls are frequently held responsible for provoking abuse based on their dress, behaviour, or mobility, whereas boys' aggression is often minimized or excused. These responses discourage disclosure and reinforce unequal power dynamics that sustain violence.

"Girls are blamed for dressing wrongly." - MSD, Nasarawa.

"Communities question the girl instead of the perpetrator." - MSD, Enugu.

"Boys' actions are excused while girls are judged." - MSD, Kano.

The informal settlement of GBV cases represents another recurring pattern. Families and community leaders frequently resolve such cases privately to avoid stigma, legal proceedings, or social conflict. Although these practices are intended to maintain social harmony, they ultimately deny survivors justice, protection, and access to psychosocial support.

"Families settle rape cases privately." - MSD, Cross River.

"Community mediation is preferred over formal reporting." - MSD, Benue.

"Cases are resolved quietly to avoid public shame." - MSD, FCT.

Stakeholders further identified behaviors that reflect the early normalization of harassment, coercion, and sexual aggression among boys. Street harassment, coercive touching, and pressure within relationships are frequently dismissed as typical adolescent behavior, thereby

reinforcing patterns of violence and control in both intimate and social contexts.

“Harassment of girls is treated as normal behaviour.”
- MSD, Lagos.
“Boys are encouraged to show dominance over girls.”
- MSD, Ebonyi.
“Young boys grow up believing control demonstrates strength.” - MSD, Edo.

Psychological and emotional violence also emerged as a significant pattern affecting adolescents. Verbal abuse, intimidation, bullying, cyber harassment, and emotional suppression were identified as common experiences that frequently go unrecognized as forms of violence, yet contribute to trauma, fear, and diminished self-worth.

“Adolescents experience verbal abuse and bullying.”
- MSD, Benue.
“Emotional suppression prevents adolescents from speaking out.” - MSD, Kano.
“Cyberbullying and stalking affect girls’ safety.” - MSD, Kaduna.

Drivers

Entrenched patriarchal norms and unequal gender power relations were identified as primary drivers of gender-based violence across multiple states. Stakeholders indicated that social systems position males as dominant and females as subordinate, reinforcing entitlement, control, and tolerance of violence against girls. These norms shape expectations within households, schools, and communities, resulting in environments where abuse is normalized rather than challenged.

“Boys are taught to dominate girls.” - MSD, Ebonyi.
“Male authority is rarely questioned in the home.” - MSD, Edo.
“Violence is tolerated because men are seen as heads of households.” - MSD, Kano.

Social stigma, victim-blaming, and cultural silence were also identified as significant barriers to reporting and accountability. Fear of shame, reputational harm, and social exclusion frequently lead families and survivors to conceal abuse, enabling perpetrators to avoid consequences and perpetuating a culture of impunity.

“Families hide abuse to avoid shame.” - MSD, Cross River.
“Victims are blamed instead of supported.” - MSD, Nasarawa.

“Speaking out brings stigma to the family.” - MSD, Kaduna.

Weak enforcement of laws and limited access to survivor-centred services further contribute to gender-based violence. Although legal frameworks exist, stakeholders noted gaps in implementation, a lack of safe shelters, inadequate reporting systems, and insufficient psychosocial support. These institutional weaknesses reduce trust in formal systems and discourage survivors from seeking justice.

“Survivors have nowhere safe to go.” - MSD, Benue.
“Cases are rarely pursued through the legal system.”
- MSD, FCT.
“Reporting mechanisms are weak and poorly trusted.” - MSD, Enugu.

Regardless, economic vulnerability and dependency were highlighted as structural drivers that increase girls’ exposure to violence and limit their ability to leave abusive situations. Poverty, transactional relationships, and financial reliance on male partners or family members reduce girls’ bargaining power and reinforce tolerance of harmful treatment.

“Girls endure abuse because they depend financially on men.” - MSD, Lagos.
“Poverty forces girls into risky relationships.” - MSD, Oyo.
“Economic hardship limits options for leaving abusive situations.” - MSD, Nasarawa.

However, harmful masculinities and the early socialization of boys into aggressive gender roles also contribute to gender-based violence. Stakeholders described that boys are encouraged to display dominance, suppress emotion, and assert control, reinforcing behaviours that normalize coercion and violence in relationships.

“Boys learn that control shows strength.” - MSD, Edo.
“Harassment is seen as part of growing into manhood.” - MSD, Kaduna.
“Young males are encouraged to assert dominance over girls.” - MSD, Kano.

Norms

Patriarchal norms prevalent across states position men as authority figures and girls as subordinate, reinforcing the acceptance of male control and limiting girls’ autonomy. Stakeholders indicated that dominant social expectations

normalize male dominance within households and relationships, creating environments where coercion and violence are tolerated as expressions of authority rather than recognized as violations of rights.

“Men are seen as heads of households whose authority should not be challenged.” - MSD, Kano.

“Girls are expected to be submissive to male authority.” - MSD, Ebonyi.

“A woman is taught to endure rather than question male control.” - MSD, Edo.

Norms emphasizing silence and family reputation significantly influence responses to violence. Communities often prioritize preserving family honour over reporting abuse, reinforcing expectations that survivors remain silent to avoid shame or social stigma. This culture of silence perpetuates impunity and discourages help-seeking behaviour.

“Family honour is protected by keeping abuse private.” - MSD, Cross River.

“Speaking about sexual violence brings shame to the household.” - MSD, Kaduna.

“Families prefer silence to avoid community stigma.” - MSD, FCT.

Victim-blaming norms perpetuate gender-based violence (GBV) by shifting responsibility onto girls. Stakeholders noted that prevailing beliefs attribute abuse to girls' dress, mobility, or behaviour, while minimizing or justifying boys' actions. These norms discourage reporting and normalize harmful treatment.

“Girls are blamed for attracting attention.” - MSD, Nasarawa.

“Communities question what the girl did wrong.” - MSD, Enugu.

“Boys' behaviour is excused as natural.” - MSD, Kano.

Norms associated with masculinity shape expectations that boys demonstrate dominance, toughness, and emotional restraint. These beliefs discourage empathy and reinforce aggression as acceptable male behaviour, contributing to coercion and violence in adolescent relationships and peer interactions.

“A real man is expected to be strong and controlling.” - MSD, Kaduna.

“Boys are discouraged from showing emotions.” - MSD, Edo.

“Dominance is equated with masculinity.” - MSD, Lagos.

Cultural and traditional beliefs legitimize GBV by framing certain forms of violence as disciplinary or corrective. Stakeholders described that physical punishment, forced control, or coercion are often perceived as acceptable methods for maintaining order, morality, or obedience within families and relationships.

“Violence is seen as discipline within the family.” - MSD, Benue.

“Correcting a girl's behaviour may involve force.” - MSD, Adamawa.

“Control is justified to protect moral values.” - MSD, Oyo.

Key GEE Behavioural Patterns, Drivers and Norms Behaviours

In multiple states, girls' involvement in economic activities is predominantly marked by early entry into low-income and informal sectors. Stakeholders indicated that girls commonly participate in petty trading, hawking, domestic labour, and small-scale services to support household needs or address personal expenses. While these activities may provide immediate income, they frequently limit opportunities for skill acquisition and impede long-term economic advancement.

“Girls are pulled from school to hawk and support the family.” - MSD, Nasarawa.

“Most girls engage in petty trading rather than skill-building work.” - MSD, Oyo.

“Domestic labour and street vending are common among adolescent girls.” - MSD, Cross River.

Economic dependency emerged as a widespread behavioural pattern. Even when girls generate income, parents, guardians, or male partners generally retain financial decision-making authority. This arrangement restricts girls' autonomy and reinforces dependency as a social norm.

