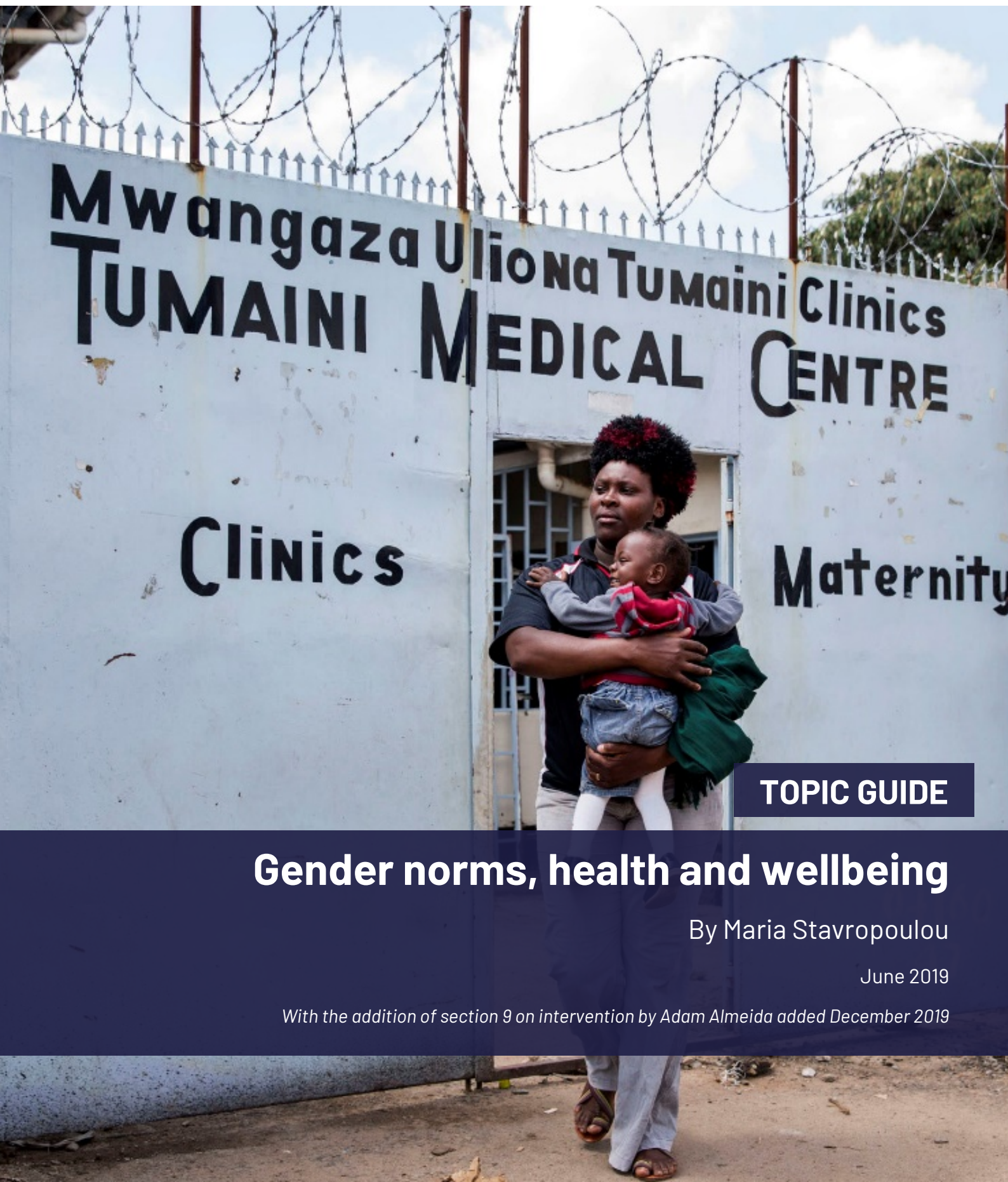


ALIGN

**Advancing Learning and
Innovation on Gender Norms**



TOPIC GUIDE

Gender norms, health and wellbeing

By Maria Stavropoulou

June 2019

With the addition of section 9 on intervention by Adam Almeida added December 2019

Contents

Gender norms, health and wellbeing	1
1. Introduction	3
Setting the scene: key concepts	4
1.1 Pathway 1: Gender norms and values, practices and behaviours.....	5
1.2 Pathway 2: Gender norms and exposure and vulnerability to disease.....	6
1.3 Pathway 3: Gender norms and health systems	8
2. Non-communicable diseases and gender norms	8
2.1 Low physical activity	8
2.2 Overweight and obesity.....	9
2.3 Tobacco use	10
2.4 Alcohol use	11
2.5 Air pollution	12
3. Communicable and infectious diseases and gender norms.....	13
4. Nutritional status and gender norms	15
5. Physical integrity and gender norms.....	18
5.1 Violence	18
5.2 Body modification.....	22
5.3 Unintentional injuries	25
6. Sexual and reproductive health and gender norms	26
7. Mental health and psychosocial wellbeing and gender norms.....	29
8. Health systems and gender norms.....	31
9. Interventions to address gender norms and health.....	34
9.1 Gender norms and sexual and reproductive health.....	34
9.2 Gender norms and health systems	39
9.3 Gender norms and infectious and communicable diseases	42
9.4 Gender norms and nutrition.....	46

Acknowledgements

The author would like to thank Jessica Levy for her valuable comments on the draft report, Caroline Harper and Fiona Samuels for their feedback, and Angela Hawke and Emily Subden for excellent editorial, design and layout support.

1. Introduction

Gender norms are informal, often implicit rules of masculinity and femininity that guide people's attitudes and behaviours. Their strong influence can harm the health and wellbeing of women and men, girls and boys in many ways, particularly by exposing them to different health risks, distorting the recognition of their health needs and embedding disparities in their access to health care.

This thematic guide brings together key evidence on how discriminatory gender norms affect health outcomes for adolescents and youth in low- and middle-income countries (LMICs). While there are several definitions of these age groups, this guide follows the [United Nations and WHO definition](#) according to which adolescents include persons aged 10–19 years and youth those between 15 and 24 years. It focuses on adolescence as a critical stage of life – a stage when many behaviours that will have a significant impact on adult health and wellbeing, begin or are consolidated. Adolescents account for a substantial proportion of the global disease and injury burden, with more than two-thirds of all adolescent deaths occurring in LMICs.

The current [call for action on the health of adolescents and youth](#) is a unique opportunity to identify and respond to their particular health needs. Although the role of gender inequality and the norms that reflect and reproduce it are often neglected, they shape boys' and girls' understanding of what is acceptable and appropriate. As such, they are clearly part of the problem and should also be addressed in both policy and programming to improve adolescent and youth health.

This thematic guide presents key evidence on the ways in which discriminatory gender norms affect the vulnerability of adolescents and youth to major health and wellbeing problems, including:

- non-communicable diseases
- communicable and infectious diseases
- poor nutritional status
- threats to physical integrity: violence, body modification and unintentional injuries
- sexual and reproductive health risks and infections
- challenges for mental health and psychosocial wellbeing
- and the gendered responses of health systems.

The guide aims to share existing knowledge and raise awareness among researchers and practitioners of the significant, yet often invisible role, played by gender norms in heightening health risks and vulnerabilities, limiting the responses of health systems and ultimately damaging the health and wellbeing of adolescents and youth in LMICs. Given the scale of the current knowledge gaps in LMICs, however, the guide also presents some relevant evidence from high-income countries (HICs).

This guide will be followed by information on best practices and promising initiatives to address harmful gender norms and promote adolescent and youth health.

Setting the scene: key concepts

According to WHO, gender is a [key social determinant of health and wellbeing](#). While sex and gender are often used interchangeably in medical literature, they are very different. Sex refers to the biological and physiological differences between women and men such as chromosomes, hormones or genitalia. Gender, however, refers to the socially-constructed characteristics, behaviours and roles of women and men.

Gender has, therefore, five main elements: relational, hierarchical, historical, contextual and institutional. Gender relations refer to the relations between women and men. They often [create hierarchies between and among groups of women and men](#) that lead to unequal power relations disadvantaging one group over another. Most societies give men privileged access and control over rights, resources and opportunities and value masculine attributes, roles and behaviours more highly than those associated with women and femininity.

Norms have been called ‘[the vital determinants](#)’ of social hierarchy as they reflect, reproduce and normalise relations of power. Gender norms, in particular, dictate what is masculine, what is feminine and how men and women should behave in their daily lives, promoting those behaviours as natural and thus legitimate ways of being and doing in a given context.

Gender norms can [harm the health and wellbeing](#) of women and men, girls and boys through multiple pathways. They shape differential exposure to health risks, differential acknowledgement of health needs and differential access to health care. Gender norms, however, are not static but can be negotiated, challenged and changed, and their harmful effects on health can be prevented or mitigated.

In 2007, [a ground-breaking paper](#) by the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health synthesised knowledge about the health outcomes of unequal gender relations. Authors Sen, Östlin and George argued that ‘Sex and society interact to determine who is well or ill, who is treated or not, who is exposed or vulnerable to ill-health and how, whose behaviour is risk-prone or risk averse, and whose health needs are acknowledged or dismissed’ (2007: xiii).

Their influential framework set out the factors that determine gender inequities in health. In particular, they identified four main causal pathways:

- discriminatory values, norms, practices and behaviours
- differential exposures and vulnerabilities to disease, disability and injuries
- biases in health systems
- and biased health research.

They also emphasised that gender interacts with other forms of social disadvantage such as those linked to socioeconomic class, race, ethnicity or caste, disability, age and stage in the lifecycle to accentuate health inequities. Those who do not conform to established gender norms, including those who do not follow ‘acceptable’ patterns of sexual orientation, may also face stigma, discrimination and poorer health outcomes.

While [Sen et al. \(2007\)](#) discuss how gender inequality damages human health, the past decade has also seen the emergence of adolescent health and wellbeing as a top priority on the global

agenda. There are two main reasons for this: first, [adolescence is a critical stage of human development](#) during which many health behaviours are acquired that may have lifelong consequences. Second, recent [epigenetic and neurodevelopmental findings](#) indicate that the adolescent brain is still developing and is much more plastic than previously believed, providing an opportunity to intervene at a pivotal moment and shape healthier behaviours. Current research is focusing on a better understanding of the transition to adulthood as adolescents start to learn, experiment with, conform to or challenge gender norms and related behaviours and roles that will influence their health and their lives.

There is a growing focus on the role of gender norms on health, as shown by the [increasing number of studies](#) that explore how gender inequality and gender norms affect health and the quality of life for all. Studies from different disciplines have also analysed the role of unequal gender relations on health conditions and outcomes ranging from infectious diseases to mental health problems and from nutrition to injuries. Recent studies have looked more closely at the role of discriminatory gender norms in relation to intimate partner violence and sexual and reproductive health.

This guide will explore the pathways through which gender norms shape key health behaviours and outcomes, building on the framework developed by Sen et al. (2007) (see Figure 1). We will focus in particular on the first three pathways they identified through which gender norms affect health and wellbeing:

- gender norms, values, practices and behaviours
- gender norms and exposure and vulnerability to disease
- and gender norms and health systems.

1.1 Pathway 1: Gender norms and values, practices and behaviours

Gender norms shape values, practices and behaviours that matter for health and wellbeing because they determine knowledge and attitudes about health and healthcare. In particular, they influence access to health information, the perceived value of the individual and their power to make decisions about their own health, risk-averse or risk-prone behaviours, health-seeking practices and access to health services.

Gender norms can damage the health and wellbeing of women and girls, as well as men and boys. In many societies, [norms associate masculinity](#) with strength, toughness, independence, self-reliance and risk-taking. Older adolescent boys and young men tend to engage in excessive alcohol consumption, unprotected sex, dangerous driving or violent practices and have higher rates of substance abuse, injuries from traffic accidents and homicides. Girls and young women, however, are often seen as more vulnerable and risk-averse and are expected to [show modesty, submission and dependence](#) while their movements are restricted and monitored and their sexuality is controlled. As a result, adolescent girls and young women tend to have lower levels of physical activity and are more likely to experience violence or suffer depression.

Gender norms on acceptable behaviours also influence the health-seeking practices of young men and women. Sickness, the expression of pain and asking for help are linked to weakness and vulnerability that contradict the masculine ideal. Men feel pressure, therefore, to [dismiss their health care needs](#), display strength and avoid or delay seeking health care. Women tend to

be more likely to seek help for physical and mental health problems, yet they are also expected to be [self-sacrificing](#) and put the needs of other family members before their own health.

Because prevalent norms about feminine and masculine behaviours regulate access to health care, they often have harmful consequences for those who do not adhere to them. Adolescent girls who become pregnant outside marriage, for example, might not seek reproductive health services because of perceived stigma. In gender-segregated contexts with restrictive norms that emphasise female modesty and purity, ‘good’ [girls and women can only move in public spaces if accompanied by a male guardian](#) and must never be examined by male health providers as this would violate established rules about acceptable interaction between genders. Similarly, [men who do not conform to the masculine heterosexual ideal](#) may avoid seeking health care for a sexually transmitted infection (STI) to avoid discrimination and humiliation.

Most importantly, access to health services is linked to the relative ‘worth’ of girls and women versus boys and men, and to unequal access to household resources, authority and decision-making. Evidence across LMICs shows that gender inequality privileges the health and wellbeing of boys and men, especially in settings characterised by a strong preference for sons. One extreme expression of this gender bias is the persistent [excess mortality of girls](#) as a result of prenatal sex selection and postnatal discrimination in some countries, especially in South and East Asia.

Women and girls often lack resources and decision-making power. They depend, therefore, on male members of their household to access the health services they need and to pay for transportation and medication. Adolescent girls, in particular, need the consent of their parents or spouse to access health services. Studies have found, however, that [men often lack the necessary health knowledge](#) and are unwilling to spend money on the health of women and girls, with some evidence suggesting that they spend a greater share of household resources on their own health needs or those of their sons. The end result is that women and girls delay accessing the care they need, have difficulty in completing treatment, or are forced to use informal healers and their therapies.

1.2 Pathway 2: Gender norms and exposure and vulnerability to disease

Gender norms and roles also shape disparities in exposure and vulnerability to health risks and disease. While [biological sex differences interact with gender](#) and other social determinants to increase vulnerability to disease (e.g. HIV infection for women), gender roles and responsibilities also expose men and women, boys and girls to health risks in different ways in both the workplace and the household.

In many settings, [men and women tend to dominate tasks and occupations](#) that are seen as suitable for their bodies and their gender roles. Men, therefore, undertake more physically intensive work and account for most workers in construction, transportation, fishing and fire-fighting, while women are concentrated in caring and service professions or light assembly work.

This gender segregation in the labour market exposes men and women to [different physical and psychosocial risks and hazards](#). Men have more occupational accidents than women and are more exposed to noise, vibration, extreme temperatures, chemicals or the long-term impact of heavy lifting and carrying. Women, however, are more exposed to highly repetitive

and monotonous work, poor postures, and increased stress and sexual harassment and violence. Those working in cash crop production, in particular, are exposed to pesticides and toxic chemicals. More women than men report musculoskeletal problems, repetitive strain injury, work-related fatigue, adverse reproductive health outcomes, infections and mental health problems.

There is also a gender division of labour within the household, with women and girls expected to shoulder most domestic and care work, [leaving them little or no time](#) for other activities. Indeed, [data from 83 countries](#) show that women spend 18% of their day on unpaid domestic and care work, compared to 7% for men, doing 2.6 times more unpaid domestic and care work than men. Women aged 25–44 who have young children allocate more time to their care than any other female age group. Similarly, [data from 33 countries](#) indicate that girls aged 7–14 do more household work than their male peers while also having to care for younger siblings.

