Experimental Evidence on Changing Gender Norms, Tackling Misinformation, and Decreasing Costs: Implications for Family Planning

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Key demand side drivers of family planning outcomes for women….

1. Opportunities for women: employment, education
   - These are likely longer term demographic shifts that influence desired fertility
   - Evidence that improved education and employment opportunities for young women decrease fertility.

2. Misinformation:
   - Adequate FP counseling often lacking, including information on side effects
   - Provider bias (particularly for young women)
   - Understanding the risk of risky sex (Dupas, Huillery, and Seban 2018)

3. Poverty
   - In some countries, contraception is not free
   - Lack of financial resources also influence investments in education, etc. that may influence family planning outcomes (cash transfer/education subsidy literature: e.g. Baird McIntosh and Özler 2011; 2019 and Duflo, Dupas, Kremer 2015; 2019)

4. Gender/Social Norms

Gender Norms vs. Social Norms (Cislaghi and Heise 2019)

Table 1 *Differences between gender norms as understood in the gender literature and social norms as understood in social psychology and behavioural economics*

Gender Norms	*Social Norms*
Gender norms are in the world, embedded in institutions and reproduced by people's actions.	Social norms are in the mind; people's beliefs are shaped by their experiences of other people's actions and manifestations of approval and disapproval.
Gender norms are produced and reproduced through peoples' actions and enforced by powerholders who benefit from people's compliance with them.	Social norms are equilibria that maintain themselves, not necessarily benefitting anyone.
Gender norms are often studied as shaping people's individual attitudes.	Social norms are often studied as diverging from people's individual attitudes.
People follow the gender norms of their culture, society or group, the boundaries of which are usually blurry.	People follow the social norms of their reference group, the boundaries of which are usually fairly defined.
Changing gender norms requires changing institutions and power dynamics. Often this will happen through conflict and renegotiation of the power equilibrium.	Changing social norms (at its simplest) requires changing people's misperceptions of what others do and approve of in their reference group.
Changing gender norms is a political project that leads to equality between women and men.	Changing social norms is a health-related project that leads to greater wellbeing for women and men.

A few relevant earlier studies…

1. Ashraf, Field and Lee (2014)
   - Experiment provided **married** women in Zambia with a voucher for free contraception.
   - Varied whether women were given access to contraceptives alone or with their husbands (**working within existing gender norms**)
     - Couple treatment: 19 percent less likely to seek family planning services, 25 percent less likely to use concealable contraception, and 27 percent more likely to give birth.
     - Individual treatment: report a lower subjective well-being, suggesting a psychosocial cost of making contraceptives more concealable.
2. Bandiera et al. (2020)
   - Adolescent development clubs that provided vocational training and information on sex, reproduction and marriage (21% take up) in Uganda
   - Four years post intervention (attrition is fairly high at 35%): 2.7 pp less likely to have a child, 6.9 pp less likely to be married, little evidence of change in contraceptive use among sexually active.
3. Ashraf, Bandeira and Jack (2014)
   - Find that non-financial incentives (not financial incentives) increase female condoms sold in Zambia: each sale is rewarded with a star stamped on the thermometer, which is labelled as measuring the stylist's contribution to the health of their community.
   - From increased effort: promoted condoms more.

Study 1: Including Males: Improving Sexual and Reproductive Health for Female Adolescents (Shah and Seager, 2020)

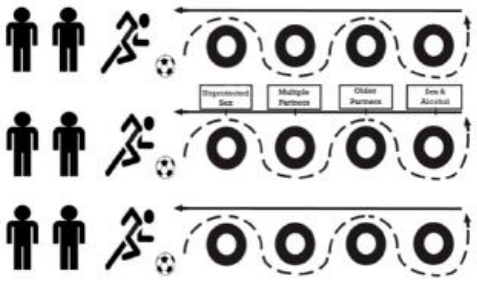
AN RCT WITH BRAC: THREE INTERVENTIONS

Research explores whether 3 interventions improve female sexual reproductive health outcomes