“Even when girls earn money, parents control how it is used.” - MSD, Benue.

“A girl's income is managed by her father or husband.” - MSD, Ebonyi.

“Girls are expected to rely on men for financial support.” - MSD, Lagos.

School withdrawal for income generation is closely linked to prevailing economic behaviours. Stakeholders observed that financial pressures often compel girls to discontinue their education to support household survival, thereby perpetuating cycles of limited educational attainment and constrained livelihood prospects.

"Parents withdraw girls from school to contribute financially." - MSD, Kano.

"Economic hardship forces girls to choose work over education." - MSD, Adamawa.

"Girls leave school early to support family income." - MSD, Kaduna.

Occupational segregation and restricted skill development were also evident. Girls are frequently steered toward traditionally feminine trades such as hairdressing, tailoring, food vending, and caregiving, while boys are encouraged to pursue technical or higher-earning fields. This practice perpetuates long-term income disparities and occupational inequality.

"Girls are trained in hairdressing while boys learn technical skills." - MSD, Enugu.

"Vocational training for girls focuses on low-income trades." - MSD, Edo.

"Communities steer girls toward 'safe' but low-earning jobs." - MSD, Oyo.

Unrecognized and unpaid labour further shapes girls' economic experiences. Stakeholders noted that girls make significant contributions to household work, caregiving, and family enterprises without acknowledgement or financial compensation, thereby reducing the time available for education, rest, or skill development.

"Girls handle most household chores without pay." - MSD, Benue.

"Caregiving responsibilities fall mainly on girls." - MSD, Cross River.

"Girls support family businesses without financial benefit." - MSD, Kaduna.

Drivers

Household poverty and economic insecurity are key determinants of girls' economic participation in some contexts. Stakeholders indicated that financial hardship often compels families to rely on girls' labour to supplement household income, prioritizing immediate survival over long-term investments in education and skill development. Under these conditions, girls' economic contributions are considered vital to family resilience.

"Economic hardship pushes families to rely on girls' income." - MSD, Nasarawa.

"Girls work to support household survival." - MSD, Adamawa.

"Poverty forces families to depend on girls' labour." - MSD, Kano.

Prevailing gender norms and expectations perpetuate economic dependency and limit girls' financial autonomy. Stakeholders noted that girls are socialized to depend on male providers, while boys are prepared for financial leadership. These norms influence household decisions related to resource allocation, education, and economic opportunities.

"Girls are raised to depend on men for financial security." - MSD, Ebonyi.

"Families invest in boys because they will become providers." - MSD, Edo.

"Economic independence is not expected of girls." - MSD, Kaduna.

Limited access to education and market-relevant skills further constrains girls' economic opportunities. Stakeholders emphasized that early school withdrawal, inadequate vocational training, and insufficient exposure to contemporary skills reduce girls' capacity to participate in higher-value economic sectors.

"Girls lack access to modern skills training." - MSD, Enugu.

"Limited education restricts girls' earning potential." - MSD, Oyo.

"Early school dropout limits future economic options." - MSD, Benue.

Institutional and structural barriers also impede girls' economic empowerment. Stakeholders identified limited access to credit, safe training environments, mentorship, and supportive policies as significant obstacles to the development of sustainable livelihoods.

"Girls have little access to credit or financial services." - MSD, Lagos.

"Safe training hubs and mentorship opportunities are limited." - MSD, Cross River.

"There are few programs supporting girls' economic growth." - MSD, FCT.

Safety concerns and mobility restrictions substantially limit girls' economic participation. Families often restrict girls' movement due to fears of harassment, violence, or reputational risk, which reduces access to training, employment, and market opportunities.

"Parents restrict girls' movement for safety reasons." - MSD, Kano.

"Fear of harassment limits girls' mobility." - MSD, Kaduna.

"Safety concerns prevent girls from pursuing opportunities." - MSD, Edo.

Norms

According to the stakeholders in this study, prevailing gender norms across states designate men as primary providers and girls as dependents, shaping economic role expectations from an early age. Stakeholders reported that girls are socialized to expect financial support from male relatives or future husbands, rather than to pursue economic self-reliance. These norms reinforce dependency and constrain aspirations for economic autonomy.

"Girls are raised to depend on men for financial security." - MSD, Ebonyi.

"A woman who relies on her husband is seen as well cared for." - MSD, Enugu.

"Men are expected to provide while women depend." - MSD, Kano.

Norms regarding appropriate work for girls significantly influence their economic trajectories. Communities frequently encourage girls to pursue traditionally feminine trades and discourage participation in technical, leadership, or higher-earning sectors. These expectations perpetuate occupational segregation and limit long-term earning potential.

"Girls are guided toward hairdressing and tailoring." - MSD, Edo.

"Technical trades are seen as unsuitable for girls." - MSD, Oyo.

"Communities steer girls into 'safe' but low-income jobs." - MSD, Kaduna.

Nonetheless, social expectations that prioritize domestic responsibilities over economic advancement further restrict girls' opportunities. Stakeholders observed that caregiving, household work, and support for family enterprises are regarded as natural duties for girls, thereby reducing the time available for education, skills development, or paid employment.

"Girls are expected to handle household chores first." - MSD, Benue.

"Caregiving responsibilities fall mainly on girls." - MSD, Cross River.

"Domestic duties take priority over girls' education or work." - MSD, Adamawa.

Norms that associate female respectability with modest economic ambition also affect girls' participation in income-generating activities. In certain communities, assertive economic behaviour or financial independence is perceived as inappropriate, discouraging girls from pursuing entrepreneurship or leadership roles.

"A girl who earns too much may be seen as disrespectful." - MSD, Nasarawa.

"Ambitious girls are sometimes viewed as challenging social order." - MSD, FCT.

"Economic independence in girls can be perceived as defiance." - MSD, Lagos.

Marriage expectations further reinforce norms of economic dependency. Stakeholders indicated that girls are frequently socialized to regard marriage as their primary source of financial security, thereby diminishing motivation to pursue long-term economic independence.

"Marriage is seen as a girl's economic future." - MSD, Kano.

"Parents prepare girls for marriage rather than careers." - MSD, Ebonyi.

"A girl's stability is expected to come through marriage." - MSD, Enugu.

Key SRH Behavioural Patterns, Drivers and Norms

Behaviours

From the multi-sectoral dialogue across states, widespread silence and secrecy surrounding sexual and reproductive health shape adolescents' information-seeking behaviours. Stakeholders noted that environments discouraging open discussion of sexuality force adolescents to rely on peers, media, or the internet for guidance. This dependence often results in misinformation and confusion about puberty, relationships, and safe practices.

"We avoid discussing sexuality with adolescents." - MSD, Nasarawa.

"Young people learn from friends instead of trusted adults." - MSD, Oyo.

"They rely on the internet because no one explains these issues." - MSD, Lagos.

Early sexual initiation and engagement in unsafe sexual practices were identified as recurring behavioural patterns. Stakeholders indicated that curiosity, peer influence, and limited access to accurate information contribute to sexual experimentation without sufficient knowledge of protection, increasing vulnerability to unintended pregnancy and sexually transmitted infections.

"Adolescents experiment sexually without understanding the risks." - MSD, Enugu.

"Peer pressure influences early sexual activity." - MSD, Edo.

"Girls engage in relationships without knowledge of protection." - MSD, Kaduna.

Evidence reluctance to seek sexual and reproductive health (SRH) services is another prevalent behaviour. Adolescents often avoid health facilities due to fear of judgment, concerns about confidentiality, or negative attitudes from providers. This avoidance limits their access to contraceptives, counselling, and treatment services.

