

Helpdesk Research Report

Social norms, contraception and family planning

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Question

What does the evidence tell us about a) social norms around the use of family planning/modern contraception (including decision-making, uptake, continuation, methods, and in relation to age/lifecycle, married/unmarried, education, income levels and other social and economic factors) and b) about interventions that have applied an understanding of social norms in efforts to increase acceptance and uptake of family planning? What has been tried, and what has worked (to increase women's and girls' ability to use voluntary modern contraception) and what hasn't, and why/why not?

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1. Overview

Family planning is enabled when individuals and couples are able to control the number of children they have, and the spacing and timing of their births. It is achieved through contraceptive methods and the treatment of involuntary infertility.¹ Social norms are understood broadly as 'widely shared beliefs and common practices within a particular group' (Jiang & Marcus, forthcoming, p.2). Interrelated social norms concerning gender, tradition/modernity, religion, social status, age, education and employment status, etc

¹ See - http://www.who.int/topics/family_planning/en/

are important factors influencing family planning and contraception use. Modern contraceptives are condoms and hormonal birth control, as opposed to traditional methods.

Social norm interventions focus at the interpersonal and community levels (Jiang & Marcus, forthcoming, p.2, based on WHO, 2002). Social norm approaches at a basic level look at 'how particular social groups' shared expectations may be modified to shift behaviour towards socially desired outcomes' (ibid). More ambitious social norm approaches can 'aim to change power relations, economic inequalities and deeply rooted ideologies and cultural values' (Jiang & Marcus, forthcoming, p.2). Both of these levels can influence contraception and family planning.

This rapid literature review found a large amount of literature in the general area of family planning and contraception use, much of this refers to social norms, and a medium amount of this literature focusses on the relationship between these two broad areas. The literature includes a variety of methodological approaches, and is produced by a broad range of academics, bilateral and multilateral agencies and non-governmental organisations (NGOs). However, despite this medium amount of literature, there is a limited amount that rigorously examines the impact of interventions on social norm changes. This query focusses on literature published since 2010, unless literature published before is referenced in a more recent paper. This query focuses on contraception and family planning within heterosexual relationships.

Taking a gendered approach

Social norms and ideals of masculinity and femininity often perpetuate inequality between men and women including:

- Social norms granting men control and decision making authority over women and resources
- Social norms that place lesser value on women and girls than on men and boys
- Social norms that a woman's purpose in life is child-bearing
- Isolation of women

These patriarchal gender norms influence many aspects of family planning and contraception use including: fertility rates; timing of marriage and childbearing; family size; sex preference and composition of children; medical rules constraining family planning (including safe abortion); age of marriage (child marriage); contraception use; etc (Schuler, Rottach & Mukiri, 2011; Campbell, Prata, & Potts, 2013).

It is widely argued that that research on reproductive health has tended to focus on women without addressing the **role of masculinity** in contributing to gender inequities, and in putting men and their partners at risk (e.g. Greene & Barker, 2011). Family planning programmes that have 'selectively accommodated rather than challenged prevailing gender norms' through targeting family planning towards women, have 'reinforced the idea that reproduction and family welfare are women's responsibilities' (Schuler, et al., 2011, p.102). The literature argues for applying a gender perspective on family planning programmes including men and masculinities to meet the health needs and rights of both men and women.

Key points:

Understanding norms:

- **Decision-making.** In many relationships, men dominate decision-making around family planning and contraception. Family and community members may also play important roles. Those making decisions may not discuss it with others involved. Key reasons for not using contraception include:

opposition by a partner, male dominance in decision-making, and misinformation. One study found a positive relationship between contraceptive use among men with more equitable attitudes toward women.

- **Early marriage, childbirth, child spacing and family size.** There is mixed evidence about the relationship between early marriage, family planning and contraception use. Some authors find early marriage prevalence strongly linked to low contraceptive use, high fertility rates, unwanted pregnancies, and unsafe abortions. In many settings societal and family expectations are that women become pregnant and give birth soon after marriage. One study finds contraceptive uptake might be higher in cases of child marriage when girls are subfecund, and/or when social norms of longer birth intervals are already practiced.
- **Contraception uptake and methods.** The traditional norm of not using modern contraception is sometimes deeply embedded and can take a long time to change, despite targeted interventions. Negative stereotypes and social stigma around contraception and sex limit uptake of contraception, especially with youth. It is critical to intervene early, when adolescents are forming their identities, and developing their understanding of social norms around sexuality and gender. Patterns vary according to rural/urban divides and levels of schooling. There are mixed findings regarding the extent to which, and how, community-level norms affect women's use of modern contraceptives.

