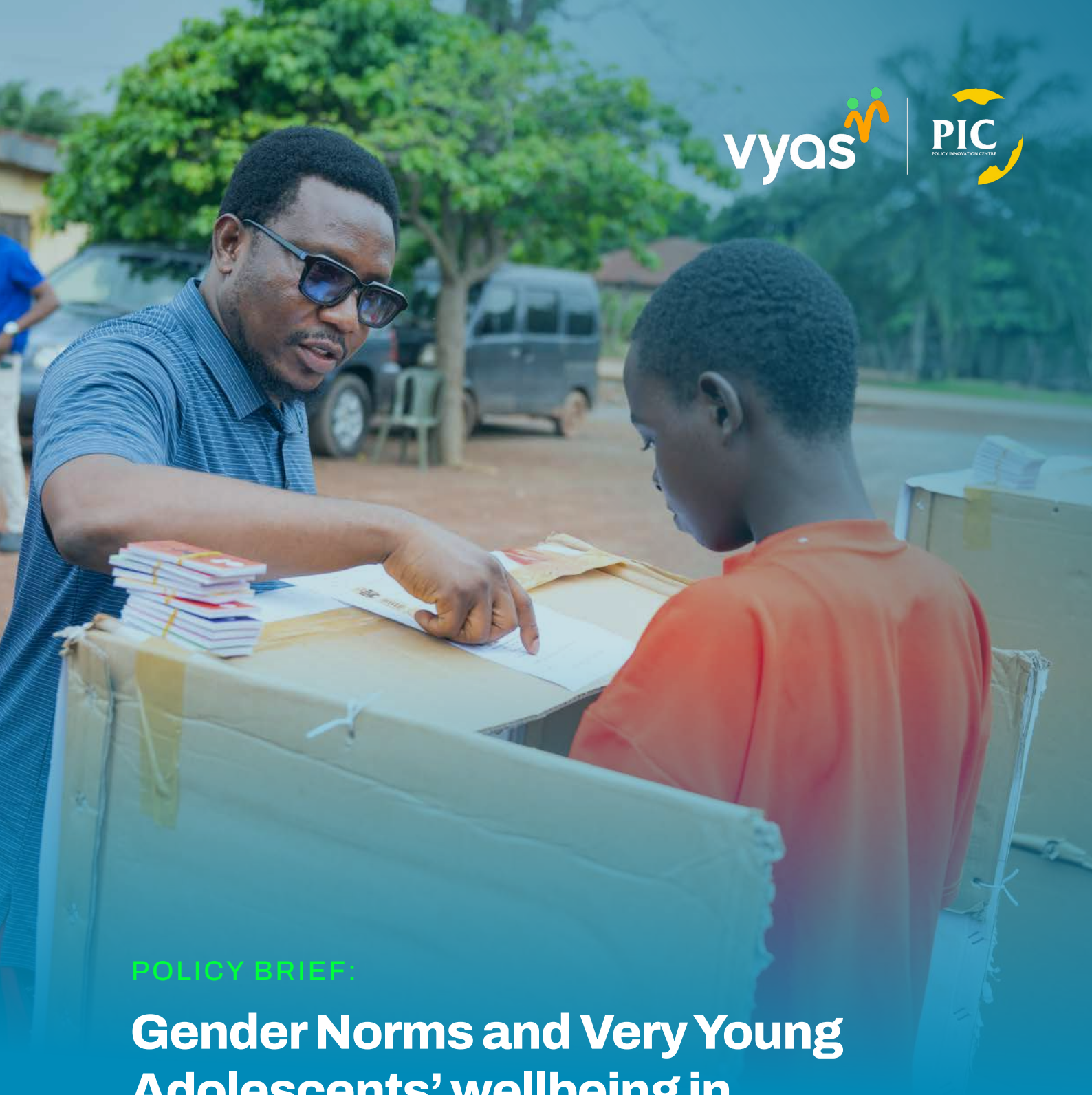

POLICY BRIEF:

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

POLICY INNOVATION CENTRE

Executive Summary

This policy brief aims to shape policies that will improve the health, protection, and wellbeing outcomes of very young adolescents (ages 10–14) in Ebonyi State by addressing the gender norms that influence decisions during early adolescence. Evidence shows that social expectations and informal sanctions influence exposure to gender-based violence, access to sexual and reproductive health information, HPV vaccination uptake, and early pathways into economic participation. Despite strong legal and policy frameworks, limited attention to these norms weakens implementation and sustains harmful practices. The brief proposes practical, norm-responsive actions to align policy with community realities and strengthen outcomes for very young adolescents.

Background and Rationale

Across Nigeria, gender norms shape key decisions in the lives of Very Young Adolescents (VYAs aged 10–14). These norms affect girls in particularly, increasing their risk of child early and forced marriage (CEFM), gender-based violence (GBV), access to reproductive health information, and limited educational and economic opportunities (UNICEF Nigeria, 2024). Early adolescence is a critical stage when these norms become internalized and begin to shape life trajectories (Mastorci, et al. 20224). Despite this, very young adolescents are largely overlooked in policy design and implementation, leaving harmful practices unaddressed and limiting the effectiveness of existing legal and programmatic frameworks (Federal Ministry of Health, 2011).

