OXFAM

Research Report

INTERSECTING INJUSTICES

The links between social norms, access to sexual and reproductive health and rights, and violence against women and girls

A study from Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) and Caraga, Philippines

KRISTINE VALERIO & ANAM PARVEZ BUTT August 2020

CREATING SPACES TO TAKE ACTION ON VIOLENCE AGAINST WOMEN & GIRLS

SHE SEXUAL HEALTH & EMPOWERMENT

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Intersecting injustices: the links between social norms, access to sexual and reproductive health and rights, and violence against women and girls.

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On the cover:

Tanumbay, 22, from Maguindanao got married at age 10 to a man 20 years older than her. 'I didn't want to marry, but I had no choice. It was my father's wish before he died,' she said. Tanumbay was 12 years old when she gave birth to her eldest son. Now, she has five children. Tanumbay never experienced going to school because of poverty.
Photo: April Abello-Bulanadi/Oxfam

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EXECUTIVE SUMMARY

In the Philippines, poor sexual and reproductive health (SRH) of women and girls is a grave public health challenge: one in five girls is a mother by age 19, two-thirds of women are not using any form of birth control, and more than a third of women's pregnancies are unwanted. This situation limits women's and girls' life choices, jeopardizes their wellbeing, and increases their risk of maternal and perinatal deaths. These risks are amplified in the conflict-affected context of Mindanao, where there is a higher incidence of violence against women and girls (VAWG). For girls who are subjected to child, early and forced marriage (CEFM), often as a result of early and unintended pregnancy or pre-arranged by parents driven by a lack of economic choices, the likelihood of adverse SRH outcomes is even greater, as girls lack autonomy, and chances of intimate partner violence (IPV) are greater.

While there are important legislative advancements that promote women's and girls' sexual and reproductive health and rights (SRHR) in the country, such as the *2012 Responsible Parenthood and Reproductive Health Act*, SRHR challenges continue. This is in large part driven by social norms, the shared beliefs around what is considered typical or appropriate behaviour, and the strong influence they exert on SRH behaviours and outcomes. These include, for instance, norms around gender roles and responsibilities that strengthen men's decision-making authority and control over partners, norms around family size that shape fertility desires, and norms around chastity that deny women and girls access to SRH services. These norms influence not only the extent to which women and girls are subjected to CEFM and VAWG, but also the information and services they can access and use, and the support they receive from health service providers and duty bearers.

This study provides insights into the social norms and other factors that act as a barrier to the access and use of SRHR information and services by women and girls. The research aims to inform two projects implemented by Oxfam Pilipinas and its partners: *Creating Spaces* and *Sexual Health and Empowerment (SHE)*. Both projects aim to reduce CEFM, VAWG, and to promote SRHR by transforming discriminatory social norms.

The study was conducted in the regions of the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM)[1] and Caraga, where SRHR vulnerabilities are further compounded by violence, conflict, and multiple and intersecting forms of discrimination and oppression based on gender, age, socio-economic class, and religion. BARMM is mainly populated by Muslim communities, while Caraga is home to indigenous people and other predominantly Christian settlers from other parts of the country. Both BARMM and Caraga are sites of intermittent conflict and are among the poorest areas in the country, which exacerbates the problem of access to SRH in these areas. Moreover, child early and forced marriage (CEFM) is practiced in these areas and sustained in part by the Code of Muslim Personal Laws (CMPL), which legalizes marriage of Muslim girls at the onset of puberty.

The research drew on an adapted version of the ecological framework of behaviour change (Cislaghi and Heise, 2018), which recognizes that various intersecting factors influence behaviour at four overlapping levels: individual, social, institutional and material. The research applied a social norms diagnostic tool, a methodology based on best-practice research methods for diagnosing social norms and rooted in a feminist participatory action research approach, in eight participatory workshops

1 This study was conducted before the January-February 2019 plebiscites that led to the creation of the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM) and effectively abolished the Autonomous Region for Muslim Mindanao.

across BARMM and Caraga held with community members and duty bearers. A total of 19 key in-depth interviews were carried out with duty bearers, such as health care providers, local government officials and community leaders,to explore the prevailing attitudes, narratives and norms that may impact sexual and reproductive health service provision.

The research findings identified four broad narratives, which demonstrate how these norms interact, weaken or reinforce each other, as well as the wider institutional, material, individual and social factors. The first of these narratives links norms around sexuality, chastity, and SRH, and the implications in terms of limited access to SRHR information and services, early pregnancy, and early marriage. Participants across both regions shared that adolescent girls and boys who are unmarried and sexually active are considered immoral and often face stigma and social disapproval. This shared belief held by parents and health service providers alike interacts with the belief that sex is a taboo topic of discussion, and limits women's and girls' access to SRHR information and services. This often leads to unplanned pregnancies and CEFM as a means of restoring the dignity of girls, who were believed to have been either involved in or subjected to moral turpitude.

The second dominant narrative to emerge from the findings revealed how traditional notions of masculinity and femininity, and deeply entrenched gender norms around roles, responsibilities, and household decision-making have limited women and girls' control over their labour, bodily integrity and family planning decision-making. The majority of participants described ideal women as being submissive and nurturing, with their primary responsibility being to look after their children and home. By contrast, ideal men were described as strong, primarily responsible for providing for their families and as the ultimate decision-makers in their households. Women and girls who are seen to transgress these norms faced strong social sanctions, such as their husbands remarrying or families, forcing them into marriage. Rooted in existing systems of power and patriarchy, these inequitable gender norms translated into women having little say in decisions around the number and spacing of children, control over their bodies, and access to SRHR information and services.

The third narrative illustrated how social norms around fertility desires and male sexual entitlement, coupled with the social stigma and misconceptions around contraceptive use, drive down the use of SRH services and modern contraceptives. The study showed it was commonly accepted for couples to have large family sizes regardless of socio-economic status, age of women and health consequences; and that this exerted a strong influence on couples choosing to have children soon after getting married. These decisions were further shaped by socio-political factors, such as children being seen as a way of strengthening family ties and political standing in Caraga, as well as religious beliefs in BARMM that contraceptive use was un-Islamic and an interference with God's will.

The fourth narrative revealed how VAWG (ranging from verbal and physical abuse to sexual assault and marital rape) is seen as an acceptable response to women who transgress their gender roles and responsibilities, women who seek SRH services or advice without their husband's knowledge or permission, or those who refuse to have sex with their husbands. It was also noted that girls who have experienced CEFM are even more vulnerable to VAWG, as they tend to have limited knowledge of their SRHR and less power and control than their husbands over decision-making.