Interventions and approaches:

- **Communication interventions** aimed at changing attitudes and behaviours include: diffusion approaches (e.g. large-scale media, social marketing campaigns, educational and entertainment approaches and other one-way communications); interpersonal (e.g. one-on-one, small group communication, and providing information and building skills); and participatory approaches (e.g. targeting communities).
- **Targeting interventions at different actors.** Family planning is affected by factors operating at the levels of the individual, family, friendship group, peer group, neighbourhood, community, institutional, and the policy environment. Effective programmes assess the barriers at each level to identify which interventions are needed in a given context, according to the level where the relevant norm is enforced.
- Norms are constructed and reinforced through multiple institutions, and they can change more quickly if new norms are promoted by **targeted interventions at multiple institutional levels.**
- **Targeting gender norms and men.** Interventions that support more equitable gender norms can contribute to increase voluntary family planning use, delay first sex, and gender equality and agency. Interventions encouraging joint decision making between women and men are important.
- Insights can be gained from general **social norms approaches.**
- **International organisations and agreements** can shape international norms on family planning and contraception.

2. Social norms, contraception and family planning

Decision-making

In many relationships, decision-making around family planning and contraception may not include, or may include to a greater or lesser extent, the potential child-bearing girls and women themselves. Men play a greater role in highly gender-stratified populations (Mishra et al., 2014). Family (e.g. mothers-in-law) and community members (e.g. elders) may also play a role in decision-making. Those making the decisions may not discuss it with others involved (for varied reasons, e.g. lack of experience, or not feeling comfortable talking about sensitive issues).

A key reason for **not using contraception** is opposition by a male partner (e.g. Nalwadda, Mirembe, Byamugisha & Faxelid, 2010). Participants in studies in Tanzania (Schuler, et al., 2011) and Uganda (Nalwadda, et. al., 2010) said that using contraception in secret or against the wishes of the husbands could lead to violence or divorce of the woman. A study in the Indian Uttar Pradesh region found ‘restrictions on wife’s mobility showed significant negative relationship with current contraceptive use’ (Mishra et al., 2014).

The same research in India found a significant and positive association with **current contraceptive use** among men who approached decision-making with high or moderate levels of gender sensitivity and equitable attitudes toward women (Mishra et al., 2014).

Schuler, Rottach and Mukiri (2011) explore the role of gender norms in reproductive decision-making and contraceptive use in Tanzania, with six focus groups, and interviews with 60 young, currently married, men and women and 12 older people who influenced family planning decisions. They find that **men’s dominance** in decision-making is a barrier to the use of modern contraceptives. While nearly all the male and female participants held discussions on family planning, the final decision is the man’s.

However, they also find that the **fear of side effects** of contraception might be a more significant deterrent than male-dominated decision making. Most of the male participants who did not use contraception were against contraception as they were **misinformed** about side effects and feared it would harm their wives. As participants believed **family planning to be a woman’s job**, men rarely sought information from reputable sources on family planning. The women participants also seemed to have similar misconceptions and fears about contraceptive. (Schuler, et al. 2011).

Early marriage, childbirth, child spacing and family size

Traditional and religious practices, financial pressures and low gender equality often support norms of early marriage. There is **mixed evidence** about the relationship between early marriage, family planning and contraception use.

In a systematic review, Muralidharan, et. al. (2014) find that early marriage prevalence is ‘strongly linked to **low contraceptive use**, high fertility rates, unwanted pregnancies, [and] unsafe abortions’, among other factors. A theoretical paper by Campbell, Prata and Potts (2013) argues that fertility decline is more dependent ‘on the degree to which the woman has freedom from unjustified and sometimes hidden **barriers to family planning**’ (including e.g. child marriage norms, access to a range of contraception choices, correct information and safe abortion). They find this is more important than wealth and education, in contradiction to common assumptions.

In many settings, particularly in Asia and sub-Saharan Africa, there are societal and family expectations for women to become pregnant and give **birth soon after marriage** and cohabitation (Daniel et al., 2008). This is particularly the case in contexts where women's gender identities and social status are tied to motherhood, such as in sub-Saharan Africa. The use of modern contraceptives is low in this region, especially among married youth (Hindin & Fatusi, 2009, p.59).

However, Amin and Bajracharya (2011) find that when marriage is early, 'contraceptive uptake might be higher as [a] function of the number of factors ... including the **absence of expectations to bear children right away** when marriage takes place potentially during a time when girls are subfecund' (p.19). They also find confirmation in their study of Bangladesh that where social norms related to longer birth intervals was already an **accepted practice among an older generation**; this will result in higher use of contraceptives among a younger generation of women.

Contraception uptake and methods

The literature identifies a number of ways that norms influence the general uptake of contraception and preferred methods.

