Sweden
Sverige

2gether 4SRHR

# SCOPING REVIEW OF SOCIAL NORMS INTERVENTIONS

## TO IMPROVE SRHR OUTCOMES AMONG ADOLESCENTS AND YOUNG PEOPLE IN SUB-SAHARAN AFRICA

UNAIDS

UNFPA

unicef
for every child

World Health Organization

accelerate RESEARCH HUB

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

UNIVERSITY OF OXFORD

# ACKNOWLEDGEMENTS

This research partnership was made possible through the Government of Sweden's support to 2gether 4 SRHR- a joint United Nations programme designed to improve sexual and reproductive health and rights in Eastern and Southern Africa. Gaia Chiti Strigelli, Jenny Yi-Chen Han, and Nicholas Niwagaba of UNICEF provided policy and programme guidance and leadership. We greatly appreciate the contributions of the members of the Oxford-UCT research team who conducted the research that is presented in this paper. This paper was written by Luciana Leite, Rachel Yates, Elona Toska, Jenny Chen-Charles, and Maria Rotaru of the Oxford-UCT research team. Laurie Gulaid of UNICEF reviewed this paper. Leah de Jager created the figures in this paper unless noted otherwise. We would also like to thank the key informants consulted, including: Clare Bangirana (Africhild and Makerere University), Paul Bukuluki (Makerere University and Eastern Africa Learning Collaborative), Ben Cislaghi (Makerere University), 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 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 including 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).

**May 2025**

This research was funded by UNICEF Eastern and Southern Africa Regional Office (UNICEF ESARO) through the 2gether 4 SRHR Programme; the UKRI GCRF Accelerating Achievement for Africa's Adolescents (Accelerate) Hub [ES/S008101/1]; Oak Foundation [OFIL-20-057].

# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

Across sub-Saharan Africa, improving sexual and reproductive health and rights (SRHR) among adolescents and young people is a key priority for achieving regional and international goals such as Agenda 2063 and the Sustainable Development Goals.

Progress in addressing gender-based violence, early pregnancy, child marriage, and the HIV epidemic has been uneven across sub-Saharan Africa. Social norms, or informal, shared rules about what are acceptable and appropriate actions within a group or community, act as critical barriers to achieving SRHR, especially for women and girls. Whilst there is widespread recognition of the importance of norms and their contribution to SRHR among adolescents and young people, there are considerable gaps in understanding how norms impact SRHR outcomes, particularly among adolescents and young people, and what works to improve SRHR outcomes through social norms interventions.

This scoping review aims to deepen our shared understanding of what works to change social norms underpinning violence and a range of other poor SRHR outcomes among adolescents and young people in sub-Saharan Africa. We define social norms interventions as those seeking to change the socially shared rules that determine acceptable and appropriate actions within a group or community. Applying social norms interventions to shift behaviours has increasingly been used as a strategy to promote the health and well-being of adolescents and young people across sub-Saharan Africa. The review examines evidence on social norms interventions in sub-Saharan Africa that use experimental and quasi-experimental designs, focusing on SRHR outcomes achieved among adolescents and young people (10–24 years). Studies were included in this scoping review if they reported single or multi-component programmes that incorporated a norms component.[1] [2] We assess the impact of different social norms interventions on specific SRHR outcomes while highlighting insights that can be applied to social norms programming more broadly.

Findings from this review, a review on the 'Network of Norms' underpinning SRHR outcomes and secondary data analyses on adolescent boys and young men, are synthesised into a technical brief. The technical brief summarises key findings from the reviews and highlights recommendations and design considerations for use by policymakers and practitioners in SRHR and social and behaviour change programming.

Key findings from the 40 studies that met the eligibility criteria for this review, which span 11 countries in sub-Saharan Africa, are as follows:

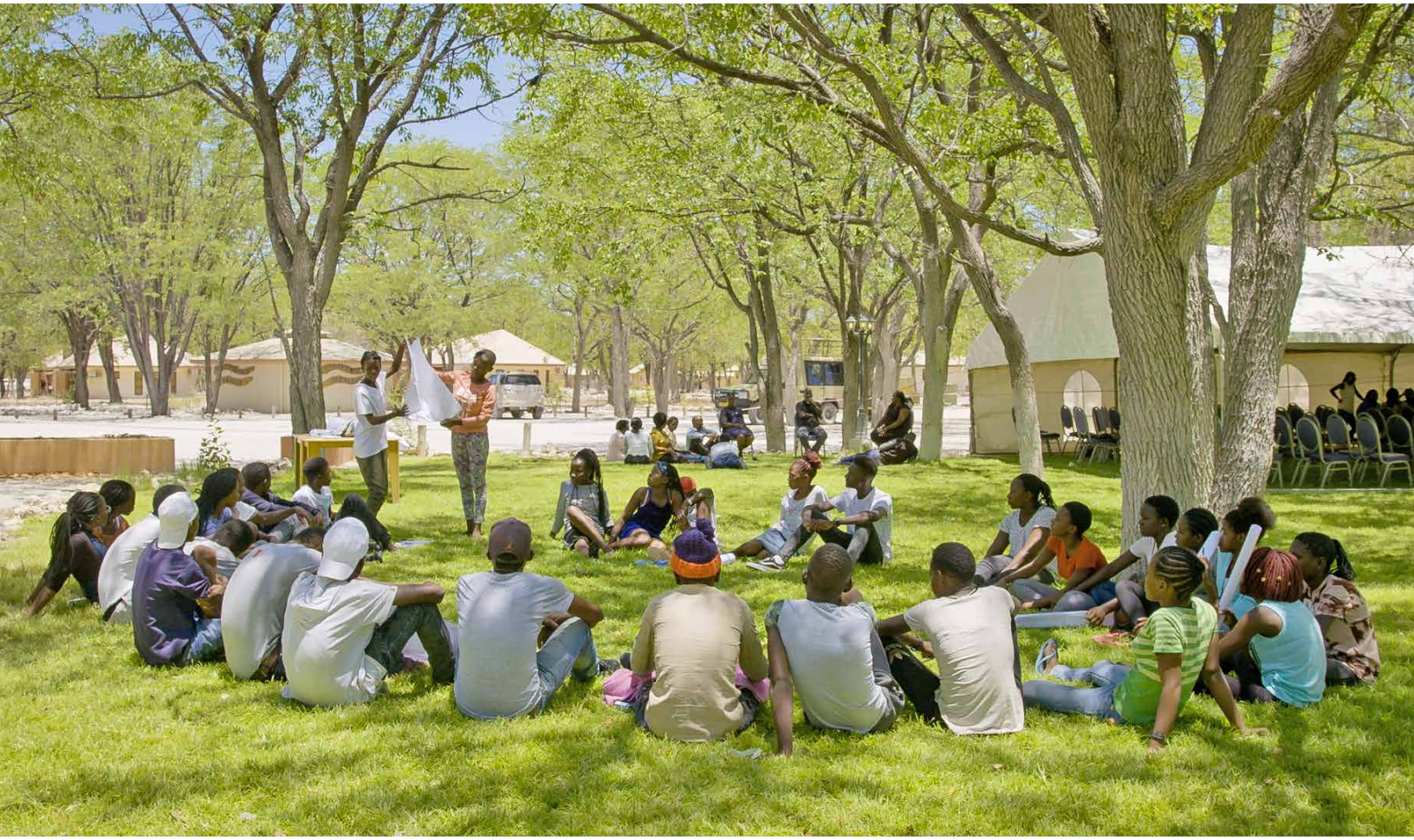
1. **Effectiveness of social norms interventions.** Included social norms interventions were most effective in reducing violence and child marriage, increasing contraceptive use, and promoting HIV testing. Mixed or null results were observed for sexual risk behaviours, early pregnancy, and HIV incidence, with limited data on other SRHR outcomes. Most studies were from South Africa (13), Kenya (6), and Uganda (5).

2. **The importance of comprehensive approaches.** Almost all interventions (97.5%) focused on changing social expectations, while fewer focused on publicising and diffusing change (37.5%) and on catalysing and reinforcing change (77.5%). Programmes that included all three elements were 2 times more likely to be effective than to lead to null or mixed results. The presence of these elements ensured that change in attitudes and behaviours was not only achieved within a small group but allowed for change to be sustained over time and diffused to a critical mass of people.
3. **Importance of gender-transformative programming.**[a] Effective interventions raised awareness and prompted critical reflections addressing gender roles, inequalities, power dynamics, youth sexuality, gendered power relations, girls' agency, existing norms around the acceptance of gender-based violence, the value of girls' education, and postponement of early marriage and childbearing.
4. **Role of reference groups.**[b] Successful interventions often took a socio-ecological approach, working at multiple levels with influential reference groups, such as caregivers, healthcare workers, teachers, and community leaders, who played a key role in shaping behaviours and addressing barriers to SRHR services access.
5. **Key intervention strategies** often combined information sharing about SRHR topics and life skills, through participatory modalities delivered in existing community spaces and guided by trained facilitators based on a defined curriculum.
6. **Knowledge and research gaps.** The evaluation of interventions was hindered by the limited availability of study designs that allowed for the analysis of the effects of individual intervention components. Most studies did not use indicators to measure the normative change, highlighting the need for better formative research, theories of change, and metrics to measure norms change over time. Short programmatic timelines limited the ability to observe long-term changes and may have discouraged the use of diffusion strategies aimed at amplifying and sustaining social norms change at scale.

a Gender-transformative approaches aim to address the structural and social root causes of gender inequality and thereby promote more equitable outcomes for children in all their diversity. (UNICEF, 2021).

b The people whose opinions and expectations matter to young people when they consider whether to engage in a behaviour. (UNICEF, 2021)

# INTRODUCTION



Adolescents and young people in sub-Saharan Africa face several barriers to reaching their full potential, including realising their sexual and reproductive health and rights (SRHR). Several countries experience high rates of HIV incidence and prevalence, which disproportionately affect adolescent girls and young women, who are three times as likely to acquire HIV as their male counterparts in sub-Saharan Africa.[3] High rates of sexual violence, adolescent pregnancy, and early marriage further compound poor outcomes among adolescent girls and young women.[4] [5] Structural barriers related to poor socio-economic conditions, such as lack of financial access and appropriate, accessible services, further heighten the risk of poor SRHR outcomes.[6] Social norms, or informal, shared rules about what are acceptable and appropriate actions within a group or community, can spread harmful misinformation and lead to poor SRHR outcomes, particularly when young people also lack accurate information and knowledge to make informed SRHR decisions.[7]

Adolescence is a time when young people establish their independence, develop behavioural patterns including health-seeking, and experience major physical, cognitive, hormonal, and social changes.[8] This can be accompanied by challenging parental and other boundaries when they explore their sexuality, taking greater risks and learning new lessons, which can make them more vulnerable to sexual exploitation. As young people reach puberty, social norms become more pronounced. Adolescence is, therefore, a critical period to support young people as they navigate their transitions to adulthood, including by promoting positive behaviours which can have life-long impacts on their health and well-being.

Social norms, including gender norms, have been identified as critical barriers to achieving better SRHR outcomes, especially for women and girls.[9,10] Social expectations of male dominance and control can restrict girls' and young women's agency over SRHR choices and increase their vulnerability to violence. Addressing social norms that sustain gender inequality and the acceptance of violence is, therefore, essential to improving overall SRHR outcomes and ensuring safety and well-being. While there is widespread recognition of the importance of norms and their application to the field of SRHR, there are significant gaps in understanding how norms impact outcomes, particularly for young people and what works to shift social norms interventions to improve SRHR outcomes.

Adolescents and young people may lack full agency over the behaviours that determine these outcomes and need supportive environments to make informed decisions.[11] These environments are shaped by reference groups, or people whose opinions and expectations matter to young people when they consider whether to engage in a specific behaviour. The groups of people included in young people's reference groups may vary by individual and by behaviour, but often include peers, parents or caregivers, and community members.

In response to these evidence gaps, 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)- has identified the need to undertake two reviews that map:

i) The network of norms underpinning SRHR outcomes, focusing on adolescents and youth;

ii) Interventions that address gender and social norms to improve SRHR programmes' impact on adolescents and young people in sub-Saharan Africa.

This review synthesises research on the effectiveness of social norms interventions to improve SRHR among adolescents and young people in sub-Saharan Africa. Social norms interventions to shift behaviours have been increasingly used as a strategy to promote the health and well-being of adolescents across Africa. Interventions related to SRHR aim to change norms that sustain harmful practices such as violence, child marriage, and female genital mutilation as well as those that shape the behaviours of adolescents in HIV prevention and treatment and contraceptive use.


The lack of consensus on the definition of social norms programmes poses a challenge for the evaluation of their effectiveness, and the development of new designs and scaled-up initiatives.[14] Existing work to categorise strategies of norms-shifting interventions tends to focus on their behavioural change strategy. However, these strategies may not always be as clearly defined in interventions to improve sexual and reproductive health. **We define social norms interventions as standalone or multi-component behavioural change interventions seeking to change the socially shared rules that determine acceptable and appropriate actions within a group or community.**[15]

In this review, we focus on social norms interventions that seek to improve SRHR outcomes among adolescents and young people in sub-Saharan Africa.[16] [17] [18] The review focuses on evaluations of interventions' effectiveness in shifting social norms to improve SRHR outcomes. It seeks to assess the impact of varied types of interventions on specific SRHR outcomes, while highlighting insights that can be applied to social norms programming across a range of outcomes.

# METHODS

We included any single or multi-component interventional study published between 2014 and 2024 that included an element aimed at norms change and assessed impacts on one or more SRHR outcomes of adolescents and young people (10-24 years old) in sub-Saharan Africa. The SRHR outcomes, selected based on consultations with key informants and UN partners, included: violence exposure including physical, sexual, and emotional forms of gender-based violence; uptake or use of contraceptives and family planning methods; HIV incidence, testing, prevention, and treatment; STI incidence including herpes simplex virus (HSV-2); early pregnancy and sexual debut; transactional sex; age-disparate sex; multiple sexual partners; female genital mutilation/cutting and other harmful gender practices; early, forced, and child marriage; menstrual hygiene management; medical male circumcision; and abortion.

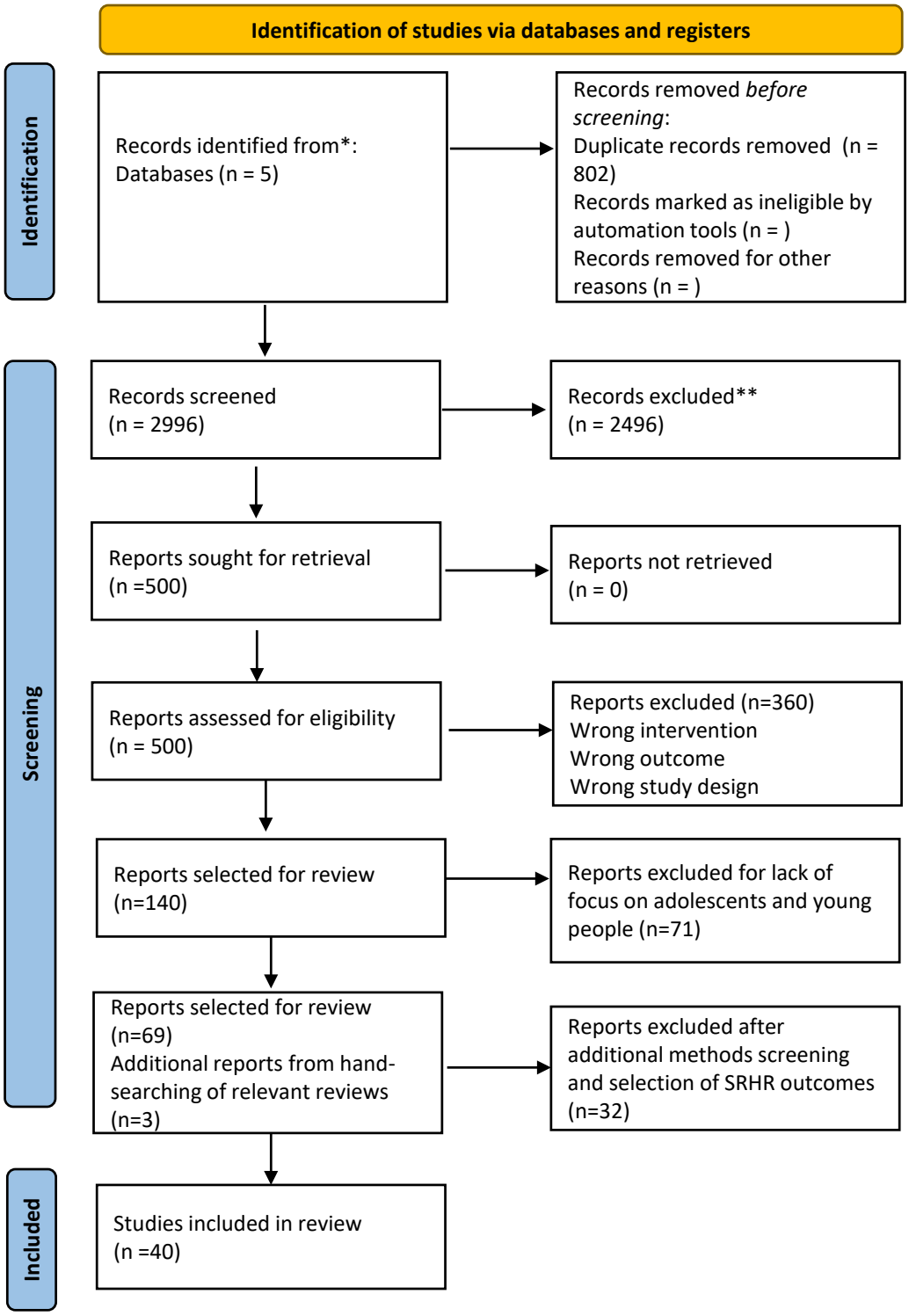
While some studies were explicit in their objective to shift social norms, we also included studies that described interventions that were implicitly aiming to bring about norms change, e.g., those addressing 'gender empowerment', 'notions of masculinity', and stigma. All included studies assessed changes in SRHR outcomes, though not all measured outcomes related to norms and attitudes. We included quantitative evaluation studies with a control group, such as randomised control trials (RCTs), and other experimental and quasi-experimental studies that assessed the effectiveness of social or gender norms interventions. Exclusively qualitative studies, or mixed methods and quantitative studies with cross-sectional and longitudinal designs, but without a control group, were not considered.

Searches were conducted in 5 databases or registries- Web of Science, ProQuest SS Premium, PubMed, Cinahl, and Cochrane - in March 2024 for peer-reviewed papers published in English. Articles in other languages were excluded. Search terms were iteratively developed within five search concepts: (1) adolescents and young people, (2) social and gender norms, (3) types of norms interventions, (4) SRHR outcomes, and (5) geographical focus. The keywords and terms were combined one after the other using Boolean Operators. The search terms are further described in Appendix A.1.

We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Guidelines.[19] Study records were exported to Covidence and titles and abstracts were screened independently by three researchers. Full texts were subsequently screened by the same three reviewers. Figure 1 presents the flow diagram of the study selection process.

Of the 2996 studies initially screened, our review identified 140 intervention studies. We then focused on interventions specifically assessing the impacts of interventions on adolescents and young people, which included 69 studies. An additional three studies were included through hand-searching of seven systematic scoping and narrative reviews, totalling 72 studies.[20 21 22 23 24 25 26]

**Figure 1: PRISMA diagram for the review**



Further studies were excluded due to lack of control group for the intervention (N=16 studies), ineligible study design (mediation analyses: N=2; feasibility studies: N=3), or for solely reporting on outcomes related to knowledge, intentions, and beliefs (N=8). Lastly, three studies focusing on female genital mutilation/cutting (N=1), menstrual hygiene management (N=1), and male circumcision (N=1) were excluded due to the low amount of available evidence for each outcome, compiling a final list of 40 intervention studies. The full list of included studies is described in Appendix A.2.