***Main Outcomes:* unintended teenage pregnancy, HIV/STI, and intimate partner violence (IPV)**

CLUSTER RANDOMIZATION: SUPPLY SIDE
Providing free contraceptives to females

INDIVIDUAL RANDOMIZATION
Empowering females through a goal-setting exercise around staying healthy and STI/HIV free



CLUSTER RANDOMIZATION: DEMAND SIDE
Educating adolescents about healthy intimate relationships; Engaging boyfriends through soccer

Study 1: Including Males: Improving Sexual and Reproductive Health for Female Adolescents (Shah and Seager, 2020)

1. Including males and goal setting improves IPV outcomes, but no impact on uptake of contraception or fertility outcomes.

2. Most surprisingly absolutely no impact of supply side intervention on any pregnancy related outcomes.
   - Less than 1% of young women use modern contraception at baseline
   - Barely changes at endline even though contraception is free of charge.

3. Why no uptake of LARC? (conjecture)
   - More constraints than just price.
   - Mothers not happy about free contraception when see it actually happening (did not target mothers)
   - Misperceptions on side effects

Study 2: Increasing the take-up of LARCs among adolescents and young women in Cameroon (Athey, Jamison, Özler, et al. ongoing)

- Pilot qualitative study highlighted attitudes (both provider, mothers, and young women) that crated barriers to uptake of family planning.

  - *"Family planning is not good for those of us that are young that have not yet put to birth"* (19yo, single, no children, does not use FP)

- Included lots of confusion and misinformation on side effects

- Price also came out as a barrier.

Study 2 cont.: Increasing the take-up of LARCs among adolescents and young women in Cameroon (Athey, Jamison, Özler, et al. ongoing)

Intervention 1: Redefining the counseling approach

- **Old/current paradigm for FP counseling**:
  - "An informed choice model in which individuals are given extensive information to make their own independent choices."
    - "**Tell the client about *ALL* the methods** and let her make a decision."

- **New paradigm/destination** :
  - Shared decision-making based on the client's goals, needs, and preferences
  - Still patient-centered (respectful, empathetic, and confidential), while hopefully more efficient and realistic (Hoyt et al. 2017)
    - "Elicit client's preferences, goals, needs, as well as her birth and medical history, and **make a recommendation**."

Intervention 2: Price Discounts

Study 2 cont.: Increasing the take-up of LARCs among adolescents and young women in Cameroon (Athey, Jamison, Özler, et al. ongoing)

	Maternity & Others		Family Planning	
	(1)	(2)	(3)	(4)
	Adolescents	Adults	Adolescents	Adults
LARC price: Free/Low	0.328**	0.366***	-0.0298	0.0645
	(0.149)	(0.0759)	(0.117)	(0.0813)
LARC price: Mid	-0.0127	0.366***	0.00248	-0.0258
	(0.126)	(0.0755)	(0.132)	(0.0824)
Control group mean	0.316	0.083	0.538	0.644
N	91	170	122	286

Robust standard error in parentheses * p<.10 ** p<.05 *** p<.01; *All regressions include SARC prices fully interacted with LARC prices;*

Study 2 cont.: Increasing the take-up of LARCs among adolescents and young women in Cameroon (Athey, Jamison, Özler, et al. ongoing)

	CFA 4,000	CFA 1,000/2,000	Free / CFA 150
Panel A: Clients who get randomized into a consultation type (n=347)			
SBS (n=199)	30.3%	42.9%	50.0%
SEQ (n=148)	44.4%	38.0%	42.3%
Panel B: Clients who do NOT get randomized into a consultation type (n=322)			
SEQ	53.7%	62.6%	73.6%

Study 3: Connect (Bangladesh/Tanzania) (Baird, Munar, and Seager, ongoing)

1. Targeting first time young mothers may be a key entry point to increased uptake of family planning.
   - Gender norms are such that in many contexts there simply is not an entry point prior to first birth (may be a long time for this to change)
   - Take this norm as too difficult, so target PPFP for FTPs
2. Connect will develop and test scalable approaches for increasing use of postpartum family planning (PPFP) among first-time parents (FTPs; ages 15-24) in Bangladesh and Tanzania
   - Build on existing platforms that interact with young mothers (not necessarily related to FP).
   - Low cost program enhancements developed through barrier and facilitator analysis and a series of virtual program workshops.