"Girls fear being judged when they visit health facilities." - MSD, Cross River.

"Health workers question adolescents seeking condoms." - MSD, Benue.

"Lack of privacy discourages adolescents from seeking care." - MSD, FCT.

The use of unsafe or unreliable sources for sexual and reproductive health (SRH) solutions was also reported. Stakeholders described adolescents' reliance on traditional remedies, misinformation from peers, or unverified products when attempting to manage pregnancy risks or address sexual health concerns.

"Adolescents rely on unverified remedies shared by peers." - MSD, Kano.

"They use unsafe methods to prevent or terminate pregnancy." - MSD, Adamawa.

"Misinformation spreads quickly among young people." - MSD, Nasarawa.

Gendered behavioural expectations significantly influence sexual and reproductive health (SRH) decision-making. Girls are often expected to remain silent and passive regarding sexuality, while boys are encouraged to be sexually assertive. These expectations limit girls' ability to negotiate safe practices and increase their vulnerability to coercion and risk.

"Girls are expected to remain silent about sexual matters." - MSD, Ebonyi.

"Boys are encouraged to prove masculinity through sexual experience." - MSD, Lagos.

"Girls struggle to negotiate protection in relationships." - MSD, Kaduna.

Drivers

Sexual and reproductive health SRH challenges for adolescents in Nigeria result from strict cultural Limited access to comprehensive and accurate sexuality education emerged in several settings as a primary determinant of adolescents' sexual health behaviours. Stakeholders indicated that cultural discomfort, parental resistance, and inconsistent school-based implementation restrict access to reliable information. In the absence of

structured guidance, adolescents frequently turn to peers or media sources, which increases their susceptibility to misinformation and risky sexual decision-making.

"Sexuality education is avoided because parents may object." - MSD, Nasarawa.

"Schools skip sensitive topics to prevent controversy." - MSD, Oyo.

"Adolescents rely on peers when formal education is absent." - MSD, Lagos.

Cultural taboos and societal silence surrounding adolescent sexuality further contribute to negative sexual and reproductive health (SRH) outcomes. Stakeholders described dominant social norms that inhibit open discussion of puberty, relationships, and protective measures, leaving adolescents uninformed and unprepared to make safe decisions.

"Talking about sexuality is considered inappropriate." - MSD, Kaduna.

"Parents avoid these discussions out of cultural discomfort." - MSD, Enugu.

"Silence leaves adolescents to figure things out alone." - MSD, Cross River.

Stigma and judgment within health systems further discourage adolescents from accessing SRH services. Stakeholders reported that negative provider attitudes, inadequate confidentiality, and fear of recognition at clinics deter adolescents from seeking contraception, counselling, and testing services.

"Health workers question adolescents seeking contraceptives." - MSD, Benue.

"Fear of judgment prevents girls from visiting clinics." - MSD, FCT.

"Lack of privacy discourages adolescents from seeking care." - MSD, Edo.

Gender inequality and power imbalances significantly influence SRH decision-making. Stakeholders emphasized that girls frequently lack the agency to negotiate safe practices, while boys are often encouraged to demonstrate sexual assertiveness. These dynamics heighten vulnerability to coercion, unsafe sexual practices, and unintended pregnancy.

"Girls cannot insist on protection in relationships." - MSD, Ebonyi.

"Boys are encouraged to prove masculinity through sexual activity." - MSD, Lagos.

"Power imbalance limits girls' decision-making." - MSD, Kano.

Economic vulnerability and engagement in transactional relationships further exacerbate SRH risks. Stakeholders described how financial hardship may compel girls to enter relationships for material support, thereby increasing their exposure to unsafe sexual practices and exploitation.

“Poverty pushes girls into relationships for financial support.” - MSD, Nasarawa.

“Economic hardship increases vulnerability to transactional relationships.” - MSD, Adamawa.

“Girls exchange relationships for basic needs.” - MSD, Oyo.

In a nutshell, these findings indicate that adolescent SRH outcomes are shaped by intersecting factors, including limited sexuality education, cultural silence, stigma within health systems, gender-based power imbalances, and economic vulnerability. These conditions create environments in which adolescents lack the information, support, and agency needed to make safe and informed decisions.

Norms

Our findings show that entrenched cultural norms inhibit open discussion of sexuality with adolescents. Stakeholders reported widespread beliefs that conversations about sexual and reproductive health encourage promiscuity or undermine moral values. Consequently, silence is often regarded as protective, even though it leaves adolescents without reliable guidance.

“Talking about sex with young people encourages promiscuity.” - MSD, Kaduna.

“Parents avoid these discussions to preserve moral values.” - MSD, Enugu.

“Silence is seen as protecting children from immoral behaviour.” - MSD, Oyo.

Norms concerning sexual purity and respectability significantly shape expectations for girls' behaviour. In some communities, there is considerable emphasis on chastity, with expectations that girls remain uninformed and passive regarding sexuality. These norms deter girls from seeking information or services, even when health risks are present.

“A respectable girl should not discuss sexual matters.” - MSD, Ebonyi.

“Girls must remain pure and uninformed until marriage.” - MSD, Kano.

“Seeking contraception suggests immoral behaviour.” - MSD, Nasarawa.

Gender norms also contribute to unequal expectations for boys and girls. Stakeholders note that boys are often encouraged to explore sexuality as a marker of masculinity, while girls are expected to demonstrate modesty and restraint. These double standards perpetuate unequal power dynamics and increase girls' vulnerability to coercion and unsafe practices.

“Boys are expected to prove manhood through sexual experience.” - MSD, Lagos.

“Girls are taught to be modest and silent.” - MSD, Edo.

“Sexual freedom is tolerated for boys but condemned for girls.” - MSD, Cross River.

Norms within health systems and communities reinforce stigma associated with adolescent access to sexual and reproductive health (SRH) services. Adolescents who seek contraception or counselling are frequently perceived as immoral or disobedient, discouraging service utilization and perpetuating secrecy.

“Girls who request condoms are seen as wayward.” - MSD, Benue.

“Health providers assume adolescents should not be sexually active.” - MSD, FCT.

“Community members judge young people who seek SRH services.” - MSD, Kaduna.

Religious and traditional beliefs influence norms governing adolescent sexuality. In certain communities, religious teachings and customary values emphasize abstinence before marriage and discourage contraceptive use, shaping attitudes toward SRH education and services.

“Religious beliefs discourage discussion of reproductive health.” - MSD, Adamawa.

“Tradition promotes silence on sexual matters.” - MSD, Enugu.

Key HPV Vaccination Behavioural Patterns, Drivers and Norms

Behaviours

Finding revealed that HPV vaccine uptake among eligible girls remains low across states, with stakeholders reporting delayed acceptance, refusal, and incomplete vaccine schedules. Caregivers often hesitate to provide consent, and some adolescents miss school-based vaccination opportunities due to absence, parental refusal, or inadequate follow-up. These behaviours reflect uncertainty, limited awareness, and inconsistent delivery mechanisms.

"Many parents decline consent for the HPV vaccine." - MSD, Kano.
"Girls miss vaccination when parents refuse approval." - MSD, Kaduna.
"Some adolescents do not return for subsequent doses." - MSD, FCT.

Avoidance and passive resistance to vaccination were also observed. Stakeholders noted that caregivers may delay decisions, avoid interactions with health workers, or quietly opt out rather than openly refuse vaccination. These behaviours contribute to incomplete coverage and insufficient follow-through.

