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Understanding the network of norms affecting adolescent sexual and reproductive health and rights in Eastern and Southern Africa

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EXECUTIVE SUMMARY

Across the Eastern and Southern Africa region (ESAR), improving sexual and reproductive health and rights (SRHR) among adolescents and young people (AYP) is a key priority for achieving continental and international goals such as Agenda 2063 and the Sustainable Development Goals. Progress in addressing early pregnancy, child marriage, the HIV epidemic, and gender-based violence (GBV) has been uneven across the region. To accelerate SRHR progress among AYP, contextually and culturally acceptable support must be found to facilitate the adoption of new behaviours.[1]

Social norms, including gender norms, are critical barriers to achieving SRHR, especially among women and girls.[2] However, while there is widespread recognition of the importance of norms and their contribution to SRHR among AYP, there are considerable gaps in understanding the pathways and mechanisms through which norms impact SRHR outcomes, particularly among AYP, and what works in improving SRHR outcomes through social norms interventions.

This review[a] aims to deepen understanding of the network of norms underpinning a range of SRHR outcomes among AYP in sub-Saharan Africa by combining secondary qualitative and conceptual literature analyses with key informant interviews with a range of social norms and SRHR experts. Through three deep dives into the qualitative literature, it identifies foundational norms that serve to create and maintain social norms[3] and maps out pathways between these norms and SRHR outcomes, focusing on GBV, contraceptive and pre-exposure prophylaxis (PrEP) use.

Findings from this review and a separate review of interventions addressing social norms are synthesised into a shorter technical brief that summarises key findings and highlights design and implementation considerations for use by policymakers and practitioners in SRHR and social and behaviour change (SBC) programming.

Key Findings from this Network of Norms Review include:

1. Understanding how foundational and social norms interact, influence and reinforce specific attitudes and behaviours is critical for designing effective SRHR interventions among AYP. Understanding social norms, particularly gender norms, crucially contributes to our understanding of risk drivers and factors that can impede or facilitate access to services – including health, education and child protection services.
2. It is essential to understand the relative importance of social norms alongside other social, psychological and environmental factors, to inform policies, programming and interventions for optimal impact on SRHR outcomes. For example, it may be necessary to address individual factors – such as lack of knowledge about puberty and pregnancy – as well as economic factors – such as lack of affordable health and education services – alongside tackling harmful norms to promote optimal SRHR outcomes.

a This review was led by researchers at the University of Oxford and the University of Cape Town in collaboration with UNICEF ESAR and has been commissioned by the Regional Interagency Thematic Team (RITT) on gender and social norms consisting of UNICEF, UNFPA, WHO and UNAIDS, as part of the 2gether 4 SRHR Programme (funded by the Government of Sweden).

3. Gender, heteronormativity, adultism and privacy are the key foundational norms identified through this review that impact multiple SRHR outcomes among AYP in ESAR.

4. Gender norms significantly impede adolescent girls and young women (AGYW)'s agency, access to SRHR services and positive SRHR outcomes. Gender norms, while manifesting differently across contexts, consistently affect SRHR outcomes among AGYW through increasing risks of coerced sex and GBV and limiting their ability to access a range of health, education and protection services to improve their well-being.

5. Gender norms can also negatively impact boys and men, including by reinforcing hypersexualised notions of what it means to be a boy or man, leading to greater sexual risk-taking, which can adversely affect adolescent boys and girls. SRHR interventions should engage adolescent boys and young men (ABYM) and AGYW to improve SRHR outcomes among AYP.

6. Heteronormativity norms, which can lead to harmful beliefs that non-heterosexual expressions of sexuality are 'deviant', have contributed to continuing stigma, discrimination and violence, particularly against non-heterosexual populations. Tackling stigma and discrimination and strengthening the rights of young key populations continues to be a priority to progress on global development goals, including ending violence and improving HIV outcomes for all.

7. Adultism norms can impede discussions on SRHR between parents, caregivers, teachers, health workers and AYP, limiting opportunities for sharing knowledge and skills that will improve SRHR outcomes among young people. Interventions are needed to improve inter-generational dialogue and create safe spaces where young people's views are heard and respected.

8. Privacy norms can create fears that healthcare and other service providers will not respect AYP patient confidentiality and are identified by AYP as a key factor deterring them from accessing family planning, PrEP and other services. Training, mentorship and supervision of primary healthcare workers and service providers to respect the rights and agency of AYP is important to ensure services are youth-friendly.

9. The last two decades have seen an impressive expansion of work related to the conceptualisation of social norms as well as qualitative and quantitative research on how social norms affect SRHR outcomes among AYP. The qualitative research which informed this review has been invaluable for helping understand which specific norms influence SRHR-related behaviours for particular AYP groups. However, there are some notable gaps. Further research is needed on how social norms impact the most at-risk AYP, particularly those from key populations, those living in conflict and crises, and those living with disabilities.

LIST OF ACRONYMS

ABYM	Adolescent boys and young men
AGYW	Adolescent girls and young women
AYP	Adolescents and young people
BDM	Behavioural Drivers Model
DFID	UK Department for International Development
FCDO	UK Foreign Commonwealth and Development Office
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
PrEP	Pre-exposure prophylaxis
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection

INTRODUCTION

Sexual and reproductive health and rights (SRHR) outcomes are strongly shaped by social norms. We are fundamentally social beings. Individual behaviour is influenced by how people expect others to behave and beliefs about how individuals should behave.[4] As young people reach puberty, social norms, including gender norms, exert increased influence on their behaviours. During adolescence, young people establish their independence, develop behavioural patterns and experience major physical, cognitive, hormonal and social changes.[5] This can be accompanied by adolescents seeking to challenge parental and other boundaries, risk-taking and learning. These changes in adolescence are considerably shaped by familial, community and social environments, including beliefs, attitudes, values and norms. Adolescence is, therefore, a critical period to support young people as they navigate their transitions to adulthood, including by promoting positive attitudes and behaviours which can have life-long impacts on their health and well-being.

There is growing recognition that improving SRHR outcomes cannot be achieved without addressing social norms and the dynamics of gender and power that are at the heart of these social norms. This has led to a quest to find 'transformative interventions' which can work at scale to address social and gender norms and create societal shifts in attitudes and behaviours to improve health-seeking behaviours and end harmful practices, including Female Genital Mutilation/Cutting (FGM/C), child marriage and intimate partner violence (IPV).

Similarly, HIV and SRHR activists and practitioners have highlighted the adverse impact of social and gender norms on people who do not conform to societal expectations relating to heteronormativity, monogamy and alcohol and drug use. Stigma faced by key populations has long been identified as a key barrier to accessing sexual health services. Moreover, failure to tackle stigma and discrimination against key populations is impeding efforts to end the HIV epidemic.[6]

This review attempts to unpack the network of norms underpinning adolescent SRHR and drill down into several SRHR outcomes. Through our 'deep dives' into a range of SRHR outcomes, we will illuminate how social norms, alongside other factors, can drive risk behaviours and health outcomes. This review can be read in conjunction with the University of Oxford and University of Cape Town evidence review of interventions addressing social norms for AYP SRHR outcomes, as well as a shorter technical brief, which summarises findings from both reviews and signposts readers to several key resources to improve social norms programming.

This research was led by the Accelerate Hub Research team, co-located at the universities of Oxford and Cape Town. Principal authors of this paper were Rachel Yates, Luciana Leite, Elona Toska, Christina Laurenzi, Chuma Busakhwe, Jenny Chen-Charles and Maria Rotaru. Leah de Jager created the figures in this paper unless noted otherwise. Gaia Chiti Strigelli, Jenny Yi-Chen Han and Nicholas Niwagaba of UNICEF Eastern and Southern Africa region (ESAR) provided significant inputs and guidance throughout.

This research partnership was made possible through funding from the Government of Sweden's support through the 2gether 4 SRHR Programme- a joint United Nations programme designed to improve SRHR in ESAR. We would also like to thank the key informants consulted, including: Ben Cislaghi (Makerere University), Clare Bangirana (Africhild and Makerere University), Paul Bukuluki (Makerere University and Eastern Africa Learning Collaborative), Alessandra Guedes (UNICEF Office of Research-Innocenti), Christine Kolbe-Stewart (UNICEF), Alice Armstrong (UNICEF), Giovanna Lauro (Equimundo), Rebecka Lundgren (University of California San Diego and Humanizing Development Collective), Gillian Mann (Child Frontiers), Jackie Repila, Rachael Hongo and Jean Casey (Girls Not Brides), Miriam Temin (Population Council), Karen Snow (University of Oxford), members of the Regional Interagency Thematic Team on gender and social norms (Lillian Langat (UNFPA), Richard Delate (UNFPA), Marietta Wildt (UNAIDS), Chris Mallouris (UNAIDS), and members of the UNITED! Movement (Munnira Katongole, Trevor Emojel, Frida Fortunatus Musilimu, Musonda Memory Chikombo, Taonga Zulu, Hakimu Kayong, Nyiko Kubai).

APPROACH AND METHODOLOGY

This review draws on both published articles and grey literature, which were identified via:

- Searches of both published and online theoretical literature, particularly papers with a focus on social norms and adolescent SRHR, including through relevant communities of practice (Social Norms Learning Collaborative; Georgetown University Institute for Reproductive Health and University of California San Diego; the ALIGN (Advancing Learning and Innovation on Gender Norms) Platform at ODI Global; Eastern Africa Learning Collaborative on Social and Gender Norms Practice), as well as programmatic resources on social norms and SRHR including those published by UNICEF, UNFPA, DFID/ FCDO and Girls Not Brides.
- Qualitative studies documenting the normative barriers and facilitators concerning AYP's access to SRHR services were purposefully selected to exemplify a range of settings, populations and social norms that shape access to services. We initially identified 160 qualitative studies focusing on social norms and adolescent SRHR in sub-Saharan Africa. Then, following input from key informants, we narrowed our focus to a subset of **31 studies** focused on contraception, PrEP and GBV across sub-Saharan Africa. Studies examined existing norms in a range of contexts, including urban and rural settings, and used a variety of qualitative research methods, including in-depth interviews and focus group discussions with young people and their key reference groups, who are the people whose thoughts and opinions AYP care about.
- We held consultations with a **range of social norms practitioners and experts** from academia (including recommendations from lead authors of a number of the included studies), UN technical specialists, and civil society representatives including youth activists. These consultations helped identify relevant grey literature and conceptual frameworks, and, in turn, fed into our conceptual framework development.
- As cultural context and location significantly shape social norms regarding AYP access to SRHR, findings from 31 qualitative studies cannot be generalised across all contexts, and studies cannot be considered to be 'representative' of the whole of ESAR. However, the studies provide a rich understanding of how social norms manifest in gender and sexual and reproductive health (SRH) attitudes and behaviours. The qualitative studies help 'give voice' to young men and women and the realities of how norms affect their relationships and outcomes.

THE IMPORTANCE OF SOCIAL NORMS IN SRHR INTERVENTIONS AMONG AYP

Social norms, or shared beliefs about what is typical and appropriate behaviour in a particular group, influence how people feel they 'should' behave. What a person believes others expect of them, and anticipation of a sanction if they transgress the norm, can be powerful drivers of an individual's attitudes and actions – hence the need for programmes to tackle harmful norms and to work with multiple influencers in the varied reference groups, of influential people whose opinons matter to AYP and surround the individual to create new shared beliefs to change harmful behaviours.