In 2013, a [report](#) by the UN Special Rapporteur on extreme poverty and human rights to the UN General Assembly acknowledged unpaid care work as a major human rights issue. It stressed that women's unequal and heavy care responsibilities are a major barrier to gender equality and to women's enjoyment of rights, exacerbating inequalities and threatening their wellbeing, including their right to health.

Globally, when unpaid work is included, women work longer hours than men, and their burden increases with poverty and social exclusion: women and girls in poor households in all countries spend more time on unpaid care because of lack of resources, basic services, adequate infrastructure and time-saving technology. The report points out that there are limits to how much care a person can provide without harming her own health as domestic and care work can be stressful, difficult or even dangerous, exposing women and girls to diseases, violence, burns or injuries.

Women and girls are also responsible for collecting water and fuel for domestic use. These tasks demand a lot of time, undermining opportunities for women and girls in terms of education and income-generation and their chance to rest.

National survey data show that they are [responsible for water collection](#) in 80% of households without access to clean water on the premises, with women and girls in the poorest rural households travelling longer distances and spending more time to reach water sources. A study of [survey data in 24 sub-Saharan African countries](#) estimated that girls are more likely than boys to be responsible for water collection in households that spend more than 30 minutes each day on this task: 62% versus 38%. Similarly, they are more likely to gather fuel wood, with girls in households that rely on it for cooking spending [18 hours each week](#) on its collection.

Gathering water and fuel is also physically demanding. Women and girls often walk long distances with loads of wood, dung or other fuels that weigh 40 kg or more on their backs or heads. These tasks expose them to [a range of risks](#) such as spinal conditions and chronic headaches, injuries, animal attacks and violence.

Gender roles and expectations about what women and men can and should do in specific contexts can also contribute to gender morbidity and mortality in natural disasters. An [analysis of data](#) from 141 countries found that women and girls are more exposed to disaster risks and are more likely to suffer higher rates of morbidity and mortality than men and boys in disasters because of their reduced ability to save themselves. Gender norms restrict their movements,

An abbreviated online version of this guide can be found at <https://www.alignplatform.org/health-guide>

as well as their access to information and warnings, and their limited skills and coping strategies only increase their vulnerability to such catastrophic events. In Sri Lanka, for example, men were more likely to survive during the tsunami because they knew how to swim and climb trees.

The study stresses that the higher the women's socioeconomic status, the weaker the impact of disasters on the life expectancy gender gap. While women are more likely to die than men during natural disasters in places where they do not enjoy the same economic and social rights as men, disasters cause the same number of deaths among men and women where they enjoy equal rights.

1.3 Pathway 3: Gender norms and health systems

While exploring this third pathway, [Sen et al.](#) (2007) stressed that health systems do not only produce health care, but also reflect, convey and reinforce societal norms and values. [Health systems are not gender or power neutral](#): their main components, such as service delivery, human resources, health financing or governance, are affected by entrenched gender norms that often compromise their effectiveness.

[Health providers](#), for example, may reproduce gender stereotypes and provide different care for men and women who are suffering from the same health problem. They may discriminate against or even abuse those who do not adhere to gender norms or refuse male involvement in health programmes for women. Female health providers are also more likely to find it difficult to advance their careers.

Many health systems continue to neglect gender and the ways in which gender relations shape access to resources, roles and responsibilities and decision making. They fail to acknowledge the different health needs and problems of both women and men and, therefore, fail to provide the health services they require.

2. Non-communicable diseases and gender norms

A number of health traits that often emerge during adolescence have been identified as leading risk factors for non-communicable diseases (NCDs) in later life. They include low physical activity, overweight and obesity, air pollution, and the use of tobacco and alcohol. Public health experts tend to discuss these as individual behaviours that threaten health outcomes in adult life without always focusing on how they are shaped by gender norms.

2.1 Low physical activity

Regular physical activity has major health benefits, yet global data indicate that [81% of adolescents have lower than the minimum recommended levels of activity](#), with adolescent girls less active than boys. Worldwide, 84% of girls compared to 78% of boys were insufficiently active in 2010, and girls become less active as they grow older. Data from the 2013/2014 Health Behaviour in School-aged Children ([HBSC](#)) study show that physical activity decreases considerably among girls age 11 to 15 in most countries, with boys being far more active. While the relationship between gender norms and physical activity in adolescence needs further research, there is evidence that gender norms affect girls' engagement in physical activities in the following ways, with variations across contexts.

Norms about feminine and masculine bodies and attributes

A [scoping review](#) of literature on high-income settings concluded that the relationship of adolescent girls with physical activity is complex, is dominated by discussions of the female body and requires the negotiation of gender roles and stereotypes. Although girls report that they enjoy physical activity, given its many benefits (such as increased self-esteem, improved health and better social relations), they often find it difficult to reconcile being feminine with being athletic and doing activities usually associated with boys.

Girls may, therefore, be more likely to take part in physical activities such as dance and gymnastics than boys, who often prefer football or hockey. Girls may also be concerned that such physical activities could make them look less feminine and more aggressive or muscular to their peers or even appear to be [challenging heterosexual normative ideals](#), provoking criticism or rejection. Girls may also believe that some qualities promoted by physical activity, such as competitiveness and strength, are incompatible with traditional feminine ideals.

Another [global review](#) also noted that physical activities in schools are often dominated by sports that promote aggression and competitiveness. Traditional norms may be reinforced by teachers and peers through the exclusion of girls and the stigmatisation of boys who cannot conform to masculine stereotypes.

Norms about mobility and safety

In conservative contexts where the mobility of girls and young women is restricted and male guardians – parents or spouses – decide where they can go, they tend to stay indoors. As a result, they cannot engage in physical activity in public spaces as this could damage their own reputation and that of their family. Such restrictions in parts of South Asia and the Middle East and North Africa (MENA) discourage them from taking part in physical activity during their leisure time and promote a sedentary lifestyle.

In recent years, however, international bodies, governments and civil society have [supported girls' right to physical education](#). They have also implemented programmes in safe spaces that combine physical activity and sports with life-skills training to empower girls and tackle the norms that constrain their lives and undermine their wellbeing.

2.2 Overweight and obesity

In 2016, almost 340 million children and adolescents aged 5–19 years worldwide [were overweight or obese](#) – almost one in every five. While HICs still have the highest prevalence rates, obesity rates for this age group are increasing much faster in LMICs. Higher socioeconomic status has been identified as a risk factor for childhood and adolescent obesity in many countries, including [countries in the MENA region](#).

Gender norms and context appear to influence diverse dietary habits, from over-eating to extreme dieting. [Two studies](#) that combined comparable obesity prevalence data with indicators of gender inequality (such as the Global Gender Gap Index and the Gender Inequality Index) concluded that gender disparities in obesity prevalence are larger in countries with greater gender inequality.

Norms about feminine and masculine bodies and attributes

Globally, a [higher proportion of boys](#) are obese than girls. However, girls have a higher prevalence rate in Africa. In [South Africa](#), two-thirds of black girls perceived fatness as a sign of happiness and wealth and saw themselves as attractive. In [some Pacific islands](#), female thinness is associated with illness and infertility.

[Gender disparities in obesity](#) are also high in the MENA region, where some societies favour larger body sizes as a sign of fertility, good health or prosperity, while also constraining women's mobility and their participation in physical activity. A [study](#) on dietary habits and physical activity among adolescents aged 15–18 in seven countries in the region found significant gender differences on perceived barriers to physical activity. Girls were more likely than boys to report personal, social and environmental barriers, including lack of motivation, support from parents and teachers, access to spaces and cultural norms prompting them to do so – in all countries between 40% and 81% of girls identified cultural factors to be important or somewhat important barriers to physical activity compared with 7% and 37% of boys.

2.3 Tobacco use

Tobacco use is a major risk factor for NCDs, including breathing difficulties and asthma among youth and cancers among adults. In 2016, [more than 1.1 billion people](#) aged 15 years and older smoked tobacco. Globally, men and boys have a far higher prevalence of smoking than women and girls (34% of men compared to 6% of women).

Tobacco is often the first substance used by youth who start smoking in early adolescence. [WHO](#) estimates that there are 24.2 million smokers aged 13–15. [Globally](#), one in every five boys aged 13–15 years and one in every ten girls of the same age uses tobacco. Prevalence rates are highest in Europe and lowest in Africa and Asia, with significant variations within regions. Most importantly, [rates of young smokers](#) are declining in HICs, but are increasing in lower middle-income countries. In addition, 13 million adolescents aged 13–15, more boys than girls, use smokeless tobacco products, especially in South-East Asia and in lower middle-income countries.

Norms about masculine and feminine behaviours

In many contexts, [tobacco use](#) has been an integral part of social and ritual life and, because men are more likely to dominate such activities and smoke, it is seen as a male attribute. Smoking has often been perceived as [unfeminine and immodest](#) and women (with the exception of elderly women) are discouraged from smoking, at least in public. However, social constraints that prevent women smoking have weakened in HICs as their autonomy and economic independence have increased, leading to high rates of smoking among women and girls.

The [reasons for smoking vary by gender](#): its association with masculinity and sexual attractiveness may motivate adolescent boys and young men to smoke, together with peer pressure and exposure to tobacco marketing – all cited as factors that influence male tobacco use. Girls and young women, however, may equate smoking with empowerment, independence, freedom, modernity and fashion. In high-income settings, female smoking can also be linked to the belief that it reduces appetite and helps to control body weight to achieve the most desirable (slim) body image.

Research has been focusing on how the tobacco industry and its [aggressive marketing strategies](#) have manipulated gender norms to expand markets and target youth and women. Traditional norms that link smoking to manhood are used when young men are targeted, while smoking is marketed to female customers as a way for them to challenge the gender norms that constrain their lives. When the industry first targeted women in HICs in the 1920s, cigarettes were sold as ‘torches of freedom’, with female smokers portrayed as representing the modern woman.

In today’s LMICs, the tobacco industry is tapping into women’s increased autonomy, the expanding middle class and large young populations as a way into new markets. Women and girls in sub-Saharan Africa, for example, are deliberately targeted by tobacco marketing through the use of trend-setters who promote and normalise the image of the African woman smoker in an effort to tackle barriers and make female smoking more socially acceptable.

Studies have also pointed out that [adolescent girls and boys are vulnerable to tobacco marketing](#) through traditional media, such as smoking imagery in films, television and magazines. At the same time, health campaigns to tackle tobacco use may reproduce gender stereotypes about the emphasis women and girls place on beauty and physical appearance by highlighting how smoking ages the skin.

2.4 Alcohol use

Harmful use of alcohol is a major risk factor not only for NCDs, but also for many injuries, including those caused by road accidents and interpersonal violence, including intimate partner violence. It is also a risk factor for infectious diseases, including HIV and STIs.

In 2016, [harmful alcohol use](#) accounted for over 5% of all deaths worldwide. While there are regional and country variations, harmful drinking patterns are more prevalent in Europe and the Americas. Although alcohol-use disorders were more prevalent in HICs in 2016, the disease burden attributable to alcohol was highest in low-income countries (LICs) and lower-middle income countries. Mortality and disability linked to alcohol and substance abuse are higher for men than for women. It also appears that cultural and religious factors and social norms affect drinking patterns, as well as the physiological differences between men and women.

The use of alcohol usually starts in adolescence. Globally, about [one in four 13-15-year-olds](#) report having used alcohol during the last 12 months, with alcohol cited as the substance used most commonly by school students worldwide. [More than a quarter of all older adolescents](#) aged 15-19 are current drinkers, with the highest prevalence of alcohol abuse found among boys in Europe, the Americas and the Western Pacific regions. The 2013 Global Burden of Disease study found that alcohol use was the [leading global health-risk factor](#) associated with mortality among adolescent boys aged 15 to 19 years. Street children and adolescents are particularly vulnerable to alcohol and substance use.

Norms about masculine and feminine behaviours

[Social attitudes](#) towards the acceptability of drinking and drunkenness are clearly influenced by masculine and feminine ideals. Drinking is typically seen as a demonstration of masculinity and, therefore, more normal or permissible for boys and men. It is particularly linked to male willingness to take risks or the male perception that alcohol enhances sexual performance. It is also promoted as a social bonding activity, especially among boys and young men. Alcohol

consumption is also seen as a way to avoid responsibilities or deal with feelings of powerlessness and vulnerability.

Difficulties in achieving the masculine ideals prescribed by prevalent norms, especially in relation to the male breadwinner role, may prompt young men to drink heavily in settings characterised by economic hardship and limited opportunities. The [sharp drop in male life expectancy recorded in Russia](#) in the 1990s, for example, was linked partly to increased risky behaviours such as heavy alcohol consumption due to high unemployment, stress and weak support networks at a time of economic and political upheaval.

The [IMAGES survey](#) has found that younger men, men with lower education levels, those with work stress and men with inequitable attitudes to gender are more likely to report regular alcohol abuse. In the case of adolescents, attitudes towards traditional gender ideals have also been found to [mediate the relationship between gender and drinking](#). Here, the effects are stronger among adolescent boys, as they are particularly exposed to messages from multiple sources that link drinking to manhood.

A considerable body of literature, largely from HICs, highlights the role of [peer](#) and [parental influence](#) on drinking for adolescent boys and girls. Boys tend to be monitored less by their parents than girls, giving them more opportunities to engage in harmful alcohol consumption. In contrast, girls may be more likely to put pressure on their female friends not to drink.

Evidence from various settings shows that [drinking is often less acceptable for women](#), especially in public spaces, as it is traditionally seen as unfeminine, immoral or immodest. Young women who get drunk may be perceived as sexually available or promiscuous. However, women in many regions have been responsible for the production and distribution of alcoholic beverages at local level. Recent changes in female education, employment and economic independence, coupled with a shift in traditional norms and gender roles, have contributed to increased alcohol consumption among women and increasing convergence in male and female drinking patterns.

Research findings from LMICs suggest that there are [considerable differences between groups of female drinkers](#). Less educated and low-income women in rural and urban settings may resort to heavy consumption of easily available, poor-quality alcoholic drinks for temporary relief. Young female drinkers in urban areas with higher education and some economic independence who see drinking as acceptable may drink to facilitate socialisation, enhance positive experiences or ease tension. Even so, persistent norms about alcohol consumption mean that women who have alcohol-related problems find it more difficult than men to access health care and face more criticism and rejection from partners and society.

There is [evidence](#) that as is the case with the tobacco industry, alcohol manufacturers are explicitly targeting urban youth and women in LMICs. Using aggressive marketing techniques that build on shifting gender norms, they aim to attract new consumers.

2.5 Air pollution

Exposure to air pollution, whether outside or in the home, has adverse and life-long health effects, including respiratory infections, heart disease, stroke and cancer, with the heaviest disease burden recorded in LMICs. WHO estimates that ambient (outdoor) [air pollution caused 4.2 million premature deaths in 2016](#), with 91% of these deaths occurring in South-East Asia

and the Western Pacific. In addition, [nearly 4 million people die prematurely each year](#) from illnesses attributed to household air pollution, largely because they lack access to clean cooking fuels and technologies.

Norms about gender roles and exposure to risk

In many LMICs, [women and girls are the main providers and users of household energy services](#) as they are responsible for domestic tasks such as preparing meals, tending fires and keeping the home warm, while having to spend more time in and around the home than men. They often use polluting fuels and technologies such as wood, dung and charcoal, open stoves, kerosene lamps and other polluting devices to meet basic household needs on a daily basis.

Their higher exposure to such polluting fuels and technologies heightens their risk of associated diseases, and women and children [accounted for 60% of all premature deaths](#) attributed to household air pollution in 2012. This makes household air pollution the second most important health-risk factor for women and girls worldwide. This particular health risk correlates strongly with poverty, as it is [low-income and rural households](#) that depend on such fuel sources.

Data from Pakistan show that more than 99% of women and girls from the poorest rural households lack access to clean fuel, compared to only 1% of those from the wealthiest urban households. Similarly, in Colombia, 76% of indigenous women and girls in the poorest rural households lack access to clean cooking fuels.

