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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: MEASURING VALUES AND NORMS TO GUIDE SWEDISH DEVELOPMENT COOPERATION

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Foreword by EBA

Sexual and reproductive health and rights (SRHR) have long been prioritised in Swedish development cooperation. Although improvements have taken place in several areas of SRHR globally and over time, serious challenges remain. Discrimination and oppression of LGBTQI people is still common, the number of child marriages is high, women die from unsafe abortions and sexuality education is often inadequate or not available at all, to name a few. SRHR is closely linked with socially and culturally constructed values and norms that need to be addressed for change to happen. In supporting partner organisations to work for changing values and norms related to SRHR, Sida and other Swedish actors working with development cooperation, need to better understand what values and norms are in specific contexts, how they interlink and how they influence people's lives. This EBA report aims to increase the understanding of values and norms related to SRHR and gender in Sub-Saharan Africa. In addition, it maps Swedish aid to SRHR and identifies gaps and opportunities for Swedish development cooperation supporting SRHR. In the first part of the study, data on values and norms related to gender and SRHR are collected through a newly developed module in the World Values Survey in three countries, namely, Ethiopia, Nigeria and Zimbabwe. This data will be publicly available for download from the World Values Survey website. The generation of a public good in the form of data was an important aspect for EBA when deciding to undertake this study. The second part of the study provides a descriptive mapping of Swedish development assistance for SRHR. The authors find that discriminatory norms and values are common in all three countries included in the study, especially around the rights of LGBTQI people, but also related to abortion, women's decision making, men's control over women and young people's sexuality and right to choose a partner. In general, there were more support for aspects related to sexual and reproductive health than for aspects related to sexual and reproductive rights. Further, they find that there

were no clear relationships between sociodemographic factors and values and norms related to SRHR. While the overall Swedish support to SRHR has increased, the proportion directed towards rights have increased over time, while the proportion directed towards health has decreased. We believe that the findings from the study will improve the understanding of the various norms and values that are present in some of the contexts where development cooperation around SRHR is taking place. In combination with the description of the current Swedish SRHR support, this can provide an opportunity for improved strategies and interventions. We also hope that the data collected as part of this project will be used widely in other research projects to further improve our knowledge and understanding of contextualised norms and values. Finally, we want to recognise the challenges related both to measuring values and norms from an outside perspective and the difficulties and complexity related to externally driven suggestions to change norms. We hope this report will therefore also stimulate a discussion on how to work with values and norms at the same time as we recognise the dimensions of power related to aid. The study has been conducted with support from a reference group chaired by Julia Schalk, member of EBA. The authors are solely responsible for the report and its conclusions.

Gothenburg October 2021

Helena Lindholm

Abbreviations

AU	the African Union
COMESA	the Common Market for Eastern and Southern Africa, one of the regional economic communities of the African Union
CSE	Comprehensive Sexuality Education
DHS	Demographic Health Survey
ECOWAS	Economic Community of West African States, one of the regional economic communities of the African Union
FGM/C	Female genital mutilation or cutting
FP2020	Family Planning 2020, a global partnership to increase access and use of contraception
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
IGAD	Intergovernmental Authority on Development, one of the regional economic communities of the African Union.
ICPD	International Conference on Population and Development
LGBTQI	Lesbian Gay Bisexual Transgender Queer and Intersex
MICS	Multiple Indicator Cluster Survey
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development

OECD DAC	OECD Development Assistance Committee
RECs	Regional Economic Communities of the African Union
SADC	Southern African Development Community, one of the regional economic communities of the African Union
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNFPA	the United Nations Populations Fund and is the United Nations sexual and reproductive health agency.
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UN Women	United Nations entity dedicated to gender equality and the empowerment of women
WHO	World Health Organisation
WVS	World Values Survey

Sammanfattning

Sexuell och reproduktiv hälsa och rättigheter (SRHR) spelar en nyckelroll för att nå Agenda 2030 och dess 17 globala mål för hållbar utveckling. Om världen ska kunna nå dessa mål till år 2030 är det helt avgörande att respekten för, och tillgången till, SRHR ökar och säkerställs i många fler länder. Sverige är ett av få länder som har haft ett långvarigt engagemang för global SRHR och jämställdhet inom ramen för sitt officiella utvecklingsbistånd, oavsett regering eller politiska dagordningar. Sveriges bilaterala och regionala SRHR-bistånd är till stor del riktat till Afrika söder om Sahara, som är den region som fortsatt har störst behov vad gäller SRHR (såsom hög mödradödlighet, hög förekomst av osäkra aborter, hiv, ett stort behov av preventivmedel).

SRHR grundar sig på mänskliga rättigheter, är nära sammankopplat med jämställdhet och påverkas av socialt och kulturellt konstruerade värderingar och normer. Dessa värderingar och normer påverkar individers förmåga att fatta beslut och få tillgång till information och vård relaterat till kroppen, sexualiteten, intima relationer samt möjligheten att planera, få eller avstå från att skaffa barn. Sociala normer och värderingar relaterade till SRHR, till exempel rätten att bestämma över sin egen kropp och fertilitet oavsett kön, könsuttryck, sexuell läggning, ålder eller civilstånd, är en avgörande faktor för att uppnå Agenda 2030, särskilt mål 5 (jämställdhet) och mål 3 (god hälsa och välbefinnande). Det finns emellertid behov av nya, nationellt representativa data om kön, makt och beslutsfattande för att förstå vilka sociala normer och värderingar som är diskriminerande (dvs. som har lägst stöd för sexuella och reproduktiva rättigheter), skadliga eller underminerar sexuell och reproduktiv hälsa, samt vilka aspekter av sexuella och reproduktiva rättigheter som har störst stöd i olika grupper. Det är också viktigt att få en bättre förståelse för hur det svenska SRHR biståndet fokuserar på frågor som relaterar och kan bidra till att ifrågasätta och på sikt förändra diskriminerande normer och värderingar utifrån lokala kontexter, både i nuvarande och kommande strategier för SRHR i Afrika söder om Sahara.

Målet med den här rapporten är att öka förståelsen för vilka normer och värderingar kopplat till SRHR och jämställdhet som är viktigast att arbeta med i Afrika söder om Sahara för att säkerställa SRHR för alla. Vi har också försökt att identifiera potentiella behov och möjligheter för att optimera svenskt utvecklingsbistånd för SRHR i lokala, regionala och nationella normativa sammanhang.

Rapporten består av två delstudier som använder sig av olika metoder. I delstudie I samlade vi in och analyserade nationellt representativa data om sociala normer och värderingar via World Values Survey i tre afrikanska länder söder om Sahara: Etiopien, Nigeria och Zimbabwe. Dessa länder bedömdes som särskilt relevanta då de dels är viktiga mottagarländer för svenskt SRHR-bistånd, dels representerar olika regioner i Afrika. Nigeria och Etiopien är dessutom de befolkningsmässigt största länderna i Afrika, och Zimbabwe är ett av länderna i södra Afrika som har bilaterala avtal med Sverige vad gäller just SRHR. Vi genomförde deskriptiva och multivariabla analyser för att undersöka om och hur normer och värderingar relaterat till SRHR skiljer sig mellan länderna, samt hur de varierar beroende på sociodemografiska faktorer. För delstudie II genomförde vi en kartläggning av svenskt SRHR-bistånd och analyserade om och hur Sidas insatser förhåller sig till de normer och värderingar som identifierades som viktigast i delstudie I. Vi intervjuade också Sida-anställda och partners inom hälsobiståndet i Zimbabwe i för att förstå i vilken utsträckning normer och värderingar för SRHR har beaktats i strategier, planer, projekt och rapportering i Sida-finansierade insatser.

Rapporten grundar sig på den integrerade definitionen av SRHR från Guttmacher-Lancet-kommissionen (2018), som betonar sambandet mellan sexuell och reproduktiv hälsa med sexuella och reproduktiva rättigheter. Vi använder oss också av teorier om sociala normer som definierar dessa som oskrivna regler om (socialt eller kulturellt lämpliga) beteenden enligt vad andra gör eller tänker, i motsatts till individens personliga övertygelser eller värderingar, som när de analyseras på en aggregerad (grupp) nivå kan ge en indikation om en bredare norm.

Resultaten från delstudie I visade att normer och värderingar varierade mellan de tre länderna, där svarsdeltagare i Etiopien generellt uttryckte mer stöd för SRHR än de i Zimbabwe och Nigeria. Skillnaderna var dock små när vi analyserade olika åldersgrupper, kön, eller bostadsort (stad eller landsbygd). I enlighet med vårt ramverk fann vi att stöd för diskriminerande normer var vanligast i förhållande till sexuella och reproduktiva rättigheter snarare än till sexuell och reproduktiv hälsa. De diskriminerande normer och värderingar som stack ut tydligast hos deltagarna rörde homosexuella, bisexuella, transpersoner, queer eller intersex (HBTQI)-personers rättigheter, abort, kvinnors beslutsfattande, mäns kontroll och makt över kvinnor, våld mot barn, skilsmässa, samt ungdomars sexualitet och rätt att välja partner. En majoritet av deltagarna var positiva till individers tillgång till preventivmedel oavsett civilstånd, och hälften visade stöd för säker abortvård. Väldigt få ansåg att kvinnlig könsstympning (FGM/C) var acceptabelt, trots en hög förekomst av denna praktik i framför allt Etiopien, vilket indikerar att förändring är möjlig.

Överblick över normer och värderingar relaterade till Sidas fokusområden för SRHR-bistånd: HBTQI-personers rättigheter, könsbaserat våld, FGM/C och barnäktenskap. Siffrorna gäller det totala urvalet.

→ HBTQI: 85% tycker inte att homosexualitet är acceptabelt, 71% tycker att homosexuella män inte är riktiga män, 64% tycker inte att människor som klär sig och beter sig som det motsatta könet bör behandlas precis som vem som helst, 83% tycker inte att det är ok att ha homosexuella till grannar och 93% tycker inte att homosexuella föräldrar är lika bra föräldrar som vem som helst.

→ Könsbaserat våld: 65% anser att om en man har en flickvän eller fru, borde han veta var hon är hela tiden, medan 23% tycker att det är acceptabelt för en man att slå sin fru.

→ FGM/C: 19% tycker att detta är acceptabelt.

→ Barnäktenskap: 33% tycker att en flicka är redo för äktenskap när hon börjar menstruera.

Vidare underströk de multivariabla analyserna komplexiteten i SRHR-normer och värderingar, men det fanns inga tydliga trender vad gällde samband med sociodemografiska faktorer. Den viktigaste oberoende faktorn för normer och värderingar som stöder sexuella och reproduktiva rättigheter var att ha en stark hushållsekonomi, och högre utbildning var även associerat med högre stöd för kvinnors rättigheter. Det fanns även en högre acceptans för HBTQI personers rättigheter i yngre åldersgrupper.

Resultaten för delstudie II visade att Sidas utvecklingsbistånd för SRHR har ökat med tiden och fokus har flyttat mellan olika SRHR områden. Det totala utvecklingsbistånd för SRHR som Sida har betalat ut ökade från 1 019 miljoner SEK (MSEK) år 2010 till 1 603 MSEK år 2018, varav det högsta beloppet på 1 981 MSEK registrerades 2017. Andelen av SRHR-biståndet som är inriktat på

sexuella och reproduktiva rättigheter har ökat med tiden, medan den andel som är inriktad på reproduktiv och sexuell hälsa har minskat. Nuvarande data för Sidas utvecklingsbistånd för SRHR möjliggör dock inte en enkel uppdelning av SRHR biståndet i specifika SRHR områden som HIV/AIDS eller abort, vilket gjorde analysen svår och tidskrävande. Det samlade intrycket är normer och värderingar verkar bli alltmer viktiga för operationaliseringen av Sidas SRHR-arbete, trots att de inte uttryckligen nämns i de samarbetsstrategier som granskats som del av detta arbete.

Sammantaget bekräftar våra resultat att normer och värderingar relaterade till SRHR inklusive jämställdhet är både komplexa och dynamiska. Dessa normer och värderingar är motstridiga, oförutsägbara och låter sig inte grupperas in i "mer" eller "mindre" SRHR-stöd på ett konsekvent sätt. Resultaten visar tydligt att en individ och en grupps stöd för en dimension av SRHR inte nödvändigtvis innebär att de stödjer en annan; till exempel kan en person stödja abort och HBTQI personers rättigheter, men ändå tycka att våld mot kvinnor kan rättfärdigas. Vi såg liknande trender på befolkningsnivå i de tre länderna, exempelvis ett genomgående lågt stöd för HBTQI rättigheter, medan acceptansen generellt var betydligt högre för preventivmedel. Att SRHR är ett komplext område blev också uppenbart i vårt försök att kategorisera svenskt utvecklingsbistånd i olika SRHR komponenter och kategorier eftersom Sidas bistånd inte kategoriseras så i nuvarande form.

Våra resultat belyser flera aspekter som skulle kunna bidra till att optimera svenskt SRHR-bistånd för att (bättre) förhålla sig till diverse normativa sammanhang och behov i olika länder i Afrika söder om Sahara. Baserat på resultaten i rapporten ger vi följande rekommendationer:

1. **För att främja SRHR är det avgörande att arbeta med normer och värderingar.** Våra resultat indikerar att diskriminerande normer och värderingar är särskilt vanliga i relation till sexuella och reproduktiva rättigheter, snarare än hälsa. Dock är alla typer av hälsoinsatser som rör SRHR nära länkade med normer och värderingar. Sida och andra biståndsorganisationer bör därför alltid överväga att beakta värderingar och normer när de initierar, handlägger och följer upp SRHR-insatser. Exakt hur en sådan analys ska se ut bör utformas i nära dialog mellan programansvariga på Sida och lokala aktörer, men ett exempel kan vara att inkludera en obligatorisk beskrivning av existerande kunskap om värderingar och normer relaterat till biståndsinsatsen.
2. **Kunskap om kontext och sammanhang är avgörande för att effektivt arbeta med diskriminerande normer.** Biståndsaktörer, inklusive Sida bör säkerställa kapacitet bland personal för att kunna förstå, bedöma och arbeta med normer och värderingar, givet komplexiteten i dessa frågor. Insatser som syftar till att ifrågasätta och/eller på sikt förändra normer och värderingar måste anpassas till den lokala kontexten, utgå ifrån ett rättighetsperspektiv samt undvika att generalisera kring normer och värderingar i en viss nationalitet eller grupp.
3. **När SRHR-normer och värderingar tydliggörs i styrningsdokument för utvecklingssamarbeten, underlättar det för ett mer strategiskt arbete med dessa frågor.** Den svenska regeringen bör inkludera normer och värderingar relaterade till SRHR i styrning, strategier och riktlinjer för utvecklingssamarbete och även säkerställa att personalen har tillräcklig kompetens och tillgång till verktyg för att bedöma hur olika insatser beaktar normer och värderingar. Detta innebär även att Sida, vid utvecklandet av underlag till regeringen för nya samarbetsstrategier för biståndet, bör understryka vikten av att beakta normer och värderingar när SRHR-relaterade mål och indikatorer analyseras.

4. **Högkvalitativa data möjliggör en bättre förståelse av den utsträckning som Sida riktar in sig på normer och värderingar i utvecklingsbistånd för SRHR.** Sida bör förbättra kvaliteten och detaljnivån på data i sitt insatshanteringssystem för att möjliggöra och effektivisera rutinmässig kategorisering, analys och uppföljning av SRHR-biståndet. Denna typ av förändringar bör genomföras i samråd med Sidas enhet för analys, statistik och data och ta i beaktande externa rapporteringskrav (från t.ex. OECD) såväl som interna behov av att bättre förstå vilka SRHR-områden Sidas SRHR bistånd går till.
5. **SRHR-normer och värderingar är komplexa, och förändring tar tid.** Insatser som ämnar att aktivt påverka bredare sociala normer såväl som individers personliga uppfattningar eller värderingar måste därför betraktas som ett långsiktigt arbete som sträcker sig utöver de vanliga (3–5 år) biståndS- och finansieringscyklerna. Tidigare forskning visar att för att nå en "tipping point" där människor överger diskriminerande normer behövs insatser på flera nivåer och med olika angreppssätt (att endast fokusera på individuell attitydförändring är tex inte tillräckligt). Normernas komplexitet indikerar även att (ökat) stöd för en aspekt av SRHR (tex preventivmedel) inte automatiskt leder till att andra mer kontroversiella diskriminerande normer förändras (som tex HBTQI). Sida bör därför överväga att klargöra sin ståndpunkt kring målet att långsiktigt förändra vissa normer som påverkar SRHR negativt, eftersom Sverige kan vara en av flera aktörer som verkar för att skapa lokala förutsättningar för "tipping points". Då denna process tar tid, bör Sida och andra biståndsorganisationer säkerställa insamling och användning av data för att vägleda och utvärdera stöd till normförändringar samt upprätthållande av normer som stöder SRHR.

Summary

Ensuring universal access to sexual and reproductive health and rights (SRHR) is essential to fulfil the 17 sustainable development goals (SDGs) of the 2030 Agenda. Sweden is one of few countries to maintain a longstanding commitment to universal SRHR and gender equality throughout its official development assistance (ODA), regardless of shifts in governments and political agendas. Much of Sweden's bilateral and regional SRHR–ODA is focused on sub-Saharan Africa, which is the region that has seen the least progress in SRHR outcomes (such as maternal mortality and morbidity, unsafe abortions, HIV, unmet need for contraceptives).

SRHR are intrinsically linked with human rights and gender equality and are strongly influenced by socially and culturally constructed values and norms. These values and norms influence individuals' abilities to make decisions and to access information and services related to their bodies, sexuality, relationships, and childbearing. Addressing social norms and values related to SRHR, for example the right to decide about one's own body and fertility regardless of gender, sexual orientation, gender expression or marital status, is key to achieving the 2030 Agenda, in particular goal 5 (gender equality) and goal 3 (good health and well-being). There is however a need for new, nationally representative data that tap into gender, power, and decision-making to understand which social norms and values are discriminatory (i.e., lowest support for sexual and reproductive rights) and undermine SRHR, as well as which aspects of sexual and reproductive rights that have the greatest support in different populations. There is also a need to better understand how Swedish SRHR ODA is addressing areas related to, and can contribute to changing, such discriminatory values and norms, as part of current and new strategies for SRHR in sub-Saharan Africa.

The goal of this report is to increase our understanding of which values and norms related to SRHR and gender are most central to address in sub-Saharan African countries in order to achieve SRHR

for all, as well as to identify potential gaps and opportunities for optimizing Swedish SRHR ODA according to the specific local, regional, and national normative contexts and needs.

The report consists of two sub studies using mixed methods. For **sub-study I,** we collected and analysed nationally representative data on social norms and values collected via the World Values Survey in three sub-Saharan African countries: Ethiopia, Nigeria, and Zimbabwe. These countries were chosen as they have high levels of ODA and represent three different sub-regions of Africa. Nigeria and Ethiopia are also the two largest countries population-wise on the continent, while Zimbabwe is a country in southern Africa that has bilateral agreements with Sweden regarding SRHR. We carried out descriptive and multivariable analyses to explore variations in norms and values across sociodemographic variables across the three countries. For **sub-study II**, we conducted a descriptive mapping of Swedish SRHR ODA and analysed if and how components targeted by Sida align with the norms and values identified in sub-study I. We also interviewed ODA officials in Zimbabwe – the only country included in this study for which Sida has a bilateral cooperation that includes SRHR – to understand the extent to which social norms and values for SRHR have been considered in strategies, plans, projects, and reporting in Sida funded interventions.

The report is grounded in a conceptual framework that builds on the Guttmacher-Lancet Commission integrated definition of SRHR, which stresses the interrelationship between sexual and reproductive **health** with sexual and reproductive **rights.** We also draw on social norms theories, defining social norms as unwritten rules about (appropriate) behaviour based on what others do or think, vs. individual's personal beliefs or values, which when analysed at the aggregate (group) level may give an indication of a broader norm.

For sub-study I, we found that norms and values varied across the three countries, with respondents in Ethiopia generally reporting more support for SRHR than respondents in Zimbabwe and Nigeria.

There were few differences between men and women, age groups or living in urban or rural areas. Guided by our conceptual framework, we found that discriminatory norms were most common in relation to sexual and reproductive rights rather than those related to reproductive health. The discriminatory values and social norms that appeared to be particularly entrenched were those related to LGBTQI rights, abortion, women's decision-making, men's control and power over women, violence against children, divorce, and young people's sexuality and right to choose a spouse. However, a majority of the respondents were in favour of accessible contraceptives regardless of marital status, and half indicated support for safe abortion services. Very few accepted female genital mutilation and cutting (FGM/C), despite a high prevalence in Ethiopia in particular, indicating an opportunity for change.

Snapshot of norms and values related to Sida's recent areas of focus for their SRHR development assistance: LGBTQI rights, gender-based violence (GBV), female genital mutilation or cutting (FGM/C) and child marriage. The numbers reflect the total sample.

→ LGBTQI: 85% do not think that homosexuality is acceptable 71% think that homosexual men are not real men, 64% think that people who dress, act as the opposite gender should not be treated as anybody else, 83% think that it is not ok to have homosexual people as neighbours and 93% do not think that homosexual parents are as good as any other parent.

→ GBV: 65% think that if a man has a girlfriend or wife, he should know where she is all the time, and 23% thinks that it is acceptable for a man to beat his wife.

→ FGM/C: 19% think that this practice is acceptable.

→ Child marriage: 33% think that a girl is ready for marriage, once she starts menstruating.

Multivariable analyses further demonstrated the complexity of SRHR norms and values, and there were no clear trends in terms of their association with sociodemographic factors. The most important independent determinant for supporting sexual and reproductive rights was having strong household economy, and higher education was associated with support for women's rights. In addition, younger age groups tended to be more accepting of LGBTQI rights.

In sub-study II, we found that Sida's development assistance for SRHR has increased over time with shifting focus between different domains of SRHR. Total development assistance for SRHR disbursed by Sida increased from 1,019 million SEK (MSEK) in 2010 to 1,603 MSEK in 2018, with the highest volume recorded in 2017 at 1,981 MSEK. The share of SRHR development assistance targeting sexual rights and reproductive rights has increased over time, while the share targeting reproductive health and sexual health has reduced. Current data on Sida's SRHR development assistance for SRHR does not allow for routine disaggregation of SRHR ODA by, for example, SRHR areas (e.g. HIV/AIDS or abortion) – making the analysis difficult and time consuming. Values and norms do, however, appear increasingly critical to operationalizing Sida's SRHR projects, despite not being explicitly mentioned in country cooperation strategies.

Taken together, our findings confirm that values and norms related to SRHR are complex and dynamic; they are contradictory and unpredictable, and not easily compartmentalized into "more" or "less" supportive. For example, it became clear that an individual's and a group's support for one dimension of SRHR does not necessarily guarantee that they support another; for example, someone might support abortion and LGBTQI rights, but still justify violence against women. However, at the same time, our results clearly show that trends at the population level are not country specific, e.g. the low support for LGBTQI rights and high

support for contraceptive use were similar in all three countries. This complexity was also apparent in our attempt to categorize Swedish ODA into components and categories of SRHR as Sida's contributions are not categorized accordingly.

Our results shed light on several aspects that could help optimize Swedish SRHR ODA to (better) fit the different normative contexts and needs within and across countries in sub-Saharan Africa. We make the following key recommendations:

1. **Advancing SRHR necessitates addressing values and social norms.** Our findings indicate that discriminatory norms are more linked to aspects of sexual and reproductive rights than health. That said, all SRHR services are intimately linked with values and norms. Therefore, Sida and other development cooperation actors should consider assessing values and norms when initiating new, and following up on, existing SRHR contributions. Exactly how such assessments should be conducted has to be developed in dialogue between programme officers and local key stakeholders but could for example include a compulsory description of existing knowledge of values and norms in relation to the contribution under consideration.
2. **Contextual knowledge is essential to effectively target discriminatory norms**. Our findings indicate that while SRHR may be conceptualized as a package, supporting one aspect of SRHR (e.g., contraceptive access) does not mean that individuals agree with other sexual and reproductive rights. Development actors including Sida should ensure sufficient capacity among staff to understand, assess and work with norms and values, given their complexity. Any norm interventions aiming to address (discriminatory) norms must be adapted to the local context and clarify the human rights perspective. It must also avoid any generalization of particular nationalities or groups.

3. **Explicitly including SRHR norms and values in official strategies signify priorities and guide project logic and evaluation processes.** We stress the need for the Swedish government to explicitly mention the importance of (addressing discriminatory) values and norms related to SRHR in strategies for development cooperation and provide staff with tools to include norm assessments and adaptions in their activities. This also requires that Sida, when providing input to the government for new strategies, stress the importance of considering norms and values as part of the analysis for SRHR related goals and targets.
4. **Increasing the quality of data allows for better understanding of the extent to which Sida is targeting values and norms in its SRHR ODA.** Sida should improve the quality and level of detail of data in their contribution management system to allow for routine disaggregation and ease of follow-up of SRHR ODA. Such changes in contribution data could be discussed with the unit for analysis, statistics and data and take into consideration both external reporting requirements (to for example OECD DAC) and internal needs for a better understanding of Sida's portfolio on SRHR.
5. **SRHR-values and norms are complex, and change takes time.** Efforts to actively influence and change broader social norms as well as individual's personal beliefs or values must therefore be regarded a long-term work that extends well beyond Sweden's regular (3–5 years) ODA strategies and funding cycles. In line with our theoretical framework, there is a need to strengthen norms and values that are (already) supportive of SRHR, as well as to address discriminatory, prevailing norms. Past research shows that interventions are needed at multiple levels to reach a "tipping point" where people abandon discriminatory norms and adopt new ones. The complexity of norms further indicates that (increased) support for one aspect of SRHR (e.g., contraceptives) does not automatically lead to change in other more controversial, discriminatory norms

(such as LGBTQI). Sida should therefore consider clarifying its position on social norms change as Sweden can be one of several actors involved in creating the conditions necessary to reach a tipping point. As this process takes time, Sida and other development actors should consider ensuring the collection and use of data to guide and evaluate its support to norm change and on sustaining norms that are supportive of SRHR.

Introduction

Ensuring universal access to sexual and reproductive health and rights (SRHR) is essential to fulfil the 17 sustainable development goals (SDGs) of the 2030 Agenda. SRHR are intrinsically linked with human rights, and gender equality, and are strongly influenced by socially and culturally constructed values and norms related to gender and power [1]. These values and norms influence individuals' abilities to make decisions and to access information and services related to their bodies, sexuality, sexual relationships, marriage, and childbearing [2–6].

In 2018, the Guttmacher-Lancet Commission proposed a new integrated definition of SRHR, which builds on globally established human rights conventions, emphasizing the right for all individuals to enjoy a state of physical, emotional, psychological, and social well-being in relation to all aspects of SRHR, not just the absence of disease, dysfunction, or injury. In other words, all individuals should have the capacity to: make decisions about their own bodies and sexuality, freely express their gender and sexual identity, and decide when, if and with whom to form relationships, have sex, marry and have children – irrespective of the social, cultural, legal and economic context (Box 1) [2]. However, it is estimated that of the world's 4.3 billion people of reproductive age, the great majority will have inadequate SRHR information and services over their life course [2].

Decades of work by national and global actors have aimed at improving universal access to essential SRHR interventions, such as comprehensive sexuality education, contraceptives, and skilled birth attendance, reducing child marriages, preventing HIV and other sexually transmitted infections (STIs), and increased acknowledgment of the rights of lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) populations. Sweden has been one of few countries to maintain a longstanding commitment to universal SRHR and gender equality throughout its official development assistance (ODA), regardless of shifts in governments and political

agendas [7]. As one of the main funders of the United Nations Population Fund, Sweden has become recognized as a country that has both credibility and legitimacy to voice support for SRHR issues that are at times considered controversial, such as abortion and LGBTQI rights. In order to enhance the strategic efforts to advance gender equality and human rights of women and girls everywhere, Sweden adopted a feminist foreign policy in 2014. This strategy pays particular attention to rights, representation and resources of girls and women [8] and underscores the need to also work with men and boys to address discriminatory gender norms. Since then, Canada, Spain and Mexico have adopted similar policies and France and Luxembourg have expressed an intention to do so [9].

While there has been progress relating to the fulfilment of SRHR and shifts towards more gender equal values over the last century, such transitions are not always sustained and should not be taken for granted. In many countries, progress has reversed over the last years [2, 10] with increasing mobilization against sexual, gender and reproductive rights that view issues such as feminism, LGBTQI rights and/or abortion as threats to "traditional" values [11–15]. In 2011, the Council of Europe convention on preventing and combatting violence against women and domestic violence, known as the Istanbul convention, was ratified by 45 countries [16]. However, Turkey later denounced their ratification, stating that "the convention normalises homosexuality". More countries have since declared that they consider withdrawing [17, 18]. Many civil society organisations promoting access to SRHR have also experienced a shrinking space to operate freely in [4]. This regressive development has become acute in light of the adverse SRHR outcomes witnessed as a consequence of the COVID-19 crisis [19].

Sub-Saharan Africa has seen the least progress in SRHR outcomes (such as maternal mortality and morbidity, unsafe abortions, people living with HIV, highest unmet need for contraceptives) of all regions [20]. This is also where Sweden focuses much of its SRHR support, either through multilateral organisations, such as UNFPA,

or regional and bilateral aid. Beyond bilateral and multilateral ODA, many African nation states are also members of regional economic communities, that have developed specific policy documents and legal infrastructures to improve SRHR and gender equality[1]. Despite this formally supportive environment for SRHR, obstacles to improve SRHR outcomes for all very often include restrictive social norms and values according to a recent overview of the status and health of women in Africa [14]. Swedish strategies for SRHR ODA have therefore identified social norms and values and the involvement of boys and men as well as religious leaders, as important obstacles for advancing SRHR, but until recently the Government has not defined specific targets for Sweden's role in addressing these [21]. In response to this, and to effectively monitor the funding commitments made in the last decade[2] there have been recent efforts to track the share of countries' ODA dedicated to SRHR [22], but mainly focusing on the health dimension of SRHR.

The overall lack of progress in SRHR is a result of a complex web of individual, social and structural factors at the national or sub-national levels. These factors include discriminatory social norms and values related to sexuality and gender that are transmitted across generations, coupled with resource-limited health systems and weak political commitment [2, 23]. For example, data from Demographic and Health Surveys (DHS) indicates that over a third of the world's adolescents (36% males, 37% females, aged 15–19) justify at least one reason for wife beating, with proportions ranging up to 79% in some settings [24].

Addressing social norms and values related to SRHR, for example the right to decide about one's own body and fertility regardless of gender, sexual orientation, gender expression or marital status, is key to achieving the 17 SDGs, in particular goal 5 (gender equality) and

[1] For example, the Southern Africa Development Community (SADC) regional SRHR strategy 2019–2030.