Along with identifying the belief systems influencing women's and girl's access and use of SRHR information and services, the report also identifies key influencing factors (e.g. conflict, class, religion, education, technology), as well as positive outliers, key allies and positive influences as potential pathways to social norm change.

1 INTRODUCTION

While total fertility rates in the Philippines have declined from six children in 1970 to three children per woman in 2013, the country continues to have the second-highest total fertility rate and the highest adolescent fertility rate in South-East Asia.[2] Underpinning these trends is a high unmet need for family planning (FP), and a lack of access to and use of sexual and reproductive health (SRH) services among Filipino women and girls. Recent government data show that 61.8% of sexually active unmarried women aged 15-19 have an unmet need for FP, and more than a third of women's and girls' pregnancies are unwanted.[3] A study shows that, while modern contraceptive use of married women and girls aged 15-49 has increased marginally from 38% in 2013 to 40 % in 2017, young people and unmarried women continue to be denied access to SRH information and services, with teen birth rates rising by 10% between 2000 and 2015.[4]

These challenges associated with the sexual and reproductive health and rights (SRHR) of women and girls in the Philippines persist despite recent important legislative and policy advancements to safeguard their rights. In 2012, the *Responsible Parenthood and Reproductive Health Act of 2012*, (hereafter referred to as RH Law) was enacted to, for the first time, guarantee universal access to FP methods, maternal care, contraceptive use, and sexuality education. The RH Law reiterates the country's total ban on abortion. However, it asserts the right of women to access post-abortion care and to be treated in a 'humane, non-judgmental, and compassionate manner.'[5] Complementing the RH Law are laws to promote the elimination of discrimination and violence against women and girls, such as the *Anti-Violence against Women and their Children Act of 2004, 2009 Magna Carta of Women*, among others. In practice, however, access to SRH information and services remains limited, especially among women and girls living in poor and conflict-affected areas.

In the regions of the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM) and Caraga, SRH vulnerabilities are further compounded by violence, conflict, and multiple and intersecting forms of discrimination and oppression based on age, class, culture, and religion. BARMM is mainly populated by Muslim communities, while Caraga is home to Indigenous people and other predominantly Christian settlers from different parts of the country. Both BARMM and Caraga experience intermittent conflict and are among the poorest areas in the country, which exacerbate SRH vulnerabilities. Moreover, child early and forced marriage (CEFM) is practiced in these areas and sustained in part by the *Code of Muslim Personal Laws* (CMPL), which legalizes marriage of children at the onset of puberty.

Global literature has demonstrated that more than laws and policies, social norms exert a strong influence on SRH behaviours and outcomes; these are unwritten rules or shared beliefs around what is considered typical or appropriate behaviour.[6] These include, for instance, norms around gender roles and responsibilities that strengthen men's decision-making authority and control over partners, norms around family size that shape

2 PSA and ICF International, 2014

3 PSA and ICF International, 2018

4 Ibid.

5 DOH, "An Act providing for a National Policy on Responsible Parenthood and Reproductive Health", https://www.doh.gov.ph/sites/default/files/policies_and_laws/ra_10354.pdf

6 Cislaghi and Heise, 2018; Herbert, 2015

fertility desires, and norms around sexuality and chastity that deny women's and girls' access to SRH services. These norms influence not only the extent to which women and girls are subjected to CEFM and VAWG, but also their ability to access and use SRH services, and the level and kinds of support they receive from health service providers and duty bearers.[7]

Improving SRHR outcomes for women and girls, therefore, requires an understanding of the underlying structural factors and social norms that create a culture of silence around SRH issues, and an environment in which women and girls have limited agency and ability to obtain SRH information and services. It also requires a critical examination of how these norms are interacting with multiple and intersecting determinants of behaviour, such as violence, class, religion, ethnicity, and conflict. Few studies, however, have sought to explore the links between social norms, SRHR, VAWG, and CEFM in the Philippines, and even fewer in the conflict-affected context of Mindanao.

1.1 RATIONALE OF THE RESEARCH

This research informs two initiatives implemented by Oxfam and its partners in the Philippines by providing evidence to guide its interventions. Firstly, the *Creating Space to Take Action on Violence against Women and Girls (Creating Spaces)* project seeks to reduce VAWG and CEFM in Bangladesh, India, Indonesia, Nepal, Pakistan, and the Philippines.[8]

7 ActionAid, 2017

8 *Creating Spaces*, funded by Global Affairs Canada, is a five-year project (2016-2021) that engages with influencers (religious, community, private sector, political actors and youth), men and boys, and women and girls to prevent violence, working at the levels of policy, and also community; supports women who have experienced or are at risk of experiencing violence through economic opportunities and strengthening the services that provide support for them for response; and helps to build the capacity of institutions and alliances that are engaged in influencing change, as well as undertaking research. See Oxfam, 2017a.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

SRHR are a comprehensive and integrated set of existing civil, political, economic, social, and cultural human rights that are already recognized in national laws, international human rights treaties, and other consensus documents.

1. Among these **RIGHTS** are the rights of all persons to the highest attainable standard of sexual and reproductive health, including access to sexual and reproductive health (SRH) services; to make decisions concerning reproduction and sexuality free of discrimination, coercion and violence; to seek, receive and share information related to sexuality; to freely define one's own sexuality, including sexual orientation, gender identity and expression (SOGIE); to freely decide whether and when to have children; to bodily integrity; to choose one's partner; to decide whether, when and whom to marry; to decide whether to be sexually active; and to have a satisfying and safe sex life.

2. Comprehensive SRH **SERVICES** include accurate, evidence-based and non-judgmental information and counselling on SRH; access to a range of contraceptive methods; maternal care (including ante- and post-natal care); safe abortion and post-abortion care (PAC); prevention and treatment of sexually transmitted infections (STIs); prevention and treatment of reproductive cancers; actions to eliminate harmful traditional practices such as female genital mutilation and child, early and forced marriage (CEFM); and prevention and counselling of gender-based violence (GBV).

See: UNFPA, The Danish Institute for Human Rights, and The Office of the United Nations High Commissioner for Human Rights. *Reproductive Rights Are Human Rights: A Handbook for Human Rights Institutions*, 2014.