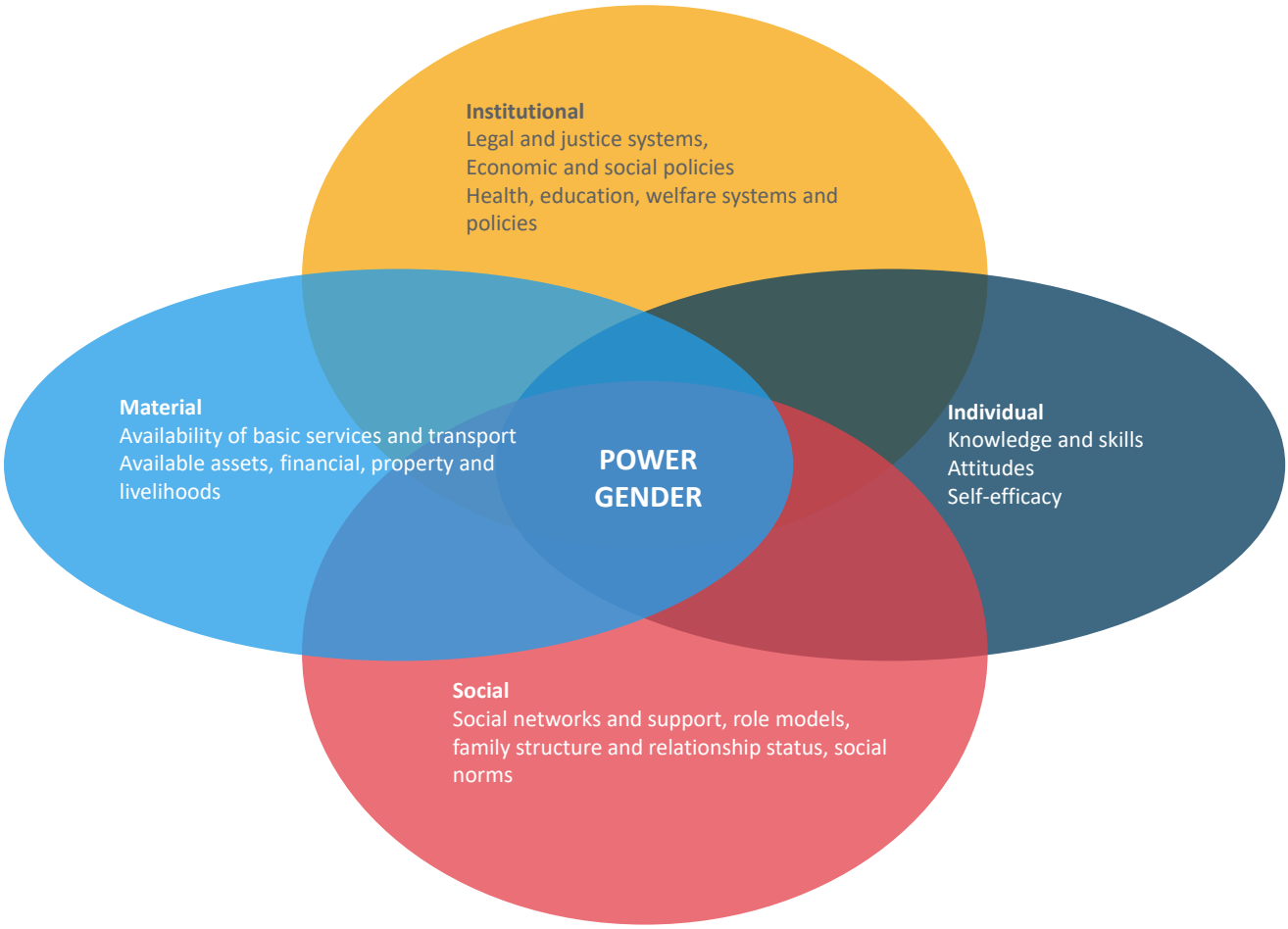
For this review, social norms are defined as "the perceived informal, mostly unwritten, rules that define acceptable, appropriate, and obligatory actions within a group or community".[7, 8] Social norms operate at many levels and may be reinforced at the interpersonal, household, community, institutional and national level. They are maintained by social sanctions of varying intensity, which can range from a mild rebuke to abandonment, social or economic exclusion, disfigurement, rape, or even death.[9] Social norms are dynamic and can shift over time, sometimes as a result of broader structural changes in society including economic opportunities, laws, policies and social movements.

The multi-disciplinary nature of social norms theory and practice makes it an exciting area of enquiry, bringing together perspectives from sociology, anthropology, social marketing, communication science, behavioural economics and gender studies, among others.[10] However, multi-disciplinarity brings with it challenges. The social norms field sometimes lacks consensus on key concepts and definitions – including what are the key **attributes** of a foundational norm or a social norms intervention. Several guidance notes and communities of practice, such as the Social Norms Learning Collaborative, have helped to develop a shared lexicon that has significantly informed this review (see Defining Social Norms and Defining Concepts (UNICEF, 2021) and Social Norms Atlas (Institute for Public Health, 2021)).[11, 12]

The conceptual framework developed by Cislaghi and Heise (2018) highlights that while addressing social norms is a critical element of public health and other adolescent interventions, it is also important to address other factors that can impede access to services, including economic factors – such as lack of facilities, – and institutional factors-such as and rules and regulations which affect health service access.[13]

Building on the well-known ecological approach to social policy interventions, Cislaghi and Heise's Flower Model (Figure 1 below), sets out a dynamic framework for social change and has been adopted by several agencies in their work on norms change in the context of adolescent SRH planning and programming.[14] This framework sets out four 'domains of influence': individual (IN), social (S), material (M), and institutional (IS). Improving access to SRHR services requires an understanding of how these domains interlink. For example, to improve access to health services by young female students, youth-friendly health services have to exist (M), students need to know (IN) what services are provided and when and where (IS), and students need to believe that they won't face negative social norms and social disapproval (S) by their family or health provider if they use the service.[15]

Figure 1: simplified flower diagram (adapted from Cislaghi & Heise 2018)



This flower framework can be used as a tool to help design social norms and SRHR interventions by identifying the factors that promote or inhibit service access and uptake and can be used within a participatory planning process, including with young people themselves, to identify where change is needed. For example, at the:

- **Institutional level:** investment in health or child protection services to make them more accessible; changing laws and policies (e.g. legislating against child marriage);
- **Material level:** improving transport to schools or health facilities;
- **Individual level:** addressing factors that may place people at heightened risk (e.g., drug and alcohol abuse, homelessness); and
- **Social level:** identifying and drawing in the networks surrounding individuals and navigating the prevailing norms which can impact attitudes and behaviours.

THE IMPORTANCE OF SOCIAL NORMS IN ADOLESCENCE

Understanding how harmful social norms affect transitions to adulthood is critical for supporting AYP as they navigate this important period in their lives. The conceptualisation of adolescence – the period when young people transition from childhood to adulthood- varies widely across cultural contexts. In some cultural contexts, puberty is seen to be the point at which children transition to become adults, bringing with it expectations of marriage and childbearing for girls. However, this view is at odds with international and African regional human rights conventions, which define anyone under the age of 18 as a child with varying provisions to protect their rights. Countries that have ratified the Convention of the Rights of the Child and the African Charter of the Rights and Welfare of the Child are expected to provide protection from child marriage and other forms of abuse and exploitation in line with international and domestic law.[16] In some countries in sub-Saharan Africa, the existence of pluralistic legal and customary systems, and exemptions in the laws, can undermine international human rights, formal laws and policies.[17] These complex and competing legal systems can help perpetuate harmful social norms and impede progress on SRHR, including the continuation of harmful practices such as early marriage, childbirth and FGM/C.

During adolescence, the influence of social norms, including gender norms, becomes more pronounced. While social norms and related attitudes are formed throughout the life-cycle, inequitable gender norms intensify for girls and boys during and after puberty.[18] This can include norms to control and regulate girls' sexuality and prevent sexual activity before marriage. Gender norms, while affecting adolescent girls disproportionately, also affect adolescent boys. As our deep dives below reveal, gender norms influence what it means to be a boy or man and, during adolescence, can intensify to create or reinforce toxic masculinities and risk-taking.

The importance of intervening in social norms in adolescence is underlined by the work of the Global Early Adolescent Study (GEAS), a longitudinal survey with adolescents ages 10-14 years. This initiative has helped deepen our understanding of how gender norms develop from early to late adolescence and how these norms might contribute to differences in health outcomes. This and other research shows how young people can hold gendered beliefs and attitudes at an early age, often influenced by

parents and older peers, and how these can affect adolescents over their life course by incentivising gendered patterns of health-seeking behaviours and reinforcing power disparities. Such research around the SRH of young adolescents is critically important in contexts where young people may be exposed to early sexual activity, especially given the trend of decreasing age of sexual debut in some African countries.[19, 20]

Rites of passage marking the transitions between childhood and adulthood are key moments in many cultures that can help instill a sense of belonging in a community. Rites of passage and initiation ceremonies can perform an important pro-social function to educate young people, increase their status within the community and foster a greater understanding of their culture. However, these coming-of-age ceremonies can also reinforce harmful norms around women being subservient to men and highlight men's rights to sexual pleasure at the expense of women's rights to consent to sex on their terms. UNFPA's recent analysis of rites of passage in ESAR highlights some of the harmful impacts on the rights of young people, including forced sex and associated HIV risk, as well as opportunities to mitigate harmful impacts, including through working with religious and traditional leaders and involving young people in discussions about how to reduce harms of these ceremonies.[21]

Adolescence and youth are crucial periods for implementing social norms interventions including:

- Working with both boys and girls to challenge harmful gender norms and behaviours – this includes interventions at early adolescence when social norms are becoming more pronounced.
- Creating safe spaces in and out of school for young people to discuss their sexuality and build confidence and aspirations which can challenge more restrictive gender norms.
- Working with religious and traditional leaders to tackle harmful rites of passage and support work on positive masculinities and ending harmful practices such as child marriage and FGM/C.

Key concepts

Social norms have been described as the 'unwritten rules' that influence what is acceptable or appropriate within a group or community. In the context of SRHR, they affect attitudes and behaviours, including on key decisions in relationships – for example, when to marry, to have sex or to have children. Norms are often sustained by social sanctions. Those who go against the norm can face criticism, social exclusion, violence and even death.

Gender norms are a sub-set of social norms that affect widely held beliefs about gender roles, the gendered division of labour, power relations, and expectations of how men, women, boys and girls should behave. These norms help sustain gendered hierarchies of power which can undermine women's and girls' rights and restrict opportunities for women, men and gender minorities.

Foundational norms, sometimes referred to as meta-norms, are overarching norms that influence multiple attitudes and behaviours through their influence on individual or community attitudes.

FOUNDATIONAL NORMS AND RELEVANCE FOR SRHR IN AYP

Within the literature on social norms, there is growing interest in the concept of meta or **foundational norms** (the term we will use throughout this series of documents) – terms that are often used interchangeably. The Social Norms Lexicon defines meta norms as foundational norms that serve to create and maintain social norms.[22] Heise and Manji (2016) define foundational norms as norms that influence multiple behaviours.[23] They give the example that shifting the meta-norm that violence is an appropriate form of punishment could impact multiple areas of well-being: affecting children by reducing corporal punishment in schools and affecting women by reducing IPV and GBV. Similarly, shifting foundational gender norms can impact multiple behaviours. For example, adopting gender-equitable foundational norms could make it more acceptable for young women to access education and SRHR services, helping them to delay early pregnancy and marriage, improving their learning outcomes and resulting in greater agency and more productive livelihood opportunities.