In Ebonyi State, available evidence reflects these risks. Even though early child marriage is uncommon, gender-based violence is prevalent, and social stigma continues to limit access to sexual and reproductive health information and services (NPC & ICF, 2024). Awareness and uptake of the HPV vaccine remain low, as social norms and structural barriers continue to limit the health, protection, and wellbeing of very young adolescents (NPC, & ICF, 2024). To address these concerns, Nigeria has established strong national frameworks such as the National Gender Policy and National Adolescent Health Strategy.

In addition, Ebonyi State has adopted relevant policies and laws, including the Ebonyi State Strategic Health Development Plan II, the Annual Operational Plan of the Ebonyi State Primary Health Care Development Agency, the Primary Health Care Human Resources for Health Policy, the Violence Against Persons (Prohibition) Law, and the Law on the Abolition of Harmful Traditional Practices against Women and Children (USAID, 2021). However, implementation across these frameworks has largely emphasized service delivery and legal enforcement, with limited engagement of household- and community-level norms shaping decisions during early adolescence.

Against this background, 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 Ebonyi state achieves her potential for VYAs. The brief provides evidence on how social and gender norms affect the health outcomes and wellbeing of VYAs across Child Early and Forced Early Marriage (CEFM), 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 in Ebonyi State.

Methodology

This brief is informed by a qualitative gender norms study conducted in Abakaliki, Ohaozara, and Ezza South LGAs in Ebonyi State among very young adolescents (VYAs) aged 10–14 years. Using a social norms mapping approach, the study identified parents and caregivers as the primary influencers of adolescent decision-making, alongside teachers, religious and traditional leaders, and health workers.

Data collection involved consultative engagements with community stakeholders, social norms mapping exercises with VYAs, focus group discussions (FGDs) with parents and caregivers, and in-depth interviews (IDIs) with key community influencers and reference groups. The study employed participatory community dialogue guides, polling booth surveys, and vignette-facilitated FGD and IDI tools to examine prevailing norms, expectations, and informal sanctions shaping adolescent wellbeing and health outcomes.

The research was conducted with appropriate ethical safeguards, including informed consent and assent procedures, confidentiality protections, and child safeguarding protocols. Data were securely managed, while field notes and interview transcripts were analysed thematically to ensure depth, contextual nuance, and a robust understanding of the gender norms influencing the wellbeing and development of very young adolescents in Ebonyi State.

Key Findings by Thematic Area

Child, Early and Forced Marriage (CEFM)

Early marriage among VYAs (10–14) is uncommon in Ebonyi State, with schooling widely prioritized. However, CEFM is tolerated in exceptional cases, where it is framed as a corrective response to restore family honour, particularly in the context of unintended pregnancy. In the context of CEFM, girls often experience school withdrawal and significant emotional pressure. Although their agency remains largely constrained, some girls attempt to exercise it by refusing the marriage, requesting postponement, or seeking support from other trusted adults. Nonetheless, decision-making power primarily rests with parents, particularly fathers, while mothers, teachers, religious leaders, and extended family members may influence the final outcome.

Sexual and Reproductive Health (Puberty and Menstruation)

Puberty and menstruation are treated as private, female-only matters and closely linked to perceptions of sexual risk, reinforcing secrecy and surveillance of girls. Mothers are the main sources of information, while fathers and boys are largely excluded. Girls show growing agency through school-based knowledge and peer support. Norms are gradually shifting as schools normalize puberty education and menstrual hygiene, reducing fear and misinformation.

Gender-Based Violence (GBV)

Physical, emotional, and verbal violence against VYAs is widespread and often normalized as discipline, attracting little reporting. Sexual violence is widely condemned but frequently concealed due to stigma, family honour, and fear of social and spiritual consequences. Survivors often bear lasting stigma, while responses prioritize protection against stigma over justice. Girls' agency is highly constrained, though selective disclosure to peers, health workers, CSOs, or police occurs. Peer networks and health workers are key reference groups, with slow shifts toward survivor-centred responses.

Human Papilloma Virus Vaccination (HPV)

Non-uptake of HPV vaccination remains the norm, driven by parental control, misinformation, and religious concerns. Girls have little decision-making power, and unsanctioned uptake may attract punishment. Mothers, health workers, pastors, teachers, and peers strongly influence decisions. Attitudes are beginning to shift through school-based delivery, repeated sensitization, and increased awareness of cervical cancer risks.