Creating Spaces is implemented in six localities in BARMM and adopts an approach that prevents, responds to, and ensures the sustainability of interventions to end VAWG and CEFM.[9] As part of the third strategic pillar of the project on knowledge generation and learning, this research will inform programming through greater understanding and evidence of the social norms that underpin VAWG and jeopardize SRHR.

Second, it supports the *Sexual Health Empowerment (SHE)* project, which aims to empower women and girls to secure their SRHR in six disadvantaged and conflict-affected regions of the Philippines, including BARMM and Caraga, where CEFM also persists. This research informs one of the two components of the SHE project: to conduct research on discriminatory gender- and sexuality-related social norms to inform awareness-raising and mobilization activities focusing on improved access to SRHR information and services, including gender-based violence (GBV) prevention and support services.

1.2. RESEARCH OBJECTIVES AND QUESTIONS

The overarching aim of this research is to contribute to the literature on barriers to the access and use of SRH information and services by women and children, particularly those who are subjected to CEFM and VAWG. The study aims to bring light to Filipino women's and girls' ability to exercise their SRHR, and how access, use and personal autonomy are influenced by social norms and other individual, material, contextual and structural factors such as beliefs, levels of income, access to services, laws etc.

The research also aims to contribute towards building an evidence base on the links between SRHR, CEFM and VAWG and the social norms that underpin them, and to inform stakeholders of initiatives like CS and SHE, which aspire to shift discriminatory social norms concerning women and girls' sexuality.

In particular, the research addresses the following questions:

1. What are the **social norms and other individual, material, institutional and social factors** that influence the extent to which girls and women in BARMM and Caraga, particularly those subjected to CEFM and VAWG, are able to access SRH information and services?

2. How do **institutional norms or personal beliefs held by duty-bearers** influence the kinds and levels of support women get from health service providers and duty bearers?

3. What are the **drivers and strategies of norms change** that can inform Oxfam programmes and influencing strategies that will improve the SRH of women and girls and end CEFM and VAWG?

9 Specifically, the project covers the municipalities of Guindulungan, Mamasapano, and Datu Saudi Ampatuan in Maguindanao province; and Marawi City, Bubong and Saguiaran in Lanao del Sur province. Partner organizations include two local Muslim women NGOs (Al-Mujadilah Development Foundation [AMDF] in Lanao del Sur, and United Youth of the Philippines-Women [UnYPhil-Women] in Maguindanao); two national NGOs (Philippine Business for Social Progress [PBSP] and Philippine Legislators' Committee for Population and Development [PLCPD]).

LITERATURE REVIEW 2

This section reviews the situation of SRHR, CEFM and VAWG in the Philippines, specifically in the context of BARMM and Caraga, and examines global and national literature exploring the links between discriminatory social norms, gendered inequalities of power, and SRH outcomes.

2.1 SRH, VAWG AND CEFM IN THE PHILIPPINES

WOMEN'S AND GIRL'S ACCESS TO SRH INFORMATION AND SERVICES

According to the World Health Organization (WHO), the Philippines has the second-highest total fertility rates and the highest adolescent fertility rates in South-East Asia. Moreover, the fertility rates in the regions of BARMM and Caraga are above the national average, at four and three, respectively.[10] The government's 2017 National Demographic and Health Survey revealed that behind high fertility rates are a high unmet need for FP, including a low contraceptive prevalence rate, and a general lack of access to and use of SRH information and services.[11] Notably, 17% of currently married Filipino women and 49% of unmarried women have an unmet need for FP, and the contraceptive prevalence rate among currently married women and sexually active unmarried women aged 15-49 is lowest in the then BARMM and Caraga Regions.[12]

Evidence also shows that adolescent girls in the Philippines are particularly at risk of unwanted pregnancies, STIs and complications arising from pregnancy. Further, 9% of women and girls aged 15-19 have already begun childbearing and, among all age groups, they had the lowest modern contraceptive prevalence rate (30%) and the highest unmet need for FP (30%).[13] While abortion is illegal under all circumstances and highly stigmatized, the procedure remains common, though often performed in unsafe conditions. Tens of thousands of women are hospitalized annually, and roughly 1,000 women die each year because of complications from unsafe abortions.[14]

VULNERABILITY TO VIOLENCE AGAINST WOMEN AND GIRLS (VAWG)

In the Philippines, one in five women (22%) aged 15-49 experienced either physical or sexual violence; among the ever-married women who have experienced sexual violence, 49% reported their current husbands/partners as perpetrators, while 32% reported former husbands/partners as the perpetrators.[15] The reported rates of VAWG differ from region to region: Caraga has a higher rate (28%), and BARMM has the lowest rate in the country (5%). However, these figures are questionable in light of underreporting, which is a key challenge in any country or locality but especially in BARMM, where discrimination against VAWG survivors has been reported.[16]

10 PSA and ICF International, 2018

11 Ibid.

12 Ibid.

13 Ibid.

14 Guttmacher Institute (2013) "Unintended Pregnancy and Unsafe Abortion in the Philippines", https://www.guttmacher.org/report/unintended-pregnancy-and-unsafe-abortion-philippines-context-and-consequences.

15 PSA and ICF International, 2018

16 Ibid.

CHILD, EARLY AND FORCED MARRIAGE IN BARMM AND CARAGA

CEFM has been a pressing concern, particularly in developing countries, where according to UNFPA, one in every four girls is married before reaching 18 and one in nine is married under the age of 15. In several countries, CEFM is recognized as a form of violence against girls that makes girls more vulnerable to domestic violence (physical, emotional and sexual), and in greater need of SRH information or services.[17]

In the Philippines, 15% of women get married before the age of 18.[18] However, CEFM is much more common in Mindanao, which is home to different ethnic groups, a persisting armed conflict, and traditional religious beliefs. Nisa and AMDF (2009) cited different factors that drive CEFM in BARMM, including social norms, cultural and religious beliefs, indigenous tradition, laws, economic conditions, personal circumstances and political reasons. Furthermore, the CMPL which was enacted in 1977 and allowed Muslims to set up courts based on Shari'a laws, effectively legalized CEFM among Muslims in the country.[19] In particular, Article 16 of the CMPL states the following:

1. Any Muslim male at least fifteen years of age and any Muslim female of the age of puberty or upwards and not suffering from any impediment under the provisions of this Code may contract marriage. A female is presumed to have attained puberty upon reaching the age of fifteen.

2. However, the Shari'a District Court may, upon petition of a proper *wali* (guardian), order the solemnization of the marriage of a female who though less than fifteen but not

below twelve years of age, has attained puberty.