## DATA EXTRACTION

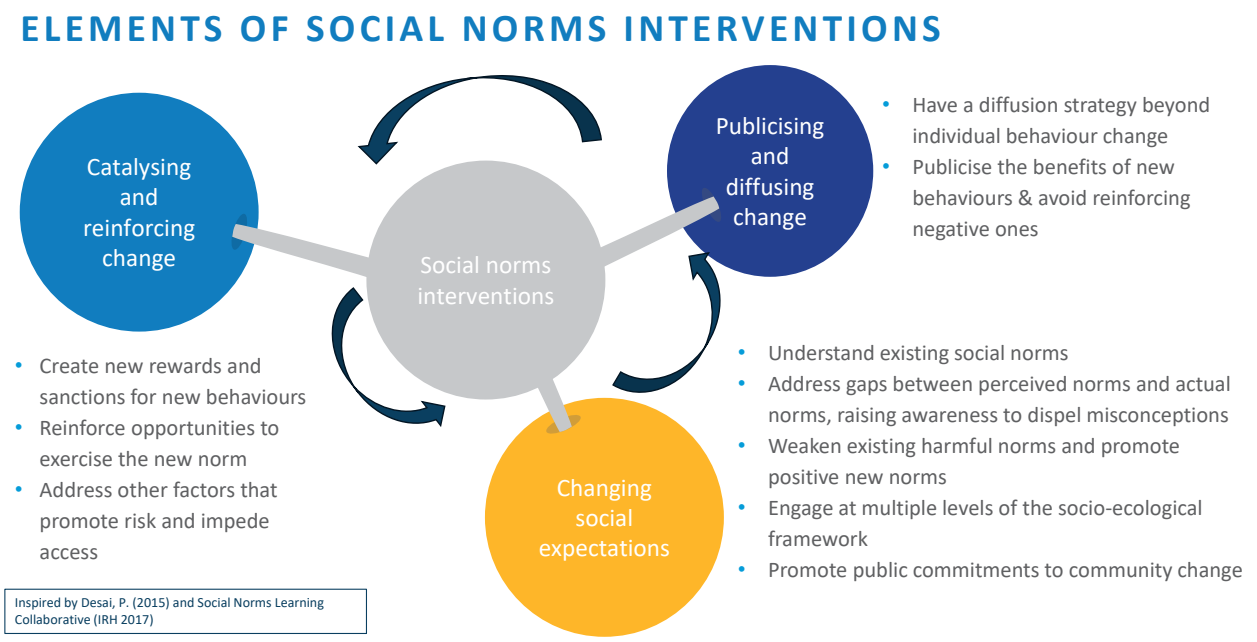
Data extracted from the final list of studies included: paper title, author names, publication year, study country, study design, population age and gender, sample size, intervention strategy, intervention description, intervention components, combined interventions, reference groups engaged, intervention setting, SRHR outcomes of interest, effect sizes, other outcomes measured, timeline of evaluation, delivery mechanism, content, and implications for programming. Data was synthesised narratively, and statistical pooling or meta-analyses were not conducted due to the variation in study designs, interventions, and outcome measures.

We categorised approaches applied in social norms interventions by strategy or entry point (e.g., life skills interventions, community dialogues, school-based programmes). In addition, to understand more about how interventions achieve norms change, we compiled a list of 10 common key attributes of

norms-shifting interventions, clustered around 3 elements informed by theory and practice. These elements are: i) changing social expectations, ii) publicising and diffusing change, and iii) catalysing and reinforcing change. We drew this list from key attributes commonly associated with effective norms-shifting interventions identified by the Learning Collaborative to Advance Normative Change and a three-stage framework of successful approaches to shifting harmful social norms described in a DFID 2016 Guidance Note for tackling violence against women and girls.[27] [28] The original nine attributes set by the Learning Collaborative are: seeking community-level change, engaging people at multiple levels, correcting misperceptions around harmful behaviours, confronting power imbalances, creating safe spaces for critical reflection by community members, rooting the issue within the community's own value systems, accurately assessing norms, using organised diffusion, and creating positive new norms. Following consultations with external experts, we added a tenth attribute on whether interventions addressed other structural barriers to norms and behaviour change. The full list of attributes for assessment of each intervention is outlined in Figure 2 below. Details on the criteria for attribute assessment are included in Appendix A.3.

All 40 eligible studies were reviewed to map whether each key attribute was reported. Attributes were assessed through a review of the main intervention publications plus any additional programmatic information including study protocols, accompanying papers, theories of change, curricula, and appendices when available online or linked to the main publication. Where the available information was not clear, partial, or missing, we marked the attribute as not reported.

**Figure 2: Key attributes of social norms interventions**

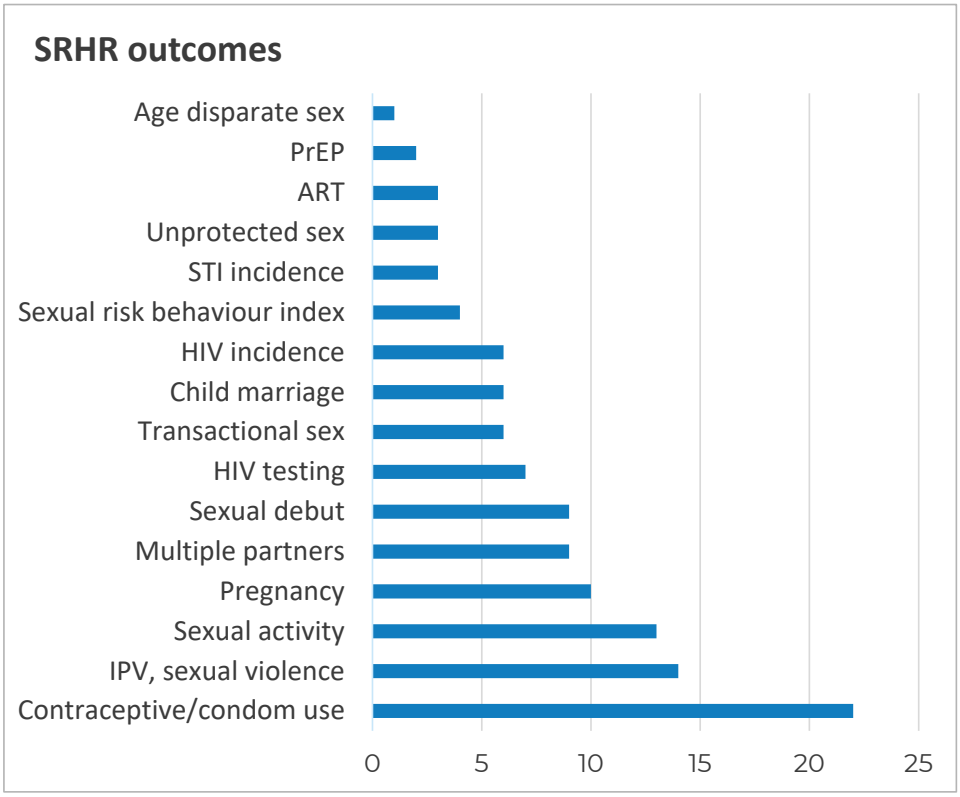


# RESULTS

Among 2996 articles identified by our search, 40 studies on 36 programmes met the review criteria. These included 25 RCTs and 15 quasi-experimental design studies or cross-sectional designs with comparison groups. The individual countries with the largest number of studies were South Africa (13), Kenya (6), and Uganda (5). Countries also included Ethiopia (3), Tanzania (3), Zambia (3), Niger (2), Nigeria (2), Zimbabwe (2), DRC (1), and Burkina Faso (1).

Six studies measured outcomes among all adolescents and young people aged 10-24, 5 amongst young adolescents 10-14 years old, 14 among adolescents 10-19 years (a few of these studies included participants younger than 10 and/or up to 20 years), and 15 studies targeted older adolescents and young people aged 14-24 (including studies with participants up to 28). Very few programmes focused on adolescents and young people with additional vulnerabilities or living in vulnerable settings. Thirty-one studies included community members, parents and caregivers, partners, healthcare providers, religious, cultural or community leaders, or teachers and school staff as reference groups of adolescents and young people, to create a supportive environment for the intervention and desired norms change.

**Figure 3: SRHR outcomes of included interventions**



Most measured outcomes were related to contraceptive or condom use, violence, sexual risk behaviours, early pregnancy, and HIV testing. Figure 3 breaks down the number of studies per outcome. We categorised these outcomes into six areas: violence, HIV, marriage, sexual risk behaviours, contraception, and pregnancy. Besides SRHR outcomes, several studies also measured outcomes related to gender-equitable attitudes (17), knowledge about an SRHR topic (18), self-efficacy and risk perception around SRHR (5), and intention to perform a desirable SRHR behaviour (3).

Interventions generally included multi-component community-based approaches that engaged adolescents and young people and their reference groups and targeted multiple SRHR outcomes.

Interventions were broadly categorised for analysis into eight categories describing entry points for delivering norms content: life skills training (23), community dialogues (14), school-based sexual and reproductive health (SRH) programming (10), parenting programmes (8), media or digital-based approaches (7), interventions with religious, cultural, or traditional leaders (5), training of healthcare professionals to provide youth-friendly services (7), and rights-based advocacy (2).

All studies included specific elements aimed at addressing social and gender norms and most delivered a variety of additional content. Twenty-five studies that met the inclusion criteria were multi-component interventions. In 15 of the programmes reviewed, norms interventions were combined with other types

of interventions, which fell into two major categories: economic support (7), healthcare service delivery (4), or both (4). Sixteen studies were evaluated over a period of one year or less, and 10 studies evaluated outcomes after 3 years or more.

Twenty-one studies applied formative research to adapt or design programmes with input from local stakeholders, according to what was disclosed in the studies themselves or study protocols. Twenty-five studies were based on theories of behaviour or norms change. The most common theoretical bases used were social cognitive theory[29] (7), theory of planned behaviour[30] (4), socio-ecological framework[31] (3), theory of reasoned action[32] (3), and asset-building theory[33] (3).

Twenty-six studies showed significant improvements in indicators measured in at least one of the intervention arms. Nine studies had null effects across outcomes, or null effects in all but one outcome when the study assessed more than 10 indicators. Five studies had negative effects in one or two outcomes, combined with a mix of other positive and null results.

Table 1 summarises the findings regarding the effectiveness of interventions by category and SRHR outcome. The direction of results is framed in terms of SRHR objectives, that is, a positive effect on GBV would represent a decrease in rates of GBV. Improvements in SRHR among adolescents and young people included: i) reductions in GBV and child marriage; ii) increase in access to, and use of, services (for example, increased HIV testing and use of PrEP); iii) decrease in sexual behaviours that increase the risk of HIV/STI incidence (for example, transactional, age-disparate, multi-partner, and condom-less sex).

Results are represented for each outcome available in the study as positive, negative, mixed, and null (green, red, yellow or dark red, and blue). Effects of individual interventions are captured by solid circles, while combined interventions are represented by hollow circles. These could be related to a combined package of interventions whose components are all included in the table (multiple norms components), or to non-norms intervention components not included in the table (such as social protection). Interventions that included separate intervention arms, or that assessed outcomes on different age or gender groups as their primary results (that is, did not report pooled effects across all populations) are represented as different circles. Mixed effects comprise a mix of positive and null results (yellow circles) or negative and null results (dark red circles), when more than one measurement per outcome category was assessed.

Appendix A.3 provides a comprehensive list of all included studies and outcomes.

## Table 1: Effectiveness of included interventions

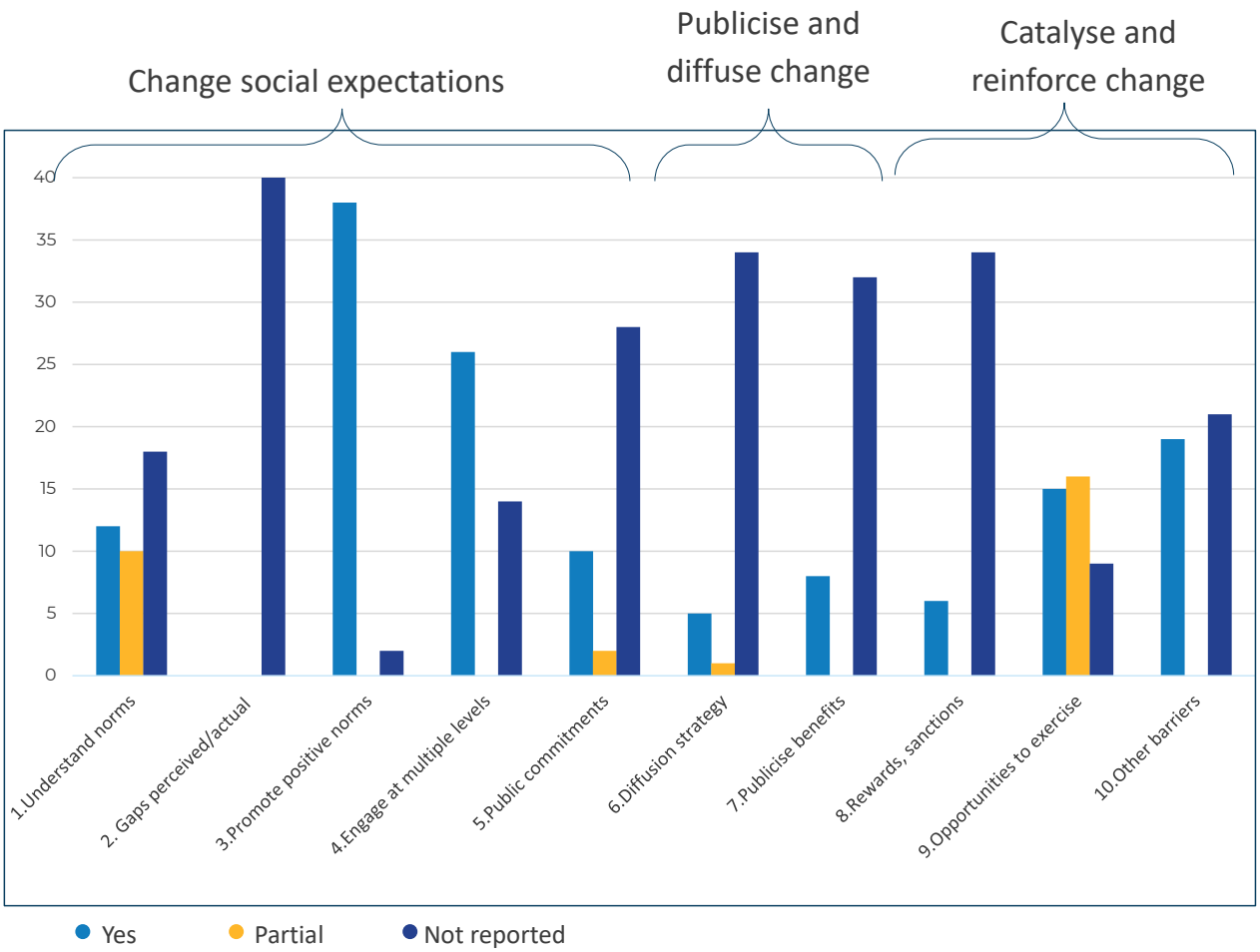
| Outcome / Intervention | Intimate Partner Violence | Any violence | HIV/STI testing | Knowledge of HIV status | HIV/STI incidence | PrEP use | ART use | Contraceptive use | No unprotected sex | Pregnancy | Sexual debut | Transactional sex | Age-disparate sex | Multiple partners | Sexual risk behaviour | Sexual activity | Child marriage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| School-based SRHR programming | ○○●●○ | ○●●●○○ | ○ | ● | ○● | | | ○○○●○●●●● | ● | ●○○●● | ○○○●○ | ●●○○ | | ○● | ○● | ○○● | |
| Life skills in group or community settings | ○○○○○○○○○ | ●○○○○○○○○ | ●○○●●○ | ○ | ●●○○○○○ | ○○ | | ●●○○○○○○○○●○○○● | ○○● | ●●○○○●○○○● | ○○○○○ | ●○○○○○○○ | ● | ●○○○●● | ●○●●● | ○○○ | ●●○○○○○○○ |
| Community dialogues | ○○○○○ | ○○○○○○○○○○ | ○ | ○ | ○○○○ | ○○ | | ○○○○○○○○○○ | ○○ | ○○○○○○ | ○○○○○○○ | ○ | | ○○○ | | ○○○○ | ○○○●○○○○ |
| Media/digital | ●● | ○○○○○ | ●●● | ●● | ● | | | ●●●●○○ | | ● | ● | | | | ○ | ●● | |
| Parenting programmes | ○○○ | ○○○ | ● | | | | ○● | ●○○ | ○ | ○○ | ○ | ○○○ | | | ○ | ○ | ○ |
| Rights-based advocacy | ○ | ○○ | ○ | ○ | ○ | ○ | | ○ | ○ | | ○ | ○ | | ○ | | ○ | |
| Training of healthcare providers | ○○ | ○○○○○○○ | ○ | | | | ○ | ○○○○○○○○ | ○ | ○ | ○○○○○ | | | ○○○ | | ○○○○ | |
| Traditional/ religious leaders | ○ | ○○○○○ | ○ | | | | | ○○○○ | | | ○○ | | | ○ | ○ | ○ | ○○○○○ |

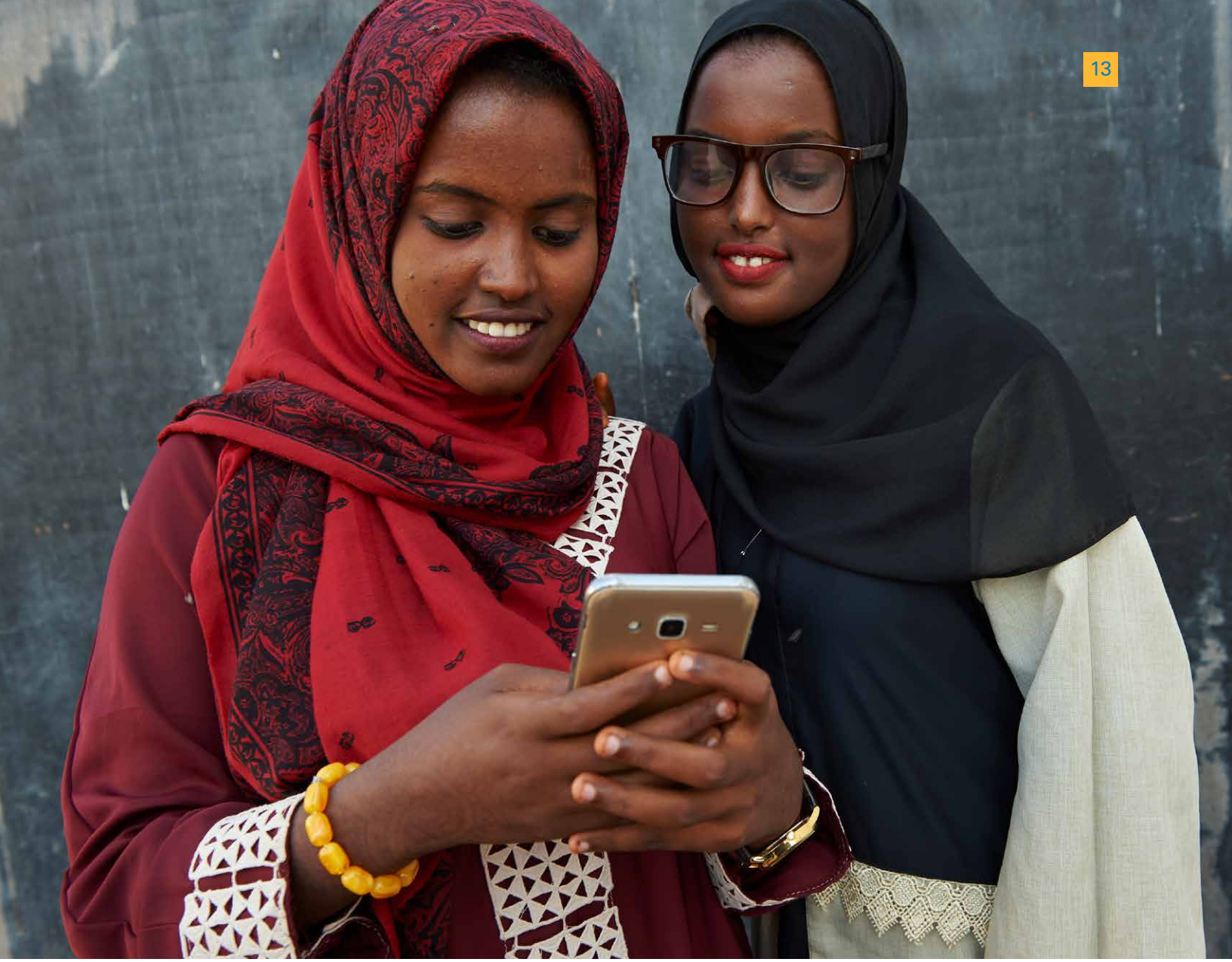
● Positive ● Negative ● Mixed (positive and null) ● Mixed (negative and null) ● Null ○ Combined effect

# INTERVENTION ATTRIBUTES

Studies included were assessed for 10 common key attributes of norms-shifting interventions, organised around three elements of change: social expectations, publicise and diffuse change, and catalyse and reinforce change. The 10 attributes describe strategies to promote positive norms and associated behaviours within intervention groups, and to spread this change to a broader community. On average, included interventions reported 3.9 social norms attributes, with at most eight attributes. PREPARE, a multi-component intervention including an educational programme on violence prevention, a school health service, and a school safety awareness programme in South Africa, included the largest number of attributes. The programme was effective in reducing adolescents' IPV victimisation, but showed no effects on sexual debut, contraceptive use, or number of sexual partners.[34]

**Figure 4: Reported attributes of social norms interventions included**





Fourteen out of the 40 studies reported on 5 or more social norms attributes. Of these, 12 studies were effective in improving one or more SRHR outcome and did not lead to any negative effects (for instance, an increase in sexual risk behaviours, or experiences of violence, as compared to control groups). Interventions that included 5 or more attributes were 3 times more likely to be effective (46% reporting 5+ attributes among effective interventions compared to 14% reporting 5+ attributes among interventions with null or mixed results). Similarly, 14 interventions reported at least one attribute from each of the three categories (changing social expectations, publicising and diffusing change, and catalysing and reinforcing change) and 11 of these interventions led to positive effects on one or more SRHR outcomes. Programmes with attributes across the three elements were 2 times more likely to be effective than to lead to null or mixed results (42% vs 21%). Among the 5 studies that documented unintended negative effects, on average 4 attributes were reported.