[2] These include commitments such as FP2020, the ICPD+25 Nairobi Summit and the Sustainable Development Goals.

goal 3 (good health and well-being). Many of the indicators for SDG 5 speak to the importance of equitable decision-making, and especially indicator 5.6.1 which assesses the "proportion of women (aged 15–49 years) who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care" [25]. However, there is currently a lack of data to monitor an estimated 80% of the indicators related to gender equality across the SDGs [26].

Existing surveys, such as the DHS and UNICEF Multiple Indicator Cluster Surveys (MICS), collect data regarding sexual and reproductive health outcomes, women's empowerment as well as attitudes towards some aspects of gender equality (such as wife beating). However, these surveys lack broader measures of social norms and values related to gender and SRHR that are necessary to understand, guide and interpret programme implementation processes and outcomes, and to monitor the SDGs [27, 28]. The DHS and MICS currently collect geocoded information on the location of respondents, allowing for the study of regional and sub-regional distributions in certain practices such as child marriage and female genital cutting and mutilation (FGM/C) [28]. A high prevalence of a practice in one specific setting, and a low in a nearby place, suggests the possibility of a difference in social norms [29], but regional variations in practices could also be due to factors such as climate crisis, ongoing conflicts, income, and education levels, rather than (only) norms. Thus, "the use of DHS and MICS data to identify and measure social norms is limited in several ways", as it does not tap into the social relations of individuals at the micro level, including what others do and what others think one should do – i.e., what social norms that exist, and to what extent these norms are reflected in individual values [28]. The Afrobarometer is another large survey that collects data on attitudes related to society, including democracy, governance, the economy, among populations in African countries.

However, collected SRHR items are limited to attitudes towards wife-beating and male circumcision, and items on gender equality are primarily focused on women's roles as leaders, and women and girls' rights to work, education, and property [30].

There is an urgent need for new, nationally representative data that tap into gender, power, and decision-making to understand which social norms and values are discriminatory (i.e., lowest support for sexual and reproductive rights) at individual and aggregated levels, and thus central to target as part of national and global SRHR agendas, as well as the aspects of sexual and reproductive rights that have the greatest support in the population. There is also a need to better understand how Swedish SRHR ODA is addressing areas related to, and can contribute to changing[3], such discriminatory values and norms.

This report seeks to bridge the gap in evidence by:

1. collecting, analysing, and disseminating new individual level data on values and norms related to gender and SRHR; and
2. relating these findings to the focus of activities undertaken as part of Sweden's SRHR support, primarily in sub-Saharan Africa.

Our analysis of values and norms and categorization of Swedish ODA does not only assess the health-related aspects of SRHR but also captures the human rights aspects in line with the Guttmacher-Lancet Commission's comprehensive definition (Box 1).

[3] Changing norms is by all means a complex issue, especially when a key actor is external to the society in which such norm change is to happen. We reflect and discuss this further under the heading "Theoretical Perspectives".

Box 1. An integrated definition of Sexual and Reproductive Health and Rights (SRHR) by the Guttmacher-Lancet Commission

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity.

Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing.

All individuals have a right to make decisions governing their bodies and to access services that support that right.

Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Aim and research questions

The overall goal of this project is to increase the understanding of what gender and SRHR-related values and norms are most central to address in sub-Saharan African countries in order to achieve SRHR for all, as well as to identify potential gaps and opportunities for Swedish ODA to optimize its support to SRHR by better adapting it to the specific local, regional, and national normative contexts and needs.

The project has **two central aims:**

1. To assess values and norms related to gender and SRHR in three sub-Saharan African countries (Ethiopia, Zimbabwe, Nigeria); and
2. To describe and categorize Sweden's ODA for SRHR disbursed by Sida between 2010–2018 and illustrate whether the SRHR components targeted by Sida align with the social norms and values identified in Aim 1.

Research questions:

1. How common are discriminatory values and norms related to gender and SRHR in three sub-Saharan countries?
2. Which sexual and reproductive rights have the greatest support in each country based on values and norms, i.e., which aspects appear to be least controversial?
3. How do discriminatory values and norms related to gender and SRHR vary across sociodemographic factors within the three countries?
4. How has the level of development assistance for SRHR through Sida changed from 2010 to 2018, and which SRHR components have been targeted?
5. In what ways and to what extent have social norms and values around SRHR been considered in strategies, plans, projects, and reporting in Sida funded interventions, using the example of Zimbabwe.

To answer these questions, we used a mixed-methods design combining the collection of new nationally representative data on gender- and SRHR-related values and norms via the World Values Survey (WVS) with a descriptive mapping of Sweden's support to SRHR interventions via Sida.

For Aim 1, we developed a new WVS module with questions on gender and SRHR-related values and norms that was first piloted in Nigeria, and then in a revised version implemented in two other sub-Saharan African countries: Ethiopia and Zimbabwe.

For Aim 2, we categorized Swedish ODA for SRHR and analysed if and how projects align with the most discriminatory values and norms (i.e., lowest support for sexual and reproductive rights).

The goal of this study is not to evaluate the effect of developmental assistance on social norms, nor to assess how values and norms shape SRHR outcomes. It seeks to map values and norms in the three sub-Saharan countries, focusing on norms that are against vs. in support of sexual and reproductive rights – including gender equality. We combine this with an analysis of trends in Swedish ODA for SRHR to explore how Sida can direct its support in a way that is more adapted to the specific local, regional, and national normative contexts and needs.

The information from this project can contribute to optimizing Swedish ODA in the area of SRHR, i.e., what Sweden should prioritize and pursue in order to address discriminatory norms in collaboration with local actors and organisations in SSA priority countries. It can further contribute useful data for the monitoring of the SDGs, specifically goals 3, 4 and 5, and other issues not included in the 2030 Agenda (e.g., norms related to LBGTQI and abortion), but that are central to achieving SRHR for all.

Report structure

The report is structured as follows: we begin with a Background on gender and SRHR in the sub-Saharan African context, SRHR in the African policy landscape, and Sweden's role and support to SRHR. This is followed by a section on Theoretical perspectives, including key definitions related to norms and values, and an overview of the study conceptual framework. We then move on to present the Methodology for each sub-study, followed by Findings with narrative descriptions, Tables, Figures as well as bullet-point summaries. A reflection on Strengths and Limitations is included before we end with a Discussion that answers our research questions, and provide recommendations based on the key findings.

Background

Gender and SRHR in sub-Saharan Africa – a snapshot in three countries

Despite great progress over the last three decades to achieve SRHR for all in sub-Saharan Africa, progress has been patchy and slow, with many of the region's countries facing persistently high rates of maternal mortality, HIV prevalence, child marriage, adolescent pregnancies, FGM/C and gender based violence (GBV), coupled with a lack of sexual and reproductive rights [31–36]. The progress towards reaching global and regional commitments on SRHR varies greatly between this report's three focus countries: Ethiopia, Nigeria, and Zimbabwe, reflecting the continent's large geographical variations. Table 1 presents key indicators for these three countries, briefly summarised below. Social norms and values are shaped by numerous historical events and specific geo-political and social contexts, but this report will focus on providing an overview.

While maternal mortality has declined substantially in sub-Saharan Africa over the last 20 years, the region still accounts for over two thirds (68%) of all maternal deaths globally [37]. Women are more likely to die from childbirth and pregnancy-related causes in the Western and Central parts of Africa than in the South-East. As shown in Table 1, Nigeria stands out with a maternal mortality ratio (MMR) of 917 maternal deaths per 100,000 live births, which is substantially higher than the other countries in this report as well as the world average. It has the highest adolescent birth rate and less than half of births are attended by a skilled attendant. The country also has the highest rate of child marriage as well as total fertility among the three countries; one in five women report unmet need for contraceptives.

The unmet need for contraceptives is by far the lowest in Zimbabwe where the contraceptive prevalence rate is also higher than in the other countries. With a larger share of girls enrolled in secondary school, Zimbabwe has lower rates of adolescent births and child marriages compared to the other countries. More births are attended by a skilled person compared to the other two countries as well as the global average. While Ethiopia has a very high share of child marriages, the highest unmet need for contraceptives, and the lowest proportion of births attended by a skilled attendant, it still has a lower ratio of maternal deaths compared to both Zimbabwe and Nigeria. Ethiopia is also the country with the most permissive abortion laws among the three countries included in this report.

The HIV prevalence in Nigeria and Ethiopia roughly reflects the global average, while it is substantially higher in Zimbabwe, where almost 13% of the adult population of reproductive age (15–49 years) live with HIV. Due to its link with HIV, progress has been made on implementing and scaling up comprehensive sexuality education (CSE) in all three countries [38]. Nigeria has strategically worked with this in the past two decades [39]. Ethiopia and Zimbabwe are both commitment makers to the Eastern and South Africa CSE Commitment of 2013, which is being tracked through various indicators. Zimbabwe has come the farthest in terms of including CSE in at least 40% of schools, providing appropriate training for teachers, health care providers and social workers as well as providing a minimum package of youth friendly services [40]. Ethiopia has yet to reach 40% of the schools, also little progress has been made on training health providers and social workers to provide appropriate care in Ethiopia [40].

Gender inequality remains a major challenge in the three countries as indicated by their rankings on the Gender Inequality Index. Beyond reproductive health, the inequality refers to the economic dimension and overall empowerment. While Ethiopia and Zimbabwe both rank among the bottom 100, not enough data is available for Nigeria. These rankings are somewhat mirrored in legislation on GBV. All countries have legislation on domestic

violence, and most of them, except Nigeria, has legislated against sexual harassment (14). About one in five women report experiencing past-year physical or sexual violence in Ethiopia and Zimbabwe. Ethiopia and Nigeria explicitly omit marital rape from the definition of rape [34]. In all the three countries, LGBTQI people risk years of imprisonment and in Nigeria, even the death penalty (Table 1).

Table 1. Key SRHR indicators for Ethiopia, Nigeria, and Zimbabwe

Indicator	World	Ethiopia	Nigeria	Zimbabwe
Population, million (UNFPA, 2020)	7,795	115	206	15
Life expectancy at birth (UNFPA, 2020)	73	67	55	62
Total Fertility Rate (UNFPA, 2020)	2.4	4	5.2	3.5
Secondary school enrolment, female % gross (World Bank)		34% (2015)	40% (2016)	51% (2013)
Gender inequality index (GII) rank (UNDP, 2017)	-	121	-	128
Poverty headcount ratio at $1.90 a day, (World Bank, 2015–2018)	9.2 (2017)	32.6 (2015)	39.1 (2018)	33.9 (2017)
Maternal Mortality Ratio per 100,000 live births (UNFPA, 2017)	211	401	917	458
Births with skilled health attendant (UNFPA, 2014–2019)	81%	28%	43%	86%
Contraceptive prevalence rate modern methods, women married/in union aged 15–49 (UNFPA, 2020)	57%	40%	14%	68%

Indicator	World	Ethiopia	Nigeria	Zimbabwe
Unmet need for contraceptives, women married/in union aged 15–49 (UNFPA, 2020)	11%	21%	19%	10%
Adolescent birth rate per 1,000 women aged 15–19 (UNFPA, 2020)	41	80	106	78
Child marriage <18 years old (UNFPA, 2019)	20%	40%	43%	34%
FGM/C girls aged 15–19 (UNFPA, 2019)	-	47%	14%	-
HIV ages 15–49 (World Bank, 2019)	0.7%	0.9%	1.3%	12.8%
Past-year physical/sexual violence against women 15–49 years old (World Bank, 2013–2016)	-	19.8%	11.0%	19.9%
Grounds for right to abortion (Center for Reproductive Rights, 2020)		Broad social or economic grounds	Save a woman's life	Preserve Health
Criminalization of consensual same-sex sexual acts between adults (ILGA, 2019)	-	Yes Up to 8 years prison	Yes 10 years – life prison or Death penalty	Yes Up to 8 years prison

Data sourced from country profiles from UNDP country profiles of 2018.
http://hdr.undp.org/sites/default/files/Country-Profiles/ETH.pdf
http://hdr.undp.org/sites/default/files/Country-Profiles/RWA.pdf
http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/NGA.pdf
http://hdr.undp.org/sites/default/files/Country-Profiles/ZWE.pdf
World Bank data: https://data.worldbank.org/
UNFPA: https://www.unfpa.org/data/world-population-dashboard
ILGA: https://ilga.org/maps-sexual-orientation-laws
Center for Reproductive Rights: https://reproductiverights.org/worldabortionlaws

COVID-19 implications on SRHR

The on-going COVID-19 pandemic will negatively affect the progress in many of these SRHR indicators [19]. Social distancing restrictions, lockdowns, fear of and stigma related to the disease and re-priorities aiming to reduce the risk of Sars-Cov-2 transmission in the world, are expected to cost more lives than the virus itself, especially among the poor and most vulnerable: children, young people and women [41]. According to the WHO, the reduction in access to care has become both more dramatic and more prolonged than a "worst case scenario" predicted by UNICEF in April 2020: 45% of low-income countries and 30% of low-middle-income countries reported a decline of 75% or more in various routine health interventions [42]. In 68% of the countries, two-thirds reported disruptions in access to maternal care. In April 2021, the results from the second follow-up round were reported by the WHO based on interviews in 135 countries conducted January–March 2021. It found that many of these declines in access to care persist more than one year into the crisis with over 40% of countries reporting a disruption to family planning, contraception and malnutrition services, and more than one third, disruptions of antenatal care, postnatal care, critical health services to ensure that pregnant women and new-borns survive and remain healthy [43].

According to modelling estimates by the Guttmacher Institute already in early 2020, disruptions in essential SRHR services, poverty and school closures leading to increased sexual violence and child marriage, were estimated to cause over 15 million unwanted pregnancies and 28,000 additional maternal deaths in low-and middle-income countries [44]. A more recent estimate published in the Lancet, estimates at least 100,000 additional maternal deaths during the first pandemic year [45], and UNICEF estimates over 10 million additional child marriages by 2030 as a results of measures taken by countries to curb SARS-CoV-2 [46]. This is in line with the pattern seen in the aftermath of the Ebola outbreak in 2014–2016 in West Africa, where the indirect consequences of the quarantine

measures and reduction in basic health care, killed more people than the disease itself [47] and led to an increase in teenage pregnancies and FGM/C, as many girls were exposed to violence and abuse [48, 49]. Finally, the impact on pandemic-associated reduced access to prevention and care among people living with HIV remains to be assessed but could be substantial in Sub-Saharan Africa.

Most countries world-wide implemented school closures, including many African countries despite a very low number of COVID-19 cases. At its peak in April 2020, 1.6 billion or 92% of learners in the world were still affected, and one year into the pandemic almost 200 million children had still not been able to return to school. UNESCO lists numerous negative consequences for children and in particular girls, including interrupted learning, lost literacy, poor nutrition (missing out on the meals normally served in school), increased school dropouts, lack of access to health care in terms of school nurses, gender-based violence including child abuse, mental, physical, and sexual violence in isolated homes, teen pregnancies and child marriage. School closures have added to the stress and financial burden of families already living in material poverty with enormous long-term effects on nutrition, general health, and trillions of lost USD in life incomes. Many children, especially girls and young women, will not return to school because they have been married off or have become pregnant [50].

While the indicators listed in the table above have become worse, especially regarding gender-based violence, in the aftermath of the COVID-19 pandemic, the actual size of this impact remains to be assessed. Hence, policies and programmes that aim to rebuild societies must take these setbacks into account and aim to address them explicitly, including the social norms and values underlying many of the behaviour and choices of people, communities, institutions, and other social actors that have caused this gender imbalanced effect of the official responses to the pandemic.

SRHR in the African Policy Landscape

The commitment to universal access to SRHR is reflected in several commitments and frameworks that have been endorsed and, in some instances, ratified and domesticated by African Union Member States (Figure 1). These frameworks explicitly link SRHR to women and girl's rights with clear statements and commitments on violence against women and girls, harmful practices, as well as HIV and maternal mortality. The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, adopted in 2003), is particularly noteworthy, as it is the first international human rights document to explicitly raise HIV/AIDS [34, 51]. There are many actors involved in the field of SRHR, but given its basis in human rights conventions, we prioritise an overview of the most salient policy frameworks on the African continent that align with and reflect the global principles.

The African Union recognizes eight regional economic communities, out of which, five have normative and institutional frameworks in place for gender equality and the rights of women and girls, a few of which are binding[4]. The normative and institutional frameworks within these regional economic communities differ and their focus is also dependant on the prevailing challenges and circumstances within their jurisdiction. While various monitoring frameworks and tracking mechanisms are in place, they are most articulated and documented within the Southern African Development Community (SADC) space. The level of civil society engagement through regional advocacy networks also varies between the regions; and social justice movements most actively involved in regional policy processes seem most pronounced in eastern and southern countries [34]. African countries have also established a

[4] Policy frameworks relevant to the countries of this report are, the COMESA Revised Gender Policy (Ethiopia and Zimbabwe are members), the ECOWAS supplementary Act of 2015 (Nigeria is a member) and the SADC Protocol on Gender and Development (Zimbabwe is a member). Ethiopia is a member of IGAD, but its Gender Policy Framework is not binding (14).

continental court to ensure protection of human rights in Africa. The African Court on Human and Peoples' Rights is key in complementing and reinforcing the functions of the African Commission on Human and Peoples' Rights [52].

While the necessary building blocks for ensuring sustained progress on SRHR and gender equality are in place at various policy levels in Africa, several key pieces to operationalize them are missing. The economic and human capital required to implement the commitments are limited, as is political will, frameworks to facilitate implementation and reporting structures to monitor and evaluate any action taken. In addition, there is a need to improve formal structures to facilitate a closer and stronger engagement between civil society and policy makers [34]. While the commitments across all regional economic communities make strong statements in support of some areas of SRHR, there is less emphasis on contested issues such as sexual rights, abortion, contraceptives for adolescents and CSE. Finally, a clear plan to address norms harmful to gender equality and SRHR is also missing. In short, SRHR needs are great and formally recognised as such in the region, but gaps remain in turning frameworks into action plans and addressing key barriers such a values and norms related to gender and SRHR.

Figure 1. Overview of Key Policy Frameworks with commitments to SRHR endorsed by all African Union Member States

Sweden's role and support to SRHR

SRHR and gender equality are key priorities for Sweden's international development cooperation, as highlighted by several of Sida's regional and global strategies [53–56] and the country's feminist foreign policy. Sweden's long-term commitment (independent of political parties in the government) to global gender equality and universal SRHR makes it a unique voice in the field of international politics and ODA. As such, Sweden has the ability and is often expected by other countries, to prioritize issues frequently considered controversial or sensitive by other governments (e.g., abortion, LGBTQI rights, adolescent sexuality) in its strategies and direction of funds. Sweden also has the political legitimacy and credibility to raise international attention to specific SRHR issues that are crucial for poverty eradication and improving quality of life for people of all genders and identities.

SRHR represents a significant share of the ODA channelled through both Sida and the Swedish Ministry for Foreign Affairs. In 2017, SRHR constituted 7% of the total Swedish ODA (down from 8% in 2016), out of which roughly 1.3 billion SEK was channelled through Sida and 1.3 billion SEK through the Ministry of Foreign Affairs [57]. SRHR is a priority throughout the multilateral, regional and bilateral ODA and is primarily covered under Sida's thematic area of health equity. SRHR support includes multiple interconnected areas such as access to modern contraceptives, CSE, prevention and treatment of HIV, prevention of sexual and GBV, access to safe abortions, the rights of LGBTQI populations, as well prevention of harmful practices. A recent analysis of Sida's SRHR portfolio highlighted the need to involve men and boys, work with religious leaders, engage with the community and empower women and girls [58] illustrating the recognition of the importance of working with values and norms to advance SRHR.

Globally, there have been several attempts at better understanding the total levels of ODA directed towards SRHR from donor countries. An early model was developed by the Netherlands Interdisciplinary Demographic Institute in collaboration with UNFPA [59] to calculate financial flows from donors in support of the implementation of the Programme of Action of the International Conference on Population and Development. This method is based on an allocation of a fixed share of selected purpose codes, and has been applied in consecutive reports to the UN [60]. The benefit of a fixed share approach is that it allows for relatively simple calculations of levels of ODA for a specific purpose. The Muskoka (and subsequent Muskoka 2) model developed to track ODA for reproductive, maternal, new-born and child health has applied a similar approach [61]. The obvious limitation with all models for tracking ODA when applied to SRHR is the field's multisectoral nature, including a variety of interventions, from health, gender equality and human rights across sectors. Also, there is no specific marker, or purpose code, for SRHR in the OECD ODA statistics database, making it difficult to use a fixed share of a selection of purpose codes. However, a recent report from the European Parliamentary Forum applied an expanded version of the Muskoka 2 model to estimate ODA for SRHR. Their method followed the same approach to apply a fixed share allocation of purpose codes, but included a larger set of purpose codes [22]. While this method is more comprehensive, it still has its limitations and does not take into consideration differences in reporting of SRHR ODA between donor countries.

Given the comprehensive new definition of SRHR developed by the Guttmacher-Lancet Commission, ODA, and tracking tools to monitor it need to be updated to align with this definition and capture the rights dimension of SRHR. This has become particularly relevant in times of pushback on these very rights. Social norms and values can be proxies for the extent to which these rights are accepted or not in a society. As such, it is not only necessary to examine the current SRHR ODA, but also understand the extent to which it is aligned with social norms and values of the countries currently receiving it.

Theoretical perspectives

Unpacking social norms and values related to gender and SRHR: key definitions

While its conceptualization varies within and across disciplines, social norms are commonly defined as the social and cultural unwritten expectations or rules that influence behaviour by prescribing what is expected, allowed, or sanctioned in specific circumstances [62, 63]. Similarly, gender norms can be defined as the "widely accepted social rules about roles, traits, behaviours status and power associated with masculinity and femininity in a given culture" [64]. Norms related to SRHR specifically, refer to those that govern what is considered acceptable (or not) in terms of sexual and reproductive preferences, identities, feelings, choices, desires, roles, and relationships – including an individual's right to associated information, services, and support [2].

Social norms can be understood and explored at the **individual level** (i.e., a person's perception about what norms that are at play), or at the **collective level** (i.e., norms that are observed in specific social groups or communities). That is, while the collective perspective considers social norms as a purely external force or code of conduct, the individual perspective represents how people perceive (whether correct or incorrect) a collective norm [65]. This is obviously not a clear-cut distinction: individuals are part of collectives, and both approaches have their benefits. An individual perspective can be especially useful in behaviour change interventions, pointing to the underlying psychological mechanisms that underlie specific practices [66]. Looking at social norms as collective constructs may, on the other hand, aid researchers and programme managers to (better)

understand historical population-level changes and the role of formal institutions. Both approaches are needed, and many studies use a combination of the two to understand how individual beliefs are embedded in broader political structures and processes [66].

Descriptive vs. injunctive social norms

Within public health and international development, interventions and research largely use an individual perspective drawing on the conceptualisation by Cialdini, Reno and Kallgren [67]: that social norms derive from what people believe is common, and what they approve of. This is the conceptualization used for the current study. The first type of belief is commonly referred to as **descriptive social norms**, i.e., what you think that most other people are doing in a given context (such as whether most men in your neighbourhood beat their wives). In contrast, the second type of belief – whether you think that most people approve of this phenomenon (e.g., most people around you believe that wife beating is ok) – is referred to as **injunctive social norms** (Figure 2). (For a full review, see Mackie et al. [28]).

Both descriptive and injunctive norms are held in place by the social approval and/or disapproval of people within a reference group in terms of what is considered as the correct behaviour [68, 69]. In other words, individuals generally comply with norms because they expect specific rewards or sanctions from the people that matter to (or have influence over) them [62]. Because forming collectives is a natural part of being human, necessary for our survival, we are reluctant to step outside of the boundaries created by our reference groups (especially for those closest to us such as family or partners) for fear of exclusion, stigma, disapproval, or even violence. Despite this, social norms do change. Understanding and changing beliefs of reference groups towards more SRHR and gender equality supportive norms and values is therefore a central part of social norms interventions [62, 63].

Values

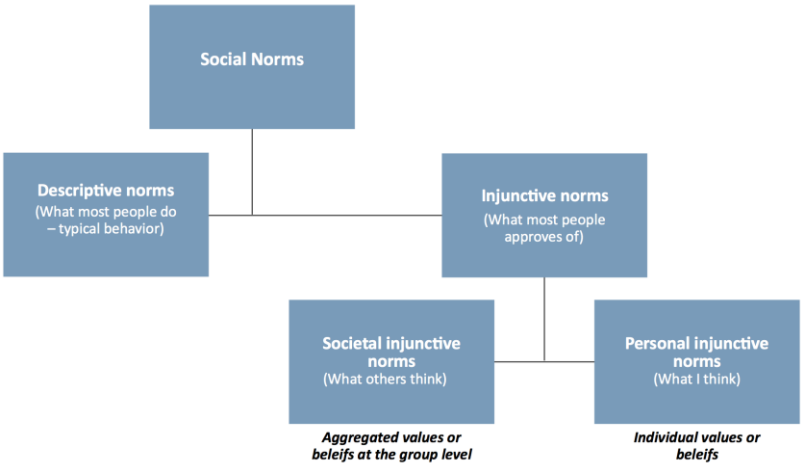
Social norms are different from, but related to, **values or beliefs,** which for the current study refers to individual "internalized preferences about desirable social outcomes" and have less to do with what others think or do [70]. Values are complex, unwritten behavioural guidelines that can encompass many different concepts. They are intangible, versatile, and diffuse; and can inspire and provide orientation. We use the terms values and beliefs interchangeably to refer to individual preferences or perceptions, given that different terminology is often used to refer to the same concept (see Box 2 for an overview of terminology). For example, many of the questions that measure individual values related to gender and SRHR in the WVS, are similar to what is referred to as "attitudes" or "beliefs" in other global surveys.

While values exist at both individual, group and societal levels, in this study we focus on measuring **individual** [70] **values** [69] as a type of personal injunctive norm (e.g., what I personally think is ok to do), which, when aggregated at the community level, reflect the **broader societal injunctive norm** that exists in a specific social or cultural setting [71]. Specifically, most questions in the WVS ask respondents whether they agree or disagree with certain statements, reflecting their own personal values or beliefs. When aggregated at a group level, the same responses can give an indication of injunctive norms and as such reflect a broader social norm. The indices and measures included in the WVS thus aim to capture changes in values and perceived norms on an individual, group, and societal level. For example, a boy might think that it is perfectly ok to be gay or lesbian but knowing the social expectations of his community he will nevertheless participate in the stigmatization and ridicule of those who divert from heterosexual norms. Alternatively, he may follow his inner beliefs and object to old descriptive norms, supporting new ways of thinking. If joined by others, this shift will eventually change the injunctive norms, as these values grow stronger.

Box 2. Definitions of values, norms, and related terms

Term	Definition	Example of survey question
Behaviour	What I do	I use contraceptives
Values, beliefs, attitudes	What I prefer, what I think, what I feel is right	Contraceptives should be available for everyone, whether one is married or not.
Descriptive norm	What I think others do	Sexual assault/rape occurs frequently in my neighbourhood
Injunctive norm	What I believe others think I should do	A woman who shows that she is interested in sex is considered indecent
Self-efficacy & agency	What I believe I can do/ have the power to do	I have freedom and choice over when to have children and how many to have
Reference group	Those whose opinion are important to me	My parents, siblings, friends, closest relatives, and my priest/imam/community leader/elders

Figure 2. Social norms framework



Source: Adapted from Stravrova et al., [13].

Addressing discriminatory norms related to gender, sexuality, and power

Social norms and values related to gender and SRHR are complex and entangled within webs of factors that influence health outcomes at multiple levels [62, 72]. The view of norms as either harmful or beneficial/positive differ greatly between contexts and time periods. Many would agree that some existing social norms e.g. with regards to child marriage or FGM/C can have harmful consequences, but still uphold and support these practices because they think that abandoning the practice would lead to more negative consequences, either socially or financially [69]. Similarly, while many may agree that using contraceptives to delay childbirth can have a positive impact on health, it may only be socially acceptable within marriage since the social norm against sex before marriage overrides the potential benefits of contraception among e.g., adolescents [73]. Norms and values may therefore appear as contradictory if analysed in isolation or out of context. To understand why some norms or values persist

despite being perceived as harmful from a health and rights perspective, it is important to analyse several related norms together, something that the WVS data allows for. Social norms are often understood as critical to our survival or likelihood of belonging and succeeding in life, and by shaping behaviours and creating social meaning across different contexts and cultures they are critical to all human interaction. For this reason, it may often be easier to create or reinforce what is perceived as positive norms, rather than directly targeting a deeply ingrained, discriminatory norm [74, 75].

Discriminatory norms related to gender and SRHR refers to deeply ingrained, often patriarchal, perceptions and control mechanisms surrounding (women's) sexuality, human rights, honour, and shame. These perceptions are often reinforced by culture and religion but also the amount of influence from elsewhere and the extent to which such norms are supported and upheld by influential groups in a society [76]. Global evidence shows that such discriminatory norms are internalized early in the life course as part of gender socialization processes. These ideals shape how individuals behave and interact in social relationships, with young people commonly endorsing norms of male dominance and sexual risk vs. female vulnerability and chastity since this often gives immediate social rewards from others and is an effective way of maintaining a position of power and status [64]. Breaking the norms on the other hand may negatively affect a young individual's opportunities to education, work, marriage and societal inclusion and contribution.

A common misperception is that discriminatory norms related to gender and sexuality are so ingrained that they feel impossible to change [72]. The reality is that these norms are challenged by changing values, negotiated, and frequently (re)shaped. Global data from the WVS indicate judgments about women, people of different ethnicities and religions, and sexual minorities have become less prejudiced, especially among young generations in rich countries [77, 78]. Furthermore, Gupta et al [72] provide several examples of how norms related to SRHR have shifted following policy and legal

changes such as paid maternity leave (increasing women's decision making power), or by working with community stakeholders such as faith-based leaders and police officers to change norms related to GBV (decreasing women's exposure to intimate partner violence); or by engaging young men as change agents to demonstrate alternative, non-violent and gender-equal masculinities. These changes make new underlying values visible.

As noted by Mackie and Le Jenue [79], the most discriminatory norms are those that "are most interdependent," requiring a "critical mass of people to change their behaviour" before others follow suit. Norm-violating behaviours sometimes diffuse slowly until enough people agree that it is the correct way to behave and, thus, a new social norm is established. There are different theories behind how these processes are played out in different societies, but it has been suggested that once a threshold of normative change has been reached, a "tipping point" sets off a new stage, in a process that could be described as norm cascade [80]. For example, Marcus and Harper [81] discuss how changing norms related to prevailing harmful practices such as FGM/C and child marriage requires convincing a critical mass or reference group to adopt a new norm (such as marrying non-circumcised brides or delaying marriage altogether). When enough people support the new norm (both injunctively i.e., perceiving that it is "right" and descriptively i.e., that it is what others do), it creates a tipping point whereby practices actually change. Addressing or changing discriminatory norms thus requires extensive knowledge of the context in order to identify reference groups and understand how to reach a critical mass.