Caraga, which is also home to several national minority groups, has different sets of beliefs on CEFM. The largest minority group practicing CEFM based on their Indigenous beliefs and traditions are the Manobo. Among the Ata Manobo in Davao, the *buya* is a practice that allows parents to choose their child's spouse as early as 12 to 14 years old.[20]

2.2. NORMS HINDERING ACCESS TO SRH INFORMATION AND SERVICES

Researchers have been aware of the influence of social norms on specific behaviours and practices for a long time.[21] Social norms are based on one's beliefs about what others do (*descriptive norms*), and what others think ought to be done (*injunctive norms*).[22] Gender norms—social expectations of appropriate roles for men, women, boys, and girls—are among the strongest social factors influencing SRHR.[23]

People conform to group expectations out of the human need for social approval and belonging, and they avoid disapproval so that they will not suffer from sanctions.[24] Studies have also revealed that these norms are held in place by a reference group, whose opinions matter to individuals making the decision. In the case of SRHR, CEFM and VAWG, decisions can be influenced by parents, influential leaders in the community, religious leaders, duty bearers, neighbours and friends.

A number of global studies have explored the links between discriminatory gender norms, gendered inequalities of power, and SRH outcomes. Adams et al. (2013) explain how social norms about gender and reproduction shape fertility desires and the

17 Hidayana, et al., 2016, and Jensen and Thornton, 2003.
18 Girls not Brides, 2017
19 Nisa and AMDF, 2009
20 Galvan Tan et al., 2013, p.10
21 Young, 2007; Mackie et al., 2015; Chung and Rimal, 2016
22 Cialdini et al., 1990
23 Barker & Nascimineto, 2007; Varga, 2003, cited in Adams et al., 2013
24 Heise, and Manji, 2016); Bicchieri, 2006

use of FP among adolescents in post-conflict northern Uganda. Specifically, societal and family expectations around procreation and its link to notions of masculinity and femininity exert a strong influence on young couple's fertility decisions and reproductive behaviours.[25] Herbert (2015) found that patriarchal gender norms promote high fertility rates, and low contraception use and uptake of other FP services, in addition to early marriage and the preference of boys over girls. All these practices negatively impact the SRH of women and girls, particularly in Asia and Sub-Saharan Africa, where women are expected to marry early and have children soon after marriage and cohabitation.[26]

Additionally, institutional norms often drive stigma and discrimination even among the duty bearers and health service providers who are responsible for providing SRH information and services; in the Philippines, Oxfam's "Gender Snapshot" of the Marawi Conflict identified the attitude of health service providers as a factor inhibiting internally displaced persons (IDPs) from accessing reproductive health care.[27]

GENDER NORMS THAT PERPETUATE CEFM, VAWG AND HINDER ACCESS TO SRH INFORMATION AND SERVICES

Gender norms or social expectations of appropriate roles for men, women, boys and girls are among the strongest social factors influencing sexual and reproductive health[28] and VAWG; they limit women's control over their bodies and sexuality, including decisions to protect their health.[29]

Adams et al. (2003) and Bicheri et al. (2014) found that traditional notions of masculinity (e.g., men as providers or decision-makers) femininity (e.g., women as obedient caretakers) influence FP attitudes and decisions. In the Philippines, Galvez Tan et al. (2014) also noted that decision-making roles assigned to males in the community extended to FP, stating that 'it is the man's role to talk and discuss family planning and the family would just listen.'

Gender norms also influence CEFM. For instance, the expectation that the chastity of women and girls needs to be preserved until after marriage to protect their honour perpetuates negative attitudes toward women's sexuality and control over their bodies, including the use of and access to SRH information and services.[30]

INTERSECTING FACTORS IN BARMM AND CARAGA

Diagnosing multiple and intersecting factors located in the four domains of influence – individual, structural, material and social – is necessary to develop effective change strategies, as social norms do not operate in a void. In BARMM and Caraga, the interplay of age, class, culture, religion and conflict reinforces discriminatory norms and sustains women's and girl's low access to SRH services.

BARMM and Caraga share a context of intermittent conflict, which has been shown to aggravate CEFM, VAWG and the social norms that hinder access to SRH information and services. The armed conflict in Mindanao has also worsened poverty and gender inequality, and has greatly affected SRH at all ages for both men and women.[31] Eight of the 10 poorest provinces in the Philippines are in Mindanao: three

25 Adams et al., 2003
26 Daniel et al., 2008
27 Oxfam in the Philippines, 2018
28 Barker and Nascimiento, 2007; Varga, 2003
29 Anderson et al., 2013
30 Adams et al., 2013; Biccheri et al., 2014
31 WHO, 2008

are in BARMM, including the two poorest areas (Lanao del Sur and Sulu), and one is in Caraga.[32] While there are public hospitals and clinics that provide free SRH information and services, these are limited, and most services come with a cost and are not affordable, especially for those who have to travel from geographically isolated and disadvantaged areas (GIDA), such as Indigenous peoples in Caraga and some communities in BARMM.

Among Indigenous communities in Caraga, even if resources were not an issue, traditional beliefs and social norms that proscribe the access and use of SRH services ultimately influence people's decisions.[33] In BARMM, Muslim women and girls face the same difficulties due to cultural, religious and logistical reasons.[34] There is a *fatwa* (religious decree) in the region stating that 'improved reproductive health condition of the Muslim people benefits the individual Muslims and strengthen the Muslim socially, economically, politically and in all other aspects of human life'; nevertheless, access to SRH information and services continues to be poor.[35]

For young Filipinos in general, access to SRH information and services remains a challenge due to, among other reasons, stigma and criminalization. Section 4.06 of the country's RH Law limits access to young people; the law states that 'minors will not be allowed access to modern methods of FP without written consent from their parents or guardians except when the minor is already a parent or has had a miscarriage.'[36]

In the interaction of age, conflict, class, religion and ethnicity, it needs to be recognized that these factors have a degree of fluidity, with one factor exerting more influence than others depending on the context. Therefore, understanding the intersection of these different factors requires a recognition of the power and gender dynamics that influence how individuals and groups develop their shared beliefs about what is normal and acceptable behaviour.

2.3 SOCIAL NORMS DYNAMIC FRAMEWORK FOR SOCIAL CHANGE

This research was guided by the dynamic framework for social change in Figure 1 below (Cislaghi and Heise, 2018), adapted from the ecological framework of behaviour change. The framework provides a structure for diagnosing intersecting factors that reinforce discriminatory norms, as well as those that challenge these norms and promote positive deviance (outlying positive behaviours). It articulates how the four domains of influence (institutional, material, social and individual) interact with each other to drive behaviours.