3. Communicable and infectious diseases and gender norms

Tuberculosis (TB), malaria and the so-called neglected tropical diseases, including schistosomiasis, trachoma and lymphatic filariasis, continue to affect millions of women and men in LMICs. Communicable or infectious diseases are associated strongly with poverty, adding to the threats to the wellbeing of people who already face hardship and poor living conditions.

Norms about gender roles and exposure to infection

Gender norms that shape the division of labour within the household, as well as work and leisure patterns and sleeping arrangements, influence [exposure to infection](#) for both women and men. Boys and young men working in forestry, fields or mines at peak mosquito biting time are more exposed to malaria infection than women who are in the kitchen, protected from insect bites by the smoke from cooking fires. Men may also have an increased risk of exposure in settings where they sit outside at dusk or sleep outdoors. Women and girls who perform household chores before dawn may also be exposed to mosquitoes and the malaria parasite, while those living in conservative communities where they have to cover their bodies for modesty have a lower risk of exposure.

Girls' and women's responsibility for collecting water and washing clothes in rivers in several LMICs exposes them to [water-borne and water-related infectious and neglected tropical diseases](#) including schistosomiasis. Yet boys who play in infected rivers and canals often have a higher prevalence and intensity of schistosomiasis infection. Where the mobility of girls and

women is restricted, as in conservative Muslim countries, they are less exposed to water and, therefore, have lower rates of the infection.

Care responsibilities leave women and girls more vulnerable to [trachoma infection](#), with women being more exposed than men to persistent infection and having a risk of trachoma-related blindness that is two to four times higher than the risk for men. Young children pass the infectious agent to their mothers, while crowded living conditions, poor hygiene and smoke from cooking fires make eyes susceptible to infection.

Norms about feminine and masculine behaviours

Because women tend to be more risk-averse, and because they have to take care of children, they are more likely to use insecticide-treated nets (ITNs) than men. While most of the literature on malaria focuses on pregnant women because of their increased vulnerability, one [study in Nigeria](#) found that adolescent boys and young men aged 15–25 were the group least likely to use an ITN.

Men's increased risk-taking, including alcohol and tobacco use, increases their exposure to TB infection. They may also wish to conform to the masculine ideal of showing strength in the face of adversity, and delay seeking care for infection. In urban Malawi, many low-income young men heading households have tried hard to display the stoicism expected of them in public and have [delayed seeking care for TB](#) or used alcohol to manage their pain in private.

Norms about gender roles and access to healthcare

Women with household responsibilities – particularly those with young children – may prioritise these and delay seeking treatment for their own severe infections. Men, however, may delay because they are more concerned about the loss of household income. The need to provide for the family and live up to the expectations associated with being the head of household may prompt men to delay seeking care.

In a context of high unemployment and low incomes, [men in urban Malawi](#) delayed treatment for TB to continue bringing money home and avoid being seen as 'less than men'. Similarly, a [study in Kenya](#) on how gender undermined follow-up appointments in a large HIV treatment programme found that work commitments were the principal reason reported by men, while women reported that family commitments were the main reason for missing scheduled visits to the clinic.

Norms about decision-making over use of household resources and access to healthcare

The health problems of adolescent girls and young women may be seen as a lower priority than male health in various settings with scarce resources. This is also linked to their limited economic autonomy and the devaluing of their contribution to household income. [Two reviews](#) on the factors that affect the uptake of malaria interventions during pregnancy in sub-Saharan Africa have pointed out that pregnant women depend on their husbands to access malaria treatment because they often control household resources, including paying for transportation to the health facility. In some cases, husbands must give their consent for their wife's attendance at a clinic or for her medication.

Although [women are more likely to use ITNs than men](#), they may also be [less able to access them](#) as they have limited decision-making power or may lack the financial capacity to buy or

re-treat nets, leaving them dependent on men for this. It has also been suggested that a male head of household who is the primary breadwinner and controls resources may be given priority use of an ITN if there are not enough nets for every household member.

Norms about stigma

Studies have identified stigma and women's greater vulnerability to discrimination as shaping their access to health care for infectious diseases. Many adolescent girls in sub-Saharan Africa find it hard to access reproductive health services, but pregnant adolescent girls (who are particularly vulnerable to malaria infection and its effects) may face even greater [difficulties in accessing ante-natal care and malaria treatment](#) because of the shame associated with adolescent pregnancy and the negative attitudes of family, community and health providers.

While data indicate that men have higher TB prevalence and mortality rates than women, some studies have questioned this finding, given the under-reporting and under-treatment of women with TB – the result of stigma and fear of social discrimination, as well as of their more limited access to health care. From [Latin America](#) to [South and East Asia](#), in settings where TB is highly stigmatising, women with TB face rejection, divorce and abandonment or are unable to find a husband after their diagnosis.

As a result, women report delaying treatment, hiding their diagnosis and relying on self-medication or traditional healers and informal health providers to ensure anonymity and privacy. Fear of family rejection and social isolation, coupled with women's higher sensitivity to stigma surrounding TB, can lead to under-reporting of female TB cases.

4. Nutritional status and gender norms

An often-cited estimate suggests that women and girls account for around 60% of the world's chronically hungry people. [Data from more than 140 countries](#) in Africa, Asia and Latin America show that women have a higher prevalence of severe food insecurity. [Higher levels of gender inequality](#) are also associated with higher levels of both acute and chronic undernutrition.

There is an emphasis on adolescent girls in the literature, given high rates of early marriage in some regions and the association of thinness with adverse pregnancy outcomes for both mother and child. South Asia, for example, has the highest [prevalence of thinness among adolescents](#). National survey data indicate that 47% of Indian adolescent girls aged 15-19 are underweight, with a body mass index (BMI) of less than 18.5. In addition, data from 21 LMICs show that more than one third of girls of this age group are anaemic. The intersection of gender with wealth, location and ethnicity increases nutritional disadvantage: in [Pakistan](#) 40.6% of the poorest rural women aged 18-49 from the Sindhi ethnic group are undernourished (with a BMI below 18.5) compared to a national average of 13.3% and an average of 2.4% among women of that age group from the richest urban households of the Punjabi majority.

At the same time, obesity is a growing global concern. Undernutrition, obesity and micronutrient deficiencies co-exist in many LMICs, with poor access to healthy food contributing to malnutrition. [Data from 10 LMICs](#) show that between 20% and 37% of girls aged 15-19 are overweight. There is also a growing focus on adolescent nutrition because the

development of healthy eating habits at this time is a foundation for good health and a safeguard against obesity and related NCDs in adulthood.

While medical and public health literature pays little attention to the role of gender norms on the nutritional outcomes of adolescent girls and young women, some research on nutrition and food security includes relevant information especially in settings still characterised by undernutrition. Meanwhile, behavioural sciences are exploring the role of norms and peer pressure on adolescent obesity and overweight.

Norms about access to food

The role of gender norms in shaping food allocation within households has emerged as a key focus of research on nutrition and food security. Studies on South Asia, for example, indicate a clear [pro-male bias in food allocation](#) and nutritional outcomes that starts early in life. Indian girls, especially second-born girls, are [breastfed for shorter periods and have lower consumption of fresh milk](#) than boys, while their nutrition is also affected by caring practices that privilege boys.

Such discrimination continues into adolescence and youth, despite variations between and within countries and some evidence of gradual change in certain contexts. In areas with a strong son preference, this bias in favour of boys persists among wealthy households because of the higher costs associated with dowries for girls.

Although women play key roles in food production, selection and preparation, men make the decisions about food allocation in contexts with persistent gender inequality. This is linked to their greater social status and access to power and resources, as well as the perception that they contribute most to the household income and should, therefore, decide who eats when and what. More food is also allocated to those carrying out heavy physical work in which performance depends on nutritional input. Some evidence has suggested that the dowry a wife brings into a household can [increase her status](#), including access to better food.

In [some South Asian communities](#), the tradition that the male head of the household is served first and that women are served after men can undermine women's nutritional status, with female household members eating last, eating only what is left over and not having enough food. In some cases, the daughter-in-law is the last to be served. Where food is not served in equal portions and men and boys eat until they are satisfied, women and adolescent girls may be left with nothing to eat, even during pregnancy and lactation. Food quality is also an issue, as men may also have preferential access to special foods of higher prestige. These gender biases are exacerbated when resources are scarce, such as the lean season or during crises and natural disasters.

Gender discrimination in food allocation is also reported in other regions. In [Ethiopia](#), for example, adolescent girls aged 13–17 in households affected by food insecurity are more likely than boys to report being food insecure (a proxy indicator for insufficient food). The largest gender gaps are reported in households that are severely food insecure, where close to 40% of girls have reported food insecurity while their brothers have not. In addition, adolescent boys and young men have greater freedom of movement and can spend more time away from home and find food elsewhere. They may also receive small amounts of money from their parents to buy snacks, which is rarely the case for girls.

Norms about food preferences and restrictions

Many cultures associate [certain foods and eating habits](#) with masculinity and others with femininity. Meat (particularly red meat) is seen as the archetypical [masculine food](#), while dieting, eating lightly or eating healthier foods are often linked to feminine eating behaviours.

Adolescent girls and young women may also face food restrictions at certain phases of their life linked to their reproductive roles. In several settings they are expected to avoid consuming certain foods during menstruation, pregnancy or lactation, even though denying them some nutritious food (and even water) can lead to undernutrition or micronutrient deficiencies. In some [parts of rural Nepal](#), for example, menstruating women and girls are seen as impure and untouchable, are forbidden to touch food or enter the kitchen, and are even confined to animal sheds with little to eat. Similarly, Hindu mothers are confined after childbirth and must avoid sour, spicy and oily food, as well as almost all fruits and many vegetables.

Norms, body image and eating behaviours

Studies on [nutrition, gender norms and adolescent girls](#), often from high-income settings, tend to focus on their dieting habits or unhealthy weight-control behaviours, rather than on healthy nutrition. Evidence shows that adolescent girls may be more concerned than their male peers about their body image and how others see them. Their eating behaviours are, therefore, associated more with the achievement of a feminine bodily ideal – particularly a body size and shape that is acceptable and desirable – than with their health.

Many studies emphasise that [adolescent girls face considerable societal pressures](#), tend to be preoccupied with their weight and report greater body dissatisfaction than boys. This belief intensifies as they move from early to older adolescence. For example, in every country and region covered by the 2013/14 [HBSC survey](#), girls reported being too fat: 43% of 15-year-old girls admitted being dissatisfied with their body appearance – nearly double the rate for boys – and 26% reported being on a diet although only 13% were overweight. A large proportion are trying to lose weight and risk developing eating disorders as dietary habits and perceptions about ‘ideal’ bodies change. Body image issues and eating disorders are also having an increasing impact on adolescent boys, who face their own pressures from family, peers and the mass media to look a certain way.

Peer pressure, exposure to media and context all shape feminine and masculine body ideals and eating habits. In several cases, the distorted body image perceived by the individual does not reflect their actual body weight and can lead to unhealthy diets and disorders. Exposure to media has a particularly strong association with problems around body image. A study of [young university students in Pakistan](#) found that those who had a high exposure to media had higher (and statistically significant) rates of dissatisfaction with their bodies than students with lower media exposure.

Another study of [high school students in urban Thailand](#) pointed out that the use of the Internet and social networks in relation to body image and eating behaviours had a positive correlation with the risks of eating disorders, bingeing, purging, and the use of laxatives and weight-loss drugs. A review of evidence on the [links between body image, eating disorders and Internet use](#) has noted frequent cyberbullying related to appearance among adolescents using social media platforms, with the greatest prevalence among girls, resulting in low self- and body-esteem.

5. Physical integrity and gender norms

Physical integrity includes issues of violence, body modification and unintentional injuries that affect adolescents and youth, in particular, in LMICs. The role of harmful and restrictive gender norms in increasing vulnerability to these issues has been identified consistently in policy, research and programming. The [Global Accelerated Action for the Health of Adolescents](#) (AA-HA!), for example, refers explicitly to gender and social norms that need to change to prevent and respond to all forms of violence against adolescents, or to prevent and mitigate road traffic injuries. Similarly, more studies and interventions are analysing different types of norms that are implicated in the perpetration of gender-based violence (GBV).

5.1 Violence

Defined by [WHO](#) as the intentional use of physical force or power against another person with a high likelihood of injury, death, psychological harm, mal-development or deprivation, violence in all its forms affects the lives of millions of young women and men worldwide, with long-lasting health and social consequences. While boys and men are affected by violence, girls and women account for the vast majority of survivors and victims.

Given its extent, violence against women has received the most attention, with intimate partner violence being the form of violence surveyed most extensively, followed by sexual and youth violence. Experts agree that violence has strong links to [social and gender norms](#) and [unequal gender relations](#): violence against women and homophobic violence, for example, are clear manifestations of power. They are rooted in hierarchical and unequal social relationships that subordinate women (and those men who do not conform to dominant gender norms) to men and are used to maintain gender inequality while reaffirming men's privileged status. There is, therefore, agreement that strategies to tackle violence should promote gender quality and explicitly include [efforts to change harmful norms](#) that support the use of violence.

Intimate partner violence

Global estimates indicate that nearly [one in three women aged 15 and over](#) has experienced physical and/or sexual violence by a male intimate partner at some point in her lifetime. Nearly 37% of women in Africa, the Eastern Mediterranean and South-East Asia report having experienced intimate partner violence (IPV) with prevalence rates higher in LMICs. The two [global studies](#) on men and violence reported IPV perpetration rates ranging from 25% to 40% or even 80% in some cases.

Such violence starts early: an estimated 29.4% of girls aged 15–19 and 31.6% of women aged 20–24 years have experienced [physical and/or sexual IPV](#). [Some evidence](#) actually [suggests](#) that the younger the woman, the higher the risk of IPV, with girls who marry early at particular risk. The context matters, with studies identifying particular gender norms that contribute to IPV, while lower prevalence is also associated with having a [higher proportion of women in the formal work force](#).

Norms about male authority and the subordination of women

In many contexts, girls and women are seen as the property of men: to be controlled and submit to male power without challenging it. The [IMAGES survey](#) found that men who adhere to rigid norms of masculinity (agreeing that 'men need sex more than women', or that 'men should dominate women') are more likely to report use of violence against a female partner. Likewise,

An abbreviated online version of this guide can be found at <https://www.alignplatform.org/health-guide>

a study of [survey data from 44 countries](#) found that living in countries or regions where there is widespread acceptance of male authority over female behaviour has significant associations with IPV.

Qualitative [research in South Asia](#) has also confirmed that both men and women accept and justify such violence as necessary to teach women obedience, control them or force them to adhere to acceptable gender behaviours. Analysis of data from [global population-based household surveys](#) has found that men with multiple sexual relationships are also more likely to resort to IPV.

Norms that justify male violence against women

Three [studies](#) that [analysed](#) population survey [data](#) concluded that attitudes supporting wife beating increase the risk of IPV. Not only is [male agreement](#) with wife beating a strong predictor of IPV, but women who [support wife beating](#) are at greater risk of IPV themselves.

Research stresses that there are many settings where the use of violence to settle tensions or resolve disputes is seen as acceptable and normalised. However, men are more likely to condone and perpetrate violence against women if they [witnessed](#) inter-parental violence and [experienced violence](#) themselves in childhood, while women who have witnessed their fathers beating their mothers are far more likely to [experience IPV](#) in most settings.

Norms about the use of violence to punish 'transgression'

Although what constitutes acceptable behaviour for women and men varies by context, studies note that the use of violence is seen as particularly [justifiable when women and men transgress gender norms](#) that regulate their sexual behaviour. For example, 'bad girls' 'easy girls' or 'sluts' are at greater risk of violence and may be seen as 'deserving' it for defying norms of female respectability. This could include engaging in 'immoral' actions such as premarital sex in contexts where sex is associated solely with marriage or exposing parts of their body to the male gaze. Such norms can also include norms about family honour, with male family members responsible for monitoring female behaviour and intervening with violence when young women act in ways that could damage the family's reputation.