Throughout this report, we relate primarily to two dimensions of approaching norms and values. First, we mapped and analysed norms and values related to gender and SRHR to learn what people believe and think about these issues. This enabled us to understand the normative contexts in the countries under study. A norm that generally infringes on people's sexual and reproductive (human) rights and/or is harmful for their sexual and reproductive health, is

here defined as a "discriminatory" norm. The second dimension that is mentioned in the report, but beyond the aim of our work, is the potential to change discriminatory SRHR norms, in line with the human rights agenda, and Sweden's SRHR strategy. To engage in norm changing programmes may, however, be complicated when relations of power between actors, funders, and recipients, are unequal.

As SRHR is situated at the nexus of issues crucial to individual's and groups' survival, identity and belonging – such as health, intimacy, and relationships, but also to population growth, gender views and reproducing culture – it is a central issue for institutions of power, whether they be religious, cultural, or political. Three decades ago, SRHR was accepted at the global level as a new way of approaching reproductive control and bodily integrity, grounding these in international human rights conventions and shifting focus from population control to individual's (primarily women's) rights, to support more dignified lives and choices [82]. However, SRHR may still be a difficult issue to engage with as a government ODA actor in light of a post-colonial history of state-driven population control measures, to be carried out on poorer populations whether at home or abroad, and could result in the abuse of power and infringement of national laws and rights [83–86]. This may be particularly critical to reflect on when engaging in programmes aimed at changing social norms related to SRHR, as they will most likely interact with the nexus of issues of human survival, identity and belonging, and hence contest, confirm or mitigate local and global relations of power as well as individual and group identities.

With respect to this complexity, we would like to underscore a two key points. First, SRHR are based on internationally recognized human rights conventions, including the Universal Declaration of Human Rights, and the right to health, the rights of the child and the conventions on eliminating discrimination against women to name a few. Many of these documents have already been turned into regional and national policy frameworks to ensure implementation

and accountability in local contexts. As such, changing norms in alignment with these conventions is not about assimilation into another country's (e.g., the donor country) culture. Secondly, different actors are already working to ensure SRHR for all in the three study countries, often based on the above-mentioned regional frameworks. As such, any out-of-country actor should be informed about, support and complement already ongoing work, rather than promote a completely different agenda. Any reference made in this report to the "changing of norms", is grounded in these perspectives.

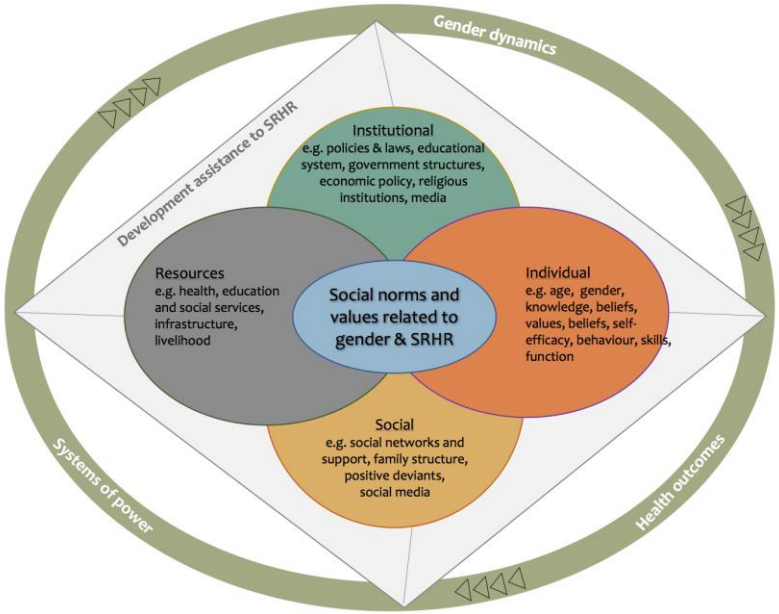
Study conceptual framework

Drawing on theories related to social norms and values, gender, power and sexuality, the current study is guided by two central frameworks. First, we use an adapted version of the conceptual framework by Cislaghi and Heise [63] to explain how (individual) values and beliefs affect different institutional, material, social and individual factors to shape norms, thereby guiding which factors need to be addressed by developmental assistance and interventions. Displayed in Figure 3, the framework points to how social norms and values are embedded within institutions at different levels (local, regional, national, international),– and are shaped by – laws, policies, distribution of resources (e.g., health services, education, livelihood), social relationships (e.g., social capital and support), as well as individual's knowledge, personal values, self-efficacy, skills opportunities, and aspirations. It also shows how norms as well as individual values (reflecting norms when aggregated at group levels) interact with systems of gender and power to shape health outcomes, including SRHR.

Given their complexity, social norms and values do not change overnight and require working holistically – both by targeting individual values and behaviours; by empowering and mobilizing actors in different sectors; and by changing policies and laws [87, 88].

Consequently, development assistance for SRHR aiming to address social norms and values needs to address different social-ecological levels as well as their intersections, viewing these as ecosystems comprised by different stakeholders (within the health-care system, other institutions, communities, media, etc), individuals and their relationships. In the framework, this is visualized by developmental assistance forming a sphere of influence on various factors that in turn shape social norms as well as health outcomes. Similar to Sida's multidimensional conceptualisation of poverty [89], this framework highlights that norms related to gender and SRHR are not only shaped by the (lack of) resources, but are a result of different opportunities and choices, power and voice, as well as levels of human security that, when combined, enable or prevent change.

Figure 3. Theoretical framework for factors that shape social norms and its interaction with development assistance, health outcomes and broader systems of gender and power



Source: Adapted from Cislaghi and Heise [63].

As stated in the aims, the goal of this study is not to evaluate the effect of developmental assistance on social norms, nor is it aiming to assess how norms shape SRHR outcomes. Rather, the study aims to map norms and values in three sub-Saharan countries, focusing on levels of support for sexual and reproductive rights – including gender equality, and relate findings to trends in Swedish ODA for SRHR. Also, for Sida and Swedish ODA strategies to effectively contribute to addressing discriminatory norms in direction that supports SRHR and human rights and contributes towards Agenda 2030 and Universal Health Coverage, one needs to have a clear in-depth understanding of prevailing norms, their inter-relationship, and norms of the reference group in each context.

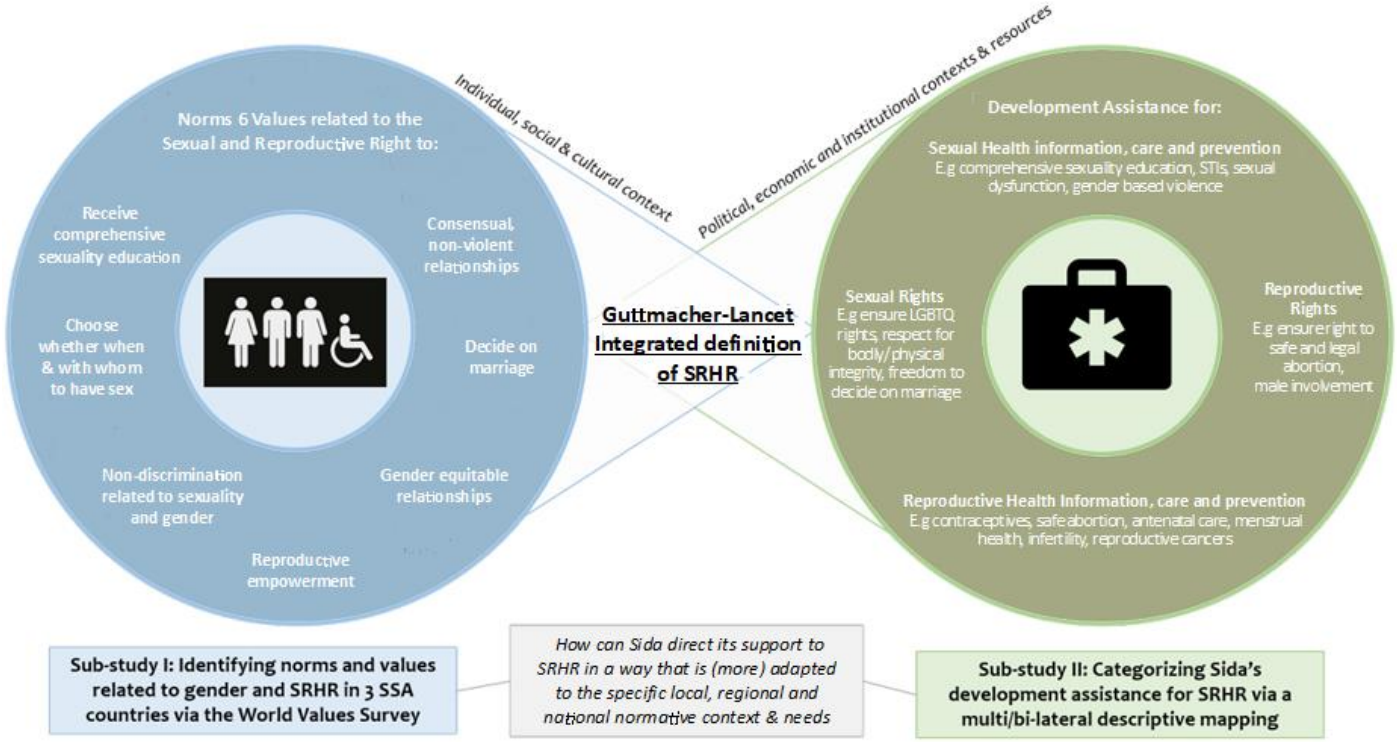
The ultimate goal is to contribute to improving universal access to essential sexual and reproductive health services and for individuals to realize their sexual and reproductive rights. A better understanding of the normative contexts and beliefs related to gender and SRHR may help to tailor health interventions according to the (different) values and preferences that exist in a certain region.

Figure 4 shows the conceptual framework for our study, using the Guttmacher-Lancet integrated definition of SRHR and its associated package of essential interventions [2] as the basis to bring the two sub-studies together. The framework highlights two intersecting wheels, with the left side representing **the first sub-study**, focused on identifying norms and values related to several domains of sexual and reproductive rights: consensual, non-violent relationships; marital decision-making; gender equitable relationships; reproductive empowerment; non-discrimination; choosing whether, when and with whom to have sex; and to receive comprehensive sexuality education. The extent to which individuals and groups support these sexual and reproductive rights may be closely shaped by their demographic background as well as social and cultural context, including values related to democracy, trust, and agency – variables which are all captured in the WVS.

In the second sub-study (right-side wheel), we take a closer look at the focus of developmental assistance for different SRHR components, including gender equality. Broadly defined, these span subcomponents of sexual health, reproductive health, sexual rights, and reproductive rights. As part of this descriptive mapping, we analysed which SRHR components that have received most support and contrasted these focus areas with the types of sexual and reproductive rights that are most vs. less supported in the selected countries.

To get a better understanding of if and how Swedish development assistance includes considerations about norms and values in development assistance programmes, we also conducted a case study of Swedish SRHR support to Zimbabwe based on document reviews and key informant interviews. The Zimbabwe case study is presented under sub-study II.

Figure 4. Study conceptual framework



Methodology

Sub-study I: Empirical study (World Values Survey)

Aim: To assess values and social norms related to gender and SRHR in three sub-Saharan African countries (Ethiopia, Zimbabwe, Nigeria)

We conducted a cross-sectional, nationally representative data collection via the World Values Survey (WVS), a politically and religiously independent multidisciplinary global research network which has collected data on social and cultural values and beliefs through standardized face-to face interviews with representative population-based samples (1,200–5,000/country and wave) since 1981. The WVS database covers over 100 countries that are home to over 90% of the world's population, funded by multiple private and governmental sources. The data are freely available online, with over 800,000 annual downloads providing information for governments, scholars, journalists and international organizations globally such as the World Bank and the United Nations [90].

Study setting and data collection

Data was collected as part of the 7th WVS wave in three sub-Saharan countries, beginning with Nigeria as part of another project (prior to the current EBA study) between Dec 2017–Jan 2018, with support from the Bill & Melinda Gates Foundation. For the current project, we also added two new countries of relevance to Sweden's SRHR support, Zimbabwe and Ethiopia. Data collection in these two countries was undertaken in March–May 2020. The study population in each country included males and females aged 18 years or above.

Participants were selected using standard WVS sampling procedures to allow for highest possible internal and external validity: 1) selection of all geo-political regions of each selected country, using population proportionate to size; 2) selection of states in each region using population proportionate to size; and 3) selection of local government areas considering the minimum number of interviews needed per unit.

The Nigeria sample included 1,237 interviews conducted in the languages Yoruba, Igbo, Hausa, and English. The Ethiopian sample comprised 1230 interviews conducted in the languages AfarOromo, Amharic, Tigrinya, and English. The Zimbabwe sample consisted of 1,215 interviews conducted in the languages Ndebele, Shona and in English. All interviews were face-to-face using computer-assisted personal interviewing (tablets), with the Kish method and geo-sampling. The quality controls were physical back checks and accompaniments, audio recording and telephone backchecking. An in-depth explanation of the WVS' standardized data collection procedures as well as a full methodological report for each country under study, can be retrieved from www.worldvaluessurvey.org.

Measures

The WVS examines values both at the individual level, showing trends in personal values in beliefs, and at the aggregated group or community level where values from a proxy measure for social norms from both descriptive and injunctive aspects (as described earlier in Figure 2). The standardized WVS questionnaire includes about 300 variables on a wide range of values such as trust and support for democracy, attitudes towards migrants and ethnic minorities, the role of religion and changing levels of religiosity, the impact of globalization, attitudes toward the environment, work, family, politics, national identity, culture, etc. Based on these responses, the WVS also provides several indices, for example the *choice index* coded based on the respondent's view on homosexuality,

divorce and abortion, and the *voice index* coded based on peoples' possibilities to make one's voice heard. Both are subindices to the overall emancipative values index, which also includes items related to autonomy and equality [90]. The standard WVS questionnaire covers some aspect of gender and SRHR through questions about the role of women in society (e.g., women's access to resources, women as politicians and/or working professionals), subjective health status, happiness, empowerment, and life satisfaction. It also includes several questions about the acceptability of issues such as homosexuality, abortion, premarital sex, casual sex, and divorce, However, questions related to gender-equitable decision-making and SRHR from a broader, more in-depth perspective (e.g., child marriage and pregnancy, FGM/C, attitudes to contraceptives, ideal number of children, where to give birth, comprehensive sexuality education, transgender issues, infertility) are lacking.

For the current study, we therefore added and implemented a new module that includes more measures related to gender- and SRHR values and norms. By building on and expanding the existing measures in the WVS, we aimed to complement other initiatives such as the DHS which focus more on health outcomes from the perspective of women's empowerment, and do not tap into other aspects of SRHR-related norms such as those around masculinity and LGBTQI populations. The new module includes 57 questions (except in Nigeria, see below) drawing on existing, validated measures of individual agreement with norms around child marriage, early childbearing, comprehensive sexuality education, contraceptive use, skilled birth attendance, premarital sex, infertility, abortion, LGBTQI issues, masculinity, and femininity. Some of these questions focus on a specific reference group (e.g., "even if a boy does not want to be married, he should honour the decisions/wishes of his family") while other are more general (e.g., "contraceptives should be available for everyone, whether or not one is married"). An initial version of the module was piloted as part of the Nigerian WVS survey in 2017–2018 and proved to be highly acceptable and easy to understand for both male and female respondents, across all

age groups. The module was further adapted for the current project, meaning that some questions were only asked in Nigeria and some only in Ethiopia and Zimbabwe. A detailed overview of the items and questions included in the module is presented in Appendix, Table 1A. The full WVS wave 7 survey and associated data for each country can be found and downloaded at: http://www.worldvaluessurvey.org/wvs.jsp

As the WVS survey is broad in scope, its many variables also allow for situating values and norms specifically related to gender and SRHR in a larger, more complex context (taking into consideration respondents sociodemographic markers and their reported level of social capital, confidence in institutions, civil-society engagement, support for gender equality at large, among others), which may inform on-going discussions of the relevance and future development of Swedish ODA focused on SRHR.

Statistical analysis

Following data cleaning according to standard WVS protocols we explored response patterns, missing values, and outliers in the data, followed by descriptive statistics (proportions, mean, median) to show the basic distributions in responses for each variable by gender (men vs. women) and country. Missing data largely comprised of "don't know" and "refuse" answers. Variables using Likert-scales (4-point, 5-point, or 10-point) were further dichotomized into agreement vs. disagreement. For example, items on a 4-grade scale (1=strongly agree, 2=agree, 3=disagree and 4=strongly disagree) were dichotomized into "agree" (1 or 2) vs. "disagree" (3 or 4), and variables on a 10-grade scale were dichotomized based on the extreme response, i.e., "never justifiable/acceptable" (response 1) vs. "some form of justification" (response 2–10).

For the Findings' section of the report and for more in-depth analyses, we purposively selected 1–2 variables to reflect each domain of the Guttmacher-Lancet definition as well as priority areas

for Swedish ODA. The variables were chosen partly based on a qualified assessment by the research team, current literature and the variables that best conveyed the message of the domain, and partly based on the robustness of the variable after descriptive exploration of all variables. Preference was also given to variables included in all three countries and to balance positively and negatively phrased questions. The EBA reference group was also consulted, and their input was thoroughly considered. An overview of the key variables chosen for the multivariable analysis across the six different SRHR domains is shown in Box 3.

Differences in responses between men and women were assessed using the Pearson chi-square test for categorial variables and the independent t-test for mean values. P-values < 0.05 were considered statistically significant. The chosen variables were further explored using multivariable logistic regression, to control for possible confounding (e.g. sociodemographic) factors. The following sociodemographic variables were included: age of respondent (18–25 vs. 26–40 vs. 41–60 vs. 61 and above), gender (female vs. male), residence (urban vs. rural), marital status (single vs. married or ever married), education level (no or primary education vs. secondary and above), subjective social class (lower and working class vs. middle class vs. upper class), religion (Christian vs. Muslim vs. Other), and self-reported level of religiosity (a religious person vs. not a religious person). In the final models, all of these covariates were included as well as country (Ethiopia vs. Nigeria vs. Zimbabwe), when analysing the outcome variables and results across the full sample. The findings are presented as odds ratios (OR) with 95% confidence intervals (CI). Sample weights were not used when analysing the data because the WVS samples are always nationally representative with regards to the sociodemographic factors mentioned above, as well as geographic area and ethnicity.

Box 3. Overview of key variables for SRHR used for multivariable analysis

Domain	Variable
Comprehensive sexuality education	• Sexuality education helps people make informed decision (Response options: strongly agree, agree, disagree, strongly disagree)[5].
Consensual, non-violent relationships and freedom from GBV	• Please tell me for each of the following actions whether you think it can always be justified, never be justified, or something in between: homosexuality. (Response options: a scale from 1 to 10, where 1 is never justifiable and 10 is always justifiable). • In some countries, there is a practice in which a girl may have part of genitals cut (sometimes called female genital circumcision). Do you think that this practice is justifiable? (Response options: a scale from 1 to 10, where 1 is never justifiable and 10 is always justifiable).
Marital decision-making	• A girl is ready for marriage once she starts menstruating (Response options strongly agree, agree, disagree, strongly disagree).
Reproductive empowerment including contraceptives and abortion	• Contraceptives should be available to anyone whether one is married or not (Response options strongly agree, agree, disagree, strongly disagree).

[5] Respondents always have the option to answer do not know, or do not want to answer to all WVS questions, including those in the gender and SRHR module.

Domain	Variable
	• Women should have access to safe abortion services to terminate an unwanted pregnancy (Response options strongly agree, agree, disagree, strongly disagree).
Non-discrimination related to sexuality and gender	• On this list are various groups of people. Could you please mention any that you would not like to have as neighbours (Response option: homosexuals)?
	• People who dress, act, and identify themselves as the opposite sex should be treated just like anybody else (Response options: strongly agree, agree, disagree, strongly disagree).
Masculinity norms	• A man should always have the final say about decisions in his relationship or marriage (Response options: strongly agree, agree, disagree, strongly disagree).

From the core WVS variables, we chose the following variables to reflect **Sida's four dimensions of poverty**:

1. **Resources** (represented by the variable "Family savings during the last year" [response 1 "save money" vs. response 2–4 "just get by", "spent some savings and borrowed money" and "spent savings and borrowed money" on a 4-grade scale]),
2. **Opportunities and choice** (represented by the variable "Employment status" [not currently working vs. self-employed vs. employed]),

3. **Power and voice** (represented by the WVS voice index [high vs. low voice dichotomised based on the median value] as well as the variable "How important is it for you to live in a democratic country?" [response 1 "not at all important" vs. 2–10 "to some extent or absolutely important" on a 10-grade scale]), and
4. **Human security** (represented by the variable "Do you feel secure in your neighbourhood?" [response 1–2 "secure" vs. 3–4 "not secure" on a 4-grade scale]).

Missing values

There were missing values for 1 (0.03%) to 316 (8.6%) of participants in the items related to gender norms and support for SRHR, largely comprised of "don't know" and "refuse to answer" replies. Missing values were distributed across all the variables of the new gender/SRHR module; the total number for each variable presented in the tables thus varies accordingly and percentages should be interpreted as the proportion of participants responding to that particular question. When scrutinizing missing values in detail, questions related to homosexuality had particularly large proportions of missing values in Ethiopia (24% for the question whether a homosexual man could be considered a "real man", 23% for the question whether a homosexual couple could be good parents, and 14% for the question whether homosexuality could be justified), indicating such questions were especially sensitive in the Ethiopian context. In contrast, the proportion of missing values for all items were generally very low in both Zimbabwe and Nigeria. The survey in Nigeria included a pilot version of the WVS/KI SRHR and Gender module, and the module was subsequently slightly revised before implemented in Ethiopia and Zimbabwe, which explains why some items were not included in the Nigerian survey.

SRHR index development

To facilitate interpretation given the large number of variables included, we originally aimed to combine different indicators into an "SRHR index" to reflect the overall (dis)agreement with sexual and reproductive rights based on 20 variables that were included in the WVS surveys in all three countries. We conducted exploratory factor analysis using scree plots and parallel analysis with oblique rotation (anticipating high correlations between factors) to calculate factor loadings and assess item relationships. Factor analysis is a statistical technique for identifying underlying "latent", or "unobserved", variables based on patterns in the observed data [91]. It does so by combining responses to multiple different questions that together reflect a broader concept, in this case – support for sexual and reproductive rights. In brief, we identified one major factor across all countries, which reflected the existing WVS "choice" index based on three questions (justification of abortion, divorce, and homosexuality). Beyond this factor, item loadings and scree plots varied substantially between the three countries, indicating that it might not be possible to identify a single underlying construct of support for sexual and reproductive rights that can be compared across settings. We therefore decided to proceed without an SRHR index as the main outcome, and instead select key items from each domain of the Guttmacher-Lancet definition for multivariable analyses.

Sub-study II: Descriptive mapping of Sida's SRHR support

Aim: To describe and categorize Sweden's ODA for SRHR disbursed by Sida between 2010–2018 and illustrate whether the SRHR components targeted by Sida align with the social norms and values identified in the WVS (aim 1).

This study adopted an approach to allow for a comprehensive analysis of Sida's SRHR support from 2010–2018 using contribution disbursement data from Sida's financial management systems. Data was requested from Sida in two batches. For the first batch (Data I), all disbursements from 2010–2018 under health-related purpose codes were requested. However, SRHR is closely linked to gender equality and human rights, and contributions in these areas are often classified under other purpose codes than health. Therefore, in order not to miss any SRHR contributions, the sampling strategy was discussed with Sida's lead policy specialist for health. After the discussion, additional purpose codes with potential SRHR contributions were identified (Data II). In the second request to Sida, all disbursements under these purpose codes were requested. In total, all disbursement from 2010–2018 for 23 purpose codes was included in the sample (Table 2).

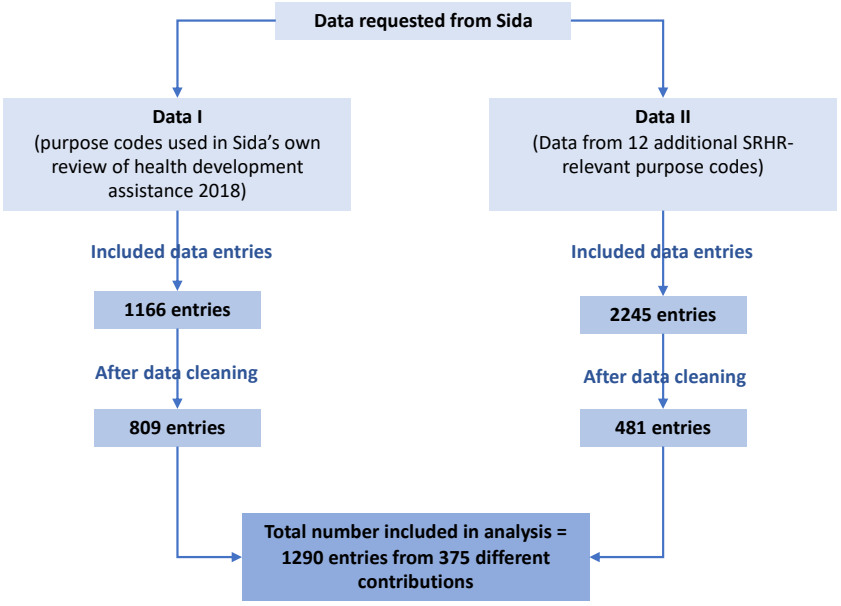
Table 2. Purpose codes included in the sample

DATA I (corresponding to purpose codes applied in Sida's own estimation of SRHR support)		DATA II (additional purpose codes to capture SRHR support linked to for example LGBTQI rights and GBV)	
Purpose code	Name	Purpose code	Name
13010	Population Policy and Administrative Management	123	Population Policies/Programmes and Reproductive Health
13020	Reproductive Health Care	13030	Family Planning
13040	STD Control including HIV/AIDS	15170	Women's Equality Organizations and Institutions
13081	Personnel Development for Population and Reproductive Health	15180	Ending Violence Against Women and Girls
12110	Health Policy and Administrative Management	16015	Social Services (incl. youth development and women and children)
12182	Medical Research	16050	Multisector Aid for Basic Social Services
12220	Basic Health Care	16064	Social Mitigation of HIV/AIDS
12230	Basic Health Infrastructure	14032	Basic Sanitation
12240	Basic Nutrition	15160	Human Rights
12261	Health Education	12181	Medical Education/Training
12281	Health Personnel Development	12191	Medical Services
		12250	Infectious Diseases

Source: https://openaid.se/app/uploads/2019/03/Stathandbook-1.htm

The final dataset from Sida comprised 3,420 entries/rows. This data was filtered and all data entries mentioning any SRHR category within the definitions of sexual health, reproductive health, sexual rights and reproductive rights, as described by the WHO [92] and the Guttmacher-Lancet Commission [2] were included. After filtration and cleaning, the final dataset comprised 1,290 entries/rows from 375 different contributions/interventions (Figure 5). At least one entry/row was generated per year and per contribution/intervention. Therefore, the number of entries/rows is much larger than the number of contributions. The mapping is limited to Sida's support to SRHR programmes. This means that development assistance channelled through the Ministry for Foreign Affairs is not covered. Support through the Ministry includes, for example, core support to important UN organizations working in SRHR such UNFPA, UNICEF and UN Women.

Figure 5. Overview of data collection and cleaning process [93]



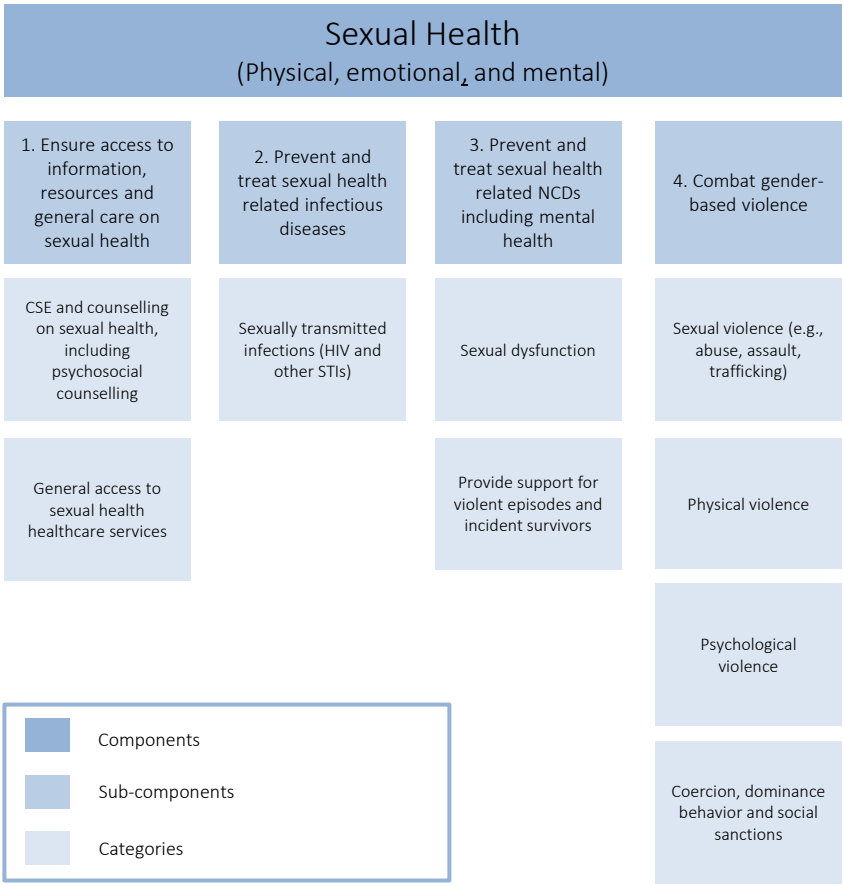
Data analysis

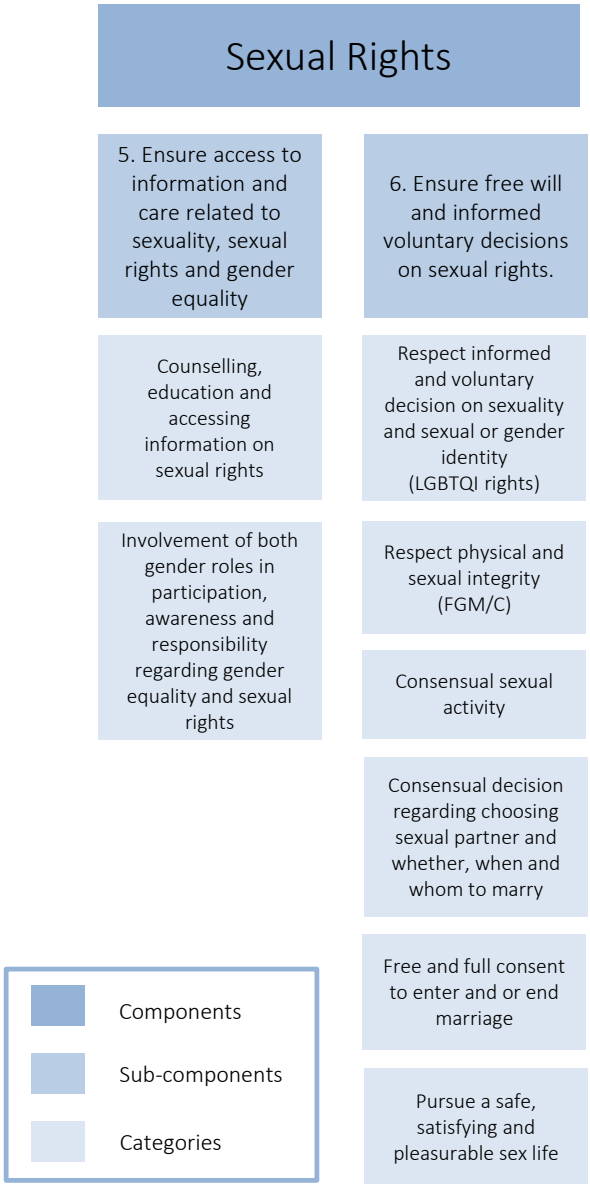
Data was reviewed entry by entry and analysed in two steps. In the first step, total SRHR support was calculated. Total support was then disaggregated to generate yearly estimates, and numbers were adjusted to account for inflation using 2018 as index year. In the second step entries were summarized in components and sub-components based on the Guttmacher-Lancet comprehensive definition of SRHR and covering sexual health, reproductive health, sexual rights, and reproductive rights. This analysis was conducted by reviewing the information from 'project description', 'strategy' and 'results area' columns of each entry and matching the disbursement with the most appropriate category. For entries that covered several categories, the amount was divided between the categories based on information in the description of the intervention/contribution. Several data entries lacked specific information on which SRHR component it supported. These entries were categorized as general SRHR support (Figure 6).