Access to SRHR can thus be understood in terms of the availability of SRH information and services (material), where these can be accessed, who offers them (institutional), and whether or not service providers will sanction those who access them (social) (Bersamin et al., 2017). As illustrated in the figure, these domains overlap and cause multiple and intersecting factors to reinforce or challenge social norms. The framework served as a guide in diagnosing and analysing norms around SRHR, CEFM and VAWG in this study.

32 PSA and ICF International, 2018

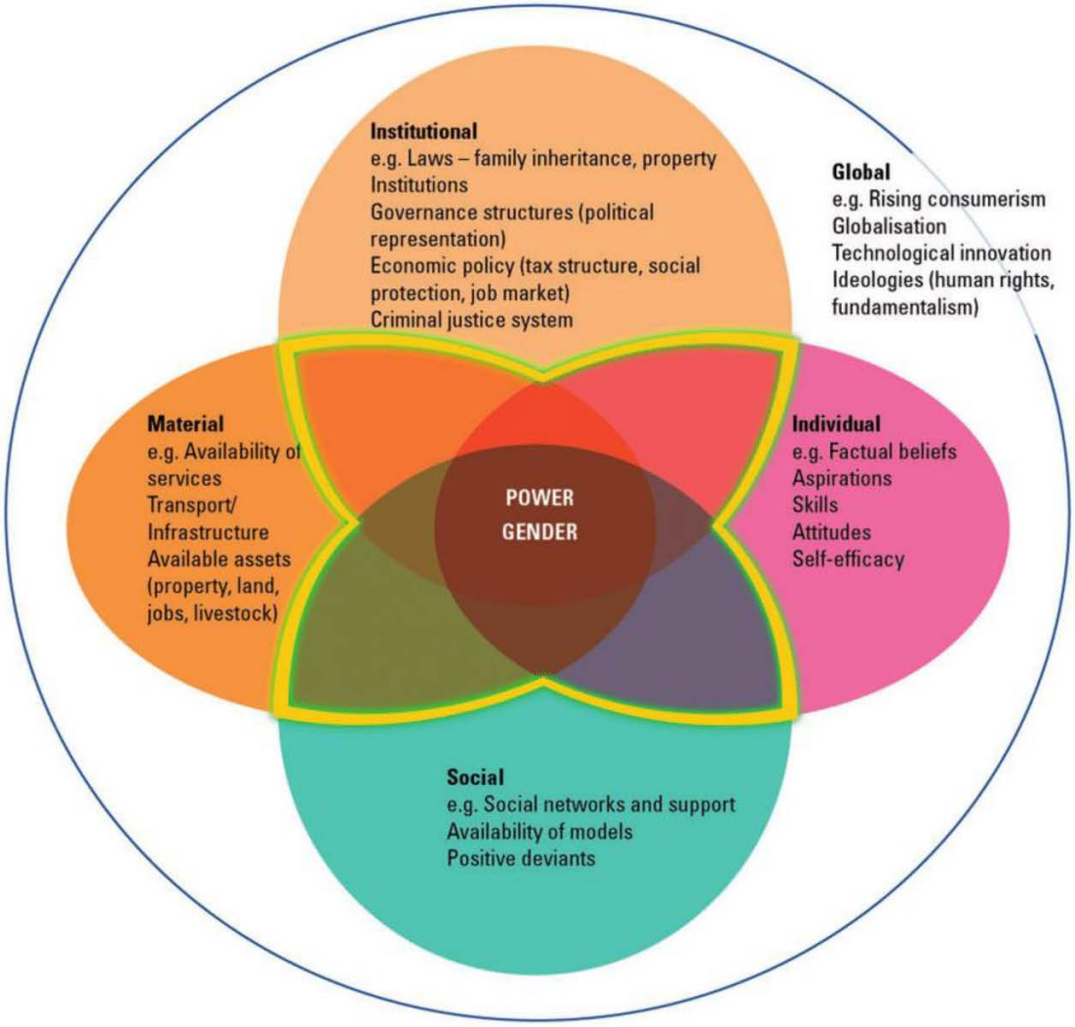
33 Galvez Tan et al., 2013

34 Nisa and AMDF, 2009

35 A *fatwa* or religious decree on reproductive health and FP was issued in 2003 by the Assembly of Darul-Ifta (a group of Muslim leaders in the country). It encourages FP and provision of other SRH services to Muslims in the context that many Muslim believers do not subscribe to FP methods as they see it against Islamic belief.

36 Government of the Republic of the Philippines, 2013

Figure 1. Social Norms Dynamic Framework
Source: Cislaghi and Heise, 2018



2.4 DISCUSSION

A review of the data and literature has revealed that global studies have explored how social norms limit women's and girl's access to SRH information and services and drive CEFM and VAWG; the prevalence-related data sheds light on the links between social norms, VAWG and CEFM. However, in the Philippines, very few studies have explored these links, and even fewer in the context of conflict-affected Mindanao. This presents a lack of evidence needed to design interventions that acknowledge the interconnected nature of SRHR, CEFM and VAWG, while tackling some of the root causes of the SRHR vulnerabilities.

This report seeks to fill this knowledge gap by providing insights into the social norms and other factors that act as a barrier to SRHR for women and girls in BARMM and Caraga, and how such norms are linked to discriminatory practices that perpetuate CEFM and VAWG.

METHODOLOGY 3

The research employed qualitative methods and was guided by a gender transformative research methodology following Oxfam's feminist research principles and guidelines, which highlight people's multiple identities and ways in which these shape the power they can (or cannot) exercise.[37] They also highlight the need for context-specific strategies when working on gender equality and women's rights, and promote the agency and involvement of women and their organizations in decision-making throughout the research process. At all times, in terms of risk assessment, protection and safeguarding, the research took into consideration how gender norms create inequalities of power that disadvantage women and girls, including female staff, and how they are shaped by inequalities based on income, class, ethnicity, age, mental/physical ability and gender or sexual identity.