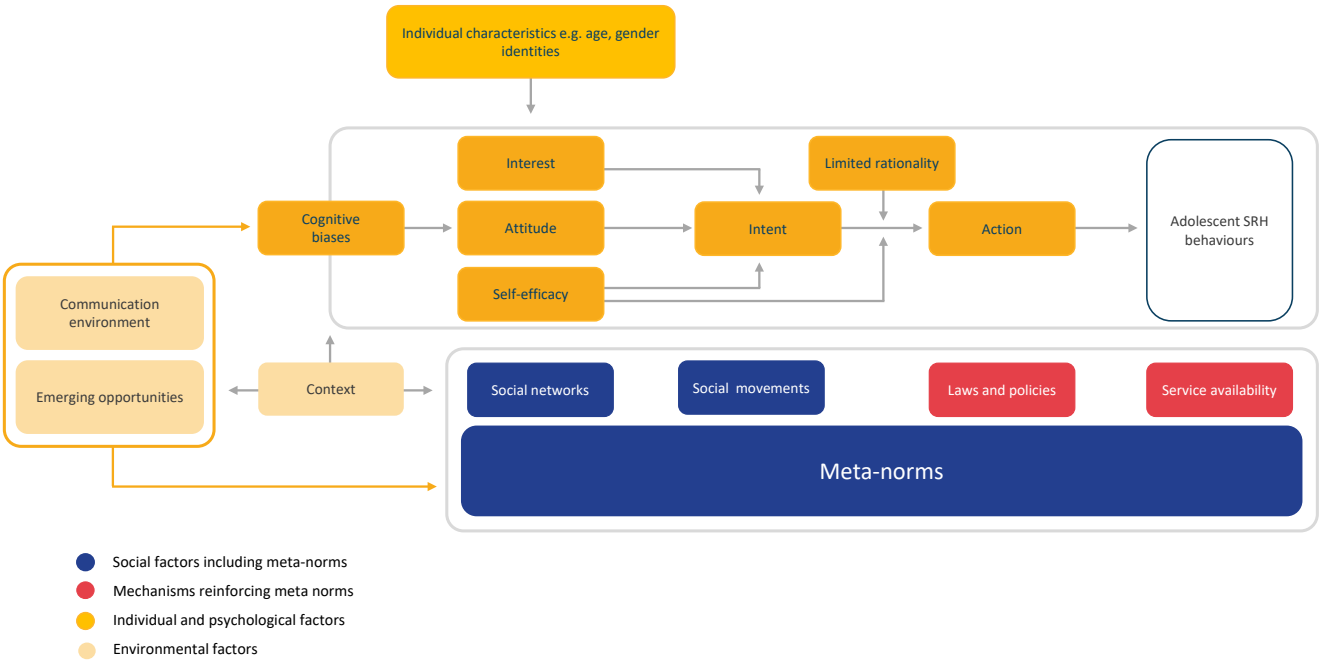
Buller and Shulte's (2018) analysis focuses on social norms relating to adolescent SRHR and highlights how foundational norms persist across communities, nations and regions and can undermine efforts to realise adolescent SRH goals. Harmful social norms create and maintain local inequalities that can negatively impact adolescent SRHR outcomes.[24] In particular, they identify the foundational/meta norms of **hierarchy, adultism, gender and heteronormativity**, which help to perpetuate notions of appropriate behaviours during childhood and adolescence and promote inequalities that can adversely affect the distribution of opportunities and resources, as well as differing values placed on adolescents according to their age, gender, race, religion, sexual orientation and other indicators of social status.

In UNICEF's 2019 Behavioural Drivers Model (BDM), foundational norms are defined as "underlying ideologies and unwritten rules deeply entrenched in people's culture and identity, cutting across sectors and conditioning a large number of behaviours".[25] This model describes how these meta-norms affect individual drivers both directly (e.g., in determining a person's attitudes), as well as indirectly, through related social norms and practices. Similar to Heise and Manji (2016) and Buller and Shulte (2018), the BDM conceptualises meta-norms as influencing a range of social norms (as in the example of gender norms above). However, the BDM extends the concept of meta-norms to explain how norms are created and maintained, for example, through laws, hierarchies of power or socialisation processes.[26]

In the BDM (see Figure 2 below), social norms and meta-norms are seen to be among many factors influencing behaviour change. Individual and psychological factors (represented in the diagram in dark yellow), as well as environmental factors (light yellow), also affect behavioural change.

In the next section, we attempt to unpack the foundational norms that influence a range of SRHR behaviours in AYP, using secondary qualitative data. We describe how these norms, along with individual and environmental factors, affect key attitudes and behaviours. At the end of this review, we revisit the BDM to articulate our key findings (see Figure 6).

Figure 2 Behavioural Drivers Model, UNICEF (2019)



DEEP DIVES INTO HOW FOUNDATIONAL NORMS SHAPE SRHR AMONG AYP

Having set out key theoretical frameworks in relation to social norms and behaviour change, we now look at the relevance of these frameworks for SRHR outcomes among AYP. Due to the large number of qualitative studies identified, we focused on a sub-set of SRHR outcomes, selected in consultations with development partners and a reduced set of 31 papers. The selected SRHR outcomes are:

i. Contraceptive use among AYP

ii. PrEP for HIV prevention in AGYW

iii. GBV among AYP

In each of the deep dives, we used the relevant published papers to examine how social norms manifested in different contexts and how they contribute to SRHR-related attitudes, practices and behaviours. We considered what are the key **foundational norms** that influence multiple attitudes and behaviours relating to these outcomes among AYP, drawing on the conceptual frameworks discussed above. As described above, foundational norms are overarching norms which influence multiple attitudes and behaviours through their influence on individual or community attitudes.[27]

While the categorisation of foundational norms has been undertaken by the University of Cape Town/University of Oxford research team, the description of how norms manifested themselves was extracted directly from the papers, including quotes from AYP and their reference groups.

From the three deep dives, we identified **four main foundational norms** among AYP in ESAR:

Foundational norm	Description
Gender norms	Norms that affect attitudes on how girls and boys 'should' behave and the power dynamics between girls/women and boys/men. Gender norms that reinforce male authority and control can increase risks of coerced sex, GBV and HIV infection. Gender norms can also negatively impact boys and men, including by reinforcing hypersexualised notions of what it means to be a boy or man, leading to greater sexual risk-taking behaviours which can adversely affect adolescent boys and girls.
Heteronormativity norms	These refer to norms that underpin harmful beliefs, laws and policies that non-heterosexual expressions of sexuality are 'deviant'. Heteronormativity norms have led to stigma, discrimination and violence against key populations. Stigma hinders access to health care including HIV testing and treatment and undermines efforts to end HIV and AIDS in the region.[28]
Adultism norms	Norms that reinforce beliefs that young people are less valued than adults and reduce their agency in the decisions that affect them. Adultism, particularly when combined with gender norms that place a high value on female virtue/ chastity, can impede discussions on SRHR between parents, caregivers, teachers, health workers and AYP, limiting opportunities for sharing knowledge and skills for better SRHR outcomes among AYP.
Privacy norms	Norms that relate to beliefs about what information is appropriate to share with whom and in what contexts. For many AYP, fears that healthcare workers will not respect AYP patient confidentiality is identified as a key factor deterring them from accessing SRH services including contraceptives and PrEP services.

The deep dive analysis of secondary qualitative research also attempts to identify the key **reference groups** for AYP for each behaviour and norm. These are people to whom we compare ourselves and our behaviour, the people we look to when deciding what to think or do, and whose thoughts and opinions we care about.[29] Understanding reference groups can help us to understand who is maintaining and reinforcing social norms and should, therefore, be targeted through social norms or broader social and behaviour change interventions.

Deep dive 1: Unpacking social norms and contraceptive use among AYP

Methods

We reviewed 13 studies, including 11 single-country studies in Guinea (2), Kenya (3), South Africa (2), Tanzania (2), Nigeria (1) and Zambia (1), and two multi-country studies in Ghana, Democratic Republic of Congo and Zimbabwe, and in Uganda, Djibouti and Kenya. The studies were published between 2017 and 2023.

Understanding the need for more research on marginalised populations, we purposefully included one paper focusing on the experience of street youth, another exploring the context of the COVID-19 pandemic, and a third study in a refugee setting.

Mapping foundational norms

Gender norms. Foundational gender norms were seen to have a profound impact on attitudes and behaviours relating to contraceptive use, including in the following ways:

- **In many instances, a high value is placed on virginity for unmarried girls and young women,** with AGYW being chastised by parents/caregivers, health providers and teachers when they are perceived to be sexually active. However, the strength of condemnation varies across cultural contexts. Norms are often reinforced by religious beliefs, with chastity often being seen as something sacred. This norm can restrict access to services, keep adolescents from engaging in conversation about contraceptive methods and serve as a barrier to contraceptive use.[30, 31, 32, 33, 34, 35] **Pro-natal norms that associate fertility and having children with social status or wealth held by family and community members,** combined with the widely held misconception that contraceptives affect future fertility, often cause family members to oppose family planning use and negatively affect AYP's contraceptive use.[36, 37]
- **Healthcare providers' condemnation of pre-marital sex by unmarried AGYW** made contraceptive services harder to access by AYP[38, 39] and caused adolescents to hide their use of services.[40]
- **AGYW who buy condoms are often perceived as promiscuous.** Boys and men are seen as responsible for buying condoms,[41] while AGYW accessing contraception face societal shaming[42] and isolation/discrimination at school, including from teachers.[43]
- **AGYW often have limited decision-making power in heterosexual relationships,** with husbands and sexual partners having control over their partners' decision to use family planning. Male partners' opposition to the use of contraception causes them to oppose their partners' access.[44, 45] Partner support can act as a facilitator for contraceptive use for birth spacing.[46] When faced with opposition, AGYW may use discreet modern methods, such as the pill[47] and injectables.[48]
- **Inequitable gender power dynamics and norms are reinforced by AGYW's financial reliance** on husbands/partners, which can be exacerbated in crisis contexts.[49]
- **Harmful gender norms and fears of accusations of infidelity and promiscuity** may lead to AGYW having an unwanted pregnancy and seeking abortion services.[50] Some AYP avoid using condoms in sexual encounters as it may be seen as an admission of HIV infection, promiscuity or lack of trust in the partner.[51, 52] Contraceptive use is also believed to be associated with infidelity for married people.[53]
- **Gender norms create stigma against pregnancy outside marriage,** which can extend to the entire family, causing some parents to encourage their children to use contraception.[54] Adolescent pregnancy can also lead to school dropout.
- **Gender norms reinforce attitudes regarding what it means to be a boy or man in a society.** These norms on acceptable masculinities can place peer pressure on boys to have sex and demonstrate confidence with sexual partners. Norms and attitudes about the centrality of male pleasure during sex have been linked to adolescent boys' reticence to use condoms.[55]

"They can think otherwise of you that, "Why is this female often buying condoms?" They will think you are immoral. The males should buy and then they put it in the pocket."

(Young Woman, Zambia)[56]

"In our culture, girls must keep their virginity until marriage. It's a source of pride for the whole family and proof to the community that you come from a good family and are well educated."