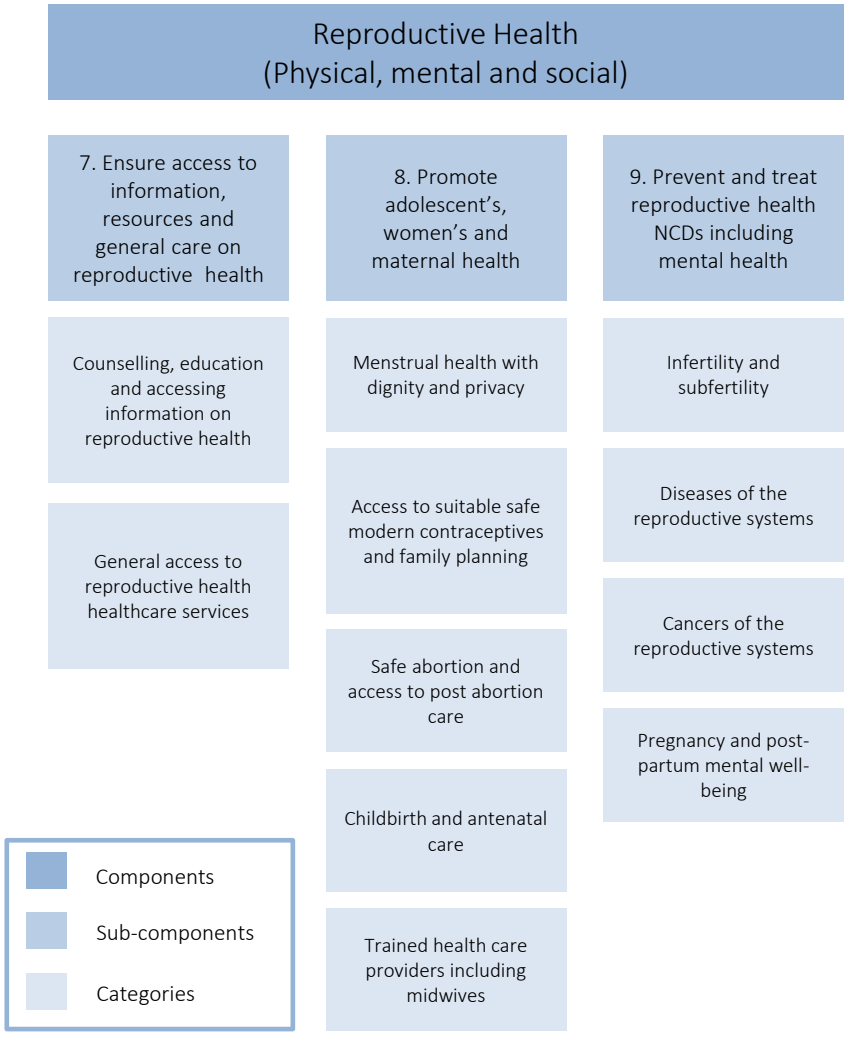
Zimbabwe case study

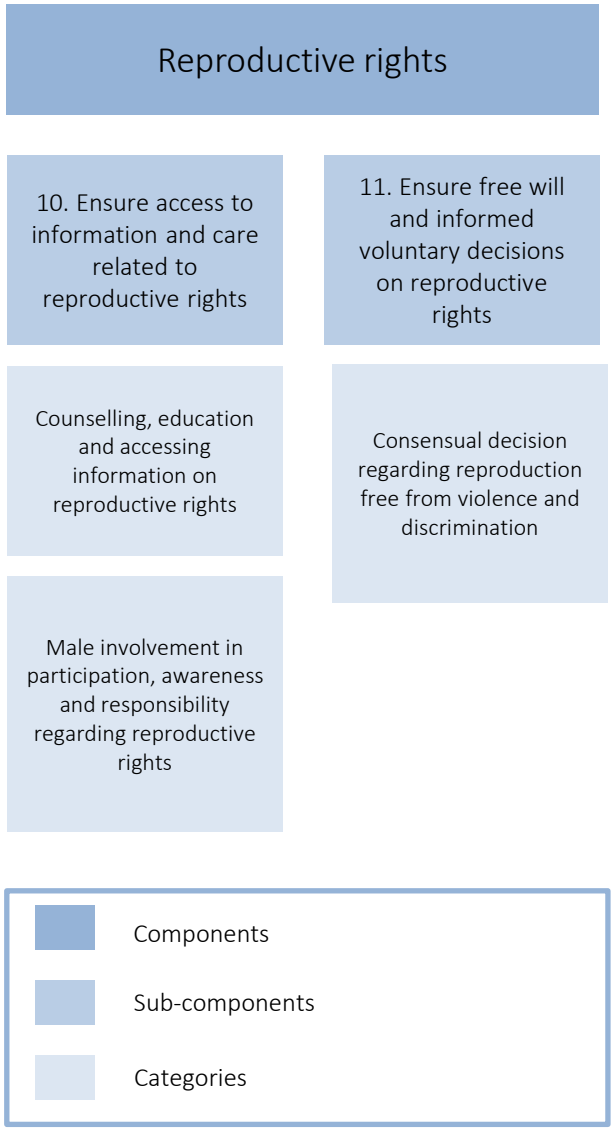
As part of the analysis of Sweden's SRHR ODA, a small case study of Zimbabwe was conducted. This deep dive into Sweden's SRHR support was conducted through a review of government documents reflecting Sweden's support to Zimbabwe including country strategies, strategy reports and plans for operationalization of the most recent Swedish strategy for Zimbabwe. In addition, three key informant interviews were conducted, one with a representative of the Embassy of Sweden in Harare and two with representatives from implementing organizations (Population Services International and Marie Stopes) funded through the Swedish support to Zimbabwe.

Figure 6. Overview of components, sub-components, categories, and highlighted sub-categories used for categorizing data




Sexual Rights
5. Ensure access to information and care related to sexuality, sexual rights and gender equality
6. Ensure free will and informed voluntary decisions on sexual rights.
Counselling, education and accessing information on sexual rights
Involvement of both gender roles in participation, awareness and responsibility regarding gender equality and sexual rights
Respect informed and voluntary decision on sexuality and sexual or gender identity (LGBTQI rights)
Respect physical and sexual integrity (FGM/C)
Consensual sexual activity
Consensual decision regarding choosing sexual partner and whether, when and whom to marry
Free and full consent to enter and or end marriage
Pursue a safe, satisfying and pleasurable sex life
Components
Sub-components
Categories


Reproductive Health
(Physical, mental and social)
7. Ensure access to information, resources and general care on reproductive health
8. Promote adolescent's, women's and maternal health
9. Prevent and treat reproductive health NCDs including mental health
Counselling, education and accessing information on reproductive health
General access to reproductive health healthcare services
Menstrual health with dignity and privacy
Access to suitable safe modern contraceptives and family planning
Safe abortion and access to post abortion care
Childbirth and antenatal care
Trained health care providers including midwives
Infertility and subfertility
Diseases of the reproductive systems
Cancers of the reproductive systems
Pregnancy and post-partum mental well-being
Components
Sub-components
Categories


Reproductive rights
10. Ensure access to information and care related to reproductive rights
11. Ensure free will and informed voluntary decisions on reproductive rights
Counselling, education and accessing information on reproductive rights
Consensual decision regarding reproduction free from violence and discrimination
Male involvement in participation, awareness and responsibility regarding reproductive rights
Components
Sub-components
Categories

Findings sub-study I: Values and norms related to gender and SRHR

A total of 3,682 participants were included in the WVS survey across Nigeria (N=1,237), Ethiopia (N=1,230) and Zimbabwe (N=1,215). The total number presented for each variable in the tables varies depending on the number of missing responses. Percentages should be interpreted as the proportion of responding participants responding to that question.

Table 3 shows the characteristics of study participants with a mean age 34.2 years (SD 13.6, range 18–100, median 30). There was an equal distribution of men and women in the cohort. Most study participants resided in rural areas (65%), were married (60%), and identified themselves as belonging to either lower-, working-, or lower-middle social class. Religious denomination varied across countries with Roman Catholic being the most common religion in Zimbabwe (64%), Orthodox being most common in Ethiopia (48%), and Muslim being most common in Nigeria (45%). More than 94% of the total respondents identified themselves as being "a religious person".

Table 3. Sociodemographic characteristics of study participants in the three study countries

	Nigeria N=1237	Ethiopia N=1230	Zimbabwe N=1215	Total N= 3682
	n (%)	n (%)	n (%)	n (%)
Age				
18–25	456 (37%)	456 (37%)	305 (25%)	1185 (32%)
26–40	531 (43%)	531 (43%)	417 (34%)	1565 (43%)
41–60	230 (19%)	230 (19%)	379 (31%)	790 (21%)
61–100	13 (1%)	13 (1%)	110 (10%)	138 (4%)
Total	**1237 (100%)**	**1230 (100%)**	**1211 (100%)**	**3678 (100%)**
Gender				
Female	611 (49%)	608 (49%)	615 (51%)	1834 (50%)
Male	626 (51%)	622 (51%)	600 (49%)	1848 (50%)
Total	**1237 (100%)**	**1230 (100%)**	**1215 (100%)**	**3682 (100%)**
Place of residence				
Urban	606 (49%)	296 (24%)	395 (33%)	1297 (35%)
Rural	632 (51%)	934 (76%)	820 (67%)	2386 (65%)
Total	**1237 (100%)**	**1230 (100%)**	**1215 (100%)**	**3682 (100%)**
Marital status				
Married	679 (55%)	772 (63%)	748 (62%)	2199 (60%)
Living together as married	7 (1%)	49 (4%)	12 (1%)	68 (2%)
Divorced/ Separated/ Widowed	44 (3%)	89 (7%)	188 (15%)	321 (8%)
Single	503 (41%)	320 (26%)	267 (22%)	1090 (30%)
Total	**1234 (100%)**	**1230 (100%)**	**1215 (100%)**	**3679 (100%)**

	Nigeria N=1237	Ethiopia N=1230	Zimbabwe N=1215	Total N= 3682
Education				
No education	198 (16%)	297 (24%)	59 (5%)	554 (15%)
Primary education	132 (11%)	306 (25%)	195 (16%)	633 (17%)
Secondary and post-secondary education	777 (63%)	441 (36%)	868 (72%)	2086 (57%)
Tertiary education	0	91 (8%)	43 (3%)	134 (4%)
University education	120 (10%)	89 (7%)	48 (4%)	257 (7%)
Total	**1228 (100%)**	**1224 (100%)**	**1213 (100%)**	**3665 (100%)**
Employment				
Employed full or part time	174 (14%)	246 (20%)	188 (16%)	608 (17%)
Self employed	588 (48%)	513 (42%)	365 (30%)	1466 (40%)
Not employed	313 (26%)	323 (26%)	604 (50%)	1240 (34%)
Student	154 (13%)	146 (12%)	56 (4%)	356 (9%)
Total	**1229 (100%)**	**1228 (100%)**	**1213 (100%)**	**3670 (100%)**
Subjective social class				
Lower	512 (41%)	275 (22%)	399 (33%)	1186 (32%)
Middle/working class	671 (55%)	921 (75%)	767 (64%)	2359 (65%)
Upper	32 (3%)	27 (3%)	37 (3%)	96 (3%)
Total	**1215 (100%)**	**1223 (100%)**	**1203 (100%)**	**3641 (100%)**
Religion				
Christian	669 (54%)	808 (66%)	857 (71%)	2334 (64%)
Muslim	559 (45%)	419 (34%)	165 (14%)	1143 (31%)
Other/no religious group	5 (1%)	3 (0%)	193 (16%)	201 (5%)
Total	**1233 (100%)**	**1230 (100%)**	**1215 (100%)**	**3678 (100%)**

*Numbers rounded off to full percentages.

Support for sexual and reproductive rights: overview of descriptive findings

This section provides a descriptive overview of key findings related to support for different aspects of SRHR, structured in line with the Guttmacher-Lancet (1) domains as well as priority areas for Swedish ODA [94] as described in the Methods section:

1. comprehensive sexuality education (CSE);
2. consensual, non-violent relationships (freedom from GBV);
3. marital decision-making and premarital/causal sex;
4. reproductive empowerment including contraceptives and abortion;
5. non-discrimination related to sexuality and gender; and
6. gender equality including masculinity norms.

Table 4 provides a summary of the agreement vs. disagreement with key norms related to different SRHR domains, including those selected for multivariable analysis (as described in the Methods section). A complete presentation of the descriptive results for each variable (including proportions of the dichotomised variables, mean and median) is available in Appendix Tables 2–9. For more details on descriptive statistics, we refer to the online analysis tool at the WVS website (https://www.worldvaluessurvey.org/WVSOnline.jsp)

Table 4. Summary of selected values and norms indicating support for SRHR, by gender and country

	Total N=3682	Men N=1848	Women N=1834	Nigeria N=1237	Ethiopia N=1230	Zimbabwe N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Comprehensive sexuality education						
Sexuality education promotes sexual activity among young people						
Agree	1540 (43%)	796 (44%)	744 (42%)	746 (62%)	298 (26%)	496 (41%)
Disagree	2027 (57%)	1012 (56%)	1015 (58%)	461 (38%)	851 (74%)	715 (59%)
Total	**3567 (100%)**	**1808 (100%)**	**1759 (100%)**	**1207 (100%)**	**1149 (100%)**	**1211 (100%)**
Mean (SD)	2.61 (0.99)	2.60 (.99)	2.62 (.98)	2.28 (0.98)	2.92 (0.94)	2.65 (0.94)
**Sexuality education helps people make informed decisions* [a]						
Agree	1747 (74%)	895 (75%)	852 (73%)	x	797 (69%)	950 (79%)
Disagree	617 (26%)	298 (25%)	319 (27%)	x	359 (31%)	258 (26%)
Total	**2364 (100%)**	**1193 (100%)**	**1171 (100%)**	**x**	**1156 (100%)**	**1208 (100%)**
Mean (SD)	2.01 (0.91)	1.99 (0.92)	2.03 (0.90)	x	2.04 (0.98)	1.98 (0.83)

	Total N=3682	Men N=1848	Women N=1834	Nigeria N=1237	Ethiopia N=1230	Zimbabwe N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Consensual, non-violent relationships						
Men may use violence to keep their wives in line						
Agree	706 (29%)	373 (31%)	333 (27%)	x	229 (19%)	477 (39%)
Disagree	1732 (71%)	846 (70%)	886 (73%)	x	996 (81%)	736 (61%)
Total	**2438 (100%)**	**1219 (100%)**	**1219 (100%)**	**x**	**1225 (100%)**	**1213 (100%)**
Mean (SD)	2.95 (0.93)	2.91 (.94)	3.00 (.91)	x	3.18 (0.86)	2.72 (0.94)
**For a man to beat his wife – never vs. always justifiable* [b]						
Wife-beating is always justifiable or justifiable to some extent	831 (23%)	447 (24%)	385 (21%)	395 (32%)	185 (15%)	251 (21%)
Wife-beating is never justifiable	2843 (77%)	1399 (76%)	1444 (79%)	840 (68%)	1042 (85%)	961 (79%)
Total	**3674 (100%)**	**1846 (100%)**	**1829 (100%)**	**1235 (100%)**	**1227 (100%)**	**1212 (100%)**
Mean (SD)	1.86 (2.08)	1.94 (2.16)	1.77 (1.99)	1.94 (1.86)	1.72 (2.11)	1.90 (2.23)

	Total	Men	Women	Nigeria	Ethiopia	Zimbabwe
	N=3682	N=1848	N=1834	N=1237	N=1230	N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
**FGM/C – never vs. always justifiable* [b]						
FGM/C is always justifiable or justifiable to some extent)	450 (19%)	234 (19%)	216 (18%)	x	192 (16%)	258 (22%)
FGM/C is never justifiable	1970 (81%)	976 (81%)	994 (82%)	x	1035 (84%)	935 (78%)
Total	**2420 (100%)**	**1210 (100%)**	**1210 (100%)**	**x**	**1227 (100%)**	**1193 (100%)**
Mean (SD)	1.99 (2.49)	2.07 (2.57)	1.91 (2.39)	x	1.99 (2.59)	1.99 (2.38)
Honour-related oppression – never vs. always justifiable [b]						
Honour-related oppression is always justifiable or justifiable to some extent)	1269 (52%)	643 (53%)	626 (51%)	x	775 (63%)	494 (41%)
Honour-related oppression is never justifiable)	1168 (48%)	576 (47%)	592 (49%)	x	448 (37%)	720 (59%)
Total	**2437 (100%)**	**1219 (100%)**	**1218 (100%)**	**x**	**1223 (100%)**	**1214 (100%)**
Mean (SD)	3.60 (3.17)	3.65 (3.19)	3.55 (3.14)	x	4.07 (3.05)	3.13 (3.22)

	Total	Men	Women	Nigeria	Ethiopia	Zimbabwe
	N=3682	N=1848	N=1834	N=1237	N=1230	N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Marital decision-making						
Even if a girl does not want to be married, she should honour the decision of her family [a]						
Agree	1749 (48%)	889 (48%)	960 (47%)	714 (58%)	635 (52%)	400 (33%)
Disagree	1922 (52%)	953 (52%)	968 (53%)	520 (42%)	591 (48%)	811 (67%)
Total	**3671 (100%)**	**1842 (100%)**	**1828 (100%)**	**1234 (100%)**	**1226 (100%)**	**1211 (100%)**
Mean (SD)	2.55 (1.04)	2.53 (1.03)	2.56 (1.05)	2.32 (1.05)	2.47 (1.09)	2.84 (0.91)
**A girl is ready for marriage once she starts menstruating* [a]						
Agree	1219 (33%)	636 (35%)	583 (32%)	481 (40%)	479 (39%)	259 (21%)
Disagree	2436 (67%)	1198 (65%)	1238 (68%)	738 (61%)	746 (61%)	952 (79%)
Total	**3655 (100%)**	**1834 (100%)**	**1821 (100%)**	**1219 (100%)**	**1225 (100%)**	**1211 (100%)**
Mean (SD)	2.83 (1.00)	2.79 (1.00)	2.88 (0.99)	2.74 (1.06)	2.72 (1.05)	3.05 (0.86)

	Total	Men	Women	Nigeria	Ethiopia	Zimbabwe
	N=3682	N=1848	N=1834	N=1237	N=1230	N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Divorce – never vs. always justifiable [b]						
Divorce is always justifiable (or justifiable to some extent)	1314 (36%)	654 (35%)	660 (36%)	507 (41%)	379 (31%)	428 (35%)
Divorce is never justifiable	2356 (64%)	1189 (64%)	1167 (64%)	723 (59%)	848 (69%)	785 (65%)
Total	**3670 (100%)**	**1843 (100%)**	**1827 (100%)**	**1230 (100%)**	**1227 (100%)**	**1213 (100%)**
Mean (SD)	2.59	2.54 (2.56)	2.64 (2.69)	2.48 (2.28)	2.59 (2.76)	2.71 (2.80)
Reproductive empowerment incl. contraception and abortion						
**Contraceptives should be available for everyone, whether or not one is married* [a]						
Agree	2364 (65%)	1206 (66%)	1155 (64%)	752 (63%)	765 (63%)	847 (70%)
Disagree	1260 (35%)	620 (34%)	640 (36%)	446 (37%)	449 (37%)	365 (30%)
Total	**3624 (100%)**	**1829 (100%)**	**1795 (100%)**	**1198 (100%)**	**1214 (100%)**	**1212 (100%)**
Mean (SD)	2.23 (0.99)	2.21 (0.98)	2.24 (0.99)	2.29 (1.02)	2.24 (1.03)	2.15 (0.92)

	Total	Men	Women	Nigeria	Ethiopia	Zimbabwe
	N=3682	N=1848	N=1834	N=1237	N=1230	N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
**Women should have access to safe abortion services to terminate an unwanted pregnancy* [a]						
Agree	1803 (50%)	925 (51%)	878 (49%)	577 (49%)	824 (68%)	402 (33%)
Disagree	1809 (50%)	889 (49%)	920 (51%)	606 (51%)	396 (33%)	807 (67%)
Total	**3612 (100%)**	**1184 (100%)**	**1798 (100%)**	**1183 (100%)**	**1220 (100%)**	**1209 (100%)**
Mean (SD)	2.54 (1.11)	2.51 (1.11)	2.53 (1.11)	2.64 (1.10)	2.06 (1.09)	2.88 (0.98)
Non-discrimination related to sexuality and gender						
Homosexuality – always vs. never justifiable [b]						
Homosexuality is always justifiable (or justifiable to some extent)	510 (15%)	240 (14%)	271 (16%)	243 (20%)	100 (9.5%)	167 (14%)
Homosexuality is never justifiable	2993 (85%)	1531 (86%)	1462 (84%)	993 (80%)	955 (91%)	1045 (86%)
Total	**3503 (100%)**	**1771 (100%)**	**1733 (100%)**	**1236 (100%)**	**1055 (100%)**	**1212 (100%)**
Mean (SD)	1.62 (1.96)	1.59 (1.93)	1.64 (1.99)	1.50 (1.47)	1.64 (2.24)	1.72 (2.14)

	Total N=3682	Men N=1848	Women N=1834	Nigeria N=1237	Ethiopia N=1230	Zimbabwe N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
**I would not like to have as neighbours…*						
Mentioned homosexuals, N (%)	3035 (83%)	1534 (84%)	1501 (82%)	1102 (89%)	850 (70%)	1083 (90%)
Not mention homosexuals, N (%)	625 (17%)	303 (17%)	322 (18%)	136 (11%)	370 (30%)	119 (10%)
Total	**3659 (100%)**	**1837 (100%)**	**1823 (100%)**	**11238 (100%)**	**1220 (100%)**	**1202 (100%)**
Mean (SD)	1.17 (0.38)	1.16 (0.37)	1.18 (0.38)	1.11 (0.31)	1.30 (0.46)	1.11 (0.30)
**People who dress, act, or identify as the opposite sex should be treated just as anyone else* [a]						
Agree	858 (36%)	437 (37%)	421 (36%)	x	333 (29%)	525 (44%)
Disagree	1507 (64%)	754 (63%)	753 (64%)	x	828 (71%)	679 (56%)
Total	**2365 (100%)**	**1191 (100%)**	**1174 (100%)**	**x**	**1161 (100%)**	**1204 (100%)**
Mean (SD)	2.80 (0.97)	2.78 (0.99)	2.81 (0.96)	x	2.93 (1.01)	2.67 (0.92)

	Total	Men	Women	Nigeria	Ethiopia	Zimbabwe
	N=3682	N=1848	N=1834	N=1237	N=1230	N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Gender equality incl. masculinity norms						
**A man should always have the final say about decisions in his relationship or marriage* [a]						
Agree	1283 (53%)	688 (56%)	595 (49%)	x	609 (50%)	674 (56%)
Disagree	1146 (47%)	530 (43%)	616 (51%)	x	607 (50%)	539 (44%)
Total	**2429 (100%)**	**1218 (100%)**	**1211 (100%)**	**x**	**1216 (100%)**	**1213 (100%)**
Mean (SD)	2.45 (0.97)	2.36 (0.97)	2.54 (096)	x	2.50 (0.99)	2.40 (0.94)
A man who discusses important decisions with his wife is considered weak [a]						
Agree	434 (18%)	237 (19%)	197 (16%)	x	88 (7%)	346 (29%)
Disagree	2002 (82%)	983 (81%)	1019 (84%)	x	1137 (93%)	865 (71%)
Total	**2436 (100%)**	**1220 (100%)**	**1216 (100%)**	**x**	**1225 (100%)**	**1211 (100%)**
Mean (SD)	3.14 (0.83)	3.12 (0.86)	3.16 (0.80)	x	3.44 (0.69)	2.84 (0.85)

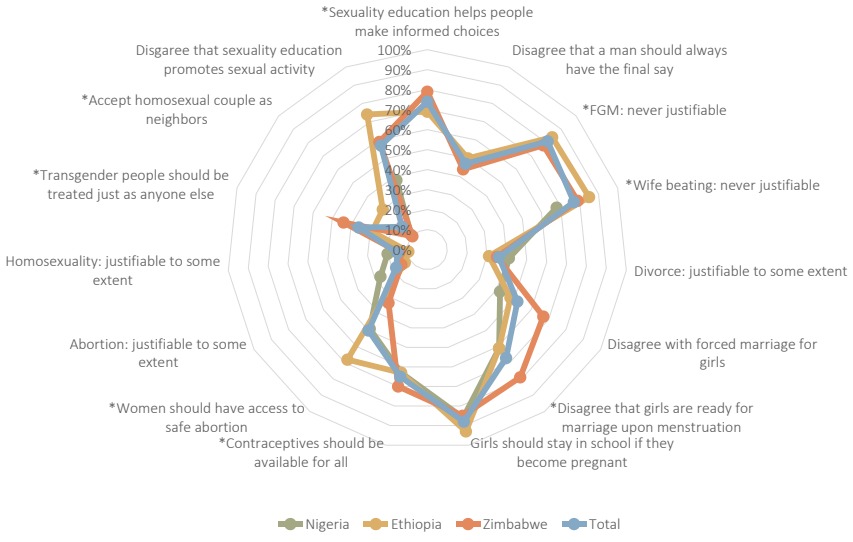
	Total	Men	Women	Nigeria	Ethiopia	Zimbabwe
	N=3682	N=1848	N=1834	N=1237	N=1230	N=1215
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A woman who shows that she is interested in sex is considered indecent [a]						
Agree	1109 (46%)	547 (45%)	562 (47%)	x	448 (37%)	661 (55%)
Disagree	1304 (54%)	663 (55%)	641 (53%)	x	755 (63%)	549 (45%)
Total	**2413 (100%)**	**1210 (100%)**	**1203 (100%)**	**x**	**1203 (100%)**	**1210 (100%)**
Mean (SD)	2.56 (1.03)	2.58 (1.03)	2.54 (1.03)	x	2.74 (1.10)	2.38 (0.93)

a) Likert scale 1–4; 1=strongly agree, 2=agree, 3=disagree, 4= strongly disagree

b) Likert scale 1–10; 1=never justifiable, 10=always justifiable

*Variable included in multivariable analysis.

Figure 7. Support for Sexual and Reproductive Rights across three sub-Saharan African countries



*Variable included in multivariable analysis.

Figure 7 further visualizes the distribution of support for sexual and reproductive rights, with higher agreement (closer to the outskirts of the 'spider net') indicating greater support[6]. As can be seen, the norms are very similar across the three countries; the support is generally lowest for rights related sexual orientation, abortion, divorce, indicating that these norms are particularly discriminatory in the countries surveyed. In contrast, support for women's rights to decide if and when to marry and use contraceptives, as well as freedom from GBV, appears to be greater. Most participants do not condone GBV and FGM/C. The few variations that do stand out include the especially high support in Nigeria for discriminatory norms related to forced/early/child marriage, wife beating and young people's right to sexuality education. In addition, the support

[6] Nigeria is missing data in the Figure for three variables that were only included in Zimbabwe and Ethiopia.

for the right to contraceptives irrespective or marital status as well as comprehensive sexuality education appears to be greater in Ethiopia and Zimbabwe. There were no differences by gender for any of the questions included in Figure 7.

Results by domain

To better analyse and understand the variation of the responses to the different questions, we categorised the level of support that an item received in the total sample, to then examine how the total sample in the three different national populations surveyed varied. Items to which a majority (>50%) of respondents agreed was considered to have high agreement. Items which got response rates between 20–49% were categorised lower, and those below 20% were considered very low. The extent to which national population totals mirrored the total sample level of support gave us an indication of the variations in values and norms.

If we look closer at the results, almost half (43%) believed that **sexuality education** promotes sexual activity among young people; such values were most common in Nigeria (62%) followed by Zimbabwe (41%), whereas in Ethiopia only 26% agreed with the statement. The idea that comprehensive sexuality education promotes sexual activity among young people is a commonly used argument against including it in school curricula [95]. As such, agreement with this statement is interpreted here as indicating low support for sexuality education. However, when it was not related specifically to young people, the majority of participants in both Ethiopia (69%) and Zimbabwe (79%) agreed that sexuality education helps people make informed decisions (this question was not asked in Nigeria). There were no statistically significant differences between men and women in any of the two questions concerning sexuality education (Table 4). While there was overall more support for, rather than against, sexuality education, the topic may be seen as more controversial when it relates to adolescents.