Study 3 cont.: Connect (Bangladesh/Tanzania) (Baird, Munar, and Seager, ongoing)

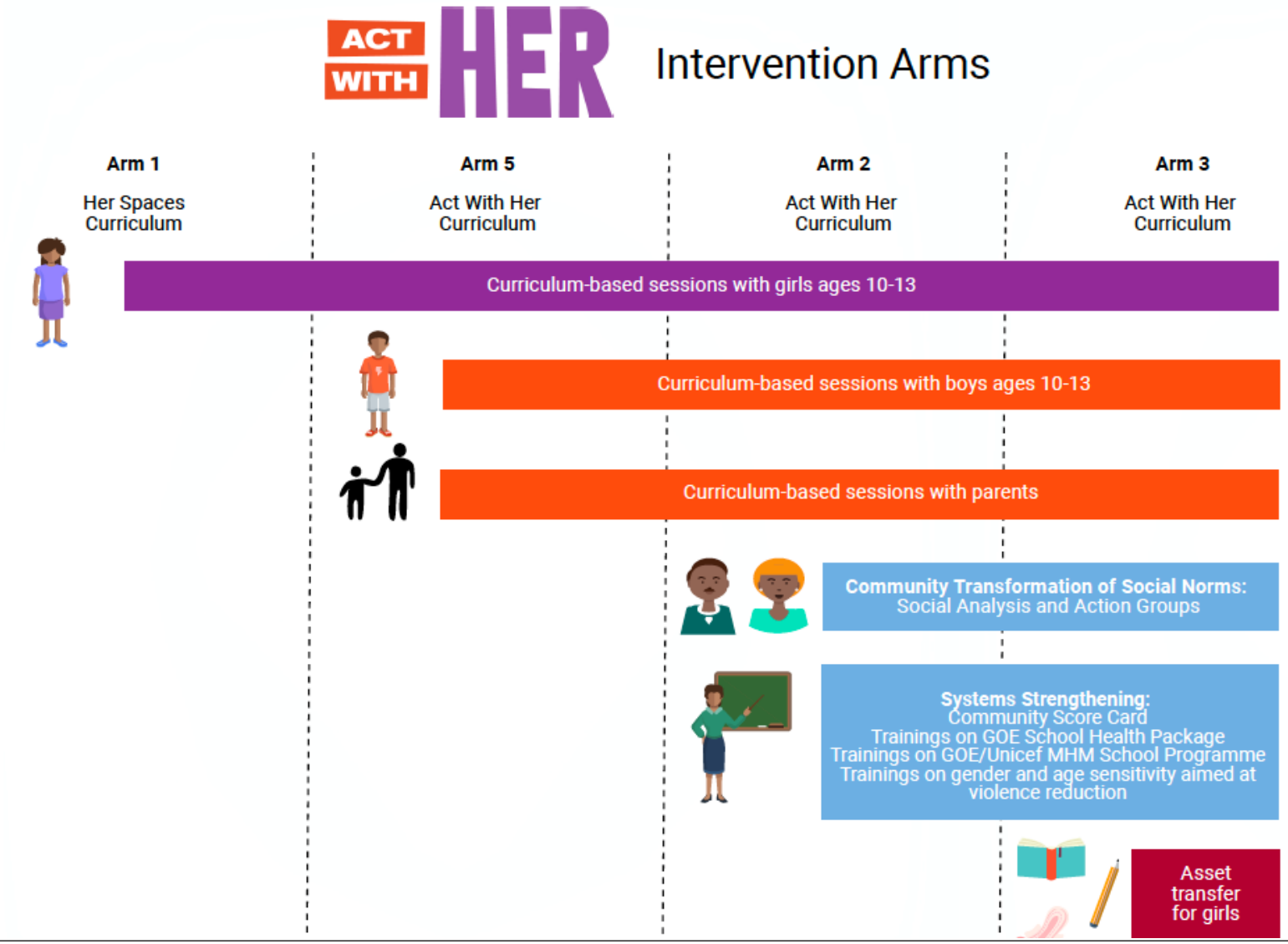
1. Barriers in Tanzania
   - **Social and gender norms** dictate that mothers, grandmothers, and male partners are the primary decision-makers, but they are often misinformed about and not supportive of service use, especially for FP.
   - Many FTMs experience **harsh and judgmental attitudes from providers** that discourage service use.
   - **Myths about FP**, especially related to infertility and malformations in newborns, are pervasive There are **missed opportunities** to integrate PPFP into other touchpoints, and to reach FTMs through CHWs.
2. Proposed program enhancement in Tanzania
   - *Facility level:* light touch training to reduce bias
   - *Community level:* utilize existing community support groups that work with pregnant and lactating mothers and incorporate home visits for FTP that utilize an adapted job aid to counsel FTMs on PPFP, including norms and myths.