The traditional **norm of not using modern contraception** is sometimes **deeply embedded** and can take a long time to change, despite interventions. In a heavily cited journal article based on analysis of longitudinal data of uptake of contraception, Munshi and Myaux (2006) explain how in rural Bangladesh, the traditional norm to regulate fertility was early and universal marriage, as a precedent for immediate and continuous childbearing. This norm was legitimised through religious belief and authority. Although the government started to promote contraception from 1978 onwards, take up was very slow. The authors found that as the institution of 'purdah' (veiling and segregation) limits women's social interactions to other women within their religious group in Bangladesh, shifts in attitudes about fertility occurred at the level of these religious groups rather than across villages, despite common family planning inputs across villages (Munshi & Myaux, 2006). The World Bank's (2015, p.54) World Development Report suggests therefore that 'fertility transitions may be better viewed as a norm-driven process than as the aggregate outcome of autonomous decisions'. In Uganda, contradictory messages about whether to use contraceptives from partners, parents, clergy, teachers, cultural leaders and health workers were identified as key obstacles to uptake (Nalwadda, et al., 2010).

Negative stereotypes, stigma, misconceptions and fear limit uptake of contraception. Social stigma, fear and embarrassment are identified as NGO Population Services International (PSI) (2014) as one of the most common barriers to young people accessing contraception services – including the attitude of the service providers. Research in Tanzania by Schuler et al. (2011) found that sexual jealousy discouraged contraceptive use, as men worried that women's use of contraception might allow them to be promiscuous and unfaithful without fear of conceiving. In Uganda, focus groups with young people found that they believed and were afraid that contraceptives could harm their fertility (Nalwadda, et al., 2010).

It is considered critical to **intervene early, when adolescents are forming their identities**, developing their understanding of social norms around sexuality and gender, and making choices (including whether/when to have sex or use contraception) that will affect the rest of their lives (expert comments). In all countries, community attitudes, such as those of parents, faith leaders, teachers, providers, and others, play a critical role in how impactful youth programmes can be. Working with parents, families, and community leaders is imperative to ensuring that young people have access to the information and services they need.

In both Bangladesh and India, adolescent women in **urban** settings demonstrated higher use of (modern) contraception than adolescents in **rural** settings. The authors suggest this is perhaps indicative of greater health facilities and concentration of mass media in urban areas, resulting in greater awareness and access (Rahman, 2010; Moore et al., 2009).

In a peer-reviewed journal article Mayaki and Kouabenan (2015) examine the variables likely to influence family planning practices in Niger through questionnaire analysis of 200 married females (aged 21-50). Their findings suggest 'that subjective norms have a direct effect on contraceptive use among women with no **formal schooling**, living in either rural or urban settings. For women with some formal schooling, it was their attitude towards family planning that had a direct effect on family planning practices' (p.249).² They suggest that targeted family planning messages should be based on cultural values and norms (Mayaki & Kouabenan, 2015).

Wang et al. (2013) synthesise wider evidence on the influence of community-level norms. They identify **mixed findings** regarding the extent to which **community-level norms** around family planning and family size affect women's use of modern contraceptives. The findings they summarise include (In Wang et al., 2013):

- In Mali, after controlling for individual-level factors, there was no evidence that women's use of modern contraceptives was affected either by **community norms about desired family size** (measured by the proportion of women desiring four or fewer children and the mean number of births per woman), or by attitudes toward family planning (measured by the proportion of women in the community who approved of family planning) (Kaggwa, et al. 2008).
- A study of six sub-Saharan African countries found that in four of the countries (Kenya, Malawi, Tanzania, and Ghana), after adjusting for individual and other community-level factors, the percentage of women in the community approving of family planning was positively associated with individual women's **current use of modern contraceptives**. In Kenya, men's community-level approval of family planning was a significant positive predictor of women's contraceptive use; this association held even after adjusting for the partner's approval of family planning at the individual level, indicating a community influence above and beyond that of the nuclear family (Stephenson, et al. 2007).
- In Nepal, a **preference for sons** appears to influence fertility and family planning norms (Brunson, 2010). And a husband's approval of family planning has been shown to be a pivotal determinant of women's contraceptive use (Kamal & Lim, 2010).

In Wang et al.'s (2013) study, they quantitatively analyse USAID data from the Demographic and Health Surveys (DHS) to identify determinants of women's **use of modern contraceptives** in Nepal and Rwanda. Four areas of **community-level influence** are studied including: fertility norms, socioeconomic development, women's empowerment, and access to family planning information and services. It uses the following indicators as proxies to measure fertility norms: average age at first marriage; longer interval between marriage and first birth; and fertility desire (p.14).