Quite a complex picture emerged from the responses to the questions on **consensual, non-violent relationships.** Almost eight in ten participants stated that it is never justifiable for a man to beat his wife, with women being less supportive than men of wife-beating (mean 1.77 vs. 1.94 [p=0.01] on a 1–10 scale with 1 representing "never justifiable", see Figure 8 for a visualisation of the distribution across the full sample (no difference across countries). Further exploration of the variables related to violence in the family showed, however, that respondents in Ethiopia were more likely to accept violence in the family when the perpetrator's gender was not given. In Zimbabwe, 39% stated that *men* may use violence to keep their wives in line, compared to 19% in Ethiopia. However, in Ethiopia 79% indicated that women should tolerate violence to keep the family together compared to 22% in Zimbabwe (Appendix, Table A3). Also, 70% in Ethiopia believed that no-one else should interfere when it comes to violence within a family compared to 31% in Zimbabwe. When asked about the acceptability of honour-related oppression, a majority (63%) of the respondents in Ethiopia agreed with this compared to just less than half (41%) of the respondents in Zimbabwe. Yet, when asked whether it is a *man's* duty to exercise guardianship over his female relatives a majority (67%) of respondents in Zimbabwe agreed with this, compared to slightly less than half (41%) in Ethiopia. Nevertheless, a majority in both Ethiopia (69%) and Zimbabwe (64%) agreed with the statement that if man has a girlfriend or wife, he should know where she is all the time (Appendix, Table 3A).

Figure 8. Histogram of the variable "Is it justifiable for a man to beat his wife?", including respondents from all three countries"

Regarding violence against other family members, there was consistently high acceptability of parents' use of violence against children (61%). This support was particularly high in Nigeria (86%), but also a majority in Zimbabwe (58%) agreed with this compared to slightly less than half (40%) in Ethiopia (Appendix Table A3). Most participants, however, disagreed with FGM/C**;** 81% stated that the practice is never justifiable (mean 1.99 on a 1–10 scale with 1 representing "never justifiable") (Table 4). Respondents in Zimbabwe also reported higher frequency of GBV in their neighbourhoods. See detailed information in Box 5 under the Zimbabwe case study.

Turning to support for the right to **decide if, when and with whom to marry,** while the majority of respondents did not think that girls are ready for marriage once they start menstruating, a third (33%) of the total sample agreed with this statement; men were more likely to do so than women (mean 2.79 vs 2.88 [p=0.008] on a 1–4 scale with 1 representing "strongly agree") (Table 4). The proportion that supports child marriage was highest in Nigeria (40%) followed by

Ethiopia (29%) and Zimbabwe (21%). Half of participants (49%) believed that both boys and girls should honour the decision of their parents to marry even if they did not want to (Table 4). Agreement with these statements – for boys and girls respectively – was particularly high in Nigeria (57%–58%) and Ethiopia (50%–52%) compared to Zimbabwe (38%–33%) (Appendix Table 5A). Most participants – men and women alike – further indicated that divorce is never justifiable (65% vs. 64%, respectively). Participants in Nigeria reported a more liberal view on premarital sex with about half (46%) stating that sex before marriage is justifiable to some extent, as compared to Zimbabwe (28%) and Ethiopia (18%) where attitudes were more restrictive. Similarly, a higher proportion of Nigerian participants (44%) stated that causal sex is justifiable as compared to 20% in Zimbabwe and 9% in Ethiopia (Appendix Table 4A).

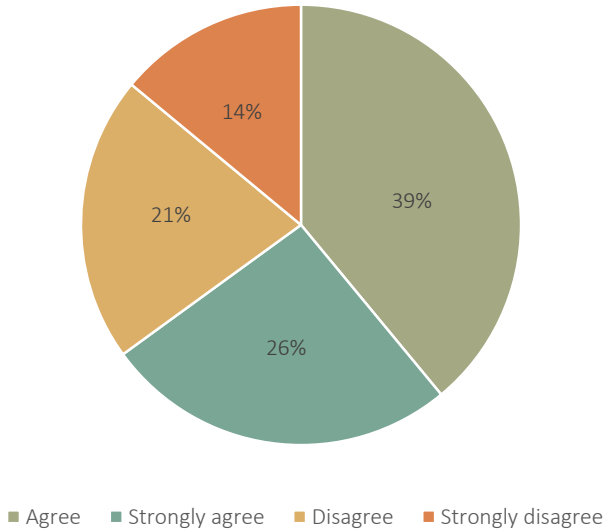
Reproductive empowerment was the domain that obtained the most support among respondents. There was consistently strong support (>50% of the respondents in agreement with the statement) across the three countries for the use of contraceptives (80%), infertility assistance (81%) (Appendix Table 7A), the safety of delivering at a clinic rather than at home (93%) (Appendix Table 9A), the importance of girls' education even if they become pregnant (88%), and against adolescent pregnancy (76%) (Appendix Table 7A). Most participants (86%) agreed that it is a duty to society to have children and a majority (95%) also responded that they considered themselves to have choice and freedom to control their family planning. While 47% of participants reported wanting between 4–9 children, 16% reported a fatalistic view stating that they would have as many children as God wanted to give them (Appendix Table 7A).

There was a lower, but consistent agreement with the statement that "only when a woman has a child is she a real woman" (37% of the total sample); higher in Nigeria (46%) and Zimbabwe (41%) compared to Ethiopia (25%). In comparison, there was very low

support for the idea that a man who cannot father children is not a real man (13% Ethiopia, 21% Zimbabwe, not asked in Nigeria). This may be interpreted as an indication that a woman's worth, as well as her identity as a woman, are contingent on their ability to bear children to a larger extent than men. Overall, a majority (59%) of respondents reported that it is a woman's responsibility to avoid getting pregnant, with the highest proportion found in Zimbabwe (70%) followed by Nigeria (60%) and Ethiopia (48%) (Appendix Table 7A).

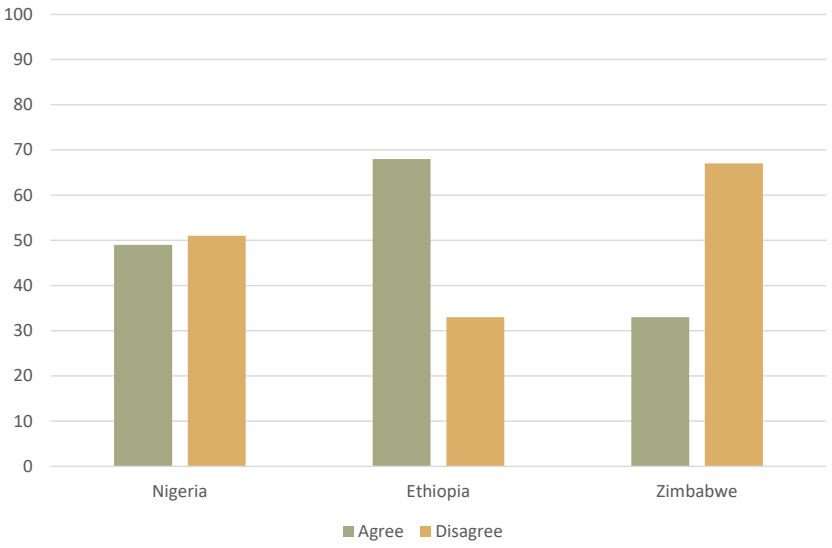
Furthermore, two thirds (65%) of the total cohort agreed that contraceptives should be available for everyone whether one is married or not (Table 4 and Figure 9). While there were no gender differences in support for contraceptive use (66% of men and 64% of women agreed that this should be available for everyone), such support was particularly strong in Zimbabwe (70%) (Table 4).

Figure 9. Proportion of respondents in the total sample agreeing vs. disagreeing that contraceptives should be available for everyone, irrespective of marital status



When discussing abortion services, respondents had seemingly contradictive views; while half (50%) of participants in all three countries indicated that women should have access to safe abortion services to terminate an unwanted pregnancy, a majority stated that abortion is never justifiable (82%, mean value 1.72 on a 1–10 scale with 1 representing "never justifiable") (Table 4). The support for safe abortion services was higher in Ethiopia (68%) as compared to Zimbabwe (33%) (Figure 10), but there were no gender differences in terms of support for such services (51% of men vs. 49% of women).

Figure 10. Proportion of respondents agreeing vs. disagreeing that women should have access to safe abortion services



In terms of **non-discrimination related to sexuality and gender,** there was consistently low support for LGBTQI people's rights, with the vast majority (83%) mentioning homosexuals as persons they would not like to have as neighbours (Table 4) and 85% stating that homosexuality is never justifiable (mean 1.62 on a 1–10 scale with 1 representing "never"), ranging from 80% in Nigeria to 91% in Ethiopia (Appendix Table 6A). There was higher agreement with the statement that people who dress, act, and identify themselves as the opposite sex should be treated just like anybody else in Zimbabwe (44%) than in Ethiopia (29%), indicating support for transgender people's rights (Table 4). Due to the overwhelmingly and consistently low support for LGBTQI people's rights, this domain could be considered particularly discriminatory.

Support for **gender equitable relationships** was complex and varied depending on country, gender as well as the question asked. Respondents generally expressed low support for women working outside the home, with 48% agreeing that being a housewife is just as fulfilling as working for pay (Appendix Table 8A). However,

gender-related beliefs also varied by country; for example, only 15% of the respondents in Zimbabwe agreed that "when women work for pay, the children suffer" compared to 41% in Nigeria and 61% in Ethiopia. In contrast, while a minority (39%) of the respondents in Ethiopia agreed with the statement "it is a man's job to earn money and women to take care of the home", twice as many (79%) of the respondents in Zimbabwe did so. Most respondents did not think that a university education is more important for a boy than for a girl, yet a substantial minority (42%) of Nigerians agreed with this statement compared to 16% in Ethiopia and 14% in Zimbabwe.

While half of participants in all three countries agreed that a man should always have the final say about decisions in his relationship (Table 4) with more men than women agreeing with this statement (mean 2.36 vs. 2.54 [$p < 0.001$] on a 1–4 scale with 1 representing "strongly agree") – 82% disagreed that a man who discusses important decisions with his wife is considered weak (Appendix Table 3A). Perceptions about masculinity norms were, however, far from stereotypical: less than 20% agreed with traditional masculinity traits or roles such as a "real" man not being able to show emotions; having as many sexual partners as he can; or use violence to get respect if needed. These perceptions also varied by country; for example, while a majority of the respondents did not agree that "a man who talks a lot about his worries, fears and problems does not deserve respect", agreement was higher in Zimbabwe (23%) than in Ethiopia (11%) (not asked in Nigeria). Opinions were also divided around the topic of women's sexuality. About half of participants in Ethiopia and Zimbabwe (46%) perceived that a woman who shows interest in sex would be considered indecent (Appendix Table 8A).

A notable finding in this domain, was the low support for women as decision-makers, whether in the public or private spheres. In particular, women were less trusted as political leaders – a total of 54% of the total sample thought that men were better political

leaders than women – but women were more trusted as business leaders (43% of the total sample thought men make better business leaders than women) (Appendix Table 8A).

Multivariable analyses of factors associated with support for sexual and reproductive health and rights

In this section we present results for the nine variables selected for the multivariable analysis, tapping into norms and values across different domains of the Guttmacher-Lancet definition of SRHR. Table 5 shows results from the adjusted analyses of the association between Sida's four dimensions of poverty and support with the selected SRHR norms and values; and the full results including associations with sociodemographic variables are presented in Appendix Table 10A.

Variations across sociodemographic factors

In terms of **country-level variations**, Zimbabwe and Nigeria generally had lower support for SRHR, based on respondent's values and perceived social norms, as compared to Ethiopia (used as reference/base category). Respondents in Zimbabwe and Nigeria were less likely than those in Ethiopia: to disagree with wife-beating as potentially justifiable; to endorse women's access to safe abortion services; and to indicate that they would not like to have a homosexual couple as neighbours. However, in Zimbabwe, where additional questions were asked (not included in Nigerian survey), there were variations across the different SRHR domains, with respondents more likely than those in Ethiopia to perceive that sexuality education can help people make informed decisions; to disagree with child marriage; and to indicate potential support for transgender rights.

There was no clear trend between respondents' **age** and support for SRHR, except for that the youngest age group (18–25 years) was more likely than those older to indicate that they would be ok with having a homosexual couple as neighbours. In terms of responses among **men and women**, women were more likely than men to disagree with wife-beating, child marriage, and that men should have the final decision in a relationship. While currently- or ever-married respondents being less likely to disagree with child marriage than those single, there were no other differences in support for SRHR by marital status.

As for **urban or rural residence**, the only variable with statistically significant results was whether a girl was ready for marriage once she starts menstruating, with respondents in urban areas being less likely than those in rural areas to support child marriage.

Respondents with **higher education** were more likely to indicate support for several aspects of SRHR, such as safe abortion services and to disagree with child marriage but were less likely to indicate that they would be ok with having a homosexual couple as neighbours as compared to respondents with no formal or only primary education.

While there were no clear trends in terms of **subjective social class**, those in the middle-class group were more likely than the lower- or working-class to disagree with wife-beating, FGM/C, child marriage, and that men should always have the final say in relationships.

In terms of **religion**, Muslim respondents were less likely to indicate support for SRHR than Christian respondents (reference group) both regarding gender-equitable relationships free of violence and access to SRHR services. However, after adjusting for religion, respondent's actual religiosity was only associated with abortion values (among the SRHR and gender variables investigated), with those perceiving themselves to be more religious being the less likely to agree with women's right to safe abortion (Appendix Table 10A).

Variations across Sida's four dimensions of poverty

As for the variables chosen to represent Sida's four dimensions of poverty (see Methods section, page 28), we found that **having family savings** during the past year as an indicator of *resources* (responding "save money" as compared to "spent savings and borrowed money") was the only variable consistently associated with expressing greater support for SRHR, even after adjusting for employment status, education level, subjective social class and other sociodemographic variables included in the model (Table 5).

Respondents who reported having family savings were more likely than those without such savings to disagree with wife-beating and FGM/C, and more likely to endorse that contraceptives should be available to anyone, as well as to express support for trans-gender rights, and that men should not have the final say in all decisions. In contrast, **employment status** as an indicator of *opportunity and choice* was only associated with support for two SRHR domains; those employed were more likely to disagree with child marriage, yet less likely to be ok with having a homosexual couple as neighbours compared to those unemployed or self-employed. Likewise, respondents who acknowledged the importance of **living in a democracy**, as an indicator of *power and voice,* and here represented by the WVS voice index, were less likely to disagree with wife-beating, but at the same time more prone to support that contraceptives should be available to anyone irrespective of marital status. The **WVS voice index**, tapping into overall emancipative values including values related to autonomy, equality, and choice, showed no statistically significant associations with the selected SRHR norms and values (Table 5). In terms of **feeling secure in one's neighbourhood**, as an indicator of *human security*, results were again conflicting across domains. For example, those perceiving their neighbourhoods as more secure were less likely to disagree with child marriage but also to disagree with universal access to contraceptives.

Table 5. Multivariable analyses of the association between Sida's four dimensions of poverty and support for the selected key SRHR norms and values in the three countries included in the survey

	Sexuality education helps people make informed decisions[a] OR (95% CI)	Wife-beating not justifiable[b] OR (95% CI)	FGM/C not justifiable[b] OR (95% CI)	Child marriage not acceptable[a] OR (95% CI)	Support safe abortion services[a] OR (95% CI)	Contra-ceptives should be available[a] OR (95% CI)	Homo-sexuals as neighbours acceptable OR (95% CI)	Agree with trans-gender rights[a] OR (95% CI)	Men should not have the final say[a] OR (95% CI)
Dimension resources: Have family savings[c]	1.24 (0.9,1.57)	**1.25 (1.02,1.52)**	**1.43 (1.07,1.92)**	1.19 (0.99,1.42)	1.17 (0.99,1.38)	**1.20 (1.01,1.43)**	1.05 (0.85,1.31)	**1.60 (1.29,1.99)**	**1.61 (1.31,1.98)**
Dimension opportunities and choice: Employed[d]	0.90 (0.67,1.20)	0.95 (0.73,1.23)	1.06 (0.76,1.49)	**1.38 (1.08,1.75)**	0.87 (0.70,1.09)	1.03 (0.82,1.29)	**0.60 (0.44,0.82)**	0.95 (0.73,1.24)	1.00 (0.78,1.29)

	Sexuality education helps people make informed decisions[a] OR (95% CI)	Wife-beating not justifiable[b] OR (95% CI)	FGM/C not justifiable[b] OR (95% CI)	Child marriage not acceptable[a] OR (95% CI)	Support safe abortion services[a] OR (95% CI)	Contra-ceptives should be available[a] OR (95% CI)	Homo-sexuals as neighbours acceptable OR (95% CI)	Agree with trans-gender rights[a] OR (95% CI)	Men should not have the final say[a] OR (95% CI)
Dimension power and voice: Important to live in a democracy[e]	1.75 (0.95,3.25)	**0.33 (0.14,0.76)**	1.33 (0.68,2.61)	1.18 (0.68,2.04)	0.91 (0.55,1.51)	**2.24 (1.37,3.66)**	0.77 (0.40,1.48)	0.91 (0.51,1.62)	1.38 (0.77,2.46)
Dimension power and voice: WVS voice index[f]	0.98 (0.81,1.19)	0.91 (0.77,1.07)	0.85 (0.68,1.06)	0.95 (0.81,1.11)	1.03 (0.89,1.19)	0.96 (0.83,1.11)	1.01 (0.83,1.22)	1.19 (0.99,1.42)	0.86 (0.72,1.02)
Dimension security: Feel secure in one's neighbourhood[g]	0.94 (0.76,1.16)	0.96 (0.80,1.15)	0.86 (0.67,1.10)	**0.79 (0.67,0.94)**	1.12 (0.96,1.31)	**0.85 (0.72,0.99)**	**1.30 (1.06,1.61)**	1.02 (0.84,1.24)	0.92 (0.77,1.11)

Total sample size varied across the different variables (between 2272 and 3497) as all questions were not asked in all countries. All results are presented as odds ratios (OR) with 95% confidence intervals (CI) and control for country, age, gender, marital status, religion, religiosity, education level, urban/rural residence, and subjective social class. Values above 1.0 indicates more support for SRHR. Figures in bold indicate statistically significant results.

a) On a 4-grade Likert scale dichotomized as 1–2 “Agree” vs. 3–4 “Disagree”.

b) On a 10-grade Likert scale dichotomized as 2–10 “Justifiable to some extent or always justifiable” vs. 1 “Never justifiable”.

c) On a 4-grade Likert scale dichotomized as 1 “Have savings” vs. 3–4 “Do not have savings”.

d) Employed vs. not employed or self-employed.

e) On a 10-grade Likert scale dichotomized as 1 “Not at all important” vs. 2–10 “Important to some extent or absolutely important”.

f) On a 0–1 Likert scale dichotomized based on the medial value to represent high vs. low voice.

g) On a 4-grade Likert scale dichotomized as 1–2 “Secure” vs. 3–4 “Not secure”.

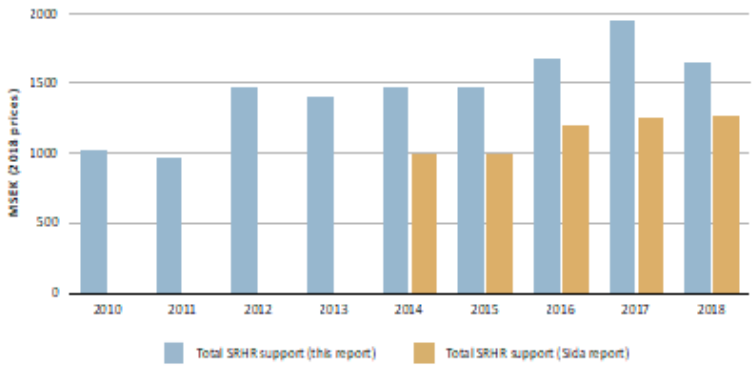
Summary of key findings from sub-study I

- Norms and values related to SRHR (including gender equality) varied across Ethiopia, Nigeria, and Zimbabwe. Generally, Ethiopia had more supportive values and norms related to SRHR than the other two countries. There were few differences by gender, age or urbanicity.
- Discriminatory norms were more common in relation to sexual and reproductive *rights* than in relation to reproductive health.
- The discriminatory norms and values that appear particularly entrenched are those related to LGBTQI rights, abortion, women's decision-making, men's control and power over women, violence against children, divorce, and young people's sexuality and right to choose a spouse.
- A majority of the respondents were in favour of accessible contraceptives regardless of marital status, and half indicated support for safe abortion services. Very few accepted female genital mutilation and cutting (FGM/C), despite a high prevalence in Ethiopia in particular.
- Multivariable analyses further demonstrated the complexity of SRHR norms and values, and there were no clear trends in terms of their association with sociodemographic factors. The most important independent determinant for supporting sexual and reproductive rights was having strong household economy, and higher education was associated with support for women's rights. In addition, younger age groups tended to be more accepting of LGBTQI rights.

Findings sub-study II: Developmental assistance for SRHR by Sida

Total development assistance for SRHR disbursed by Sida increased from 1,019 Million SEK (MSEK) in 2010 to 1,603 MSEK in 2018, with the highest volume recorded in 2017 at 1,981 MSEK. These numbers are higher than the Swedish government's own calculations which estimated the total SRHR development assistance through Sida at 1,001 MSEK in 2014 rising to 1,280 in 2018 (Figure 11).

Figure 11. Total development assistance for SRHR 2010–2018, 2018 prices



Source: data for this report and [5].

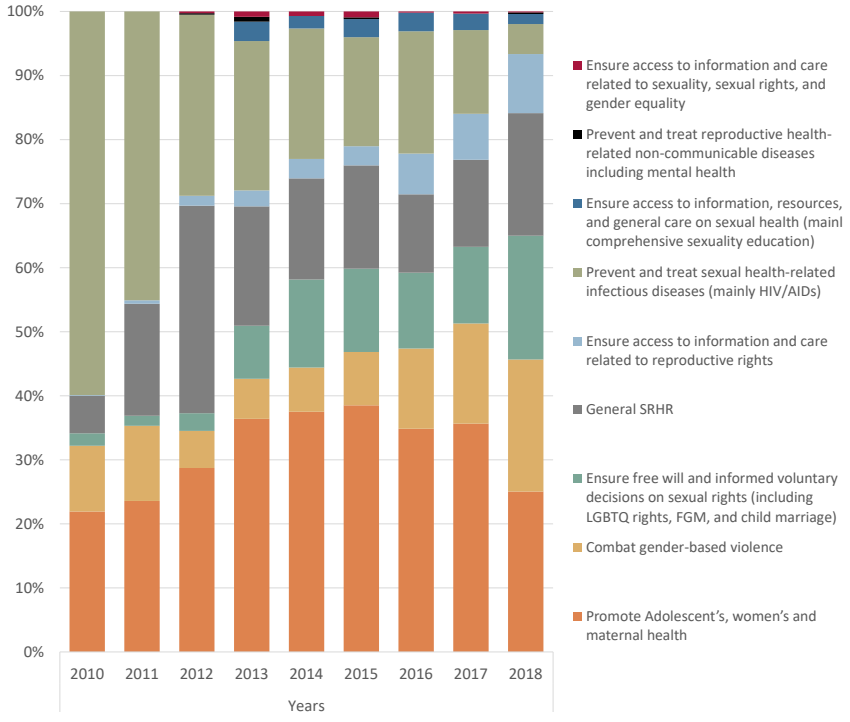
The higher level of development assistance for SRHR estimated in our review is not surprising as additional purpose codes[7] were included to capture SRHR interventions in areas of human rights and gender. These purpose codes were not included in the internal government review. The approach taken in this study thus likely

[7] All development assistance contributions are allocated a purpose code according to the main thematic area of the contribution.

gives a more comprehensive account of Sida's SRHR support. The higher annual volatility observed is most likely explained by the fact that large disbursements, such as core support for International Planned Parenthood Federation or a large country programme can vary substantially from year to year, contributing to volatility when actual disbursements are considered.

Disaggregated by sub-components (Figure 12) in line with the Guttmacher-Lancet comprehensive definition, there were clear changes over the 9 years analysed. Since 2010, the share of Sida's SRHR support directed towards HIV has been reduced from over 60% to less than 10%. While this probably reflects an absolute decrease, it can also be a reflection of the integration agenda where HIV is included as part of more general SRHR support, a category which has increased over the same time period. Another observation is that interventions categorized under GBV have increased over time, comprising the second largest category in 2018. An additional area that has grown substantially relates to LGBTQI people's rights, FGM/C, and child marriage (Figure 12).

Figure 12. Global development assistance from Sida 2010–2018 disaggregated by SRHR categories

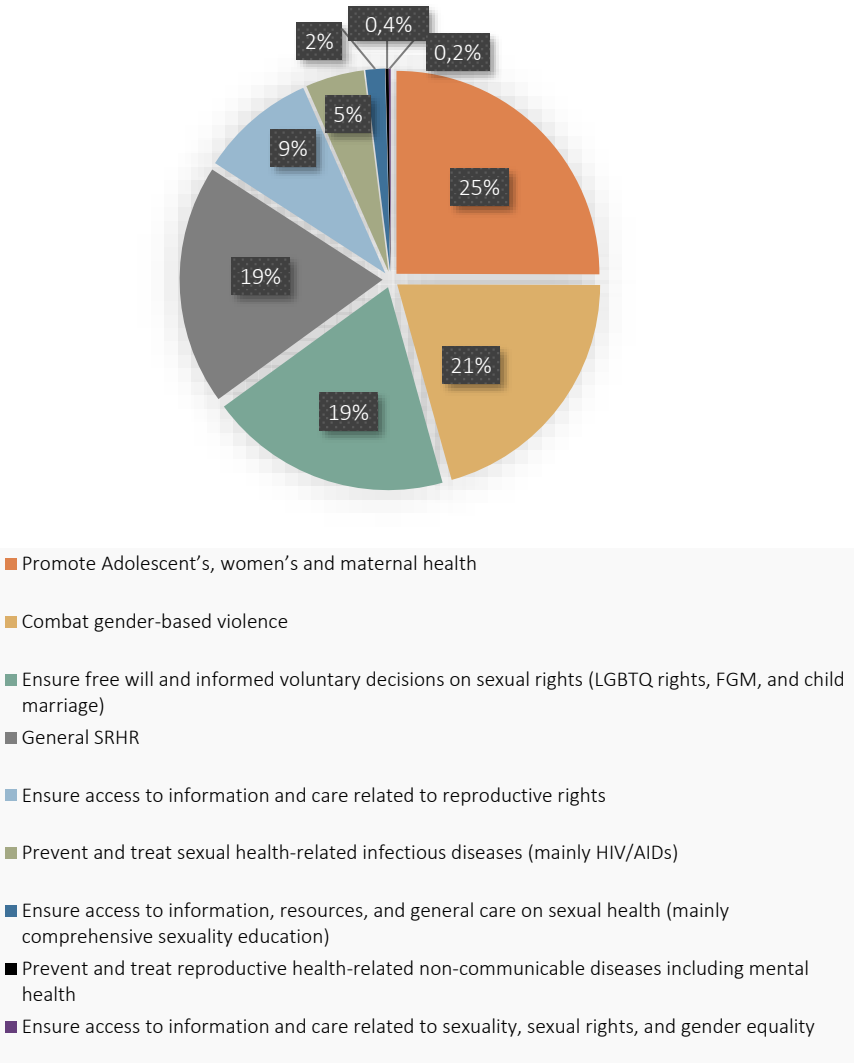


Source: data for this report and [93]

Looking closer at 2018 (Figure 13), we can see that reproductive health is the SRHR component that receives the least support. Only one of the reproductive health sub-components (sub-component 10: Ensure access to information and care related to reproductive rights) received support in 2018, and the support only amounted to 9% of total SRHR support from Sida. Adolescent, women, and maternal health (sub-component 8) is the largest area of support. This support is likely underestimated as much of what is categorized under the broad label of "General SRHR" commonly focuses on broader SRHR interventions, and maternal and reproductive health has historically been the focus of such support. The components of sexual health and sexual rights receive relatively equal levels of

resources. In sexual health, focus has been mainly on interventions targeting GBV and HIV; and in sexual rights, programmes address LGTBQI rights, FGM/C, and child marriage.

Figure 13. SRHR support from Sida 2018 by SRHR categories



Source: the current review and [93].

Case study: Zimbabwe

In addition to analysing how Sida's SRHR ODA has developed over time, the purpose of sub-study II is also to explore in what ways, and to what extent, social norms, and values around SRHR have been considered in strategies, plans, projects and reporting in Sida funded interventions. For that purpose, a brief case study was conducted of Sida's support for SRHR in Zimbabwe – the only country in our study which receives bilateral development assistance to the health sector from Sweden. Zimbabwe therefore constitutes an illustrative case for a closer look at how values and norms are reflected in Sida's programmes at country level.

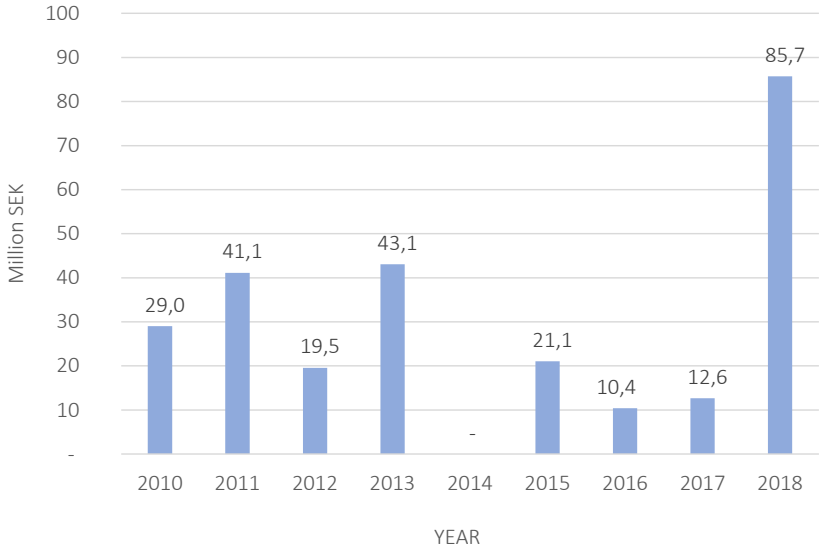
Sweden's country strategy for Zimbabwe

The current 2017–2021 Swedish strategy for development cooperation with Zimbabwe lists health as one of the focus areas. There is a particular focus on women and children and increased access to, and respect for, sexual and reproductive health and rights (SRHR) [96]. In the process of operationalizing the strategy, the Embassy conducted an analysis of challenges related to SRHR. The analysis highlighted that access to, and knowledge of, SRHR, especially for young people is grossly insufficient. Unwanted pregnancies and child marriages also constitute challenges and violations to women's and girls' rights and health [97].

While the strategy does not mention the importance of values and norms in relation to SRHR, the Embassy, in the plan for operationalization, emphasized that gender-based norms and prevailing values strongly influence social norms and views of adolescent sexuality, particularly affecting young women, limiting their access to services and information. Access to contraceptives, information about SRHR and the knowledge about risk factors for and the prevention of HIV, is extremely limited [98].