"Parents postpone decisions until the opportunity passes." - MSD, Lagos.
"Some families avoid vaccination teams entirely." - MSD, Nasarawa.
"Caregivers quietly opt out instead of refusing openly." - MSD, Oyo.

Peer and community influences significantly shape vaccination behaviour. Acceptance or refusal often spreads through social networks, as rumours and shared experiences influence parental decisions and adolescents' willingness to receive vaccination.

"Parents follow what other families decide." - MSD, Cross River.
"When neighbours refuse, others follow." - MSD, Edo.
"Community rumours influence acceptance." - MSD, Adamawa.

Drivers

Misinformation and concerns regarding vaccine safety emerged as primary drivers of low uptake. Stakeholders frequently report apprehensions that the vaccine may cause infertility, promote promiscuity, or result in unknown long-term effects. These fears significantly influence parental decision-making.

"Parents fear the vaccine will cause infertility." - MSD, Kano.
"Rumours say the vaccine affects future childbirth." - MSD, Enugu.
"Caregivers worry about hidden side effects." - MSD, Kaduna.

Limited awareness and inadequate communication about HPV and cervical cancer prevention further contribute to low uptake. Some caregivers lack understanding of the vaccine's purpose, benefits, and eligibility criteria, which diminishes their motivation to provide consent.

"Many parents do not understand what the vaccine prevents." - MSD, Benue.
"There is little awareness about cervical cancer prevention." - MSD, Oyo.
"Families lack clear information about HPV vaccination." - MSD, Nasarawa.

Health system and delivery challenges also affect vaccine uptake. Stakeholders identified gaps in community engagement, insufficient health worker training, and inconsistent school-based delivery as factors undermining trust and reducing coverage.

"Health workers need more training to address concerns." - MSD, Cross River.
"School-based delivery is inconsistent." - MSD, FCT.
"Community engagement before vaccination is limited." - MSD, Edo.

Norms

Norms linking vaccination to sexuality and morality influence acceptance. In some communities, the HPV vaccine is perceived as encouraging early sexual activity or indicating promiscuity, leading caregivers to hesitate in consenting for young girls.

"Some believe the vaccine encourages sexual activity." - MSD, Kano.
"Parents fear vaccination will promote promiscuity." - MSD, Kaduna.
"Immunization is seen as unnecessary for 'good girls.'" - MSD, Ebonyi.

Gender norms and decision-making hierarchies further influence acceptance. Fathers, elders, or male household heads often make health decisions, and mothers may lack the authority to provide independent consent. This structure can delay or prevent vaccination.

"Fathers often make final decisions on vaccination." - MSD, Nasarawa.
"Mothers cannot consent without approval." - MSD, Benue.
"Household heads determine health decisions." - MSD, Adamawa.

Trust in religious and community leaders shapes normative acceptance. Communities often seek guidance from these leaders, and their endorsement or scepticism can influence collective attitudes toward vaccination.

"Religious leaders' views influence acceptance." - MSD, Oyo.

“Community leaders shape trust in vaccination.” - MSD, Cross River.

“Families follow guidance from faith leaders.” - MSD, Enugu.

These findings indicate that HPV vaccination uptake is shaped by behavioural hesitancy, misinformation, limited awareness, challenges in health system delivery, and norms related to morality, gender authority, and community trust. Addressing these factors requires trusted communication, community engagement, and norm-sensitive strategies to enhance acceptance.

Cross-cutting behaviours

Multi-state consultations revealed a wide range of behaviours affecting adolescent girls across several thematic areas, including gender-based violence, child, early and forced marriage, economic empowerment, sexual and reproductive health, and HPV vaccination. Recurring patterns across these domains demonstrate how harmful norms, economic hardship, misinformation, and service delivery gaps interact to shape the risks, decisions, and opportunities available to girls. The findings indicate that addressing harmful behaviours requires more than awareness campaigns; coordinated efforts are necessary to strengthen institutional systems, expand access to safe and adolescent-friendly services, and support community-led transformation of harmful norms.

Silence and non-disclosure emerged as a cross-cutting behaviour across thematic areas. Survivors of GBV frequently avoid reporting abuse due to fear of blame, retaliation, or family shame. Adolescents rarely discuss sensitive topics such as sexuality, contraception, or menstruation with parents or trusted adults. Girls infrequently challenge forced marriage decisions or express concerns about vaccinations. This silence also extends to economic opportunities, where girls seldom question unequal access to education, training, or financial resources.

This reluctance to disclose or challenge harmful practices does not reflect simple passivity, but rather constrained agency within unequal social structures. Stakeholders noted that fear of stigma, social exclusion, punishment, and loss of family support discourages girls from speaking out. Economic dependence, restricted mobility, and exclusion from decision-making further limit their ability to resist harmful practices. Socialization processes that emphasize obedience, respect for authority, and conflict avoidance reinforce compliance. In this context, acceptance often serves as a protective coping strategy rather than genuine consent. Girls may accept family settlements in GBV cases, comply with marriage decisions, withdraw from school to support household

priorities, or remain silent in the face of misinformation to avoid social repercussions.

Risky coping strategies and peer influence further reinforce these dynamics. Peer pressure contributes to unsafe sexual practices, increasing the risk of unplanned pregnancy and sexually transmitted infections. Such pregnancies may lead to early marriage, perpetuating harmful cycles. Peer norms also shape spending behaviours and financial decision-making, sometimes discouraging saving or long-term planning. Fear of stigma and rumours can deter HPV vaccination, while misinformation about infertility, contraception, and reproductive health continues to influence decision-making. Misconceptions regarding girls' rights to inheritance and property ownership further undermine their confidence to pursue economic independence.

Consequently, these interconnected behaviours demonstrate how silence, constrained agency, peer influence, and misinformation function within broader structural and normative systems. Addressing these challenges requires integrated strategies that strengthen protective systems, promote access to trusted information, expand youth-friendly services, and support community-led norm change to create environments where girls can exercise voice, choice, and agency.

Cross-cutting drivers

The research identified several interrelated drivers of adolescent girls' well-being, many of which recur across thematic areas. These drivers illustrate how gender norms, economic hardship, misinformation, and institutional gaps collectively shape risks, including early marriage, violence, adverse health outcomes, and economic dependency. Addressing these challenges requires coordinated efforts to strengthen protective systems, expand safe, youth-friendly services, improve access to accurate information, and support community-led initiatives to transform social norms to safeguard girls' rights and well-being.

Patriarchal gender norms emerged as a central social and cultural influence. Stakeholders indicated that these norms normalize violence, associate girls' social value with marriageability, reinforce expectations of dependency, discourage open discussion of sexuality, and perpetuate harmful myths. Economic hardship and survival-driven family decisions further contribute to early marriage, economic dependence, engagement in hazardous or low-return work, and restricted access to sexual and reproductive health services, including HPV vaccination.

Silence, stigma, and fear of disclosure pervasively influence. Underreporting of gender-based violence (GBV), reluctance to seek sexual and reproductive health (SRH)

services, and avoidance of vaccination are reinforced by fears of blame, social exclusion, and reputational harm. Weak law enforcement and limited accountability mechanisms further undermine responses to GBV, perpetuate harmful marriage practices, restrict girls' economic participation, and erode confidence in health and protection systems. The absence of safe spaces and youth-friendly services limits support for survivors, diminishes girls' capacity to resist harmful practices, restricts access to skills training, and impedes adolescent-focused health outreach.

Misinformation and harmful myths exert significant influence on behaviours and decision-making. Misconceptions about contraception, infertility, vaccines, and gender roles contribute to fear and avoidance of sexual and reproductive health (SRH) services, reduced HPV vaccine uptake, reinforcement of victim-blaming attitudes, and justification of early marriage. Inadequate parent-child communication further restricts adolescents' access to accurate information, perpetuates silence around gender-based violence (GBV), limits financial guidance and economic decision-making, and influences parental choices regarding vaccination.