Across the 40 included studies, most interventions focused on **changing social expectations and awareness**, particularly by promoting positive gender norms, building

agency and decision-making among young people, and encouraging healthy relationships between adolescents and young people and their reference groups. Over half of the interventions reported conducting some formative research to understand local contexts and engage communities in intervention design, with 12 programmes articulating how this participatory research allowed researchers to identify key social norms and power dynamics amongst local intervention communities. Twenty-six interventions engaged with multiple levels of the socio-ecological framework, including community and family members, delivering specific content or components targeting reference groups beyond young people.

Few interventions reported **publicising and diffusing strategies** to spread the expected social norms change to the wider community through media or a process of engagement of participants' networks.[35] Of the 15 studies that reported at least one attribute from this element, 10 effectively improved one or more SRHR outcomes without any negative effects. Some examples of diffusion strategies include interventions in which religious leaders were trained and mobilised to pass on messages of the interventions in their villages or places of worship.[36] [37]

Effective examples of publicising role models included through a mass media TV series (*MTV Shuga Down South*) and in group intervention settings, such as in *Momentum*, where key influencers of young people who were positive deviants of an intervention-targeted health behaviour shared their experience in front of a live audience of their peers, followed by a facilitated discussion session.[38] [39] [40] Similarly, in the *REAL Fathers* intervention in Uganda, publicising comprised posters with photographs of local fathers engaging in a desired parenting behaviour, alongside statements indicating that others approved of that action.[41] In addition, several interventions trained peer educators or young mentors from the community to deliver intervention content. Although these mentors were not widely publicised as role models, their interaction with young participants encouraged positive behaviour change by highlighting the positive effects of alternative behaviours that may not have previously seemed possible.

More often, the studies described **strategies to catalyse and reinforce new norms and behaviours** – 31 studies included at least one 'reinforcing' attribute. Common strategies to reinforce new norms and behaviours included skills practice through role-playing and interactive group activities. Many interventions included a component aimed at improving access to healthcare services, offering participants opportunities to exercise their health-seeking behaviours and choices.

This mapping of attributes suggests that programmers should ensure that intervention designs cover all three elements of change, so programmes show whether the new behaviors are accepted and practised by a majority of people. Specifically, comprehensive social norms change should not only promote new positive norms and behaviours, but also plan for the diffusion of this change to a wider population beyond the primary target audience. Such consideration could improve the potential for longer-term transformational, sustainable norm shifts and potentially more cost-effective programming if diffusion strategies achieve economies of scale. Future research should explore further how these attributes align with effective programming for norms change.

# INTERVENTIONS BY SRHR OUTCOME

## Violence

We identified 14 studies measuring violence outcomes. Eight studies measured reported experiences or perpetration of over the past month to 2 years, or using an index of frequent exposure. Two studies included measures of severe IPV, and one measured separate physical, verbal, and psychological components of IPV. Sexual violence was the second most reported outcome (N=6). Most of the studies measured any sexual abuse or rape, not specifying whether from partners or non-partners. Two studies reported measures of experiencing violence from police (study participants were sex workers) and using physical punishment against children (study participants were fathers).

Six of 14 interventions involved female participants only, and one intervention was targeted at male caregivers, while the remaining studies had mixed-sex participants. Of the studies that included male and female adolescents and young people, four differentiated violence outcomes by gender by measuring violence perpetration for boys and violence experience for girls, one only measured IPV for girls, and the remaining studies measured the same outcomes for both genders. Most studies evaluated the effectiveness of interventions between three months and three years, with one study measuring outcomes after four and a half years. Six studies analysed effects in one year or less. Half of the studies were conducted in South Africa and Uganda (N=7).

## Interventions

**Number of Interventions Studies**


**Number of Interventions engagements**

Studies included 10 life skills interventions, seven community dialogue interventions, five parenting programmes, four school-based SRH programmes, and three interventions training healthcare providers. Interventions engaged parents (N=5), partners (N=4), religious and traditional leaders (N=4), community members (N=4), teachers or school staff (N=3), and healthcare providers (N=2).

Ten interventions led to statistically significant improvements in at least one violence outcome assessed in at least one of the intervention arms, including four that found reductions across all arms and populations where effects were assessed. Three studies found no significant effects in any intervention arm, while one life skills intervention showed an increase in violence reports. However, the authors of this study described the increased reports as girls being "more likely to come forward and report sexual abuse to their mentors".[42] Effective interventions included *PREPARE* in South Africa, the *Responsible, Engaged, and Loving (REAL) Fathers* intervention in Uganda, and an intervention layering a football activity for males and a goal-setting activity for girls on top of the *Empowerment and Livelihood for Adolescents (ELA)* clubs in Tanzania.[43] [44]

Of the six studies separately measuring sexual violence outcomes, three interventions effectively reduced experiences of sexual violence. Two of these were an individually delivered school-based SRH programme in South Africa and a combination of a school-based programme with community dialogues and healthcare provider training in Kenya.[45] [46]

While most interventions measuring violence outcomes combined multiple approaches, two single-component interventions showed positive effects on violence outcomes. A digital intervention offering young women a gamified WhatsApp chatbot that engaged them in critical reflection on power and unhealthy relationship behaviours and built their self-efficacy to protect themselves, led to significant reductions in IPV.[47] The school-based *Let Us Protect Our Future* intervention in South Africa also reduced reports of forced sex perpetration over several follow-ups. The content of the intervention included gender issues and rape myth beliefs, and the programme sought to increase adolescents' self-efficacy to avoid risky situations.[48]

Across the studies evaluating interventions' effectiveness on IPV outcomes, community dialogues and life skills training in group-based settings showed the most evidence of effectiveness in combined approaches, including when applied together. Of the 10 interventions associated with significant improvements in at least one violence outcome, only three described programmes with social norms components combined with other intervention components unrelated to social norms, of which two offered health services provision. In the included studies, the layering of economic empowerment components did not appear to be associated with higher effectiveness. Community dialogues, consistently applied with other interventions, also showed evidence of effectiveness in terms of reduction in overall violence or violence perpetrated by non-partners.

For instance, the *Reaching Married Adolescents* intervention in Niger combined health and life skills training, including content on gender norms and female autonomy, couple communication

regarding fertility decisions, and gender-based violence, with community dialogues involving key influencers to create a supportive environment for married adolescent girls and their husbands.[49] The intervention effectively reduced reports of IPV across two arms of the study including community dialogues and life skills training, with one of these arms also including home visits by community health workers.

The evidence points to the effectiveness of interventions engaging key reference groups, such as parents or caregivers, partners, community members, religious leaders, and peers, including men and boys, for interventions focused on adolescent girls and young women. Of the 10 interventions that were effective in reducing violence, eight engaged with one of these reference groups, highlighting the importance of working with them.

Four interventions involved religious, traditional, or cultural leaders, and three of these were effective. However, their level of engagement varied greatly, from helping design interventions to general support in organising community dialogues. An effective example includes the *Gender Roles, Equality and Transformation intervention* in Uganda, which implemented an iterative community mobilisation process. It engaged community leaders to reflect on gender inequality, violence, and SRH, to identify priority issues, and to make plans with their communities. The programme, which also trained healthcare providers and included a radio-based intervention and a life skills training component in safe spaces, reduced violence amongst older participants but not amongst very young adolescents.[50]

Of the 10 effective interventions, programme content delivered through a variety of modes often included reflections on gender roles, joint problem-solving and power in relationships, nonviolent responses to couple conflict and communication, and self-efficacy to avoid risky situations.

## HIV outcomes

Seventeen studies measured outcomes related to HIV and STIs, including interventions to improve HIV/STI testing, prevention, and treatment outcomes. HIV risk behaviours are assessed separately below. Eight studies measured the effects of interventions on HIV testing, ever or in the past year to 3 months, two studies measured HIV incidence (HIV status or infection), and four studies assessed effects on young people's knowledge of their own HIV status. Two studies were related to pre-exposure prophylaxis (PrEP) outcomes, including if it was ever taken, uptake, continuation, and adherence; two studies looked at antiretroviral therapy (ART) outcomes, including adherence and viral suppression. Five studies measured STI outcomes, including herpes simplex virus (HSV-2) infection/serostatus (2) and STI prevalence (3).

Eight studies measured outcomes for female participants only, while the remaining nine assessed them for male and female adolescents and young people. The timeline of interventions' evaluation was considerably longer on average than for other outcomes: while it was one year or less for eight studies, five studies measured effects after three years or more. Seven studies were conducted in South Africa.

## Interventions

**Number of Interventions Studies**


**Number of Interventions engagements**


Studies included 10 life skills interventions, four community dialogue interventions, four media or digital-based interventions, three school-based SRH programmes, three parenting programmes, two interventions training healthcare providers, two rights-based advocacy approaches, and one intervention with community leaders. Interventions engaged community members (N=7), parents (N=6), religious and traditional leaders (N=3), partners (N=2), teachers or school staff (N=2), and healthcare providers (N=2). Six interventions did not engage any reference groups.

Thirteen interventions led to statistically significant improvements in at least one outcome assessed in at least one of the intervention arms, and eight found reductions across all intervention arms and populations where effects were assessed, including five that measured

only one outcome and one intervention arm. Effective intervention studies included an action research study with parenting and life skills programme arms in Nigeria, the *Ujana Salama* multi-component intervention in Tanzania, and the *VUKA* family intervention in South Africa.[51] [52] [53]

Interventions proved to be highly effective for increasing HIV testing, had mixed results on knowledge of status, and obtained mostly null results in attempts to lower HIV incidence. Life skills approaches and media or digital-based interventions including social norms components showed the most evidence of effectiveness in terms of increasing HIV testing rates. However, there is also some evidence pointing to the effectiveness of social norms interventions as part of parenting programmes and combined community dialogues, rights-based advocacy approaches, healthcare provider training, and interventions with religious or cultural leaders.

The effective life skills interventions were almost always described as offering safe spaces for young people, and these included both single and mixed-sex youth clubs. In the context of SRHR, safe spaces may offer the opportunity to discuss sensitive matters and obtain services in a safe and non-stigmatised way. An example of an effective single-component intervention that significantly increased rates of HIV testing was the *Sista2Sista* programme for vulnerable adolescent girls and young women in Zimbabwe. The programme included girls-only weekly clubs organised by age group and led by female mentors, in which interactive learning approaches were used. Participation in *Sista2Sista* also improved adolescent girls' use of contraception and decreased their likelihood of getting married or falling pregnant.[54]

Media or digital-based approaches showed some positive effects on knowledge of HIV status and HIV incidence, as well as testing. Interestingly, these programmes were not implemented in combination with other approaches. Two of these studies evaluated the implementation of *MTV Shuga Down South*, a mass media educational drama series broadcast on national television in South Africa. The series covered topics related to HIV prevention, family planning, sexual identity, and safe and healthy sexual relationships in a destigmatising manner through the show's characters. However, the studies showed mixed results in other outcomes and highlighted challenges related to the lack of participant exposure to the series and the need for interventions to improve the supply of services.[55] [56]

Despite some studies showing the significant effects of community dialogues and life skills programmes delivered in safe spaces on reducing HIV incidence, the evidence largely points to null effects. We found very little experimental evidence on the uptake, usage or adherence to PrEP and ART. Positive results on PrEP uptake, and null results on other HIV outcomes were found from two studies in Zimbabwe and Kenya evaluating the implementation of *DREAMS*, a package of community and group-based interventions for girls and their families and communities aimed at empowering girls and reducing sexual risk behaviours.[57] [58]

## Child Marriage

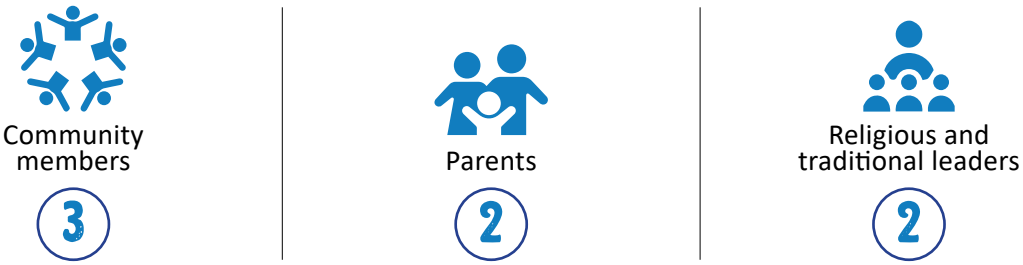
Six studies included in the review assessed the effects of social norms interventions on child marriage outcomes. All studies included only female participants. The outcome of five studies was whether a girl was ever married, measured for girls under 18. One study assessed the effects on marriage over a seven-year intervention period, and was the only study that included participants above the age of 19. One study was set in a refugee camp.

One study assessed changes in outcomes over one year, four over a two to four-year period, and one intervention was extended and evaluated after 7 years. Study countries included Ethiopia (2), Kenya, Zambia, and Zimbabwe in single-country studies, and Burkina Faso and Tanzania in a multi-country study.

## Interventions

**Number of Interventions Studies**


**Number of Interventions engagements**




All six studies in this group included life skills training interventions. Three studies included a community dialogue component, two targeting community and religious leaders, and one parenting intervention. Two studies assessed the effectiveness of single-component interventions. Interventions engaged community members (N=3), parents (N=2), and religious and traditional leaders (N=2). Two interventions did not engage any reference groups.

Four studies found effectiveness in at least one intervention arm, including two that had only one norms intervention arm. Two studies showed null results across arms. Although studies were concentrated within three categories of interventions (life skills, community dialogues, and interventions with leaders), and more evidence is needed to assess the effectiveness of other strategies, the existing evidence showed that community dialogues, combined with other interventions, were the most effective type of norms intervention.

Most studies evaluated combined interventions. However, Oberth et al. (2021) demonstrate an example of an effective single-component life skills training intervention that decreased the likelihood of getting married under 18 years of age. In the *Sista2Sista* girls-only clubs evaluated in the study, girls completed interactive exercises on topics including gender and power and traditional and cultural practices and reflected on girls' rights and the consequences of child marriage. Effective dialogue interventions engaged community members to reflect on the consequences of marriage, and the value of girls' education, and to discuss and dispel common myths surrounding the practice.

Four out of six interventions aimed at addressing child marriage included an economic support component, such as cash transfers, payment of school-related fees, and livestock asset transfers. These do not appear to be associated with increased effectiveness: out of a total of nine intervention arms that combined an economic support component with a norms component (community dialogues, life skills interventions, or both), only two led to significant reductions in child marriage rates.

## Sexual risk behaviours (sexual debut, sexual activity, multiple sexual partners, transactional and age-disparate sex)

Twenty studies had an outcome measure related to sexual risk behaviours. Most of these were set in South Africa (N=6), Uganda (N=3), and Kenya (N=3). Eight studies evaluated outcome changes in one year or less, and seven assessed effects over three years or more. Six of the 20 studies included female participants only.

Seven studies measured the effects of interventions on transactional sex, which was usually defined as exchanging sex for money, food, or gifts. Studies measured this outcome having occurred ever or in the previous 6 to 18 months. One study with young female sex workers assessed the effects of the intervention on whether selling sex was the primary means by which women supported themselves, if they had been unable to decline sex in the past month, and the number of sex work clients in the past month. A study with young people living in slum areas assessed whether they were persuaded with money or gifts to have sex.

Having age-disparate sex was an outcome in only one study and was defined as a sexual partnership where there was an age gap larger than five years.

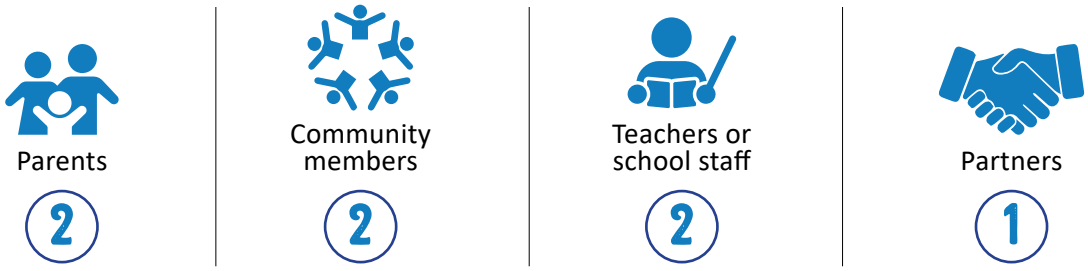
Thirteen studies examined outcome measures related to sexual debut and sexual activity. These measures included questions on whether participants had ever had sex, the age at sexual debut (represented under sexual debut in Table 1), and having sexual activity in the past 1 to 12 months (represented as sexual activity). One study assessed a sexual activity index. Ten out of 13 studies included male and female participants. Three studies included index measures on risky sexual behaviours, all of which were composed of measures on multiple sexual partnerships and inconsistent condom use.

Six studies measured the effects on outcomes related to having multiple partners, assessed as having multiple sexual partners in the previous six months to one year and the number of partners. One study considered the number of lifetime partners.

## Interventions

**Number of Interventions Studies**


**Number of Interventions engagements**




The studies included 11 life skills interventions, seven school-based SRH programmes, five community dialogues, four parenting programmes, three media or digital-based interventions, three training programmes for healthcare providers, two rights-based advocacy approaches, and two interventions with religious leaders. Interventions engaged parents (N=2), community members (N=2), teachers or school staff (N=2), and partners (N=1). One intervention did not engage any reference groups.

Included social norms interventions showed little effectiveness on sexual risk behavioural outcomes. The interventions showed some more promising results in delaying sexual debut and reducing sexual activity, although some studies also led to the opposite effect. Only six out of 20 studies in this outcome category indicated reduced sexual risk behaviours in at least one intervention arm and

outcome without leading to a negative effect in any other risk behaviour outcome. The evidence showed mostly null effects of interventions on having multiple sexual partners, transactional sex, and age-disparate sex (despite limited evidence on this outcome). No specific intervention strategy stands out as more effective in shifting these behaviours. Ten studies found null effects across all measures of sexual risk behaviours. Effective interventions included the *Soul Buddyz* clubs and the *Let Us Protect Our Future intervention* in South Africa, and the *Research Initiative to Support the Empowerment of Girls (RISE)* programme in Zambia.[60] [61] [62]

Four interventions had negative effects on sexual risk behaviour outcomes including age at sexual debut, multiple partnerships, and sexual activity.[63] [64] [65] [66] The studies reported no explanation for these negative results, although these negative outcomes were sometimes used to indicate the need for design adaptations in the next iterations of the programmes.

Birdthistle et al. (2022) found that participants exposed to the *MTV Shuga Down South* media campaign were more likely to have had sex than those not exposed, which was particularly true for older respondents, but that those who reported having sex were also more likely to report condom use at last sex. Austrian et al. (2020), evaluating a girls' group meetings intervention combined with the provision of a health voucher, found an increase in the percentage of girls who had had sex relative to control at a second follow-up assessment after 4 years from baseline, which was not observed after two years. Njue and co-authors' (2015) evaluation of a community discussion intervention around adolescents' SRH issues showed a small increase in the number of participants' lifetime partners by 0.2. A community-based multi-component intervention including SRHR life skills training in youth clubs, community dialogues, and rights-based advocacy interventions, combined with social protection and health provision components, led to an increase in the proportion of young people who had ever had sex and a decrease of 1.5 years in the mean age of sexual debut.

