ANNOTATED BIBLIOGRAPHY

Gender norms and youth-friendly sexual and reproductive health services

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Acknowledgements

Acronyms

ASRH	adolescent sexual and reproductive health
CSE	comprehensive sexuality education
GREAT	Gender Roles, Equality and Transformation project
HRH2030	Human Resources for Health
IPPF	International Planned Parenthood Federation
Lao PDR	Lao People's Democratic Republic
MC	mystery client
PRB	Population Reference Bureau
SRH	sexual and reproductive health
STI	sexually transmitted infection
USAID	United States Agency for International Development
YFHS	youth-friendly health services
WHO	World Health Organization

Introduction

Around the world, gender and other social norms have a tremendous impact on the sexual and reproductive health (SRH) of young people. Cultural constructions of gender shape expectations related to sexuality and play an essential part in defining what roles and behaviours are considered appropriate for adolescent girls and boys. Additional social norms relating to age, acceptability of premarital sex, ideal family size and pressure to prove fertility soon after marriage also feed into constructions of sexuality. All of these norms intersect with class and ethnicity to determine how youth are positioned in social structures and the extent to which they are able to make decisions for themselves. In more collectivist societies – such as those in central America and Asia, for example – youth are more likely to depend on decisions made by their parents, in-laws or other extended family members. Gender norms are particularly relevant, because in large part they determine who has access to power, resources and opportunities.

There is growing recognition that in order to make SRH services more accessible to young people, gender norms must be addressed at the community, institutional and policy levels in addition to increasing individual knowledge. Successful efforts to improve youth-friendly health services (YFHS) will need to implement a more holistic package of interventions that include comprehensive sex education (CSE); raising awareness about services to generate more demand among young people for SRH; and building community support that will decrease stigma and encourage youth to engage in discussions about SRH and seek out services. In addition, the quality of services also needs to be improved by putting policies into place that support the provision of a variety of contraceptive methods to youth and that clarify if/when consent is necessary from a parent or spouse. These actions will have a greater cummulative impact on improving access to YFHS if they explicitly challenge discriminatory gender norms as well.

Normative expectations embedded in many societies about gender and sexuality create a double standard – which may manifest differently in various settings – that typically encourages sexual liberty for men and demands sexual constraint from women. This values purity and virginity above all else for girls while giving adolescent boys more freedom, including room to explore, experiment and engage in sexual relationships. This double standard also places the majority of the burden on females to reject sexual advances from males and to take precautions to avoid pregnancy and sexually transmitted infections (STIs), with females often blamed for STIs and unintended pregnancies. This contributes to the idea that reproductive health is a female responsibility with no role for men.

Norms related to masculinity also affect both young men and young women and their access to YFHS. Due to norms related to masculinity, men are more likely to control resources and make decisions for their partners, and may not allow their partners to use contraception. In order to adhere to expectations of masculinity and strength, men are often less likely to seek out medical services. In many cases, men may view SRH as a woman's domain and therefore believe it would not be appropriate for them to seek out those services. YFHS should make an effort to be friendly to young men as well as women, and to promote a shared responsibility for SRH.

In many societies, it is taboo to discuss sex openly, particularly for young people. This leads to a tendency to withhold information from young people about sex and makes it difficult for them to learn how to protect themselves. Many people view sex as a moral or religious issue and therefore believe parents should be the ones to educate their children about it. However, as several articles included in this annotated bibliography indicate (Sridawruang et al., 2010; Kennedy et al., 2013; Birhanu et al., 2018), most parents are not comfortable talking to their children about sex, often due to their perception that talking about sex encourages children to initiate sexual activity. This taboo expands beyond the realm of parent–child communication and also makes many service providers uncomfortable discussing issues related to sex with their clients, especially unmarried youth.

Similarly, sexual activity outside of marriage is strictly prohibited in many cultures. The prevailing norm that unmarried youth should not be sexually active makes young people less likely to seek SRH services for fear they will be judged as too young or will be lectured because they are engaging in sexual activity. The double standard can come into play here and make providers more likely to be biased when young women seek out SRH services (Godia et al., 2013; Engender Health and USAID, 2018). Norms about chastity as an expectation before marriage can lead service providers to lecture female

youth for being sexually active or even refusing to provide condoms or other contraception especially if they don't have permission from their husband or parents.

Social norms influence not only expressions of sexuality but also the barriers young people experience to accessing YFHS. The barriers are classified under the following categories: availability, accessibility, acceptability and quality (Bruce, 1990; Tylee et al., 2007; Mazur et al., 2018). Social norms – especially those related to gender, age and marital status – intersect with all of these dimensions to influence YFHS.

Gender norms can also impact whether an individual is able to afford particular health services, as young women are less likely to work outside of the house and therefore may not be able to access the resources needed. Concerted efforts to improve health systems can counter some of these barriers by providing YFHS at affordable prices, often through subsidised services or voucher programmes.

Interventions to improve access to YFHS should also focus on facilitating access to services by offering them at times and places that are convenient for young people, such as after school hours and at locations within walking distance. If a long waiting line prevents a youth from being seen during the first visit, a young person might feel discouraged or unable to return, particularly if they had to pay a bus fare or miss school or work to attend the clinic. In this domain, gender norms can also affect mobility – how far and freely a person can move throughout their community, as well as control over one's schedule and free time to be able to seek out services. The mobility of adolescent girls and young women is often restricted or they may need to be accompanied by a chaperone. Girls are also more likely to be expected to dedicate a substantial portion of their free time to household chores, leaving them few opportunities to access services.

Increasing the acceptability of YFHS among young people is another key dimension to improve service provision and uptake. Young people consistently indicate that privacy and confidentiality are among their top priorities. The negative norms associated with sex, and youth sexuality in particular, relate to experiences of shame and stigma that emerge in all settings as powerful barriers to accessing YFHS. Social norms come into play in relation to stigma that can result from being seen at an SRH clinic or shame that arises in response to being chastised by a service provider for being sexually active.

Quality of services is influenced by norms that are prevalent in the community and the beliefs of service providers. Service providers are often reluctant to discuss sexual issues with patients (and vice versa) unless they receive specific training that builds their knowledge, skills and comfort in discussing these issues with young people. Additional barriers arise from norms related to: associations between contraceptive use and promiscuity; myths about the effect of hormonal contraceptive methods on long-term fertility; pressure to have children soon after marriage; and cultural expectations about the ideal number and timing of children. All of these norms are 'layered on' to service providers and have a great influence on the quality of SRH care they are willing to provide, regardless of their level of individual knowledge (Starling et al., 2017).

This annotated bibliography searched (mostly) open source resources that examine how gender norms influence access to and design and uptake of YFHS in low- and middle-income countries. Youth is defined as individuals between the ages of 10 and 24 years, although the majority of the studies focus on a smaller subset of this range (14–18 years). The electronic databases searched were PubMed, Web of Science, Medline, JSTOR, HeinOnline, Social Science Research Network and Google Scholar. The following search terms were used: 'gender norms', 'social norms', 'normative approaches', 'gender inequality', 'sexual and reproductive health and rights', 'sexuality', 'youth-friendly health services', 'adolescent-friendly health services', 'provider attitudes', 'contraception' and 'family planning'. Resources were also retrieved manually from the following organisations: the International Planned Parenthood Federation (IPPF), Guttmacher, Advocates for Youth, Pathfinder, Plan International, the Institute for Reproductive Health at Georgetown University, the Learning Collaborative to Advance Work on Normative Change for Adolescent Sexual and Reproductive Health, FHI360, Population Council, CARE, Engender Health, Promundo, the International Center for Research on Women, the International Coalition for Women's Health, Population Services International and Save the Children. Resources were selected to cover a range of SRH topics such as family planning and HIV; perspectives on youth, parents and service providers; and to reflect some geographical diversity.

Part 1. The evolution of YFHS and ongoing barriers

This section provides a brief overview of how YFHS service provision has developed over the last several decades and introduces barriers that youth commonly face when they attempt to access SRH services.

The development of YFHS over time

Tylee et al. (2007) take stock of the early research about YFHS and broadly categorise the barriers that youth face when trying to access care in relation to "availability, accessibility, acceptability and equity of health services". Chandra-Mouli et al. (2015) build on that foundation and make key recommendations to develop support for youth-friendly SRH education and services and to promote attitudes and beliefs that shift norms related to gender equality.