(Young married woman, Guinea)[57]

Adultism norms. Foundational adultism norms can translate to attitudes and behaviours towards contraceptive use in the following ways:

- **AGYW face stigma and discrimination from healthcare providers when utilising services.** AYP often avoid seeking contraception due to past experiences of judgement by health providers,[58] and may instead choose to consult with traditional healers.[59] Some AYP may seek private clinics, as they expect to receive less judgemental attitudes there.[60]
- **Street youth may face additional barriers to accessing care,** with healthcare providers describing being unable to build trust with street youth, who are perceived as valuing advice from peers more than healthcare provider advice.[61]
- **Norms against sexual activity and pre-marital sex by AYP.** Our review found widely held beliefs that contraception encourages AYP to become sexually active, a view often held by healthcare providers, parents, teachers and caregivers. AGYW often feel judged by healthcare workers and/or discouraged from seeking SRHR and contraception services.[62, 63, 64] Some parents or caregivers oppose contraceptive use and avoid open discussions on SRHR topics with their children.[65, 66, 67] The inability to obtain advice from adults may impede AYP from accessing safe SRHR services.[68] This norm is also associated with the stigmatisation of AGYW who have an abortion and pregnant adolescents.[69]
- **Adolescents lack power over their own decisions, including those related to access to contraceptives,** which limits their contraception options to traditional or cheaper methods.[70, 71] Financial insecurity resulted in some girls engaging in transactional sex and having unwanted pregnancies.[72]

"There are things that culture does not permit a child to do, so if adolescents want to get access to contraceptive services and information, they will be feeling somehow (afraid). They will hide to get access because they know that our culture is against it (adolescents accessing contraceptive information and services)."

(Female state policymaker)[73]

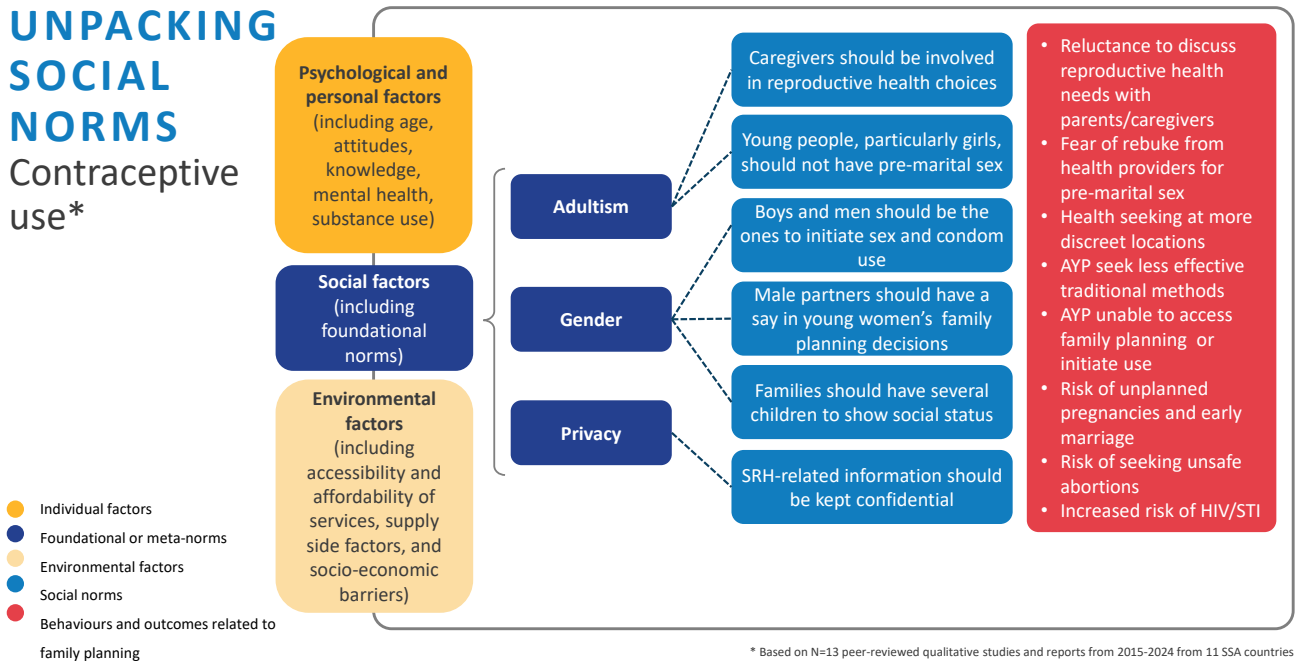
Privacy norms. Foundational privacy norms can translate to attitudes and behaviours related to contraceptives in the following ways:

- **Adolescents consider that their SRHR information should be kept private.** Lack of privacy in healthcare systems keeps AYP from seeking services,[74] and some adolescents seek private clinics because they expect to be less likely to see a family member there.[75, 76] Privacy concerns affect AGYW's perception of the provision of contraceptives in certain locations, such as schools, hospitals or drugstores.[77, 78] Privacy concerns may increase when household members spend more time at home due to external shocks, such as the COVID-19 pandemic.[79] Some SRHR issues, such as abortions, are seen as particularly important to be kept secret.[80]
- **Fear of social sanctions if hidden contraceptive use was discovered.** AGYW may hide contraceptive use due to expected backlash from other community members if the use is discovered. The risk of being outed to the community as deviant or being positioned as unfaithful may discourage AGYW from contraceptive use.[81]

> *"Aah, I don't think it will be easy because they are afraid that people will talk, and when they talk, the talk might end up reaching their homes because not everyone can be trusted, especially here at school... I don't see them getting contraceptives here at school where everyone is looking."*
>
> **(Female, South Africa, in age group 15-18 years)[82]**

The key foundational norms of gender, adultism and privacy identified in our review of the 13 studies are captured in dark blue in Figure 3 below. The figure shows how these foundational norms affect norms and beliefs relating to sexual and health-seeking behaviours (light blue boxes) and the red box shows the impact of these norms on SRHR outcomes.

Figure 3 Unpacking social norms influencing contraceptive use



Key reference groups

Male partners in heterosexual relationships, parents/caregivers, peers, health providers, teachers, religious leaders and community members all uphold gender norms that can act as barriers to AGYW's use of contraceptives. Religious leaders often reinforce gender norms preventing contraceptive use, particularly promoting beliefs regarding female pre-marital chastity and condemnation of sex outside of marriage, particularly for girls. Norms upheld by partners and peers may also lead to AGYW who seek contraception to be labelled as promiscuous and reinforce misconceptions about the side effects of contraceptives.

Adultism norms are largely influenced by parents, caregivers, healthcare providers, teachers and the wider community. Young women and men often anticipate facing stigma or judgment from healthcare providers and are discouraged from seeking SRHR services. Many parents avoid discussing SRHR with their adolescent children, and in schools, teachers may feel unable or unwilling to engage in discussions on SRHR, limiting opportunities for knowledge acquisition.

As set out in the Behavioural Drivers Model (Figure 2), individual or environmental factors (shown in yellow in Figure 3) can influence attitudes, behaviours and contraceptive use outcomes. Our review identified the following key individual and environmental factors:

- **Lack of knowledge of reproductive health and fear of side effects:** Harmful norms are often reinforced by a lack of knowledge about reproduction and how contraception works. Peers and partners often associate contraceptive use with decreased sexual desire and future infertility, causing them to oppose their use.[83, 84, 85] For example, AYP often avoided implants, which were believed to stay in the body for longer periods of time[86] and affect body weight.[87] Many AYP and some in their key reference groups believe that contraceptive use may lead to difficulties in future pregnancies, including complications in childbirth and birth defects,[88, 89, 90] or link them to acquiring STIs or even cancer.[91] In some cases, condoms were not trusted or were seen as containing bacteria/viruses.[92] Side effects of contraceptives, such as changes to menstrual cycles and weight gain, can also discourage use.[93]
- **Financial and physical barriers:** costs of contraceptives and consultations, transportation costs and distance to health facilities were often identified as barriers to access.
- **Supply barriers:** supply chain issues, poor quality of facilities, limited specialised services, waiting times, lack of training of providers and lack of privacy in facilities.
- **Individual factors:** emotional distress, alcohol and substance abuse, self-efficacy to negotiate condom use, lack of documentation to obtain services and language barriers (particularly for refugee settings).
- **Crisis contexts:** additional barriers related to the COVID-19 pandemic, conflict or extreme weather.
- **Socio-economic barriers:** poverty, legislation, policy, institutional capacity.
- **Other harmful attitudes:** discrimination against refugees in humanitarian settings.

How are social norms changing?

Some studies highlighted that social norms and attitudes associated with contraceptive use were shifting. As contraceptives are more widely used, female peers may advise others to use contraceptives regardless of the lack of support from their partners.[94] Adolescents

can also share knowledge and correct others' SRHR misconceptions.[95] At the same time, crisis contexts and resulting changes in community and household dynamics may lead to a shift in key reference groups, with AGYW having reduced access to their friends and spending more time with their partners or caregivers.[96] More examples of what works to shift norms about contraceptive use can be found in the separate scoping review of social norms interventions.

Deep dive 2: Unpacking social norms and PrEP among AGYW

Methods

This deep dive examines the influence of foundational norms on the uptake and use of pre-exposure prophylaxis (PrEP) among AGYW across different Southern and Eastern African countries, including Zimbabwe (1), South Africa (5), Tanzania (2), Uganda (1) and Kenya (1). Ten qualitative studies published between 2020 and 2023 were selected for regional variation.

Mapping foundational norms

Gender norms. Foundational gender norms, including patriarchal norms, were seen to influence social norms and behaviours around the decision to initiate or continue PrEP in the following ways:

- **Harmful gender norms led partners to perceive PrEP use as a sign of infidelity and in some cases, generating a lack of trust.** Women expressed concerns that taking PrEP could lead their male partners to suspect them of being unfaithful, thereby jeopardising their relationships.[97, 98, 99]
- **Gender norms underlie stigma related to HIV and concerns by AYP not to be seen to be promiscuous.** In multiple studies, PrEP has often been conflated with HIV treatment, leading to the misconception that those who take PrEP are HIV-positive. This stigma faced by people taking antiretrovirals (ARVs) and PrEP is particularly acute in communities where HIV-related discrimination is highly prevalent. The combination of HIV-related stigma and gender norms significantly hinders PrEP uptake among AGYW. Anticipated stigma causes some AGYW to discard their PrEP pills near the study site to avoid being seen with them, as they feared being labelled as HIV-positive by their peers and community members.[100] The misconception that PrEP is only used by sex workers could also prevent AGYW from using PrEP, due to the fear of being mislabelled.[101, 102]
- **Gender foundational norms are often maintained by the threat of IPV,** which can significantly inhibit PrEP use among AGYW. Fear of partner violence is the predominant reason why AGYW either did not disclose their PrEP use or discontinued it altogether.[103] The potential for IPV creates an environment where AGYW must carefully navigate their sexual health choices, often prioritising their immediate safety over effective HIV prevention. Some male partners expressed the potential to engage in violence if they found out their partner was using PrEP.[104]

> *Rosemary remarked that if her partner found out she was taking PrEP, 'he may even beat me up'.*
>
> **(Female, 20 , Tanzania)[105]**

"For that, only I could be mad at her…for this, I will send her home…I could even beat her…it could affect us very much, and I would even divorce her."

(Male partner, 30, Tanzania)[106]

"…If people see you taking PrEP, they will think you are a prostitute, and that is why you are taking PrEP—so that you don't get sick."

(Young woman, Kenya)[107]

"'Okay, I did not want to take it up [PrEP] because if I get it and take it home, my family would like to know why I have PrEP. That's like an outing myself. Then they will suspect that I'm one sex worker."