Although most interventions in this list were multi-component, there were a few single-component media-based, school-based, or life skills programmes. Most of these were not effective in reducing sexual risk behaviours, however, one school and curriculum-based SRH programme and a school-based extracurricular youth club programme reduced sexual risk behaviours.[67] [68]

The six interventions that were shown to be effective in reducing sexual risk behaviours included four life skills training components, which were delivered in both single-sex and mixed-sex groups. Nearly all (5/6) engaged some or multiple reference groups, even when they were individual component interventions. Half of these were delivered in combination with other non-norms components, including cash transfers and the provision of free contraceptives. Regardless of the intervention category, these effective programmes engaged adolescents and young people through interactive, youth-friendly methods, including sports-based activities, brainstorming, role-playing, and games. Effective interventions focused on the impact of risky behaviours on young people's dreams and aspirations, encouraged them to set goals and consider the consequences of risky sexual behaviours, and provided knowledge and skills to protect themselves and avoid risky situations.

## Contraception and family planning

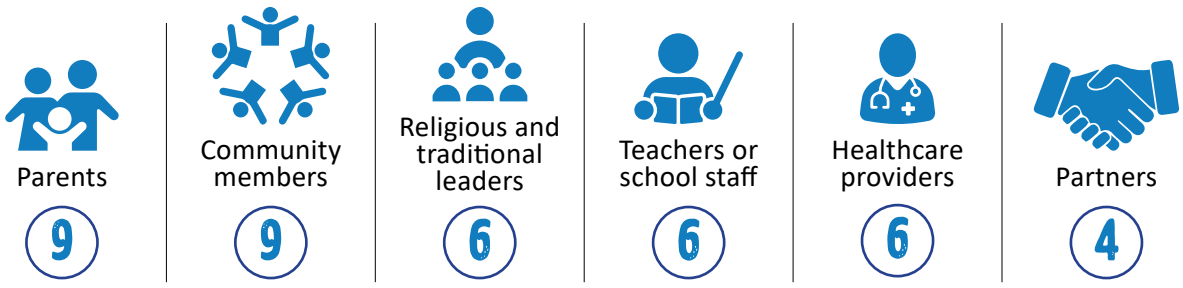
Twenty-three studies measured outcomes related to condoms, contraceptives, and family planning, the largest body of evidence in this review. The most common outcome was current use of modern contraceptive or family planning method (N=13), followed by condom use at last sex (N=9), consistent condom use (N=5), number of condom-less or unprotected sex in the past 1 to 3 months (N=5), and condom use at first sex (N=4). Two studies constructed measures on the frequency of condom use or the proportion of protected sex. One study analysed post-delivery contraceptive use by young mothers.

Fourteen studies had both female and male participants, while the remaining nine targeted girls and young women. Seven studies had a timeline of evaluations of one year or less, and eight were assessed over three years or more. Study settings spanned 10 countries, with the most common being South Africa (N=9) and Uganda (N=3).

## Interventions

**Number of Interventions Studies**


**Number of Interventions engagements**



The studies included 15 life skills interventions, eight community dialogues, six school-based SRH programmes, six training programmes for healthcare providers, five media or digital-based interventions, three parenting programmes, two rights-based advocacy approaches, and two interventions with religious leaders. Interventions engaged parents (N=9), community members (N=9), religious and traditional leaders (N=6), teachers or school staff (N=6), healthcare providers (N=6), and partners (N=4). Seven interventions did not engage any reference groups.

Included interventions showed significant effectiveness in improving sexually active young people's use of contraceptives. The evidence points to the high potential of media-based interventions, community dialogues, training of healthcare providers, and life skills programmes. Fifteen studies found effectiveness across at least one intervention arm or group of participants, while eight showed null effects. The effectiveness of community dialogues and healthcare interventions was always tested in combination with other components, while media or digital interventions were often delivered in isolation.

The effectiveness of these combined interventions is exemplified by two studies on the *Reaching Married Adolescents* intervention including community dialogues, life skills components, and healthcare training components. Silverman et al. (2023) found that single-sex small discussion groups delivering health and life skills content were effective only when combined with both household visits by trained community health workers and village-level community dialogues to increase support for modern contraceptive use. A separate arm testing the combination of community dialogues and healthcare home visits was also effective in increasing modern contraceptive use. Through different levels of societal engagement, the interventions challenged gender norms that limit young women's agency to decide on contraceptive use and fertility decisions including birth spacing. Erhardt-Ohren et al. (2023), assessing the same intervention over a longer timeframe (1.5 years after Silverman and co-authors), found effectiveness across all three arms, including one delivering the small life skills group discussions and community dialogues. It also found improvements in the use of long-acting reversible contraceptives (LARC) in the home visits and community dialogues arm, as well as in the intervention arm combining all three interventions.[69] [70]

Given the effectiveness of intervention arms including home visits, *Reaching Married Adolescents* offers a promising example of a week-long training of community health workers that covered not only content on SRH knowledge to be delivered, including contraceptive methods and the healthy timing and spacing of pregnancies, but also discussed gender equity and youth and adolescent rights.

Effective interventions including community dialogues often described engaging key influencers and gatekeepers, both at the community level, including religious and community leaders, and at the individual level from young people's perspectives, including parents and in-laws. The interventions used trained facilitators to convene the dialogues, and nearly all of them used a multimedia strategy to engage participants, including radio, theatre, and video production.

One effective intervention also explored the use of positive deviants by highlighting examples of key influencers who did not practice a certain risky behaviour.[71]

Three media or digital-based single-component intervention studies showed improvement in contraceptive use outcomes, including two studies on *MTV Shuga Down South*. In addition, Ybarra and co-authors (2021) examined a text-messaging-based programme for older adolescents and young people (18–22-year-olds), with a primary HIV prevention target. The programme, which led to higher rates of condom-protected sex, delivered five to 10 text messages to young people daily for seven weeks covering HIV information and behavioural skills but also addressing societal expectations for gendered sexual interactions between males and females, healthy relationships, and communication strategies. It also integrated two game-like features encouraging behavioural outcomes, highlighting the role of interactive approaches in digital interventions.[72]

Some of the evidence showed that life skills training approaches can improve contraceptive use both as single-component interventions (including the *Sista2Sista* girls' clubs) and when combined with other components, as exemplified above by the *Reaching Married Adolescents* intervention.[73] [74] [75]

Three of the 15 effective studies included combined norms interventions with non-norms components, including programmes offering economic support and healthcare services. By contrast, 10 of the 15 studies included multiple norms intervention components.

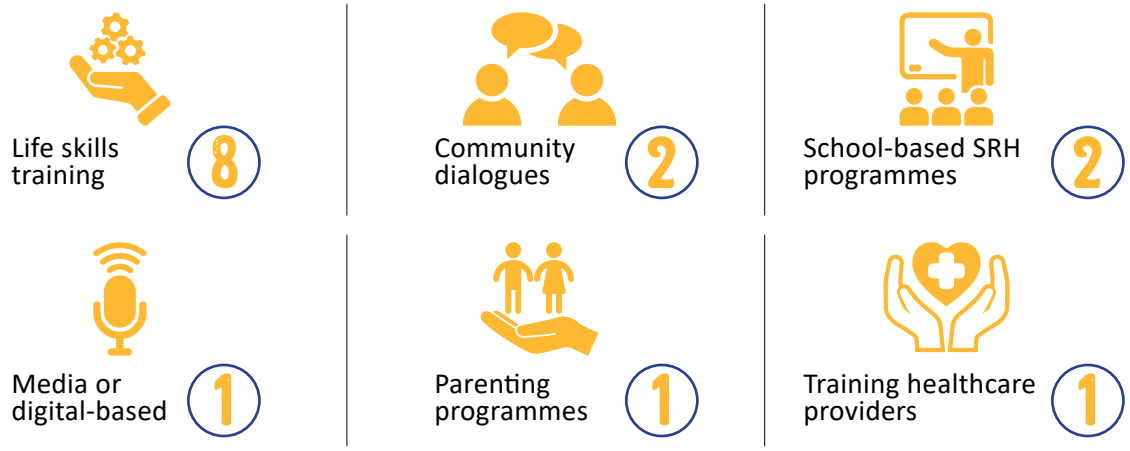
## Early Pregnancy

Ten studies measured the effects of interventions on outcomes related to pregnancy amongst adolescent girls and young women. The most common outcome was having ever been pregnant (N=6). Studies also measured pregnancy status (N=2), any new pregnancy during the intervention period (N=2), any new adolescent pregnancy during the same period (for participants below age 20) (N=2), and ever given birth (N=2). One study asked male participants if they had ever gotten a female pregnant, and one study measured school dropout due to pregnancy.

Two studies included both male and female participants, and 8 others targeted girls and young women only. Four studies were set in South Africa, 3 in Kenya, and 3 in Tanzania, Zambia, and Zimbabwe.

## Interventions

**Number of Interventions Studies**




**Number of Interventions engagements**


Studies included eight life skills interventions, two community dialogue interventions, two school-based SRH programmes, one media-based intervention, one parenting programme, and one intervention training healthcare providers. Interventions engaged community members (N=4), parents (N=3), teachers or school staff (N=2), religious and traditional leaders (N=1), and healthcare providers (N=1). Four interventions did not engage any reference groups.

Most of the intervention studies showed no signitificant positive results in reducing early pregnancy among adolescents and young people. Four studies reported positive effects in at least one arm and outcome, five had null effects, and one found a mix of negative and null results. The effective interventions included two life skills programmes, one school-based SRH programme, and one community dialogue combined with an economic support intervention.

Sarnquist et al. (2017) and Johnson et al. (2018) provide two examples of single-component effective interventions: a six-week curriculum and school-based SRH programme that focused

on empowerment and self-efficacy training for girls, and gender equality, positive masculinity, and bystander interventions training for boys decreased the annual incidence of school dropout due to pregnancy in intervention schools. Similarly, the *Soul Buddyz Clubs*, introduced as a social support extracurricular activity at primary schools in South Africa, decreased experiences of pregnancy- though not significantly- for adolescent girls.[76] [77]

The *Adolescent Girls Initiative-Kenya (AGI-K)* layered intervention design provides a way to compare packages of interventions. The programme was successful in reducing pregnancy in a pastoralist community with the combination of cash transfers and violence prevention community conversations, which focused on discussing and creating action plans to change inequitable gender norms underpinning violence against girls. The effects were not significant, however, when layering additional SRH life skills meetings for girls, or financial literacy training sessions.[78] Kangwana and co-authors found no significant effects of any combinations of the same interventions on pregnancy outcomes in an urban informal setting.[79]

# INTERVENTIONS BY STRATEGY

This section summarises the evidence on different intervention strategies as entry points for leveraging social norms approaches to prevent poor SRHR outcomes. It describes 8 strategies: life skills, school-based SRH programming, community dialogues, media or digital-based interventions, parenting programmes, healthcare provider training, interventions with community leaders, and rights-based advocacy (summarised in Table 2). For each strategy we report on evidence of impact, definitions and designs, modes of delivery, and content.

**Evidence of impact.** Across all considered outcomes, social norms interventions appear to be most effective in reducing violence and child marriage and increasing HIV testing and contraceptive use.

**Modes of delivery.** Life skills training interventions incorporating social norms components, delivered in safe spaces or other group settings, were likely to be effective in preventing violence and child marriage and improving HIV testing and condom use. Community dialogue interventions, in combination with other components, were also particularly effective in violence prevention, contraceptive use, sexual debut, sexual activity, and early pregnancy and marriage. Mass media and digital approaches demonstrated effectiveness, both through individual interventions and combined delivery, particularly for HIV prevention, contraceptive use, and reducing violence. There is emerging evidence on parenting programmes and school-based SRH programming. Effective interventions were usually led by trained facilitators recruited from local communities, equipped with dialogue facilitation skills, gender-equitable attitudes, and SRH content.

**Content and reference groups.** Across all types of intervention strategies, common content of effective interventions included reflections on gender roles and inequalities, youth sexuality, gendered power relations, girls' agency, norms underlying the acceptance of gender-based violence, and the value of girls' education and postponement of early marriage and childbearing. This type of messaging promoting positive gender norms was often combined with practical knowledge about SRHR topics and life skills, including decision-making, conflict resolution, and goal-setting skills.

Effective interventions engaged with the reference groups influencing the behaviours and SRHR outcomes of adolescents and young people. Out of the 26 studies that showed significant improvements in indicators measured in at least one of the intervention arms across all strategies, 22 engaged one or more reference groups beyond adolescents and young people themselves.

| Component | | Example of effective interventions | Key characteristics |
|---|---|---|---|
|  | **Life skills** | Adolescent Girls Initiative (Kenya), Soul Buddyz (South Africa) | • Delivered individually or in combination<br>• Group-based, often separated by gender (safe spaces)<br>• Trained facilitators |
|  | **School-based SRH programming** | Skhokho for Schools (South Africa), Let Us Protect Our Future (South Africa) | • Delivered individually or in combination<br>• Curriculum-based with interactive content<br>• Trained facilitators or school staff |
|  | **Community dialogues** | Gender Roles, Equality and Transformations (GREAT) (Uganda), Momentum (DRC) | • Delivered in combination<br>• Often held in village religious or civic centres and health facilities<br>• Trained facilitators or cultural/religious leaders |
|  | **Parenting and intergenerational programmes** | Responsible, Engaged, and Loving (REAL) Fathers Initiative (Uganda), VUKA family intervention (South Africa) | • Delivered individually or in combination<br>• Used established community structures such as religious centres<br>• Focused on positive communication and conflict-solving skills |
|  | **Media and digital interventions** | MTV Shuga Down South (South Africa), InThistoGether (Uganda) | • Delivered individually or in combination<br>• Used quasi-experimental study designs<br>• Promising digital approaches |
|  | **Healthcare provider training** | Reaching Married Adolescents (Niger), Gender Roles, Equality and Transformations (GREAT) (Uganda) | • Delivered in combination<br>• Trained providers to deliver youth-friendly health services<br>• Little detail on programmes |
|  | **Interventions with community leaders** | UPLIFT (Uganda), Gender Roles, Equality and Transformations (GREAT) (Uganda) | • Delivered in combination<br>• Engaged leaders in intervention design<br>• Trained leaders to deliver programming |
|  | **Rights-based advocacy** | DREAMS + Sisters with a Voice (Zimbabwe), UPLIFT (Uganda) | • Delivered in combination<br>• Little evidence |

## Life skills

**Evidence of impact.** Life skills approaches which included social or gender norms content were found in 23 studies. Fourteen of these interventions improved at least one SRHR outcome. Most of the evidence on the effectiveness of these interventions was in the areas of violence prevention, HIV testing, condom use, and early marriage. Six interventions found no effects across all outcomes measured or positive effects in only one outcome amongst several measured. The effects of three interventions included some negative impacts, namely an increase in early sexual activity among adolescents and young people, and an increase in reports of sexual abuse (although this could indicate that young people felt more comfortable or empowered to share experiences of abuse).[80] [81] [82]

**Definitions and designs.** The group-based settings where life skills interventions were delivered were often referred to as 'safe spaces', although the definitions for this term may differ in terms of engaging boys and girls separately. Safe spaces can be an effective way to engage young people in reflection and discussion, offering them a place where they feel physically and emotionally protected and supported to express themselves and learn new information and skills, which can be particularly sensitive with SRHR content. By creating frequent interaction between group members, safe space interventions can also expand young people's social networks and improve their confidence to perform new and safe behaviours.[83] When they target girls and young women specifically, safe spaces are often referred to as girl clubs, which meet regularly, with a leader using various pedagogical methods to address SRHR, life skills, economic and financial outcomes, and other topics.[84]

The safe space groups were often divided according to sex (17 out of 23 interventions), aiming to deliver content appropriate for participants' age and to bypass existing norms around discussing sexuality with members of the opposite sex. The evidence suggests that these separate sex groups may be more effective to address social norms underpinning SRHR outcomes: out of the 14 effective studies, 11 were implemented in separate sex group settings, with six studies including both girls' and boys' groups and the remaining five offering girls' groups only.

**Modes of delivery.** Eleven of the 14 effective life skills interventions were led by trained facilitators or mentors, who were young adults recruited from local communities or community health workers. When single-sex groups were created, chosen mentors were the same sex as the safe space participants. Mentors were trained on SRHR and gender equality, among other topics, and were instructed to facilitate discussions rather than teach. Three effective interventions engaged peer educators to recruit members to safe space groups.

Groups usually included 10 to 25 participants and met weekly over a period of 10-15 weeks in a variety of community locations, including schools and health facilities. Three effective interventions stratified group membership by age, school enrolment status, and marital or fertility status to ensure the appropriateness of content. The interventions always included interactive learning techniques, including role plays, media production, and participatory methods. Printed resources, including illustrative vignettes, toolkits, and curricula, guided participatory activities.

Life skills programmes including norms interventions were often delivered in combination with other components (74% of included studies with life skills components), and the evidence shows the potential effectiveness of both individual and combined delivery. Life skills interventions were individually evaluated in seven studies, three of which were effective in improving multiple SRHR outcomes and did not have any negative impact.

**Content.** Common topics and curriculum content of effective interventions covered SRHR and life skills knowledge, rights of children and young people, gender inequalities, gender roles, sexuality, power relations, myths and misconceptions around SRHR, gender-based violence (including how to protect oneself and how to seek help), decision-making and problem-solving skills, as well as hopes, dreams, and goals.

## School-based SRH programming

**Evidence of impact.** Eleven interventions included school-based SRH programming components. These school-based programmes showed some limited positive evidence on violence, early pregnancy, and sexual risk behaviours. Six studies demonstrated positive effects in at least one outcome or intervention arm, while five studies had null results across outcomes and arms.

**Definitions and designs.** Amongst the 11 studies, six evaluated school-based interventions delivered individually, four evaluated combined interventions, and one study compared a school-based intervention-only arm to another arm combining it with a parenting and a life skills programme. This last study is the only one allowing for comparison between individually delivered and combined programmes. The *Skhokho for Schools* intervention in South Africa was found to be individually effective in decreasing early pregnancy and increasing condom use amongst girls; however, when combined with workshops for caregivers and children and school-based clubs, no significant impact was found in any of the outcomes measured.[85]

**Modes of delivery.** Positive effects on at least one outcome were more likely to be seen with individual interventions. For example, the *Let Us Protect Our Future* intervention in South Africa, led to a long-term reduction in forced sex perpetration, unprotected sex, self-reported, and STIs. The intervention was delivered over six consecutive school days with interactive activities led by facilitators. It sought to improve HIV/STI risk reduction knowledge but also addressed gender issues and rape myth beliefs relevant to the perpetration of forced sex.[86] [87]

Effective interventions were delivered by teachers (2), university staff (1), and facilitators from local communities (3), all of whom received training before interventions. Delivery periods ranged from six weeks to three school terms. All effective interventions were curriculum-based and included interactive content, such as games, brainstorming, role play, skills practice, and youth-friendly workbooks.

It is important to note that school-based interventions do not reach out-of-school youth, who may be at increased risk of violence victimisation and HIV infection. To reach these populations, delivering life skills interventions in other community-based settings may be more appropriate.

**Content.** Effective school-based interventions included normative content on identifying risky situations and building young people's self-efficacy in SRHR, sexuality, gender roles, and gendered and intergenerational relationship power dynamics. This content was often combined with modules on correct condom use and condom-use negotiation and beliefs.

## Community dialogues

**Evidence of impact.** Interventions included community dialogues in 14 studies. These offered significant data on the combined effects of community discussions on violence prevention, contraceptive use, sexual debut, sexual activity, and early pregnancy and marriage. Community dialogues showed strong evidence of effectiveness in preventing violence and child marriage and improving contraceptive use. Across all outcomes, 12 studies showed positive effects on more than one SRHR outcome (or one outcome in two cases where only one outcome was measured), and no studies reported having only null effects. Two studies reported a mix of negative, positive, and null results. There were four instances of negative combined effects on sexual risk behaviours (increasing risky behaviours), which warrant further study.