SRHR development assistance to Zimbabwe

Figure 14. Disbursements from Sida 2010–2018 to SRHR programmes in Zimbabwe (MSEK, 2018 prices)



Source: authors' calculations based on data from Sida.

Bilateral SRHR development assistance to Zimbabwe[8] has increased over time, from 29 MSEK in 2010 to 85.7 MSEK in 2018, but with large variations in disbursements[9] from year to year (Figure 15). The current strategy (2017–2021) has an increased focus on health and SRHR, which contributes to the large increase in the amount of

[8] Bilateral development assistance is defined as development assistance from Sida financed from the Zimbabwe country strategy. Sida also finances additional development cooperation projects, fully or partially implemented in Zimbabwe, through e.g., the regional SRHR strategy for sub-Saharan Africa and Global strategies.

[9] For this report we have relied on data on financial disbursements from Sida's reporting system. Most Sida programmes run for multiple year, but sequencing of disbursements for these programmes at times vary from year to year. For example, a 3 year programme can have a budget of 10 million SEK per year but disbursements to the programme might look very different from year to year.

SRHR assistance from 2017 to 2018. According to Sida's strategy report for 2018, the most pressing SRHR challenges in Zimbabwe are related to lack of SRHR services and condemning attitudes towards young people and their sexuality. There is also lack of access to HIV testing without parental consent and persistent marginalization of LGBTQI individuals who are often denied access to health care [99].

SRHR programming and social norms

Sweden is currently supporting SRHR programmes in Zimbabwe related to GBV (through UNICEF and UNFPA), access to SRHR services (through Population Services International and Marie Stopes), SRHR information (through civil society organization SAYWHAT) [100] and safe abortion (through Amplify Change) [101]. Sida funds family planning clinics and outreach activities that include services such as menstrual health, provision of modern contraceptives and condoms, HIV and STI services and access to post-abortion care. In addition, Sida supports demand-generating activities related to SRHR and behaviour change interventions for SRHR and GBV. Both Sida and their implementing partners emphasized the importance of norms and values for advancing SRHR in the Zimbabwe context. Interviewees brought up both cultural and religious beliefs as important factors that need to be understood in order to implement the Swedish strategy effectively. For example, while it is illegal to marry a person below the age of 18, child marriages are culturally accepted in many communities. Furthermore, it is difficult to speak about young people's access to SRHR as it is not accepted for young people to be sexually active before marriage. According to the respondents, a common attitude against the promotion of modern contraceptives and condom use (family planning) would be "why do you need to plan for a family when you do not have a family?" Gender equality was reported as a another common SRHR challenge since women are often seen as

requiring disciplining and control. Respondents described it as "a man's world" and with high prevalence of GBV. They also described large regional differences with rural areas and specific religious communities carrying most of the resistance towards SRHR services.

The interviewees agreed that effective provision of support for SRHR services, requires an awareness of existing norms, as well as investment in community engagement to allow access to communities. Community engagement is a process that requires patience and time but emphasized by respondents as critical to avoid unnecessary resistance and to increase access to services. To better understand existing norms and values in communities, Sida's partners also use a method described as "community diagnosis". This includes questions such as "what are the differences between men and women?" and "how are decision made in your household?". Sida's partners also solicit comments from clients who use their services to better understand how these can be made more accessible by working against norms and values that act as SRHR service barriers. Sida's partners felt confident in having good knowledge of existing norms and values through their experience and the community diagnosis method, acknowledging room for improvement, in particular at the sub-national level, where in-depth knowledge on how values and norms differ across communities are lacking.

While the Swedish strategy for development cooperation with Zimbabwe does not explicitly mention norms and values, they were considered important for operationalizing all SRHR interventions in the strategy. Overall, both Sida and its partners showed a good understanding of the importance of norms and values for advancing SRHR and optimizing their programming in Zimbabwe.

Box 5. Quick facts: Overview of select norms and values in Zimbabwe

Child marriage: 21% stated that a girl is ready for marriage once she starts menstruating (Appendix Table 5A).

Young people and sexuality education: Just under half of the respondents (41%) stated that sexual education promotes sexual activity among young people while a majority (79%) thought that sexual education helps people make informed decisions (Appendix Table 2A).

Gender-based violence: while a majority (61%) of respondents did not agree that men may use violence to keep their wives in line and 79% stated that it is never justifiable for a man to beat his wife, almost two thirds (64%) thought that if a man has a girlfriend or wife, he should know where she is all the time. Most respondents (67%) also thought that it is a man's duty to exercise guardianship over his female relatives, but 59% said that honor-related oppression (that the family decide on young women's life choices) is never acceptable. However, 22% of respondents thought that FGM/C is acceptable. About in 1 in 5 (22%) of all respondents stated that a woman should tolerate violence to keep the family together, and almost a third (31%) believed that no-one else should interfere when it comes to violence within the family (Appendix Table 3A).

Prostitution, and getting paid for pornographic photos or films had very low levels (<20%) of acceptance among respondents in Zimbabwe, however in comparison to Ethiopia, respondents in Zimbabwe were slightly more supportive (Appendix Table 3A).

Similarly, 13% of respondents in Zimbabwe agreed that having sex in exchange for gifts or favors was acceptable, which was slightly higher than the respondents in Ethiopia (9% reported this as acceptable).

Of all countries surveyed, respondents in Zimbabwe reported more frequent occurrence of sexual harassment, men and boys hurting women and girls, as well as girls and women trading sex for money in the neighbourhood. A large majority (69%) of respondents said that women and girls trade sex for money, and slightly more than half (55%) said that sexual harassment of women and girls is frequent in their neighbourhood. Less than a majority, but still a substantial number of respondents (41%) said that men and boys hurt women and almost a quarter (23%) reported that rape and sexual assault occurs frequently in their neighbourhood (Appendix Table 3A).

Summary of key findings from sub-study II:

- Sida's development assistance for SRHR has increased over time and the focus has shifted between components of SRHR.
- The total development assistance for SRHR disbursed by Sida increased from 1,019 Million SEK (MSEK) in 2010 to 1,603 MSEK in 2018, with the highest volume recorded in 2017 at 1,981 MSEK.
- The share of SRHR development assistance targeting sexual rights and reproductive rights has increased over time, while the share targeting reproductive health and sexual health has reduced.
- Current data on Sida's SRHR development assistance for SRHR does not allow for routine disaggregation of SRHR ODA by, for example SRHR components or thematic areas making analysis difficult and time consuming.
- Values and norms appear increasingly central to Sida's SRHR projects, despite not being explicitly mentioned in country cooperation strategies.

Strengths and Limitations

A major strength of our study is the opportunity for Sida and other key stakeholders including civil society to benefit from the established WVS structure for data collection and data analysis. The rich dataset with new as well as existing measures tapping into values and norms related to gender and SRHR, coupled with the representative samples in three sub-Saharan African countries, provides a unique material. Our review of Sida's system to categorize ODA also offers unique insights.

Our results also demonstrate the complexity of studying norms and values related to SRHR, and the benefits and drawbacks of using pre-defined categories and frameworks such as the Guttmacher-Lancet integrated definition of SRHR. Moreover, it demonstrates that the prevalence of discriminatory norms and values related to gender and SRHR differ both between and within countries and are thus amenable to change. To achieve Agenda 2030 and optimize the implementation of Sweden's development agenda, it is necessary to take norms and values into consideration.

Our findings should also be interpreted in light of its limitations. **For sub-study I**, the cross-sectional nature of the data provides a snapshot of norms and values but does not allow for conclusions about causality. While the face-to-face data collection conducted as part of the WVS is important to gather valid and reliable responses to sensitive questions, it may also lead to social desirability bias where respondents answered according to what they may think is most acceptable (by the interviewer or broader community), or to non-response. We addressed this potential source of bias via rigorous training of skilled interviewers, following the WVS longstanding routine for collecting data.

Further, while we strived to capture norms and values related to all domains of the definition, we were limited by the survey length. Questions related to menstrual health and hygiene, HIV, and cancers of the reproductive organs were not included. The dichotomization of variables that were originally asked using Likert-scales may also have resulted in loss of information (such as between agree and strongly agree); we chose this approach in order to compare a broad range of variables in the multivariable analysis. In addition, most of the questions in the WVS measure individual values, and fewer questions tap into descriptive norms, sanctions, or reference groups. As we were limited in our inquiry on social norms and values related to marginalized groups of people, it is not possible to draw conclusions related to intersectionality, i.e., whether individuals perceive different sexual and reproductive rights according to different characteristics such as race, ethnicity, disability, etc. Finally, although the three countries included in the WVS sample represent three different sub-regions within sub-Saharan Africa, they are not representative of the full region.

For sub-study II, the analysis of Sida's SRHR ODA and the categorization by SRHR components and sub-components should be interpreted with some caution. Despite our best efforts to be systematic in our categorization it is difficult because of the limited level of detail in the data. Data entries that report on specific results in the Swedish development cooperation strategies, have been used as our first choice for categorizing each entry. However, many contributions are broad and cover several SRHR components. A contribution can, for example, cover safe abortion, GBV and access to information, but when reported it is reflected in the statistics system at Sida as working towards "increased access to SRHR and freedom from GBV". When possible, we have tried to mitigate this limitation by reading the project description and disaggregate these entries further. However, due to both time and data constraints (the project descriptions in Sida's systems are sometimes very short or non-existent) this approach was not feasible

for all data entries. Therefore, the results from the categorization should mainly be used for understanding the overall trends. Finally, the Zimbabwe case study serves as an illustrative example of how norms are considered in Sida's programmes but does not represent a comprehensive account of Sida's work in Zimbabwe nor is it generalizable to other contexts.

Discussion and Recommendations

This report set out to investigate values and norms in three sub-Saharan countries, focusing on the extent to which individuals and groups support sexual and reproductive rights, including gender equality. This was combined with a trend analysis of Swedish ODA for SRHR in order to guide Sida's support to SRHR in a way that is more adapted to the specific local, regional and national normative contexts and needs. Below we discuss the key findings related to our research questions, and end with conclusions and recommendations.

Values and norms related to gender and SRHR are complex and dynamic

Guided by our conceptual framework (Figure 4), we investigated norms and values related to different domains of SRHR in line with the Guttmacher-Lancet definition [2]. These domains worked well, gave a clear structure, and helped us in the selection of key indicators that in turn provided a good overview of all essential categories. However, while useful, our application of the framework also confirmed that values and norms related to gender and SRHR are complex and dynamic, and thus not easily compartmentalized into "more" or "less" supportive [4, 102]. For example, it became clear that an individual's or groups' support for one dimension of SRHR does not necessarily guarantee that they support another; for example, someone might support abortion and LGBTQI rights, but still justify wife beating. At the same time, while values and norms are very specific, they also appear, paradoxically, as borderless as were clear by the trends in levels of support for SRHR that were similar throughout the three countries (Figure 7).

The results of this study clearly show that this complexity can be contradictory and unpredictable. This may in turn explain why we could not identify an overall SRHR index, an initial aim of the report.

In addition, categorizing Swedish ODA into components and categories of SRHR proved challenging as Sida's contributions are not categorized accordingly. Furthermore, information in Sida's systems is limited and inconsistent, making categorization very time consuming as each contribution must be assessed manually.

The lesson learnt is that while the comprehensive definition of SRHR may be useful at the academic and conceptual level, there may be a risk of lumping several very different sexual and reproductive rights together when analysing progress towards SRHR. As such, it is important to analyse each type of right separately as well as their intersection, or the resulting findings could be seen as conflicting and contradictory. The assumption that all rights-related norms are associated and should lead in the same direction, at the same point in time, may lead to too hasty conclusions. Learning from history in Sweden, for example, support for LBTQI rights came significantly later than support for women's rights and the resistance against gender-based violence [103][104]. The time dimension may need to be considered and could be used to strategically leverage the promotion of sexual and reproductive rights as human rights in Sida's strategies through different channels.

The complexity of norms and values related to SRHR may also give an indication of the importance and meaning of other, underlying social and cultural norms, particularly regarding power and hierarchy. For example, the varied results in the domain of consensual, non-violent relationships may indicate that this is an area that not only provides meaningful information about men's use of violence, but also on the acceptability of violence in the family in general [69]. Another example is comprehensive sexuality education; when the target group of the sexual education is not specified, it garners more support among the respondents. This may be an indication of other cultural norms surrounding adolescents in a particular context – when does one cease to be a child and what does it mean to be an adolescent, how is adulthood and responsibility

conceptualized and communicated? Finally, the questions on abortion indicate that there may be a benefit from situating safe abortion as a health service rather than as a moral concept in and of itself.

Need to address values and norms related to sexual and reproductive rights

As our analysis of values and norms confirms, discriminatory norms and values are more often found in relation to sexual and reproductive *rights* rather than in relation to reproductive health [2, 4]. The values and norms that appear to be particularly entrenched based on our findings are those related to abortion, LGBTQI rights, women's decision-making, men's control and power over women, violence against children, divorce, and young people's sexuality and right to choose a spouse. These are issues that are often stigmatized and sometimes even illegal in the countries studied as well as in other sub-Saharan African countries [105], they also mirror the areas in which the regional communities' commitments on SRHR are lacking, wherefore it is not surprising that perceptions around these sexual and reproductive rights remain discriminatory at a group level. Sweden's support to SRHR via Sida focuses on these specific areas, with issues such as abortion, LGBTQI and young people's right to sexuality education being priority areas, and thus makes an important contribution to addressing these discriminatory views.

While most of the respondents did not support discriminatory norms and values, a substantial minority (ranging from 20–49%) often does. Our reflection on these results is that the minority's restrictive views may still play an important role in society. First, it is relevant to consider that the minority may be part of influential groups, such as community leadership or other reference groups, and therefore have disproportional impact on other people's behaviour. Second, it is possible that while a minority of respondents have low

levels of support for a range of SRHR dimensions, this number may still be large enough to impact society. For example, although only one third of respondents think that girls are ready for marriage upon the onset of menarche, this may be a large enough number to impact the lives of girls and young women. Third, many may believe or hold a certain value that is not reflected in their behaviour due to social norms and associated sanctions, which may constrict the possibility for them to live accordingly. Women as well as men may not personally support FGM/C, but uphold this practice in order to avoid social exclusion. Indeed, while only 16% of the WVS respondents in Ethiopia showed some support for FGM/C, population data indicates that about half (47%) of girls aged 15–19 years have experienced it (Table 1) – further emphasizing the complexity of social norms and values for SRHR, and their relationship to local structures of power and hierarchy.

Little consensus on values and norms for SRHR across countries in sub-Saharan Africa

Our analysis show that norms and values vary both between and within countries, and support for sexual and reproductive rights exist in all countries in certain population groups. We saw consistently high support across the three countries in support of safe child delivery, girls' education, access to contraceptives, disagreement with FGM/C and, to some extent, rejection of stereotypical masculinity norms. This provides a window of opportunity to keep addressing perceptions related to these SRHR dimensions, as well as an entry point to address more stigmatized issues as part of "more approved" services, e.g., introduce the idea of safe abortion or adolescents' access to contraceptives as part of already accepted family planning services.

The difference seen between educated vs. non-educated and younger vs. older age groups indicates that working with local communities that have achieved change and are more supportive may be a way forward if one wants to change norms [62, 75]. Leveraging existing norms that support certain aspects of SRHR may also be a way forward to understand why certain projects are less successful, to set reasonable aims and contextualize interventions via pre-assessments.

The varying (and sometimes lack of) association between SRHR norms and values with sociodemographic factors and dimensions of poverty confirms that development assistance for SRHR needs to address the intersection between different *social-ecological levels*, in line with the social norms theoretical framework that guided our study [63]. An example of *institutional* influence, is how respondents in Ethiopia were the most supportive of access to safe abortion services, reflected in its law on abortion which is the most permissive out of the three countries surveyed. As for *resources*, having family savings appeared to be especially strongly linked with supporting a range of different dimensions of SRHR. At the same time, higher education was associated with more support for several aspects of SRHR such as safe abortion services, but less accepting of others, such as LGBQTI rights. *Social factors* such as marital status was not associated with supporting any of the key variables, and we only found minor differences in terms of *individual* factors such as respondents' age, sex and religiosity.

In order words, there is no "silver bullet" or key factor such as education level or religion that needs to be targeted in order to address discriminatory norms and values; this suggests that there is not one intervention or programme – such as only increasing hospitals or schools – that will change norms and values. Rather, as contexts vary, it underscores the need for Sida and other key stakeholders to take into consideration the local normative environment when planning and implementing health and behaviour change interventions in order make a meaningful contribution with its SRHR assistance.

Development assistance for SRHR has increased and is increasingly targeting rights

Our review of Sida's development assistance for SRHR shows that the levels have increased over time 2010–2018, and that the focus has shifted between domains of SRHR to become more rights oriented. Our approach included additional data in comparison to Sweden/Sida's own review of development assistance for SRHR. However, the absolute level of SRHR support is arguably not the most important issues to study.

The main added value of this approach is the detailed analysis of each data entry which allows for disaggregation of SRHR support in a way that is not possible when using more generic methods that do not analyse the content of the SRHR projects and programmes. This reflects an increased focus on issues such as of LGBTQI rights, the right to abortion, freedom from harmful practices such as female genital mutilation and child marriage; several of which remain the most controversial and thus essential to address based on our findings in sub-study I.

Our brief case study of Zimbabwe reinforces the notion that values, and norms are increasingly central to Sida's SRHR projects, despite not being explicitly mentioned in the country cooperation strategy. In the operationalization plan for the Zimbabwe country strategy 2017–2020, the importance of values and social norms in relation to SRHR in Zimbabwe is mentioned. In interviews with Sida's representative and partner organizations, it was clear that while values and social norms often are thoroughly considered and factored into SRHR projects and programmes, there is not necessarily an explicit plan to change norms, but rather to navigate the context to optimize programme implementation.

The trend observed in this study is also increasingly reflected in the Swedish government's position on the importance of social norms and values for increased SRHR. The recently announced new strategy for SRHR in sub-Saharan Africa [106] with an increased budget further reinforces this development as the government directives to Sida stipulates that the new regional SRHR strategy should consider social norms and values.

How can Sweden optimize its support to SRHR by better adapting it to the specific local, regional, and national normative contexts and needs?

Our results point to several general recommendations that may help guide the optimization of Swedish ODA to (better) adapt SRHR support to the different normative contexts and needs within and across countries in sub-Saharan Africa. While we provide examples of what some of these recommendations may mean; it is beyond our role as researchers to discuss in detail their practical implementation.

1. **Advancing SRHR necessitates addressing values and social norms.** Our findings indicate that discriminatory norms are more linked to aspects of sexual and reproductive *rights* than health. That said, all SRHR services are intimately linked with values and social norms. Therefore, Sida and other development cooperation actors should consider assessing values and social norms when initiating new, and following up on, existing SRHR contributions. Exactly how such assessments should be conducted has to be developed in dialogue between programme officers responsible for SRHR contributions together with local key stakeholders, but an example could be to include a compulsory description of existing knowledge of values and norms in relation to the contribution under consideration.

2. **Contextual knowledge is essential to effectively target discriminatory norms**. Our findings indicate that while SRHR may be conceptualized as a package, supporting one aspect of SRHR (e.g., contraceptive access) does not mean that individuals agree with other sexual and reproductive rights. A complete understanding of the underlying factors that explain why a certain norm exists, is rarely possible given the complexity of how social norms are constructed, embedded, and sustained in societies and cultures. Using accepted norms that are supportive of SRHR as an entry point to address more discriminatory norms may be a way forward. Involving influential groups who hold SRHR supportive views, e.g., against child marriage or FGM/C, may also be effective. Development actors including Sida should ensure sufficient capacity among staff to understand, assess and work with norms and values, given their complexity, in close collaboration with local key stakeholders. Any intervention aiming to challenge or transform norms must be adapted to the local context and clarify the human rights perspective as well as avoid generalization of particular nationalities or groups.
3. **Explicitly including SRHR norms and values in official strategies signify priorities and guide project logic and evaluation processes.** While the findings from our Zimbabwe case study suggest that values and norms are considered when making decisions, despite not explicitly mentioned in Sweden's strategy, it is unclear whether this is systematically implemented across all programmes, leaving room for improvement. Goals and targets that are explicitly mentioned in country strategies are often used as point of reference for follow-up of Sida's work. We therefore stress the need for the Swedish government to explicitly mention the importance of (addressing discriminatory) values and norms related to SRHR in future strategies for development cooperation and provide staff with tools to include

norm assessments and adaptions in their activities. This also requires that Sida, when providing input to the government for new strategies, stress the importance of considering norms and values as part of the analysis for SRHR related goals and targets.

4. **Increasing the quality of data allows for better understanding of the extent to which Sida is targeting values and social norms in its SRHR ODA.** Gender equality and SRHR are some of Sweden's top priorities in development cooperation. While there are methods for rapid estimations of the total level of SRHR ODA, current data on ODA contribution do not allow for routine disaggregation of SRHR ODA when and where this is needed. Increasing the quality of the data would also allow for a better understanding of the extent to which Sida is targeting values and social norms in its SRHR ODA. We recommend that Sida improve the quality and level of detail of data in their contribution management system to allow for routine disaggregation and ease of follow-up of SRHR ODA. Such changes in contribution data could be discussed with Sida's unit for analysis, statistics and data, and take into consideration both external reporting requirements (to for example OECD DAC) and internal needs for a better understanding of Sida's portfolio on SRHR.
5. **SRHR-values and norms are complex, and change takes time.** Efforts to actively influence and change broader social norms as well as individual's personal beliefs or values must therefore be considered a long-term effort that stretches well beyond the Sweden's regular (3–5 years) strategy and funding cycles. In line with our theoretical framework, there is a need to strengthen norms and values that are (already) supportive of SRHR, as well as to address discriminatory, prevailing norms across different contexts. Past research shows that to reach a "tipping point" where people abandon discriminatory norms, interventions are needed at multiple levels of the social-ecological framework, i.e., focusing on advocacy or on individual attitude change in isolation is not enough. This "tipping point",

or the proportion of a population group that needs to agree for a norm to change, varies considerably between contexts and SRHR-issues. The complexity of norms further indicates that (increased) support for one aspect of SRHR (e.g., contraceptives) does not automatically lead to change in other more controversial, discriminatory norms (such as LGBTQI). Sida should therefore consider clarifying its position on social norms change as Sweden can be one of several actors involved in creating the conditions necessary to reach a tipping point. As this process takes time, Sida and other development actors should also consider ensuring the collection and use of data to guide and evaluate its support to norm change and on sustaining norms that are supportive of SRHR. The WVS website is one example of an existing source where development actors can download and analyse data on norms and values, free of charge.

References

1. CESCR. General comment no. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights). 2016 [Available from: https://digitallibrary.un.org/record/832961].

2. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. (1474-547X (Electronic)).

3. Klugman J, Hanmer L, Twigg S, Hasan T, McCleary-Sills J, Santamaria J. Voice and Agency – Empowering women and girls for shared prosperity. Washington, DC: World Bank Group; 2014. [Available from https://openknowledge.worldbank.org/handle/10986/19036].

4. UNFPA. State of World Population 2021: My Body is My Own – Claiming the right to autonomy and self-determination. UNFPA; 2021. [Available from https://www.unfpa.org/sites/default/files/pub-pdf/SoWP2021_Report_-_EN_web.3.21_0.pdf].

5. Edmeades J, Mejia C, Parsons J, Sebany M. A conceptual framework for reproductive empowerment: empowering individuals and couples to improve their health. Washington DC: International Center for Research on Women (ICRW); 2018.

6. Karp C, Wood SN, Galadanci H, Sebina Kibira SP, Makumbi F, Omoluabi E, et al. 'I am the master key that opens and locks': Presentation and application of a conceptual framework for women's and girls' empowerment in reproductive health. Soc Sci Med. 2020;258:113086.

7. Irwin R. Sweden's engagement in global health: a historical review. Global Health. 2019;15(1):79.

8. Government Offices of Sweden, Ministry of Foreign Affairs. The Swedish Foreign Service action plan for feminist foreign policy 2019–2022, including direction and measures for 2021. 2021. Contract No: June 4. [Available from https://www.government.se/49700e/contentassets/9992f701ab40423bb7b37b2c455aed9a/utrikesforvaltningens-handlingsplan-for-feministisk-utrikespolitik-2021_eng.pdf].

9. The centre for feminist foreign policy. [Available from: https://centreforfeministforeignpolicy.org/feminist-foreign-policy].

10. Liang M, Simelane S, Fortuny Fillo G, Chalasani S, Weny K, Salazar Canelos P, et al. The State of Adolescent Sexual and Reproductive Health. Journal of Adolescent Health. 2019;65(6):S3-S15.

11. Riksförbundet för Sexuell Upplysning (Rfsu). Oppression and opportunity. A study on SRHR and shrinking space. Stockholm, Sweden: Rfsu; 2019. [Available from https://www.rfsu.se/globalassets/bilder/om-rfsu/rfsu-nyheter/2019/oppression-and-opportunity-a-study-on-srhr-and-shrinking-space-1.pdf].

12. openDemocracy. 50.50. Trackling the backlash [Available from: https://www.opendemocracy.net/en/5050/tracking-the-backlash/].

13. Kaoma K. Colonizing African Values How the U.S. Christian Right is Transforming Sexual Politics in Africa. Political Research Associates; 2012.

14. Dhatta N. Restoring the natural order. The religious extremists' vision to mobilize European societies against human rights on sexuality and reproduction. Brussels: European Parliamentary Forum on Population and Development; 2018.

15. Edenborg E. Traditionella värderingar som politiskt vapen. Världspolitiska Dagsfrågor. 2019.

16. Council of Europe. Council of Europe Convention on preventing and combating violence against women and domestic violence. 11 May 2011. [Available from https://www.refworld.org/docid/4ddb74f72.htm].

17. United Nations Human Rights Office of the high commissioner (OHCHR). Turkey: Withdrawal from Istanbul Convention is a pushback against women's rights, say human rights experts 2021 [Available from: https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=26936&LangID=E].

18. Strzyzynska W. Poland accused of abandoning domestic violence victims. The guardian. 2021 April 7. [Available from https://www.theguardian.com/world/2021/apr/07/poland-accused-of-abandoning-domestic-violence-victims].

19. UNFPA. Covid-19 Pandemic. [Available from: https://www.unfpa.org/covid19].

20. WHO regional office for Africa. Sexual and reproductive health fact sheet 2020. WHO; 2020. [Available from https://www.afro.who.int/sites/default/files/2020-06/Sexual%20and%20reproductive%20health-%20Fact%20sheet%2028-05-2020.pdf].

21. Utrikesdepartementet. Strategi för Sveriges utvecklingssamarbete med Rwanda 2020-2024. 2020. [Available from https://www.regeringen.se/artiklar/2020/05/strategi-rwanda-2020-2024].

22. DSW, European Parliamentary Forum. Donors delivering for SRHR Report 2020: tracking OECD donor funding for sexual and reproductive health and rights. 2020.

23. Chandra-Mouli V, Ferguson BJ, Plesons M, Paul M, Chalasani S, Amin A, et al. The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development. Journal of Adolescent Health. 2019;65(6):S16-S40.

24. Unicef. Attitudes and social norms on violence . Unicef; 2020 [Available from https://data.unicef.org/topic/child-protection/violence/attitudes-and-social-norms-on-violence/].

25. United Nations (UN). Sustainable Development Goals [Available from: https://www.un.org/sustainabledevelopment/sustainable-development-goals/].

26. UN Women. SDG Monitoring in gender equality: UN Women; [Available from: https://data.unwomen.org/sdg-monitoring].

27. Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, et al. Global health 2035: a world converging within a generation. The Lancet. 2013;382(9908):1898-955.

28. Mackie G, Moneti F, Shakya H, Denny E. What are social norms? How are they measured? UNICEF Working Paper. San Diego: University of California, San Diegom Center on Global Justice UNICEF; 2015.

29. Weber AM, Cislaghi B, Meausoone V, Abdalla S, Mejía-Guevara I, Loftus P, et al. Gender norms and health: insights from global survey data. The Lancet. 2019;393(10189):2455-68.

30. Afrobarometer. The Online Analysis Tool. [Available from: https://afrobarometer.org/online-data-analysis/analyse-online].

31. UNFPA West and Central Africa. Adolescent pregnancy [Available from: https://wcaro.unfpa.org/en/node/6068].

32. Gebremedhin M, Semahegn A, Usmael T, Tesfaye G. Unsafe abortion and associated factors among reproductive aged women in Sub-Saharan Africa: a protocol for a systematic review and meta-analysis. Systematic Reviews. 2018;7(1):130.

33. Kandala N-B, Ezejimofor MC, Uthman OA, Komba P. Secular trends in the prevalence of female genital mutilation/cutting among girls: a systematic analysis. BMJ Global Health. 2018;3(5):e000549.

34. UNFPA. The state of African women: UNFPA; 2018 [Available from: https://www.ippfar.org/sites/ippfar/files/2018-09/SOAW-Report-FULL%20VERSION.pdf].

35. WHO. Maternal health [Available from: https://www.who.int/health-topics/maternal-health#tab=tab_2].

36. WHO. Maternal mortality 2019 [Available from: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality].

37. Unicef. Maternal mortality 2019 [Available from: https://data.unicef.org/topic/maternal-health/maternal-mortality/].

38. Murunga Wekesah F, Nyakangi V, Onguss M, Njagi J, Bangha M. Comprehensive Sexuality Education in Sub-Saharan Africa. Nairobi, Kenya: African Population and Health Research Center (APHRC); 2019.

39. Huaynoca S, Chandra-Mouli V, Yaqub Jr N, Denno DM. Scaling up comprehensive sexuality education in Nigeria: from national policy to nationwide application. Sex Education. 2014;14(2):191-209.

40. Young people today. Across the Region, there is Growing Recognition of the Importance of High-Quality Comprehensive Sexuality Education. [Available from: https://www.youngpeopletoday.org/progress-overview/].

41. As COVID-19 devastates already fragile health systems, over 6,000 additional children under five could die a day, without urgent action [press release]. New York: Unicef, 12 May 2020.

42. WHO. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report. WHO; 2020 27 August.

43. WHO. Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic January-March 2021. WHO; 2021 23 April.

44. Riley T, Sully E, Ahmed Z, Biddlecom A. Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health In Low- and Middle-Income Countries. Int Perspect Sex Reprod Health. 2020;46:73-6.

45. Chmielewska B, Barratt I, Townsend R, Kalafat E, van der Meulen J, Gurol-Urganci I, et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. The Lancet Global Health. 2021;9(6):e759-e72.

46. Reliefweb. COVID-19: A threat to progress against child marriage 2021. [Available from: https://reliefweb.int/report/world/covid-19-threat-progress-against-child-marriage].