When guided by a feminist approach, gender transformative research has the potential to shift individual attitudes towards the topic of research being explored, shift the relationships of power present within the research project, and shift ownership of the research project to participants. Starting from the premise that research participants are the experts of their own lived realities, Oxfam's feminist approach to gender transformative research re-conceptualizes participants from 'research subjects' to 'research leads' and enables them to drive all stages of research (question definition, data collection, analysis, validation, and dissemination). Incorporating a feminist approach to research means prioritizing partner timelines, work plans, and including research capacity strengthening into the project in a learning-by-doing manner. It also means ensuring that data collection, analysis, sense-making and validation is carried out in an inclusive, participatory, ethical and non-extractive manner, enabling participants to define outputs and agree together how data will be used and disseminated. Finally, Oxfam's approach to gender transformative research is action-oriented, and supports research that contributes to a broader societal transformation.

Throughout the research process, an explicit focus was placed on understanding social norms, power relations and other structural barriers to gender inequality. Community members were engaged not as passive participants, but as analysts making sense of the data and as agents of change identifying solutions to their problems. Furthermore, the research instruments were contextualized with partners to reflect local realities and to ensure active engagement of research participants during the discussion. Data was analyzed beyond sex disaggregation to explore multiple and intersecting forms of oppression and discrimination against women and girls, such as gender, age, location, religion, culture, class and position in community that reinforce and exacerbate discriminatory norms. A key limitation of the research is that we did not ask questions or disaggregate data by gender identity or sexual orientation so the analysis is limited in the extent to which it is sensitive to and inclusive of differences based upon gender identity and sexual orientation. There was also no active outreach to trans and gender non-conforming people so we cannot be certain that the sampling is gender inclusive.

3.1. RESEARCH METHODS AND SAMPLING APPROACH

Qualitative data was gathered through eight sets of participatory exercises using the Social Norms Diagnostic Tool (discussed below), and 19 key informant interviews (KIIs) held from August to October 2018, in selected project locations of Creating Spaces in BARMM and of the SHE project in Caraga.

37 Oxfam Canada, 2018.

Participants were identified with partners to reflect diverse backgrounds, perspectives and roles. Separate FGDs were held for duty bearers and influential leaders and respondents were further sub-divided by gender for half of the activities, recognizing the impact of power dynamics inherent to the group's social dynamics on participation. KII were held with duty bearers and service providers, who were responsible for, or had knowledge of, SRH provisions and the prevention and response to VAWG.

Table 1. Sampling Framework – participatory exercise

LOCATION	PARTICIPATORY EXERCISE 1 Community Members	PARTICIPATORY EXERCISE 2 Duty bearers and community/ religious leaders	TOTAL
BARMM- Maguindanao	5 male 5 female	6 male 4 female	20
BARMM-Lanao del Sur	5 male 5 female	3 male 5 female	18
Caraga- Surigao del Sur	Municipality of Cagwait 6 male 5 female	Municipality of Lianga 5 male 5 female	21
Caraga- Agusan del Norte	5 female 4 male	5 male 5 female	19
TOTAL 78 (39 male: 39 female)			

Photo credit: Vina Salazar – Oxfam 2019

Table 2. Sampling Framework – Key informant interviews

LOCATION	CHARACTERISTICS		TOTAL NO. OF RESPONDENTS
	Designation	Sex	
BARMM-Maguindanao	- Datu Saudi Amapatuan Admin Staff	M	5
	- Datu Saudi Amapatuan Admin Staff	M	
	- Datu Saudi Ampatuan Barangay Health Worker	F	
	- Community Leader	F	
	- Community Leader	F	
BARMM-Lanao del Sur	- Public Health Nurse, Lanao del Sur Integrated Provincial Health Office	F	5
	- Marawi City Social Welfare and Development	F	
	- Saguiran Philippine Nationa Police (PNP), Women and Children Protection Desk	F	
	- Saguiran Social Welfare and Development	F	
	- Saguiran Gender and Development Focal Person	F	
Caraga-Surigao del Sur	- Lianga Population Commission	F	4
	- Lianga Philippine Nationa Police (PNP), Women and Children Protection Desk	F	
	- Lianga Social Welfare and Development	F	
	- Regional Health Unit, Doctor	M	
Caraga-Agusan del Norte	- Administrative Aide I, Pre-Marriage Council Member, Santiago Agusan del Norte	F	5
	- Asst. Women and Children Protection Desk (WCPD), Santiago, Agusan del Norte	F	
	- Santiago Municipal Social Welfare and Development	F	
	- National Commission for Indigenous Peoples (NCIP), Cabadbaran City, Agusan del Norte	F	
	- Santiago Department of Health	F	
TOTAL 16 F, 3 M			19

3.2 SOCIAL NORMS DIAGNOSTIC TOOL

The 'Social Norms Diagnostic Tool' used in this research was developed in consultation with Oxfam Great Britain, Oxfam Pilipinas and its partners to guide the focus group discussions.[38] It is a participatory research methodology organized as a set of participatory exercises designed to identify social norms and perceptions that hinder access to SRH information and services. The tool also explores how these norms shape, constrain or promote CEFM and VAWG within the context of BARMM and Caraga. Informed by the ecological framework of behaviour change, it explores the influencing factors and influencers who either reinforce norms or drive change. It intends to develop initial ideas for change strategies. The exercises were complementary to Oxfam's policies and interventions on gender justice, ending VAWG, and promoting SRHR.

ACTIVITIES

Discussing broader gender norms. The first activity began with introducing the purpose of the research and defining social norms. This was followed by an activity which focused on getting the participants to understand the broader context of gender norms and to share their related experiences. It tackled norms on gender roles, responsibilities and decision-making and identified traditional notions of masculinity and femininity and how they affect perceptions of 'ideal' men and women. This was vital for participants to begin thinking about how different kinds of violence, access to SRH, ideals of masculinity and femininity and gender norms are interconnected and have a common foundation.

Vignettes, role plays and discussions on early marriage/pregnancy, intimate partner violence and SRH. For the third, fourth and fifth activities, vignettes (short stories of imaginary but relatable characters) co-developed with partners were shared involving three girls; one who has been subjected to CEFM, another to early pregnancy, and another who is unmarried and sexually active. Names and other details of the stories were changed to make them relevant to the context of BARMM and Caraga.

I will tell you a story of a mother called Fatma, a father named Amer and their daughter Sitti, who is 14 years old. Fatma, Amer and Sitti live in a community like you. They live in a village in Maguindanao where a bombing just took place recently.

One day, Sophia, Fatma's cousin, comes over to visit the family. Sophia announces that her daughter, Sarah, who is also 14, is engaged and getting married in a month. Sophia says that she believes that Fatma's daughter, Sitti, should also get married as she is becoming a woman and should have children soon.