**Definitions and designs.** Effective community dialogues were frequently implemented to address gender norms, social norms around family planning among adolescent girls,

gendered decision-making power and agency, gender roles and expectations, violence acceptance norms, and norms around the value of girls' education and postponement of early marriage and childbearing. These conversations aimed to prompt community members to reflect on the consequences of harmful behaviours and attitudes, dispel myths and misconceptions around SRHR, and build empathy and sensitize them to young people's SRHR challenges. The collective nature of interventions created a way through which different groups within communities were receiving and discussing similar messages and offered a public forum where members could commit to positive new behaviours, supporting norms change.

Five out of the 12 studies with more than one outcome improvement, or with improvements across all outcomes assessed, also measured intervention effects on outcomes related to norms and attitudes. Four of these found evidence of changes in attitudes, which included increased women's decision-making power, perceived community support for family planning use, and reduced odds of endorsing inequitable gender attitudes and justifying violence.

In all 14 studies, dialogues were evaluated in combination with other approaches, which included a life skills training component in 12 studies. Seven of the 12 studies incorporated a non-norms intervention component, including five providing economic support components. Erulkar et al. (2020), the only study where community dialogues were evaluated individually, highlights some lessons in their implementation. It compared two strategies of engaging community members in dialogue to address social norms related to child marriage and found that a structured approach using dedicated, paid facilitators and a set curriculum was more effective than a less rigorous method using existing community leaders to pass messages during routine meetings. However, the structured approach was only effective when implemented as an individual intervention but led to null effects when combined with the payment of school fees.[88]

**Modes of delivery.** At least eight effective community dialogues were led by trained facilitators recruited from local communities, trained in dialogue facilitation skills, gender equality, and SRH content. Two effective interventions trained religious or cultural leaders to lead community conversations. The meetings were often held in village religious or civic centres and health facilities, on a weekly to monthly basis. Seven of these interventions were implemented over relatively long intervention exposure periods of 1.5 to 2 years.

Some interventions described strategies for recruitment of community members to participate and facilitators to lead sessions through formative work before intervention implementation. For example, facilitators were recommended by local community and political leaders and a local NGO partner in the *Reaching Married Adolescents* programme in Niger.[89] Similarly, the *Research Initiative to Support the Empowerment of Girls (RISE)* intervention in Zambia engaged cultural and religious leaders, school staff, and caregivers to support activities before recruitment and used local radio for community sensitization of the programme.[90]

Nine studies on effective interventions described specifically aiming to engage 'gatekeepers' or members of reference groups that exerted influence over young people's access to SRH services. These included religious leaders, male partners, and parents and caregivers. Three studies described interventions that prompted community members to design action plans to address issues affecting young people.[91] [92] [93]

## Parenting and intergenerational programmes

**Evidence of impact.** Eight studies included parenting interventions. These studies were distributed across several outcome areas, with most data focused on their effectiveness in reducing violence and transactional sex and increasing contraceptive use. Five interventions found improvements in SRHR outcomes, and three had exclusively null results. There was some evidence of improvements in HIV testing, ART adherence, contraceptive use, reduced IPV experiences, sexual risk behaviours, and sexual activity. Each of these, however, is supported by only one or two studies.

**Definitions and designs.** Except for two studies, all others evaluated the effectiveness of combined interventions. The data shows similar effectiveness of these two types of implementations. Four parenting programmes were combined with life skills interventions. For instance, the *Research Initiative to Support the Empowerment of Girls (RISE)* intervention in Zambia combined parent and community meetings to improve attitudes towards the value of girls' education and postponement of early marriage and childbearing, with youth clubs offering girls and boys life skills training, and an economic support component. The combined intervention arm effectively lowered any sexual activity and unprotected sexual activity for girls.[94]

**Modes of delivery.** At least three out of five effective interventions engaged caregivers in group settings through established community structures, such as religious congregations, which were seen as recognised institutions attended by all family members.[95] Programmes were delivered by lay counsellors and mentors following a structured curriculum. They were often theory-based and focused on discussions, problem-solving, and practising new skills through in-session rehearsal. Two studies also used multimedia aids including posters and cartoon storylines.

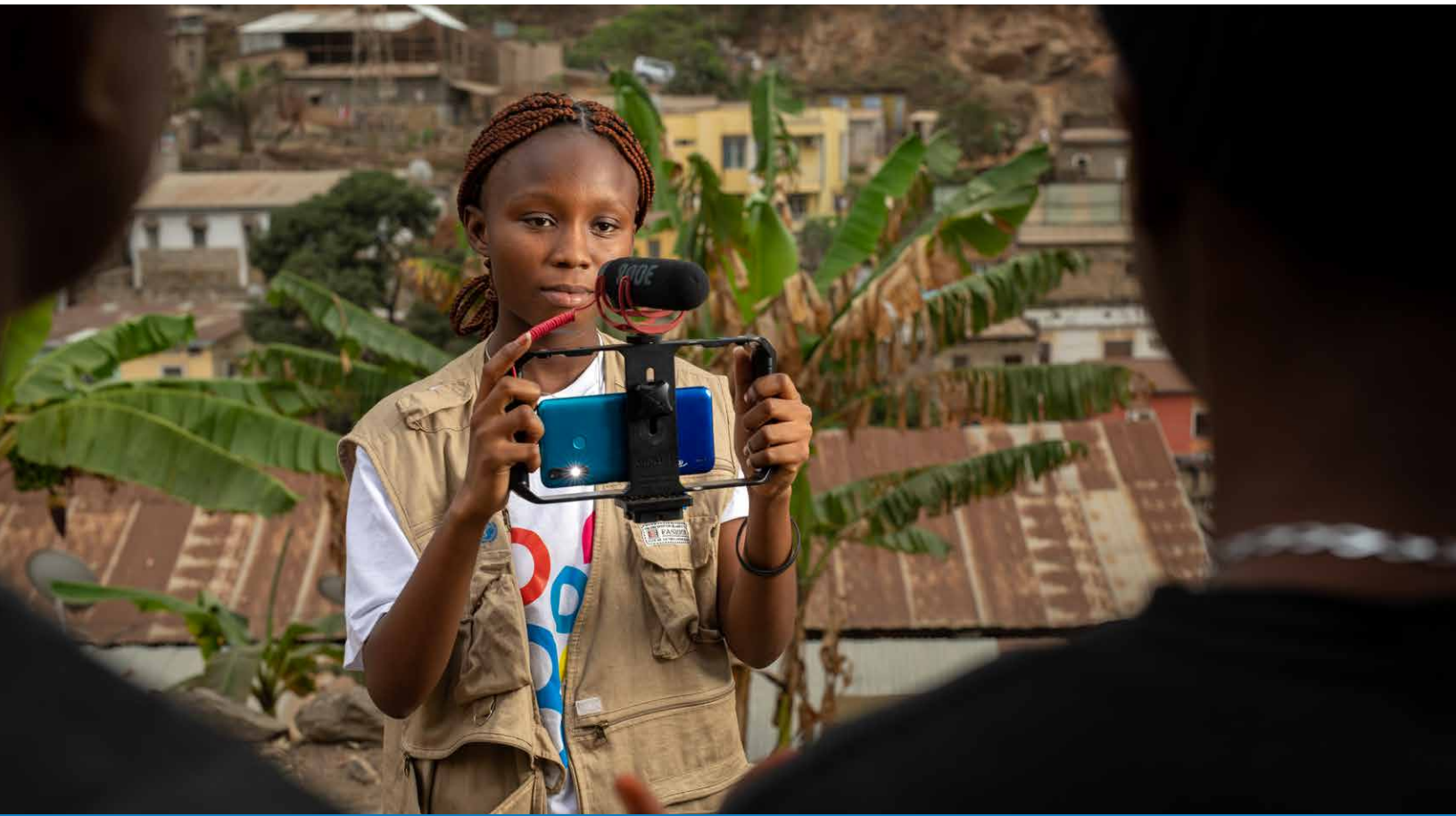
**Content.** Parenting and family interventions covered positive communication and conflict-solving skills, alternative solutions to violence, and family goal-setting. Interventions aimed at HIV prevention or targeting participants living with HIV also included topics on youth identity, acceptance, disclosure and coping with HIV, stigma and discrimination, treatment knowledge, and caregiver-child communication on sensitive topics including HIV and puberty.

As described, only one study focused on male caregivers. The *REAL Fathers* intervention for Ugandan young male caregivers with toddler children decreased perpetrations of IPV against wives, as well as psychological and verbal violence against children. The programme offered both individual and group mentoring sessions for fathers, some of which were attended by their wives, where participants engaged in self-reflection on gender roles, and practised couple communication skills, joint problem-solving, and nonviolent responses. Posters were also displayed in community locations capturing desired behaviours from male caregivers.[96]

## Media and digital interventions

**Evidence of impact.** Intervention studies included seven examples of the use of media or digital-based approaches to improve adolescents and young people's SRHR outcomes. Studies were concentrated on outcome areas related to HIV, contraceptive use, and violence prevention. Four interventions found positive results of interventions, and only one had null effects. One study reported a mix of positive results with one negative result, namely an increase in the proportion of young people who had ever had sex. One social media-based intervention component was not evaluated due to low exposure.

**Definitions and designs.** The evidence of the effectiveness of digital and mass media interventions is particularly strong in terms of increasing HIV testing and contraceptive use. Mass media approaches showed effectiveness in both individual and combined delivery. There was evidence of improvements in HIV and contraceptive outcomes from the single-component *MTV Shuga Down South* intervention, a television drama with storylines including information on HIV prevention options in South Africa.[97] Similarly, the *Gender Roles, Equality and Transformations (GREAT)* intervention in Uganda increased the use of family planning and decreased violence experiences, particularly for older participants, through a serial radio drama with storylines on gender, violence, and SRHR in combination with a community mobilisation process, participatory activities for youth clubs, and the training of community healthcare workers.[98]



One issue when evaluating mass media-based approaches is the challenge of implementing a randomised controlled trial with a control group that does not have exposure to media messaging. Therefore, the effectiveness found in these studies should be considered carefully. At the same time, they offer insights into the use of quasi-experimental study designs to evaluate interventions without a clear control group.

**Modes of delivery.** Interventions included four digital or social media-based approaches, such as text messaging and television and radio-based drama interventions. Two effective interventions used text messaging-based applications and included game-like features to improve engagement. *ChattyCuz* was a WhatsApp gamified chatbot that decreased experiences of IPV for young women in South Africa. The chatbot was designed to appear approachable and build women's self-efficacy, healthy communication, and safety planning skills. Through quizzes and narratives, the intervention offered reflections on power in relationships and was effective in improving attitudes and beliefs about power balance.[99] Similarly, *InThistoGether* delivered five to ten daily text messages to young people in Uganda for seven weeks, including content on healthy relationships and communication and societal expectations for gendered sexual interactions. It improved rates of condom-protected sex and HIV testing. Both interventions offered symbolic rewards such as badges for specified safe behavioural outcomes to motivate users.[100]

**Content.** Effective media or digital-based interventions often included content on healthy relationships and prompted participants to critically reflect on power imbalance and control in relationships and societal expectations for gendered sexual interactions.

## Healthcare provider training

**Evidence of impact.** Seven studies included a component of training healthcare professionals to provide youth-friendly services, all of which were combined with other interventions. Four studies were effective in improving one or more outcomes measured. Two interventions had null effects across all outcomes or all but one outcome when numerous results were evaluated. One intervention led to several positive outcomes including increasing the age of sexual debut and condom use and decreasing non-consensual sex but also resulted in a small increase in the number of adolescents' lifetime partners.

**Definitions and designs.** The lack of individually delivered healthcare training programmes hinders the evaluation of programmes' effectiveness, not allowing for the separation of the effects of these types of interventions on SRHR outcomes. Interventions' lack of focus on this type of training – which is often described as the last component of packages and with little detail on design – conflicts with adolescents' accounts which cite stigmatising attitudes and judgement by healthcare providers as reasons to avoid seeking services (see Network of Norms review).

**Modes of delivery and content.** Two of the studies which showed improved outcomes offered no details on the interventions beyond the fact that healthcare teams were trained to provide youth-friendly health services. The other two studies which led to improved outcomes described the healthcare training provided in the *Reaching Married Adolescents* intervention in Niger. In this programme, community health volunteers were recruited from study villages to provide gender-matched home visits to married adolescent girls and their husbands. Prior to the visits, they received a one-week training on topics including contraceptive methods, healthy spacing of pregnancies, provision of family planning counselling, as well as gender equality and youth and adolescent rights.[101] [102]

## Interventions with community leaders

**Evidence of impact.** Five studies included interventions with religious, cultural, or traditional leaders, all of which were delivered in combination with other components. Four of these studies provide evidence from child marriage, violence prevention, and family planning programmes. The studies find a mix of positive and null results across all outcomes.

Two programmes engaged leaders in the intervention development, using community-based participatory methods.[103] [104]
In Puffer et al., 2016, the intervention was delivered in a religious setting following worship services. Both studies show a mix of positive and null results. Two interventions targeting child marriage recruited and trained leaders as community conversation facilitators. One of these reduced child marriage rates and the other found null results.[105] [106] One study had a specific focus on training religious leaders from different institutions with SRH information with the aim that they would mobilise youth involved in commercial sex to seek these services. The intervention contributed to increased HIV testing and increased the age at sexual debut.[107]

## Rights-based advocacy

**Evidence of impact.** Two studies included rights-based advocacy strategies, which had a specific focus on marginalised groups: young women who sell sex and young people living in slums. The studies found a mix of positive and null results. More research on such approaches is needed to draw evidence-based conclusions.

# DISCUSSION

## Key principles

This review highlights the transformative impact of social norms interventions on improving adolescent SRHR outcomes, particularly in preventing violence and child marriage and increasing HIV testing and contraceptive use. Our findings highlight the importance of addressing foundational social norms, particularly gender norms, to improve outcomes among adolescents and young people and how these interventions can promote multiple positive outcomes.

Integrating gender-transformative approaches was a key element of comprehensive programming aimed at improving SRHR outcomes. The evidence suggests that many effective approaches for addressing harmful social and gender norms focused on creating or leveraging shared community spaces and were guided by a trained facilitator. These spaces provided a platform for discussions and critical reflection on gender inequities, gender roles, sexuality, power relations, and myths and misconceptions around SRHR, and norms underpinning gender-based violence.

Another key finding of the review was the importance of taking a socio-ecological approach and designing programmes that go beyond engagement with adolescents and young people themselves and target the reference groups influencing their behaviours and outcomes, particularly at a family and community level.

Reference groups can serve as sources of accurate SRHR information and create social support for young people's behaviour change. Reference groups' influence may differ by the individual, community, or behaviour, and highlighting the importance of conducting formative research, including power mapping, to understand the social networks that can sustain and challenge social norms.

Strategies for engaging reference groups can also help to reinforce and spread changes in norms and behaviours beyond the small group of adolescents and young people directly participating in an intervention. To maximise the reach of social norms interventions and achieve tipping points in terms of community-wide norms change at scale, organised diffusion strategies are needed to amplify and expand normative change beyond the immediate participants.[108] This review highlights the need for greater focus on developing diffusion strategies to drive broader societal change. Successful approaches may include leveraging mass media or empowering participants to diffuse messages themselves within their communities. These strategies can enhance the visibility and adoption of new norms, ultimately strengthening their long-term sustainability.

## Effective Intervention Strategies

Included studies offered insights into the most effective intervention strategies and their design.

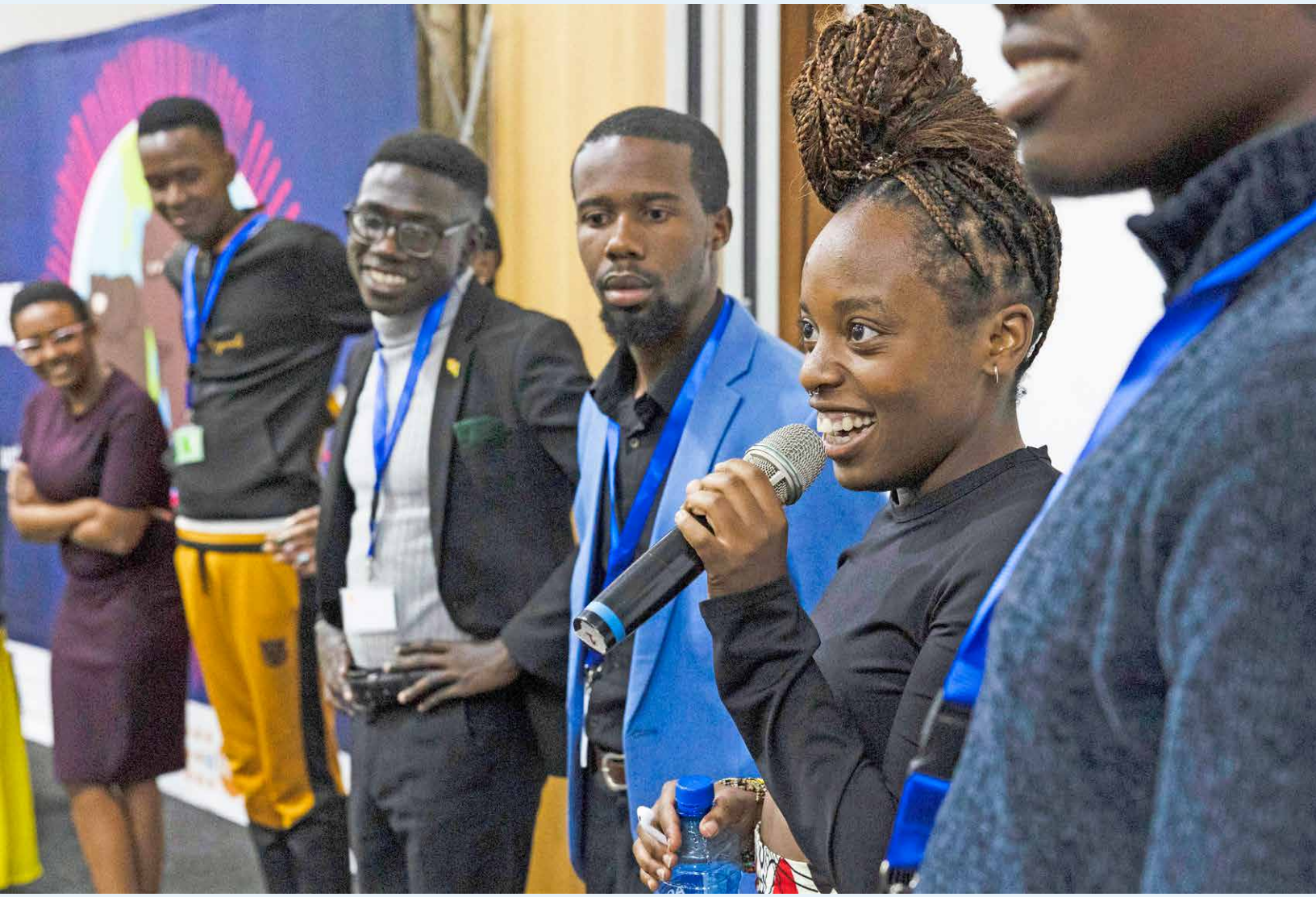
Life skills training interventions incorporating social norms components, delivered in safe spaces or other group settings both in combination with other components or alone, were found to be effective in preventing violence and child marriage and improving HIV testing and condom use. Life skills interventions offer potential entry points to provide adolescents and young people with SRHR information, foster social support through safe spaces where experiences can be shared, and build adolescents' and young people's confidence to perform new behaviours.[109] Successful approaches were found in the evaluation of single-sex life skills groups, which more easily allows for the discussion of sensitive topics including gender roles.

Community dialogue interventions, in combination with other components, were effective in violence prevention, contraceptive use, sexual debut, sexual activity, early pregnancy, and child marriage. These interventions engaged community members in reflections on gender roles and power and built mutual understanding and shared values. By offering a setting in which different groups received and discussed the same SRHR messages, the interventions also helped dispel misconceptions about SRHR and encouraged intergenerational dialogues. The evidence showed it was important to engage with influential reference groups within the communities, such as religious leaders, to ensure buy-in before or during intervention activities and to avoid backlash.

We found compelling data on mass media and digital approaches' effectiveness, both through individual interventions and combined delivery, particularly for reducing violence, HIV prevention, and increased contraceptive use.