47. Wilhelm JA, Helleringer S. Utilization of non-Ebola health care services during Ebola outbreaks: a systematic review and meta-analysis. J Glob Health. 2019;9(1):010406.

48. Bjälkander O, Nordenstedt H, Brolin K, Ekström AM. FGM in the time of Ebola-carpe opportunitatem. Lancet Glob Health. 2016;4(7):e447-8.

49. UNDP. Assessing Sexual and Gender-Based Violence during the Ebola Crisis in Sierra Leone: UNDP; 2014. [Available from http://www.sl.undp.org/content/sierraleone/en/home/library/crisis_prevention_and_recovery/assessing-sexual-and-gender-based-violence-during-the-ebola-cris.html].

50. UNESCO. Covid-19. Adverse consequences of school closures 2021. [Available from: https://en.unesco.org/covid19/educationresponse/consequences].

51. African Union. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa 11 July 2003. [Available from: https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa].

52. African Court on Human and People's Rights – protecting human rights in Africa. [Available from: https://www.african-court.org/wpafc].

53. Regeringskansliet. Strategy for Sexual and Reproductive Health and Rights in Sub-Saharan Africa 2015-2019. Article No: UD 15.032. Stockholm, Sweden: Regeringskansliet; 2015.

54. Regeringskansliet. Strategy for Sweden's Global Development Cooperation in Sustainable Social Development 2018-2022. Stockholm, Sweden: Regeringskansliet; 2018.

55. Regeringskansliet. Strategy for Sweden's Development Cooperation for Global Gender Equality and Women's and Girls' Rights 2018-2022. Stockholm, Sweden: Regeringskansliet; 2018.

56. Regeringskansliet. Sweden's Work On Global Health – Implementing The 2030 Agenda. Stockholm. Article no: 18.010. . Stockholm, Sweden: Regeringskansliet; 2018.

57. Sida. Sveriges hälsobistånd 2017. Stockholm, Sweden: Sida; 2018.

58. Koning Kd. Draft 1: Mapping and gap analysis of Sida's SRHR portfolio. Amsterdam; 2017.

59. UNFPA. Financial Resource flows for population activities in 2012. UNFPA; 2014.

60. United Nations. Flow of financial resources for assisting in the further implmentation of the Programme of Action of the International Conference on Population and Development. United Nations Economic and Social Council; 2018.

61. Dingle A, Schäferhoff M, Borghi J, Lewis Sabin M, Arregoces L, Martinez-Alvarez M, et al. Estimates of aid for reproductive, maternal, newborn, and child health: findings from application of the Muskoka2 method, 2002-17. Lancet Glob Health. 2020;8(3):e374-e86.

62. Cislaghi B, Heise L. Theory and practice of social norms interventions: eight common pitfalls. Globalization and Health. 2018;14(1):83.

63. Cislaghi B, Heise L. Using social norms theory for health promotion in low-income countries. Health Promot Int. 2019;34(3):616-23.

64. Kågesten A, Gibbs S, Blum RW, Moreau C, Chandra-Mouli V, Herbert A, et al. Understanding Factors that Shape Gender Attitudes in Early Adolescence Globally: A Mixed-Methods Systematic Review. PLoS One. 2016;11(6):e0157805-e.

65. Chung A, Rimal R. Social norms: a review. Review of Communication Research. 2016:1–28.

66. Legros S, Cislaghi B. Mapping the Social-Norms Literature: An Overview of Reviews. Perspectives on Psychological Science. 2019;15(1):62-80.

67. Cialdini RB, Kallgren CA, Reno RR. A Focus Theory of Normative Conduct: A Theoretical Refinement and Reevaluation of the Role of Norms in Human Behavior. In: Zanna MP, editor. Advances in Experimental Social Psychology. 24: Academic Press; 1991. p. 201-34.

68. Bicchieri C, Xiao E. Do the right thing: but only if others do so. Journal of Behavioral Decision Making. 2009;22(2):191-208.

69. Vaitla B, Taylor A, Van Horn J, Cislagh B. Social Norms and Girls' Well-Being: Linking.

Theory and Practice. . Washington, D.C: Data2X; 2017.

70. Kistler D, Thöni C, Welzel C. World Values Survey Response and Behavior. . World Values Research. 2015;8(3):101-22.

71. Stavrova O, Schlösser T, Fetchenhauer D. Are the unemployed equally unhappy all around the world? The role of the social norms to work and welfare state provision in 28 OECD countries. Journal of Economic Psychology. 2011;32(1):159-71.

72. Gupta GR, Oomman N, Grown C, Conn K, Hawkes S, Shawar YR, et al. Gender equality and gender norms: framing the opportunities for health. The Lancet. 2019;393(10190):2550-62.

73. Sedlander E, Rimal RN. Beyond Individual-Level Theorizing in Social Norms Research: How Collective Norms and Media Access Affect Adolescents' Use of Contraception. J Adolesc Health. 2019;64(4S): S31-S6.

74. Bicchieri C. The grammar of society: The nature and dynamics of social norms. Cambridge University Press; 2005.

75. Bicchieri C. Norms in the wild: How to diagnose, measure, and change social norms: Oxford University Press; 2016.

76. Watson C. Understanding changing social norms and practices around girls' education and marriage. Lessons learned and emerging issues from year 2 of a multicountry field study. Overseas Development Institute (ODI); 2014.

77. Inglehart R, Norris P, Ronald I. Rising tide: Gender equality and cultural change around the world: Cambridge University Press; 2003.

78. Inglehart RF. Changing values among western publics from 1970 to 2006. West european politics. 2008;31(1-2):130-46.

79. Mackie G, LeJenue J. Social dynamics of abandonment of harmful practces: a new look at the theory. Innocenti Working Paper No. 2009-06. Florence: Unicef Innocenti Research Centre; 2009.

80. Finnemore M, Sikkink K. International Norm Dynamics and Political Change. International Organization. 1998;52(4):887-917.

81. Marcus R, Harper C. Gender justice and social norms – processes of change for adolescent girls. ODI; 2014.

82. UNFPA. Programme of action of the International Conference on Population Development. 20th Anniversary ed. New York: UNFPA; 2014 [Available from: https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf].

83. Kaufman CE. Reproductive control in apartheid South Africa. Population Studies. 2000;54(1):105-14.

84. Kaler A. A threat to the nation and a threat to the men: the banning of Depo-Provera in Zimbabwe, 1981. Journal of Southern African Studies. 1998;24(2):347-76.

85. Connelly M. Fatal Misconception: The Struggle to Control World Population Cambridge. Cambridge, MA, and London: Harvard University Press; 2008.

86. Conceiving the new world order: The global politics of reproduction. Ginsburg FD, Rapp R, editors. Berkely, CL: University of California Press; 1995.

87. Heise L, Greene ME, Opper N, Stavropoulou M, Harper C, Nascimento M, et al. Gender inequality and restrictive gender norms: framing the challenges to health. The Lancet. 2019;393(10189):2440-54.

88. Marcus R, Mathur D, Shepherd A. Impact of Civil Society Anti-Discrimination Initiatives: A Rapid Review. EBA Report 2019:05. Stockholm: Expert Group for Aid Studies (EBA); 2019.

89. Sida. Dimensions of Poverty Sida's Conceptual Framework. Sida; 2017.

90. World Values Survey. [Available from: www.worldvaluessurvey.org].

91. DeVellis RF. Scale development: Theory and applications: Sage publications; 2016.

92. World Health Organization. Defining sexual health: a report of a technical consultation on sexual health, 28-31 January 2002. Geneva: WHO; 2006.

93. Abeer A. Development Assistance for SRHR: Descriptive analysis of disbursement by the Swedish International Development Cooperation Agency (Sida) for 2010-2018 using a developed tracking model. Uppsala: Uppsala University; 2020.

94. Sida. Sexuell och reproduktiv hälsa och rättighter. [Available from: https://www.sida.se/sida-i-varlden/sexuell-och-reproduktiv-halsa-och-rattigheter].

95. UNESCO. Review of the evidence on sexuality education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education. Paris: UNESCO; 2016.

96. Regeringskansliet. Strategi för Sveriges utvecklingssamarbete med Zimbabwe 2017-2021. Utrikesdepartementet; 2017.

97. Embassy of Sweden H. Operationalization plan Swedish development cooperatioin with Zimbabwe, 2017-2021. Harare; 2017.

98. Embassy of Sweden in Harare. Operationalization plan Swedish development cooperation with Zimbabwe 2017-2021. 2017.

99. Sida. Strategirapport för Zimbabwe 2017-2021. 2019.

100. Saywhat. Available from: https://saywhat.org.zw/.

101. Amplify Change. [Available from: https://amplifychange.org/].

102. Moreau C, Li M, Ahmed S, Zuo X, Cislaghi B. Assessing the Spectrum of Gender Norms Perceptions in Early Adolescence: A Cross-Cultural Analysis of the Global Early Adolescent Study. Journal of Adolescent Health. 2021;69(1, Supplement):S16-S22.

103. RFSU. Viktiga årtal och reformer 2017 [Available from: https://www.rfsu.se/om-rfsu/om-oss/rfsus-historia/viktiga-artal-och-reformer/].

104. Regeringskansliet. Historik om utvecklingen av hbtq-personers rättigheter i Sverige. 2018 June 25. [Available from https://www.regeringen.se/artiklar/2018/06/historik-om-utvecklingen-av-hbtq-personers-rattigheter-i-sverige/].

105. Ramon Mendos L, Botha K, Carrano Lelis R, López de la Peña E, Savelev I, Tan D. ILGA-World. State-Sponsored Homophobia 2020: Global Legislation Overview Update. Geneva: ILGA; 2020 December.

106. Regeringen ger Sida uppdrag att ta fram ett underlag för en ny, förstärkt strategi för sexuell och reproduktiv hälsa och rättigheter (SRHR) med Afrika söder om Sahara [press release]. Regeringskansliet, March 24 2021.

Appendices

Appendix Table 1A. Overview of all variables in the gender/SRHR module across the 4 countries, and other relevant WVS variables.

Appendix Table 2A. Norms and values related to SRHR information.

Appendix Table 3A. Norms and values related to consensual, non-violent relationships (have their bodily integrity respected, engage in consensual sexual relations).

Appendix Table 4A. Norms and values related to satisfying sexual life (choose sexual partner, decide whether to be sexually active or not, pursue a sexually satisfying sexual life).

Appendix Table 5A. Norms and values related to marriage (choose whether, when, and whom to marry, enter into marriage with free and full consent and with equality between spouses in and at the dissolution of marriage).

Appendix Table 6A. Norms and values related to non-discrimination in terms of sexuality, sexual orientation and gender identity (make free, informed, and voluntary decisions on their sexuality, sexual orientation, and gender identity).

Appendix Table 7A. Norms and values related to contraception and reproduction (make decisions concerning reproduction free of discrimination, coercion, and violence).

Appendix Table 8A. Norms and values related to gender-equitable relations.

Appendix Table 9A. Privacy and confidentiality (privacy, confidentiality, respect, and informed consent).

Appendix Table 10A. Multivariable analyses of the associations between support for the selected key SRHR norms and values and sociodemographic characteristics as well as Sida's four dimensions of poverty. All results are presented as odds ratios (OR) with 95% confidence intervals (CI) and are adjusted for all co-variables. Values above 1.0 indicates more support for SRHR. Figures in bold indicate statistically significant results.

Appendix Table 1A. Overview of all variables in the gender/SRHR module across the 4 countries, and other relevant WVS variables

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
SRH information *Seek, receive, and impart information related to sexuality* *Receive comprehensive, evidence-based, sexuality education*	Sexuality education	• Sexuality education promotes sexual activity among young people	Gender & SRHR module	X	X	X
	Sexuality education	• Sexuality education helps people make informed decisions.	Gender & SRHR module		X	X
Consensual, non-violent relationships *Have their bodily integrity respected* *Engage in consensual sexual relations*	GBV	• A husband shouldn't have to do household chores • A man who discusses important decisions with his wife is considered weak • A man should pay more attention to his mother's opinion than his wife's • A woman who shows that she is interested in sex is considered indecent/rude/ill-mannered/vulgar	Gender & SRHR module		X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
		• Men may use violence to keep their wives in line • Parents may use violence or threats when bringing up their children • A woman should tolerate violence to keep the family together • No-one else should interfere when it comes to violence within a family				
	Controlling behaviour	• If a man has a girlfriend or wife, he should know where she is all the time	Gender & SRHR module		X	X
	Honour-related oppression	• It is a man's duty to exercise guardianship over his female relatives	Gender & SRHR module		X	X
	Honour-related oppression	• Attitude on honour related oppression	Gender & SRHR module		X	X
	GBV	• For a man to beat his wife (always – never justified)	Standard WVS	X	X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
	GBV	• Parents beating children (always – never justified)	Standard WVS	X	X	X
	GBV/Sexual violence	• How frequently do the following occur in your neighbourhood: sexual assault/rape	Gender & SRHR module		X	X
	GBV	• How frequently do the following occur in your neighbourhood: Men and boys hurting women and girls	Gender & SRHR module		X	X
	Sexual harassment	• How frequently do the following occur in your neighbourhood: Men and boys making unwanted sexual comments or gestures toward girls or women	Gender & SRHR module		X	X
	Sex work/ prostitution	• How frequently do the following occur in your neighbourhood: Women and girls trading sex for money	Gender & SRHR module		X	X
		• It is acceptable to have sex with someone in exchange for gifts and favours	Gender & SRHR module		X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
		• Prostitution (always – never justified)			X	X
	Pornography	• Participating in Pornography (always – never justified)	Gender & SRHR module		X	X
	FGM/C	• Female genital cutting (always – never justified)	Gender & SRHR module		X	X
Satisfying sexual life *Choose their sexual partner* *Decide whether to be sexually active or not* *Pursue a satisfying, safe, and pleasurable sexual life, free from stigma and discrimination*	Sex outside of marriage or relationships	• Premarital sex: always-never justified	Standard WVS	X	X	X
		• Causal sex: always-never justified	Standard WVS	X	X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
Decide on marriage *Choose whether, when, and whom to marry* *Enter into marriage with free and full consent and with equality between spouses in and at the dissolution of marriage*	Child marriage	• A girl is ready for marriage once she starts menstruating	Gender & SRHR module	X	X	X
		• Even if a girl does not want to be married, she should honour the decisions/wishes of her family	Gender & SRHR module	X	X	X
		• Even if a boy does not want to be married, he should honour the decisions/wishes of his family	Gender & SRHR module	X	X	X
		• Girls and women should themselves decide when, if and with whom they should marry	Gender & SRHR module	X	X	X
	Divorce	• Divorce (always-never justifiable)*	Standard WVS	X	X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
Non-discrimination related to sexuality, sexual orientation and gender identity *Make free, informed, and voluntary decisions on their sexuality, sexual orientation, and gender identity*	Stigma and discrimi-nation of LBGTQI	• Whether would live next to homosexual	Standard WVS	X	X	X
		• Homosexual couples are as good parents as other couples	Standard WVS	X	X	X
		• Homosexuality (always-never justifiable)*	Standard WVS	X	X	X
		• People who dress, act or identify as the opposite sex should be treated just as anyone else	Gender & SRHR module		X	X
Reproductive empowerment *Make decisions concerning reproduction free of discrimination, coercion, and violence*	Contra-ceptives	• Contraceptives should be available for everyone, whether or not one is married	Gender & SRHR module	X	X	X
		• It's a woman's responsibility to avoid getting pregnant	Gender & SRHR module	X	X	X
		• Use contraceptives (always-never justified)	Gender & SRHR module	X	X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
	Re-productive agency and history (not an attitude or norm)	• *How much freedom and choice do you have over your own family planning?*	Gender & SRHR module	X	X	X
		• *How old were you when you had your first child?*	Gender & SRHR module	X	X	X
		• *How many children would you like to have?*	Gender & SRHR module		X	X
	Abortion	• Women should have access to safe abortion services (to terminate an unwanted pregnancy).	Gender & SRHR module	X	X	X
		• Abortion (always-never justifiable)*	Standard WVS	X	X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
	Adolescent childbearing	• It is important for girls to continue their schooling even if they become pregnant and have children	Gender & SRHR module	X	X	X
		• A girl should wait to have children until she is at least 18 years old, even if she is married	Gender & SRHR module		X	X
	Infertility	• Only when a woman has a child is she a real woman	Gender & SRHR module	X	X	X
		• A man who cannot father children is not a real man	Gender & SRHR module		X	X
		• A couple who wants to have children but cannot conceive should have access to infertility services	Gender & SRHR module		X	X
	Trust in SRH services/providers	• It is safer for a woman to give birth at a clinic than at home.	Gender & SRHR module	X	X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
Gender equitable relationships *Mutually respectful and equitable gender relations*	Gender equality	• *Gender equality sub-index*	Standard WVS	X	X	X
		• When a mother works for pay, the children suffer				
		• One the whole, men make better political leaders than women				
		• A university education is more important for a boy than a girl				
		• On the whole, men make better business leaders than women do				
		• Being a housewife is just as fulfilling as working for pay				
		• It is not good for a boy to be taught how to cook, sew, clean the house, and take care of younger children	Gender & SRHR module		X	X
		• Men should really be the ones to bring money home to provide for their families, not women	Gender & SRHR module		X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
		• A man should always have the final say about decisions in his relationship or marriage	Gender & SRHR module		X	X
		• There is no doubt that gainful employment is good but that what most women really want is a home and children	Gender & SRHR module		X	X
		• On the whole, family life suffers when women work full time	Gender & SRHR module		X	X
		• It is a man's job to earn money and a women's job to take care of home and family	Gender & SRHR module		X	X
		• *ManBox scale* • A man shouldn't have to do household chores • A man should use violence, if necessary, to get respect • A real man should have as many sexual partners as he can	Gender & SRHR module		X	X

Guttmacher-Lancet definition of sexual and reproductive rights	Domain	WVS questions/variable	Module	Countries included in		
				N	E	Z
		• A man who talks a lot about his worries, fears, and problems doesn't deserve respect • A homosexual guy is not a "real man"				

*Included in the WVS "choice" index.

Appendix Table 2A. Norms and values related to SRHR information

Item related to SRHR information	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Sexuality education promotes sexual activity among young people (1=strongly agree, 4= strongly disagree)				
Mean (SD)	2.28 (0.98)	2.92 (0.94)	2.65 (0.94)	2.61 (0.99)
Median	2	3	3	3
Agree, N (%)	746 (62%)	298 (26%)	496 (41%)	1540 (43%)
Disagree, N (%)	461 (38%)	851 (74%)	715 (59%)	2027 (57%)
Total, N (%)	1207 (100%)	1149 (100%)	1211 (100%)	3567 (100%)
Sexuality education helps people make informed decisions (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.04 (0.98)	1.98 (0.83)	2.01 (0.91)
Median	x	2	2	2
Agree, N (%)	x	797 (69%)	950 (79%)	1747 (74%)
Disagree, N (%)	x	359 (31%)	258 (21%)	617 (26%)
Total, N (%)	x	1156 (100%)	1208 (100%)	2364 (100%)

Appendix Table 3A. Norms and values related to consensual, non-violent relationships (have their bodily integrity respected, engage in consensual sexual relations)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Gender-based violence				
A husband shouldn't have to do household chores (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.27 (0.92)	2.79 (0.86)	3.03 (0.92)
Median	x	4	3	3
Agree, N (%)	x	212 (17%)	389 (32%)	601 (25%)
Disagree, N (%)	x	1017 (83%)	826 (68%)	1843 (75%)
Total, N (%)	x	1229 (100%)	1215 (100%)	2444 (100%)
A man who discusses important decisions with his wife is considered weak (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.44 (0.69)	2.84 (0.85)	3.14 (0.83)
Median	x	4	3	3
Agree, N (%)	x	88 (7%)	346 (29%)	434 (18%)
Disagree, N (%)	x	1137 (93%)	865 (71%)	2002 (82%)
Total, N (%)	x	1225 (100%)	1211 (100%)	2436 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
A man should pay more attention to his mother's opinion than his wife's (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.98 (0.93)	3.09 (0.79)	3.04 (0.87)
Median	x	3	3	3
Agree, N (%)	x	328 (27%)	200 (17%)	528 (22%)
Disagree, N (%)	x	897 (73%)	1010 (84%)	1907 (78%)
Total, N (%)	x	1225 (100%)	1210 (100%)	2435 (100%)
A woman who shows that she is interested in sex is considered indecent (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.74 (1.10)	2.38 (0.93)	2.56 (1.03)
Median	x	3	2	3
Agree, N (%)	x	448 (37%)	661 (55%)	1109 (46%)
Disagree, N (%)	x	755 (63%)	549 (45%)	1304 (54%)
Total, N (%)	x	1203 (100%)	1210 (100%)	2413 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Men may use violence to keep their wives in line (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.18 (0.86)	2.72 (0.94)	2.95 (0.93)
Median	x	3	3	3
Agree, N (%)	x	229 (19%)	477 (39%)	706 (29%)
Disagree, N (%)	x	996 (81%)	736 (61%)	1732 (71%)
Total, N (%)	x	1225 (100%)	1213 (100%)	2438 (100%)
Parents may use violence and threats when bringing up their children (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.69 (0.93)	2.44 (0.91)	2.56 (0.93)
Median	x	3	2	3
Agree, N (%)	x	542 (44%)	656 (54%)	1198 (49%)
Disagree, N (%)	x	684 (56%)	557 (46%)	1241 (51%)
Total, N (%)	x	1226 (100%)	1213 (100%)	2439 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
A woman should tolerate violence to keep the family together (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	1.91 (0.91)	3.05 (0.84)	2.48 (1.05)
Median	x	2	3	2
Agree, N (%)	x	969 (79%)	271 (22%)	1240 (51%)
Disagree, N (%)	x	257 (21%)	943 (78%)	1200 (49%)
Total, N (%)	x	1226 (100%)	1214 (100%)	2440 (100%)
No-one else should interfere when it comes to violence within a family (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.11 (0.96)	2.84 (0.88)	2.47 (0.99)
Median	x	2	3	2
Agree, N (%)	x	861 (70%)	373 (31%)	1234 (51%)
Disagree, N (%)	x	365 (30%)	838 (69%)	1203 (49%)
Total, N (%)	x	1226 (100%)	1211 (100%)	2437 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Is it justifiable for a man to beat his wife? (1=never justifiable, 10=always justifiable)				
Mean (SD)	1.94 (1.86)	1.72 (2.11)	1.90 (2.23)	1.86 (2.08)
Median	1	1	1	1
Never justifiable (1), N (%)	840 (68%)	1042 (85%)	961 (79%)	2843 (77%)
Justifiable (2-10), N (%)	395 (32%)	185 (15%)	251 (21%)	831 (23%)
Total, N (%)	1235 (100%)	1227 (100%)	1212 (100%)	3674 (100%)
Is it justifiable for parents to beat their children? (1=never justifiable, 10=always justifiable)				
Mean (SD)	6.05 (3.13)	2.93 (2.81)	4.33 (3.45)	4.43 (3.38)
Median	6	1	4	4
Never justifiable (1), N (%)	179 (15%)	740 (60%)	505 (42%)	1424 (39%)
Justifiable (2-10), N (%)	1057 (86%)	487 (40%)	699 (58%)	2243 (61%)
Total, N (%)	1236 (100%)	1227 (100%)	1204 (100%)	3667 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
How frequently do the following occur in your neighbourhood: sexual assault/rape (1=very frequently, 4=not at all frequently)				
Mean (SD)	x	3.50 (0.70)	2.91 (0.87)	3.21 (0.84)
Median	x	4	3	3
Frequently, N (%)	x	102 (8%)	282 (23%)	384 (16%)
Not frequently, N (%)	x	1118 (92%)	931 (77%)	2049 (84%)
Total, N (%)	x	1220 (100%)	1213 (100%)	2433 (100%)
How frequently do the following occur in your neighbourhood: Men and boys hurting women and girls (1=very frequently, 4=not at all frequently)				
Mean (SD)	x	3.44 (0.80)	2.56 (1.04)	3.01 (1.03)
Median	x	4	3	3
Frequently, N (%)	x	166 (14%)	500 (41%)	666 (27%)
Not frequently, N (%)	x	1053 (86%)	708 (59%)	1761 (73%)
Total, N (%)	x	1219 (100%)	1208 (100%)	2427 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Controlling behaviour				
If a man has a girlfriend or wife, he should know where she is all the time (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.13 (1.02)	2.24 (0.91)	2.19 (0.96)
Median	x	2	2	2
Agree, N (%)	x	818 (69%)	771 (64%)	1589 (65%)
Disagree, N (%)	x	404 (33%)	443 (37%)	847 (35%)
Total, N (%)	x	1222 (100%)	1214 (100%)	2436 (100%)
Domain: Honour-related oppression				
It is a man's duty to exercise guardianship over his female relatives (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.67 (0.96)	2.22 (0.87)	2.45 (0.94)
Median	x	3	2	2
Agree, N (%)	x	505 (41%)	810 (67%)	1315 (54%)
Disagree, N (%)	x	719 (59%)	399 (33%)	1118 (46%)
Total, N (%)	x	1224 (100%)	1209 (100%)	2433 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Honour-related oppression deals with the fact that the family or relatives decide primarily on young women's life choices (1=can never be accepted, 10= should always be accepted)				
Mean (SD)	x	4.07 (3.05)	3.13 (3.22)	3.60 (3.17)
Median	x	4	1	2
Never accepted (1), N (%)	x	448 (37%)	720 (59%)	1168 (48%)
Accepted (2-10), N (%)	x	775 (63%)	494 (41%)	1269 (52%)
Total, N (%)	x	1223 (100%)	1214 (100%)	2437 (100%)
Domain: Sexual harassment				
How frequently do the following occur in your neighbourhood: Men and boys making unwanted sexual comments or gestures toward girls or women? (1=very frequently, 4=not at all frequently)				
Mean (SD)	x	3.26 (0.96)	2.29 (1.08)	2.78 (1.13)
Median	x	4	2	3
Frequently, N (%)	x	286 (24%)	663 (55%)	949 (39%)
Not frequently, N (%)	x	932 (77%)	536 (45%)	1478 (61%)
Total, N (%)	x	1218 (100%)	1209 (100%)	2427 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Sex work/prostitution				
How frequently do the following occur in your neighbourhood: Women and girls trading sex for money? (1=very frequently, 4=not at all frequently)				
Mean (SD)	x	3.46 (0.84)	1.92 (1.06)	2.69 (1.23)
Median	x	4	1	3
Frequently, N (%)	x	178 (15%)	832 (69%)	1010 (42%)
Not frequently, N (%)	x	1041 (85%)	378 (31%)	1419 (58%)
Total, N (%)	x	1219 (100%)	1210 (100%)	2429 (100%)
It is acceptable to have sex with someone in exchange for gifts and favours? (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.44 (0.74)	3.24 (0.76)	3.34 (0.76)
Median	x	4	3	3
Agree, N (%)	x	105 (9%)	154 (13%)	259 (11%)
Disagree, N (%)	x	1082 (91%)	1059 (87%)	2141 (89%)
Total, N (%)	x	1187 (100%)	1213 (100%)	2400 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Is it justifiable with prostitution? (1=never justifiable, 10=always justifiable)				
Mean (SD)	1.64 (1.54)	1.70 (2.14)	1.80 (2.20)	1.71 (1.97)
Median	1	1	1	1
Never justifiable (1), N (%)	943 (77%)	1067 (87%)	1012 (83%)	3022 (82%)
Justifiable (2-10), N (%)	290 (24%)	154 (13%)	203 (17%)	647 (18%)
Total, N (%)	1233 (100%)	1221 (100%)	1215 (100%)	3669 (100%)
Domain: Pornography				
Is it justifiable getting paid for pornographic photos or films? (1=never justifiable, 10=always justifiable)				
Mean (SD)	x	1.21 (1.26)	1.65 (2.03)	1.43 (1.69)
Median	x	1	1	1
Never justifiable (1), N (%)	x	1165 (95%)	1035 (86%)	2200 (90%)
Justifiable (2-10), N (%)	x	58 (5%)	176 (15%)	234 (10%)
Total, N (%)	x	1223 (100%)	1211 (100%)	2434 (100%)

Items related to consensual, non-violent relationships	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Female genital cutting				
Is it justifiable with female genital cutting? (1=never justifiable, 10=always justifiable)				
Mean (SD)	x	1.99 (2.59)	1.99 (2.38)	1.99 (2.49)
Median	x	1	1	1
Never justifiable (1), N (%)	x	1035 (84%)	935 (78%)	1970 (81%)
Justifiable (2-10), N (%)	x	192 (16%)	258 (22%)	450 (19%)
Total, N (%)	x	1227 (100%)	1193 (100%)	2420 (100%)

Appendix Table 4A. Norms and values related to satisfying sexual life (choose sexual partner, decide whether to be sexually active or not, pursue a sexually satisfying sexual life)

Item related to satisfying sexual life	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Is sex before marriage justifiable? (1=never justifiable, 10=always justifiable)				
Mean (SD)	2.69 (2.54)	1.91 (2.32)	2.37 (2.66)	2.32 (2.53)
Median	1	1	1	1
Never justifiable (1), N (%)	659 (54%)	1010 (82%)	876 (72%)	2545 (70%)
Justifiable (2-10), N (%)	565 (46%)	218 (18%)	333 (28%)	1116 (31%)
Total, N (%)	1224 (100%)	1228 (100%)	1209 (100%)	3661 (100%)
Is having casual sex justifiable? (1=never justifiable, 10=always justifiable)				
Mean (SD)	2.56 (2.36)	1.52 (1.96)	1.96 (2.35)	2.02 (2.28)
Median	1	1	1	1
Never justifiable (1), N (%)	691 (56%)	1115 (91%)	971 (80%)	2777 (76%)
Justifiable (2-10), N (%)	535 (44%)	113 (9%)	242 (20%)	890 (24%)
Total, N (%)	1226 (100%)	1228 (100%)	1213 (100%)	3667 (100%)

Appendix Table 5A. Norms and values related to marriage (choose whether, when, and whom to marry, enter into marriage with free and full consent and with equality between spouses in and at the dissolution of marriage)

Items related to marriage	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Child marriage				
A girl is ready for marriage once she starts menstruating (1=strongly agree, 4= strongly disagree)				
Mean (SD)	2.74 (1.06)	2.72 (1.05)	3.05 (0.86)	2.83 (1.00)
Median	3	3	3	3
Agree, N (%)	481 (40%)	479 (39%)	259 (21%)	1219 (33%)
Disagree, N (%)	738 (61%)	746 (61%)	952 (79%)	2436 (67%)
Total, N (%)	1219 (100%)	1225 (100%)	1211 (100%)	3655 (100%)