Since the lack of knowledge about SRH is consistently identified as a primary barrier to accessing care, it is important to look at how CSE is designed to provide accurate information to young people about how they can protect themselves from pregnancy and STIs. Haberland (2015) builds a persuasive case illustrating that sexuality and education programmes that include discussion of gender and power dynamics are nearly five times more effective at reducing rates of STIs and unintended pregnancy than curricula that ignore gender norms. This article lays the foundation for considering power as an integral component of any intervention to improve SRH. Svanemyr et al. (2015) explain that dealing with quality of and access to YFHS is not sufficient to improve youth SRH. They convey that it is essential to address barriers at various levels across the ecological framework[1] – including the individual, relationship, community and policy levels – to create an enabling environment to support youth access to YFHS.

Tylee, A., Haller, D. M., Graham, T., Churchill, R. and Sanci, L. A. (2007) 'Youth-friendly primary-care services: how are we doing and what more needs to be done?' Lancet 369 (9572): 1565-1573.

This article takes stock of the early research about YFHS and the increasing recognition of the importance of providing health services that are geared towards the specific needs of youth and their unique biological, cognitive and psychosocial transition into adulthood. By 2007, two decades of research provided ample evidence of the barriers that youth face in accessing care, especially in relation to SRH. However, the field struggled with inconclusive evidence about how to overcome these barriers and how to translate this research into comprehensive interventions.

The authors broadly categorise the barriers to accessing care in terms of:
- availability – the costs and limited availability of affordable services
- accessibility – the convenience of facility hours and location, and the lack of knowledge about services offered due to low visibility and publicity
- acceptability – confidentiality (especially to parents), stigma of being seen at the clinic and lack of training for providers
- equity of health services – the different levels of service provision and access according to wealth, ethnicity and gender.

The authors highlight that, for the most part, the field started off by focusing on availability and access, until a turning point when interventions begin to shift towards incorporating an understanding of how social norms can shape how services are approached and used. At this point, the importance of gender equality became central to interventions, even though it was not yet explicitly articulated as 'gender norms'. The authors mention two norm-based barriers to accessing health services – the fear of being scolded by providers and cultural norms that forbid premarital sex – that can be

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1   The 'ecological framework' posits that behaviour and outcomes are complex and are affected by interwoven factors from the individual, relationship, community and societal/policy levels (Violence Prevention Alliance, n.d.). Most health outcomes cannot be effectively addressed by working at one level while disregarding the others.

addressed through sensitivity training for providers and community mobilisation to create an enabling environment to support and encourage youth to access SRH services. This paper begins to build a case for more integrated approaches that work across societal levels (especially at the community and policy levels), that involve young people in programme design and that create linkages with the community.

Chandra-Mouli, V., Svanemyr, J., Amin, A., Fogstad, H., Say, L., Girard, F. and Temmerman, M. (2015) 'Twenty years after the International Conference on Population and Development: where are we with adolescent sexual and reproductive health and rights?' Journal of Adolescent Health 56 (1): S1–S6.

This article takes stock of 20 years of progress since the 1994 International Conference on Population and Development in Cairo[2] defined 'reproductive health' and urged countries to educate teens and give them tools to build a responsible relationship with their sexuality. As Chandra-Mouli and colleagues reflect on how to shape the post-2015 agenda, they lay the groundwork for addressing gender norms and creating an enabling environment to increase support of SRH provision for young people by working at multiple levels across the ecological model (Chandra-Mouli et al., 2015: s1).

The authors' key recommendations are to make both sexuality education and SRH services readily available to young people; to create an enabling environment that will encourage youth to use SRH education and services; and to address the underlying norms that affect attitudes and beliefs about gender equality. The authors also stressed that these efforts should start early and deliver age appropriate information to young people between the ages of 10–14 years. They suggest that it is important to reach young adolescents since much of this group is already sexually active, while others will soon be sexually active, and that 'attitudes and values related to gender equality, sexuality and health behaviours are often established in this period and have important implications for health and social well-being in later life' (ibid: 55).

Haberland, N. A. (2015) 'The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies' International Perspectives on Sexual and Reproductive Health 41 (1): 31-42   This article lays the foundation for considering power as an essential component of gender norms and sexuality. CSE is a specific type of rights-based sexuality education that aims to deliver scientifically accurate information combined with decision making skills that will allow young people to make responsible and informed decisions free from coercion. The information should be age and culturally sensitive while informing youth that they have sexual rights which should be respected. Haberland's review of evaluations of sexuality education programmes demonstrates that programmes that have created space for critical reflection on gender and power dynamics are nearly five times more effective at reducing rates of STIs and unintended pregnancy than conventional curricula that ignore gender.

The author classifies curricula that deal with gender in a meaningful way if they cover gender inequality and discuss how gender norms can lead to harmful practices or biased behaviour. such as caregiving or sexual scripts which are normative expectations about how to behave in a sexual relationship. Haberland specifies that curricula have to "go beyond the conventional content on refusal skills" to resist sexual advances and should "include at least one explicit lesson covering an aspect of gender or power in sexual relationships" (Haberland, 2015: 33) Some examples of topics include: how notions of masculinity and femininity can have a harmful affect on behaviours and impact relationship dynamics; rights, consent and coercion; skill building exercises that encourage young women to exercise their agency; and recognize how gender influences patterns of condom use (Ibid.)

This review identifies the following specific qualities of a gender and power programme that have contributed to positive results: 'using participatory and learner-centred teaching approaches, fostering both critical thinking and personal reflection about how these concepts affect one's own life and relationships, and valuing one's own potential as an individual and as a change agent' (ibid: 37). Effective programmes used a variety of strategies and activities with their participants, such as critically examining and analysing images of females in visual media and music and playing games which required them to reflect on their own relationships. Some programmes also facilitated discussions about power and inequality in relationships, and how often gender norms can influence condom use.

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2   https://www.un.org/popin/icpd2.htm

In some way, all of these programmes created opportunities for participants to critically reflect on gender inequality and power dynamics, to understand gender norms and how they can increase their sexual risk, and to consider what more equitable relationships would look like. This article paved the way for human rights and a gender framework to become standard parts of CSE, as illustrated in the updated United Nations Population Fund *Operational guidance for comprehensive sexuality education* (UNFPA, 2014) and the United Nations Environmental, Scientific and Cultural Organization's *International technical guidance on sexuality education* (UNESCO, 2009).

Svanemyr, J., Amin, A., Robles, O. J. and Greene, M. E. (2015) 'Creating an enabling environment for adolescent sexual and reproductive health: a framework and promising approaches' Journal of Adolescent Health 56 (1): S7-S14.

Svanemyr et al. emphasize that adolescent sexual and reproductive health (ASRH) is embedded in cultural, political, and economic systems. After taking stock of ASRH interventions from the last several decades, they conclude that improving access to and the quality of YFHS will not be effective unless programs also address these socioeconomic systems that increase adolescents' vulnerability. These factors are influenced and shaped by gender norms, and create barriers to adolescents' access to SRH information and services. This article provides a broad overview of the key elements across each level of the ecological framework that contribute to creating an enabling environment for ASRH.

The framework highlights:
"*...the importance of interventions at the individual level, to strengthen agency and facilitate empowerment of adolescents; at the relationship level, to promote supportive relationships with partners, parents and peers; at the community level, to create an enabling environment for adolescents to learn about their sexuality, to access services and to challenge harmful practices; and at the societal level (policies, laws, and media campaigns) to create both state and institutional accountability and to encourage broader structural change in support of ASRH*" Chandra-Mouli, et al., 2015: p. 53) .

The report explains that "high-level messaging on the part of heads of state and prominent individuals can also be useful in signalling a government's position as a basis for advocacy interventions" (Svanemyr, et al., 2015: s. 12). At the policy level, even where comprehensive laws and national frameworks are already in place, measures need to be taken to create systems of accountability that will facilitate more effective implementation.

Understanding the gender and social norms that affect adolescents' and young people's access to SRH services

This section takes a closer look at how gender norms that impact youth sexuality manifest in different contexts and how they shape young people's experiences when they seek out SRH services. In a systematic review of studies that identified barriers to accessing YFHS, Newton-Levinson et al. (2016) identify shame (on the personal level) and stigma (at the community level) as the most powerful barriers to accessing YFHS across all of the studies they reviewed. Several articles examine how traditional norms in Ethiopia (Birhanu et al., 2018), Thailand (Sridawruang et al., 2010) and Vanuatu (Kennedy et al., 2013) contribute to a basic lack of understanding about SRH, prevent parents from communicating with children about sex, and inhibit adolescents from accessing services. Even in contexts where cultural norms are more accepting of premarital sex, for instance in Lao People's Democratic Republic (Lao PDR), Sychareun et al. (2018) find that people still avoid conversations about sex and lack knowledge about how to prevent pregnancy and STIs, while many young participants reported being scolded by healthcare providers for seeking SRH services.

