POLICY BRIEF:

Gender Norms and Very Young Adolescents' wellbeing in North-West Nigeria: Emerging Insights for Policy and Programming

POLICY INNOVATION CENTRE

Background and Rationale

Adolescence is a critical transition period during which investments in health and wellbeing shape immediate outcomes for a healthy adulthood (Federal Ministry of Health, 2007). For Very Young Adolescents (VYAs) aged 10-14, this period is a critical window during which gender norms exert strong influence on their access to education, information, and health services. Specifically, norms around adolescent wellbeing shape caregivers' responses to Reproductive Health (RH) services, including hesitancy toward puberty education and HPV vaccination (Ogunleye, Adeoye, Musa, 2023). These norms further shape their exposure to gender-based violence, early marriage, and pregnancy (UNICEF, 2023; APHRC, 2023). In Kano State, these dynamics are defined by entrenched cultural and social norms that restricts girls' mobility and schooling, contributes to early marriage, and normalizes unequal power relations within local communities (Uroko, 2025; CARE, 2024). For example, in 2021, 39% of women in Kano were married before age 18 (UNICEF, 2021).

Recognizing the need to address these normative barriers, the state has committed to adolescent wellbeing through institutionalization of the Child Protection Law (UNICEF, 2021), Adolescent Youth-Friendly Health Services (Ibrahim, 2025), the 2021–2025 Development Plan, and the SBCC strategy for RMNCAH+N communication (Historica Nigeria, 2025) Despite these frameworks, systemic implementation gaps remain. To bridge this gap between policy and impact, complementary norm-transformative strategies are essential.

The Social Norms Exploration (SNE) conducted as part of the Nigeria Survey on Gender Norms, Health, Attitude and Wellbeing Project provides critical community-specific insights needed to ensure Kano state achieves her potential for VYAs. This brief provides evidence on how social and gender norms affect the health outcomes and wellbeing of VYAs across Early Marriage (EM), Gender Based Violence (GBV), Reproductive Health (RH), Human Papilloma Virus vaccination (HPVv), and Women Economic Empowerment (WEE), and the reference groups that influence their decisions. The findings offer actionable insights to strengthen the implementation of Nigeria's National Gender Policy and Adolescent Health Policy in Kano state, guiding more effective interventions to shift harmful norms and advance SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), and SDG 5 (Gender Equality).

Methodology

The Social Norms Exploration (SNE) study adopted a qualitative, participatory design across six Nigerian states (Adamawa, Benue, Ebonyi, Edo, Kano, and Lagos). In Kano, the study engaged participants through consultative workshops with community stakeholders (40 participants), social network mapping (SNM) with VYAs (60 participants), Focus Group Discussions (FGDs) with parents/caregivers (12 FGD sessions), and in-depth interviews (IDIs) with reference groups (15 participants). Data collection instruments included participatory community dialogue guides, the polling booth survey, vignette-facilitated FGD and IDI guides. Ethical approval was obtained from Kano State Health Research Ethical Unit (SHREC), with informed consent and assent procedures in place, alongside a comprehensive child protection and referral protocol. Research data were securely managed and field notes were analysed thematically, to ensure depth and contextual understanding of the gender norms influencing VYAs' health outcomes.

3.0 Thematic Findings (Early Marriage, GBV, RH, HPVv, WEE)

Analysis of five key areas shows a normative landscape in transition: entrenched harmful practices are increasingly contested by new attitudes and behaviors, with the pace and acceptance of positive shifts markedly higher in urban and semi-urban settings compared to rural and Fulani communities. Early marriage is sustained by norms linking obedience and honor, but faces an emerging trend of delay until 18+ as a result of education, health risk awareness and extreme resistance, including self-harm. Gender-based violence remains widely underreported due to stigma, victim-blaming, and forced marriage to perpetrators, countered by growing demands for clinical treatment, accountability, and increased reporting of boys' abuse. On reproductive health, culture of silence persists but is increasingly challenged as girls access information through schools, mothers and media. HPV vaccination uptake is hindered by misinformation and paternal control, with mothers emerging as key influencers for acceptance. Finally, economic empowerment for girls is often deprioritized, though financially independent girls are praised as role models, even as this leads to delayed marriage.