² In this study the 'Theory of Planned Behaviour' is used which defines subjective norms and attitudes as follows: 'Behavioural beliefs refer to an individual's attitude towards a given behaviour. Normative beliefs (subjective norms) represent people's perception of the pressure exerted by others in their environment, especially by significant others whose beliefs one cares about, that is, what each person holds to be the expectations of his or her reference group' (Mayaki & Kouabenan, 2015, p. 250)

It finds that community-level fertility norms are important determinants of contraception use – specifically, the number of children desired by others in the community affects use of contraception by women (Wang et al., 2013). However, family planning programmes in Nepal and Rwanda have successfully encouraged people to have small families. In Rwanda, women’s desired number of children has ‘decreased substantially’ over the past decade (p.34). However it concludes that among the factors explored in the research, socioeconomic development and access to family planning services appear to have played a bigger role in affecting women’s contraceptive behaviours than the community gender and fertility norms did (p.35).

3. Interventions and approaches

Communication interventions

Communication initiatives aimed at changing individual attitudes and behaviours include: diffusion approaches (involving large-scale media and social marketing campaigns and other one-way communications); interpersonal (one-on-one or small group communication) and participatory approaches (targeting communities) (Tufté and Mefalopoulos, 2009 in Haider, 2012).

Social marketing applies commercial marketing methods to target messages to particular segments of society in order to increase knowledge, change attitudes, behaviours and practices for social good (PSI, 2014; Haider, 2012). PSI’s behaviour change communication interventions use ‘commercial marketing techniques to position products and services with messages that promote knowledge and help normalize and reinforce healthy behaviours. Campaigns are disseminated to target audiences through a variety of channels – such as mass media, peer education, school programs, community theatre, mobile multi-media events, interpersonal communication, and special event sponsorship – and are presented in many ways so that those with various levels of education can benefit’ (p.7). E.g. The Association Nigerienne de Marketing Social (Animas-Sutura) implemented a social marketing campaign in Niger to address issues of reproductive health and family planning, sexually transmitted infections, and HIV/AIDS (Adams 2009 in Haider, 2012). Lessons from the initiative include the importance of relying on local culture to develop a campaign, utilising professional marketing and communication expertise, forming broad community coalitions, and engaging masses of people interactively.

In a blog for PSI, Jackson sets out the following three ‘key steps to win men’s support for family planning’ and examples of when they have been used by PSI in their **marketing campaigns**:³

1. **‘Understand the situation:** Which men oppose contraception and why? How did some men come to support it?’

Example: In Kinshasa, DRC, the Association de Santé Familale (ASF)/PSI used focus group discussions and interviews and found out that the ‘top reasons why some men opposed contraceptive use included rumors about health effects, real side effects, and beliefs that contraception is against the will of God’. They used these findings to design a campaign promoting couple communication about family planning (due to start in 2015).

2. **‘Tailor marketing to your audience:** Use messengers trusted by your audience to convey appealing messages with a specific call to action.’

³ See - <http://psiimpact.com/2015/06/3-key-steps-to-win-mens-support-for-family-planning/>

Example: In Senegal, the first national family planning communication campaign in 2013 addressed men as the primary audience. The campaign slogan used a traditional saying 'avoid closely spaced births', with the messages 'Birth spacing. I talk about it with my wife and give her my support.' Among the messengers and influencers depicted in the campaign were supportive Muslim religious leaders. According to the blog, 'The male engagement campaign appears to have made a contribution [to an increase in] modern contraceptive use... a survey of 1800 men showed that more than 68% initiated a discussion with their partner about family planning and more than 12% reported that their partner now practices family planning as a result of the campaign'.

3. 'For lasting impact, **transform gender norms**: Challenge gender inequality and highlight alternative male role models who are proud to respect women and girls.'

Example: In Madagascar, PSI and IntraHealth adapted and implemented IntraHealth's Healthy Images of Manhood (HIM) approach to engage young men in supporting contraceptive use. Peer educators worked with male and female youth to reflect upon the effects of gender norms on health, as well as the value of contraception, through debates and games. Since the campaign began in 2014, more than 13,844 young men have approached PSI-affiliated clinics for contraceptive counselling, often with their partners (compared to 9,281 in 2013 over the same length of time).

The literature identifies approaches that combines **entertainment and education** ('Edutainment'). E.g. the NGO FilmAid's participatory film activities in Kenya contributes to greater knowledge of family planning, HIV and other gender issues and greater willingness to discuss these issues. It provides communication tools, information and opportunities for people to come together, explore, express and debate ideas. Its activities in the Kakuma Refugee Camp in Kenya included educational film screenings and participatory video tools, whereby young people learn to use video as a story-telling tool (Lee and Bolton, 2007, p. 16; In Haider, 2011). The effectiveness of a media programmes to persuade may be 'affected by the social context in which it is consumed' – in the US adolescents watching a comedy with information on contraception reported greater gains in knowledge when it was watched with a parent or trusted adult as it led to discussions with further information (Collins In World Bank, 2015, p.76).