Through both mass and social media-based approaches, including television and radio, these interventions seek to reach a critical audience with information, be that a mass or key targeted audience. By including content on social and gender norms, these approaches can empower adolescents and young people with information, provide role models, and create a supportive environment for norms change. This review highlights emerging evidence on the use of digital technologies, whose potential for large-scale change, with wide reach and low cost, should be further explored. When designing these interventions, it is crucial to consider mobile coverage and phone access and ownership, as well as combining digital interventions with other activities.[110] Future research on media and digital-based interventions should consider the gender dynamics of online communities and emerging trends, including online spaces promoting harmful gender stereotypes amongst young men.[111]

Our review showed some promising practice for changing social norms through parenting programmes that reduced violence and sexual risk behaviours and improved HIV testing, ART adherence, and contraceptive use. Effective interventions often engaged adolescents and young people and their caregivers in discussions and skills-building for positive communication, non-violent conflict resolution, and reflection on harmful gender norms. A recent review of programmes aimed at reducing violence against children and intimate partner violence recommended expanding parenting programmes to involve other community members and reduce the intergenerational transmission of violence-endorsing attitudes. The review also highlighted a crucial evidence gap around studies targeting caregivers of adolescents.[112]



Promising practices were also found in examples of school-based SRH programming, particularly in preventing sexual violence, although the overall evidence is mixed. A UNESCO report on school curricula in 10 countries in Eastern and Southern Africa found that very few interventions focused sufficiently on the influence of media on gender norms, nor addressed adolescent and young people's diversity and sexual rights. Many school-based interventions approached sexuality in a negative way.[113] Given the number of school-based interventions with null effects, more implementation research is needed to enhance their effectiveness in addressing SRHR.

## Challenges & considerations

Further research is needed to explore whether norms and behaviour changes are sustained past short programmatic timelines. Of the studies reviewed, 26 demonstrated significant improvements in SRHR indicators in at least one intervention arm, with no negative effects reported. In addition to our findings on SRHR behavioural outcomes, several of the interventions found significant improvements in measures of SRHR knowledge and intentions to adopt health-seeking behaviours. These intermediate outcomes suggest that interventions may be effective even when the short timelines are insufficient to observe actual behavioural change. This underscores the importance of designing a clear theory of change for interventions, with metrics that correspond with the duration of implementation, as well as indicators of norms change.[114] [115] Longer intervention timelines may be required to achieve change in certain behavioural outcomes, allowing for longer timelines of exposure to support a change in the actual social norms underpinning behaviours and attitudes.

Although 25 of the studies included in this review described combined approaches, we found a few effective single-component programmes including mass media interventions. It is important to ensure that such interventions consider the supply-side barriers to promoting adolescents' and young people's access to services. Other non-normative supply-side factors affecting SRH outcomes include the availability, accessibility, and quality of services. Persistent inequalities in these supply-side factors exist amongst adolescents and young people in sub-Saharan Africa based on education, urban-rural residence, and household economic status, underscoring the need to combine norms interventions with widened service access.[116]

While many social norms interventions focus on creating demand for SRH services, outcomes may not improve without also ensuring that there is an effective supply-side response, including adolescent-friendly health, education, and violence prevention and response services. Working with adult reference groups, including healthcare workers, caregivers, religious leaders, and teachers, can help address adultism[c] norms that can be a significant barrier to accessing services and impede discussions on SRHR between adults and young people. For instance, in the delivery of healthcare provider training, interventions ensuring that the training content went beyond SRHR knowledge and included topics on gender equality and adolescent rights were shown to be effective. Further research should focus on effective strategies for training healthcare professionals to provide SRHR services in a destigmatising manner that respects adolescents' and young people's rights to privacy.

Additionally, future research should examine mechanisms to anticipate, track, and respond to potential harmful impacts of interventions. Social norms interventions need to include mechanisms to mitigate backlash, including increased violence perpetration or stigmatisation at the community level. Such impacts may be experienced by programme participants including early adopters of new norms, those who resist the new norms or behaviours, and staff members involved in programme delivery. Such considerations are essential to avoid unintentional harmful impacts of social norms programmes.

c 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. Reference: Shier, H. (2012). What does 'equality' mean for children in relation to adults? [Official background paper for UN Global Thematic Consultation on 'Addressing Inequalities Post-2015]. CESESMA.

# LIMITATIONS

**This review has several limitations.** First, whilst our review focused on SRHR outcomes, it did not focus on the effects of interventions on SRHR-related norms, attitudes, knowledge, and awareness. As a result, potential impacts on these important intermediate outcomes were not captured. Another limitation is the inclusion of combined interventions without study designs that allowed for the separation of individual components' contributions. This made it difficult to determine which elements of multi-faceted programmes were driving observed outcomes. Additionally, due to the wide range of outcomes and intervention types, we were not able to meta-analyse studies in order to compare intervention effect sizes. The review was further constrained by a lack of detailed information on many of the interventions' design and implementation, limiting the depth of analysis. Lastly, the exclusive focus on published experimental evidence may have restricted the review's ability to include certain types of interventions on which experimental evidence is still thin.

# EVIDENCE GAPS

Several important evidence gaps emerged from this review, highlighting areas where further research is needed to better understand the effectiveness of interventions aimed at improving SRHR outcomes.

- **Implementation research exploring how the dosage, fidelity, and quality of intervention delivery affect outcomes:** Understanding how interventions are executed in real-world settings is essential to ensure their effectiveness and to guide future programmes. There is also a lack of consideration and understanding of the potential unanticipated negative consequences of interventions to address social norms in existing research. Future research should examine mechanisms to anticipate, track, and respond to potential harmful impacts of interventions and mitigate backlash that may be experienced by programme participants, early adopters of new norms, and staff members involved in programme delivery.
- **Quantitative studies on certain SRHR outcomes:** There is a scarcity of quantitative studies on interventions addressing outcomes such as access to medical male circumcision, ART, PrEP, menstrual health, and protection from female genital mutilation/cutting and other harmful traditional practices.
- **Quantitative studies on certain intervention types:** Rights-based advocacy, interventions to change laws and policies, and movement-building interventions (including on women and girl-led movements) are underrepresented in the experimental literature. Discussions with policymakers and civil society networks, however, highlight the critical importance of these interventions for achieving systemic and structural changes.
- **Interventions seeking to improve SRHR outcomes for marginalised adolescents and young people and key populations:** Very few studies examine interventions that address the intersectionality of social norms and various dimensions of discrimination, such as race, ethnicity, disability, and sexual behaviour, that affect the well-being of marginalised youth.
- **Programming and research for boys and men:** While many studies focus on adolescent girls and young women, there is a notable lack of research focusing on boys and men. Given the influence of gender norms on SRHR outcomes, more interventions should be designed to engage the male peers and partners of adolescent girls and young women. Addressing these gaps could help achieve gender-transformative outcomes.
- **Studies in crisis and conflict settings:** Evidence from crisis and conflict-affected areas is limited, despite the heightened vulnerability of populations in these settings. More evidence on how to adapt or redesign interventions to these contexts is needed.
- **Geographical spread of evidence:** Our review includes studies from 12 countries. However, 24 out of 40 studies are concentrated in a few countries, notably South Africa, Kenya, and Uganda. Expanding research to other countries in the region is critical to ensure that interventions are contextually relevant and applicable across diverse settings.

- **Long-term evaluations:** There is a lack of long-term ex-poste evaluations to assess whether the changes achieved by interventions are sustained over time.
- **Multi-component interventions:** Many interventions include multiple components, but few evaluations are designed to disentangle the effectiveness of each component. Future studies should aim to compare individual elements of multi-component interventions to better understand which strategies are most effective.
- **Costing data and cost-effectiveness analysis:** Finally, there is a lack of data on the costs and cost-effectiveness of interventions. Understanding the funding requirements and potential for scalability is crucial for policymakers and funders who are looking to sustain and expand effective programmes.

Addressing these evidence gaps would provide a more comprehensive understanding of what works in social norms interventions to improve SRHR outcomes and how best to scale and sustain successful interventions.

# REFERENCES


1 Cotterill, S., Tang, M. Y., Powell, R., et al. (2020). Social norms interventions to change clinical behaviour in health workers: A systematic review and meta-analysis. In Health Services and Delivery Research (Vol. 8, No. 41, Chapter 1). NIHR Journals Library. https://www.ncbi.nlm.nih.gov/books/NBK563674/

2 Learning Collaborative to Advance Normative Change. (2019). Norms and social influence: Understanding the attributes. ALIGN. https://www.alignplatform.org/sites/default/files/2019-11/lc_nsi_attributes_brief_final_08262019_eng.pdf

3 UNAIDS. (2024). Spectrum Estimates https://aidsinfo.unaids.org/

4 World Health Organization. (2022, February 8). Adolescent pregnancy. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

5 Melesse, D. Y., Mutua, M. K., Choudhury, A., Wado, Y. D., Faye, C. M., Neal, S., & Boerma, T. (2020). Adolescent sexual and reproductive health in sub-Saharan Africa: Who is left behind? BMJ Global Health, 5(1), e002231. https://doi.org/10.1136/bmjgh-2019-002231

6 Akwara, E., Pinchoff, J., Abularrage, T., White, C., & Ngo, T. D. (2023). The urban environment and disparities in sexual and reproductive health outcomes in the Global South: A scoping review. Journal of Urban Health, 100(3), 525-561. https://doi.org/10.1007/s11524-023-00724-z

7 Cislaghi, B., & Shakya, H. (2018). Social norms and adolescents' sexual health: An introduction for practitioners working in low and mid-income African countries. African Journal of Reproductive Health, 22(1), 38-46. https://doi.org/10.29063/ajrh2018/v22i1.4

8 World Health Organization. Adolescent health [Internet]. Geneva: World Health Organization. Available from: https://www.who.int/health-topics/adolescent-health#tab=tab_1

9 ALIGN Platform. Gender norms and sexual and reproductive health [Internet]. London: ALIGN Platform; 2025. Available from: https://www.alignplatform.org/gender-norms-and-sexual-and-reproductive-health

10 Buller AM, Schulte MC. Aligning human rights and social norms for adolescent sexual and reproductive health and rights. Reprod Health Matters. 2018;26(52):38-45. doi: 10.1080/09688080.2018.1542914.

11 World Health Organization. (n.d.). Promoting adolescent well-being [Internet]. World Health Organization. Retrieved March 12, 2025, from https://www.who.int/health-topics/adolescent-health/promoting-adolescent-well-being#tab=tab_1

12 UNICEF (2021a). Social norms: Definitions. UNICEF. https://www.unicef.org/media/111061/file/Social-norms-definitions-2021.pdf

13 UNICEF (2021b). Technical note on gender norms. UNICEF. https://www.unicef.org/media/65381/file/GP-2020-Technical-Note-Gender-Norms.pdf

14 Learning Collaborative to Advance Normative Change. (2019). Ibid.

15 UNICEF SBC Guidance. Social Norms. https://www.sbcguidance.org/do/social-norms

16 UNICEF (2021a). Ibid.

17 Cotterill et al. (2020). Ibid.

18 Learning Collaborative to Advance Normative Change. (2019). Ibid.

19 Page, M. J., McKenzie, J. E., Bossuyt, P. M., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ, 372, n71. https://doi.org/10.1136/bmj.n71

20 Musindo, O., Jafry, S., Nyamiobo, J., Becker, K. D., Gellatly, R., Maloy, C., Lozano-Ruiz, A., Romero-Gonzalez, B., Kola, L., Merali, Z., Chorpita, B. F., & Kumar, M. (2023). Mental health and psychosocial interventions integrating sexual and reproductive rights and health, and HIV care and prevention for adolescents and young people (10-24 years) in sub-Saharan Africa: A systematic scoping review. EClinicalMedicine, 57, Article 101835. https://doi.org/10.1016/j.eclinm.2023.101835

21 Marcus, R., Rivett, J., & Kruja, K. (2021). How far do parenting programmes help change norms underpinning violence against adolescents? Evidence from low and middle-income countries. Global public health, 16(6), 820–841. https://doi.org/10.1080/17441692.2020.1776364

22 Bose, D. L., Hundal, A., Singh, S., Singh, S., Seth, K., Hadi, S. u., Saran, A., Joseph, J., Goyal, K., & Salve, S. (2023). Evidence and gap map report: Social and Behavior Change Communication (SBCC) interventions for strengthening HIV prevention and research among adolescent girls and young women (AGYW) in low- and middle-income countries (LMICs). Campbell Systematic Reviews, 19, e1297. https://doi.org/10.1002/cl2.1297

23 Greene, M. E., Siddiqi, M., & Abularrage, T. F. (2023). Systematic scoping review of interventions to prevent and respond to child marriage across Africa: progress, gaps and priorities. BMJ open, 13(5), e061315. https://doi.org/10.1136/bmjopen-2022-061315

24 Evans, W. D., Ulasevich, A., Hatheway, M., & Deperthes, B. (2020). Systematic Review of Peer-Reviewed Literature on Global Condom Promotion Programs. International journal of environmental research and public health, 17(7), 2262. https://doi.org/10.3390/ijerph17072262

25 Achen, D., Fernandes, D., Kemigisha, E., Rukundo, G. Z., Nyakato, V. N., & Coene, G. (2023). Trends and challenges in comprehensive sex education (CSE) research in sub-Saharan Africa: A narrative review. Current Sexual Health Reports, 1–9. https://doi.org/10.1007/s11930-023-00362-1

26 Heymann, J., Darmstadt, G. L., & et al. (2019). Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. The Lancet, 393(10190), 2522-2534. https://doi.org/10.1016/S0140-6736(19)30525-9

27 Alexander-Scott, M. Bell, E. and Holden, J. (2016) DFID Guidance Note: Shifting Social Norms to Tackle Violence Against Women and Girls (VAWG). London: VAWG Helpdesk

28 The Learning Collaborative to Advance Normative Change. (2017). Identifying and describing approaches and attributes of norms-shifting interventions. Institute for Reproductive Health, Georgetown University.

29 Bandura, A. (1994). Social cognitive theory of mass communication. In J. Bryant & D. Zillmann (Eds.), Media effects: Advances in theory and research (pp. 61–90). Lawrence Erlbaum Associates, Inc.

30 Ajzen, I. (1991). The theory of planned behavior. Organizational Behavior and Human Decision Processes, 50(2), 179-211. https://doi.org/10.1016/0749-5978(91)90020-T

31 Blum, R. W., Bastos, F. I., Kabiru, C. W., & Le, L. C. (2012). Adolescent health in the 21st century. The Lancet, 379(9826), 1567–1568. https://doi.org/10.1016/S0140-6736(12)60407-3

32 Fishbein, M., & Yzer, M. C. (2003). Using theory to design effective health behavior interventions. Communication Theory, 13(2), 164–183. https://doi.org/10.1111/j.1468-2885.2003.tb00287.x

33 Population Council. (2005). Building assets for safe, productive lives: A report on a workshop on adolescent girls' livelihoods. New York: Population Council.

34 Mathews, C., Eggers, S. M., Townsend, L., Aarø, L. E., de Vries, P. J., Mason-Jones, A. J., De Koker, P., McClinton Appollis, T., Mtshizana, Y., Koech, J., Wubs, A., & De Vries, H. (2016). Effects of PREPARE, a Multi-component, School-Based HIV and Intimate Partner Violence (IPV) Prevention Programme on Adolescent Sexual Risk Behaviour and IPV: Cluster Randomised Controlled Trial. AIDS and behavior, 20(9), 1821–1840. https://doi.org/10.1007/s10461-016-1410-1

35 Cislaghi, B., Denny, E. K., Cissé, M., Gueye, P., Shrestha, B., Shrestha, P. N., Ferguson, G., Hughes, C., & Clark, C. J. (2019). Changing Social Norms: the Importance of "Organized Diffusion" for Scaling Up Community Health Promotion and Women Empowerment Interventions. Prevention science: the official journal of the Society for Prevention Research, 20(6), 936–946. https://doi.org/10.1007/s11121-019-00998-3

36 Erulkar, A., Medhin, G., Weissman, E., Kabore, G., & Ouedraogo, J. (2020). Designing and Evaluating Scalable Child Marriage Prevention Programs in Burkina Faso and Tanzania: A Quasi-Experiment and Costing Study. Global health, science and practice, 8(1), 68–81. https://doi.org/10.9745/GHSP-D-19-00132

37 Puffer, E. S., Green, E. P., Sikkema, K. J., Broverman, S. A., Ogwang-Odhiambo, R. A., & Pian, J. (2016). A church-based intervention for families to promote mental health and prevent HIV among adolescents in rural Kenya: Results of a randomized trial. Journal of Consulting and Clinical Psychology, 84(6), 511–525.

38 Birdthistle, I., Mulwa, S., Sarrassat, S., Baker, V., Khanyile, D., O'Donnell, D., Cawood, C., & Cousens, S. (2022). Effects of a multimedia campaign on HIV self-testing and PrEP outcomes among young people in South Africa: A mixed-methods impact evaluation of 'MTV Shuga Down South'. AIDS and Behavior, 26(3), 655-669. https://doi.org/10.1007/s10461-021-03580-6

39 Chimbindi, N., Mthiyane, N., Chidumwa, G., Zuma, T., Dreyer, J., Birdthistle, I., Floyd, S., Kyegombe, N., Grundy, C., Cawood, D., Danaviah, S., Smit, T., Pillay, D., Baisley, K., Harling, G., & Seeley, J. (2023). Evaluating use of mass-media communication intervention MTV-Shuga on increased awareness and demand for HIV and sexual health services by adolescent girls and young women in South Africa: An observational study. BMJ Open, 13, e062804. https://doi.org/10.1136/bmjopen-2022-062804

40 Gage, A. J., Akilimali, P. Z., Wood, F. E., Gay, R., Padis, C. O., & Bertrand, J. T. (2023). Evaluation of the effect of the Momentum project on family planning outcomes among first-time mothers aged 15-24 years in Kinshasa, DRC. International Journal of Population Studies, 9(1), 1-14. https://doi.org/10.18063/IJPS.V9I1.417

41 Ashburn, K., Kerner, B., Ojamuge, D., & Lundgren, R. (2017). Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on physical child punishment and intimate partner violence in northern Uganda. Global Health: Science and Practice, 5(1), 82-94. https://doi.org/10.9745/GHSP-D-16-00315

42 Oberth, G., Chinhengo, T., Katsande, T., Mhonde, R., Hanisch, D., Kasere, P., Chihumela, B., & Madzima, B. (2021). Effectiveness of the Sista2Sista programme in improving HIV and other sexual and reproductive health outcomes among vulnerable adolescent girls and young women in Zimbabwe. AIDS and Behavior, 25(3), 723-736. https://doi.org/10.1007/s10461-020-03056-y

43 Shah, M., Seager, J., Montalvao, J., & Goldstein, M. (2022). Two sides of gender: Sex, power, and adolescence (Policy Research Working Paper No. 10072). World Bank. https://doi.org/10.1596/1813-9450-10072

44 Roberts, S. T., Hartmann, M., Minnis, A. M., Otticha, S. O., Browne, E. N., Montgomery, E. T., & Agot, K. (2023). Breaking down relationship barriers to increase PrEP uptake and adherence among adolescent girls and young women in Kenya: Safety and preliminary effectiveness results from a pilot cluster-randomized trial. BMC Public Health, 23(1), 1-13. https://doi.org/10.1186/s12889-023-05543-6

45 Njue, C., Voeten, H. A. C. M., Ohuma, E., Looman, C., Habbema, D. F., & Askew, I. (2015). Findings of an evaluation of community and school-based reproductive health and HIV prevention programs in Kenya. BMC Public Health, 15(1), 1-11. https://doi.org/10.1186/s12889-015-1764-4

46 Jemmott, J. B. 3rd, O'Leary, A., Jemmott, L. S., Ngwane, Z. P., Teitelman, A., Makiwane, M. B., Bellamy, S. L. (2018). Effect of a behavioral intervention on perpetrating and experiencing forced sex among South African adolescents: A secondary analysis of a cluster randomized trial. JAMA Pediatrics, 172(2), e174421. https://doi.org/10.1001/jamapediatrics.2017.4421

47 De Filippo, A., Bellatin, P., Tietz, N., Grant, E., Whitefield, A., Nkopane, P., Devereux, C., Crawford, K., Vermeulen, B., & Hatcher, A. M. (2023). Effects of a digital chatbot on gender attitudes and exposure to intimate partner violence among young women in South Africa. Global Health: Science and Practice, 11(2). https://doi.org/10.9745/GHSP-D-22-00415

48 Jemmott et al. (2018). Ibid.

49 Silverman, J. G., Brooks, M. I., Aliou, S., Johns, N. E., Challa, S., Nouhou, A. M., Tomar, S., Baker, H., Boyce, S. C., McDougal, L., DeLong, S., & Raj, A. (2023). Effects of the reaching married adolescents program on modern contraceptive use and intimate partner violence: Results of a cluster randomized controlled trial among married adolescent girls and their husbands in Dosso, Niger. BMC Public Health, 23(1), 1-10. https://doi.org/10.1186/s12889-023-05582-5