Gender norms also contribute to ideas about who is responsible for reproductive health, when it is appropriate to use contraception and SRH services, and what methods are appropriate for adolescents. Kabagenyi et al. (2014) conducted a study in Uganda to examine barriers to male involvement in SRH. They find that even though most men subscribe to the gender norm that contraception is a female responsibility, they are open to becoming more involved. In Kenya, Godia et al. (2013) report that health service providers said they were aware they could not deny young people SRH services, but they were nonetheless reluctant to provide them, particularly hormonal contraception, because of their own cultural and

religious beliefs. This research highlights a commonly held myth that family planning use for an extended time prior to childbearing results in difficulty conceiving or infertility.

Marital status is another key factor tied to social norms and traditions often dictate that new wives must demonstrate their fertility and produce children shortly after marriage. Once a young woman has given birth this pressure begins to subside, and young women are more likely to find community support and overall societal acceptance of their use of family planning methods. However, Velonjara et al. (2018) find that in Kenya, service providers were still reluctant to give contraception to young women even after having their first child, because of cultural preferences for large families and the misconception that hormonal contraception will interfere with fertility in the long run. For all of these reasons, providers are often judgmental or paternalistic and do not feel it is appropriate to provide any/hormonal methods of contraception.

Newton-Levinson, A., Leichliter, J. S. and Chandra-Mouli, V. (2016) 'Sexually transmitted infection services for adolescents and youth in low- and middle-income countries: perceived and experienced barriers to accessing care', Journal of Adolescent Health 59 (1): 7–16.

This systematic review identifies 19 studies that focus on barriers adolescents experience in accessing SRH care in relation to STIs. In addition to barriers related to knowledge and awareness, availability, accessibility and acceptability, the review identifies shame and stigma as the most powerful barriers mentioned in every study. The authors find that across cultures and geographical settings, the prevailing norm that youth should not be sexually active or use SRH services contributes to shame and stigma and has an impact across the spectrum in terms of availability, accessibility and acceptability of SRH-related services and products. This makes it difficult for youth to access care and interferes with providers' ability and comfort in providing the needed SRH care.

Stigma occurs at a community or society level and relates to being perceived or labelled as having undesirable characteristics or somehow being connected to inappropriate behaviour. Shame and embarrassment are personal feelings, often defined as 'negative emotion having to do with the experience of failure in relation to personal or social standards' (Newton-Levinson et al., 2016: 8). The studies reviewed by Newton-Levinson et al. detail various causes of shame and stigma. Both can arise from seeking SRH care, since it provides evidence of sexual activity, and some participants expressed a fear of seeking services. One unmarried male in India reported, 'If someone saw me buying a condom, word would spread', illustrating not just a fear of seeking services, but also the repercussions of gossip if other people witnessed his behaviour. Providers can also impart shame and stigma when they are rude to young people seeking SRH services and judgemental about their sexual activity. Both married and unmarried study participants said seeking treatment for STIs was associated with infidelity, and therefore they feared seeking care because of the related stigma. One participant questioned, 'How can I seek healthcare for STIs while I am married and still living with my husband? It is a shame for me' (male nurse quoting a female patient, Ethiopia). Regardless of whether it was her or her husband engaging in extramarital sexual activity, the shame would fall on the wife for seeking SRH services. Women reported experiencing more shame, stigma and judgement than their male counterparts.

This review consistently finds that religious leaders, community members and young people all felt sex was a taboo topic that was shameful to talk about and therefore they could not provide adequate education about adolescent sexuality. A quote from a nurse in Vanuatu illustrates how health providers also experience societal pressures: 'the important reproductive health issues I don't talk about because I am not allowed to talk about condoms. I don't feel good. We have many problems but we don't talk about them … some communities and churches [say] you can't' (nurse, Vanuatu). The authors conclude that strategies to improve access to and quality of YFHS must target social norms – especially those that contribute to shame and stigma related to youth sexuality.

Birhanu, Z., Tushune, K. and Jebena, M. G. (2018) 'Sexual and reproductive health services use, perceptions and barriers among young people in southwest Oromia, Ethiopia' Ethiopian Journal of Health Sciences 28 (1): 37-48.

In this cross-sectional study of youth use of SRH services in south-west Ethiopia, the authors find that several cultural norms have led to an incomplete understanding about the purpose of SRH services in this population and, as a result, a very small proportion of young people in the region are using such services. The researchers collected data from 1,262 people between the ages of 10 and 24 years in south-west Ethiopia and defined SRH as information and educational services on sexual health, counselling on and treatment for STIs, as well as contraception and family planning. The study used qualitative data from focus group discussions and quantitative data from a survey.

Birhanu et al. find that less than 40% of male and female respondents reported utilising SRH services. Married and sexually active persons were more likely to seek such services, as were those with strong lines of communication with their fathers, and those with access to SRH service providers in discrete areas that offered privacy. The authors also find that many young people perceived SRH as abstinence prior to marriage or in relation to maternal health. One 21-year-old participant told researchers 'When two people married and reproduce children we can say that is SRH'.

Both male and female participants reported significant stigma and shame associated with seeking SRH services and a fear that healthcare providers would not keep their visit confidential. They did not want their parents to know they were seeking SRH services or experience shame from being seen seeking services, so the need for privacy and confidentiality was of the utmost importance in this setting. Interestingly, this study finds that young people in rural areas sought SRH services more often than their counterparts from peri-urban areas, because these services were more likely to be integrated into standard health centres that were less likely to be stigmatised. The authors conclude that cultural expectations about sexual activity and abstinence, and a lack of knowledge about how to prevent pregnancy and STIs, remain huge barriers to utilisation of SRH services in this region. They recommend implementing SRH programmes that specifically address these cultural and psychological factors with sensitivity and that also include parents in educational programming.

Sridawruang, C., Pfeil, M. and Crozier, K. (2010) 'Why Thai parents do not discuss sex with their children: a qualitative study' Nursing and Health Sciences 12 (4): 437-443. [not open access].

This study examines Thai adolescents' and their parents' attitudes towards discussing sex with one another. The authors identify several recurring themes in their focus group discussions, but 'traditional' Thai cultural norms and taboos around sexuality remain a central barrier to more open dialogue between teens and parents. The authors conducted 11 focus groups that included a total of 18 male teenagers, 18 female teenagers and 36 parents in Udon Thani Province. In this area of Thailand more than half of all STIs occur in young people, and more than 30% of all abortions are performed on teenagers. This article describes certain taboos about sex among unmarried youth in Thailand and the negative impact that the lack of discussion on the topic has had on youth sexuality.

The authors explain that the Thai government recognises the importance of sexuality education, and they specifically note the importance of families in informing views on sexuality and sexual health. However, the focus group discussions revealed that traditional Thai cultural norms prevent families from communicating about the issue. Male and female teens alike told researchers that their parents believe that abstinence until marriage is the only acceptable choice. Sex is a taboo and is considered impolite and embarrassing to discuss. 'I only tell my daughters: "Do not have sexual relations while a student". I forbid it as inappropriate behavior and unacceptable for a Thai "good" girl,' one parent told researchers.

To the extent that the young women surveyed said they did discuss sex with their parents, many spoke of instances where pregnant teens – perhaps as seen on television or in media – were used as an example of why they should fear sexual activity and early pregnancy. Young men said parents sometimes discussed condom use, although female participants reported that they only discussed contraception with their parents as something that was appropriate if they were married. Parent participants generally reported feeling embarrassed to discuss sex with their children, and many reported believing that it was not important and not their duty. Many perceived that their teens would view them as 'old fashioned' were they to bring up the issue.

Both male and female teen participants understood that their parents associated sexual activity prior to marriage with a certain stigma and shame. Subsequently, they sought information about sex from their peers and the internet. The authors conclude that the responses highlight the need for additional research in order to develop the best possible educational approaches for parents to improve parent–child communication about sex.

Kennedy, E. C., Bulu, S., Harris, J., Humphreys, D., Malverus, J. and Gray, N. J. (2013) '"Be kind to young people so they feel at home": a qualitative study of adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu' BioMedCentral Health Services Research 13 (1): 455.

This qualitative study explores the barriers and enablers of accessing YFHS among adolescents aged 15–19 years old in Vanuatu, an island nation in the South Pacific. A total of 66 focus group discussions were conducted involving 341 participants segmented by age (15–17 and 18–19 years) and gender (single-sex groups were facilitated by someone of the same gender). The study found that cultural taboos about sexual behaviour among adolescents acted as barriers to adolescents accessing SRH services. In Vanuatu, *kastom* is the traditional culture that defines values and the social customs and practices of everyday life. Adolescents frequently cited the role of *kastom* as a contributing factor to the stigma associated with sexual behaviour and discussions about it, as well as their lack of access to services like condom distribution.