(Female, 22, Zimbabwe)[108]

Adultism. Foundational adultism norms can affect PrEP use attitudes and behaviours in the following ways:

- **Norms related to adultism can lead to deference to adult authority figures, which restricts the autonomy of AYP** in independently seeking health services when they want/need them. Young women often face pressure to seek permission from their parents or elder relatives before starting PrEP.[109]

"I told her that they wanted me to take PrEP, and she just said no, she said, 'If you do it, then just know that you would be doing it against my will.' You know when a parent says that, yoh, yoh, it's heartbreaking, she makes you feel bad. [But] I just had no say."

(Female, 19, South Africa)[110]

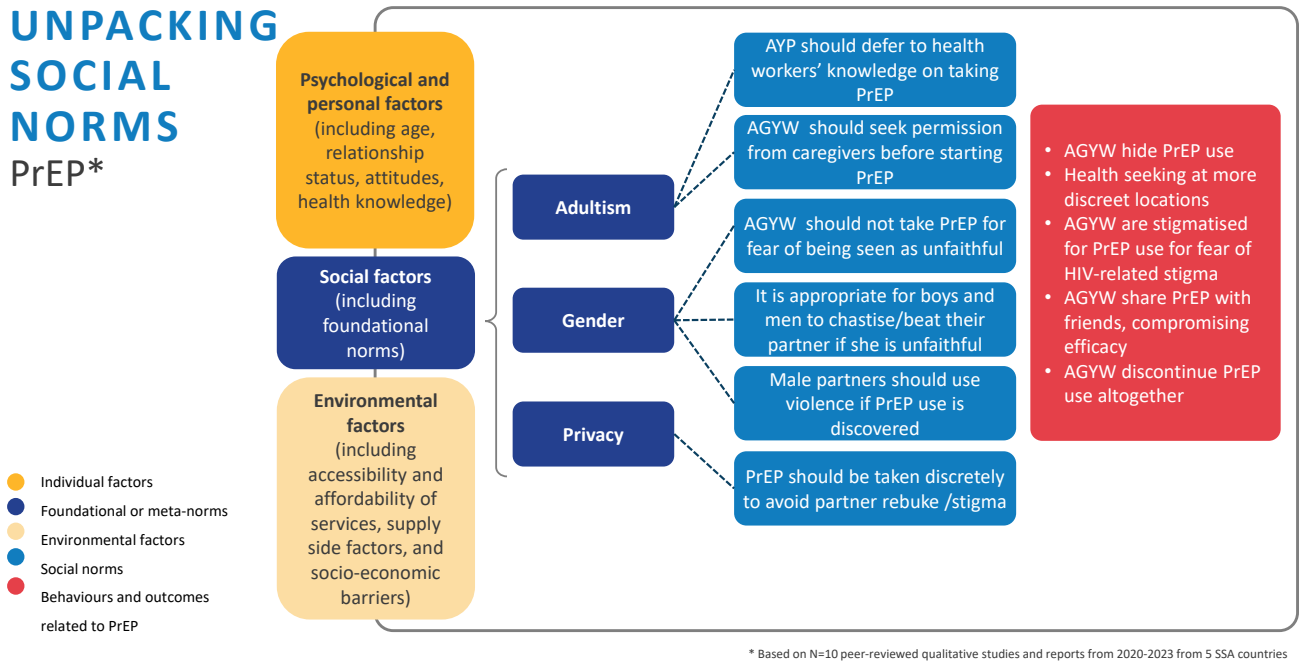
"How do I go out from home without permission, and I must explain where I am going?… I also chose consciously not to hide because I live with them."

(Female, 20, Tanzania)[111]

Privacy norms. Foundational privacy norms can translate to PrEP use attitudes and behaviours in the following ways:

- **AGYW have a strong desire to keep PrEP use private,** individuals often discard PrEP near study sites or in toilets to avoid being seen with the pills by community members or family.[112]
- **Stigma in public clinic settings and ill-treatment and judgement from providers** can deter PrEP use.[113]
- **Expectations of parental and partner disapproval can cause some individuals to hide their use** and create significant barriers to PrEP uptake and consistent use. Furthermore, the fear of relationship dissolution or violence often outweighed the perceived benefits of PrEP, leading many young women to either hide their PrEP use or discontinue it altogether.[114, 115]

Figure 4 Unpacking social norms affecting PrEP



* Based on N=10 peer-reviewed qualitative studies and reports from 2020-2023 from 5 SSA countries

Key reference groups.

- Male partners are a critical reference group. The need for male financial and emotional support may compel many AGYW to hide or decline PrEP use to avoid confrontation or rejection.[116] Studies show that while men felt they could start PrEP without prior discussion with their partners, some women felt they needed to obtain their partner's permission to use PrEP.[117]
- Parents have significant influence over healthseeking behaviours, particularly for AGYW, as they can disallow or stigmatise PrEP use.[118] [119]
- As well as caregivers, healthcare workers can uphold adultism norms affecting PrEP uptake among AGYW through their professional authority and trusted relationships with young women, which can significantly influence perceptions of PrEP.

The foundational norms identified in our review of the 10 qualitative studies are represented in Figure 4 in dark blue, with light blue boxes showing how these influence norms on how people feel they should behave, and the red box showing the impact on behaviours related to PrEP use. As with the contraception uptake deep dive above, individual and environmental factors (in yellow boxes in Figure 4) also affect PrEP uptake and use behaviours. Our review identified the following key individual and environmental factors:

- **Structural factors, including economic dependence** on male partners, compel AGYW to conform to their partners' authority regarding PrEP use. As mentioned above, the fear of losing financial support from male partners can lead to non-initiation or discontinuation of PrEP.[120] This economic reliance not only limits AGYW's ability to make autonomous health decisions but

also reinforces the power imbalance in relationships, where male partners exert control over critical aspects of women's health behaviours.

- **Health perception factors:** Many AYP struggle with the idea of taking daily medication like PrEP while feeling healthy, as they associate medication with illness and old age, conflicting with their self-image of being robust and healthy. In Kenya and Uganda, participants expressed discomfort with taking daily medication when they didn't perceive themselves as sick.[121]
- **Financial and logistical barriers:** transportation costs, distance to facilities, clinic opening times, and costs of services impede access in some contexts.

How are social norms changing in relation to PrEP?

Despite the strong influence of social norms, some studies indicate that norms and attitudes are changing. The qualitative studies highlight how educational interventions and family engagement programmes appear to be shifting attitudes and reducing barriers to PrEP use. For instance, efforts to educate both partners and families about PrEP benefits are helping to improve support and autonomy in health decisions.[122] [123] However, these changes are gradual and require ongoing efforts to address the deeply ingrained authority norms affecting AGYW.

Interventions that include male partners in PrEP education and counselling have shown some promise in reducing IPV and increasing support for PrEP use. In a study in South Africa, women who received PrEP disclosure counselling were more successful in gaining their partners' support, highlighting the potential for targeted interventions to shift harmful norms.[124]

Deep dive 3: Unpacking social norms and gender-based violence among AYP

Methods

For our deep dive into GBV, we reviewed eight studies from sub-Saharan Africa, including six single-country studies in South Africa (3), Ethiopia (1), Mozambique (1) and Zambia (1), and two multi-country studies in Rwanda and South Africa (1), and the Democratic Republic of Congo and Ethiopia (1). Studies were purposively selected to examine how foundational norms affect a range of populations including AGYW, ABYM, and AYP in conflict-affected settings (including refugee settlements) and in settings with high rates of early marriage. Across these contexts, both urban and rural settings were included. The studies were published between 2010 and 2024.

Mapping foundational norms

Gender norms. Foundational gender norms including patriarchy were seen to influence social norms and behaviours related to GBV in the following ways:

- **Gender norms manifest in acceptance of male dominance and expectations that girls and women should submit to male authority.** In a study conducted in Zambia, power imbalances associated with gender norms and expectations became particularly significant in the context of marriage.[125] Participants across different groups consistently noted that young women are socialised to accept unequal power dynamics and control within marriages. This acceptance is seen as a sign of respect and an acknowledgement of their new social role, often aligning with traditional economic

dependency on husbands. Tolerating violence is viewed as part of this arrangement. AGYW participants spoke about a 'default' acquiescence to men, which pervaded relationships and marriages but also set foundations for excusing violence.

- **Gender norms underpin the idea that marriage can be a space where male decision-making authority is cemented and where sexual consent of women is not required.**[126] This was true even in cases of violence.[127] In most of the narratives reviewed, explicit consent for sex was missing. Many caregivers and girls believed that having a boyfriend or visiting a boy's or man's house implied consent to sex.
- **Male dominance and control were also manifested in a spectrum of acceptable physical or other forms of violence,** especially within the institution of marriage.[128, 129] Evidence highlighted the negative psychological implications of experiencing verbal violence and belittlement.[130] Some AGYW made a distinction between acceptable and unacceptable verbal abuse, indicating acceptability if a wife were to come home late or refute her husband.[131]
- **Male hypersexuality, linked to male control and dominance,** was evident across several studies, most notably among one focused on adolescent girls and boys. For young Zulu men, masculinity is frequently connected to the concept of Asoka, which is rooted in cultural and traditional beliefs. This concept ties manhood to having several female partners simultaneously (*ubusoka*).[132, 133] Adolescents reported that coercive sexual behaviours by males are common in their heterosexual relationships. These behaviours include boys begging for sex, giving gifts, threatening to end the relationship if sex is not provided, and showing pornographic films. Such actions can sometimes escalate to more aggressive forms of sexual assault.[134]
- **Girls and women were subject to violence because of their relative lack of value in society and their ability to use their bodies for instrumental purposes,** especially in the context of high poverty levels.[135] Conflicting with this narrative of social devaluation was a competing narrative of being a 'good' girl that emerged from multi-generational interviews, where girls' and women's safety, and the violence experienced, was placed as their responsibility. Victim blaming extended into the marital sphere, where violence was seen as justifiable and something that women should make efforts to circumvent. GBV can also be a cause of adolescent pregnancy, which in turn places girls at even higher risk of violence and stigma within their households and communities, often leading to induced abortions.[136]

> *"The way people say, 'a man will always be a man', it's like they give man power to say whatever a man says is right. You can't do anything. You just do what he says."*
>
> **(Female respondent, Zambia)[137]**

> *"**Interviewer:** So when a girl is married, the man has the right to do whatever he wants with her, including having sex by force?*
>
> ***Respondent:** She came into his house by her own will, so it's no longer by force."*
>
> **(Young female respondent, DRC)[138]**

"Because the parents sometimes, with a 16-year old daughter, they force her to date even though she doesn't want to....Lots of parents do this. So she'll start dating, to get soap, to get food....And when she's with the man then comes pregnancy."

(Young female respondent, Mozambique)[139]

"In the event that a wife was hit by her husband, I would first tell her to try to understand why her husband did it, because a husband wouldn't just hit his wife if she hadn't done anything wrong. In this case, she would have to do everything that is in her power to change her own behaviour."

(Female caregiver, DRC)[140]

Heteronormativity norms. Foundational heteronormativity norms and heterosexism were seen to influence social norms and behaviours related to GBV in the following ways:

- **Boys face immense pressure to engage in sexual activities with female partners.** From young men's perspective, this involves taking control of sexual negotiations, with girls assuming a more passive role.[141] Young men are often expected to prove themselves, including with multiple sexual partners, to be seen as 'real' men.

"We are overjoyed after sex, we feel like men! If you don't do it, other boys say you are gay or an idiot."