Community-based initiatives can be effective in mobilising communities, empowering women, and promoting community dialogue and changes on issues of gender equality. Group education is considered effective in promoting attitudinal and behavioural change. The aim is to promote critical reflection on how gender norms are social constructed (Haider, 2012).

Providing information and building skills is often identified as a useful intervention (e.g. the Malawi Male Motivator' intervention). In a well-cited journal article, Shattuck, Kerner, Gilles, Hartmann, Ng'ombe & Guest (2011) evaluate the 'the Malawi Male Motivator' intervention that aims to increase family planning use in young couples by educating men about family planning. The intervention is designed by Save the Children and is based on evidence that 'men tend to get reproductive health information from peers'. The evaluation methodology includes baseline and post-intervention surveys of 400 men randomised into an intervention and control group, and in-depth interviews with some participants.

The activities are carried out by a male outreach worker (so-called 'male motivator') – who are married, aged 30 years or older, and enthusiastic about modern contraception. The aim is to provide information and help build skills. The male motivators discuss with the participants modern family-planning options, local facilities offering these methods, and instructions on correct contraception use. They share their own experiences, discuss gender roles and norms can lead to negative outcomes, and challenge norms (e.g. a

large family being a sign of virility). They encourage participants to discuss family planning with their wives and girlfriends, with an emphasis on joint decision-making power. (Shattuck, et al., 2011).

The study found that contraceptive use increased significantly in both the intervention and control groups, but that the increase was 'significantly greater' in the intervention group. Their data indicates 'that increased ease and frequency of communication within couples were the only significant predictors of uptake' of contraception use. (Shattuck, et al., 2011).

Targeting interventions

Family planning use is affected by factors operating at the levels of the individual, family, friendship group, peer group, neighbourhood, community, institutional (including health care providers), and the policy environment. Effective programmes assess the barriers at each of these levels to identify which interventions are needed in a given context, and to 'identify the group or social network within which a relevant norm is enforced (World Bank, 2015). Targeting norm change can generate resistance, Jiang and Marcus (forthcoming) highlight the importance of engaging with individuals and groups who are likely to oppose norm change.

Various research on promoting awareness and behaviour change in relation to gender equality emphasise the need to involve **religious leaders** in order to secure buy-in for programmes and their aims and to increase the reach of initiatives (Friej, 2010 In Haider, 2012). In order to minimise opposition from religious leaders and communities to sensitive programming, programmes (such as promoting condom use) should be implemented gradually. Targeted information and responses must be specifically tailored to the knowledge, beliefs, and the practices of that particular community (Clarke et al., 2011, in Haider, 2012).

As mentioned above, Munshi and Myaux (2006) highlight the importance of targeting the **religious** group that women socialise within to influence their attitudes to, and uptake of, contraception. Their article is based on analysis of what they call 'possibly the most intensive family planning program ever put in place' – the Maternal Child Health–Family Planning (MCH-FP) project, funded by the research centre – the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The MCH-FP project started in 1978, covering seventy villages in Matlab thana, Comilla district of Bangladesh. All households in the intervention area received visits by a community health worker once every two weeks, and contraceptives provided free of cost. They note that despite this sustained pressure and economic incentives, change was very slow. They conclude and suggest that a programme where women meet at a primary health clinic to discuss their options together 'might have been more effective than the contraceptive program that delivered information and inputs to women individually in their homes' as fertility change in Bangladesh occurred at the social norm level rather than at the individual behavioural level.

In Bihar, India, where contraceptive use has been very low, various behaviour change communication interventions directed not only at young couples, but also at **parents, in-laws and influential community members** contributed to a rise in the demand and use of contraception. The aim of the interventions was to promote the use of contraception to delay and increase the spacing of births (Daniel et al., 2008 in Haider, 2011). Based on focus groups in Pennsylvania, Akers, Schwarz, Borrero, and Corbie-Smith (2010) argue that 'parent-adolescent communication interventions should improve contraceptive knowledge, help parents understand the harmful effects of gender biases in information dissemination, and provide mothers and fathers with communication skills tailored to enhance the role they play in their adolescents' sexual development'.

Interventions at multiple levels

As 'norms are upheld by and disseminated through multiple institutions (e.g. schools, the media, households, community governance institutions etc.) norms often change more rapidly if new norms are promoted through a range of institutions' (Jiang & Marcus, forthcoming).

PRACHAR ('promote' in Hindi) was a 12 year programme targeting reproductive behaviours of young couples and the social norms that pressure unmarried adolescents into early marriage, early child bearing, and inadequate child spacing in India.⁴ It was designed and implemented by Pathfinder International, and funded by the David and Lucile Packard Foundation (with extra funding from UNFPA in 2009).