The study participants identified the presence of friendly caregivers as being most important to facilitating YFHS – someone who would be kind, give accurate information and ensure confidentiality. Both boys and girls said it would be easier for them to access services if they felt they had support from parents, friends and teachers who could provide information and advice on accessing SRH services. A female participant explained, 'If parents let you [access SRH services], teachers, friends support you, parents want you to have a healthy life. [It is easier if] parents take her [fictional character], friends tell her what will happen at the check-up, or her boyfriend takes her.' In addition, respondents also felt that support from community gatekeepers would also raise awareness about services and decrease any judgemental attitudes of service providers: 'Chiefs should allow awareness in the communities so people can hear about services. Health workers must talk with young people about the clinic services.'

The authors conclude that service-provider training should be improved in combination with strategies that aim to create a more supportive environment for adolescent SRH at the community level. This would help address barriers related to both the demand- (awareness of SRH services among youth) and supply-side (availability, privacy, cost and quality of services) that contribute to low utilisation of SRH services in Vanuatu.

Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J. and Atuyambe, L. (2014) 'Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda' Reproductive Health 11(1): 21.

This qualitative study examines the barriers to the involvement of men in contraceptive decision-making in urban and rural Uganda. Its conclusions demonstrate the need for additional research and development of better methods to encourage men to support and participate in reproductive health, along with their female partners. The authors present a compelling case for the feasibility and necessity of gender-transformative health programmes in this part of the world. The authors interviewed 154 Ugandans and conducted 18 focus group discussions. The participants were all in married or unmarried partnerships, between the ages of 15 and 54 years, and were living in the Bugiri and Mpigi Districts at the time of the study, representing both urban and rural settings.

The authors identify five primary reasons why Ugandan men struggle to become meaningfully involved in making contraceptive decisions, namely: 1) frustration with the side effects of birth control methods on their female partners (primarily due to the tendency of those side effects to hinder their own sexual enjoyment); 2) dissatisfaction with male contraceptive options available; 3) beliefs that family planning is the responsibility of the woman; 4) preference for large families; and 5) fears that a female partner's birth-control use is symptomatic of promiscuous behaviour. While some of the study's male participants expressed more openness to considering their involvement in family planning – even implying that they would be open to male contraceptive methods other than vasectomy and condoms should they

become available – these men still cited a lack of knowledge or resources for why they did not communicate effectively with their partners and become more involved with SRH. Other men in the survey said that not only did they believe contraception should not be discussed, it should not even be used, since having as many children as possible was part of both their religious belief system and a symbol of their own fertility and power.

A female key informant explained that 'Condoms, especially youths, use them to avoid impregnating ladies and also to avoid HIV/AIDS. Other men especially the adults in their 50s do not want family planning and have a negative attitude towards it. Men regularly say that use of condoms is a waste of time and can even ruin their homes.' This quote also alludes to how using condoms can be an impetus for distrust among couples because it signals extramarital activity.

This article demonstrates that although most men subscribe to the gender norm that family planning is a woman's responsibility, they are open to becoming more involved and essentially shifting this gender norm. This is a key area for future research to explore the promotion of family planning as a shared responsibility. This study points to the need to not only encourage men to take an active role in contraceptive choices, but to do so in a way that takes into account their current cultural norms such as the reliance on a large family for economic gain and social status and the cost of care to treat side effects from birth control as compared to the cost of raising a child.

Sychareun, V., Vongxay, V., Houaboun, S., Thammavongsa, V., Phummavongsa, P., Chaleunvong, K. and Durham, J. (2018) 'Determinants of adolescent pregnancy and access to reproductive and sexual health services for married and unmarried adolescents in rural Lao PDR: a qualitative study' BioMedCentral Pregnancy and Childbirth 18 (1): 219.

This qualitative study examines the factors behind the high rates of teen pregnancy in rural Lao PDR. The authors find that a culture of acceptance around teen pregnancy and teen sex – and a prevalence of early marriage – combined with inadequate and incomplete knowledge of SRH services has led to poor health and socioeconomic outcomes in rural areas. Sychareun et al. conducted in-depth interviews and focus group discussions with both adolescent mothers and unmarried adolescent girls between the ages of 12 and 19 years. They also interviewed key informants such as the mothers-in-law of adolescent mothers (who have authority and influence over a wife's childbearing activities in patrilineal societies prevalent in the region), the husbands of adolescent mothers, community leaders and health providers.

The authors find that social and cultural norms in these communities were accepting of premarital sex, early marriage and early parenthood, but at the same time they find that general knowledge about sexual health and communication skills about SRH was lacking. The married adolescents reported experiencing regional language barriers, as well as feeling a need to be accompanied by their husband to visit a sexual-health provider, which proved difficult due to work and transportation constraints. Most reported having received antenatal or prenatal care, but not to the extent recommended by health officials.

Even though premarital sex is accepted for the most part in Lao – and is even considered a cultural norm among some ethnic groups – many participants reported being scolded by healthcare providers. The healthcare providers interviewed in the study reported that they had not received SRH-specific training. Unmarried adolescent participants reported fearing anxiety and judgement in seeking STI prevention and treatment as well as contraception. One female adolescent participant said, 'If you go to [the] health center, you will be asked many detailed questions such as why you want to get it ... if you are an unmarried adolescent, the providers are more likely to speak not nicely and get angry'. So even in places where premarital sex among unmarried youth is relatively common and even mostly accepted, it is still common for providers to take on a parental role, ask judgemental questions and discourage youth seeking SRH care.

The authors also cite the cost of SRH services and a lack of education around maternal health and SRH as barriers to participants receiving adequate care and knowledge. They conclude that the causes of teen pregnancy in rural Lao are multifaceted – some of which are an inherent part of the region's culture which may be resistant to change. Therefore, they conclude that policy and service-provider responses should acknowledge the culture and should help teens to develop more knowledge and communication skills to act as their own agents in sexual healthcare and contraceptive choices.

Godia, P. M., Olenja, J. M., Lavussa, J. A., Quinney, D., Hofman, J. J. and van den Broek, N. (2013) 'Sexual reproductive health service provision to young people in Kenya; health service providers' experiences' BioMedCentral Health Services Research 13 (1): 476.

In its *Second national health sector strategic plan of Kenya NHSSP II* covering 2005–2010 (MoH, 2005), the Government of Kenya made a commitment to increase the number of facilities that provide YFHS and established national guidelines to specify what that entails. Godia et al. focus on the experiences of health service providers that deliver SRH care to youth either through integrated models where young people receive services in the general health system or through youth centres that cater specifically to the needs of young people. Focus group discussions and key informant interviews were designed to assess knowledge of the national policies and guidelines, as well as general perceptions about providing SRH services to young people, barriers that impede its accessibility, and recommendations to improve the quality of services to young people.

This study finds that the majority of service providers were not comfortable providing contraception (other than condoms) to young people, since they do not protect against HIV and other STIs, and because of beliefs that hormonal contraception (especially long-acting methods such as injections, implants and intrauterine devices (IUDs)) can have an adverse effect on the ability to conceive in the future. While respondents expressed fewer reservations about the contraceptive pill, they commonly expressed a belief that contraception was not appropriate for young people. One said: 'Family planning should not be given to adolescents; they should be educated only because [family planning] is good for married people only'. Most health service providers said they were comfortable giving HIV tests and providing counselling, but that they were very dismissive of young people if they return for another test soon after.

Many health service providers said they were aware they could not deny services, but they were nonetheless reluctant to provide some services, particularly hormonal contraception, because of their own cultural and religious beliefs. The providers also often said they were not equipped or trained to provide SRH services and hadn't received specialist training on caring for adolescents' SRH needs.

This study builds on a body of research that finds that service providers' cultural norms and religious values affect their individual beliefs which may deter them from providing SRH services. Even service providers who had received training to provide YFHS and understood that young people have a right to receive SRH care reported sometimes denying such services to young people, especially girls. The authors recommend that health service providers receive training to address how their existing cultural biases impede their caregiving.

Velonjara, J., Crouthamel, B., O'Malley, G., Wiggins, M., Matemo, D., John-Stewart, G., Unger, J.A., Kinuthia, J. and Drake, A.L. (2018) 'Motherhood increases support for family planning among Kenyan adolescents' Sexual & Reproductive Healthcare 16: 124-131.

The authors of this mixed-methods study focus their research on access to and use of family planning methods among adolescent Kenyan women who have already given birth. They conducted surveys and focus group discussions with 32 postpartum adolescents and 28 family planning providers at two maternal healthcare clinics in Kisumu and Siaya Counties between October and November 2013. The authors find that contraceptive use is associated with intense shame and stigma because of pressure to remain abstinent before marriage, but also after marriage because of social pressure to demonstrate fertility and produce children. Once an adolescent has given birth, this pressure begins to subside, and young women are more likely to find community support and overall societal acceptance of their use of family planning methods.