50 Dagadu, N. A., Barker, K. M., Okello, S. B. T., Kerner, B., & Nabembezi, D. (2022). Fostering gender equality and reproductive and sexual health among adolescents: Results from a quasi-experimental study in Northern Uganda. BMC Public Health, 22(1), 1-13. https://doi.org/10.1186/s12889-022-12934-5

51 Arije, O., Udoh, E., Ijadunola, K., Afolabi, O., Aransiola, J., Omoregie, G., Tomori-Adeleye, O., Ukeme-Edet, O., Fajemisin, O., Titus, R., & Onayade, A. (2023). Combination prevention package of interventions for reducing vulnerability to HIV among adolescent girls and young women in Nigeria: An action research. PloS one, 18(1), e0279077. https://doi.org/10.1371/journal.pone.0279077

52 Waidler, J., Gilbert, U., Mulokozi, A., & Palermo, T. (2022). A "Plus" Model for Safe Transitions to Adulthood: Impacts of an Integrated Intervention Layered onto A National Social Protection Program on Sexual Behavior and Health Seeking among Tanzania's Youth. Studies in family planning, 53(2), 233–258. https://doi.org/10.1111/sifp.12190

53 Bhana, A., Mellins, C. A., Petersen, I., Alicea, S., Myeza, N., Holst, H., Abrams, E., John, S., Chhagan, M., Nestadt, D. F., Leu, C.-S., & McKay, M. (2014). The VUKA family program: Piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. Global Health: Science and Practice, 2(3), 310-324. https://doi.org/10.9745/GHSP-D-14-00007

54 Oberth et al. (2021). Ibid.

55 Birdthistle et al. (2022). Ibid.

56 Chimbindi et al. (2023). Ibid.

57 Chabata, S. T., Hensen, B., Chiyaka, T., Mushati, P., Musemburi, S., Dirawo, J., Busza, J., Floyd, S., Birdthistle, I., Hargreaves, J. R., & Cowan, F. M. (2021). The impact of the DREAMS partnership on HIV incidence among young women who sell sex in two Zimbabwean cities: Results of a non-randomised study. The Lancet HIV, 8(6), e357-e368. https://doi.org/10.1016/S2352-3018(20)30426-9

58 Roberts et al. (2023). Ibid.

59 Oberth et al. (2021) Ibid.

60 Johnson, S., Magni, S., Dube, Z., & Goldstein, S. (2018). Extracurricular school-based social change communication program associated with reduced HIV infection among young women in South Africa. International Journal of Public Health, 63(3), 307-318. https://doi.org/10.1007/s00038-017-1025-0

61 Silverman et al. (2023) Ibid.

62 Hegdahl, H. K., Musonda, P., Svanemyr, J., Zulu, J. M., Grønvik, T., Jacobs, C., & Fos, I. (2022). Effects of economic support, comprehensive sexuality education, and community dialogue on sexual behaviour: Findings from a cluster-RCT among adolescent girls in rural Zambia. BMC Public Health, 22(1), 1-12. https://doi.org/10.1186/s12889-022-13867-2

63 Jemmott, J. B., 3rd, Jemmott, L. S., O'Leary, A., Ngwane, Z., Lewis, D. A., Bellamy, S. L., Icard, L. D., Carty, C., Heeren, G. A., Tyler, J. C., Makiwane, M. B., & Teitelman, A. (2015). HIV/STI risk-reduction intervention efficacy with South African adolescents over 54 months. Health psychology : official journal of the Division of Health Psychology, American Psychological Association, 34(6), 610–621. https://doi.org/10.1037/hea0000140

64 Austrian, K., Soler-Hampejsek, E., Behrman, J. R., Digitale, J., Hachonda, N. J., Bweupe, M., & Hewett, P. C. (2020). The impact of the Adolescent Girls Empowerment Program (AGEP) on short and long term social, economic, education, and fertility outcomes: A cluster randomized controlled trial in Zambia. BMC Public Health, 20(1), 1-12. https://doi.org/10.1186/s12889-020-09699-3

65 Renzaho, A. M. N., Kamara, J. K., Doh, D., Bukuluki, P., Mahumud, R. A., & Galukande, M. (2022). Do community-based livelihood interventions affect sexual and reproductive health and rights of young people in slum areas of Uganda: A difference-in-difference with kernel propensity score matching analysis. BMC Public Health, 22(1), 1-13. https://doi.org/10.1186/s12889-022-13830-1

66 Njue et al. (2015). Ibid.

67 Birdthistle et al. (2022) Ibid.

68 Sidamo et al. (2023) Ibid.

69 Johnson et al. (2018). Ibid.

70 Silverman et al. (2023) Ibid.

71 Erhardt-Ohren, B., Brooks, M., Aliou, S., Osseni, A. A., Oumarou, A., Challa, S., Tomar, S., & Silverman, J. (2023). Sustained impact of community-based interventions on contraceptive use among married adolescent girls in rural Niger: Results from a cluster randomized controlled trial. BMC Public Health, 23(1), 1-12. https://doi.org/10.1186/s12889-023-05578-6

72 Gage et al. (2023). Ibid.

73 Ybarra, M. L., Agaba, E., & Nyemara, N. (2021). A pilot RCT evaluating InThistoGether, an mHealth HIV prevention program for Ugandan youth. AIDS and Behavior, 25(6), 1677-1690. https://doi.org/10.1007/s10461-020-02969-8

74 Oberth et al. (2021) Ibid.

75 Silverman et al. (2023) Ibid.

76 Erhardt-Ohren et al. (2023) Ibid.

77 Sarnquist, C., Sinclair, J., Mboya, B. O., Langat, N., Paiva, L., Halpern-Felsher, B., Golden, N. H., Maldonado, Y. A., & Baiocchi, M. T. (2017). Evidence that classroom-based behavioral interventions reduce pregnancy-related school dropout among Nairobi adolescents. Global Health: Science and Practice, 5(2), 264-277. https://doi.org/10.9745/GHSP-D-16-00340

78 Johnson et al. (2018) Ibid.

79 Austrian, K., Soler-Hampejsek, E., Kangwana, B., Maddox, N., Diaw, M., Wado, Y. D., Abuya, B., Muluve, E., Mbushi, F., Mohammed, H., Aden, A., & Maluccio, J. A. (2022). Impacts of multisectoral cash plus programs on marriage and fertility after 4 years in pastoralist Kenya: A randomized trial. BMC Public Health, 22(1), 1-13. https://doi.org/10.1186/s12889-022-13967-4

80 Kangwana, B., Austrian, K., Soler-Hampejsek, E., Maddox, N., Sapire, R. J., Dibaba Wado, Y., Abuya, B., Muluve, E., Mbushi, F., Koech, J., & Maluccio, J. A. (2022). Impacts of multisectoral cash plus programs after four years in an urban informal settlement: Adolescent Girls Initiative-Kenya (AGI-K) randomized trial. BMC Public Health, 22(1), 1-13. https://doi.org/10.1186/s12889-022-13821-2

81 Oberth et al. (2021) Ibid.

82 Renzaho et al. (2022). Ibid.

83 Austrian et al. (2020). Ibid.

84 Austrian, K., & Ghati, D. (2010). Girl-centered program design: A toolkit to develop, strengthen and expand adolescent girls programs. Nairobi: Population Council.

85 Temin, M., & Heck, C. J. (2020). Close to home: Evidence on the impact of community-based girl groups. Global Health: Science and Practice, 8(2), 300-324. https://doi.org/10.9745/GHSP-D-20-00015

86 Jewkes et al. (2019). Ibid.

87 Jemmott et al. (2015). Ibid.

88 Jemmott et al. (2018). Ibid.

89 Erulkar et al. (2020). Ibid

90 Erhardt-Ohren et al. (2023). Ibid.

91 Hegdahl et al. (2022). Ibid.

92 Kangwana et al. (2022). Ibid.

93 Austrian et al. (2022). Ibid.

94 Dagadu et al. (2022). Ibid.

95 Hegdahl et al. (2022). Ibid.

96 Puffer et al. (2016). Ibid.

97 Ashburn et al. (2017). Ibid.

98 Chimbindi et al. (2023). Ibid.

99 Dagadu et al. (2022). Ibid

100 De Filippo et al. (2023). Ibid.

101 Ybarra et al. (2021). Ibid.

102 Erhardt-Ohren et al. (2023). Ibid.

103 Silverman et al. (2023). Ibid.

104 Dagadu et al. (2022). Ibid.

105 Puffer et al. (2016). Ibid.

106 Erulkar et al. (2020). Ibid

107 Chow, V., & Vivalt, E. (2022). Challenges in changing social norms: Evidence from interventions targeting child marriage in Ethiopia. World Development, 156. https://doi.org/10.1016/j.worlddev.2022.105925

108 Renzaho et al. (2022). Ibid.

109 Cislaghi et al. (2019). Ibid.

110 UNICEF. (2019). Life skills education: A technical note. UNICEF. Retrieved March 12, 2025, from https://www.unicef.org/media/104841/file/Life-skills-technical-note-2019.pdf

111 Gorman, C., & Amazon-Brown, I. (2017). Voices for Change Legacy Paper: Using the digital space to catalyse social change at scale (Issue August). Voices 4 Change.

112 Gorman, S., & Jones, J. (2024). Manosphere rewired: Understanding masculinities online. Equimundo: Center for Masculinities and Social Justice. https://www.equimundo.org/wp-content/uploads/2024/06/Manosphere-Rewired.pdf

113 Bacchus, L. J., Colombini, M., Pearson, I., Gevers, A., Stöckl, H., & Guedes, A. C. (2024). Interventions that prevent or respond to intimate partner violence against women and violence against children: A systematic review. The Lancet Public Health, 9(5), e326-e338. https://doi.org/10.1016/S2468-2667(23)00214-7

114 UNESCO. (2021). Education and the health of girls: What do we know? https://unesdoc.unesco.org/in/rest/annotationSVC/DownloadWatermarkedAttachment/attach_import_854c7922-737a-4934-8935-4226c5aa7761?_%3D221121eng.pdf

115 SBC Guidance. (2023). Selecting results: How to build your Theory of Change and Results Framework. https://www.sbcguidance.org/sites/default/files/2023-04/3-3-1%20Create%20-%20Selecting%20Results.pdf

116 Greene, M. E., Edmeades, J., & Siddiqi, M. (2024). Scope, range, and effectiveness of interventions to address social norms to prevent and delay child marriage and empower adolescent girls: A systematic review. BMJ Open, 14, e071275. https://doi.org/10.1136/bmjopen-2022-071275

117 Melesse et al. (2020). Ibid.

# APPENDICES

## Appendix A.1: Description of search terms

### Search terms

| |
|---|
| 1. Adolescent or adolescents or teen or teens or “young adults” or youth or girls or boys or “young people” or “young women” or “young men” |
| 2. Norms or “social norms” or “gender norms” or “peer norms” or “gender ideologies” or “gender attitudes” or “beliefs” or “family roles” or “family dynamics” or “power dynamics” or “positive deviants” or “perception of the child” or “control” or “patriarchy” or “adultism” or “heteronormativity” or “social hierarchy” or “gender division of labo*” or “privacy norms” or “protection norms” or stigma or discrimination |
| 3. “girls’ clubs” or “boys’ clubs” or “peer clubs” or “social marketing” or “social networks” or “sports for empowerment” or “positive masculinities” or “feminist movement” or “social movement” or “youth leadership” or “family program*” or “parenting program*” or “media campaign” or “community conversation*” or “religious leader*” or “community leader*” or “community mobili*” or “attitudes of healthcare provider*” or “regulatory change” or “multiple interventions” or “intervention” |
| 4. PLHIV or HIV or “HIV-affected” or “HIV infected” or “HIV incidence” or “sexually transmitted diseases” or STI or HPV or “sexual risk behavio*” or “early marriage” or “forced marriage” or “child marriage” or “female genital mutilation” or FGM or “female genital cutting” or FGC or “breast ironing” or “harmful gender practices” or “early pregnancy” or “adolescent pregnancy” or “unintended pregnancy” or “early sexual debut” or “contraceptive uptake” or “family planning” or “transactional sex” or “condom use” or abortion or “gender violence” or GBV or “intimate partner violence” or IPV or “violence perpetration” or “alcohol use” or “drug use” or “adolescent sensitive health workers” or “adolescent friendly health services” or “health service” or “sexual and reproductive health” or SRHR |
| 5. Africa or “Sub-Saharan Africa” or SSA or LMIC* or “Low income countr*” or “Eastern and Southern Africa” or ESAR or Burundi or Comoros or Djibouti or Ethiopia or Eritrea or Kenya or Madagascar or Malawi or Mauritius or Mozambique or Réunion or Rwanda or Seychelles or Somalia or Somaliland or Tanzania or Uganda or Zambia or Zimbabwe or Botswana or Lesotho or Namibia or Swaziland or Eswatini or “South Africa” |