Women's Economic Empowerment (WEE)

Schooling and skill acquisition for girls aged 10–14 (where formal education is unaffordable) is widely supported. Girls' education and skill acquisition are becoming normative, often viewed as essential for self-reliance and household resilience, with declining acceptance of gendered investment gaps. Girls express growing aspirations and preferences, though poverty limits options. Parents especially mothers along with teachers and role models shape these outcomes, reflecting a clear shift toward parity in valuing girls' and boys' economic futures.

Cross-Cutting Insights

Gendered power structures and reference groups reinforce control

Across all five thematic areas, decisions affecting girls are largely controlled by parents and other adult gatekeepers, reinforced by norms around obedience, honour, and fertility and enforced through informal sanctions such as reprimand and withdrawal of schooling. Girls' agency is constrained but increases with schooling, access to accurate information, and support from trusted adults. Mothers, teachers, health workers, religious leaders, peers, and extended family consistently emerge as key reference groups and critical entry points for norm-responsive interventions.

Education and exposure (school, media, health workers) as key levers of change

Shifts in restrictive gender norms are occurring gradually through everyday exposure to schools, health services, media, and trusted community actors rather than through direct confrontation. School attendance normalizes delayed marriage, improves SRH knowledge, reduces stigma, and expands girls' agency, while teachers and health workers act as trusted brokers who support protective choices. Media, CSOs, and some government agencies reinforce these changes by legitimizing education continuation and health-seeking without triggering social backlash.

Gender norms link all five thematic areas

Shared norms regulating girls' sexuality and decision-making underpin early marriage, GBV, limited SRH access, low HPV vaccination uptake, and uneven investment in girls' education and skills. Evidence shows that interventions keeping girls in school, expanding adolescent-friendly health services, and supporting early economic skills weaken these controls across multiple domains. This underscores the need for integrated, cross-sectoral policies that address education, health, protection, and economic empowerment together.

Policy and Program Implications

State Government:

Findings show that when state responses support punishment or moral judgment of girls, VYAs are more likely to drop out of school and avoid health services, particularly during puberty and early adolescence. In contrast, policies that prioritize protection and support could help VYAs manage pubertal changes safely, and seek care without fear of stigma or punishment. This points to the need for state policies that remove barriers to school re-entry for pregnant and parenting adolescents, support safe and dignified menstrual health management, and promote adolescent-friendly health services for all young people.

Health Sector:

The findings show that adolescents often avoid health services due to fear of judgment or exposure, especially for SRH, pregnancy, or after experiencing violence. This implies that health facilities need to provide confidential, adolescent-friendly services where young people feel safe and respected. Health workers should be trained to address stigma, provide adolescent-friendly care, accurate information, and connect adolescents to school, protection, or support services. Strengthening these services will make health facilities trusted community hubs that support adolescent wellbeing rather than reinforce fear or silence

Traditional and Religious Institutions:

Given their role as moral reference authorities, traditional and religious institutions significantly influence whether families stigmatize or support adolescent girls. The findings imply that normative change is unlikely without their visible alignment with education continuation, delayed marriage, and non-stigmatization.

Development Partners:

The findings show that normative change is emerging but uneven, with best practices around education continuation, community dialogue, and support for adolescent mothers. This points to a role for development partners in piloting and documenting integrated, norm-responsive approaches that link education re-entry, mentorship, and household economic support. Clear evidence from these models can lower government hesitation, inform policy adoption, and align external investments with sustained improvements in adolescent wellbeing.

Recommendations

01. **Guarantee Inclusive and Continuous Education:** Ensure that all adolescents, including pregnant or parenting girls and boys at risk of dropping out, can return to school without barriers. Schools should integrate second-chance education, school-based sexual and reproductive health (SRH) and life skills programs, and menstrual hygiene support, including emergency sanitary pads for first-time menstruators, to reduce absenteeism and strengthen agency.

02. **Strengthen Adolescent-Friendly Health Services:** Expand confidential, non-judgmental health services that address SRH, HPV vaccination, and post-GBV care. Train health workers to provide trust-based guidance, counter misinformation, and link adolescents to protection and education services, making health facilities safe and supportive community entry points.

03. **Enforce Child Protection and Harm-Reduction Policies:** Consistently implement laws against child early and forced marriage, gender-based violence, and other harmful practices. Combine enforcement with community sensitization, so families understand legal protections and the social benefits of keeping adolescents safe in and out of school.

04. **Engage Key Reference Groups to Shift Norms:** Work with mothers, teachers, religious and traditional leaders, extended family members, and adolescents, to model positive behaviors, mentor adolescents, and reinforce protective practices. Examples include community dialogues, mentorship programs, and faith- or school-based campaigns to discourage early marriage, reduce stigma around pregnancy, and promote girls' and boys' autonomy.

05. **Integrate Multi-Sectoral, Norm-Responsive Programs:** Coordinate efforts across education, health, protection, and livelihoods to link second-chance education, mentorship, livelihood skills, and community awareness. Harmonize government and CSO programs to ensure consistent messaging, joint monitoring, and support that strengthens adolescent agency and wellbeing across all domains.

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