The postpartum adolescents reported an interest in family planning, a desire for more education on family planning methods, and an appreciation for the hardships of mothering. However, adolescents who had already given birth still faced barriers to obtaining accurate information and care concerning contraceptive methods, ranging from misinformation and misconceptions about various methods of birth control to fear of side effects of certain birth-control methods, fear of judgement from peers or family, and structural barriers such as access to family planning clinics and clinic costs. The researchers find that these adolescents need better education on the intricacies of various

contraceptive methods, as many myths and misconceptions exist. For example, there is little use of or accurate knowledge about long-acting reversible contraceptives, despite their effectiveness and concealability – two desirable attributes in contraception for this population. In addition, many postpartum adolescents faced the same stigmas from healthcare providers common to other adolescents seeking family planning, as many providers still believe contraception is not appropriate for adolescents and will refuse to provide it to them.

Velonjara et al. conclude that the postpartum adolescent population presents a unique opportunity to test new approaches for supporting adolescent use of family planning. They recommend increasing efforts to improve family planning counselling services in the region, with a specific focus on education about the use of long-acting reversible contraception.

Adams, M., Salazar, E. and Lundgren, R. (2013) 'Tell them you are planning for the future: gender norms and family planning among adolescents in northern Uganda' International Journal of Gynecology and Obstetrics 123 (s1): e7–e10.

Adams et al. conducted interviews on the life histories of 20 teenage males and 20 teenage females between the ages of 10 and 19 years in north-central Uganda. The youth resided in areas that have been affected by decades of armed conflict that upended gender roles at times as women assumed traditional male responsibilities like farming and selling goods in order to provide for their communities.

The authors find that all participants subscribed to traditional ideas of femininity and masculinity, coded by agreeing with statements such as: 'ideal women obey their husbands'; 'distrust of contraception owing to potential effects on future fertility'; 'children bring status and recognition to young couples'; and viewing women as 'nurturers' and men as 'providers'. While many participants acknowledged that the conflict had changed gender roles, and some even challenged existing norms related to family planning, contraception and gender roles – particularly in regards to new realities of ideal family size in a post-conflict country where smaller families seem more desirable – traditional ideas about gender and reproduction prevailed. Survey results reveal a bias against the use of contraception. One 17-year-old female told researchers she believed that using contraception prior to bearing a child would 'make you barren', while many young men told researchers they associated a woman's contraceptive use with promiscuity and insisted upon being the primary decision-makers in family planning decisions with their partners.

The study concludes that increasing SRH services alone will not meet the health needs of these adolescents. Rather, gender-transformative interventions – including helping couples actualise and realise their ideal fertility and family planning scenarios based on health and challenging cultural norms – is more effective in promoting healthy relationships and gender-equitable communities.

Part 2. Working with service providers at different levels to improve the quality of YFHS

Working with service providers

This section continues to build on the premise that it is not sufficient to increase individual knowledge of either service providers or adolescents only to improve YFHS. There is often a naïve analysis that identifies lack of provider skills or knowledge as the cause of poor SRH service provision. What was previously referred to as quality of care is now shifting towards a discussion of provider behaviour change that involves a critical analysis of the root problems of poor service provision or uptake, not merely a lack of provider motivation. For example, if a provider feels that unmarried girls should

not have sex, increasing their knowledge about contraceptive methods may not be sufficient to get them to provide good quality counselling. Similarly, it is important to note that the environment matters. If providers are poorly paid, overburdened or don't have support from their supervisors, they will be unable to provide quality care regardless of their beliefs and knowledge.

Human Resources for Health 2030 (HRH2030, 2018) provides a framework that defines the necessary competencies to deliver gender-equitable family planning care. Two tools from the Beyond Bias consortium are included in this review. The first is a literature review (Starling et al., 2017) that finds that health practitioners bring their own values and beliefs into their care which has an impact on adolescent reproductive healthcare experiences. Their subsequent provider survey and segmentation findings (Camber Collective et al., 2018), however, demonstrate that a variety of additional factors also have an impact, such as being overworked or feeling unsupported to allow young people to access a variety of contraceptive methods.

HRH2030 – Human Resources for Health2030 (2018) Defining and advancing gender-competent family planning service providers: a competency framework and technical brief. Arlington, VA: Chemonics International.

In collaboration with the United States Agency for International Development (USAID) and expert consultations, HRH2030 developed a 'Gender competency framework for family planning service providers' to lay out the competencies necessary to deliver gender-equitable family planning care. Their framework applies a gender lens to a rights-based approach to bolster reproductive empowerment by supporting an individual's right to choose whether, when and how many children to have; the ability to act on those choices free from coercion and violence; and to access services without facing discrimination. This framework focuses largely on overcoming gender-based barriers that providers may inadvertently usher in when their own values and expectations about gender and youth interfere with the care they provide to young people.

To advance their mission of workforce development, the HRH2030 framework establishes specific capabilities that increase service providers' proficiency to provide youth-friendly services. This framework can be utilised by a wide range of health service providers including nurses, midwives, community health workers, volunteers, health educators, clinicians, physicians and pharmacists. The framework describes gender-competent family planning providers as:

"... a health worker with the capacity to identify how different norms, social constructs, roles, expectations, power differentials, opportunities and constraints assigned to women, men, girls and boys influence [reproductive health] behaviour and choices, and the awareness of how perception and treatment of male or female individuals influence the clients' voluntary and informed [family planning] decision-making. A gender-competent [family planning] provider strives to apply the needed knowledge, skills and attitudes to create equitable opportunities for women, men, girls and boys to make voluntary and informed [family planning/reproductive health] decisions based on their needs." (HRH2030, 2018: 4)

This framework does not address clinical knowledge. Instead, it adds another layer of knowledge, skills and attitudes related to gender norms to increase the efficacy of service providers. The framework goes on to establish six domains (ibid.: 4-7) that are inherently rooted in power and gender norms:

- *Using gender-sensitive communication* refers to a provider's ability to transmit information through verbal and non-verbal communication in a way that recognises unequal power structures and promotes equality for all clients; it is client-centered.
- *Promoting individual agency* refers to a provider's capacity to support an individual client's voluntary and informed decisions about whether, when and how often to reproduce, without pressure to conform to gender and cultural norms.
- *Supporting legal rights and status related to family planning* refers to a provider's ability to provide information and services to clients in accordance with rights and local laws and without interference of personal bias.
- *Engaging men and boys as partners and users* refers to a provider's recognition of men and boys as supportive partners to women and as potential users of family planning.

- *Facilitating positive couples' communication and cooperative decision-making* refers to a provider's capacity to help clients articulate, discuss and negotiate reproductive intentions and to make joint reproductive decisions as a couple.
- *Addressing gender-based violence* refers to a provider's ability to respond to such violence through brief empathetic counselling, safety planning and appropriate referrals.

This framework focuses on training providers to address and transform gender norms, but it also acknowledges that interventions should address systemic issues: for example, the ability to go to the pharmacy to obtain contraceptives depends on a young person's autonomy, mobility, safety, time and financial resources.

Starling, S., Burgess, S., Bennette, N. and Neighbor, H. (2017) Beyond Bias: literature review and expert interviews on provider bias in the provision of youth contraceptive services: research summary and synthesis. Watertown, MA: Beyond Bias Consortium, Pathfinder International.

This literature review conducted by the Beyond Bias Consortium examines provider bias in adolescent reproductive health services and finds that, in general, health practitioners bring their own values and beliefs into their care, which can have a tremendous impact on adolescent reproductive healthcare experiences.

The consortium reviewed more than 400 publications and conducted more than 20 expert interviews and field observations, with the goal of assessing the demand for various types of contraception and then ultimately developing appropriate interventions. The expansive review includes studies from all strata, but highlights findings in countries where interventions have been developed by Beyond Bias, including in Tanzania, Burkina Faso and Pakistan.

The review first identifies common drivers of provider bias. The authors find that social norms were the biggest driver, particularly when a community's attitudes towards premarital adolescent sexual activity were unfavourable and when young women in a culture were expected to bear children earlier in their lives. The review also looks at working conditions and health system incentives as well as the background of individual providers and also adolescents seeking SRH services. For example, in situations where health providers are overstretched with caseloads that are too large to handle, they may become frustrated with adolescents who present issues that they do not have enough time to address, and can express negative biases in these situations. In some cultures, health providers will consult male partners (i.e. a patient's husband) or superiors at the clinic before providing contraception to adolescents and may consider financial incentives for their clinics before directing patients to choose certain types of contraception over others. The literature review also discusses the ways in which an individual provider's background and personal experiences contribute to how they have treated patients: for example, if a provider has had negative experiences that have confirmed certain stereotypes about young adults, this was often reflected in his or her treatment of patients.