Norms about male toughness and aggression

Evidence from the [IMAGES study](#) suggests that men who carry firearms, and who are involved in other violent acts or criminal behaviour, are more likely to report having used IPV. Similarly, [analysis of population survey data](#) has also found that men who often resort to violence and fight other men are more likely to abuse their partners than those who avoid fighting in general. Here, men adhere to masculinity ideals linked to aggression and the use of violence to demonstrate and reaffirm their manhood.

Norms about gender roles

Men who are cannot live up to the [traditional gender role of the provider and protector](#) of the family and who feel that their identity is at stake may resort to violence to reaffirm their damaged masculinity and retain their control over the women in their household. The [IMAGES survey](#) found that men in some contexts who experienced work-related stress were more likely to report using violence against their intimate partners. In most countries covered by the

survey, there was a clear association between men reporting economic stress and higher rates of IPV.

Sexual violence

Sexual violence includes violence perpetrated by either an intimate partner or a non-partner, although it appears that sexual violence by an intimate partner is more [common](#). Global estimates indicate that [18% of girls and 8% of boys have experienced sexual abuse](#). Worldwide, [over 7% of women](#) report having experienced sexual violence by a non-intimate partner.

In the [UN multi-country study](#) on men and violence in Asia and the Pacific, between 10% and 62% of all men interviewed reported perpetrating some form of rape against a girl or a woman in their lifetime, with half of men reporting doing so for the first time when they were adolescents. Between 2% and 8% of men also reported having perpetrated rape against another man. Most men who raped another man had also raped a female non-partner, and the greatest overlap in reporting was seen in male rape and the gang rape of women.

Sexual violence intensifies during conflict. A [systematic review](#) has estimated that nearly one in five refugee or displaced women in humanitarian settings reported some form of sexual violence. Given the sensitivity of such information and how difficult it is to disclose, this is very likely to be an underestimate of the true extent of the problem. As well as sexual violence by armed combatants, women and girls are also at [high risk of sexual violence](#) at the hands of their intimate partners and other civilians.

Boys and young men are also vulnerable to sexual violence during conflict. For example, [sexual violence against men](#) was reported in 25 countries affected by conflict between 1998 and 2008. A [UNHCR study](#) found that Syrian refugee adolescent boys and men are vulnerable to sexual abuse both in Syria and in host countries.

Norms about heterosexual performance and sexual dominance

Studies find that sexual violence is often associated with the performance of [aggressive masculinity](#): an extreme demonstration of heterosexual masculinity and sexual dominance over women or men who do not conform to prevalent norms about sexuality. Sexual violence can, therefore, be used as a tool to regulate the gender performance of women and men.

The [UN study on men and violence](#) argued that the perpetration of rape has strong associations with having multiple sexual partners, engaging in transactional sex, and participating in violence and fighting between men with weapons. Similarly, findings from the [IMAGES study](#) show that men who engaged in transactional sex, who had multiple sexual partners and who held inequitable attitudes towards gender were more likely to perpetrate rape. Having a score below average on the [Gender-Equitable Men \(GEM\) scale](#), which measures attitudes towards gender norms, increased the likelihood of men's reported sexual violence by as much as 3.5 times.

The [IMAGES study](#) also emphasised that men who were exposed to violent experiences in their childhood – whether having experienced physical or sexual violence or parental neglect or having witnessed violence against their mothers – tend to perpetrate sexual violence at higher rates than those who were not.

Considerable attention has also been paid to male peer groups such as gangs, which tend to be characterised by norms around the need to demonstrate heterosexual prowess. For example, [evidence from Southern Africa](#) shows that gang culture is characterised by dominant notions of masculinity, with new members having to undergo initiation rituals that can involve violence and the rape of women and girls. Members who fail to display such prowess can be [ridiculed](#), insulted or attacked.

Norms about the male 'right' to sex and the use of female bodies

In many settings, 'real men' are seen as those who appear unable to control their sex drive – a drive that they are also entitled to satisfy as they wish. Such norms coexist with norms that devalue and objectify women. [Norms about male sexual entitlement](#) exclude both the possibility of a woman rejecting a sexual advance and any notion that she has the right to make her own decisions about sexual intercourse and consent. A considerable body of evidence focuses on the role of media that objectify women's bodies and tolerate violence against them.

Norms about masculine behaviours and access to support services

Studies have also noted that dominant norms and expectations of masculinity have [negative consequences for boys and men](#) who experience sexual violence and abuse. Male survivors face great difficulties in accessing health care and support services, not only because they need to show strength but also because of the stigma linked to homophobia. In Kenya, only 46% of women and 36% of men who experienced sexual violence in childhood revealed the incident. In some cases, male vulnerability to sexual violence is seen as inconceivable and boys and men may have even less legal protection than girls and women, resulting in more limited access to relevant services.

Youth violence

Over 80% of deaths caused by youth violence occur among men. In particular, adolescent boys and young men aged 15-29 have the highest [homicide rate](#) of any age group – 18.2 per 100,000 compared to average rates of 10.8 for males and 3.2 for their female peers, with young women largely victims of IPV. Most youth homicide deaths occur in LMICs, and particularly in Latin America where youth violence is linked to the use of firearms in violent encounters and participation in street gangs, followed by West and Central Africa.

Norms around male toughness, aggression and dominance

Boys in many settings are taught that they must be strong, tough and aggressive. Indeed, data confirm that [boys are more vulnerable to physical abuse than girls](#) in childhood.

The use of violence as a legitimate way to resolve tensions can be promoted by the belief that parents and teachers should use physical violence to control children, with boys being more likely to be physically punished. Boys often learn that physical violence is normal and that violence against peers demonstrates masculinity and is a valid way to earn peer respect, with nearly one in two males across all countries reporting [involvement in physical fighting](#) compared to one in four females.

Military training also creates an environment that accepts violence, while [studies from Latin America](#) show that gangs confer higher status on members who are physically stronger and who conform to dominant and violent norms of masculinity.

In contrast, boys who display traits that challenge acceptable standards of gender presentation and sexual orientation are often bullied by their peers, facing greater sanctions than girls who often enjoy greater flexibility. A study with younger adolescents aged 11-13 years in urban poor sites in four countries found that [boys who challenged local gender stereotypes](#), because their appearance or behaviour were perceived feminine, faced insults and name-calling such as 'gay', 'sissy' or 'weirdo'.

Analysis of a large [national sample of American youth](#) aged 14-22 found that gay males and lesbians were more likely to report having been bullied than their heterosexual peers. Another study found that adolescent [boys who do not demonstrate standard masculinity traits](#) in terms of being muscular, tall, heterosexual and dominant are more likely to be targeted by their peers in school. Those who were short, overweight, had a disability, belonged to an ethnic minority, had a different religion or were perceived to be poor were also thought to be weak and became easy targets for other boys who wanted to demonstrate dominance and prove their manhood.

Norms around male risk-taking behaviours

In some settings, the possession of weapons (including firearms), is a symbol of masculinity and their use is normalised and tolerated as a way for men to settle their disputes. The [IMAGES study](#) found that gender attitudes are linked to criminal activity: men who adhere to more inequitable gender norms are more likely to have a firearm and to have engaged in fighting with a weapon. However, the most significant risk factor for men's participation in criminal activity is their socioeconomic status.

5.2 Body modification

Gender norms also influence body modification practices that change the appearance and shape of the body to make an individual more 'acceptable' or 'attractive'. These range from tattooing and skin lightening to muscle-toning and cosmetic surgery. Some practices are seen as voluntary, individual choices, while others are seen as a prerequisite for membership in a group and are imposed on the individual.

Female genital mutilation/cutting (FGM/C), for example, is a traditional practice embedded in broader cultural systems that is seen as essential for personhood and identity, even though it harms the health and wellbeing of girls. In contrast, [tattoos and body piercings](#) are popular among adolescents and youth, especially in HICs. This ancient art has been linked to rites of passage in various cultures worldwide, and has been linked to particular groups, as well as masculine and high-risk identities such as sailors, prisoners or members of motorcycle gangs. Since the 1990s tattooing and piercing have become part of popular consumer culture.

While public health experts focus on hygiene and health risks, sociological analyses argue that tattooing can be seen as a sign of control over one's body and as an expression of one's identity and beliefs. [Evidence](#) from Western contexts suggested that adolescents, in particular, use tattoos to assert their autonomy and challenge standard norms of appearance or demonstrate group membership.

Existing research, mostly in HICs, indicates that adolescents and youth are often concerned about their appearance and are vulnerable to social pressures about how they should look. It has identified the critical role of social norms that prompt youth to follow specific practices, and of gender inequality and related norms that force women in particular, but also men, to

undergo sometimes harmful practices that have serious consequences for their health and wellbeing.

Girls appear to be more vulnerable than boys to pressures from family, friends and mass media, tend to express greater dissatisfaction with their developing bodies and increased body fat, and are more likely to change them to bolster their self-esteem and gain social acceptance. Studies find that young adolescent boys and girls often [equate femininity with beauty and attractiveness](#), and that the physical appearance of girls is assessed constantly against established standards, with their peers playing an active role in the enforcement of such norms.

Norms about feminine bodies and behaviours

Adolescent girls and young women undergo various types of body modification practices, including tattooing, skin lightening, strict diets or surgical procedures. While they may sometimes be aiming to challenge established norms, in most cases the goal is to re-shape their bodies so that they align with the dominant gender expectations of how they should look.

While [tattoos](#) indicated membership of male sub-cultures in Western contexts in the past, some women, including upper-class women, also acquired tattoos. This challenged normative ideals about feminine beauty and was often socially rejected, with tattooed women seen as sexually promiscuous or of lower social status. Today, however, tattoos are normalised as part of youth popular culture worldwide. Women's tattoos have various [motivations](#) and [communicate](#) a range of personal and cultural messages from embellishing the body to reclaiming its control, and – depending on the designs – from conforming to gender stereotypes to challenging them.

Where darker skin is believed to be less attractive, women and girls may resort to using skin lightening creams and cosmetics. In [sub-Saharan Africa](#), the [Middle East](#) and [Asia](#), lighter skin tones are associated with beauty, higher self-esteem and social status and better opportunities for marriage and employment. However, many of these substances are toxic and result in serious health problems.

As well as following restrictive dietary regimes that can lead to eating disorders, young women increasingly go under the knife, having various types of cosmetic surgery to change body parts that they believe are inadequate, and that fail to conform to dominant ideals of feminine beauty. Breast enhancement, rhinoplasty, liposuction and genital surgery rates are on the rise, as is the number of adolescent girls modifying their bodies, as seen in [Brazil](#).

Studies note that body modification is sometimes presented as a form of agency and individual determination that can improve perceptions of the self. Yet Western [feminist scholarship's critique](#) of cosmetic surgery has stressed that patriarchy has always reduced women to their looks. They have been conceptualised as objects of the male gaze, constraining their agency and autonomy, and have been manipulated to conform to patriarchal beauty ideals.

Globalisation, consumer culture and mass media have made cosmetic surgery popular among women – and increasingly among men – in both high and low-income settings in recent years.

Norms about female modesty, family honour and subordination of women are embedded in traditional body modification practices and entrenched in broader cultural systems. They are maintained because communities see them as essential for group identity and beneficial for

girls, regardless of their harmful consequences for health and wellbeing. For example, [breast-ironing](#) is practised in West Africa and refers to pounding or massaging the developing breasts of girls with hot objects to suppress their growth and flatten them so that they do not attract male attention.

[Foot binding](#) was an ancient tradition practised on young girls in China for nearly a thousand years because a small foot was seen as vital for girls' marriageability and was associated with restricted mobility, sexual control and the subordination of women. Its abandonment in just one generation was achieved through education campaigns to show that the practice was not universal and to highlight the advantages of natural feet, and through the creation of societies whose members pledged to leave their daughters' feet unbound and refuse to let their sons marry girls with bound feet.

FGM/C is another traditional practice performed on female genitals for non-medical reasons with very harmful effects. While accurate data are unavailable, it is estimated that [at least 200 million girls and women have been cut in 30 countries](#), and that the practice continues in some migrant communities in Europe and North America. There are variations in the form of FGM/C used and the age at which girls are cut, with differences observed even within the same country.

FGM/C is widely perceived as a form of [violence against women and girls](#) and a violation of their rights. Yet its supporters argue that it is important for a woman's status, chastity and family honour, marriageability, beauty or even health. Research finds that its continuation may also be linked to ethnic identity, perceived religious obligation or adolescent rites of passage.

The causal factors vary by context: research in West Africa has found that FGM/C is not linked directly to marriageability but is [upheld by a peer convention](#) signalling to other women that a girl can be included in their social network, with the practice seen as central to personhood, social cohesion and cultural identity. One common thread is that the practice has a collective character and involves [social rewards](#) as well as punishments for those who do not conform to group requirements.

It is no coincidence that FGM/C is often referred to as a social norm and its abandonment has been linked to the adoption of a social-norms perspective. As the practice is embedded in context-specific systems of values and beliefs, current efforts for its elimination focus on [work with communities](#), including boys and men as well as traditional and faith leaders, to change attitudes and behaviours, alongside legislative change and targeted campaigns to raise awareness.

Norms about masculine bodies and behaviours

Although most research has focused on women, body modification issues are increasingly affecting men, who are no longer immune to pressures around their appearance. Young men are vulnerable to gender norms about masculine ideals linked to the body, and are increasingly undergoing cosmetic surgery, and using skin lightening and other beauty products or adopt exercise and dietary regimes to deal with body dissatisfaction. One study with a representative sample in [Mexico, UK and the US](#) found that nearly half of the young men surveyed admitted to being dissatisfied with the size of their muscles and said that their weight or body shape were the aspects of their physical appearance they would most like to change.

A lean, muscular body is often promoted by popular culture and mass media as the ideal body shape for men. Where masculinity is linked to muscularity, adolescent boys and young men exposed to normative male ideals may engage in [muscle-enhancing techniques](#), such as excessive exercise, or use muscle-enhancing substances such as anabolic steroids and other supplements to achieve the desired appearance. Such substances can expose youth to serious health risks.

A study on the [use of internet and social media](#) by secondary-school students in Bangkok, Thailand, to find content on body image found that girls purchased more beauty products, while more boys bought sporting equipment and muscle-strengthening or weight-gain products. Their media usage had a negative association with body satisfaction and a positive association with the drive for muscularity among boys. Similarly, a significant percentage of young Lebanese men exposed to overly muscular male models in media, including pornography, were more likely to believe that women prefer muscular men, and [used dietary supplements or steroids](#) to enhance their body image.

5.3 Unintentional injuries

Hundreds of thousands of adolescent and youth die from unintentional injuries every year, while those who survive often face serious health and social consequences. [Unintentional injuries](#) are a leading cause of death and disability for adolescents, especially those living in LMICs and in poor settings. There are five main types: road traffic injuries, drowning, burns, falls and poisonings. With the exception of burns, boys and young men are more vulnerable to unintentional injuries and suffer more frequent and more severe injuries than girls and young women.

Adolescent boys and young men are [at high risk](#) of suffering injuries from road traffic accidents in LMICs, especially where road safety is poorly developed. They are also twice as likely to drown as females. Nearly 60% of drowning deaths occur among under the age of 30 years, with drowning the third leading cause of death worldwide for children and early adolescents aged 5–14 years. Once again, over 90% of drowning deaths occur in LMICs.