Items related to marriage	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Even if a girl does not want to be married, she should honour the decision of her family (1=strongly agree, 4= strongly disagree)				
Mean (SD)	2.32 (1.05)	2.47 (1.09)	2.84 (0.91)	2.55 (1.04)
Median	2	2	3	3
Agree, N (%)	714 (58%)	635 (52%)	400 (33%)	1749 (48%)
Disagree, N (%)	520 (42%)	591 (48%)	811 (67%)	1922 (52%)
Total, N (%)	1234 (100%)	1226 (100%)	1211 (100%)	3671 (100%)
Even if a boy does not want to be married, he should honour the decision of his family (1=strongly agree, 4= strongly disagree)				
Mean (SD)	2.34 (1.08)	2.50 (1.09)	2.75 (0.94)	2.53 (1.05)
Median	2	2	3	3
Agree, N (%)	703 (57%)	619 (50%)	460 (38%)	1782 (49%)
Disagree, N (%)	531 (43%)	608 (50%)	753 (62%)	1892 (52%)
Total, N (%)	1234 (100%)	1227 (100%)	1213 (100%)	3674 (100%)

Items related to marriage	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Divorce				
Is it justifiable with divorce? (1=never justifiable, 10=always justifiable)				
Mean (SD)	2.48 (2.28)	2.59 (2.76)	2.71 (2.80)	2.59 (2.63)
Median	1	1	1	1
Never justifiable (1), N (%)	723 (59%)	848 (69%)	785 (65%)	2356 (64%)
Justifiable (2-10), N (%)	507 (41%)	379 (31%)	428 (35%)	1314 (36%)
Total, N (%)	1230 (100%)	1227 (100%)	1213 (100%)	3670 (100%)

Appendix Table 6A. Norms and values related to non-discrimination in terms of sexuality, sexual orientation and gender identity (make free, informed, and voluntary decisions on their sexuality, sexual orientation, and gender identity)

Item related to non-discrimination related to sexuality, sexual orientation and gender identity	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Stigma and discrimination of LBGTQI				
I would not like to have as neighbours… (1=mentioned homosexuals, 2=not mentioned homosexuals)				
Mean (SD)	1.11 (0.31)	1.30 (0.46)	1.11 (0.30)	1.17 (0.38)
Median	1	1	1	1
Mentioned homosexuals, N (%)	1102 (89%)	850 (70%)	1083 (90%)	3035 (83%)
Not mention homosexuals, N (%)	136 (11%)	370 (30%)	119 (10%)	625 (17%)
Total, N (%)				

Item related to non-discrimination related to sexuality, sexual orientation and gender identity	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Homosexual couples are as good parents as other couples (1=strongly agree, 5= strongly disagree)				
Mean (SD)	4.32 (1.03)	4.55 (0.83)	4.24 (0.95)	4.35 (0.96)
Median	4	5	4	5
Agree, N (%)	110 (9%)	45 (5%)	97 (8%)	252 (7%)
Disagree or neither agree nor disagree, N (%)	1112 (91%)	906 (95%)	1094 (92%)	3112 (93%)
Total, N (%)	1222 (100%)	951 (100%)	1191 (100%)	3364 (100%)
Homosexuality is… (1=never justifiable, 10=always justifiable)				
Mean (SD)	1.50 (1.47)	1.64 (2.24)	1.72 (2.14)	1.62 (1.62)
Median	1	1	1	1
Never justifiable (1), N (%)	993 (80%)	955 (91%)	1045 (86%)	2993 (85%)
Justifiable (2-10), N (%)	243 (20%)	100 (9.5%)	167 (14%)	510 (15%)
Total, N (%)	1236 (100%)	1055 (100%)	1212 (100%)	3503 (100%)

Item related to non-discrimination related to sexuality, sexual orientation and gender identity	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
People who dress, act or identify as the opposite sex should be treated just as anyone else (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	2.93 (1.01)	2.67 (0.92)	2.80 (0.97)
Median	x	3	3	3
Agree, N (%)	x	333 (29%)	525 (44%)	858 (36%)
Disagree, N (%)	x	828 (71%)	679 (56%)	1507 (64%)
Total, N (%)	x	1161 (100%)	1204 (100%)	2365 (100%)
A homosexual man is not a “real man” (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	1.86 (1.13)	2.02 (1.00)	1.94 (1.06)
Median	x	1	2	2
Agree, N (%)	x	669 (71%)	832 (70%)	1501 (71%)
Disagree, N (%)	x	272 (29%)	356 (30%)	628 (30%)
Total, N (%)	x	941 (100%)	1188 (100%)	2129 (100%)

Appendix Table 7A. Norms and values related to contraception and reproduction (make decisions concerning reproduction free of discrimination, coercion, and violence)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
Domain: Contraceptives				
Contraceptives should be available for everyone, whether or not one is married (1=strongly agree, 4= strongly disagree)				
Mean (SD)	2.29 (1.02)	2.24 (1.03)	2.15 (0.92)	2.23 (0.99)
Median	2	2	2	2
Agree, N (%)	752 (63%)	765 (63%)	847 (70%)	2364 (65%)
Disagree, N (%)	446 (37%)	449 (37%)	365 (30%)	1260 (35%)
Total, N (%)	1198 (100%)	1214 (100%)	1212 (100%)	3624 (100%)
It is a woman's responsibility to avoid getting pregnant (1=strongly agree, 4= strongly disagree)				
Mean (SD)	2.22 (0.97)	2.54 (1.05)	2.17 (0.87)	2.31 (0.98)
Median	2	3	2	2
Agree, N (%)	732 (60%)	580 (48%)	847 (70%)	2159 (59%)
Disagree, N (%)	487 (40%)	642 (53%)	365 (30%)	1494 (41%)
Total, N (%)	1219 (100%)	1222 (100%)	1212 (100%)	3653 (100%)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
To use contraceptives is… (1=never justifiable, 10=always justifiable)				
Mean (SD)	x	6.21 (3.65)	7.96 (3.17)	7.07 (3.53)
Median	x	7	10	9
Never justifiable (1), N (%)	x	327 (27%)	154 (13%)	481 (20%)
Justifiable (2-10), N (%)	x	897 (73%)	1046 (87%)	1943 (80%)
Total, N (%)	x	1224 (100%)	1200 (100%)	2424 (100%)
Domain: Reproductive agency and history				
How much freedom and choice do you feel that you have over your own family planning? (1=no choice at all, 10=a great deal of choice)				
Mean (SD)	6.71 (2.65) (men)	7.53 (2.77)	8.10 (2.75)	7.55 (2.81)
Median	7 (men)	8	10	8
No choice at all (1), N (%)	34 (6%) (men)	59 (5%)	73 (6%)	166 (5%)
Have choice (2-10), N (%)	567 (94%) (men)	1158 (95%)	1122 (94%)	2847 (95%)
Total, N (%)	601 (100%)	1217 (100%)	1195 (100%)	3013 (100%)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
How many children would you like to have?				
0	x	14 (1.1%)	36 (3.1%)	50 (2.1%)
1-3	x	206 (17%)	509 (43%)	715 (30%)
4-9	x	558 (46%)	569 (48%)	1127 (47%)
>10	x	95 (7.7%)	29 (2.5%)	124 (5.2%)
As many as God will give us	x	354 (29%)	36 (3.1%)	390 (16%)
Total, N (%)	x	1227 (100%)	1179 (100%)	2406 (100%)
It is a duty towards society to have children (1=strongly agree, 5=strongly disagree)				
Mean (SD)	2.03 (1.16)	1.99 (1.15)	1.93 (0.93)	1.98 (1.09)
Median	2	2	2	2
Agree or neither agree nor disagree, N (%)	1030 (84%)	1021 (83%)	1087 (90%)	3138 (86%)
Disagree, N (%)	198 (16%)	206 (17%)	126 (10%)	530 (14%)
Total, N (%)	1228 (100%)	1227 (100%)	1213 (100%)	3668 (100%)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
Domain: Abortion				
Women should have access to safe abortion services to terminate an unwanted pregnancy (1=strongly agree, 4=strongly disagree)				
Mean (SD)	2.64 (1.10)	2.06 (1.09)	2.88 (0.98)	2.54 (1.11)
Median	3	2	3	3
Agree, N (%)	577 (49%)	824 (68%)	402 (33%)	1803 (50%)
Disagree, N (%)	606 (51%)	396 (33%)	807 (67%)	1809 (50%)
Total, N (%)	1183 (100%)	1220 (100%)	1209 (100%)	3612 (100%)
Abortion is… (1=never justifiable, 10=always justifiable)				
Mean (SD)	1.71 (1.56)	1.68 (2.12)	1.77 (2.19)	1.72 (1.98)
Median	1	1	1	1
Never justifiable (1), N (%)	902 (73%)	1071 (87%)	1027 (85%)	3000 (82%)
Justifiable (2-10), N (%)	328 (27%)	154 (13%)	186 (15%)	668 (18%)
Total, N (%)	1230 (100%)	1225 (100%)	1213 (100%)	3668 (100%)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
Domain: Adolescent childbearing				
It is important for girls to continue their schooling even if they become pregnant and have children (1=strongly agree, 4=strongly disagree)				
Mean (SD)	1.67 (0.82)	1.36 (0.66)	1.76 (0.83)	1.60 (0.79)
Median	1	1	2	1
Agree, N (%)	1061 (86%)	1144 (93%)	1031 (85%)	3236 (88%)
Disagree, N (%)	170 (14%)	83 (7%)	180 (15%)	433 (12%)
Total, N (%)	1231 (100%)	1227 (100%)	1211 (100%)	3669 (100%)
A girl should wait to have children until she is at least 18 years old, even if she is married (1=strongly agree, 4=strongly disagree)				
Mean (SD)	1.76 (0.84)	1.72 (0.88)	2.20 (0.95)	1.89 (0.91)
Median	2	1	2	2
Agree, N (%)	1002 (82%)	1007 (82%)	765 (63%)	2774 (76%)
Disagree, N (%)	223 (18%)	220 (18%)	447 (37%)	890 (24%)
Total, N (%)	1225 (100%)	1227 (100%)	1212 (100%)	3664 (100%)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
Domain: Infertility				
Only when a woman has a child is she a real woman (1=strongly agree, 4=strongly disagree)				
Mean (SD)	2.57 (1.07)	3.02 (0.98)	2.70 (0.95)	2.76 (1.02)
Median	3	3	3	3
Agree, N (%)	560 (46%)	303 (25%)	490 (41%)	1353 (37%)
Disagree, N (%)	671 (55%)	922 (75%)	720 (60%)	2313 (63%)
Total, N (%)	1231 (100%)	1225 (100%)	1210 (100%)	3666 (100%)
A man who cannot father children is not a real man (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	3.35 (0.82)	3.08 (0.88)	3.21 (0.86)
Median	x	4	3	3
Agree, N (%)	x	150 (13%)	249 (21%)	399 (17%)
Disagree, N (%)	x	1054 (88%)	961 (80%)	2015 (84%)
Total, N (%)	x	1204 (100%)	1210 (100%)	2414 (100%)

Item related to contraception and reproduction	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N=3682
A couple who wants to have children but cannot conceive should have access to infertility services (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	1.76 (0.92)	1.91 (0.83)	1.83 (0.88)
Median	x	1	2	2
Agree, N (%)	x	972 (82%)	976 (81%)	1948 (81%)
Disagree, N (%)	x	221 (19%)	234 (19%)	455 (19%)
Total, N (%)	x	1193 (100%)	1210 (100%)	2403 (100%)

Appendix Table 8A. Norms and values related to gender-equitable relations

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Gender equality subindex				
When a mother works for pay, the children suffer (1=strongly agree, 4=strongly disagree)				
Mean (SD)	2.70 (1.06)	2.23 (0.93)	3.03 (0.79)	2.65 (0.99)
Median	3	2	3	3
Agree, N (%)	506 (41%)	752 (61%)	215 (18%)	1473 (40%)
Disagree, N (%)	724 (59%)	474 (39%)	994 (82%)	2192 (60%)
Total, N (%)	1230 (100%)	1226 (100%)	1209 (100%)	3665 (100%)
On the whole, men make better political leaders than women (1=strongly agree, 4=strongly disagree)				
Mean (SD)	1.87 (0.96)	2.65 (0.97)	2.55 (0.97)	2.35 (1.03)
Median	2	3	3	2
Agree, N (%)	924 (76%)	491 (41%)	539 (45%)	1954 (54%)
Disagree, N (%)	298 (24%)	715 (59%)	658 (55%)	1671 (46%)
Total, N (%)	1222 (100%)	1206 (100%)	1197 (100%)	3625 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
A university education is more important for a boy than a girl (1=strongly agree, 4=strongly disagree)				
Mean (SD)	2.63 (1.14)	3.20 (0.88)	3.18 (0.82)	3.00 (0.99)
Median	3	3	3	3
Agree, N (%)	516 (42%)	197 (16%)	173 (14%)	886 (24%)
Disagree, N (%)	712 (58%)	1027 (84%)	1035 (86%)	2774 (76%)
Total, N (%)	1228 (100%)	1224 (100%)	1208 (100%)	3660 (100%)
On the whole, men make better business leaders than women do (1=strongly agree, 4=strongly disagree)				
Mean (SD)	2.15 (1.04)	2.80 (0.97)	2.84 (0.90)	2.60 (1.02)
Median	2	3	3	3
Agree, N (%)	793 (64%)	426 (35%)	369 (31%)	1588 (43%)
Disagree, N (%)	438 (36%)	798 (65%)	841 (70%)	2077 (57%)
Total, N (%)	1231 (100%)	1224 (100%)	1210 (100%)	3665 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Being a housewife is just as fulfilling as working for pay (1=strongly agree, 4=strongly disagree)				
Mean (SD)	2.72 (1.03)	2.43 (1.02)	2.39 (0.98)	2.51
Median	3	2	2	3
Agree, N (%)	472 (39%)	631 (52%)	639 (53%)	1742 (48%)
Disagree, N (%)	755 (62%)	589 (48%)	573 (47%)	1917 (52%)
Total, N (%)	1227 (100%)	1220 (100%)	1212 (100%)	3659 (100%)
Gender Equality				
It is not good for a boy to be taught how to cook, sew, clean the house, and take care of younger children (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	3.29 (0.86)	3.14 (0.83)	3.22 (0.85)
Median	x	3	3	3
Agree, N (%)	x	181 (15%)	188 (16%)	369 (15%)
Disagree, N (%)	x	1042 (85%)	1026 (85%)	2068 (85%)
Total, N (%)	x	1223 (100%)	1214 (100%)	2437 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Men should really be the ones to bring money home to provide for their families, not women (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	3.05 (0.92)	2.70 (0.93)	2.87 (0.94)
Median	x	3	3	3
Agree, N (%)	x	271 (22%)	444 (37%)	715 (29%)
Disagree, N (%)	x	952 (78%)	771 (64%)	1723 (71%)
Total, N (%)	x	1223 (100%)	1215 (100%)	2438 (100%)
A man should always have the final say about decisions in his relationship or marriage (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	2.50 (0.99)	2.40 (0.94)	2.45 (0.97)
Median	x	2	2	2
Agree, N (%)	x	609 (50%)	674 (56%)	1283 (53%)
Disagree, N (%)	x	607 (50%)	539 (44%)	1146 (47%)
Total, N (%)	x	1216 (100%)	1213 (100%)	2429 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
There is no doubt that gainful employment is good but that what most women really want is a home and children (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	2.33 (0.99)	2.05 (0.83)	2.19 (0.93)
Median	x	2	2	2
Agree, N (%)	x	718 (59%)	906 (75%)	1624 (67%)
Disagree, N (%)	x	501 (41%)	306 (25%)	807 (33%)
Total, N (%)	x	1219 (100%)	1212 (100%)	2431 (100%)
On the whole, family life suffers when women work full time (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	2.35 (0.96)	2.28 (0.89)	2.31 (0.93)
Median	x	2	2	2
Agree, N (%)	x	733 (60%)	745 (61%)	1478 (61%)
Disagree, N (%)	x	486 (40%)	470 (39%)	956 (39%)
Total, N (%)	x	1219 (100%)	1215 (100%)	2434 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
It is a man's job to earn money and a women's job to take care of home and family (1=strongly agree, 4=strongly disagree)				
Mean (SD)	x	2.68 (1.01)	2.08 (0.87)	2.38 (0.99)
Median	x	3	2	2
Agree, N (%)	x	475 (39%)	870 (72%)	1345 (55%)
Disagree, N (%)	x	747 (61%)	344 (28%)	1091 (45%)
Total, N (%)	x	1222 (100%)	1214 (100%)	2436 (100%)
Man-Box scale				
A husband shouldn't have to do household chores (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.27 (0.92)	2.79 (0.86)	3.03 (0.92)
Median	x	4	3	3
Agree, N (%)	x	212 (17%)	389 (32%)	601 (25%)
Disagree, N (%)	x	1017 (83%)	826 (68%)	1843 (75%)
Total, N (%)	x	1229 (100%)	1215 (100%)	2444 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
A man should use violence, if necessary, to get respect (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.34 (0.77)	3.28 (0.75)	3.31 (0.76)
Median	x	3	3	3
Agree, N (%)	x	140 (12%)	130 (11%)	270 (11%)
Disagree, N (%)	x	1059 (88%)	1080 (89%)	2139 (89%)
Total, N (%)	x	1199 (100%)	1210 (100%)	2409 (100%)
A real man should have as many sexual partners as he can (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.36 (0.87)	3.39 (0.67)	3.37 (0.77)
Median	x	4	3	4
Agree, N (%)	x	161 (14%)	81 (7%)	242 (10%)
Disagree, N (%)	x	1021 (86%)	1129 (93%)	2150 (90%)
Total, N (%)	x	1182 (100%)	1210 (100%)	2392 (100%)

Item related to gender-equitable relations	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
A man who talks a lot about his worries, fears, and problems doesn't deserve respect (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	3.29 (0.78)	2.98 (0.85)	3.14 (0.83)
Median	x	3	3	3
Agree, N (%)	x	127 (11%)	276 (23%)	403 (17%)
Disagree, N (%)	x	1073 (89%)	934 (77%)	2007 (83%)
Total, N (%)	x	1200 (100%)	1210 (100%)	2410 (100%)
A homosexual man is not a "real man" (1=strongly agree, 4= strongly disagree)				
Mean (SD)	x	1.86 (1.13)	2.02 (1.00)	1.94 (1.06)
Median	x	1	2	2
Agree, N (%)	x	669 (71%)	832 (70%)	1501 (71%)
Disagree, N (%)	x	272 (29%)	356 (30%)	628 (30%)
Total, N (%)	x	941 (100%)	1188 (100%)	2129 (100%)

Appendix Table 9A. Privacy and confidentiality (privacy, confidentiality, respect, and informed consent)

Item related to privacy and confidentiality	Nigeria Total N=1237	Ethiopia Total N=1230	Zimbabwe Total N=1215	All countries Total N= 3682
Domain: Trust in SRH services				
It is safer for a woman to give birth at a clinic than at home (1=strongly agree, 4=strongly disagree)				
Mean (SD)	1.41 (0.64)	1.26 (0.58)	1.59 (0.78)	1.42
Median	1	1	1	1
Agree, N (%)	1168 (95%)	1170 (95%)	1082 (89%)	3420 (93%)
Disagree, N (%)	65 (5%)	56 (5%)	132 (11%)	253 (7%)
Total, N (%)	1233 (100%)	1226 (100%)	1214 (100%)	3673 (100%)

Appendix Table 10A. Multivariable analyses of the associations between support for the selected key SRHR norms and values and sociodemographic characteristics as well as Sida's four dimensions of poverty

	Sexual education helps	Wife-beating not justifiable	FGM/C not justifiable	Child marriage not acceptable	Access to safe abortion	Contra-ceptives should be available	Homo-sexual neighbours acceptable	Agree with trans-gender rights	Men should not always have final say	Choice index
Country										
Ethiopia	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Nigeria		**0.37 (0.29,0.46)**		0.86 (0.70,1.04)	**0.40 (0.33,0.49)**	0.96 (0.79,1.16)	**0.34 (0.27,0.43)**			**1.30 (1.09,1.56)**
Zimbabwe	**1.80 (1.43,2.27)**	**0.56 (0.44,0.72)**	**0.50 (0.38,0.66)**	**1.85 (1.49,2.30)**	**0.19 (0.15,0.23)**	1.22 (0.99,1.49)	**0.32 (0.25,0.42)**	**2.15 (1.74,2.66)**	**0.69 (0.56,0.85)**	0.90 (0.75,1.09)
Age										
18 to 25	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
26 to 40	**1.38 (1.06,1.80)**	1.03 (0.82,1.28)	0.96 (0.70,1.31)	1.05 (0.86,1.29)	1.07 (0.88,1.29)	0.96 (0.79,1.17)	**0.72 (0.56,0.92)**	1.05 (0.82,1.35)	**1.42 (1.12,1.81)**	0.92 (0.77,1.10)
41 to 60	0.95 (0.70,1.30)	1.23 (0.93,1.62)	0.94 (0.66,1.34)	**1.39 (1.08,1.79)**	0.87 (0.69,1.10)	0.80 (0.63,1.02)	**0.63 (0.46,0.85)**	0.79 (0.59,1.06)	**1.34 (1.01,1.77)**	0.85 (0.68,1.07)
61 to 100	0.88 (0.53,1.45)	1.08 (0.67,1.72)	**1.88 (1.00,3.54)**	1.17 (0.76,1.81)	**0.44 (0.27,0.70)**	1.05 (0.68,1.61)	**0.39 (0.20,0.75)**	0.67 (0.42,1.07)	1.01 (0.63,1.61)	(0.55,1.23)

	Sexual education helps	Wife-beating not justifiable	FGM/C not justifiable	Child marriage not acceptable	Access to safe abortion	Contra-ceptives should be available	Homo-sexual neighbours acceptable	Agree with trans-gender rights	Men should not always have final say	Choice index
Gender										
Men	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Women	0.81 (0.65,1.00)	**1.21 (1.02,1.45)**	1.18 (0.92,1.51)	**1.41 (1.19,1.67)**	0.92 (0.78,1.07)	0.95 (0.81,1.12)	0.91 (0.74,1.13)	0.87 (0.72,1.06)	**1.46 (1.21,1.76)**	1.03 (0.88,1.19)
Marital status										
Single	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Currently or ever married	1.00 (0.75,1.34)	1.09 (0.86,1.38)	0.93 (0.66,1.30)	**0.74 (0.59,0.92)**	0.91 (0.74,1.12)	0.83 (0.67,1.02)	0.93 (0.71,1.22)	1.05 (0.80,1.37)	1.03 (0.80,1.33)	0.89 (0.73,1.08)
Residence										
Rural residence	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Urban residence	1.14 (0.91,1.43)	1.09 (0.91,1.31)	0.88 (0.67,1.14)	**1.81 (1.52,2.16)**	0.93 (0.79,1.09)	1.00 (0.85,1.18)	0.87 (0.70,1.08)	1.15 (0.93,1.41)	1.11 (0.91,1.36)	1.04 (0.89,1.21)

	Sexual education helps	Wife-beating not justifiable	FGM/C not justifiable	Child marriage not acceptable	Access to safe abortion	Contra-ceptives should be available	Homo-sexual neighbours acceptable	Agree with trans-gender rights	Men should not always have final say	Choice index
Education										
None or primary	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Secondary and above	0.99 (0.78,1.25)	1.12 (0.92,1.37)	1.11 (0.85,1.46)	**1.65 (1.38,1.97)**	**1.41 (1.18,1.69)**	1.10 (0.93,1.32)	**0.53 (0.42,0.66)**	0.88 (0.70,1.09)	**1.73 (1.40,2.14)**	0.85 (0.72,1.01)
Subjective social class										
Lower or working class	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Middle class	0.96 (0.78,1.17)	**1.23 (1.03,1.46)**	**1.26 (1.00,1.59)**	**1.31 (1.11,1.53)**	**0.83 (0.72,0.97)**	**0.78 (0.67,0.91)**	1.18 (0.97,1.44)	0.84 (0.70,1.01)	**1.21 (1.02,1.45)**	0.97 (0.84,1.12)
Upper class	1.09 (0.58,2.05)	1.22 (0.70,2.13)	0.89 (0.45,1.74)	1.18 (0.70,2.00)	1.06 (0.67,1.68)	0.74 (0.47,1.18)	0.66 (0.31,1.37)	1.43 (0.83,2.45)	1.18 (0.69,2.03)	0.92 (0.59,1.43)
Employment status										
Not currently working	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Self-employed	0.87 (0.69,1.09)	0.89 (0.73,1.08)	1.00 (0.77,1.31)	1.18 (0.98,1.41)	0.89 (0.75,1.06)	0.95 (0.80,1.13)	0.91 (0.73,1.13)	0.85 (0.68,1.05)	0.83 (0.68,1.02)	0.94 (0.80,1.10)
Employed	0.90 (0.67,1.20)	0.95 (0.73,1.23)	1.06 (0.76,1.49)	**1.38 (1.08,1.75)**	0.87 (0.70,1.09)	1.03 (0.82,1.29)	**0.60 (0.44,0.82)**	0.95 (0.73,1.24)	1.00 (0.78,1.29)	0.94 (0.76,1.16)

	Sexual education helps	Wife-beating not justifiable	FGM/C not justifiable	Child marriage not acceptable	Access to safe abortion	Contra-ceptives should be available	Homo-sexual neighbours acceptable	Agree with trans-gender rights	Men should not always have final say	Choice index
Religion										
Christian	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Muslim	0.85 (0.68,1.08)	**0.79 (0.66,0.96)**	**0.31 (0.24,0.40)**	**0.41 (0.35,0.49)**	**0.57 (0.48,0.68)**	**0.54 (0.46,0.64)**	1.02 (0.82,1.26)	0.92 (0.73,1.15)	**0.69 (0.56,0.85)**	1.05 (0.89,1.22)
Others	0.69 (0.34,1.40)	1.10 (0.59,2.05)	0.65 (0.33,1.29)	0.81 (0.45,1.45)	0.83 (0.49,1.42)	1.90 (0.97,3.70)	**2.11 (1.08,4.13)**	1.70 (0.91,3.18)	0.55 (0.29,1.06)	1.46 (0.87,2.43)
Religiosity										
Not a religious person	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
A religious person	0.97 (0.62,1.52)	1.04 (0.72,1.50)	1.59 (1.00,2.55)	1.33 (0.96,1.85)	**0.68 (0.49,0.94)**	0.86 (0.61,1.20)	1.10 (0.73,1.65)	1.03 (0.68,1.57)	0.92 (0.62,1.37)	0.93 (0.69,1.25)

	Sexual education helps	Wife-beating not justifiable	FGM/C not justifiable	Child marriage not acceptable	Access to safe abortion	Contra-ceptives should be available	Homo-sexual neighbours acceptable	Agree with trans-gender rights	Men should not always have final say	Choice index
Sida's four dimensions of poverty										
Resources										
Do not have family savings	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Have family saving	1.24 (0.98,1.57)	**1.25 (1.02,1.52)**	**1.43 (1.07,1.92)**	1.19 (0.99,1.42)	1.17 (0.99,1.38)	**1.20 (1.01,1.43)**	1.05 (0.85,1.31)	**1.60 (1.29,1.99)**	**1.61 (1.31,1.98)**	1.00 (0.85,1.17)
Opportunities and choice										
Not currently working	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Self-employed	0.87 (0.69,1.09)	0.89 (0.73,1.08)	1.00 (0.77,1.31)	1.18 (0.98,1.41)	0.89 (0.75,1.06)	0.95 (0.80,1.13)	0.91 (0.73,1.13)	0.85 (0.68,1.05)	0.83 (0.68,1.02)	0.94 (0.80,1.10)
Employed	0.90 (0.67,1.20)	0.95 (0.73,1.23)	1.06 (0.76,1.49)	**1.38 (1.08,1.75)**	0.87 (0.70,1.09)	1.03 (0.82,1.29)	**0.60 (0.44,0.82)**	0.95 (0.73,1.24)	1.00 (0.78,1.29)	0.94 (0.76,1.16)
Power and voice										
Not important to live in democracy	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)

	Sexual education helps	Wife-beating not justifiable	FGM/C not justifiable	Child marriage not acceptable	Access to safe abortion	Contra-ceptives should be available	Homo-sexual neighbours acceptable	Agree with trans-gender rights	Men should not always have final say	Choice index
Important to live in democracy	1.75 (0.95,3.25)	**0.33 (0.14,0.76)**	1.33 (0.68,2.61)	1.18 (0.68,2.04)	0.91 (0.55,1.51)	**2.24 (1.37,3.66)**	0.77 (0.40,1.48)	0.91 (0.51,1.62)	1.38 (0.77,2.46)	1.63 (0.98,2.73)
Low score on WVS voice index	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
High score on WVS voice index	0.98 (0.81,1.19)	0.91 (0.77,1.07)	0.85 (0.68,1.06)	0.95 (0.81,1.11)	1.03 (0.89,1.19)	0.96 (0.83,1.11)	1.01 (0.83,1.22)	1.19 (0.99,1.42)	0.86 (0.72,1.02)	**1.15 (1.00,1.32)**
Human security										
Not secure in neighbour-hood	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Secure neighbour-hood	0.94 (0.76,1.16)	0.96 (0.80,1.15)	0.86 (0.67,1.10)	**0.79 (0.67,0.94)**	1.12 (0.96,1.31)	**0.85 (0.72,0.99)**	**1.30 (1.06,1.61)**	1.02 (0.84,1.24)	0.92 (0.77,1.11)	0.92 (0.79,1.06)
Number of total observations										
	2272	3497	2325	3479	3443	3455	3485	2275	2331	3504

All results are presented as odds ratios (OR) with 95% confidence intervals (CI) and are adjusted for all co-variables. Values above 1.0 indicates more support for SRHR. Figures in bold indicate statistically significant results.

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Den här rapporten syftar till att öka förståelsen för normer och värderingar kring sexuell och reproduktiv hälsa och rättigheter (SRHR), samt att identifiera olika möjligheter för hur svenskt utvecklingssamarbete kan förhålla sig till dessa normer och värderingar. Resultaten bygger på enkätdata som samlats in av World Values Survey genom intervjuer med över 3 600 kvinnor och män i Nigeria, Etiopien och Zimbabwe, samt en noggrann genomgång och analys av svenskt SRHR-bistånd i Afrika mellan åren 2010 och 2018.

This report aims to improve the understanding of values and norms related to sexual and reproductive health and rights (SRHR) as well as to identify the possibilities for Swedish development cooperation to relate to these values and norms. The results are based on large survey data collected through face-to-face interviews with over 3,600 men and women in Nigeria, Ethiopia and Zimbabwe, combined with a thorough review and analysis of Swedish development assistance for SRHR in Africa between 2010 and 2018.

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Expertgruppen för biståndsanalys (EBA) är en statlig kommitté som oberoende analyserar och utvärderar svenskt internationellt bistånd.

The Expert Group for Aid Studies (EBA) is a government committee with a mandate to independently analyse and evaluate Swedish international development aid.