Starling et al. also sought to analyse the literature to determine common outcomes of provider bias and find that existing research does not tend to come to many common or specific conclusions, which they attribute to 'methodological challenges'. The authors suggest that there is an opportunity to think more about how bias manifests itself, and note that researchers are still working on methods to measure bias. Much of the literature reviewed used a complex, computer-based questionnaire known as the Implicit Association Test. While this test has its limitations (i.e. it is difficult to administer in under-resourced settings), the authors and Beyond Bias believe it is helpful in detecting bias towards specific groups, along with qualitative methods like direct observations. The review ultimately concludes that an additional set of qualitative provider archetypes are needed.

Finally, the authors examine literature on how behaviour-change interventions to combat provider bias have worked, finding many 'client-focused' interventions that target provider bias. However, the literature review and subsequent interviews reveal that 'kitchen sink' approaches to bias interventions are common and unscalable. The authors stress the importance of creating interventions that don't shame providers for their biases and include positive feedback.

Camber Collective, Pathfinder and Y Labs (2018) Beyond Bias: provider survey and segmentation findings. Watertown, MA: Beyond Bias Consortium and Pathfinder International.

This report presents foundational research conducted by Camber Collective, Pathfinder and Y Labs to increase access to a range of contraceptive methods by fostering high quality provider–client interactions. The report summarises research that has informed the development of seven potential strategies to improve contraceptive counselling and service provision for young people aged 15–24 years in targeted areas of Tanzania, Burkina Faso and Pakistan. This first phase of quantitative and qualitative analysis sought to deepen understanding of provider bias in these settings and identifies six distinct profiles for providers in relation to providing family planning care.

The report presents the results from a survey of providers to test the key drivers of provider bias. These are classified into three categories. The first and most narrow category of bias drivers derives from the biography details of providers' personal experiences (their knowledge, ability to improvise and willingness to adapt) and are significant determinants in shaping the severity of an individual provider's biased behaviour towards youth. The second category is driven by situational characteristics such as the working conditions and incentives of the particular health system in which the provider operates. The third and broadest category of drivers is social norms which the authors determine play a formidable role in shaping adolescent–provider interactions and discrimination based on age, marital status and parity. The most prevalent norms relate to promoting abstinence before marriage (45% of participants expressed this motivation) and protecting women's fertility (60% reported this was a priority). Although the initial questionnaire appears to reveal age as a strong standalone driver of bias, the subsequent vignette scenario responses suggest that marital status and parity have a far greater influence, with age being a confounding factor across each geographic area and provider segment (segmented based on attitudes and degree of interaction with young clients). This helped the authors to identify the characteristics of service providers who would be most likely to respond to training and other strategies.

The authors developed country-specific surveys with a maximum of five questions to rapidly assess provider segment so training strategies can be tailored to align with their respective characteristics. Service providers classified as 'average passives' offer the greatest potential to target interventions against provider bias as this is the segment with the most practitioners (33% overall, 92% in Burkina Faso) but also because their relatively moderate degree of bias makes them more amenable to change during training. The characteristics of 'detached professionals' and 'content conservatives' also make them good candidates for potential intervention.

The authors find that attitudes were not the primary driver of denying family planning services and therefore interventions that focus on improving provider attitudes may not have wide-reaching impact. Instead, 'being overworked' or 'feeling unsupported' were more likely to result in providers refusing services. Misinformation about hormonal methods is also identified as a driver of bias, which indicates that providers may be misinformed in multiple ways about the efficacy or safety of hormonal methods. According to this report, work-flow management, personnel support and providing more convincing evidence that hormonal contraception does not affect fertility in the long term should also be a part of any training to improve youth access to SRH services.

Phase two of this project will utilise human-centred design to test and identify the most promising approaches to changing the behaviours of SRH service providers, while phase three will go on to implement and rigorously evaluate the cost and effectiveness of the most promising solutions that emerge.

Working at multiple levels

To be successful, YFHS programmes need to offer a package of interventions tailored to the context that includes education, generating adolescent demand for SRH services, training and support of health workers, improving the youth-friendliness of health facilities, and building community support for SRH service delivery. Underlying gender norms that affect YFHS must also be addressed in meaningful ways at both the community and policy levels.

A review of the literature and programmes conducted by the World Health Organization (WHO, 2009) concludes it is also necessary to engage a range of gatekeepers, from parents to religious leaders and other influential community members, to shift norms about the acceptability of youth-friendly SRH services and to garner community acceptance and support. The *Gender Roles, Equality and Transformation (GREAT) project how-to guide* (Institute for Reproductive

Health, 2016) describes a detailed model to implement a community-based participatory process that has demonstrated an impact on reducing gender-based violence and improving SRH outcomes in post-conflict communities in northern Uganda. The Passages Project (Institute for Reproductive Health and Save the Children, 2016) reviews normative change interventions that have achieved positive changes in individual behaviour to increase uptake of adolescent SRH services.

WHO – World Health Organization (2009) Generating demand and community support for sexual and reproductive health services for young people: a review of literature and programmes. Geneva: WHO.

This literature review seeks to expand the evidence base for two interrelated aspects of increasing use of adolescent SRH services: 1) generating demand among adolescents for SRH services and 2) increasing acceptance among communities so they will encourage youth to utilize SRH services. The review finds that the more adolescents were informed about where SRH services were available – sometimes through youth and community groups, parents or school – the higher the demand for such services. Adolescents need to know when and where they can access these services as well as why they should use them. Strategies to address this aspect of generating demand include providing information and education through several different channels such as school-based education, community-based education, youth centres, and the use of vouchers to subsidize the costs of accessing services.

However, adolescents' use of SRH services can be a sensitive issue in many communities, so increasing adolescent knowledge is not sufficient to increase utilisation of services. It is also necessary to engage gatekeepers, including parents, religious leaders and other influential community members, about how they can support young people to use SRH services. This WHO review also assesses strategies to shift norms about the acceptability of youth-friendly SRH services and to garner community acceptance and support. Mass media is a promising strategy because of the way it can easily reach a substantial audience, but it has been difficult to adequately evaluate the impact of media efforts on increasing uptake of services and shifting gender norms. Media programmes demonstrate the most impact when they are delivered in combination with activities such as social marketing of adolescent SRH services.

The review identifies financial interventions that subsidise adolescent SRH services as a strategy that has demonstrated great potential, even in conservative contexts, because it makes SRH services more readily available to adolescents. Voucher schemes can create partnerships with the private sector to realise an unmet demand for care and provide adolescents with the opportunity to chose which services best suit them. Even though offering financial incentives for adolescent SRH care is promising, there is little rigorously evaluated evidence because these studies are often difficult and expensive to implement.

The review suggests that providing information to influential community members is a key component to creating community support for adolescent SRH services. The authors reviewed a variety of channels, such as community education, critical reflection discussion groups, as well as dissemination of information at community events such as festivals, sporting events and celebrations to foster opportunities for inclusive community action. In order to access care young people need not just relevant information but also life skills that are responsive to their gender, developmental stage, marital status and cultural context.

The authors cite multisectoral approaches as the most promising way to meet the unique and varying needs of youth, and highlight the African Youth Alliance as an example of a comprehensive intervention implemented in Botswana, Ghana, Tanzania and Uganda that aimed to increase community involvement. The programme helped local community leaders (including elected officials and religious figures), parents and youth to understand how to sensitively define and become involved in SRH responses and interventions.

Gender-norm change happens at the community level in these sorts of programmes and the evidence from the 30 studies reviewed by the WHO suggests that the cumulative impact of multicomponent and multisectoral interventions is greatest when they are able to combine approaches to reach adolescents through a variety of channels that are mutually reinforcing. This review also highlights that comprehensive strategies to improve adolescent use of health services must work with communities as a whole in a more cohesive manner.

Institute for Reproductive Health (2016) GREAT project how-to guide: GREAT's approach to improving adolescent sexual and reproductive health and reducing gender-based violence. Washington, DC: Institute for Reproductive Health at Georgetown University.

The GREAT project aims to reduce gender-based violence and improve SRH outcomes in post-conflict communities in northern Uganda. The GREAT model promotes gender-equitable attitudes and behaviours among adolescents (ages 10–19 years) by mobilizing community collaboration. GREAT's approach includes: 1) simple steps to bring communities together to take action to improve adolescent well-being; 2) a serial radio drama with stories and songs about young people and their families living in northern Uganda; 3) orientation to help Village Health Teams (VHTs) offer youth-friendly services; and 4) a toolkit with lively stories and games (GREAT, 2016: 5). The project details specific methods and tools for each of these four components.