Adolescents and youth in hazardous occupations are particularly vulnerable to falls, while older adolescents have a high prevalence of poisoning that may be linked to substance use such as unintentional drug overdoses or to participation in risks related to their work. In contrast, young women [have higher rates](#) of death from burns than men: in some cases they exceed those of men by up to 50%. The vast majority of burns occur in LMICs with almost two-thirds in Africa and South Asia. Gender norms about masculine and feminine behaviours and gender roles tend to shape adolescent and youth vulnerability to unintentional injuries.

Norms about masculine behaviours

Taking risks is typically seen as a masculine trait in many settings. Adolescent boys and young men, therefore, may engage in [behaviours that increase their risk of traffic injury](#) such as consuming large amounts of alcohol, driving at high speeds and engaging in illegal racing, especially as members of male groups, to demonstrate their masculinity. Research in [Mexico, the UK and the US](#) has demonstrated that young men conforming to traditional masculine norms are two to three times more likely to report having been in recent traffic accidents. Peer pressure can also have a negative effect, with some research signalling that young drivers experience higher peer pressure than older drivers to [commit traffic violations](#) such as

speeding, not using seat belts, or drinking and driving. Consuming alcohol and then trying to swim also increases the risk of drowning.

Norms about mobility and exposure to risk

Different rates of injuries between male and female youth in some settings are linked to norms about mobility. While norms may restrict female mobility, young men are encouraged to be more active, and spend more time outdoors as pedestrians, passengers, bicyclists, motorcyclists or car drivers. As a result, they are more likely to [experience traffic injuries](#).

Norms about gender roles and exposure to risk

Because older adolescent boys and young men in many settings are more engaged in income-generating activities and hazardous employment, they are more vulnerable to traffic accidents, drowning, falls and occupational injuries. Girls and young women, however, tend to spend a considerable amount of time in the kitchen, where they are [more exposed to fire and hot substances](#).

In low-income settings, female burns are often caused by the use of open-fire cooking or unsafe cook stoves and by flames that ignite loose female clothing. However, growing evidence from South Asia links higher incidence of burns among young women to self-directed or interpersonal violence. In [India, for example](#), burn-related injuries and deaths among young women could be caused by kitchen accidents related to use of kerosene and flammable garments, but also by domestic and intimate partner violence, or even suicide disguised as an accident. In some cases, burns could be linked to dowry-related violence.

6. Sexual and reproductive health and gender norms

Sexual and reproductive health is of critical importance for adolescent health and wellbeing and for a successful transition into adulthood. Data, however, paint an alarming picture: more than [18 million adolescent girls](#) give birth every year in LMICs. Complications in pregnancy and childbirth are a leading cause of female adolescent mortality.

[Twenty million girls](#) aged 15–19 in LMICs have an unmet need for modern contraception. [Nearly half](#) of pregnancies among this age group are unintended and some [3.9 million girls](#) have unsafe abortions. Girls are also highly vulnerable to STIs and [HIV](#): in 2017, they accounted for two thirds of all new HIV infections among adolescents. In sub-Saharan Africa they were three times more likely to be infected than boys, while boys accounted for most of the new infections among adolescents in East Asia and the Pacific, Latin America and the Middle East and North Africa.

A growing body of literature on adolescent sexual and reproductive health has identified some key problems, with limited access to sexual education, lack of youth-friendly services and traditional norms about sexuality and procreation identified consistently as [key barriers](#) that compromise the sexual and reproductive health of adolescents. These barriers operate at all levels from the individual to the health system, and affect both the supply of and demand for relevant services.

Adolescent sexuality and sexual activity outside marriage remain taboo issues in many countries. While adolescents have the right to access accurate information, make informed

choices and use quality services, [laws](#) may still be in place that require their parental consent and adolescent sexual and reproductive health may be a low policy priority. In addition, parents, teachers, faith leaders and health workers are often [uncomfortable about discussing such issues](#) or about supporting the access of youth to the information and services they need, assuming that talking about sex encourages it.

Adolescents themselves report their own [reluctance](#) to access services because of a lack of privacy and confidentiality, the judgemental attitudes of health providers, and fear of stigma and humiliation. As a result, adolescents often start to engage in sexual activity [without understanding the risks involved](#) and without any accurate knowledge about safe sex and the prevention of pregnancies and STIs. Those belonging to [sexual minorities](#) face increased difficulty, especially where laws criminalise same-sex sexual activity.

The role of gender norms in shaping sexual and reproductive health outcomes has long been recognised in research. There has been a focus on adolescent girls and young women who bear the brunt of inadequate policy and programming, particularly within contexts of persistent gender inequality that deny girls their legitimate right to understand and control their bodies and their life choices.

Norms about feminine behaviours

Studies confirm that the sexual activity of girls is particularly condemned in many LMICs where purity is a key characteristic of adolescent femininity, with girls expected to refrain from sexual activity until marriage. Norms about female purity can stop girls accessing information and learning about their bodies, puberty and sexuality. A review of [knowledge and experiences of puberty and menstruation](#) among young adolescent girls in LMICs found that they tend to have limited knowledge and poor understanding of menstruation, develop negative emotions about it and try to conceal it, citing a study from Jordan in which girls shared they belief that talking about menstruation is socially unacceptable.

Girls who appear to know too much, fail to keep boys at a distance, or act in a sexual way can [ruin their own reputation](#), be labelled as ‘bad girls’, and even face harassment and shaming. To avoid such risks, girls may have to cover up their changing bodies as soon as they reach puberty. Their movements may be constrained and their social interactions closely monitored by parents and brothers to maintain family honour. To ensure their purity, parents may marry them off at an early age without allowing them any say in that decision.

Married girls are often expected to start childbearing and they have limited decision-making power over their sexual activity within marriage or family planning. Husbands and partners (and in some cases, mothers-in-law) may dominate such decisions, with little involvement of the girls or women concerned.

Evidence shows that [communication with a partner](#) is important if a woman is to achieve her fertility preferences. Young women who have difficulty communicating with their husbands are less likely to use contraception or more likely to conceal its use. Male partners may also restrict contraceptive use and the fear of violence may leave women without much choice. Indeed, [data from 45 countries](#), mostly in sub-Saharan Africa, show that only 52% of women of reproductive age who are married or in a union make their own decisions about sexual relations, contraceptive use or health care. In contrast, [research in urban India](#) found a

significant and positive link between gender equitable attitudes among men and contraceptive use.

The paradox is that contraception may also be seen as the woman's responsibility, with unmarried girls engaging in sexual activity often left alone to deal with any unplanned pregnancy or with a STI. Where there is social disapproval of any premarital sex, girls may encounter [judgemental attitudes or mistreatment](#) from health providers and face social stigma for being immoral and dishonouring their families. Girls experience far greater sanctions about their sexual behaviour and report facing [stigma from health providers](#) more frequently than young men.

Fear, limited knowledge, lack of resources or services and discriminatory laws often prompt girls to resort to informal practitioners and dangerous practices to end a pregnancy or deal with a sexual problem. The relationship between pregnancy and access to safe abortion is also influenced by gender norms, with abortion being a highly stigmatising practice in many contexts. An [ALIGN-commissioned annotated bibliography](#) on safe abortion and norms provides key resources that explore various aspects of this topic and identifies existing evidence gaps.

Obedience and submission to male authority are two other features that are typical of traditional femininity with, once again, harmful implications for the sexual and reproductive health of adolescent girls and young women. Even when they are aware of the need for safe sex and the prevention of an unplanned pregnancy, they may be unable to protect themselves. Studies have shown that in settings characterised by unequal gender relations, [girls have limited ability to negotiate condom use](#) as they may be seen as unfaithful or promiscuous, or face partner violence and sexual coercion that increase their vulnerability to unwanted pregnancies, STIs and HIV.

Research in countries in sub-Saharan Africa with high HIV rates among young women has noted that unequal gender norms promoting male dominance limit women's ability to control their sexual relationships and ask men to use condoms. One study in [Botswana and Eswatini](#) found that women's greater adherence to unequal gender norms was associated with limited control over their own sexual health and their sexual activity with much older men.

The intersection of gender with age and poverty increases female vulnerability. Young women with much older partners and those who are economically dependent on men find it more difficult to negotiate safe sex practices. [Evidence from Southern Africa](#) shows that women with partners who are ten or more years older than them, those who are abused and those who are dependent on their partners are less likely to suggest condom use. Similarly, [survey data](#) from 24 countries in sub-Saharan Africa show that rates of condom use are very low during high-risk sex by women in the lowest wealth quintile and those who have no formal education.

Norms about masculine behaviours

While rigid gender norms have significant implications for the health and lives of adolescent girls, they also affect adolescent boys. Masculine norms about taking sexual risks, having many heterosexual partners, engaging in sexual intercourse as proof of manhood or avoiding health care, leave boys [vulnerable to sexual risks and infections](#), and contribute to [poor sexual and reproductive health outcomes](#).

With the onset of puberty, girls and boys often have to follow different rules about ‘acceptable’ engagement in intimate and sexual relationships. Known as the [sexual double standard](#), this set of norms expects girls to show modesty and maintain their purity, while boys are encouraged to engage in sexual activity to live up to masculine ideals and prove their sexual prowess.

According to [such ideals](#), sexual intercourse is an act of conquest and an affirmation of masculine power – and one that rejects intimacy and emotional bonding as feminine qualities. Boys are often [socialised](#) to the idea that the male sexual drive is biologically determined, uncontrollable and must be satisfied through the conquest and submission of girls, legitimising forced sexual intercourse. Norms that equate masculinity with risk-taking also prompt men to avoid safe sexual practices, including condom use. Research in [Ethiopia](#) has concluded that unmarried adolescent boys and young men with friends who have used condoms are more likely to use condoms themselves.

Boys often feel [pressured](#) to live up to masculine expectations endorsed by their male peers and display their virility to build their reputation and avoid ridicule, including homophobic comments. Traditional gender norms promote heterosexuality, leading to homophobia and stigmatisation of same-sex relations, and boys who do not align themselves with aggressive heterosexual norms face greater sanctions than girls with alternative sexual identities.

Similarly, communication with partners and joint decision-making are not considered appropriate for ‘real men’. Studies have shown that [greater adherence to inequitable gender norms](#) is associated with increased male-controlled sexual decision-making, perpetration of rape, unprotected sex and multiple sex partners for men.

Adolescent boys may also think that they should appear to know everything, even though they often have inadequate information about sexual health. Norms that promote male strength and self-reliance may discourage them from seeking information or help. As well as norms that disapprove of adolescent sexual activity and shape negative attitudes from health providers, gender norms may prompt boys to avoid or delay seeking medical assistance such as STI testing and treatment. Greater adherence to inequitable gender norms has been [linked to lower levels](#) of HIV testing and health-seeking.

7. Mental health and psychosocial wellbeing and gender norms

Adolescent mental health and psychosocial wellbeing are gaining greater recognition as public health concerns. [Mental health problems](#) account for 16% of the global burden of disease and injury among adolescents, with depression being the leading cause of illness and disability, and suicide one of the leading causes of death among older adolescents, in particular. Although adolescence is considered a relatively healthy period in the life-cycle, many common mental health disorders, such as depression and anxiety, start at this time and continue into adulthood, with serious consequences for an individual’s health and life. Experts note that [biological, emotional and cognitive processes interact with environmental factors](#) during this period and can lead to mental health problems.

[Gender differentials](#) that characterise adult populations emerge during adolescence. Although accurate data are scarce in many countries, girls are between 1.5 and 2 times more likely than boys to be diagnosed with depression. In general, they have a higher prevalence of depression

An abbreviated online version of this guide can be found at <https://www.alignplatform.org/health-guide>

and are more likely to have suicidal thoughts and engage in self-harm than boys. Yet boys die more frequently as a result of suicide, with a few country exceptions. [India](#) is one such exception, with suicide the leading cause of deaths among adolescent girls and young women, with married women accounting for the highest proportion in 2016.

[WHO](#) recognises that rigid gender norms, roles and responsibilities can increase vulnerability to mental health risks and have negative implications for the psychosocial wellbeing of women but also of men. In contexts characterised by gender inequality, young women often experience limited mobility, autonomy and decision-making power, are highly vulnerable to discrimination and violence, and are expected to submit to male authority. Men, meanwhile, are expected to take risks, repress their emotions and demonstrate toughness and independence.

Norms about feminine behaviours

Gender norms and expectations have serious implications for adolescent girls and young women. [Evidence from diverse settings across LMICs](#) shows that lack of control over their life and of parental support, weak peer and social relationships, and exposure to violence (particularly sexual abuse), lead to poor psychosocial wellbeing, as well as suicidal behaviour.

Indeed, [puberty increases girls' exposure](#) to factors that contribute to their mental health problems. Where norms emphasise female purity and related family honour, adolescent girls face significant restrictions and are vulnerable to early marriage. Studies have also examined the links between violence and mental health and have concluded that violence is a major contributor to mental health problems.

[One global study](#), for example, estimated that women who have experienced intimate partner violence are almost twice as likely to experience depression as those who have not. Evidence from contexts with high rates of gender-based violence and early marriage reinforce this finding. A [recent study in rural India](#) found high levels of psychological distress among young low-caste adolescent girls and identified its strong associations with sexual harassment and abuse, school dropout and early marriage, with one third of girls reporting that they had no hope for the future.

Similarly, [research in Ethiopia](#) found that girls who had ever been married, promised in marriage or had received marriage requests were far more likely to have had suicidal thoughts than those who had not been involved in any marriage process; indeed, the likelihood of suicide attempts among those with marriage requests were twice as high.

In contrast, positive family and peer relationships, staying in school and having some control over one's life in line with one's evolving capacities all serve as protective factors. An [ALIGN-commissioned piece](#) provides comprehensive information about how gender norms drive psychosocial distress among girls and identifies promising initiatives for its mitigation.

Norms about masculine behaviours

[Traditional masculine norms](#) require that men show resilience in the face of adversity, tolerate pain, manage negative emotions and refrain from seeking help. Any inability to abide by these norms is viewed as a sign of weakness that is equated with femininity. The popular saying 'boys don't cry' is a common expression of such norms, guiding boys to hide their fear or sadness and deal with such feelings alone. Evidence confirms that where masculine self-reliance is promoted, young men are often reluctant to seek psychological help and may resort to negative

An abbreviated online version of this guide can be found at <https://www.alignplatform.org/health-guide>

coping strategies such as social withdrawal and substance abuse to deal with their emotional pain.

A large body of literature shows that conformity to traditional norms contributes to poor mental health outcomes for men. A study with a representative sample of young men in [Mexico, the UK and the US](#) identified strong links between adherence to rigid masculine norms and mental health problems; in all three countries men who did what was expected of them were far more likely to report depressive symptoms, including suicidal thoughts, than peers who held more equitable gender attitudes. Not only can conformity to traditional norms contribute to distress, but it also inhibits men's access to services and treatment: a systematic [review](#) noted that this conformity affects their ability to recognise and communicate symptoms of depression, their intention to seek help, the way in which they seek help and the effectiveness of any treatment.

Norms, sexuality and psychosocial wellbeing

Adolescents and youth whose sexual orientation does not conform to traditional gender norms often face [increased stigma and discrimination](#), gender-based violence and exclusion. Studies also report an [increased risk of mental health problems](#), including anxiety, depression and substance use. Evidence from LMICs is limited, but a [study in Viet Nam](#) found that over 70% of LGBT students experienced physical and verbal abuse in school, with almost a quarter reporting suicidal thoughts and 15% having attempted self-harm or suicide.

8. Health systems and gender norms

Health systems, including their workforces, institutions and resources, are expected to provide quality services to all people in a timely and efficient way. However, as part of the wider context in which they operate, [health systems are not gender neutral](#). On the contrary, they [reflect and reproduce](#) established gender norms, thereby contributing to gender inequities in health and in society at large. There are two main pathways through which this shapes health outcomes for young women and men: the first relates to service delivery and provider-patient interactions; and the second to the involvement of men and women in health care provision – both formal and informal.