Develop and pilot enhancement and data collection tools; refine, launch full scale mixed methods impact evaluation.

Study 4: Multi-Level Programming Aimed at Gender Norms Transformation to Improve Capabilities of Young Adolescents in Ethiopia (Baird, Hamory, Jones, and Woldehanna, ongoing)

- Unequal gender norms and power dynamics are often reinforced by adolescents' peers, families, communities and the broader institutional structures that surround them.
- As part of GAGE, evaluating *Act with Her-Ethiopia* (AWH-E), a two-year multi-level program including curriculum-based programming aimed at gender norm transformation and empowerment for young adolescent girls and boys (aged 11-13), and their primary caregivers, as well as community-level engagement and systems strengthening.
- Aims to address critical evidence gaps:
  i. Potential value of beginning interventions with very young adolescents
  ii. the added value of specific components of complex interventions such as asset transfers and community level systems strengthening; and
  iii. the short- and medium-term impacts of multi-level interventions that seek to transform gender norms and support adolescent girls' healthy transitions across a range of domains.

Study 4 cont.: Multi-Level Programming Aimed at Gender Norms Transformation to Improve Capabilities of Young Adolescents in Ethiopia (Baird, Hamory, Jones, and Woldehanna, ongoing)



Study 4 cont.: Multi-Level Programming Aimed at Gender Norms Transformation to Improve Capabilities of Young Adolescents in Ethiopia (Baird, Hamory, Jones, and Woldehanna, ongoing)

1. Remember these are still young adolescents, so mostly not sexually active, and many not even menstruating yet;
   - Need to measure outcomes early in the causal pathway towards family planning outcomes
2. Some large short-run impacts:
   - ***Voice and Agency:*** increased say in decision making in the household, more comfortable expressing oneself, feel they are listed to and can speak up.
   - **Knowledge:** puberty, nutrition, FGMC
   - ***Health and Nutrition:*** For those menstruating, improved menstrual hygiene and management
3. But, mixed bag on changing gender attitudes and norms. In fact, appears to be reinforcing them in some cases ('good girl'); and large regional differences (context is local)

Will continue to follow them as they become sexually active to see if sustained impacts.

A few concluding thoughts…

1. Common themes: misinformation, cost, gender norms, context
   - May need to target multiple constraints to get an impact.
   - Need to really understand the context you are working on
2. May need to accept certain gendered norms, and work within them
   - Even if targeting gender norms may still focus on married and/or first time parents for contraceptive uptake.
   - But there is scope for movement even without progress on gender norms!
3. Need to understand who the gender norms benefit and who has the power, and ensure that you target norms at the right (and multiple) levels
4. Interventions targeted at unmarried adolescents appear to be more successful at delaying sexual debut/fertility/marriage, as opposed to increasing contraceptive uptake.

THANK YOU