One chapter, 'The community action cycle', details how GREAT works with communities to create space for reflection about gender equality. The cycle outlines a tested model of mobilisation and collective dialogue that engages communities and leaders in reflection about how to shift gender norms to prevent gender-based violence and promote adolescent SRH, and foster long-term behaviour change. Discussions revolve around how gender norms materialize, and how they influence the way people access information and services with a particular focus on young people and the barriers they face when they seek out SRH services. Young people are often considered 'too young to need services', or automatically deemed as promiscuous for accessing services. This chapter highlights how a community-based participatory process sets the foundation to catalyse normative change and create an enabling environment for YFHS so that adolescents will be treated with respect when they do seek SRH services.

Another chapter, 'Village health teams and youth-friendly services', discusses how to incorporate YFHS into community programmes. It is important to note that the GREAT programme does not directly provide YFHS, but it does work with existing health services to make SRH services more youth friendly. They do this by mapping out the existing health services, rapidly assessing their youth-friendliness, and then providing training to healthcare providers to ensure they have the knowledge and skills to provide accurate information, counselling and services to adolescent girls and boys. As part of the community action cycle described above, programmers should collect information together with the community to map out a basic overview of existing health services in the area. They then use the checklist provided to conduct rapid facility assessments to identify gaps and priority areas for interventions to improve youth-friendly services. Conducting this assessment with the community will begin the essential process of building relationships and linkages between community programmes and health services that will improve awareness of and access to YFHS and referrals as necessary.

The report suggests that efforts to create linkages between YFHS providers and community leaders should involve feedback systems that allow them to regularly interact. Fostering this participatory process should involve: inviting both YFHS providers and community leaders to all relevant meetings,, treating YFHS providers as key stakeholders who should be included in the core group of community action members, aiming to have monthly or quarterly meetings where they will have ample opportunity to interact, and/or consider involving community leaders in the same training that healthcare providers undergo to make health services more youth-friendly.

This chapter goes on to provide an agenda for a four-day training with health service providers accompanied by detailed step-by-step instructions for each exercise. Like the community action cycle, there is an emphasis on shifting norms related to gender and adolescent SRH. The exercises aim to increase understanding of different types of power, the various stages of adolescent development, and myths and misconceptions related to SRH. Participants are guided through exercises to identify barriers and facilitators to accessing SRH services, different forms of verbal and non-verbal communication, and values clarification to explore how their personal beliefs may affect the care they provide. Several relevant handouts are provided along with a 'gender pulse' to identify any persistent attitudes that individuals are reluctant to change, and a pre- and post-test to evaluate the learning process.

Institute for Reproductive Health and Save the Children (2016) Scaling up normative change interventions for adolescent and youth sexual and reproductive health: literature review findings and recommendations. Washington, DC: Institute for Reproductive Health at Georgetown University and Save the Children for USAID.

Conducted as part of the Passages Project, this literature review explores the qualities of various normative change interventions to improve adolescent SRH. Normative change interventions are defined as 'strategies designed to catalyze communities to reflect on and challenge existing social norms that support individual attitudes and behaviors leading to poor AYSRH [adolescent and youth sexual and reproductive health] (e.g., gender-based and interpersonal violence, early pregnancy, child marriage, coercive male decision-making on issues of family planning, lack of adult support to adolescents vis-à-vis SRH advice and choices)' (Institute for Reproductive Health and Save the Children, 2016: 4).

Of 303 projects initially identified, 42 were eventually included in the review. The majority of the interventions (27) specifically targeted gender-norms, while others focused on HIV/AIDS (9), family planning (6), and early-marriage (2). Slightly more than a quarter of the interventions (12) measured perceived norm changes in the community and only four specified exactly what norms they measured. The authors of the review highlight the following two lessons about normative change as being most relevant:

1) Measurement and monitoring are key: Much of the literature was lacking in any assessment of normative change after interventions took place. The authors determine that improving evaluating normative change is critical.
2) 'Providers need to reflect on their own attitudes and beliefs: The authors recommend that staff and service providers living in the communities they serve examine their own views and biases around gender roles in order change the norms and culture around YFSH in those communities.

Part 3. Evaluating impact and bringing about change

Assessing the impact and quality of YFHS

This section details two different approaches to assess the quality of YFHS at the organisational and national policy levels. A systematic literature review of evaluations utilising youth as mystery clients (MCs) posing as undercover patients determined it was an effective method to assess various facets of an organisation's or clinic's capacity to provide YFHS (Chandra-Mouli et al., 2018). Focusing on the legal-political level of the ecological model, the Population Reference Bureau (PRB, 2018) designed a national 'Youth family planning policy scorecard' to rate the most effective legal approaches to promote uptake of contraception among youth.

Chandra-Mouli V., Lenz, C., Adebayo, E., Lang Lundgren, I., Gomez Garbero, L. and Chatteriee, S. (2018) 'A systematic review of the use of adolescent mystery clients in assessing the adolescent friendliness of health services in high-, middle-, and low-income countries' Global Health Action 11 (1): 1536412.

In this 2018 paper published in *Global Health Action*, Chandra-Mouli et al. evaluate whether an MC research methodology, when practiced with adolescents, is an effective way to study the efficacy of ASRH services. Through a comprehensive literature review of studies of adolescent MCs in high-, middle- and low-income countries, the study finds that the use of this method can be a helpful way to learn about how well ASRH services meet the needs of young people

across a variety of contexts, including in publicly and privately run hospitals, health clinics, pharmacies and across other family planning services such as those that distribute contraception and HIV testing.

When researchers use the MC methodology, study participants pose undercover as patients seeking access to services to evaluate various facets of the practice. This article evaluates more than 30 studies across a range of countries which used qualitative and quantitative methods to study how adolescents perceived ASRH services available to them. In most of the studies MCs identified health service providers as friendly, while in 14 studies MCs reported 'inappropriate behaviour', including mocking and sexual harassment. One MC in Mwanza reported: 'When I started to explain my need of [family planning] methods s/he asked me twice, "family planning? So, are you married?"'. Female MCs in Bolivia reported instances of physicians sexually harassing female MCs. And other literature reviewed found that adolescents seeking SRH services cannot always do so in a safe, friendly environment.

In other studies, MCs found differing levels of care and attitudes towards them based on gender, with male MCs more likely to report that they found their services 'satisfactory' than female MCs. Chandra-Mouli et al. conclude that the MC methodology was generally perceived to be an effective and worthwhile investment of resources that provided useful information to help improve service delivery.

PRB – Population Reference Bureau (2018) Youth family planning policy scorecard. Washington, DC: PRB.

PRB designed the 'Youth family planning policy scorecard' to identify and analyse the most effective legal approaches and programme interventions to increase contraception use among youth. They scored 16 African countries to compare and assess policies that institutionalise adolescent rights to access health services including family planning for people between the ages of 15 and 24 years. They did not include adolescents ages 10–14 years in the review because of limited data for this age group. PRB mapped out key policies and programmes across the 14 countries that have an impact on young people's access to SRH information and services.

They provide a snapshot with a green, yellow, red and grey (no policy) rating for each indicator for all 16 countries and then go on to provide a more detailed profile and description for each country. Based on a systematic literature review and expert consultation, PRB designated the following eight indicators as selection criteria: "1) parental and spousal consent, 2) provider authorisation, 3) restrictions based on age, 4) restrictions based on marital status, 5) access to a full range of family planning methods, 6) CSE, 7) youth-friendly family planning service provision, and 8) an enabling social environment" (PRB, 2018: p. 6). Youth-friendly services – number 7 in the report – is the most relevant indicator related to gender.

There are two components under the enabling social environment indicator (number 8): gender norms and connecting services delivery with activities that build enabling communities. The authors find that working with groups and within communities – instead of just individuals – can help change social norms around SRH and contraceptive use.

Eleven of the 16 countries detail how they are approaching the goal of building youth family planning services and dialogue within their policies, including communication interventions intended to educate the general population in their communities as well as leaders and parents on why youth family planning services are critical.

Implementation of country commitments is beyond the scope of this scorecard though it did identify an interesting correlation between supportive policy environments for YFHS and modern contractive use. Ethiopia, Kenya and Tanzania had the highest scores on both of these measures.

Toolkits to improve service provision

The following three resources summarise toolkits that are designed to train service providers to tailor their services for married youth (Engender Health and USAID, 2008), to effectively incorporate YFHS services into youth-friendly centres (IPPF, 2012), and to implement a gender-transformative approach when delivering SRH services to men and adolescent boys (IPPF/UNFPA, 2017).