## Appendix A.2: Supplementary Table 2: List of included studies

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| De Filippo, A., Bellatin, P., Tietz, N., Grant, E., Whitefield, A., Nkopane, P., Devereux, C., Crawford, K., Vermeulen, B., & Hatcher, A. M | Effects of digital chatbot on gender attitudes and exposure to intimate partner violence among young women in South Africa | 2023 | South Africa | Young women (18–24 years old) | **Violence:** Past month IPV | Digital-based | ChattyCuz |
| Mathews, C., Eggers, S. M., Townsend, L., Aarø, L. E., de Vries, P. J., Mason-Jones, A. J., De Koker, P., McClinton Appollis, T., Mtshizana, Y., Koech, J., Wubs, A., & De Vries, H. | Effects of PREPARE, a Multi-component, School-Based HIV and Intimate Partner Violence (IPV) Prevention Programme on Adolescent Sexual Risk Behaviour and IPV: Cluster Randomised Controlled Trial | 2016 | South Africa | Adolescents in Grade 8 (average age 13) in public high schools | **Violence:** IPV victimisation or perpetration in last 6 months<br>**Sexual risk behaviours:** sexual debut; number of sexual partners in the past 6 months<br>**Contraception:** self-reported condom use at last sex; using contraception (other than condoms) | Multiple interventions; School-based SRH programming | PREPARE |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Silverman, J. G., Brooks, M. I., Aliou, S., Johns, N. E., Challa, S., Nouhou, A. M., Tomar, S., Baker, H., Boyce, S. C., McDougal, L., DeLong, S., & Raj, A. | Effects of the reaching married adolescents program on modern contraceptive use and intimate partner violence: results of a cluster randomized controlled trial among married adolescent girls and their husbands in Dosso, Niger. | 2023 | Niger | Married adolescent girls (ages 13–19) and their husbands | **Violence:** past year IPV<br>**Contraception:** current modern contraceptive use | Multiple interventions; Community dialogues; Life skills; Training of healthcare providers | Reaching Married Adolescents |
| Oberth, G., Chinhengo, T., Katsande, T., Mhonde, R., Hanisch, D., Kasere, P., Chihumela, B., & Madzima, B. | Effectiveness of the Sista2Sista programme in improving HIV and other sexual and reproductive health outcomes among vulnerable adolescent girls and young women in Zimbabwe. | 2021 | Zimbabwe | Adolescent girls and young women 10-24 | **Violence:** reported sexual abuse<br>HIV/STI: HIV testing<br>**Child marriage:** likelihood of getting married; getting married under 18<br>**Contraception:** use of a modern family planning method<br>**Early pregnancy:** likelihood of falling pregnant; falling pregnant as a teenager 10-19 | Life skills | Sista2Sista |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Chabata, S. T., Hensen, B., Chiyaka, T., Mushati, P., Musemburi, S., Dirawo, J., Busza, J., Floyd, S., Birdthistle, I., Hargreaves, J. R., & Cowan, F. M. | The impact of the DREAMS partnership on HIV incidence among young women who sell sex in two Zimbabwean cities: results of a non-randomised study. | 2021 | Zimbabwe | Young women who sell sex ages 18-24 | **Violence:** experience of violence from partners in past 12 months; experience of violence from police in past 12 months<br>**HIV/STI:** HIV infection; knowledge of HIV status; ever taken PrEP<br>**Contraception:** condom-less sex with regular partner in the past month, condom-less sex with client in the past month,<br>**Sexual risk behaviours:** whether selling sex was the primary means by which women support themselves; ever unable to decline sex in past month; number of sex work clients in past month | Multiple Interventions; Community dialogues, Life skills; Rights-based advocacy | DREAMS and Sisters with a Voice |
| Njue, C., Voeten, H. A. C. M., Ohuma, E., Looman, C., Habbema, D. F., & Askew, I. | Findings of an evaluation of community and school-based reproductive health and HIV prevention programs in Kenya | 2015 | Kenya | Adolescents aged 10-19 years | **Violence:** ever had non-consensual sex<br>**Sexual risk behaviours:** ever had sex; age at first sex; had sex in past 6 months; mean number of lifetime partners<br>**Contraception:** currently uses modern contraceptive; used condom at last sex; used modern contraceptive or condom at first sex | Multiple interventions; Community dialogues; School-based SRH programming; Training of healthcare providers | Kenya Adolescent Reproductive Health |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Shah, M., Seager, J., Montalvao, J., & Goldstein, M. | Two Sides of Gender: Sex, Power, and Adolescence | 2022 | Tanzania | Females aged 10-24 and their boyfriends | **Violence:** IPV often index; IPV within last 2 years index<br>Sexual risk behaviours: sexual activity index (ever had sex, currently has partner, had partner past 2 years, total sex partners ever, hours with boyfriend in past day) | Multiple interventions; Life skills | |
| Stark, L., Asghar, K., Seff, I., Falb, K., Puffer, E. S., Iram, D., & Annan, J. | Preventing violence against refugee adolescent girls: findings from a cluster randomised controlled trial in Ethiopia | 2018 | Ethiopia | Girls aged 13–19 years residing in refugee camps | **Violence:** exposure to sexual violence in the previous 12 months; 12-month exposure to forced sex (having sex unwillingly); unwanted sexual touching and coerced sex in the previous 12 months; 12-month exposure to physical violence; 12-month exposure to emotional violence<br>**Sexual risk behaviours:** engagement in transactional sex Child marriage: child marriage | Multiple interventions; Life skills; Parenting programme | COMPASS |
| Roberts, S. T., Hartmann, M., Minnis, A. M., Otticha, S. O., Browne, E. N., Montgomery, E. T., & Agot, K. | Breaking down relationship barriers to increase PrEP uptake and adherence among adolescent girls and young women in Kenya: safety and preliminary effectiveness results from a pilot cluster-randomized trial | 2023 | Kenya | Adolescent girls and young women 17-24 | **Violence:** Physical, sexual and emotional IPV episodes; severe IPV events, resulting in physical injury<br>**HIV/STI:** PrEP uptake (initiating during study period); PrEP continuation (continuing to take PrEP at study exit); PrEP adherence (number of days with a Wisepill opening during the self-reported period of PrEP use) | Multiple interventions; Life skills; Community dialogues | Tu'Washindi and DREAMS |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Jemmott, J. B. 3rd, O'Leary, A., Jemmott, L. S., Ngwane, Z. P., Teitelman, A., Makiwane, M. B., Bellamy, S. L. | Effect of a Behavioral Intervention on Perpetrating and Experiencing Forced Sex Among South African Adolescents A Secondary Analysis of a Cluster Randomized Trial | 2018 | South Africa | adolescents aged 9 to 18 years | **Violence:** perpetrating and experiencing forced vaginal intercourse | School-based SRH programming | Let Us Protect Our Future |
| Dagadu, N. A., Barker, K. M., Okello, S. B. T., Kerner, B., & Nabembezi, D. | Fostering gender equality and reproductive and sexual health among adolescents: results from a quasi-experimental study in Northern Uganda | 2022 | Uganda | Male and female unmarried adolescents (10-14 years, 15-19 years), and married adolescents (15-19 years) and adults (over the age of 19 years) | **Violence:** touching (for boys) or having been touched (for girls) on the buttocks or breasts without permission in the past 3 months<br>Contraception: current family planning use | Multiple interventions; Media-based; Intervention with traditional/ religious leaders; Community dialogues; Life skills; Training of healthcare providers | Gender Roles, Equality and Transformations (GREAT) |
| Jewkes, R., Gevers, A., Chirwa, E., Mahlangu, P., Shamu, S., Shai, N., & et al. | RCT evaluation of Skhokho: A holistic school intervention to prevent gender-based violence among South African Grade 8s. | 2019 | South Africa | Grade 8 learners aged 12-19 years | **Violence:** incidence of any IPV; severe IPV; non-partner rape<br>Contraception: condom use; contraceptive use<br>**Sexual risk behaviours:** transactional sex<br>**Early pregnancy:** ever having been pregnant | Multiple Interventions; School-based SRH programming; Parenting programme; Life skills | Skhokho |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Ashburn, K., Kerner, B., Ojamuge, D., & Lundgren, R. | Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on physical child punishment and intimate partner violence in northern Uganda. | 2017 | Uganda | Young fathers aged 16 to 25 who have toddler-aged children (1–3 years) | **Violence:** IPV in the past 3 months (have you shouted or yelled at your wife, slapped your wife, and pushed or shoved your wife?); perpetration of psychological IPV; perpetration of verbal IPV; physical punishment against child in the past month (have you done the following to discipline the child shook him/her, shouted, yelled, or screamed at him/her, and spanked, hit, or slapped him/her on the bottom with bare hand) | Multiple interventions; Parenting programme; Community dialogue | Responsible, Engaged, and Loving (REAL)<br>Fathers Initiative |
| Renzaho, A. M. N., Kamara, J. K., Doh, D., Bukuluki, P., Mahumud, R. A., & Galukande, M. | Do Community-based Livelihood Interventions Affect Sexual and Reproductive Health and Rights of Young People in Slum Areas of Uganda: a Difference-in-difference with Kernel Propensity Score Matching Analysis | 2022 | Uganda | Young people living in the slum areas aged 13-24 years | **Violence:** consensual sex at sexual debut; persuaded with money/gifts, tricked/deceived, raped/forced at sexual debut; had sex in the last 12 months; no. of people had sex with in the last 12 months; consensual sex in the last 12 months; persuaded with money/ gifts, tricked/ deceived, forced/ raped in sex in last 12 months<br>**Sexual risk behaviours:** ever had sex; age at first sex<br>**Contraception:** used condom at sexual debut<br>**HIV/STI:** ever had HIV test; got tested and knows result | Multiple interventions; Life skills; Rights-based advocacy; Community dialogues; Interventions with religious/ cultural leaders | UPLIFT |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Mantell, J. E., Smit, J. A., Exner, T. M., Mabude, Z., Hoffman, S., Beksinska, M., Kelvin, E. A., Ngoloyi, C., Leu, C.-S., & Stein, Z. A. | Promoting Female Condom Use Among Female University Students in KwaZulu-Natal, South Africa: Results of a Randomized Behavioral Trial | 2015 | South Africa | Female university students aged 18-28 | **Contraception:** number of female condoms used; proportion of female condom-protected vaginal intercourse occasions across all partners; male condom/female condom use at last sex occasion; number of vaginal intercourse occasions unprotected by male or female condoms; proportion of vaginal intercourse occasions protected by either a female or male condom | Life skills | |
| Gage, A. J., Akilimali, P. Z., Wood, F. E., Gay, R., Padis, C. O., & Bertrand, J. T. | Evaluation of the effect of the Momentum project on family planning outcomes among first-time mothers aged 15-24 years in Kinshasa, DRC | 2023 | DRC | Nulliparous women aged 15-24 years, 6 months pregnant at baseline, and their male partners | **Contraception:** modern contraceptive use within 12 months of delivery; obtaining a contraceptive method within 6 weeks of delivery | Multiple Interventions; Life skills; Community dialogues | Momentum |
| Birdthistle, I., Mulwa, S., Sarrassat, S., Baker, V., Khanyile, D., O'Donnell, D., Cawood, C., & Cousens, S. | Effects of a multimedia campaign on HIV self-testing and PrEP outcomes among young people in South Africa: a mixed-methods impact evaluation of 'MTV Shuga Down South'. | 2022 | South Africa | Males and females 15-24 | **HIV/STI:** knowledge of HIV status (tested for HIV in the past year and received the result, or ever tested HIV positive); ever or past-year use of HIV self-test<br>**Sexual risk behaviours:** have had sex, ever and in the past 12 months Contraception: condom use at last sex | Mass media | MTV Shuga Down South |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Johnson, S., Magni, S., Dube, Z., & Goldstein, S | Extracurricular School-Based Social Change Communication Program Associated with Reduced HIV Infection Among Young Women in South Africa | 2018 | South Africa | Women aged 18–28 years who ever had sex | **Sexual risk behaviours:** having multiple sexual partners in the past year<br>**Contraception:** used a condom at first sex; condom use at last sex; transactional sex; age-disparate sex<br>**Early pregnancy:** ever been pregnant; teenage pregnancy<br>HIV/STI: HIV status | Life skills | Soul Buddyz |
| Erhardt-Ohren, B., Brooks, M., Aliou, S., Osseni, A. A., Oumarou, A., Challa, S., Tomar, S., & Silverman, J. | Sustained impact of community-based interventions on contraceptive use among married adolescent girls in rural Niger: Results from a cluster randomized controlled trial. | 2023 | Niger | Married adolescent girls 13-19 years old and their husbands | **Contraception:** current use of any modern contraceptive; current use of any LARC method | Multiple interventions; Community dialogues; Life skills; Training of healthcare providers | Reaching Married Adolescents |
| Arije, O., Udoh, E., Ijadunola, K., Afolabi, O., Aransiola, J., Omoregie, G., Tomori-Adeleye, O., Ukeme-Edet, O., Fajemisin, O., Titus, R., & Onayade, A. | Combination prevention package of interventions for reducing vulnerability to HIV among adolescent girls and young women in Nigeria: An action research | 2023 | Nigeria | Females aged 15 to 24 years old | **HIV/STI:** uptake of HIV testing; STI treatment<br>**Contraception:** getting condoms; using family planning services | Parenting programme; Life skills; Media-based | |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Akande, O. W., Muzigaba, M., Igumbor, E. U., Elimian, K., Bolarinwa, O. A., Musa, O. I., & Akande, T. M. | The effectiveness of an m-Health intervention on the sexual and reproductive health of in-school adolescents: a cluster randomized controlled trial in Nigeria. | 2024 | Nigeria | In-school adolescents aged 10–19 years | **Sexual risk behaviours:** practice of risky sexual behaviour (defined as reporting one or more of the following: multiple sexual partners, exchange of material gift or money for sex, inconsistent/incorrect/ non-use use of condoms at least once during sexual intercourse, getting infected by an STI, and sexual debut before the age of 18 years) | Digital-based, School-based SRH programming | Family Life and HIV Education |
| Sarnquist, C., Sinclair, J., Mboya, B. O., Langat, N., Paiva, L., Halpern-Felsher, B., Golden, N. H., Maldonado, Y. A., & Baiocchi, M. T. | Evidence That Classroom-Based Behavioral Interventions Reduce Pregnancy-Related School Dropout Among Nairobi Adolescents | 2017 | Kenya | Girls aged 13 to 20 years | **Early pregnancy:** school dropouts due to pregnancy | School-based SRH programming | |
| Austrian, K., Soler-Hampejsek, E., Kangwana, B., Maddox, N., Diaw, M., Wado, Y. D., Abuya, B., Muluve, E., Mbushi, F., Mohammed, H., Aden, A., & Maluccio, J. A. | Impacts of Multisectoral Cash Plus Programs on Marriage and Fertility After 4 Years in Pastoralist Kenya: A Randomized Trial. | 2022 | Kenya | Girls aged 11-14 years | **Child marriage:** ever been married<br>Early pregnancy: ever been pregnant; ever given birth | Multiple interventions; Community dialogues; Life skills | Adolescent Girls Initiative-Kenya (AGI-K) |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Waidler, J., Gilbert, U., Mulokozi, A., & Palermo, T. | A "Plus" Model for Safe Transitions to Adulthood: Impacts of an Integrated Intervention Layered onto A National Social Protection Program on Sexual Behavior and Health Seeking among Tanzania's Youth. | 2022 | Tanzania | Adolescents aged 14–19 years | **Child marriage:** ever married<br>**Sexual risk behaviours:** ever had sex; age of sexual debut; number of sexual partners in last 12 months; had concurrent sexual relationships in the last 12 months<br>**Early pregnancy:** current pregnancy status (female); ever pregnant (females); ever gotten a female pregnant (males)<br>**Contraception:** used condom at last sex; currently using contraceptive; currently using modern contraceptive<br>**HIV/STI:** tested for HIV in last 12 months | Multiple interventions; Life skills; Training of healthcare providers | Ujana Salama |
| Harrison, A., Hoffman, S., Mantell, J. E., Smit, J. A., Leu, C. S., Exner, T. M., & Stein, Z. A | Gender-focused HIV and pregnancy prevention for school-going adolescents: The Mpondombili pilot intervention in KwaZulu-Natal, South Africa | 2016 | South Africa | Boys and girls in grades 8–10 (ages 14–17) | **Contraception:** Condom use at last sex | School-based SRH programming | Mpondombili |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Ybarra, M. L., Agaba, E., & Nyemara, N. | A Pilot RCT Evaluating InThistoGether, an mHealth HIV Prevention Program for Ugandan Youth | 2021 | Uganda | 18–22-year-old youth | **Sexual risk behaviours:** how many times had vaginal/anal sex in past 3 months<br>**Contraception:** times having condom-protected sex<br>HIV/STI: HIV testing in the past 3 months | Digital-based | InThistoGether (ITG) |
| Sidamo, B., Negussie, N., Hussen, S., Shimbre, M. S., Zerihun, E., Boynito, W. G., Abebe, S., Shibiru, T., Shibiru, S., Gebretsadik, W., Desalegn, N., Oumer, B., Temesgen Birgoda, G., & Abdulkadir, H. | Effectiveness of curriculum-based sexual and reproductive health education on healthy sexual behaviors among year one students at Arba Minch University: A quasi-experimental study | 2023 | Ethiopia | Year one undergraduate students 19-24 years | **Sexual risk behaviours:** sexual risk behaviour scale (Have you ever had sexual intercourse without a condom? During your life, with how many people have you had sexual intercourse? During the past 3 months, with how many people did you have sexual intercourse? The last time you had sexual intercourse, did you or your partner use a condom? The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?)<br>**HIV/STI:** ever screen for HIV<br>**Contraception:** consistent and correct use of condoms, contraception utilization | School-based SRH programming | Curriculum-based sexual and reproductive health education (CBSRHE) |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Denison, J. A., Packer, C., Nyambe, N., Hershow, R. B., Caldas, S., Miti, S., Sudarsan, S., Chen, M., Bernholc, A., Mwansa, J. K., & McCarraher, D. R. | Family Connections randomized controlled trial: assessing the feasibility and acceptability of an intervention with adolescents living with HIV and their caregivers in Ndola, Zambia | 2022 | Zambia | Adolescents 15-19 years and on ART > 6 months and their caregivers | **HIV/STI:** ART adherence, viral failure | Training of healthcare providers; Parenting programme | Family Connections |
| Puffer, E. S., Green, E. P., Sikkema, K. J., Broverman, S. A., Ogwang-Odhiambo, R. A., & Pian, J. | A Church-Based Intervention for Families to Promote Mental Health and Prevent HIV Among Adolescents in Rural Kenya: Results of a Randomized Trial | 2016 | Kenya | Adolescents ages 10 to 16 and caregivers | **Sexual risk behaviours:** having ever had vaginal intercourse; having had high risk sex in the past 3 months (defined by not using a condom during at least one sexual encounter and/or having more than one sexual partner in that time period) | Parenting programme; Intervention with traditional/ religious leaders | READY |
| Jemmott, J. B., 3rd, Jemmott, L. S., O'Leary, A., Ngwane, Z., Lewis, D. A., Bellamy, S. L., Icard, L. D., Carty, C., Heeren, G. A., Tyler, J. C., Makiwane, M. B., & Teitelman, A. | HIV/STI Risk-Reduction Intervention Efficacy With South African Adolescents Over 54 Months | 2015 | South Africa | Grade 6 learners | **Sexual risk behaviours:** having unprotected vaginal intercourse in the past 3 months; vaginal sex; multiple partners; heterosexual anal sex<br>**Contraception:** consistent condom use; frequency of condom use; condom use at last sex<br>**HIV/STI:** biologically confirmed curable STIs; HSV-2 serostatus | School-based SRH programming | Let Us Protect Our Future intervention |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Burke, H. M., Chen, M., Murray, K., Bezuidenhout, C., Ngwepe, P., Bernholc, A., & Medina-Marino, A. | The effects of the integration of an economic strengthening and HIV prevention education programme on the prevalence of sexually transmitted infections and savings behaviours among adolescents: a full-factorial randomised controlled trial in South Africa | 2020 | South Africa | Adolescents 14-17 years | **HIV/STI:** STI prevalence (positive test result for gonorrhoea, trichomoniasis or chlamydia infection)<br>**Sexual risk behaviours:** engaging in protective sexual behaviour (abstinence or a condom used every time over the past 6 months); engaging in transactional sex in the past 6 months; having two or more sexual partners in the past 6 months<br>**Early pregnancy:** pregnancy | Multiple interventions; Life skills | Vhutshilo 2.0 and Impumelelo |
| Kemigisha, E., Bruce, K., Ivanova, O., Leye, E., Coene, G., Ruzaaza, G., Ninsiima, A., Mlahagwa, W., Nyakato, V., & Michielsen, K. | Evaluation of a school based comprehensive sexuality education program among very young adolescents in rural Uganda | 2019 | Uganda | Very young adolescents aged 10-14 years | **Sexual risk behaviours:** ever had sex | School-based SRH programming | |
| Bhana, A., Mellins, C. A., Petersen, I., Alicea, S., Myeza, N., Holst, H., Abrams, E., John, S., Chhagan, M., Nestadt, D. F., Leu, C.-S., & McKay, M. | The VUKA family program: Piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa | 2014 | South Africa | Very young adolescents aged 10-13 years | **HIV/STI:** youth adherence to ART (how often missed medications over past 6 months) | Parenting programme | VUKA family intervention |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Hegdahl, H. K., Musonda, P., Svanemyr, J., Zulu, J. M., Grønvik, T., Jacobs, C., & Fos, I | Effects of economic support, comprehensive sexuality education and community dialogue on sexual behaviour: Findings from a cluster-RCT among adolescent girls in rural Zambia | 2022 | Zambia | Girls in grade 7 | **Sexual risk behaviours:** sexual activity in the previous four weeks; unprotected sexual activity in the previous four weeks<br>**Contraception:** recent use of modern contraceptives among those reporting ever having been sexually active; current use of modern contraceptives among those who were sexually active in the previous four weeks | Multiple Interventions; Community dialogues; Parenting/ couples programme; Life skills in safe spaces; Training of healthcare providers | Research Initiative to Support the Empowerment of Girls (RISE) |
| Pike, C., Coakley, C., Ahmed, N., Lee, D., Little, F., Padian, N., & Bekker, L. G. | Goals for girls: a cluster-randomized trial to investigate a school-based sexual health programme amongst female learners in South Africa | 2023 | South Africa | Female adolescents non-pregnant in secondary school grades 8–10, aged 8-21 years | **HIV/STI:** STI prevalence; HIV status<br>**Early pregnancy:** pregnancy<br>**Contraception:** contraceptive use | Life skills; School-based SRH programming | SKILLZ Streets |
| Austrian, K., Soler-Hampejsek, E., Behrman, J. R., Digitale, J., Hachonda, N. J., Bweupe, M., & Hewett, P. C. | The impact of the Adolescent Girls Empowerment Program (AGEP) on short and long term social, economic, education and fertility outcomes: a cluster randomized controlled trial in Zambia | 2020 | Zambia | Never-married girls aged 10-19 | **Contraception:** used condom at first sex<br>**Sexual risk behaviours:** having had transactional sex (evaluated among girls aged 15 years and older who had initiated sex); ever had sex<br>**Early pregnancy:** ever been pregnant; ever given birth<br>**Child marriage:** ever been married (evaluated among girls aged 15 years and older) | Multiple interventions; Life skills | Adolescent Girls Empowerment Program (AGEP) |

| Authors | Title | Year | Country | Population | SRHR outcome | Norms intervention type | Intervention name |
|---|---|---|---|---|---|---|---|
| Kangwana, B., Austrian, K., Soler-Hampejsek, E., Maddox, N., Sapire, R. J., Dibaba Wado, Y., Abuya, B., Muluve, E., Mbushi, F., Koech, J., & Maluccio, J. A. | Impacts of multisectoral cash plus programs after four years in an urban informal settlement: Adolescent Girls Initiative-Kenya (AGI-K) randomized trial | 2022 | Kenya | girls 11–14 years | **Sexual risk behaviours:** ever had sex<br>**Early pregnancy:** ever been pregnant or given birth;<br>**HIV/STI:** tested positive for HSV-2 at endline; tested positive for HSV-2 at endline having tested negative at baseline<br>**Contraception:** contraceptive use | Multiple interventions; Community dialogues; Life skills | Adolescent Girls Initiative-Kenya (AGI-K) |
| Erulkar, A., Medhin, G., Weissman, E., Kabore, G., & Ouedraogo, J. | Designing and Evaluating Scalable Child Marriage Prevention Programs in Burkina Faso and Tanzania: A Quasi-Experiment and Costing Study | 2020 | Burkina Faso and Tanzania | Girls aged 12 to 17 years | **Child marriage:** ever been married or lived with a person as married | Multiple interventions; Community dialogues; Intervention with traditional/ religious leaders (Tanzania); Life skills (Tanzania) | |
| Chow, V., & Vivalt, E. | Challenges in Changing Social Norms: Evidence from Interventions Targeting Child Marriage in Ethiopia | 2022 | Ethiopia | Girls aged 8-17 years | **Child marriage:** ever married | Multiple interventions; Community dialogues; Life skills; Intervention with traditional/ religious leaders | |

## Appendix A.3: Supplementary Table 3: Criteria for attribute assessment

| | Attributes | Criteria |
|---|---|---|
| **Change Social Expectations** | 1. Has accurate understanding of existing social norms, power dynamics and reference groups | Uses formative/participatory research with intervention communities to understand local contexts or engage them in intervention design, fully articulating what the norms, power dynamics and reference groups are |
| | 2. Targets pluralistic ignorance where there is a discrepancy between the actual norm and what people think others expect of them | Presents information on the prevalence of norms or behaviours to participants, including through mass media, social marketing campaigns or small group workshops in which the group norm is assessed and the misperception is discussed |
| | 3. Promotes a positive new norm or associated behaviour and/or seeks to weaken existing harmful norms by correcting associated knowledge | Emphasizes positive norms and related behaviours such as healthy relationships, gender empowerment, non-violent relationships, positive communication, use of SRHR services<br><br>Presents information to change harmful beliefs, including in relation to gender inequitable attitudes, stigma and harmful cultural/community beliefs |
| | 4. Engages at multiple levels of the socio-ecological framework including by creating spaces for family and community and institutional change | Includes tailored intervention messaging, content, or design with reference groups beyond young people in mind |
| | 5. Promotes commitments to community change | Prompts community members to publicly commit to change using pacts, pledges, action plans, goal setting |

| | Attributes | Criteria |
|---|---|---|
| **Publicise & diffuse** | 6. Has a diffusion strategy beyond individual behaviour change | Encourages participants to share learnings with peers, family, and community members to raise awareness<br><br>Sparks critical reflection to shift norms first within a core group, who then engage others to have community-level impact.<br><br>May include promoting social movements to diffuse change. May include mass media, but only applies when media is used to publicize change in behaviours/norms in participants in the intervention.<br><br>Has a strategy to track diffusion. |
| | 7. Publicises role models and benefits of new behaviour and /or avoids reinforcing negative norms and behaviours. | Publicises role models including intervention participants, community members, peer educators or 'digital role models' and their positive behaviours |
| **Catalyse & reinforce** | 8. Creates new rewards and sanctions, including legal and policy change | Changes in legal framework to reward or sanction behaviours, or advocates for legal/ policy change with institutions |
| | 9. Reinforces opportunities to behave in accordance with new norm | Provides availability of SRH services encouraged in intervention, or opportunities to apply new knowledge in group discussions or through intervention, clearly articulating these as opportunities to practice behaviours |
| | 10. Addresses other institutional or individual factors that promote risk behaviours and impede access to SRH services | Provides socioeconomic support, health services, or other services that address other barriers to behavioural change. |

Sweden
Sverige

2gether 4SRHR

UNAIDS

UNFPA

unicef
for every child

World Health Organization

accelerate
RESEARCH HUB

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

UNIVERSITY OF
OXFORD