(Young man, Zambia)[142]

- **An extreme manifestation of heteronormativity has been seen in cases of so-called 'corrective rape',** where Black lesbian women and gender nonconforming individuals have been targeted in violent assaults and, in some cases, murdered by one or multiple men.[143]

  In a study on so-called corrective rape from South Africa, the authors highlights that expressions of lesbians' sexuality can place women at heightened risk and suggests that lesbian undermine "monolithic notions of heteronormativity by resisting the demarcation of their bodies as male property.''[144]

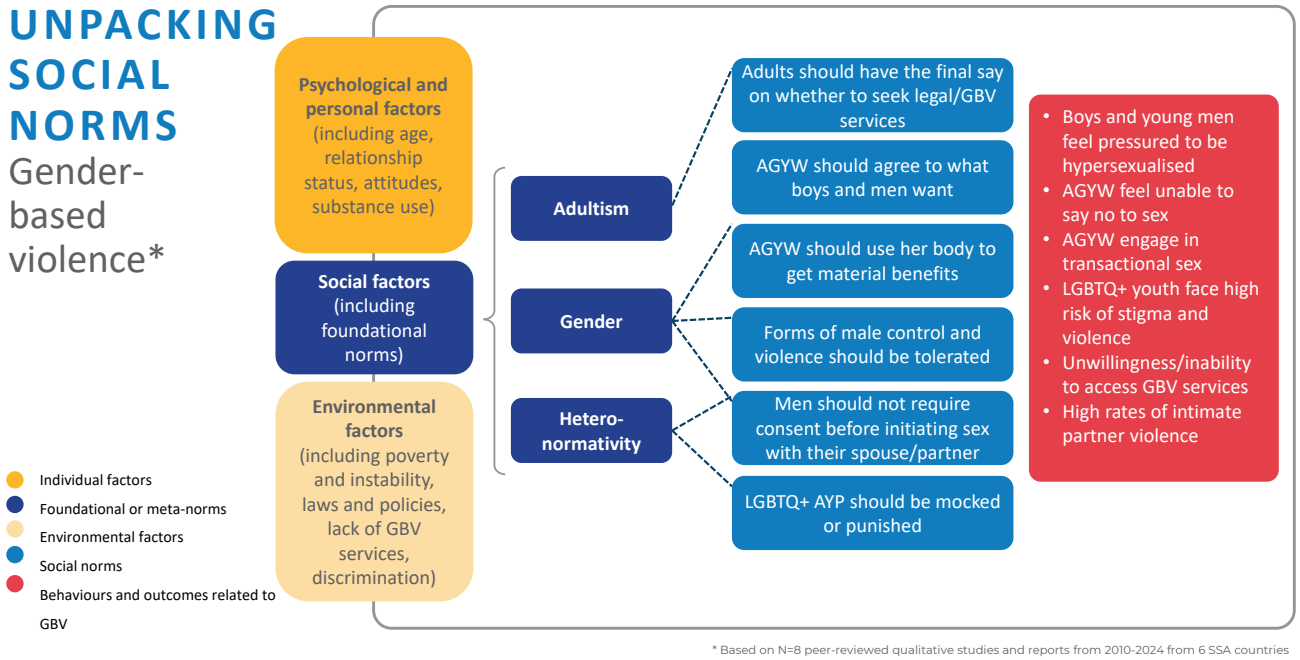
Adultism norms were seen to influence social norms and in some cases, reduced the agency of young women, who spoke about the 'final say' that adults had when it came to decision-making, social expectations, and immediate next steps in the aftermath of violence.[145]

"She saw that it was too much, she was being beaten every time, beaten every time. So, she left to look for elders for advice. The elders told her to go back and stay because men change. From there, she went home. After she went home, the problem continued."

(Young woman narrating a 'persona' peer narrative, Zambia)[146]

Figure 5 sets out how the foundational norms, alongside individual and environmental factors, shape attitudes and behaviours relating to GBV.

Figure 5 Unpacking social norms underpinning GBV



* Based on N=8 peer-reviewed qualitative studies and reports from 2010-2024 from 6 SSA countries

Key reference groups. Parents and older community members emerged as a key reference groups, for gender and adultism norms, with some continuation of this influence as individuals grew older. Importantly, while some of these norms seemed to inherently devalue girls and women, other examples show that norms may have a pro-social role, playing a protective function and aiming to protect younger women from harm. Adolescent girls noted the role that older individuals, such as parents/caregivers and community and religious leaders, can play in their communities.

Male sexual partners were also identified as a key reference group upholding these gender norms associated with GBV. As mentioned above, gender norms may intensify when young men marry, linked to beliefs that certain forms of violence, for example, forced sex, are more acceptable within marriage.

As with the other deep dives, it is important to consider individual and environmental factors (highlighted in the yellow boxes in Figure 5). Our review of the eight studies identified the following key individual and environmental factors which contribute to the perpetuation of GBV:

- **Poverty and economic dependence on male partners** make it difficult to leave abusive relationships.
- **Lack of effective laws and policies** to protect women from and respond to GBV.
- **Lack of or inappropriate formal services** supporting AGYW who experience GBV.
- **Financial and logistical barriers,** including transportation costs, cost of health services, distance to facilities and clinic opening times.
- **Stigma and discrimination,** including those targeting sexual minorities.
- **Individual factors,** including emotional distress, alcohol and substance abuse, motivation and self-efficacy to access available services.

INSIGHTS ON SOCIAL NORMS FROM THE DEEP DIVES

Our analysis of the 31 studies reviewed focusing on contraceptive use, PrEP and GBV shows how the foundational norms of **gender, heteronormativity, adultism** and **privacy** influence AYP's SRHR-related behaviours. In this section, we further unpack each of these norms and their importance.

Gender norms

Gender norms were central to the pathways and mechanisms mapped in the three deep dives. These foundational norms affect widely held beliefs about gender roles, power relations, and social expectations of how men, women, boys and girls 'should' behave. Inequitable gender norms sustain gendered hierarchies of power and privilege which undermine women's and girls' rights and restrict opportunities for women, men and gender minorities.[147] Our analysis highlights how gender norms and gender inequalities are powerful determinants of health and well-being.[148]

Gender norms and hierarchies of power clearly affect girls' and young women's agency, particularly where their partners' approval or disapproval heavily influences their health-seeking behaviours. This control is exacerbated where there is economic dependence and fear of IPV.

Foundational gender norms also underpin norms relating to AGYW's sexuality, which has considerable implications for SRHR outcomes. We see that in many contexts, high value is placed on the virginity of unmarried AGYW. Norms around the desirability of sexual purity can restrict access to services, keep adolescents from engaging in conversations about contraceptive methods and serve as a barrier to use. Often the community condemnation of girls' sexuality fails to take into account the gendered power dynamics and coercion into sexual activity that is faced by many AGYW. Within the region, gender norms can be reinforced by some religious beliefs.

Although some norms inherently devalue girls and women, in some contexts, these norms might also offer protective and pro-social benefits. In several of the studies reviewed, we sometimes see gender and adultism norms having a pro-social function in protecting AGYW from violence or social exclusion. Norms and beliefs around girls' sexual debut are informed by the desire of parents and caregivers to ensure girls come to no harm, for example, by being ostracised in the wider community or angering their male partner.

Foundational gender norms also inform attitudes and behaviours about what it means to be a 'real man', including beliefs about male dominance. In several studies, we see gender norms underpinning hypersexualised attitudes and behaviours about boys 'needing' more sex and multiple partners – which can place both young men and women at risk.[149] These inequitable norms put pressure on ABYM to perform forms of 'toxic' masculinities, damaging their relationships and trapping them in cycles of violence perpetration, mental health issues and substance use.

Structural factors like poverty, unemployment, and traditional rites of passage have been seen as further entrenching patriarchal norms and reinforcing the role of sexual identity and masculinity in maintaining power. Men are often socialised to view their partners' autonomous health decisions, such as PrEP use, as a threat to their authority, leading to conflict and violence rather than contributing to a healthy partnership or relationship. Further, ABYM are primarily identified as upholders of heteronormative and heterosexist norms. Parenting practices can perpetuate toxic masculinities, including through favouring boys or condoning aggressive and violent behaviours, which highlights the importance of parenting initiatives – in connection with both younger children and adolescents – to address harmful gender norms.

Programmes and research addressing the needs of boys and men and how gender norms affect their well-being and SRHR should complement efforts to promote girls' empowerment. Equimundo has produced a number of useful research reports relevant for promoting gender equality and SRHR.[150]

Heteronormativity

Foundational norms of heteronormativity, which position non-heterosexual expressions of sexuality as 'deviant', have contributed to poor SRHR outcomes in ESAR. Heteronormativity contributes to stigma and discrimination against LGBTQ+ populations.[151] The 2016 Afrobarometer survey, for example, showed the extent of discrimination faced by homosexuals in Africa.[152] The survey shows only 21% of citizens across 33 countries saying they would like or would not mind having homosexual neighbours. However, the survey showed considerable variation, with South Africa expressing more accepting attitudes (67% of people would strongly/somewhat like or do not care about having a neighbour who is homosexual), while intolerance towards homosexuals was seen to be widespread in Uganda (95%).

Heteronormativity can be reinforced by punitive laws and policies. Several countries in the region have sought to criminalise same-sex behaviour. Such restrictive laws are correlated with lower rates of HIV testing and higher HIV prevalence among gay men and other men who have sex with men, which may include men who identify as heterosexual.[153] Heteronormativity, including cisnormativity, can place non-heterosexual youth – particularly those belonging to transgender populations – at heightened risk of violence and HIV and other STIs.

An extreme manifestation of heteronormativity was seen in the GBV deep dive, where this foundational norm underpins the practice of so-called 'corrective' rape, where Black lesbian women and gender-nonconforming individuals have been targeted in violent assaults, in some cases leading to femicide.[154] This example foregrounds the intersection of gender and heteronormative norms, with severe consequences for lesbian women who do not conform to these norms.

Stigma and discrimination, underpinned by harmful social norms, contribute to rights violations, inequitable health outcomes and violence against young men and women. UNAIDS have developed tools for monitoring HIV-related stigma which can affect both people living with HIV as well as key populations and identified promising interventions for addressing stigma and discrimination including engaging affected populations, community leaders, health care providers and addressing punitive legislation. See more examples here.

Adultism

In the context of adolescent SRHR, adultism can be a significant barrier to accessing services. Adultism has been defined as a belief system based on the idea that the adult human being is in some sense superior to the child [or young person] or of greater worth, and thus the child, by default, inferior or of lesser worth and possessing less autonomy and power.[155] Adultism can result in AYP anticipating that they will face stigma or judgment from healthcare providers and consequent reluctance to seek SRHR services. Healthcare, education and social services providers often hold beliefs on the limited autonomy and independence of AYP, often

underpinned by religious norms that they should not be engaging in sexual activity at a young age or outside of marriage.

Adultism may lead parents to avoid discussing SRHR topics with their older children or adolescents, often driven by the myth that discussing these topics will encourage AYP to engage in sexual activity. However, evidence shows that lack of communication with parents, caregivers and adult role models on SRHR is associated with poorer access to services and worse SRHR outcomes among AYP. Not all adults hold judgemental attitudes. In some cases, AGYW perceive female caregivers, such as mothers and aunts, as more accepting of contraceptive use and more approachable than fathers to discuss the topic.[156] It is, therefore, important in the design of effective social norms interventions to understand the relational and communication dynamics between different groups of adults and AYP.