Norms and health service delivery

[Health systems](#) often overlook gendered power relations that shape gender differentials in health needs and outcomes and, as a result, they fail to plan and provide appropriate services. [Gender norms](#) can influence whether health systems and their providers recognise a condition as a health problem and provide the appropriate treatment. For example, chronic pain or depression among women is often normalised, and domestic violence is not always considered an issue that demands a health response.

Health providers and systems may also [discourage](#) the active involvement of men in maternal and child care. An [analysis of demographic and health survey \(DHS\)](#) data from 36 countries found that men's presence at prenatal care visits reached or exceeded 60% in only six of them. Even when men want to support and accompany their partners, they may be discouraged to do so as childbirth is still considered '[women's business](#)' in some contexts.

Health systems may also pay [insufficient attention to gender gaps](#) in access to services and, as a result, fail to make appropriate provisions. They may not recognise, for example, that the ability of low-income women to access care is compromised by their limited financial resources, weak decision-making power or heavy domestic workload. Health systems may also overlook the critical role of gender norms in shaping women's mobility and social interactions and fail to plan accordingly. In settings characterised by conservative norms and gender segregation, lack of female health providers becomes a barrier for girls and women's access to health services, as any interaction with men, let alone physical contact or the examination of private parts, violates what is deemed acceptable and harms female reputation and family honour.

The gendered attitudes and behaviours of health providers in their interactions with patients also shape patients' access to, and use of, health care. Where female sexuality is only acceptable within marriage, the judgemental attitudes of health workers can discourage unmarried girls and women from accessing sexual and reproductive health services.

Studies from various settings point out that in adolescents, in particular, are afraid of [providers' attitudes towards premarital sexual activity](#), while health workers also find it difficult to provide information and services to them. Such attitudes compromise efforts to prevent or deal with STIs or unwanted pregnancies, prompting girls to resort to informal providers and unsafe practices that contribute to obstetric complications and maternal mortality.

Fear of (or actual) mistreatment during childbirth makes women reluctant to access professional care. A [systematic review](#) found that physical and verbal abuse of women by health providers was reported across all regions, together with stigma and lack of privacy and confidentiality. Women from different ethnic backgrounds, unmarried girls and women, and poor women often report greater stigma and discrimination. [Single mothers](#) seeking maternal services in public health facilities, in particular, can face stigma and abusive treatment.

Disrespectful comments, discriminatory attitudes and even denial of treatment are accentuated in the case of groups who transgress gender norms and face increased vulnerability, such as [sexual minorities](#). Negative experiences in service provision may deter them from seeking care in health facilities: in [Argentina](#), 67% of young transgender women reported having faced discrimination from health workers and 32% by other patients, with those who have had negative experiences being three times more likely to avoid using health services than those without such experiences.

Norms and the health workforce

Gender norms do not only shape the attitudes and behaviours of health providers and their interactions with service users: they also shape the structure and hierarchies of the health workforce and compromise the development of effective and equitable health systems.

Gender norms and stereotypes about what women and men can do influence their participation in the health workforce. In essence, [they may not have equal chances](#) of entering a health profession, acquiring the necessary skills, getting a job, and enjoying equal payment, training and progression opportunities because gender norms shape their education, employment and professional experiences.

Women account for [the majority of the global health workforce](#), which is nevertheless characterised by horizontal and vertical occupational segregation. In many settings, they comprise the majority of nurses, community health workers and midwives, while men dominate jobs seen as requiring 'higher' skills in health delivery and management positions. [Nursing](#), for example, has been linked traditionally to the maternal instinct of caring and has, therefore, been considered less of a specialised profession but rather a 'natural' feminine characteristic. Analysis of [data from Kenya](#) identified differences among female and male students, with nursing, nutrition and community health work being seen as 'women's work' and jobs in pharmacies seen as considered 'men's work'.

The number of men studying nursing is, however, increasing, challenging the norms that associate women with caregiving roles and that label those doing 'women's work' as less masculine. In addition, [women's participation](#) in medical schools is increasing, although they are often less likely than men to practise medicine once they are trained and more likely to practise medicine, gynaecology or paediatrics than surgery or other well-paid specialties. In [Rwanda](#), 47% of male junior medical students reported surgery as their first speciality preference, compared to just 20% of their female counterparts.

As well as affecting education and employment patterns, gender norms also influence [the work experiences and opportunities](#) of health workers, including the pay and benefits they receive and that are necessary to ensure a competent and productive health workforce for the delivery of quality care. [Evidence from health facility surveys](#) in six LMICs shows that women nurses and midwives are far less likely than their male counterparts to have accessed training.

In addition, women often receive lower wages – a [global review of data](#) from 20 countries found that one additional percentage point in the rate of women in one health occupational group is associated with an 8% decrease in its wage rank on a scale from 16 to 1, a clear indication of women's skills and occupations being de-valued as 'female'. Women health workers are also more vulnerable to [workplace violence](#) and abuse: in [Rwanda](#) they accounted for three quarters of the health workers who reported being sexually harassed at work. Family responsibilities and related norms also hinder women's ability to access training or advance their health careers, with women over-represented in general practice and other medical occupations that allow for more flexible arrangements.

Women also comprise the vast [majority of unpaid care workers](#) for family members with chronic medical conditions or disabilities. Such work can be physically and emotionally demanding, with a negative impact on caregivers' physical and mental wellbeing, while also limiting the opportunities of women and girls for education and employment. Despite their crucial contributions as they cover the gaps left by formal health care, their caregiving work is often undervalued and taken for granted as part of their domestic responsibilities. Yet [estimates](#) indicate that the average annual value of women's unpaid contributions to health accounts for between 2.27% and 2.43% of global GDP.

9. Interventions to address gender norms and health

This section was researched and written by Adam Almeida (December 2019)

This section presents promising interventions and policies which address the impacts of gender discriminatory norms in four key areas: nutrition, sexual and reproductive health, health systems, and communicable diseases.

9.1 Gender norms and sexual and reproductive health

There is widespread recognition of the importance of gender norms and their application to the field of sexual and reproductive health (SRH), as rigid and traditional gender roles often dictate the terms in which intimate relations, sexual activity and reproduction take place. These norms, which are ubiquitous both globally and across many cultures, place pressure on the individual to conform to pre-conceived expectations of how they should act, behave and interact [according to their gender](#).

Women and girls are conditioned to prioritise purity and modesty in sexual and romantic relationships, while men and boys are encouraged to take more risks and to employ control over their partners. Transgender and gender non-conforming people are often pressured to associate themselves with one particular gender to access appropriate sexual health services and could face punishment if they are unable or unwilling to do so.

An emerging body of research on the effects of gender norm-transformative programmes on health outcomes is [available in the literature](#). In relation to the SRH field, interventions that challenge masculine gender norms are [most often focussed on gender-based violence prevention and HIV](#). These interventions are most effective in [small-group participatory settings which encourage critical reflection of unequal gender norms](#). Furthermore, culturally-held norms about women's reproduction have contributed significantly to an [unmet need among women for family planning services](#). A [lack of discussion within couples and limited male involvement are](#) evident across studies in low- and middle-income countries (LMICs).

Meaningful and sustained gender norm change requires interventions that do not only target individual boys, but also [incorporate entire communities through a sociological approach](#).

The focus of the work to date has been on the impact of [gender norm change on men and boys](#) to achieve positive health outcomes for themselves, their female partners and their families. One key explanation for this is that programmes are often situated within their patriarchal contexts, where women [may experience domestic violence or poor health if they take on new norms in an inequitable and unchanged environment](#). As a result, the potential for gender norm change in women lags behind that of men and interventions depend, ultimately, on transformation taking place first in men.

Programmes that target men and adolescent boys most often involved [group educational activities \(38%\)](#), followed by [service-based programmes \(14%\)](#), [community outreach \(12%\)](#) or an [integration of different intervention types \(36%\)](#). Most small focus-group activities involved the use of male facilitators, as this has been shown to be more influential in creating relatability among male participants. Service-based programmes include counselling and usually take place in the context of family planning. Typically, these sessions involve fathers of new-born or small children in one-on-one counselling or with their female partner.

An abbreviated online version of this guide can be found at <https://www.alignplatform.org/health-guide>

A review by Svanemyr et al. (2015) determined that adolescent boys are instrumental in gender-norm change programming, because [attitudes and behaviours are malleable and are more susceptible to influence at a younger age](#). They also confirmed that conformity with traditional masculinity norms is closely correlated to riskier sexual and health decision-making, the perpetuation of violence and unequal decision-making with women and girls.

Gender-norm change programmes are implemented most commonly in North America, followed by Latin America and the Caribbean, sub-Saharan Africa and Asia. Interventions are most often designed to target men and boys with the aim of improving the health outcomes and autonomy of women, who are assumed to be their sexual and romantic partners. However, this assumption enforces the idea of heteronormativity: that adherence to masculinity in men and boys is understood as only harmful to women and girls as partners, and not to partners who are other men and boys.

Adherence to strict and traditional gender norms is often measured through the use of gender scales, especially the [Gender Equity Men scale \(GEM scale\)](#). Researchers either use Barker's original scale or use data from the field site to adapt the questionnaire to ensure that it is contextually- and culturally-specific. Researchers will also follow up their intervention with diagnostic testing for the health marker of interest (such as testing for HIV or other sexually transmitted infection (STIs), or testing for pregnancy) or a test of behavioural patterns (such as number of sexual partners, number of abusive episodes against romantic or sexual partner).

The research has consistently found that [equitable gender norm attitudes can form in a short timeframe, but that they do not necessarily translate into changed behaviours](#). This means that many factors that could be employed to achieve more positive health outcomes, such as longer intervention periods, more experienced focus-group leaders and the greater involvement of women to achieve a more significant cultural shift.

Men and adolescent boys, and their association to masculine gender norms, are determined to be [harmful to the health status of themselves and to women and girls](#). Men and adolescent boys who hold more gender inequitable views are more likely to engage in risky sexual behaviours, leading to unprotected sex and higher STI rates for themselves and their sexual partners. There is a clear need to address the potential impact of gender norm transformation on women and girls and their association to feminine gender norms for potentially beneficial health outcomes.

There are many avenues of study for investigators interested in the field of gender-norm change and its relation to sexual and reproductive health. The following section outlines programmes that present good examples of gender-norm transformation. They suggest that interventions that include community-based organising and target the wider social environment were more successful at maintaining change in attitudes and behaviours overtime. However, studies tend to assess only the change in gender equity norms and not its latter impact on health outcomes.

[Promoting Healthy Relationships and HIV/STI Prevention for Young Men: Positive Findings from an Intervention Study in Brazil](#) – Pulerwitz, J. and Barker, G. (2004)

Health interventions that seek to curtail the rise of sexually transmitted infections (STIs) in young people have increasingly targeted young men through their programmes. Because traditional gender norms surrounding masculinity emphasise the man as the primary decision-

maker in sexual relationships, researchers have used young men as a point of intervention to challenge and re-shape norms as more gender-equitable and gender-aware. Pulerwitz and Barker (2004) studied the relationship between support for gender-inequitable norms and risky sexual behaviours and the early onset of sexual activity. They hypothesised that interventions that promoted gender equity would reduce both STI symptomology and the likelihood of HIV infection.

The study took place in three sites in Rio de Janeiro, Brazil, and used a quasi-experimental design with 780 men and boys aged 14 to 25 exposed to two different intervention types: group-based educational sessions led by adult male facilitators; and group-based educational sessions coupled with a community-wide social marketing campaign that promoted condom use and gender-equitable messaging.

The study determined that young men who supported inequitable gender norms were more likely to indicate STI symptomology, lack of contraceptive use, and engage in violence with their primary or recent sexual partner. In both intervention types, symptomology decreased six months after intervention, but the decrease was statistically significant where both group education and community social marketing took place. In addition, condom use at last sex with a primary partner increased significantly. The researchers found that improvements in sexual health activity were maintained in intervention groups, even a full year after the programme.

CHARM, a gender equity and family planning intervention for men and couples in rural India: protocol for the cluster randomized controlled trial evaluation - Yore, J., Dasgupta, A., Ghule M. et al. (2016)

and

Can a Gender Equity and Family Planning Intervention for Men change men's gender ideology? Results from the CHARM cluster randomized controlled trial in rural India - Fleming, P.J., Silverman, J., Ghule, M. et al. (2018)

Men act as the key decision-makers in their wife's family planning processes in many settings worldwide. In India, women experience a large unmet need for reproductive health services as 1 in 4 pregnancies are unintended, with two-thirds of these found to occur among women who report no modern contraceptive use. Longer spacing between consecutive births has been shown to improve maternal and neonatal health outcomes. However, Yore et al. (2016) identified a lack of research on birth-spacing interventions that accounted for these gendered dynamics.

The researchers developed, implemented and studied a family planning service that exposed married men to gender-equitable messaging in three sessions with village health providers (VHP). The programme, 'Counselling Husbands to Achieve Reproductive Health and Marital Equity' (CHARM), was developed through in-depth interviews with married women, men and mothers-in-law to capture the gender norms, behaviours and hierarchies that are present in families when family planning decisions are being made. The CHARM curriculum relied on the standard national public health family planning counselling guide, as well as formative research that emerged during interviews.

The first two sessions were attended by married men and were most often facilitated by a male VHP, in a one-on-one context. The men's wives were invited to attend the third and final session. The men, and later couples, were counselled on the importance of healthy and shared family planning decision-making with pictorial information made available.

The study of this intervention utilised a cluster randomised control trial, with half of the couples assigned to a control group. Survey data were taken at baseline, 9 months post-intervention, and 18 months post-intervention. The results showed that male participants improved their attitudes towards gender-equitable norms significantly between baseline and the 9-month mark, based on their GEM scale scores. The study also found that the CHARM programme had a significant effect on men's attitudes towards household decision-making but had no effect on their gender ideology. The improved views on gender-equity, however, were not sustained over time and plateaued at the 18-month mark.

Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Grey Literature - *Hindin M.J., Kalamar, A.M., Thompson, T.A., Upadhyay, U.D. (2016)*

Adolescent girls seeking to diminish the likelihood of an unwanted pregnancy face multiple obstacles as a result of gender norms. Girls in low- and middle-income countries (LMICs) are affected disproportionately by unintended pregnancy, lacking access to health services, knowledge and prevention measures. Gender norms dictate that adolescent girls are not supposed to engage in premarital sex in these contexts, as they will be perceived as dishonourable and immoral. One way to combat these rigid gender norms is to addressing their particular health, as targeted interventions respond to an unmet need that is meant to be invisible in society and validate the view that it is acceptable for adolescent girls to engage in safe sexual practices.

Hindin et al. (2016) undertook a systematic review of scientific databases, as well as reports, government documents and working papers, to determine which interventions in LMICs have had the greatest success in decreasing early pregnancy and increasing contraceptive use. They identified a number of evaluated interventions that targeted girls or boys and girls aged 10 to 26 in sub-Saharan Africa, Asia, Latin America and the Caribbean. These were community-, school-, household- and facility-based interventions that used different modalities, including cash transfers, life-skills training, education curricula changes, contraceptive service provision and mass media campaigns.

Of the 16 papers focussing on pregnancy, 9 papers revealed that such interventions had a statistically significant impact on adolescent pregnancy rates. Six programmes showed significant impact on decreasing pregnancy, two showed mixed results and one showed a significant negative impact (demonstrating increasing pregnancy rates).

The interventions with the greatest impact involved cash-transfer components: the first, [Oportunidades](#), took place in Mexico and provided community-wide, conditional cash transfers to girls under 21 years of age who attended school and received sexual and reproductive health education and services. The second programme, a [South African social protection programme](#), was a household-targeted, unconditional cash transfer to boys and girls under 21 years of age living in poverty.