Peer and community pressure reinforce social expectations in multiple domains. Stakeholders indicated that social influence normalizes early marriage, perpetuates tolerance of violence, shapes financial behaviours, and contributes to risky sexual practices. Harmful peer group norms, such as substance abuse and exploitative social networks, were also reported to increase vulnerability to violence and sexual risk, while diminishing trust in health interventions. Furthermore, limited adolescent-focused education and outreach weaken prevention efforts,

restrict comprehensive sexual and reproductive health (SRH) knowledge, constrain economic empowerment opportunities, reduce HPV vaccine uptake, and perpetuate harmful practices.

These drivers interact within broader social, economic, and institutional systems. Their interconnectedness underscores the need for integrated responses that address structural inequalities, strengthen protective services, promote access to reliable information, and support community-led change to foster safer and more enabling environments for adolescent girls.

Across the study states, certain factors often influenced adolescent vulnerabilities. Patriarchal gender norms, economic hardship, silence around sexuality and violence, and widespread misinformation were common challenges. However, how these factors manifested differed by location. In conflict-affected and displacement settings, the struggle to survive increased risks of early marriage, exploitation, and disrupted access to important services. Rural communities experienced the influence of traditional authority, long-standing norms, and limited services, while urban and peri-urban areas encountered greater media exposure, economic instability, and the risks of transactional relationships. These differences suggest that while root causes may be similar, their effects and intensity vary depending on the environment.

Intersectional vulnerabilities

The study identifies intersecting vulnerabilities among very young adolescents in Nigeria, where overlapping social, structural, and institutional disadvantages increase their risk of harm. At this stage, adolescents rely on adults and institutions for information, protection, and essential services. Stakeholder discussions revealed that silence around sexuality, finances, and abuse, along with limited access to trusted guidance, often leaves adolescents to navigate complex risks with little support. Peer influence, social media exposure, and a lack of mentors further shape decision-making and heighten vulnerability to risky behaviours. VYAs are often excluded from economic empowerment and sexual and reproductive health initiatives, even as they face early transitions such as pregnancy, forced marriage, and school dropout. These findings highlight the need for age-responsive programs that offer life skills, safe spaces, mentorship, and peer support tailored to early adolescence (Fig. 2).

Adolescent girls with disabilities experience multiple layers of exclusion and increased risk of hidden violence. Stakeholders noted that stigma, overprotection, and social invisibility often lead to neglected sexual and reproductive health needs and limited access to protection. Safe spaces, inclusive health services, GBV reporting pathways, and livelihood programs are often inaccessible. In some cases, abuse is hidden due to assumptions

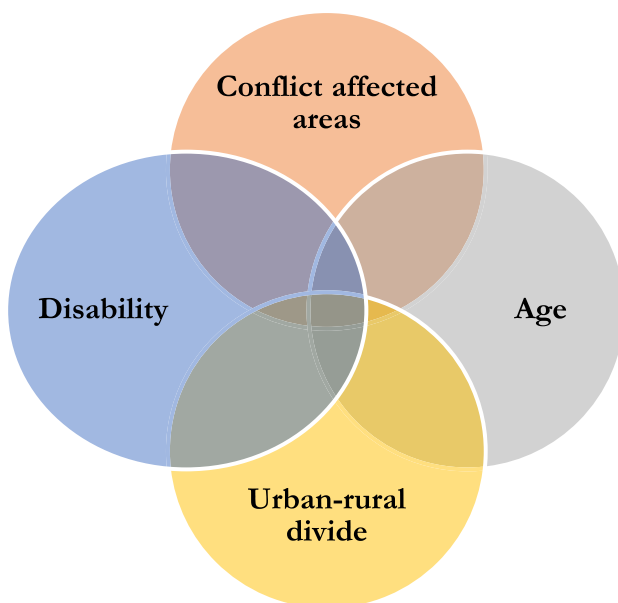


Fig. 2 Intersectional vulnerabilities

that girls with disabilities cannot report or will not be believed. These findings emphasize the need for disability-inclusive programs that ensure accessible SRH services, targeted GBV protection, and equitable economic opportunities.

In conflict-affected areas, including IDP camps in Benue and Nasarawa, adolescents face compounded vulnerabilities from poverty, insecurity, and disrupted social support. Stakeholders reported that survival pressures can lead to early marriage, while girls are at greater risk of exploitation, transactional sex, and gender-based violence. Limited access to reporting mechanisms, shelters, health outreach, and schooling restricts SRH information, HPV vaccination, and livelihood skills. Responses should prioritize mobile service delivery, peer support, and flexible cash or livelihood assistance to reduce vulnerability and strengthen protective networks.

Geographic context also shapes risk environments. In remote rural communities, patriarchal norms, early marriage traditions, and limited services restrict girls' choices, with traditional authorities strongly influencing expectations. In urban and peri-urban areas, girls face pressures such as media exposure, peer influence, and economic insecurity, which can lead to early sexual activity, unsafe work, or exploitation. While services may exist in urban areas, cost, stigma, overcrowding, and confidentiality concerns often limit access. Addressing these disparities requires context-specific approaches that

combine norm change with practical service delivery, such as community mediation and mobile outreach in rural areas, and safe, confidential, youth-friendly centers in urban settings.

Opportunities and strategic entry points for adolescents' wellbeing in Nigeria

The study demonstrates that achieving large-scale behaviour change to enhance adolescent wellbeing in Nigeria requires coordinated action across communities, institutions, and policy systems. Stakeholders emphasize the importance of trusted local leadership, effective service delivery systems, and clearly defined policy implementation frameworks that support adolescent protection, health, and development. Sustainable progress depends on empowering communities through long-term programming and strengthening connections to state, federal, and donor-supported resources (Fig. 3).

The findings identify strategic entry points for enhancing adolescents' access to information, protection, and economic opportunities. Schools serve as critical platforms for delivering age-appropriate sexuality education, financial literacy, gender equality messaging, and market-relevant skills. Peer-led clubs, mentorship programs, and school-based counselling units provide safe spaces for dialogue, support, and early referral. Faith-based institutions and traditional councils are essential channels for