Thematic Areas	Normative	Non-Normative	Transitional Norm	Sanctions	Key Reference Groups
Early Marriage	Early marriage is associated with preserving family honour, while obedience and submissiveness are viewed as qualities of a "good daughter." Puberty is often interpreted as readiness for marriage.	Poverty, limited access to education, and economic hardship contribute to early marriage practices. Rising marriage costs and mediation efforts by institutions such as Hisbah can delay or prevent forced marriage.	There is increasing resistance among girls to forced marriage due to increased awareness of the dangers of early marriage. Growing urban disapproval of both early and forced marriage practices.	Girls who delay marriage may face Backlash in the society Some rural and Fulani communities continue to positively reinforce early marriage practices as socially and culturally acceptable. Forced marriage is increasingly criticized in urban settings.	Parents; Community Elders; Religious leaders.
GBV	Within many communities, silence surrounding GBV is frequently upheld as a means of preserving family reputation, while expressions of male aggression are often treated as socially acceptable or culturally normative In some contexts, survivors are pressured into marrying perpetrators to "restore" family honour at the expense of their dignity, safety, and autonomy.	High reporting costs, weak justice systems, and poor access to health services shape responses to GBV cases.	Reporting rape and GBV cases is becoming more accepted, and communities are increasingly seeking formal medical care rather than relying solely on traditional remedies.	There is widespread victim-blaming of survivors, social isolation of individuals who report or speak openly about violence, and social respect often accorded to families that conceal such cases to protect their reputation. Survivors may experience victim-blaming, stigma, and social isolation, while families that conceal incidents may receive social respect.	Parents, community leaders
RH	Modesty, silence, and shyness are valued traits for girls, while mothers are expected to guide daughters on reproductive health matters.	Availability of school-based RH programs, menstrual products, and safe spaces influences access to RH information and services.	Girls are becoming more open about discussing bodily changes, and mothers are increasingly providing RH guidance to daughters.	Open discussion of RH issues may attract ridicule, while silence is morally approved. Seeking information from mothers and teachers is becoming more accepted.	Mothers, teachers, siblings, friends

HPVv	Fathers are commonly regarded as primary decision-makers for vaccination consent. Fears of infertility and harm influence perceptions of the vaccine.	Awareness gaps, trust in health systems, availability of vaccination services, and incentive-based uptake affect vaccine acceptance.	Mothers are gradually gaining greater agency in vaccination decisions, alongside growing cautious acceptance of HPV vaccination.	Girls and mothers may face criticism for bypassing paternal consent. There are generally no strong penalties attached to vaccine acceptance or refusal.	Fathers, mothers, health workers, religious leaders
WEE	Fathers are often expected to decide on girls' education and skills development. Obedience to parental decisions on skills and education is associated with good upbringing.	Exorbitant schooling costs, limited empowerment opportunities, and weak mentorship structures influence women's economic participation.	Support for girls' education is increasing due to a high level of awareness of the importance of education. Women's economic participation is becoming more socially accepted.	Girls who comply with their parent's demand to get married are respected within the communities, while economically independent women may receive praise and experience delayed marriage opportunities.	Parents, community elders

Cross-Cutting Insights

The study reveals that harmful norms are sustained not in isolation, but through an interconnected system. The table below summarizes the core components of this system and how they interact across all thematic areas to constrain girls' wellbeing.

Crosscutting Factors	How it Works	Impact Across Thematic Areas
Gendered Power Structures	· Decision-making power is concentrated among parents (especially fathers), elders, and religious authorities. · Girls' agency is relational and expressed through negotiation, not autonomy.	· Parents are the primary determinants of marriage timing of their children. · Survivors are encouraged to tolerate GBV so as to protect family reputation · Parents dictate RH/HPV access. · There are also limited economic choices available to adolescents.
Social Reinforcement & Sanctions	· Community approval and disapproval, like gossip, praise, stigma, or exclusion, determine normative boundaries for VYAs.	· Early marriage is rewarded in context where where adolescedolescents do not objets do not object to the marr to the marriage prage proposal.Wheposal. · When survivors report GBV, they may face sanctions in their communities. · Open RH discussions are often frowned at, and community criticizes bypassing paternal authority for HPV vaccination and other RH services · Community also praises girls who are not educationally over ambitious.