Engender Health and USAID – United States Agency for International Development (2008) Youth-friendly services for married youth: a curriculum for trainers. New York: The ACQUIRE Project.

This curriculum seeks to enhance healthcare providers' ability to serve the reproductive health needs of young married men and women. The curriculum includes several sample agendas, activities, handouts and discussion guides for trainings with YFHS service providers. Sample activities and trainings can be tailored to specific health programmes and clinics and include modifications for low-literacy populations.

Many of the handouts and activities instruct healthcare providers to reflect on how their own experiences, biases and culturally ingrained ideas about marriage, sex and gender roles may impact on their interactions with married teens. Information is then given on sexual health and sexuality topics such as the difficulties and pressures young married couples face fulfilling rigid, traditional gender roles. For example, one exercise asks providers to identify what it means to be told to 'act like a man' or 'act like a woman', and to reflect upon how those stereotypes and norms they may have grown up internalising can be limiting for both genders. Another exercise teaches and asks providers to reflect on their understanding of sexuality, and teaches the 'five circles of sexuality', which include sensuality, intimacy/relationships, sexual identity, sexual health and the use of sexuality to control others. The curriculum also urges healthcare providers to involve the broader community and other adults in creating a more supportive and safer environment for young married couples.

The sample guides include before-and-after questionnaires for participants in order to measure changes in their knowledge and attitudes. This includes agree/disagree statements, such as: 'All adolescents must be able to receive reproductive health services, regardless of their marital status' and 'Service providers should give contraceptives to a married girl if she requests them, even without her partner or family's consent'. These questions help increase the effectiveness of the training in targeting service provider beliefs and biases that may prevent them from giving optimal care.

IPPF – International Planned Parenthood Federation (2012) Springboard: a hands-on guide to developing youth-friendly centres. London: IPPF.

The IPPF's Springboard guide uses the organisation's data-driven findings on the centrality of youth centres in many communities in Botswana, Burkina Faso and Ghana and looks at how their services include SRH as part of their comprehensive youth programming.

IPPF find that such centres are valuable to youth in these three countries, and that many offer SRH counselling services (STI testing, pregnancy testing, contraceptive counselling, relationship counselling, sexual-abuse counselling and in some cases abortion and abortion-related services) in addition to non-SRH services (such as games and access to library services, the internet and career skills training). Although there has been debate and controversy about the value of these centres in the SRH sector, IPPF's guide aims to equip these centres with new tools to develop effective SRH programming that best suits the needs of the youth who use their facilities and services. IPPF also recommends giving young people an active role in discussions about youth-centre programming and activities.

The guide provides practical guidance for staff about activities they can offer to complement SRH programming, clear suggestions on the kinds of SRH issues and policies that should be addressed, and tips on how to link SRH activities offered by the centres with non-SRH activities. The guide provides many examples of possible links, including sports and SRH to promote health and physical well-being; the use of library facilities or activities to view information related to SRH; and film showings that cover themes of love, relationships and sexuality, etc.

The guide also recommends that centres take care to plan activities that are inclusive of both genders and that they are aware of the differing needs of each (i.e. planning 'girls only' activities and days). At the same time, IPPF recommends thinking through how to address stereotypes and to avoid reinforcing prevalent gender norms in their programming. Centres should address the tendency demonstrated by IPPF's data that young men use the centres for recreation while women use the clinical services. The guide suggests that centres work to encourage women to participate in all aspects of centre activities, including the purchase of condoms, and that they should hold events to introduce young women to

female role models in their communities. IPPF sees the centres as an important part of community and organisational advocacy for youth services and youth SRH and rights, as well as places from which to advocate for youth reproductive rights/policy and gender equality more broadly in those countries.

IPPF and UNFPA – United Nations Population Fund (2017) Global sexual and reproductive health service package for men and adolescent boys. London: IPPF.

This package is intended to aid SRH providers in increasing the range and quality of services they provide for men, using a gender-transformative approach. IPPF developed the package specifically for men and boys because it recognises that this group has unique SRH needs that require tailored services coupled with a gender-transformative approach that 'actively strive[s] to examine, question and change rigid gender norms and imbalances of power as a means of reaching health as well as gender equity objectives' (IPPF and UNFPA, 2017: 16). The service package provides an in-depth description of why it is important to take a gender-transformative approach when developing SRH programmes for men and how to build and operationalise those programmes. It suggests factors to consider when developing programmes for men that relate to gender identity and sexual orientation, and finally provides links to further resources.

One example of a gender-transformative consideration included in the package is the concept of the 'Gender integration continuum' – a framework that teaches about the differences between gender-blind programmes and gender-aware programmes. The former is designed without consideration for outcomes specific to gender, the latter describes programmes that have fully thought through gender issues. In the continuum, gender-aware programmes must then 'seek to do no harm' so that they do not unintentionally reinforce gender inequalities. When applied to men's reproductive health, this means encouraging men to support and respect their partner's sexual and reproductive health in addition to their own.

Although the authors of the package take pains to note that a focus on the SRH needs of adolescent men is not intended to detract from a necessary focus on women and children, they also note that the 'lessons' from women and children's health (which they acknowledge is under-resourced in regions with high levels of poverty) should often be applied to addressing men's care as well, particularly with regards to the focus on prevention of STIs and pregnancy and ensuring confidentiality.

However, the authors note that men have specific needs and issues when they seek SRH care that can differ to women. They suggest that men are less likely to honestly disclose symptoms of an STI and to access services in general due to feelings of shame, but also because of the pressure to conform to the norm of becoming/being the primary economic provider in their families. This can contribute to a belief that seeking health services is a poor use of their time and money. The package also notes that many men report having had bad experiences in seeking SRH care, including encounters with inadequate or unavailable treatment and a lack of discretion in keeping information confidential.

Reflection on evidence gaps

Currently, gender norms are often taken into consideration when working with ASRH and YFHS. A vast amount of research has been conducted to identify and understand how gender norms manifest in specific contexts and how they might facilitate or impede young people's access to SRH services. It has been recognised that increasing individual knowledge about SRH is often not enough to improve young people's access to YFHS, and subsequently more programmes are starting to work across levels to foster an enabling environment to increase demand for YFHS. However, there is less understanding of how to work with gender norms in practical terms in interventions. Gender norms are often conflated with individual attitudes that fail to account for how young people perceive they are expected to act. Furthermore, robust evidence is needed regarding best practices to measure shifts in gender norms so that behaviour changes can be evaluated effectively.

Further resources

Bruce, J. (1990) 'Fundamental elements of the quality of care: a simple framework' *Studies in Family Planning* 21(2): 61–91 (https://www.ncbi.nlm.nih.gov/pubmed/2191476)

Mazur, A., Brindis, C. D. and Decker, M. J. (2018) 'Assessing youth-friendly sexual and reproductive health services: a systematic review' *BMC Health Services Research* 18(1): 216 (https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2982-4)

MoH – Ministry of Health, Kenya (2005) *Reversing the trends: the second national health sector strategic plan of Kenya NHSSP II 2005–2010.* Nairobi: Ministry of Health, Kenya (http://www.healthyfutures.eu/images/healthy/deliverables/D5.1/Kenya/kenya%20second%20national%20health%20sector%20strategic%20plan%202005%20-%202010.pdf)

UNFPA – United Nations Population Fund (2014) *Operational guidance for comprehensive sexuality education: a focus on human rights and gender.* New York: UNFPA (https://unfpa.org/sites/default/files/pub-pdf/UNFPA_OperationalGuidance_WEB3.pdf)

UNESCO – United Nations Educational, Scientific and Cultural Organization (2009) *International technical guidance on sexuality education: an evidence-informed approach for schools, teachers and health educators.* Paris: UNESCO (http://portal.unesco.org/en/ev.php-URL_ID=47268&URL_DO=DO_TOPIC&URL_SECTION=201.html)

Violence Prevention Alliance (n.d.) 'The ecological framework'. Geneva: Secretariat of the Violence Prevention Alliance, World Health Organization (https://www.who.int/violenceprevention/approach/ecology/en/)

ALiGN Advancing Learning and Innovation on Gender Norms

About ALIGN

ALIGN is a four-year project aimed at establishing a digital platform for the Community of Practice (CoP) centred on gendered norms affecting adolescents and young adults. Project ALIGN seeks to advance understanding and challenge and change harmful gender norms by connecting a global community of researchers and thought leaders committed to gender justice and equality for adolescents and young adults. Through the sharing of information and the facilitation of mutual learning, ALIGN aims to ensure knowledge on norm change contributes to sustainable gender justice.

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