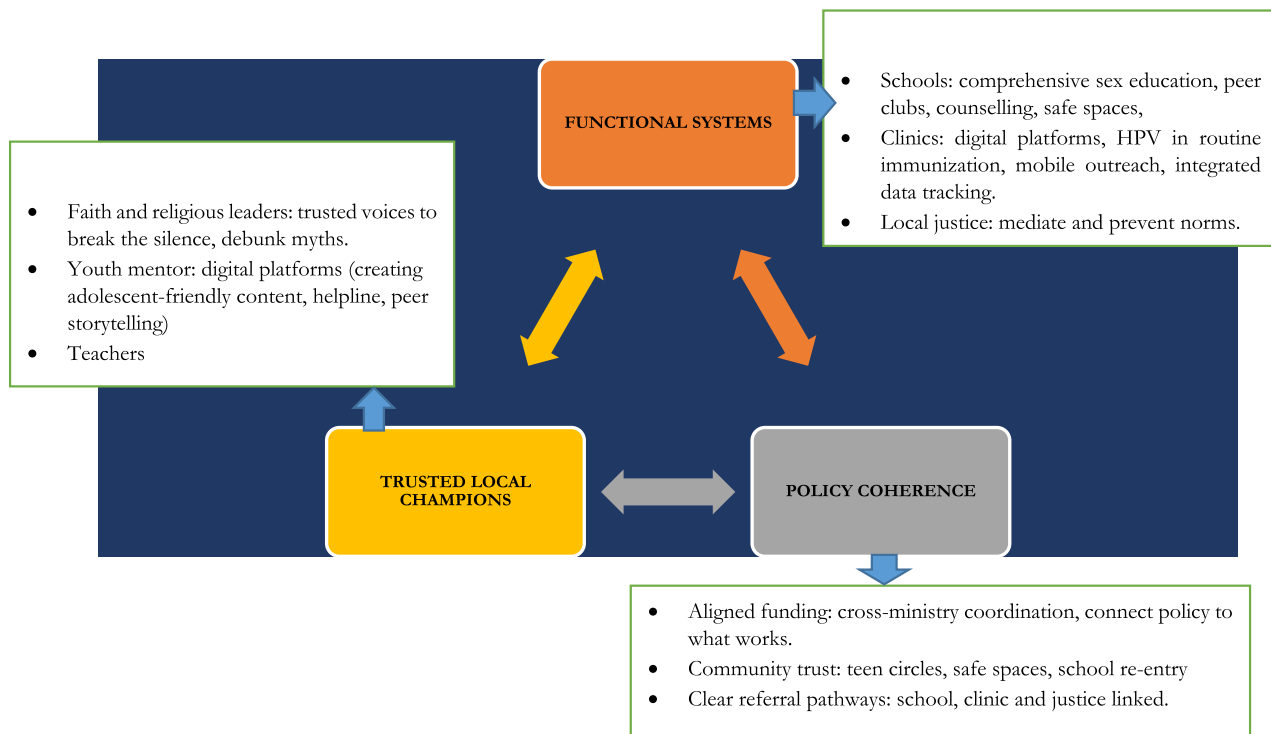


Fig. 3 Opportunities and strategic entry points for adolescent wellbeing

reaching households that are less accessible to formal systems; their leaders can challenge harmful norms, reinforce protective practices, and address misinformation. Nigeria's expanding digital ecosystem offers additional opportunities for youth engagement through helplines, moderated platforms, and peer-led storytelling that counters misinformation and promotes positive norms.

Stakeholders identified effective community-driven approaches that address harmful norms and strengthen protective environments. Women's cooperatives have facilitated financial literacy circles for adolescents, traditional leaders have intervened to prevent child marriage, and peer educators have established safe spaces in displacement settings. These locally grounded initiatives demonstrate how protective alternatives, trusted community networks, and adaptable support mechanisms can enhance resilience and promote normative change.

Encouragingly, several states are piloting coordinated initiatives with potential for scale. Benue has integrated HPV vaccination into routine immunization platforms. Cross River has strengthened referral pathways and layered support services for GBV survivors. Nasarawa and Ebonyi are localizing child protection laws through multi-stakeholder task forces and community accountability mechanisms. These state-level innovations suggest that coordinated, locally adapted approaches can strengthen service delivery, improve accountability, and support sustained behaviour change.

Discussion

This study, "Landscaping the behaviours, drivers, and norms influencing the well-being of VYAs: an exploration of stakeholders' perspectives in Nigeria," provides an in-depth look at the social factors affecting the health and lives of VYAs aged 10–14 across 12 Nigerian states. The findings confirm that harmful gender norms, socio-cultural expectations, and structural inequities strongly shape outcomes related to CEFM, GBV, GEE, SRH, and HPV vaccination [8, 23, 24]. While consistent with global evidence on adolescent vulnerabilities, they also highlight context-specific dynamics that require closer attention. The findings emphasize the urgent need to align existing national policy frameworks with practical actions and donor investments, noting that current donor resources may become scattered unless routed through trusted local systems. Additionally, strengthening coordination among different ministries is crucial for unifying messaging, addressing service gaps, and creating a consistent environment for protective behaviours.

In relation to CEFM: early pregnancies, parental neglect, and school dropout converge to heighten girls' risk of marriage. This parallels evidence from sub-Saharan Africa and South Asia, where economic survival and gender inequality drive families into early unions [25–27].

The Nigerian pattern of pregnancies outside marriage leading to rushed unions echoes findings from Ghana and Mexico, where family honour remains decisive [25, 28, 29]. By contrast, evidence from Mozambique and Bangladesh shows that higher educational attainment and shifting parental aspirations can delay marriage even in poor households [28, 30, 31]. Our results, therefore, point not only to poverty but also to weak school systems and limited parental investment as critical drivers. Comparative evidence from Ethiopia, India, and Malawi demonstrates that stronger school retention mechanisms substantially reduce early marriage risk [32–36].

Findings on GBV reveal widespread silence, limited parental supervision, and a lack of safe reporting spaces. These dynamics reflect patterns in Uganda and Nepal, where stigma and fears of dishonour deter disclosure [10, 37–39]. Our results also highlight community reluctance to discuss sexual matters, blurring the boundary between GBV and broader SRH vulnerabilities. Similar cultures of silence have been reported in conservative contexts, where sexuality remains shrouded in shame. Interventions from other settings show, however, that silence is not inevitable: confidential safe spaces and engagement with trusted leaders can begin to dismantle taboos and encourage reporting [40–42].

Regarding GEE, girls often leave school or miss opportunities so their brothers can advance, reinforcing a gendered division of labour where male siblings are expected to provide [43–45]. This mirrors findings from Ethiopia and India, where girls' education is frequently deprioritized. However, studies show that introducing social protection or conditional cash transfers leads households to prioritise girls' schooling [46]. This indicates that Nigeria's challenge is both cultural and economic, and that targeted incentives, combined with norm change strategies, could encourage greater investment in girls.

The study identifies high rates of unprotected sex, early pregnancies, STIs, and low contraceptive use, largely due to poor parent-adolescent communication and unwelcoming health services. This aligns with broader trends in sub-Saharan Africa, where communication barriers and unresponsive facilities limit SRH access [47–51]. Evidence from Latin America shows that comprehensive sexuality education increases contraceptive use and delays sexual debut [52]. In Nigeria, the National Sexuality Education Curriculum has had limited effect because of cultural resistance and inconsistent implementation [53]. Adolescents' distrust of health providers, seen as judgmental and unapproachable, is another barrier. This is similar to findings in Malawi and Zambia, but contrasts with Rwanda, where school-based health initiatives have built trust [54–58]. These comparisons indicate that Nigeria should pair education reforms with adolescent-friendly, community-based health services.

Results on HPV vaccination reveal alarmingly low uptake, driven by myths, misinformation, and parental consent requirements. Similar barriers are documented in Kenya and Zambia [14, 57–59]. However, Rwanda and Tanzania provide counterexamples, achieving high coverage through political commitment, school-based delivery, and intensive community mobilisation [60–62]. These contrasting reports show that low coverage is not inevitable: systemic reforms and trusted community engagement can dramatically improve uptake.

A striking feature of our findings is the relative uniformity of behaviours and norms across Nigeria, despite its cultural and ethnic diversity. This consistency reflects the pervasive influence of patriarchal gender norms and poverty, which cut across ethnic and religious divides [63, 64]. The perspectives of parents, teachers, health workers, CSOs, and community leaders reinforce this picture, highlighting that these vulnerabilities are perceived not as isolated problems but as systemic, multi-layered challenges. For example, some parents emphasized family honour, while teachers pointed to school dropout, yet both concerns converged on the same outcomes of early marriage, limited education, and constrained opportunities.