Education and Exposure as Levers for Shifting Norms	· Culture of silence and expected modesty restricts open discussion around GBV, early marriage and RH.	· Education and increasing awareness of the negative impact of early marriage is positively shifting norms by increasing community acceptance of delayed marriage. · Awareness of reporting channels is gradually transforming silence around GBV into reporting and accountability, · Community health outreaches are improving RH knowledge and health service uptake, including HPV vaccination · and redefining the value of girls' education and economic participation.
Intersection between the five thematic areas	· Gendered power structures and sanctions form a self-reinforcing cycle across all thematic areas · Power dynamics creates the rules for adhering to the norms. · Education and exposure are the primary levers that disrupt the negative norms cycle by providing the knowledge, alternative role models, and social proof needed to reshape community expectations.	· A girl's lack of education and limited economic empowerment (WEE/Power) reduces her access to reproductive health (RH) knowledge and decision-making agency, which increases the likelihood of early marriage (EM). Early marriage further heightens her vulnerability to gender-based violence (GBV) and silence around abuse, thereby reinforcing cycles of disempowerment and exclusion. · Investing in education disrupts this chain, empowering girls to delay marriage, seek health services, and report abuse.

Policy and Programmatic Implications

01. **State Government:** Weak enforcement of laws and policies related to child marriage, GBV, and adolescent health continues to sustain harmful social norms and practices. State governments should strengthen enforcement mechanisms, improve accountability systems, and promote multi-sectoral coordination within state development and planning frameworks. In addition, statewide communication and social behaviour change initiatives should promote delayed marriage, adolescent wellbeing, girls' protection, and positive gender norms.

02. **Health Sector:** Stigma, misinformation, weak referral systems, and inadequate GBV response mechanisms continue to limit adolescents' access to reproductive health (RH) and HPV-related services. Health policies and programmes should ensure strict adherence to adolescent-friendly service protocols and GBV referral standards, while strengthening the capacity of health workers through training on stigma-free counselling, survivor-centred care, confidentiality, and effective community outreach. Greater investment is also needed in adolescent-responsive health education and service delivery systems.

03. **Education Sector:** Limited access to puberty and reproductive health education, weak safeguarding structures, and inadequate hygiene and sanitation support in schools increase girls' vulnerability and school drop-out. Schools should integrate age-appropriate RH and life-skills education into curricula, strengthen safeguarding and GBV reporting mechanisms, and provide functional WASH facilities that support girls' dignity and retention in school. Teachers should also be equipped as positive norms influencers, while safe spaces and clubs for very young adolescents (VYAs) are established to build confidence, agency, and peer support.

04. **Traditional & Religious Institutions:** Social norms that reinforce early marriage, silence around GBV, and restrictions on girls' mobility and decision-making remain deeply rooted within many communities. Traditional and religious institutions should support faith- and culture-sensitive guidelines that promote girls' education, wellbeing, and protection. Religious and community leaders should be actively integrated into community wellbeing platforms, where they can lead dialogues, challenge harmful misconceptions, support mediation and referral pathways, and strengthen community-based protection and accountability systems.

05. **Development Partners:** Progress in normative change remains uneven despite promising gains in areas such as girls' education continuation and adolescent engagement. Development partners should align interventions with local priorities and existing systems, while sustaining investments in social norms analysis, gender-transformative programming, and evidence generation. Greater support is needed for VYA-focused interventions, CSO capacity strengthening, multimedia RH education campaigns, girls' empowerment initiatives, and integrated approaches that address the interconnected drivers of GBV, early marriage, and adolescent vulnerability.

Recommendations

01. State Government should mainstream social norms for responsive programming within existing Kano State frameworks (State Development Plan, SBCC Strategy, AYFHS) by integrating adolescent wellbeing interventions that promote positive gender norms.

02. Parents and Religious Leaders should be engaged as primary gatekeepers of change through structured dialogue and capacity building sessions that emphasize positive parenting, girls' education, and responsible masculinity.

03. Community Actors including Civil Society Organizations and Non-governmental Organizations should expand safe, trusted spaces for VYAs, particularly girls, by establishing/strengthening mentorship clubs, peer support groups, and psychosocial services where they can access age appropriate RH information without fear of stigma or punishment.

04. Ministry of Education and School Administrators should strengthen schools as protective and transformative spaces by mandating puberty and RH education, improving WASH and menstrual hygiene facilities, and enforcing safeguarding and referral mechanisms within the school system.

05. Health Workers, Teachers, Religious Leaders, and Local Media should scale targeted community sensitization by using trusted messengers to counter misinformation on HPV vaccination and girls' education through outreach, sermons, and media campaigns.

06. Schools and Community Platforms should integrate gender transformative skills and financial literacy programmes for VYAs by embedding life skills in curricula, running community workshops, and projecting empowered girls as role models within communities.

07. State Government, Ministries (Health, Education, Women Affairs), Civil Society, and Religious Institutions should improve cross sector coordination and accountability by establishing a state level adolescent wellbeing platform that links services, tracks progress, and ensures joint action across sectors.

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