Of the 10 papers focussing on contraceptive use, seven found that interventions showed a statistically significant increase in contraceptive use, one had mixed results and the final two showed significant decrease in contraceptive use. The three most significant interventions included free contraceptive provision and educational materials for boys and girls in China, the provision of contraceptive implants for girls seeking treatment in Kenya and life skills and vocational training for girls in Uganda.

These interventions, which aimed to prevent early pregnancy and increase contraceptive use, demonstrate that there is no one 'silver bullet' to mitigate adolescent pregnancy. However, each intervention contained at least one component that challenged gender norms. For example, cash-transfer programmes and life skills or vocational training elevate girls' status in society and allow them the resources to be more financially self-sufficient and seek sexual and reproductive health services. Sexual and reproductive health education and contraceptives for young girls and boys acknowledge need among a population that is engaging in sexual activity and is recognised as valid and worthy of service by health providers. Interventions should utilise different components to best address the issue of adolescent pregnancy and should always be rooted in gender-transformative principles.

Community Gender Norms Change as a Part of a Multilevel Approach to Sexual Health Among Married Women in Mumbai, India - Schensul, S.L., Singh, R., Schensul, J.J. et al. (2015)

Community mobilisation has often been cited as one of the most effective ways to reshape social norms. As a range of key actors in a given setting coordinate their messaging to change specific normative values, the intended audience begins to synthesise the received information and shift their own internalised social norms accordingly. The literature makes a strong case for the connection between belief in more gender-equitable norms among men and women and the reduction of HIV risk. Schensul et al. (2015) used these ideas to develop a multilevel intervention approach to document community gender norms, use community leaders to disseminate gender equitable messaging, and evaluate the response in the population over time.

The researchers chose a predominantly Muslim community in a slum area of north-eastern Mumbai, India. The study selected a quasi-experimental study design, using a similar community nearby as the control group. The researchers conducted 173 in-depth interviews with married women, men, and couples (aged 21-60) and surveyed 2,408 married men to identify the particular gender norms that were entrenched in the community.

Next, the researchers reached out to two separate community-based bodies that would convey their new, gender-equitable messaging: NGOs working in the area that were providing a variety of services to women and men, and the Muslim clergy (*imams*) broadcasting sermons to nearly 20,000 men on a weekly basis. The men received both the NGO and religious-based messaging, while the women only received the NGO messaging.

The study used the GEM scale and found that gender equitable norms had increased among the men and women who received the intervention at the end of three-year period. Interestingly, men reported a far greater positive shift in gender equity scoring than their female counterparts in the intervention group. Furthermore, women in the control group maintained higher gender-equity scoring than women in the intervention groups for two years after the

intervention. The researchers explain that this result (men demonstrating greater gender equity norm change than women) could signal the effectiveness of imams in shifting norms in men, especially in gender-segregated settings. The study, however, did not include reporting of health outcomes

9.2 Gender norms and health systems

Gender norms are entrenched in every society and are reflected and reinforced in the ways institutions and systems are structured and interact with people every day. The health system is a prime example.

There are two main ways in which gender norms are expressed in – and compromise – health outcomes and system effectiveness: [service provision and labour force](#). Gendered service provision, for example, means that those seeking health care may not receive the treatment they need if they do not conform to prevalent gender stereotypes. At the same time, a gendered labour force within the health service means that the distribution and value of roles within the service are not distributed evenly by gender. As a result, women accessing health services face a multitude of factors that hinder their ability to receive the treatment they need in a dignified and respectful way.

Norm-setting health governance bodies, such as the [World Health Organization](#) and the [United Nations General Assembly](#), have identified 'addressing gender norms in the healthcare field' as vital to improve health outcomes and achieve gender equity. To improve service provision to women, interventions should be [women-centred, trauma-informed and consider the lived experiences of women seeking treatment](#). In relation to gender norms in the health labour force, [evidence-based strategies](#) show that the recruitment, retention and upward mobility of women in decision- and policy-making positions have a transformative effect on gender norms in health systems and improve health outcomes.

Men and their interactions with health systems are also informed by gender norms that may make them vulnerable to stigma, discrimination and ill-health. The literature has thoroughly determined that [men are much less likely to seek preventive or treatment health services](#) and argues that this is a factor in [their shortened lifespans when compared to women](#). Male engagement strategies are usually focussed on the role of fathers in [improving maternal, neonatal and childhood health and in broader family planning services](#). Furthermore, Western media sources have encouraged the uptake of traditionally female-dominated roles in health, such as nursing and social work, [by men and male students](#).

Lesbian, gay, bisexual, transgender and queer (LGBTQ) people face poor treatment, discrimination and disengagement from health systems because they do not conform to gender norms. One major obstacle to their access to health care is the strained relationship between health provider and patient. The key elements that have been found to improve such relationships are [awareness raising and training, compliance with anti-discrimination legislature and creating a more inclusive setting through gender-neutral bathrooms and non-normative gender options in forms](#).

The three examples presented below explore promising interventions and policy developments to mitigate institutionalised gender norms in health systems. [Dubin et al. \(2018\)](#) investigate the effectiveness of transgender and gender non-conforming education and training for medical students in North American universities, while [Downe et al. \(2018\)](#) examine the interventions

that had the greatest success in improving respectful maternal care in four African nations. Finally, [van der Berg et al. \(2015\)](#) discuss the South African national family planning policy that aims to better address male partner involvement in the prevention of mother-to-child HIV transmission.

Transgender health care: improving medical students' and residents' training and awareness – *Dubin S.N., Nolan I.T., Streed C.G. Jr., Greene R.E., Radix A.E., Morrison S.D. (2018)*

Transgender and gender nonconforming (TGNC) people often report poor treatment and health outcomes when seeking medical treatment from healthcare systems. TGNC people are conceptualised by some as being 'gender deviant,' as their gender does not correspond to their assigned sex at birth. For this reason, they are viewed as a threat to wider heteronormative society and its gendered value systems, beliefs and ideals. So when it comes to the healthcare system, TGNC people face discrimination, violence or lack of appropriate treatment by medical staff who often lack the awareness, training or knowledge to provide proper treatment to people of non-normative gender expressions.

A review paper from Dubin et al. (2018) based on 131 papers found that the majority (52%) of North American undergraduate and graduate medical education programmes did not include any LGBTQ training. When LGBTQ health topics were part of curricula, they were taught as if LGBTQ people were one aggregated population and inter-group differences were not looked at in any detail. In undergraduate medical education courses, only 31% of studies contained transgender-specific content and none included training specific to gender nonconforming people.

Because this is a new and emerging field of study, no consensus was established for the most effective training techniques that would improve the knowledge, attitudes and skills of medical students around health care for TGNC people. However, commonalities across different interventions showed promising results. These interventions included: mandatory in-class or optional lunchtime series to teach TGNC-specific political and social issues; assessing patient anatomy before and after gender-affirming surgeries; and the ability to take sexual histories, and examine and discuss hormone therapies with patients.

As a result of these interventions, the findings show a significant and marked increase in knowledge about TGNC people, transgender health practices, and gender and sexuality ideologies. Medical students also reported feeling less discomfort in treating TGNC people and a reduction in transphobic views.

It is important to note, however, that the results were based on survey data from medical students who have undergone the programming, and it is not certain that these students will maintain their new and improved perspectives once they have joined the medical labour force. In addition, the review does not include the experiences of TGNC people when accessing the healthcare system and whether the interventions resulted in their adequate treatment and care by service providers. Nonetheless, the paper presents promising results for TGNC people who do not adhere to traditional gender norms and reflects a growing interest from the health community to better understand and serve TGNC people and meet their specific health needs.

Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review - Downe S., Lawrie T.A., Finlayson K., Oladapo O.T. (2018)

Reports of disrespect and abuse from women undergoing childbirth have become an increasingly prominent public health issue in recent years. Disrespect and abuse fall under the umbrella term of 'obstetric violence', or violence during childbirth through derogatory comments, over-medicalisation, lack of consent to medical procedures and, at times, physical violence from medical staff. Obstetric violence represents a form of institutionalised violence against women within the health system, with women attacked and victimised at a time of acute vulnerability, which may well deter them from using the health service in the future.

In their systematic review on the topic, Downe et al. (2018) identify five studies in settings where respectful maternal care (RMC) policies were enacted (Kenya, South Africa, Sudan and Tanzania), and examine their impact on women's experiences of disrespect and abuse during childbirth. The systematic review presents the findings as evaluations of these policies and their uptake by health providers. RMC policy was defined as increasing 'staff attitudes and behaviours that respect women's basic dignity, privacy, and autonomy, the right to consent, and the right not to be exposed to verbal or physical abuse, neglect, or detention.' Three of the studies took place in hospitals, with the evaluation including data collection at baseline and endline. The remaining two involved multiple sites with a control group that did not receive any intervention.

The policies that were reviewed included: training maternal care providers in respectful care principles; community education programmes to increase women's knowledge about the in-facility service and care that would be provided; infrastructural changes to increase privacy; and exit surveys from mothers who delivered in the hospital. In one intervention in South Africa, women received counselling on the importance of *birth companionship*, or encouraging male partners to accompany women to childbirth to promote a more woman-friendly service. The intervention sites also included multimedia campaigns through posters, banners and videos, to promote birth companionship and shift the norms dictating that men should not participate in the birthing process.

This norm change increases their presence in the delivery room and allows them to act as advocates for their female partners while they are in such a vulnerable position during birth. The results showed that women were far more likely to report respectful care during their hospital stay and measurably reduced disrespectful or abusive care and physical abuse. In terms of clinical outcomes, one study found that RMC policies reduced episiotomy (a surgical cut at the opening on the vagina during childbirth, performed routinely or liberally in cases of obstetric violence) by 13%.

The review shows that implementing respectful maternal care policies improve the experiences of women accessing healthcare facilities during childbirth, and diminish gender norms that see institutionalised violence against women as acceptable.

Improving Men's Participation in Preventing Mother-to-Child Transmission of HIV as a Maternal, Neonatal, and Child Health Priority in South Africa - Van den Berg W., Brittain K., Mercer G., Peacock D., Stinson K., et al. (2015)

Involving male partners in maternal and childhood health has been shown to improve health outcomes for women and children, increase men's own health-seeking behaviours, improve their communication with female partners and make them more involved fathers.

Preventing mother-to-child HIV transmission (PMTCT) is one of the main goals for improving maternal and child morbidity in sub-Saharan Africa. Historically, outreach has targeted only women and has largely ignored the gender norms that shape the decision-making power men hold in these settings. Actively targeting men in the outreach process not only improves the health of their family members, but also has the potential to reduce mortality and morbidity by dispelling the stigma associated with men engaging with health systems for maternal and childcare issues.

In their 2015 study, van den Berg et al. investigate South African family planning policies that enforced the traditional gender norms that do not see maternal health as involving or requiring male participation and that see women as solely responsible for their own health and the health of their children. They note that while the issue of male partner involvement in PMTCT has been raised in multiple recent policies in South Africa, its inclusion is quite limited and is rarely strategised explicitly, alongside comprehensive aims.

They therefore set out three policy recommendations, all supported by evidence-based best practices. First, men should be engaged directly as supportive partners in maternal, neonatal and child health (MNCH). Methods to achieve this could involve couples' HIV testing as the first step to receiving antenatal care, sending written invitations to male partners to join women during appointments and creating a welcoming and warm learning environment in health centres for men.

Second, MNCH services should target male health needs more effectively. These needs could include male circumcision (an effective method of decreasing HIV transmission) and erectile dysfunction. By including male-specific services, MNCH health centres could change the norm that these are spaces that can be utilised only by women.

Third, community-based campaigns to encourage men to challenge traditional gender norms and gender-inequitable beliefs have demonstrated tremendous success. Civil society organisations should work in conjunction with health services to challenge the idea that men's participation in antenatal care is unmanly and effeminate. Uptake of these policy recommendations has the potential to achieve PMTCT and better integrate men into the healthcare system.

9.3 Gender norms and infectious and communicable diseases

Data indicate a shift in the global burden of disease. Worldwide, between 1990 and 2017, there was a [41% decrease in death and disability caused by communicable diseases](#) and a [40% increase in non-communicable diseases](#). There have been impressive successes in limiting the impact of communicable diseases – diseases that spread from one person or vector to the next. Even so, communicable diseases still threaten the [health and wellbeing of people living in low-income settings](#).

Communicable diseases include the triplex of malaria, HIV and tuberculosis (TB), which have been a focus for health governance bodies, prompting the establishment of [the Global Fund, and the global commitment to Goal three of the UN Sustainable Development Goals, which aims](#) to address their combined threat. In addition, the emerging dangers of infectious diseases such as the Zika virus and Ebola have captured the attention of the global health community.

Because the transmission of communicable diseases depends on interactions between those who are infected and those who are not, or contact with disease-bearing vectors, such as mosquitos or water, a significant [behavioural context allows these diseases to continue to propagate](#). The behaviour patterns of individuals – including gender norms – often shape the likelihood of being infected.

A mass of evidence tells us that gender norms dictate how men and women live their lives and the activities they are allowed to undertake. In the context of communicable and infectious diseases, gender norms interact with the method of transmission and shape infection rates that differ for men and women.

Malaria and Zika virus, for example, are both diseases transmitted by mosquitos. As men are more likely to spend time outside, either working in forested areas, socialising at night or sleeping outside, [their likelihood of infection by mosquito vector is higher than for women](#). Gender-sensitive interventions are, therefore, required to address these infectious diseases comprehensively. Some programmes have focussed on [gender gaps in health knowledge and access, formal education and livestock ownership](#) and on identifying gender equity disparities as the opportune point of intervention in preventing the spread of mosquito-borne disease. In addition, interventions to tackle specific gender norms have been developed in response to malaria and Zika epidemics and are highlighted below.

Zika virus is also propagated through sexual contact and shares that feature with HIV and other sexually transmitted infections. When an infectious disease contains a link to sexual contact, the issue is often [immediately framed as a reproductive and sexual health issue and, as such, falls into the realm of women's health and family planning](#). As a result, such diseases are often framed as the sole 'responsibility' of women and interventions will use prevention and education tactics around family planning, as well as during counselling sessions for women in antenatal care.

There are, however, examples of gender transformative interventions that aim to tackle this type of communicable disease. Studies reveal, for example, the positive impact of elevating a woman's socioeconomic status and position in society to decrease her likelihood of infection, as well as measures to expand men's involvement beyond the scope of family planning to share responsibility and decision-making equitably with their female partners.

It is noteworthy that [tuberculosis and the impact of gender norms on stigma and discrimination have been widely identified in the literature](#). There are interventions that acknowledge the role of gender norms in TB infection and respond specifically to the health issues they create, such as [female-only TB support groups in India that facilitate discussion of women's experience with TB and gender-based stigma](#). However, the effectiveness of these interventions has not been studied in depth and further pressure should be applied by the global health community to elevate these programmes.

Three studies, in particular, demonstrate promising interventions and policy developments to address gender norms and their impact on communicable diseases and are outlined below:

- a qualitative study from Monroe et al. (2019) of male migrant labourers in Zanzibar and community-led efforts to eliminate malaria cases.
- a randomised control trial from Baird et al. (2012) in Malawi to study the impact of cash-transfer programmes in the mitigation of HIV and herpes simplex type 2.
- a policy advocacy case from Osamar and Grady (2016) pushing for the greater inclusion and active participation of men in confronting the Zika epidemic.

Human behaviour and residual malaria transmission in Zanzibar: findings from in-depth interviews and direct observation of community events – Monroe, A., Mihayo, K., Okumu, F., Finda, M. et al. (2019)

Malaria and the global burden of disease it causes have both decreased significantly since the turn of the 21st century. As various countries in Africa, Asia and Latin America have eliminated malaria cases, its complete eradication has become conceivable.