A systematic review of gender-integrated health programmes in low and middle income countries identifies the PRACHAR programme as 'effective' with 'greater participation by women in decisions about contraceptive use; and increased demand for and use of contraceptives' (Muralidharan, Fehringer, Pappa, Rottach, Das & Mandal, 2014, p.16).

The programme used a lifecycle approach with targeted communication strategies at different levels (individual, household/family, group and community) with different stakeholders (youth, parents, community leaders, healthcare providers, etc). It used 'change agents' to carry out interactive group activities/training workshops to identify and address barriers to healthy reproductive behaviours (including: parental and societal norms and pressures that encourage early marriage and childbearing; myths, fears, and misconceptions about pregnancy and contraception; negotiation skills with spouse, in-laws, and parents). The change agents also made regular household visits and carried out refresher training sessions to reinforce key messages. E.g. interactive activities included newlywed ceremonies with couples to promote spousal communication and joint decision making for contraceptive use and family planning (Pathfinder International, 2011b in Muralidharan, et al., 2014, p.16).

Targeting gender norms and men

Interventions that seek to foster equitable gender norms can contribute to increase voluntary family planning use, delay first sex, and contribute to gender equality and agency (expert comment; Shattuck, et al., 2011).

Shattuck, et al. (2011) identify interventions **targeting men** through traditional **public health forums** including: communication skills counselling, promotion through local leaders and extension workers, and mass-media campaigns. In Ethiopia, involving men in family-planning discussions was found to increase uptake of modern contraceptives (Terefe & Larson In Shattuck, et al., 2011). In Bangladesh, counselling husbands about contraceptives was found to lower spouses' discontinuation rates for long-acting methods (Amatya, Akhter, McMahan, Williamson, Gates & Ahmed In Shattuck, et al., 2011).

In a self-evaluation of its work in Benin, PSI identifies in its successes its 'Amour et Vie' **youth programme**. This combines a youth magazine, and a weekly call-in radio programme to encourage youth to make responsible sexual health decisions. It reaches tens of thousands of Beninese youth around the country with messages including: negotiating the delay of sexual relations with one's partner; the dangers of teen pregnancy and STIs; negotiating condom use; and discussing the future in a romantic relationship. The

⁴ See - <http://www.pathfind.org/our-work/projects/prachar-promoting-change-in-reproductive-behavior-in-bihar-india.html?referrer=https://www.google.co.uk/>

evaluation does not further detail the impact of these activities on behaviour change (Emmet, Kessou, Gay & McLellan, 2011, p.178).

Schuler, et al. (2011, p.106) conclude that it is important to design communications interventions that address factors related to gender and to the misinformation/fears about modern contraceptive methods. They argue that family planning messages and interventions should engage both men and women and encourage **equitable decision-making**, and should encourage both to access reliable information about contraceptive methods (p.106).

A PSI paper makes the distinction between programmes that *involve* rather than *engage* men. A programme that intends to engage with men will try to understand men's knowledge, views, fears, etc to develop a partnership. The paper argues "involving men" can help create wider consensus and support on issues, while "engaging men" encourages the development of effective partnerships between men and women' (Public Health Foundation of India, Health Policy Project, MEASURE Evaluation, and International Center for Research on Women. 2014, p.2).

A systematic review examines evaluations of 146 gender-integrated health programmes in low and middle income countries (Muralidharan, Fehringer, Pappa, Rottach, Das & Mandal, 2014). This includes reproductive health, among other issues. It classifies 91 of these as '**gender transformative**' – defined as facilitating a 'critical examination of gender norms, roles, and relationships; strengthened or created systems that support gender equity; and/or questioned and changed gender norms and dynamics'. 55 are classified as '**gender-accommodating**' – defined as recognising and working around or adjusting for 'inequitable gender norms, roles, and relationships' (p.v). Almost a third of the programmes were implemented in South Asia. The majority were designed and implemented by NGOs, with limited evidence of governments integrating them or scaling them up. The methodologies used in the evaluation include: randomised controlled trials (26), quasi-experimental studies (61), and non-experimental studies (52). The gender-accommodating programmes used one or more of the following five strategies (p.vi):

1. 'Challenge gender norms and inequalities that impede access to health services and healthy behaviors.
2. Promote equitable relationships and decision making.
3. Empower girls and women through economic opportunities, education, and collective action.
4. Adjust health systems to address barriers to health information and health services.
5. Involve the community to disseminate information and support behavior change'.

It finds gender-aware programmes have improved health status, behaviours and knowledge. Several transformative programmes also shaped 'gender-equitable attitudes, increasing the frequency of joint decision making by men and women, and increasing women's self-confidence and self-efficacy' (p.vi). Overarching it recommends: carrying out gender analysis to be able to disaggregate health needs and behaviours; identifying evidence-based strategies to target the gender barriers of each specific group; and integrating and scaling up gender-aware strategies through government health systems with NGO and private sector partners (p.vi).