While there is convergence, the study also identified differences in how risks are experienced and managed. In conflict-affected and displacement settings, survival pressures and disrupted protection systems increased vulnerabilities to early marriage, exploitation, and limited-service access. Rural communities showed greater influence of traditional authority structures and ongoing service gaps, while urban and peri-urban environments saw more exposure to sexualized media, peer pressures, and transactional risks tied to economic instability. These variations do not contradict the shared structural drivers identified across states but instead show how local conditions shape how vulnerabilities emerge.

The study also identified recurring behaviours that cut across domains and frequently reinforce one another. School dropout consistently emerged as a gateway behaviour, heightening vulnerability to CEFM, reducing economic opportunities, and restricting access to accurate sexual and reproductive health information. Silence and non-disclosure in cases of GBV mirrored adolescents' reluctance to seek SRH services or vaccination, both shaped by stigma and fear of judgment. Early unprotected sex was directly linked to pregnancy, often triggering rushed marriages, interrupted schooling, and cycles of exclusion. These interconnected behaviours demonstrate that vulnerabilities rarely occur in isolation but cluster and intensify across multiple aspects of adolescent life.

Underlying these patterns are interconnected drivers. Patriarchal norms devalue girls' education, normalize

early marriage, silence discussions of sexuality, and reinforce expectations that men provide, producing a self-reinforcing system of exclusion. Poverty intensifies these dynamics, pushing families to prioritize boys' education or arrange early marriages as a survival strategy. Weak institutional systems (under-resourced schools, judgmental health services, and ineffective GBV response mechanisms) further exacerbate risks by failing to protect or empower adolescents. Misinformation and cultural taboos cut across domains, discouraging contraceptive use, limiting dialogue about GBV, and fuelling resistance to HPV vaccination. Once an adolescent becomes vulnerable in one area, he/she is likely to face compounded risks in others, highlighting how these drivers intersect to sustain cycles of disadvantage.

In summary, these results demonstrate that Nigeria's VYAs face both unique and globally recognized challenges. Where our findings align with international evidence (such as poverty-driven child marriage, silence around GBV, and vaccine hesitancy) they underscore the urgency of a coordinated policy action. Where contrasting evidence exists (such as the success of sexuality education in Latin America or higher HPV coverage in East Africa) they provide practical lessons for adaptation in Nigeria. Addressing these interlinked challenges requires coordinated, multi-sectoral interventions spanning education, health, justice, and community systems, as well as deliberate efforts to break cultural silences, strengthen accountability, and rebuild trust in institutions. Without such measures, cycles of vulnerability are likely to persist; with them, Nigeria can shift the trajectory of its youngest adolescents toward healthier and more empowered futures.

The multi-state stakeholder engagement and data synthesis offer valuable insights into the lives of adolescents, especially girls aged 10–14, in twelve different Nigerian states. However, it is important to recognize several limitations that should guide the interpretation of the findings. First, while qualitative stakeholder engagement adds depth to the research, it can also introduce biases. These biases include selection bias, social desirability, and the opinions of more vocal individuals. The perspectives captured may represent experiences from institutions, programs, or urban areas and may not fully reflect the lives of adolescents in remote or culturally conservative regions.

Additionally, due to time and resource limitations, the voices of adolescents, particularly VYAs aged 10–14, were not included directly at this stage of the research. Instead, the study relied on adult stakeholders, parents, community leaders, civil society members, and program implementers to provide insights on adolescent needs and vulnerabilities. This method limits the detail and authenticity of views centred on adolescents and

highlights the need for their direct involvement in future research. The absence of direct adolescent participants limited analysis of socio-demographic influences, future research will address this gap through ethically appropriate engagement with adolescents.

Conclusion

Nigeria's evolving socio-political and economic landscape, characterized by shifting policy priorities, changes in donor support, and emerging pressures such as humanitarian crises and disease outbreaks, demonstrates that the contextual conditions influencing adolescent wellbeing are dynamic. Consequently, these findings should be interpreted as contextually grounded insights rather than universally generalizable conditions.

Despite these limitations, the study identified stakeholders' perspectives on how prevailing norms related to child, early, and forced marriage; gender-based violence (GBV); sexual and reproductive health (SRH) knowledge and access; human papillomavirus (HPV) vaccination uptake; and restricted economic opportunities for girls present challenges to adolescent wellbeing across the states studied. These perspectives illustrate the ways in which harmful norms, misinformation, economic constraints, and service delivery gaps interact to shape risks and opportunities for adolescent girls. By elucidating these interconnected influences, this study provides an evidence-informed foundation for future research, integrated programming, and policy implementation to strengthen protective environments and expand opportunities for adolescent girls across diverse Nigerian contexts.

Implications for legal and policy interventions

Creating a protective and enabling environment for adolescents necessitates coordinated action across legal, policy, and service-delivery systems. Stakeholders emphasized the need to strengthen the implementation and enforcement of existing legal frameworks, including the Child Rights Act and the Violence Against Persons (Prohibition) Act, while improving coordination among federal, state, and community levels. Effective protection depends not only on legislation but also on consistent local enforcement, robust accountability mechanisms, and accessible reporting and referral systems.

The findings indicate that prevailing norms of silence and fear of stigma continue to undermine the effectiveness of protective laws and services. Concerns regarding blame, retaliation, or social exclusion discourage girls from reporting abuse, contesting forced marriage decisions, seeking sexual and reproductive health information, pursuing economic opportunities, or accessing vaccination services. Addressing these barriers requires policy and programmatic responses that prioritize

confidentiality, survivor-centered approaches, and trusted community-based reporting pathways.

As task forces and community mechanisms to prevent forced marriage and gender-based violence expand, stakeholders emphasized the necessity of integrating comprehensive sexuality education (CSE) into school curricula and ensuring its consistent implementation. Improving adolescent-friendly health services, expanding confidential counseling and referral systems, and strengthening school-to-service linkages are essential for increasing access to sexual and reproductive health information, HPV vaccination, and psychosocial support. Legal and policy responses should also address structural barriers to girls' economic participation and protection. Advancing girls' economic rights, reinforcing social protection measures, and ensuring safe access to education and skills training can reduce vulnerability to early marriage, exploitation, and dependency. Furthermore, services must be inclusive and accessible to adolescents with disabilities, including accessible health facilities, adapted communication materials, and tailored protection mechanisms. Ultimately, strengthening legal and policy frameworks must be complemented by efforts to create environments in which adolescents can safely access services and exercise their rights without fear or stigma. This includes community engagement to shift harmful norms, reinforcing accountability systems, and ensuring that protective policies are translated into practical, accessible support for adolescents across diverse contexts (see Fig. 4).

Implications for behaviour change communication initiatives

Effective social and behaviour change communication (SBCC) is critical for addressing harmful gender norms, misinformation, and the culture of silence that restricts adolescents' access to protection, health services, and opportunities. Stakeholders emphasize that communication strategies should be locally grounded and delivered through trusted sources, including community leaders, youth mentors, peer educators, and survivor advocates, to enhance credibility, reduce stigma, and foster trust.

SBCC initiatives should leverage trusted platforms, including schools, faith-based institutions, community radio, and social media, to facilitate open family dialogue on sexual and reproductive health, the risks of child, early, and forced marriage, and the benefits of HPV vaccination. Messaging must address prevalent parental concerns and misconceptions, such as fears regarding fertility and vaccine safety, while promoting informed adolescent participation in health-related decision-making.