Adultism is further manifested in the legal or informal barriers to accessing specific health services linked to age.[157] For example, in South Africa and Tanzania, young women often face pressure to seek permission from their parents or elder relatives before starting PrEP,[158] even though AGYW can legally consent to PrEP from the age of 12 in South Africa. Here, the foundational norm of adultism can lead to deference to parental authority, which restricts their autonomy in health-seeking behaviours.

Adultism also shapes decision-making and social expectations around the aftermath of experiencing GBV. Young women who experienced violence highlight the 'final say' that adults have when it came to decisions to access health or legal services in the aftermath of IPV.[159] The analysis in the GBV deep dive shows how adultism and AYP's deference to parents' decisions can be a barrier to accessing justice, health and psychosocial care.

Privacy

Privacy foundational norms relate to the type of personal information that is acceptable and appropriate to share with others.[160] Privacy norms are particularly important in contexts where there may be stigma and discrimination faced by AYP associated with the uptake of services, including HIV treatment and PrEP.

From the qualitative analysis described in deep dives on PrEP and contraceptive use above, lack of privacy in healthcare keeps AYP from seeking health services, and some adolescents seek private or mobile clinics because they expect to be less likely to encounter a family or community member.[161, 162, 163] Privacy concerns affect AGYW's perception of the provision of contraceptives in locations such as schools, hospitals or drugstores.[164, 165] These concerns may increase when household members spend more time at home due to external shocks, such as the COVID-19 pandemic.[166] Some SRHR issues, such as terminations of pregnancies, are seen as particularly important to be kept secret.

Foundational norms of adultism and privacy also interact in impacting the health-seeking behaviours of AGYW. Adultism often manifests in parents and healthcare providers through dismissive attitudes and a lack of respect for AGYW's autonomy, while privacy concerns can deter AGYW from accessing healthcare services, as they worry about their health information being disclosed to parents, guardians or peers. These interlinked foundational norms thus create an environment where AGYW may avoid seeking care to protect their dignity and privacy, hindering their access to essential health services. Similarly, foundational norms of privacy and gender may combine to create an insurmountable barrier to accessing essential services. For example, if a young woman fears confidentiality will not be respected and she will be condemned as promiscuous for taking PrEP.

Privacy norms may be more evident where there is a strong risk of disapproval by parents or partners or social sanctions from the community. However, privacy norms should be understood in the context of community and communal systems of care, which exist in many ESAR countries. These informal care networks can provide vital support for families, including AYP, enabled through positive normative systems such as Ubuntu. These value systems embed the individual in communal care approaches which can offer vital support, but can threaten an individual's privacy when coupled with inequitable and harmful norms[167].

Importance of individual factors

The deep dives also highlight that, in addition to social norms, other individual factors affect SRHR-related attitudes and behaviours. An individual's knowledge about different contraception methods and ability to question some of the myths and misconceptions about contraception clearly affects health-seeking behaviours. Individual factors such as age and age differences among intimate partners, as well as relationship status also affect AGYW's agency and decision-making powers in relation to SRHR choices.

Importance of environmental factors in behaviour change

In unpacking social norms and their impact on SRHR-related behaviours in AYP, it is crucial to consider the influence of environmental factors, such as poverty and instability. For example, studies from informal settlements highlight the additional stressors, such as inadequate housing and overcrowding, that can contribute to GBV. Experiencing childhood violence can shape gender norms and violence perpetration, particularly in boys and men. Economic instability and crises, such as those experienced during economic downturns, climate shocks or conflicts that force people to move as refugees or internally displaced people, can exacerbate harmful gender norms. In such contexts, AGYW may become more dependent on their partners and adult caregivers and fearful of alienating them and risk losing financial or social support. This, in turn, may limit their agency in SRH decision-making. Understanding these factors can help design effective interventions that address not only the social norms but also environmental factors contributing to violence and other poor SRH outcomes.

Legal and policy frameworks that support access to SRH services can help shift these norms. Studies have shown how adolescents, particularly those who may face additional pressures such as adolescent mothers, have to navigate complex normative, legal and policy environments.[168] More enabling legal and policy environments, including age-of-consent provisions to access SRH services and HIV testing, can enable these adolescents to access relevant services including contraception, health care and HIV treatment and care. However, even when the necessary legal and policy provisions are in place, pressure at the community level often remains a dominant influence. For instance, we see that even where PrEP is supported through enabling laws and policies, social stigma continues to deter AGYW from using it. However, some studies show that as PrEP became more widely available, stigma reduced – showing that norms and attitudes are not fixed and can change over time.

Our analyses highlight the need for further research on marginalised youth, including street youth, refugees and key HIV-affected populations, who may face multiple normative and structural barriers and forms of discrimination. Research is also needed to explore contexts where norms and reference groups may shift due to new structural barriers and dynamics, including settings affected by climate crises, pandemics and conflict.

HOW ARE SOCIAL NORMS REINFORCED OR CHANGED?

From our review, it is clear that social norms can change over time and understanding how norms change is critical for the design of programmatic interventions. While this review does not explore the attributes of norms change initiatives in-depth (which are discussed in the accompanying review of interventions), we pull out here some key concepts which are important for understanding how norms change and relate these concepts to what we have observed from our secondary analysis of qualitative studies. This section looks briefly at the importance of reference groups in change processes, understanding the strength of social norms, transformative approaches to norms change, and decolonising work on social norms.

As set out earlier, **reference groups** are the people to whom we compare ourselves and our behaviour, the people we look to when deciding what to think or do, and the people whose thoughts and opinions we care about.[169] In our analysis of the three SRHR outcomes, and reviews of the wider SRHR and social norms literature, several important reference groups emerge who maintain social norms and are key stakeholders for norms interventions. The relative importance of particular reference groups, and the strength of their attitudes and beliefs relating to particular norms, is highly context-dependent, which underscores the need for participatory analysis as part of a design process of social norms interventions.

Male partners in heterosexual relationships have a key role in upholding gender norms and behaviours, including in decisions on initiating sex, determining when violence is seen to be an appropriate response, as well as influencing decisions about accessing contraceptives and PrEP.

Peers play an important role in creating and reinforcing gender norms among AYP, including shaming girls seen to be promiscuous or mocking boys who are seen to be effeminate or not manly enough, perpetuating toxic masculinities. Peers also play an important role in conveying SRHR information, including unhelpful myths and misconceptions, which highlights the need for interventions that address SRHR knowledge as well as norms and attitudes. The importance of peer-based networks for shaping and shifting norms and promoting more gender-transformative attitudes to sex and relationships is often at the core of many girls' groups and safe space initiatives, which is discussed more in the review of social norms interventions.

Parents and caregivers are important reference groups that play a role in socialising children and young people and reinforce norms of what it means to be a 'good' girl or boy. Parents and caregivers are often reluctant to discuss SRHR with young people, but are also important gatekeepers who influence when and if AGYW are able to access PrEP or SRH services, including contraception. They play an important role in determining whether their daughters seek healthcare or justice following GBV and, in some cases, they normalise levels of violence within marriage.

Health providers are an important reference group upholding gender and adultism norms which contribute to attitudes and behaviours seen as judgemental by AYP and shaping their trust in, and motivation to use, healthcare

services. This was notable when healthcare providers labelled sexually active AGYW as shameful or promiscuous when accessing contraception services. This can lead AYP to be reluctant to access public health services and turn instead to private sector health providers or pharmacists.

Teachers are a key reference group who can influence SRHR behaviours and often demonstrate concerns about expressions of adolescent sexuality and stigmatise girls who transgress social norms of chastity – including girls who become pregnant while at school. Supporting adolescent and young mothers to return to school is a core approach to promoting SRHR, with a growing body of evidence on how to support teachers and school staff to positively shift norms and enable the right to education for AGYW.[170, 171]

Norms held by parents and caregivers, health workers and teachers are often underpinned by religious beliefs, which reinforce norms of sexual purity, gender roles, virtues of motherhood, the status associated with larger families and, in some cases, modern contraceptive methods and abortion.

In our consultations, members of the UNITED! Movement[b] stated that religious leaders can perpetuate negative attitudes towards pre-marital sex and pregnancy and stigmatise young people seeking contraception, comprising a major barrier to service access. As we see from the discussion on rites of passage above, religious and traditional leaders play an important role in undertaking rituals which can reinforce social norms of gender and heteronormativity during 'coming of age' ceremonies. Conversely, as the UNFPA review of rites of passage demonstrates,[172] religious and traditional leaders can also be critical in modifying rites of passage to ensure they do no harm to young people and instead focus on pro-social values.

Understanding the types and strengths of relationships and power dynamics between individuals and their reference groups is key for understanding how norms are reinforced. As described in the analysis of gender norms above, power imbalances, including the use of force or violence, are often used to ensure that AGYW submit to the will of their sexual partner, placing AGYW at risk of unwanted pregnancy, sexual abuse and inability to access contraception or PrEP. Understanding power dynamics across different groups of stakeholders by age, sex/gender, religion, employment/professional and social status in each community is an important step in planning social norms and SRHR interventions. It is also important to identify the early adopters and champions of change who may amplify these changes to reach community-wide tipping points.

UNDERSTANDING THE STRENGTH OF SOCIAL NORMS

In addition to understanding who are the reference groups, behaviour change requires an understanding of the strength of particular norms and how much they influence particular outcomes. Social norms can be seen along a spectrum with variable effects.[173] In some

b UNITED! is a joint movement, working closely with UNICEF, that aims to strengthen youth engagement in advocacy for SRHR. The movement includes youth leaders from 14 countries. Members from UNITED! were consulted as part of the universities of Cape Town and Oxford reviews into social norms and SRHR outcomes for AYP.

cases, norms can make a practice obligatory (for example, communities may have a shared belief that all girls must get married by the age of 20) or the norm may be more loosely adhered to (for example, a community may believe that while it is socially desirable to marry when young, there are few sanctions enforcing this practice). Understanding the strength of the norm and how it exerts influence on behaviours alongside other environmental, social and individual factors is important for designing SRHR interventions among AYP. For example, in the context of programming to address child marriage, this entails considering how much investment should go into directly changing social norms as opposed to addressing other factors that might be driving the practice (for example, expanding opportunities for education and livelihoods).

In our deep dive analyses above, we see different strengths and impacts of the particular norms in different contexts and situations. In the GBV deep dive, we see how harmful gender norms may strengthen according to the marital status of AGYW – in some cases, young women who are married are expected to tolerate IPV more than women who are unmarried. In the PrEP deep dive, we see that AGYW's ability to access PrEP and transgress norms of adultism and gender varies depending on the perceived strength of those gender norms in a particular community, as well as the community's prevailing knowledge and take-up of PrEP. When PrEP becomes more available, take-up may become more 'normalised' and the influence of restrictive gender norms may diminish.

NORMS CORRECTION VERSUS NORMS TRANSFORMATION

There have been several different approaches to social norms interventions as described by Cislaghi et al., 2021.[174] **Norms correction** approaches responded to the realisation that peer influence can have a significant influence on people's behaviours and choices and that people often overestimate other people's unhealthy behaviours.[175] Norms correction approaches were used to reduce a variety of harmful behaviours which could adversely impact health outcomes, including alcohol and tobacco use, sexual assault and driving while under the influence of alcohol or drugs. These studies were mainly undertaken in high-income contexts.

Since 2000, there has been a growth in **norms transformation approaches**. Central to these is the belief that bottom-up, rather than top-down, approaches (such as community conversations) can more effectively establish and galvanise compliance with new positive norms. Programmes taking this approach usually encourage the spread of these new positive norms to the wider community through processes of 'organised diffusion'.[176] In our accompanying review of interventions, we look in detail at the various elements of norms change, including organised diffusion. The brief example below shows one attempt to diffuse new gender norms in West Africa.