Insights from general social norms approaches

A GSDRC topic guide based on literature review highlights the following insights related to the influence of social norms on behaviour (Jiang & Marcus, forthcoming, p.12):

- People comply with social norms largely because of the social approval they gain from compliance, or because they fear social sanctions.
- People can behave in ways that contradict their personal beliefs or their self-interest because they believe others expect them to.
- Norms can often be underpinned by pluralistic ignorance (where people misperceive others' views).
- People's reference groups are the strongest influence on behaviour.
- What others do (descriptive norms) is typically a stronger motivator of behaviour than idealised standards of behaviour (injunctive norms).
- Norms fulfil a range of purposes.
- Norms do not exist in a vacuum.
- Norms are often invisible.

International level approaches

Various international organisations and agreements act to shape international norms on family planning and contraception. These can percolate into national spheres by encouraging the allocation of resources, the prioritisation and implementation of programmes in this area, and by providing a mandate for advocacy. Examples include:

- The **WHO** is working to promote family planning by producing evidence-based guidelines on safety and service delivery of contraceptive methods, developing quality standards and providing pre-qualification of contraceptive commodities, and helping countries introduce, adapt and implement these tools to meet their needs. WHO is also developing new methods to expand contraceptive choices for men and women.⁵
- The **United Nations Population Fund (UNFPA)** provides 'technical assistance for development of norms and good practices for [sexual and reproductive health] SRH components within health planning and reforms, including standards and protocols, competency definition and certification, human resources development and planning, costing, budgeting and financing, logistics and infrastructure and health information systems' (UNFPA, 2008 p.17).
- **PSI** carries out international and in-country advocacy, and provides advocacy training, to support communication campaigns to drive government policy change on sexual health products and services (PSI, 2014).

4. References

- Amin, S. & Bajracharya, A. (2011). Marriage and First Birth Intervals in Early and Late Marrying Societies: An Exploration of Determinants, Paper prepared for the 2011 Annual Meetings of the Population Association of America, 31 March – 2 April, Washington, DC
<http://paa2011.princeton.edu/download.aspx?submissionId=111970>
- Akers, A. Y., Schwarz, E. B., Borrero, S., & Corbie-Smith, G. (2010). Family discussions about contraception and family planning: a qualitative exploration of black parent and adolescent perspectives.

⁵ See - <http://www.who.int/mediacentre/factsheets/fs351/en/>

- Perspectives on sexual and reproductive health, 42(3), 160-167.
<http://onlinelibrary.wiley.com/doi/10.1363/4216010/abstract;jsessionid=BA2CB042A9444ED8B4E7C3FBEF4CDB7B.f04t01?userIsAuthenticated=false&deniedAccessCustomisedMessage=>
- Campbell, M. M., Prata, N., & Potts, M. (2013). The impact of freedom on fertility decline. *Journal of Family Planning and Reproductive Health Care*, 39(1), 44-50.
<http://jfprhc.bmj.com/content/39/1/44.full>
- Daniel, E. E., Masilamani, R. and Rahman, M. (2008). The Effect of Community-Based Reproductive Health Communication Interventions on Contraceptive Use Among Young Married Couples in Bihar, India, *International Family Planning Perspectives*, vol. 34, no. 4, pp. 189–197
<http://www.jstor.org/pss/27642886>
- Emmet, W. Kessou, L. Gay, J. & McLellan, I. (2011). USAID/Benin: Evaluation Of Family Health Activities. USAID.
<http://ghpro.dexiconline.com/sites/default/files/resources/legacy/sites/default/files/1.450%20Benin%20Evaluation%20Full%20Report%20-%208.12.11%20508.pdf>
- Greene, M., & Barker, G. (2011). Masculinity and its public health implications for sexual and reproductive health and HIV prevention. Edited by R. Parker & Marni Sommer. New York: Routledge.
- Haider, H. (2011). Early marriage and sexual and reproductive health. (GSDRC Helpdesk Research Report 784). Birmingham, UK: GSDRC, University of Birmingham.
<http://www.gsdrc.org/docs/open/HD784.pdf>
- Haider, H. (2012). Changing attitudes and behaviours in relation to gender equality. (GSDRC Helpdesk report 817). Birmingham, UK: GSDRC, University of Birmingham.
<http://www.gsdrc.org/docs/open/HDQ817.pdf>
- High Impact Practices in Family Planning (HIP). Health communication: enabling voluntary and informed decision-making. Washington, DC: USAID. <http://www.fphighimpactpractices.org/resources/health-communication-enabling-voluntary-and-informed-decision-making>
- Hindin, M. J. & Fatusi, A. O., (2009). Adolescent Sexual and Reproductive Health in Developing Countries: An Overview of Trends and Interventions, vol. 35, no. 2
<http://www.guttmacher.org/pubs/journals/3505809.pdf>
- Jiang, T. & Marcus, R. (forthcoming). Effective Development Programming: Integrating Insights from Behavioural Economics and Social Norms. GSDRC Topic Guide.
- Kangas, A., Haider, H., and Fraser, E. (2014). Gender: Topic Guide. Revised edition with E. Browne. Birmingham: GSDRC, University of Birmingham, UK. <http://www.gsdrc.org/docs/open/gender.pdf>
- Levtov, R.G., Barker, G., Contreras-Urbina, M., Heilman, B., & Verma, R. (2014). Pathways to Gender Equitable Men Findings from the International Men and Gender Equality Survey in Eight Countries. *Men and Masculinities*,
<http://jmm.sagepub.com/content/early/2014/11/06/1097184X14558234.full.pdf+html?hwshib2=authn%3A1439380132%3A20150811%253A7ef0ca64-c790-4688-bba2-b5f48f9d2029%3A0%3A0%3A0%3As6Mx7%2FinnSZXCqrRZgKYVg%3D%3D>
- Mayaki, F., & Kouabenan, D. R. (2015). Social norms in promoting family planning: a study in Niger. *South African Journal of Psychology*, 45(2), 249-259. <http://sap.sagepub.com/content/45/2/249.full.pdf>
- Mishra, A., Nanda, P., Speizer, I. S., Calhoun, L. M., Zimmerman, A., & Bhardwaj, R. (2014). Men's attitudes on gender equality and their contraceptive use in Uttar Pradesh India. *Reproductive health*, 11(1), 41. <http://www.reproductive-health-journal.com/content/11/1/41>