Zanzibar, an island off the coast of Tanzania, offers great potential for its elimination as community-based efforts are mobilised to keep malaria cases ultra-low. 'The last mile,' or the final step in the delivery of preventive measures, has identified one sub-group as a target population for full eradication: male seasonal workers who travel frequently between the island and the mainland. Monroe et al. (2019) focus on an interesting intervention on the island, where workers come from the mainland to work in farms, small business and hotels for different months during the year.

Interventions with local residents have been tremendously successful and have relied on the use of insecticide-treated nets (ITNs) to prevent transmission of the malaria parasite. As a result of gender norms, men enjoy staying longer outside at night to socialise with other community members. Yet local prevention efforts are not focussed on outdoor prevention, which leaves men more susceptible to malaria. Men are also more likely to sleep outside, while women and children report sleeping indoors.

In addition, adult men account for the majority of the seasonable labour force who arrive to earn money to provide for their families on the mainland. They rarely arrive on the island with insecticide-treated nets (ITNs) or any other means of preventing malaria infection. The low use of ITNs among migrant workers is thought to be a result of low access and a lack of connection to the local community.

Community-based health workers, called locally *sheha* and *assistant sheha*, have been instrumental in targeting subgroups as part of the drive towards malaria elimination. In the case of seasonal workers, these health workers act as gatekeepers to their communities and ensure that malaria is not transmitted from the mainland to the island.

Migrant labourers must register on arrival with the *sheha* and undergo malaria diagnostic testing in order to stay in their assigned region. In addition, *sheha* have led educational campaigns to teach people about prevention tactics they can outdoors, which include the purchasing and use of mosquito repellents.

As seasonal workers and men are less likely to engage with local health services, their interactions with and testing by *sheha* have the potential to shift the gender norm that men should not use health-seeking behaviours. *Sheha* recognise the reality of daily life for men and workers in their communities and instead of instructing them to change their behaviour, they introduce effective alternatives to prevention that are adapted to their cultural contexts.

Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial – Baird, S.J., Garfein, R.S., McIntosh, C.T., Ozler, B. (2012)

Shifting culturally-based gender norms does not always rely on targeted, community-based messaging. Current social norms often dictate that women should rely on men for financial stability and, as a result, women are put in a position where they engage in risky sexual behaviours in exchange for gifts, money, and assistance. This creates an environment where sexually-transmitted communicable diseases, such as HIV, syphilis and herpes simplex virus 2 (HSV-2), are propagated and where unwanted pregnancies continue.

Cash transfers to young women have been proposed and studied as a possible intervention to change gender norms, providing women with autonomy and improving their health. Given that these gender norms represent a widespread reality of insufficient and unequal distribution of resources and opportunities for boys and girls, cash transfers offer a chance to counter that reality.

Baird et al. (2012) chose to study the impact of cash transfers in the Zomba district of southern Malawi, using a randomised control trial, with half of the study areas receiving the cash transfer and the other half being the control group. The intervention areas received either unconditional or conditional cash transfers, with the condition being school attendance. The participants were never-married women aged 13 to 22, who were also selected randomly and given randomly assigned monthly payments. Data were obtained through interviews and biomarker tests.

The study found an overall decrease in the frequency of sexual activity and the age of sexual partners, which resulted in a decrease in HIV and HSV-2 prevalence in the cash transfer intervention group. In particular, HIV prevalence and the likelihood of having had a sexual partner aged 25 or older were both reduced significantly in the conditional cash group in comparison to the control group. In addition, the likelihood of being pregnant, having sexual intercourse once per week, and HSV-2 prevalence at the 18-month mark after the programme ended, had also decreased significantly when the unconditional cash transfer group was compared to the control group.

These findings demonstrate that a cash-transfer programme targeted towards women – even one that includes no measures or training related to communicable disease transmission – can have a major impact on health outcomes. Furthermore, the lack of health-related factors in the intervention shows that shifting gender norms by economically empowering women and girls who traditionally experience lower socioeconomic status, has an ameliorative effect on the condition of women burdened by communicable diseases, such as HIV and HSV-2.

Zika Virus: Promoting Male Involvement in the Health of Women and Families -

Osamor, P.E. and Grady, G. (2016)

When Zika virus seized the urgent attention of the global health community in 2015, a coordinated and comprehensive response had to be crafted. Zika's effect on an adult is relatively mild, causing fever, rash and muscle and joint pain. However, its effect on unborn children is far more harmful: babies are born with *microcephaly*, or clinically smaller heads, as well as intellectual and physical disabilities. Pregnant women and women trying to get pregnant are a key focus for healthcare professionals, but they do not bear the sole responsibility for the prevention of Zika virus transmission to their children.

Engaging men in health interventions has been repeatedly cited as critical to ensuring equitable health outcomes in communicable diseases, especially when transmission can occur through sexual activity, as in the Zika virus. Gender norms dictate that men act as the primary decision-makers around sexual activity, and whether they and their partners have safe sex or not.

Osamor and Grady (2016) recommend promoting male participation in discourses surrounding Zika virus and involving them more actively in processes to address outbreaks. They emphasise the need for male involvement that goes well beyond family planning and contraceptive use to instil meaningful change. A Zika outbreak, they argue, is a community issue, not only a women's health issue.

Programmes should, therefore, include educational campaigns that target men specifically, rather than simply relying on their presence during antenatal care appointments, which men may or may not attend depending on geographic and cultural contexts. Counselling sessions that advocate for shared decision-making with their female partners and shared responsibility for contraceptive use and caring for Zika-affected children are crucial to address Zika outbreaks effectively.

This suggested approach is an interesting and novel gateway to help men begin to take more accountability for the health and wellbeing of themselves and their families. In the case of communicable diseases like Zika, community-based approaches and gender-transformative interventions are valuable solutions that have real potential to improve health outcomes and reduce the burden of disease.

9.4 Gender norms and nutrition

Research into food and nutrition has identified—very explicitly— the harmful role of discriminatory gender norms. These norms affect [access to food, food preferences and restrictions, and body image and eating disorders](#). Women in resource-poor settings experience elevated rates of [food insecurity, poor food distribution and poor intake of micronutrients](#). In resource-rich settings, women account for most of those with eating disorders cases and [experience pressure to appear and act feminine through diet and exercise](#). Furthermore, men who conform more closely to traditional masculine gender norms, may suffer from [increased muscle dissatisfaction and engage in risky health behaviours in order to achieve a body ideal](#).

Research on overcoming undernutrition and food insecurity has resulted in programmes that include [empowering women to participate and lead in the realm of agriculture and farming](#). The outcomes appear to be multiple in nature: [women take a more active and involved role in their families and communities; agriculture and farming provide an opportunity for economic empowerment; and small-holder farming provides greater food security for members of the community](#). In addition, women enhance their autonomy and self-reliance, while they also enjoy elevated status in their communities as a result of their active participation in income-generation for their households.

Other types of intervention include those that provide cash. [While cash transfers are a widely-used method to alleviate poverty in low-income countries](#), they have also been identified as a possible way to improve both nutrition and gender equity. Cash-based interventions related to food security and nutrition will often run alongside [food assistance trainings, livelihood programmes and school feeding](#). These programmes rely less on women's farming practices and more on education and on enabling participants to buy more and better-quality (therefore nutritious) food for themselves and their families.

Research into the gendered roles that shape eating disorders and body image have [typically taken place in high-income countries \(HICs\)](#). Because the prevalence and associated research into eating disorders and body image issues are new and emerging in low- and middle-income countries (LMICs), little or no attention has been paid to changing the gender norms that influence these challenges. Evidence of programmes that [address gender roles to improve eating disorder health outcomes has mostly come from HICs](#). The research that has been undertaken has focussed on group-based activities and discussions and tends to be led by a facilitator.

A variety of reviews and articles have studied the impact of gender norm change or transformation on food security and nutritional health outcomes. Some interventions, such as the three outlined below, are representative of programming that identify 'gender norm change' explicitly as the motivation for the study. Other programmes, such as [cooking oil in exchange for school attendance by girls](#), are also used to elevate the status of adolescent girls and women to change gender norms.

Such interventions do not, however, have gender norm transformation as an explicit objective. The three programmes outlined below are: [Friis-Hansen's 2012 study](#) of farmer field schools in western Kenya as a site to promote women's active participation in agricultural work; the [World Food Programme's 2019 review](#) of cash-based interventions for food assistance in LMICs; and [Brown and Keel's 2015 study](#) of the gender role-component treatment of eating disorders among gay men in the southern United States.

[Less noise in the household: the impact of Farmer Field Schools on Gender Relations – Friis-Hansen, E., Duveskog, D., Taylor, E.W. \(2012\)](#)

The presence of Farmer Field Schools (FFS) in east Africa has grown in popularity, with 3,000 schools operating as recently as 2012. FFS are non-formal, educational groups that use collective action to teach farming techniques to community members. FFS employ curriculum-based courses and are instructed by a facilitator who encourages active participation, leadership and discussion from the members of the group.

The ultimate goal of the schools is to increase informed decision-making on crop-growing and livestock management. FFS also provide an interesting point of intervention and site of gender-transformative potential: focus groups are usually mixed-sex and require the full participation of each of member. In addition, the curriculum discusses sensitive topics, such as HIV/AIDS, domestic violence and alcoholism. FFS have, therefore, been used to study the effectiveness of gender-equity messaging and widening the role of women and men in the sphere of food production.

Friis-Hansen et al. studied FFS groups and their members in the Kakamega district of western Kenya. Through individual interviews with current members or recent graduates of FFS courses and group discussions, the researchers were able to collect and analyse primary data on the impact of these workshops on gender-role transformation. The resulting data showed that the collective action structure of the FFS (individuals uniting to achieve a common goal of improved crop and livestock conditions) allowed women to fulfil roles traditionally ascribed to men in order to reach a collective goal.

This enabled men to conceptualise the abilities and power of women in society and everyday life. They also took up roles traditionally ascribed to women, including weeding, planting, child-rearing, cooking, and fetching water and firewood. Furthermore, women in the FFS were required to lead and facilitate group discussions and even interrupt male participants to allow others to contribute. While such behaviour was not socially acceptable, the FFS setting provided a space where women led and collaborated with men who were not necessarily their partners. The FFS can, therefore, create a social space where gender norms and relations can be challenged and changed to empower women in their households and communities.

Multiple participants noted the changes in household gender roles and attitudes. Men noted that despite societal perceptions that women are unwise, incapable and in need of guidance to complete work successfully, they realised that a woman is just as capable as a man and that they too can alleviate poverty through their work and empowerment.

At the same time, women expressed excitement in participating in farming practices, perceived themselves as effective and capable workers and felt empowered after completion of the FFS. They also reported that men spent less time drinking.

This intervention assessed the transformative potential of group-based learning to change traditionally-set gender roles, using agriculture and farming as the site of transformation. As such, women's involvement in small-holder farming establishes their involvement in their area's main economic activity and contributes to their food security.

The potential of cash-based interventions to promote gender equality and women's empowerment - *The World Food Programme (2019)*

Shifting gender norms does not always rely on targeted, community-based messaging. Gender norms may also transform when the position and rights of women within society change.

As a result of patriarchal social structures, men typically act as primary decision-makers in their families or communities. Cash transfer interventions that target individuals and households have been proposed and studied as a possible intervention to provide women with more autonomy and, therefore, improve food security and nutrition-related outcomes. In relation to food insecurity, a cash-based transfer programme can have the dual effect of

providing food security and improved nutrition-related outcomes as well as outcomes that are gender-transformative.

A multi-country study by the World Food Programme (WFP) analysed the effects of cash-based interventions run by local civil society organisations to support people in different food insecure settings, including ultra-poor women, young women and men, school-aged boys and girls and food-insecure households, depending on where the programme was located. The study included programmes with different features in six countries: Bangladesh, Egypt, El Salvador, Jordan, Mali and Rwanda.

The researchers studied which programme components were most important for improving food security and gender equity within households. All interventions included complimentary nutrition- or food-related programming, such as gardening and farming, or nutrition and food-distribution awareness training. After several months of qualitative data collection, WFP researchers identified the most significant components for improving nutrition and health outcomes.

The cash-based transfer programmes in Bangladesh, Egypt, El Salvador and Rwanda were most successful at generating a transformative gender role change. Of these programmes, the first three targeted individuals who fulfilled food-related training programmes that were conditional to receive cash. Participants pointed out that the use of programme activities (and specifically awareness-raising, training and support groups) was most important element in improving gender equity outcomes. In awareness-raising sessions, participants (female, male and children) learned about the ways in which gender roles impact the nutrition of different family members and how gender-inequitable norms impact the health outcomes of the entire household. The WFP found that participants in all programmes had more and better-quality food to eat, regardless of whether there was a food- or nutrition-related training conditionality or not.

The cash modality, however, is the factor that enabled their participation in the programming and was essential as a pre-condition to undergo the group-based, gender-transformative activities. Women received the cash, justifying their participation in programmes to their husbands who held the gendered belief that women should not take part in activities outside of the house.

In the Bangladeshi case study, ultra-poor women were given cash as compensation for completion of a livelihoods programme that focussed on their training for future employment. The programme also included additional awareness-raising sessions and showed participants how gender impacts the amount and time women can eat in family settings.

Women were able to take time away from their households and, first through cash transfer during the programme and then through income generation after its completion, provide more and better food for themselves and their families. The additional income elevated their status in their families and their newly esteemed positions motivated family members to share meals more equitably, potentially improving their nutrition. The study concluded that cash-based interventions are most successful at improving nutrition and food security when the causes of social inequality are addressed explicitly in the programme design.

A randomized controlled trial of a peer co-led dissonance-based eating disorder prevention program for gay men – Brown T.A., Keel P.K. (2015)

Eating disorders and negative body image have been framed consistently as health issues that largely affect women. Over time however, there has been an incremental rise in eating disorders in men and, in the present day, males represent up to 33% of all eating disorder cases in the United States. The increasing prevalence of such cases in men challenges the idea that body ideals harm only women and indicates that the gender norms that shape ideals around physical appearance can also have a negative effect on men.

Gay men are affected disproportionately by negative body image (in comparison to straight men) as a result of simultaneously pursuing body ideals to attract sexual partners and regular bodily comparison with other gay men in their community. The resulting ideal is a thin, muscular body type that is supposedly achieved through the use of steroids, caloric restriction and excessive exercise. Prevalent gender norms in the American gay community emphasise this body ideal alongside masculine behaviours and attitudes, whether within themselves or in their sexual or romantic partners. As a result, [gay men in the US are estimated to account for 5% of the total male population, yet account for 42% of male eating disorder cases.](#)

The study by Brown and Keel (2015) focussed on the higher prevalence of eating disorders among gay men in the southern United States. They sought to build upon the success of cognitive dissonance-based (DB) interventions on women with eating disorders. In the context of eating disorders, DB intervention exposes the competing and conflictual ideals that are held, such as feelings of dissatisfaction in one's own body and the understanding that the thin-ideal is an unachievable, unhealthy reality. Brown and Keel adapted a study that challenged these distinct issues specific to gay men and their associated gender norms, such as a thin, muscular-ideal body type.

A randomised control trial was used, with the participants assigned to one of two groups: one that underwent DB programming and a control group. The DB group experienced two group-based sessions led by gay male facilitators and focussed on the expectations present in the gay community. Group discussions allowed space to criticise the pressures that gay men experience and to foster positive language and body acceptability. The result was that the DB group experienced decreased body dissatisfaction, drive for masculinity, bulimic pathology and objectification compared to the control group, immediately after intervention and over the following four months. In relation to gender roles in the gay community, the DB group also showed a reduction in desire to meet masculine behaviours, less internalisation of body ideals and decreased self- and partner-objectification.

Brown and Keel's research, therefore, affirms the success of cognitive-based interventions in the treatment of eating disorders. It also highlights the need to use group activity and discussion to counter gender-norm expectations of gay males and other specific populations.