But Fatma and Amer don't want Sitti to marry and have children at this age. Sitti has told them that she wants to finish secondary school, and find paid work before getting married. Fatma and Amer announce to the visitors that they do not want Sitti to marry at this age.

38 Butt and Valerio, 2019. See Annex.

The vignettes were also presented using an animated video to spark the imaginations of participants. These vignettes were followed by question-prompted discussions to identify social norms relating to early marriage and early pregnancy, and to explore how these relate to SRHR and VAWG the influencing factors, and key influencers of such experiences. One of the vignettes used is shared below:

These activities also involved role playing exercises, in which participants got involved in acting out vignettes through theatre based performances and later analysed and transform the vignettes being played out. The facilitators began to provide less direction, and participants took more of a leading role in shaping and changing the vignettes given through role-play suggesting solutions and thus becoming agents of change.

Brainstorming. Finally, participants were asked to brainstorm strategies for change and to prioritize them based on community acceptance and available resources. This activity helped form influencing strategies that will support *Creating Spaces* and *SHE* projects.

RESEARCH PROCESS

Once the Social Norms Diagnostics Tool was completed, two sets of research design workshops were conducted with local partners to ensure the tool along with the sampling framework and other research tools were context-specific and culturally sensitive. Prior to actual data collection, facilitators' training workshops were held. Feedback was sought from facilitators on the practical implementation of the tool on the field. Following this workshop, the tool was further refined, and pilot tested before being implemented. Data was then collected, transcribed verbatim and translated from the local language into English. In keeping with the feminist participatory approach of the research, sense-making workshops were held bringing together Oxfam's researchers, programme and campaign staff; project partners; research facilitators and participants to validate, analyse and refine the preliminary findings. Participants also prioritized norms, key influencers and influencing factors based on their perceived relevance, prevalence and level of influence on behaviours. Outputs from the sense-making workshop served as critical inputs in discussions on programme design. Influencing and dissemination strategies were then identified to communicate findings to different audiences for maximum impact. See Annex for a summary of the research process.

KEY FINDINGS

4

4.1 DOMINANT NARRATIVES AND RELATED NORMS

Fifteen norms were identified in this study that hinder access to SRH information and services and perpetuate CEFM and VAWG. These norms were grouped into four thematic narratives that emerged from the findings and demonstrate how the social norms interact, weaken, or reinforce each other. Furthermore, the key findings highlight broader institutional, material, individual and social factors that impact on SRHR, CEFM, and VAWG. Finally, this section ends with potential pathways to norm change by identifying positive deviances (see Glossary of Terms), key allies and factors of positive normative influence that can support the Creating Spaces and SHE Project interventions and influencing strategies.

See Table 3 for a summary of key findings.

Photo credit: Vina Salazar – Oxfam 2019

Table 3. Identified social norms that impact on SRHR and perpetuate CEFM and VAWG

IDENTIFIED SOCIAL NORM	DESCRIPTION / IMPLICATIONS	STRENGTH	EXAMPLES OF NORM CHANGE/ EXCEPTIONS *(where applicable and documented)*
NARRATIVE 1: Limited Access to SRH information and services, early pregnancy and early marriage: A vicious cycle			
1.1 Women and girls (even men and boys) who engage in sexual activities before marriage are immoral.	Women and girls should not engage in sexual activities before marriage. Those who do are seen as dishonouring their families and deemed immoral. Consequently, women and girls do not disclose sexual activities and avoid seeking SRH information and services.	Very Strong	
1.2 Sex is a taboo topic of discussion.	Women and girls typically do not discuss their sexual activity and SRH needs with their parents nor with SRH service providers until an un-planned pregnancy occurs, because talking about sex is considered a taboo.	Strong	
1.3 Provision of SRH information and services to young people would mean that service providers encourage promiscuity.	Providing SRH services to young people is considered tantamount to encouraging promiscuity. As a result, young people seeking contraceptives often face discrimination, mistreatment or outright refusal of services.	Strong	Some service providers are willing to inform young people about teenage pregnancy and they offer SRH services, due to provisions in the *RH Law*.
1.4 CEFM is an acceptable course of action when adolescents get pregnant or are sexually active.	In both Caraga and BARMM, adolescent girls are often forced by their parents to get married to their sexual partner when they find out they have been sexually active, and especially in the event of pregnancy.	Very strong	In Caraga, it is becoming more acceptable for young couples to live together (live-in) in the event of pregnancy.
1.5 Parents should and typically do decide for young people.	Parents typically do decide when and to whom their children get married, and they make decisions on FP. The RH Law, which requires minors to acquire parental or guardian consent before accessing SRH information and services, reinforces this norm.	Strong	While parental/guardian consent is required by the RH law, some key influencers exhibited positive deviance by supporting couples to make their own decisions.
NARRATIVE 2: Gender norms around ideal men/women and FP decision-making			
2.1 Traditional gender roles and notions of masculinity and femininity.	Ideal women are characterized as submissive, emotional, obedient, nurturing, with their primary responsibility being to look after their children and home. Ideal men were described as strong, primarily r esponsible for providing for their families and as ultimate decision-makers. Women and girls are seen to transgress their role face strong social sanctions, including divorce by their husbands and forced marriage.	Strong	
2.2 Men should and typically do decide on FP use.	Men should and typically do make decisions on FP. This prevents women from exercising control over their SRH. In Lanao, it is common for health service providers to ask for the consent of the husband, before providing FP services and information to women over the age of 18.	Medium	The law is starting to shift perspectives on women's rights to SRH services and information.