- Moore, A. M., et al., (2009). Adolescent Marriage and Childbearing in India: Current Situation and Recent Trends, Guttmacher Institute, New York City and Washington, DC
<http://www.guttmacher.org/pubs/2009/06/04/AdolescentMarriageIndia.pdf>
- Munshi, K., & Myaux, J. (2006). Social norms and the fertility transition. *Journal of development Economics*, 80(1), 1-38.
<http://www.econ.nyu.edu/user/debraj/Courses/GrDev14Warwick/Readings/MunshiMyaux.pdf>
- Muralidharan, A., J. Fehringer, S. Pappa, E. Rottach, M. Das and M. Mandal. 2014. Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries. Washington DC: Futures Group, Health Policy Project; and Chapel Hill, North Carolina: MEASURE Evaluation
http://www.healthpolicyproject.com/pubs/381_GPMIndiaSummaryReport.pdf
- Nalwadda, G., Mirembe, F., Byamugisha, J., & Fixelid, E. (2010). Persistent high fertility in Uganda: young people recount obstacles and enabling factors to use of contraceptives. *BMC public health*, 10(1), 530. <http://www.biomedcentral.com/1471-2458/10/530/>
- Population Services International (2014). PSI's Sexual and Reproductive Health Programs for Youth. Washington, DC: PSI.
https://www.k4health.org/sites/default/files/psi_youth_program_brief_2014.pdf
- Public Health Foundation of India, Health Policy Project, MEASURE Evaluation, and International Center for Research on Women. 2014. Evidence-based Strategies to Engage Men and Boys in Gender-integrated Health Interventions. Washington, DC: Futures Group, Health Policy Project.
http://www.healthpolicyproject.com/pubs/382_MenandBoysBrief.pdf
- Rahman, M. (2010). Early Motherhood and Contraceptive Use among Adolescents: A Study from Rajshahi District of Bangladesh, *Journal of Nepal Paediatric Society*, vol. 30, no. 1, pp. 8-17
<http://nepjol.info/index.php/JNPS/article/viewArticle/2454>
- Schuler, S. R., Rottach, E., & Mukiri, P. (2011). Gender norms and family planning decision-making in Tanzania: a qualitative study. *Journal of Public Health in Africa*, 2(2), 25.
- Shattuck, D., Kerner, B., Gilles, K., Hartmann, M., Ng'ombe, T., & Guest, G. (2011). Encouraging contraceptive uptake by motivating men to communicate about family planning: the Malawi Male Motivator project. *American Journal of Public Health*, 101(6), 1089.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3093271/>
- UNFPA. (2008). 'Making Reproductive Rights and Sexual and Reproductive Health A Reality for All', United Nations Population Fund (UNFPA)
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/SRH_Framework.pdf
- Wang, W., Alva, S., Winter, R., & Burgert, C. (2013). Contextual influences of modern contraceptive use among rural women in Rwanda and Nepal. *DHS Analytical Studies No. 41*. USAID.
http://pdf.usaid.gov/pdf_docs/pnaec676.pdf

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