Community dialogue and peer-led storytelling can prompt families to reconsider harmful beliefs and to adopt protective norms. To translate awareness into

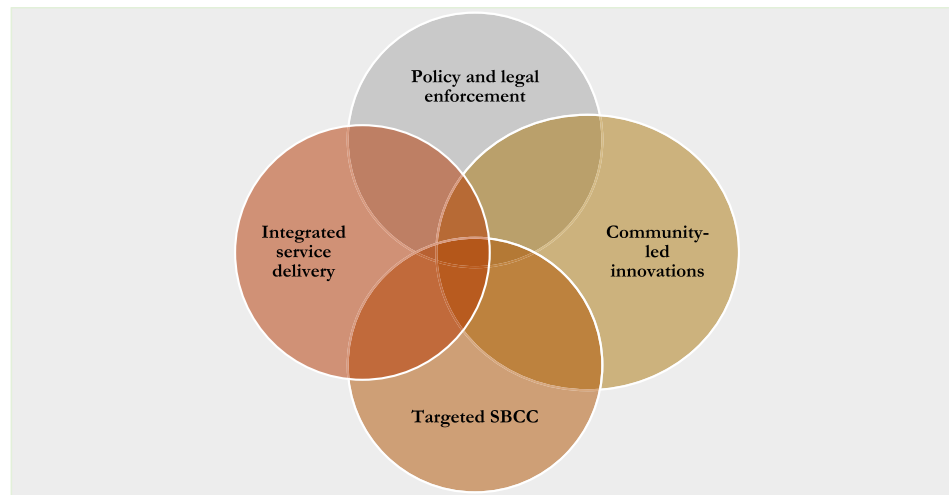


Fig. 4 Implications for legal and policy interventions

action, SBCC efforts should be linked to clear referral pathways, ensuring that information is accompanied by accessible adolescent-friendly health services, protection mechanisms, and support systems.

Communication approaches should be age-appropriate, culturally responsive, and grounded in rights-based information addressing sexual and reproductive health, gender-based violence prevention, child marriage risks, and girls' economic empowerment. Nigeria's expanding digital landscape presents further opportunities to engage adolescents through moderated platforms, helplines, and peer-led digital storytelling that promote healthy decision-making and counter misinformation. Strengthened SBCC efforts can foster safer and more supportive environments by encouraging open dialogue, reducing stigma related to reporting abuse and seeking services, and building community trust in protective systems.

The coexistence of cross-state similarities and contextual variation underscores the importance of combining nationally coordinated norm-change and service strengthening efforts with locally adapted approaches that respond to conflict exposure, urbanization pressures, and rural service constraints.

Implications for integrated service delivery models

The findings demonstrate that challenges affecting adolescent girls are interconnected and require coordinated service delivery rather than isolated interventions. Stakeholders highlighted the significance of integrated models that offer comprehensive support by linking protection, health, education, and economic strengthening services. These approaches facilitate connections between GBV survivor support, such as safe shelters, legal assistance, psychosocial care, and referral mechanisms, and adolescent-friendly health services and economic

empowerment initiatives to ensure continuity of care. Enhancing adolescent-friendly health services remains a priority, particularly to guarantee confidential access to sexual and reproductive health information, counselling, and HPV vaccination. School platforms present strategic opportunities to broaden service reach through coordinated health outreach, integration of HPV vaccination into school-based delivery schedules where feasible, and the creation of peer-led clubs and counselling units that offer safe spaces for dialogue, early support, and referral.

Mobile and outreach services are critical for reaching marginalized populations, including out-of-school adolescents, those in rural communities, and adolescents in conflict-affected or displacement settings. Flexible service delivery models can improve access to health services, protection mechanisms, skills training, and economic opportunities for populations that may be excluded from facility-based services. Strengthened coordination across sectors at the state and local levels is essential to ensure comprehensive, accessible, and responsive services. Multi-sector collaboration spanning health, education, social protection, justice, and community structures can improve referral systems, reduce service fragmentation, and support sustained improvements in adolescent well-being across thematic areas.

Implications for future research and programme design

The behavioural mapping findings have important implications for future research and program design. The results highlight the need for evidence-informed programming that integrates context-specific insights into behaviours, drivers, and norms to develop interventions addressing the root causes of gender inequality. Future initiatives should move beyond single-issue approaches and implement integrated strategies that address the interconnected effects of harmful norms, economic

hardship, misinformation, and inadequate institutional responses.

Programs should prioritize age-responsive approaches that address the developmental needs and vulnerabilities of VYAs (10–14 years), a group often overlooked in service provision yet subject to early transitions that influence long-term wellbeing. Interventions must be accessible, protective, and developmentally appropriate for this population. The findings also highlight the importance of strengthening local ownership and sustainability. Community-led approaches, engagement with trusted local leaders, and support for youth champions can facilitate norm change and enhance community accountability. At the same time, programs should reinforce system linkages across sectors to ensure that awareness initiatives are supported by accessible services and protection mechanisms. Future research should build on these findings by examining the evolution of norms over time, evaluating the effectiveness of integrated interventions, and identifying strategies to improve adolescent access to services in diverse contexts. Strengthening monitoring, evaluation, and learning systems is essential for tracking changes in norms, behaviours, and service utilization, and for informing adaptive programming. Sustained progress will require continued attention to policy implementation and accountability to ensure that existing protective laws and adolescent-focused policies translate into accessible and effective services and safeguards at the community level.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

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Authors' contributions

Osasuyi Dirisu provided overall leadership for the study, contributed to the conceptualization, design, interpretation of findings, and critically reviewed the manuscript for intellectual content and appropriateness. Emmanuel Nwala, Isaac Oritogun, and Akinwunmi Akinola contributed to the conceptualization and design, led data collection, analysis and interpretation,

and Emmanuel drafted the manuscript. Jane Ohiogame, Oluseyi Anwo, Oladunni Adenuga, Busola Oni, Bukola George, Niyi Adekanla, and Manasseh Ibrahim contributed to data collection and analysis. All authors read and approved the final manuscript.

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Data availability

All data supporting the findings of this study are available within the paper and its supplementary information. See Tables 1–15 for details. The authors are also available to provide all transcripts, audio files, tools and materials used in this research. However, the researchers developed the tool for this research and uploaded this as a supplementary file (see consultative workshop tool). The authors declare that the tool has not been published before or elsewhere.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was obtained from the National Health Research Ethics Committee (NHREC) of the Federal Ministry of Health (NHREC/01/01/2007-08/08/2025). This shows the study's commitment to national and international standards (Helsinki Declaration) for research involving human participants. Participants were purposively chosen based on their relevance to the study's focus and their ability to provide valuable insights into adolescent and gender norm issues related to CEFM, GBV, WEE, SRH, and HPV vaccination. Prior to data collection, letters seeking consent to participate in the workshops were sent to the prospective participants and only those who provided feedback and indicated interest to participate were invited. During the workshop, oral and written informed consent was obtained from the participants prior to data collection. Participation was completely voluntary and went through a strong informed consent process. This ensured that individuals fully understood the study's goals and how their contributions would be used, and only those who consented to the study were included. To address the risks of discussing sensitive topics, facilitators created a safe and supportive atmosphere. They made it clear that individual responses would remain anonymous unless permission was given. Consent forms and information sheets helped promote participant choice and build trust. Strict confidentiality rules were followed during data collection. While interactive tools like breakout sessions and dot-voting encouraged involvement, any identifying information was anonymized or used only with consent. Audio recordings and field notes were kept secure and accessible only to authorized research staff for analysis. Findings were reported in summary form to protect individual identities.

These ethical measures, including data protection, voluntary participation, and confidentiality, complied with the Nigeria Data Protection Regulation (NDPR) and upheld the principles of beneficence, justice, and respect for individuals. This ensured that participants' rights, safety, and dignity were fully protected throughout the research process.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

¹Policy Innovation Centre, Abuja, Nigeria

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