Tostan International, an NGO based in West Africa, undertook an innovative norms transformation approach to address FGM/C. Their social mobilisation process encouraged each participant in a Tostan class to 'adopt' a friend, neighbour or family member and share with them new knowledge learned during the class. This practice ensured that the concepts discussed spread throughout the community. Tostan estimates that this approach allowed their work to impact roughly ten individuals for every one direct participant. For more information go to the Tostan website here.

DECOLONISING SOCIAL NORMS

From discussions with key informants, social norms programmers have been giving consideration to how to decolonise social norms interventions. Debates have focused on how to move beyond top-down, foreign aid-driven behaviour change interventions and support power shifts which build on community perspectives. Alongside, there is a growing focus on amplifying the voices of those most affected by harmful social norms. Similarly, there is heightened recognition of the importance of building and supporting social movements for tackling harmful social norms, including the importance of enhancing the agency of young people to shift social norms at scale.

An example of this is the work undertaken to eliminate FGM/C and other forms of GBV, where women's and feminist movements are driving norms change. Women's movements in West Africa have been active and effective in shifting gender norms and promoting legal change that can reduce FGM/C and GBV, including in Senegal and Sierra Leone.[177] Women-led social movements across the continent have been instrumental in promoting gender justice through community-level, legal and policy change to create more enabling environments for girls and women.

Mirroring this women-led activity, among many agencies working on ending violence, there is a push for greater investments in youth and girl-led movements for norms change. While there are some examples of such advocacy leading to change, there is a need for evidence-based evaluations of the impact of women- and youth-led movements, both at community-level and on national laws and policies.

> Promotion of sustainable change requires identification of activists and social movements operating at local, national and international levels, who can support social norms and behaviour change at different levels, and where possible, join forces to identify shared priority concerns and opportunities for joint advocacy, including on shifting laws and policies.

Adopting a decolonising approach to behaviour change including work on social norms requires researchers and implementers to adapt theories to the local context, working with regional experts and communities. The work of Bukuluki has highlighted the importance of understanding the philosophy of Ubuntu for social norms change. A system of values emphasising the interconnectedness of individuals and of humanity towards others, Ubuntu is influential in large parts of southern and central Africa to create a positive sense of community. The concept of Ubuntu can be seen as pro-social in helping to contribute to social cohesion and, at the same time, holding potential to perpetuate social norms (pro-social or harmful). Ubuntu has been shown to foster a sense of collective identity in many African societies, engendering empathy and compassion for one another. At the same time, the value placed on social cohesion and people living harmoniously, may make it difficult for an individual to express agency where their needs and/or behaviour deviates from the norm. Bukuluki's work raises interesting questions about challenging norms and whether the Western perspective of agency (especially the primacy of individual agency) aligns with the African philosophy of Ubuntu, which stresses the importance of collective identity and harmony.[178]

SUMMARY AND CONCLUSIONS

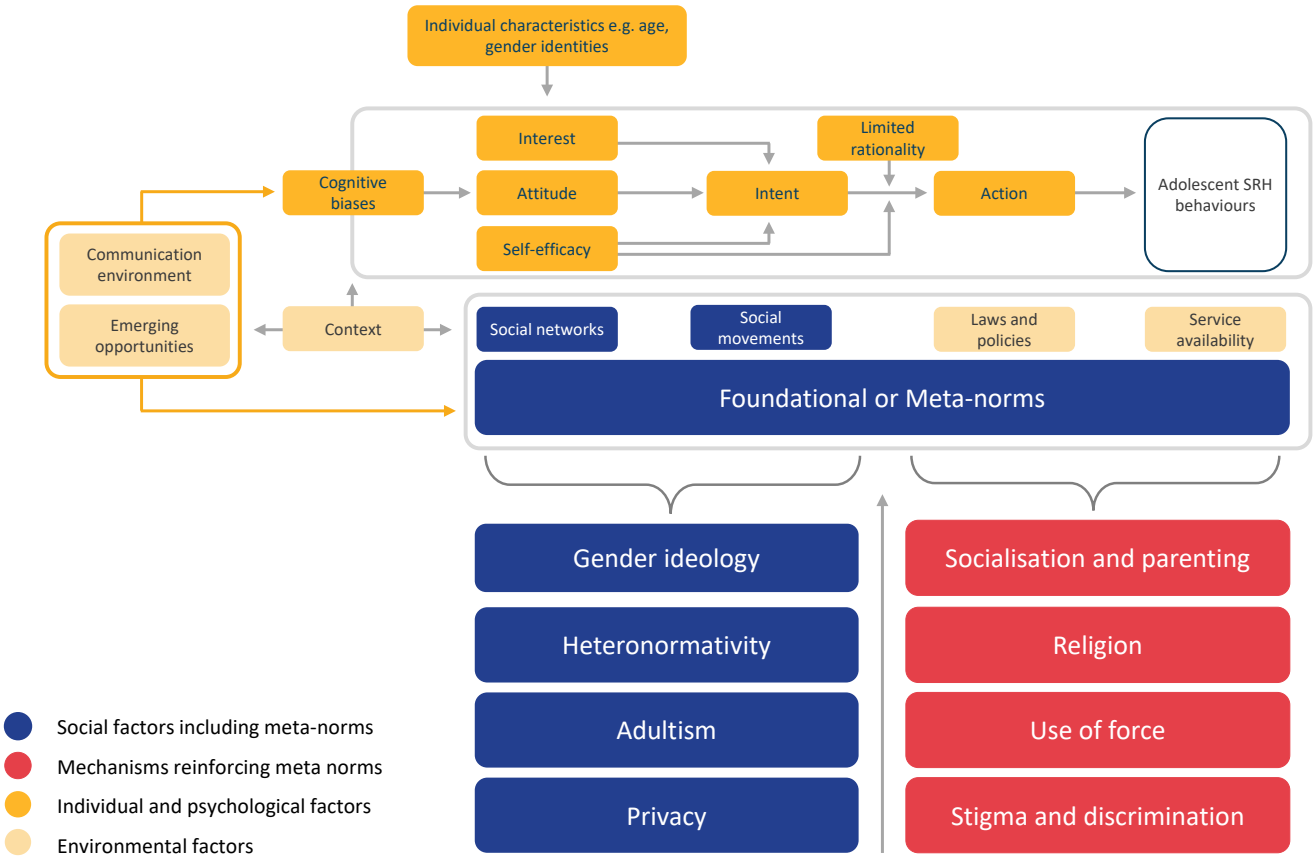
This review highlights the importance of understanding and addressing social norms for improving SRHR outcomes among AYP. Our literature review of conceptual models and qualitative data highlights key foundational norms which impact a wide range of attitudes and behaviours, as well as the reference groups that help create, maintain and change these norms. We see the critical role that gender and other social norms play in shaping attitudes and behaviours, which can both help or hinder SRHR outcomes. In this review, we have identified prominent **foundational norms** across the region. While **gender** foundational norms are potentially the most influential on adolescent SRHR outcomes, we also see how foundational norms of **heteronormativity, adultism** and **privacy** affect risk-taking and SRHR-seeking behaviours, through both relationship dynamics and health-seeking behaviours. In Figure 6 below, we highlight these foundational norms in blue.

We also highlight (in the pink boxes in Figure 6) some of the processes through which norms

are created and maintained. These include socialisation processes, such as parenting and caregiving practices which can reinforce gender norms on what is appropriate behaviour for young women and young men in a particular society. Similarly, religion often supports gender norms, with religious texts used to reinforce hierarchies and gender ideologies, and religious leaders being a critical reference group that can sanction those people who transgress norms. As set out in the deep dives, we also see how stigma and discrimination can perpetuate harmful social norms, marginalise key populations, hinder access to services and lead to acts of extreme violence against those who deviate from the social norms.

While we see similar patterns of norms and mechanisms to reinforce them across the region, understanding the context in which these norms emerge and are enacted is critical. Identifying which norms are the most important, which reference groups are most influential, and mapping additional structural barriers that need to be addressed requires well-resourced formative and participatory research that informs programme design and implementation. Participatory, bottom-up formative research is an important strategy in decolonising norms interventions, and can prevent interventions from being too top-down and instead, respond to AYP and communities' realities and concerns.

Figure 6 Expanded Behavioural Drivers Model showing foundational norms for SRHR in AYP



Our analysis, building on conceptual frameworks such as Cislaghi and Heise's Flower Model and UNICEF's BDM set out above, highlights the need to understand the relative importance of social norms alongside individual and environmental factors, such as poverty, legal barriers and limited availability of services (health, education, protection, etc.). As detailed in our accompanying scoping review, many social norms interventions for improving SRHR outcomes are combined with interventions that tackle both environmental factors (e.g,. economic support) and individual-level interventions (including improving SRHR knowledge). The key is to find the right 'mix' of interventions to respond to the local context.

KEY FINDINGS AND IMPLICATIONS FOR ACTION

1. It is essential to understand the relative importance of social norms alongside other social, individual and environmental factors for optimal impact on SRHR outcomes. For example, it may be necessary to support social norms programmes alongside investments in adolescent-friendly health/ GBV services and interventions that tackle the economic drivers of SRHR risk.
2. Understanding how foundational norms and social norms interact, influence and reinforce particular attitudes and

behaviours is critical for designing effective interventions for adolescent SRHR. Understanding social norms, particularly gender norms, enhances our grasp of the risk drivers and factors that can impede or facilitate access to SRHR services among AYP in their full diversity.

3. Key foundational norms that impact multiple SRHR outcomes among AYP in ESAR include **gender**, **heteronormativity**, **adultism** and **privacy norms**.

4. Gender norms, while manifesting differently across contexts, consistently affect SRHR outcomes among AGYW through increasing risks of coerced sex and GBV, and maintaining norms regarding the desirability of girls' chastity before marriage. Foundational gender norms significantly impede girls' agency, access to SRHR services and positive SRHR outcomes.

5. Gender norms can also negatively impact boys and men, including by reinforcing hypersexualised notions of what it means to be a boy or man, leading to greater sexual risk-taking, which can adversely affect adolescent boys and girls. Therefore, SRHR interventions should involve working with ABYM and AGYW to improve outcomes among AYP.

6. Heteronormativity norms contribute to continuing stigma, discrimination and violence, particularly against non-heterosexual populations. Tackling stigma and discrimination and the rights of young LGBTQ+ populations continues to be a priority to progress on global goals, including in relation to ending violence and improving HIV outcomes.

7. Adultism can impede discussions on SRHR between parents, caregivers, teachers and health workers and AYP, limiting opportunities for sharing knowledge and skills that will improve SRHR outcomes among AYP. Interventions are needed to improve inter-generational dialogues and create safe spaces where AYP's views are heard and respected.

8. Privacy norms and fears that healthcare providers will not respect AYP's patient confidentiality are seen as factors deterring access to SRH services among AYP. This highlights the need for better training and supervision of primary healthcare workers to respect the rights and agency of AYP.

9. Participatory research and intervention co-design with AYP and those who influence them (including parents, partners and community leaders) are critical for identifying the key norms that affect SRHR-related attitudes and behaviours for each AYP group in their context. This approach can also help to pinpoint who are the important reference groups and entry points for interventions.

10. In this review, we found few studies addressing social norms and SRHR outcomes for key populations and AYP facing multiple deprivations (including those living in conflict and crisis contexts). There is a need for further research to investigate norms and foundational norms among the most at-risk and marginalised AYP.

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