IDENTIFIED SOCIAL NORM	DESCRIPTION / IMPLICATIONS	STRENGTH	EXAMPLES OF NORM CHANGE/ EXCEPTIONS *(where applicable and documented)*
2.3 Norms around dowry treat women as a commodity.	In exchange for the dowry, women are expected by both families to relinquish control over their labour, bodily integrity and decision-making.	Medium	
2.4 Polygamy is commonplace when women cannot bear children.	When childbearing is not possible for a couple, the husband is entitled to look for another woman to marry, and hence, polygamy becomes a sanction.	Strong	Polygamy is no longer practised in Caraga due to the *Revised Penal Code* of the Philippines.
2.5 Love marriage as a positive deviance in FP and decision-making.	Husbands are more willing to listen to their wives and make joint decisions related to FP when a couple gets married out of love.	Very strong	
NARRATIVE 3: FP and contraceptive use			
3.1 A woman should give birth right after her marriage.	The use of contraceptive methods before married couples have their first child was deemed unacceptable and prohibited by Islam.	Very strong	Some married women and girls are deciding when to have a child and do not give birth right after marriage.
3.2 A large family size is common and socially desirable.	It is expected that couples have large family sizes regardless of socio-economic status, age of women, and health consequences. This is further reinforced and shaped by socio-political factors, such as strengthening family ties and political standing, as well as religious beliefs.	Strong	With improved access to education, people are learning the practical challenges of having many children and some couples are using contraceptive methods.
3.3 Contraceptive use is un-Islamic.	Contraception and birth spacing should not be used as they are un-Islamic, and an interference with God's will.	Medium	Some progressive religious leaders don't share this belief and are supportive of contraceptive use.
3.4 Condoms should not be used as they do not sexually satisfy men.	Across the region, a strong social norm was rooted in men's sense of sexual pleasure and entitlement; condoms were seen as an unacceptable form of contraception because 'they don't satisfy men.'	Strong	There is evidence of younger generations of men being more open and supportive of condom use.
NARRATIVE 4: VAWG as an acceptable response to women who are transgressing their roles beyond what is an ideal woman			
3.1 Men can abuse their wives if women seek FP services or advice without their knowledge or permission	Domestic violence was seen to be an acceptable punishment for women who defied men's decision-making authority by seeking SRH or contraceptive services and information without their permission.	Medium	
3.2 Sexual assault and marital rape are an acceptable behaviour by men if their wives refuse to have sex.	In both regions, women and girls who refused to have sex with their partners experienced assault; married girls were more vulnerable. Both men and women disagreed that marital rape exists because wives are expected to fulfil their husband's wishes.	Medium	

NARRATIVE 1: Limited access to SRH information and services, early pregnancy and early marriage: A vicious cycle

Across both regions, the first narrative to emerge related to young people. Participants across both regions shared that adolescent girls and boys, who are unmarried and sexually active, often face stigma and social disapproval from parents and duty bearers alike, thereby limiting their access to the SRH information and services they need. This leads to unplanned pregnancies, which is one of the primary causes of CEFM. This narrative connects five norms.

1.1. NORMS AROUND SEXUALITY AND CHASTITY: WOMEN AND GIRLS (EVEN MEN AND BOYS) WHO ENGAGE IN SEXUAL ACTIVITIES BEFORE MARRIAGE ARE IMMORAL.

Strength: **Very strong**

Participants from BARMM and Caraga shared that in their communities, it is believed that women and girls should not engage in sexual activities before marriage. Those who do are seen as dishonouring their families and deemed immoral. 'Women should be clean before marriage,' according to a female Muslim religious leader from BARMM. Consequently, women and girls would not disclose sexual activities to anyone in their community, above all, to their parents and family.

These findings echo Anderson et al. (2013) observation that 'marriage is often considered the only context in which it is permissible for young people to be sexually active' and, hence, 'unmarried, sexually active young people are often denied access to sexual health services and information.'[39]

Such social expectations discourage women and girls from visiting health centres and seeking SRH information and services for fear of making their sexual behaviours known to the community. A duty bearer from BARMM shared, 'If a woman is not yet married [and engages in sexual activities], she is not allowed at the health centre. I think there's a penalty for her.' Some women and girls who attempt to access SRH services might visit health centres outside their areas of residence where they are unknown. As another duty-bearer explained: 'If they are going to the city health centre far from their residence], I think it is okay, there is no problem.' This injunctive norm exerted a strong influence in both regions.

While chastity norms are very strong injunctive norms across regions, there are women and girls engaging in sexual activities before marriage, despite the sanctions they may face once their sexual activities are disclosed.

1.2. SEX IS A TABOO TOPIC OF DISCUSSION.

Strength: **Strong**

Chastity and sexuality norms not only shape women's and girls' decisions regarding pre-marital sex, how they are perceived when they do, and the degree of access to SRH information and services, but also the extent to which the topic of sex is discussed in both regions. Women and girls shared that they typically do not discuss their SRH experiences with their parents nor with SRH service providers until an unplanned pregnancy occurs, because sex is considered a taboo topic of discussion. Parents are also reluctant to discuss SRH information and service options with their children. This culture of silence further limits the avenues through which women and girls can obtain SRH information and services.

1.3. PROVISION OF SRH INFORMATION AND SERVICES TO YOUNG PEOPLE WOULD MEAN THAT SERVICE PROVIDERS ENCOURAGE PROMISCUITY.

Strength: **Strong**

39 Anderson et al.'s, 2013, p. 5.

Related to the chastity norm, a strong norm held by health service providers across both regions was that providing SRH services to young people is tantamount to encouraging promiscuity. This is in spite of the 2012 RH Law, which mandates universal access to SRH services and information, including contraception, fertility control, sex education, and maternal care. This further reveals how norms can exert a stronger influence on behaviour than laws and policies.

Community members also shared that young people seeking contraceptives often face discrimination, mistreatment or outright refusal of services. In the words of a service provider from BARMM: 'We won't give [young people] pills. However, we [still] don't have a case wherein a 14-year-old asked for pills.'

Another participant from Caraga, who is a *datu* (community leader) shared that when he was young, he sought contraceptives:

> 'The usual question is, "What do you need?" Then during the interview, you have to admit that you already had sex. That's related to your morals. It's a very personal and private matter. That could be one of the reasons why [girls] hesitate to visit the health centre.'

Similarly, Anderson et al. (2013) noted that 'young people often have to confront discrimination and judgmental, negative attitudes from service providers when they seek reproductive and sexual health services.'[40] Even in BARMM, where early marriage exists and is legal (as stipulated in the CMPL), providing SRH information and services to young people in the absence of their parents is still not accepted and considered immoral.

While some of the service providers interviewed subscribed to this discriminatory norm, some did appear to go against it; they were willing to inform young people about teenage pregnancy and to offer SRH services, citing the *RH Law* as a reason. A service provider from Caraga shared, 'We have sets [of advocacy campaigns] for high school [students] and older.' She explained that the Department of Health (DOH) had released a policy that ensures quality health care to adolescent sexual and reproductive health (ASRH) so they have a responsibility to implement it as service providers.

While at the municipal level they welcome young clients, the municipal health unit is aware that in the *barangay* (village) level, teenage clients will be afraid to visit the local health centres as service providers in the area may know their parents and family.

1.4. CEFM AS AN ACCEPTABLE SANCTION TOWARDS ADOLESCENTS WHO GET PREGNANT OR ARE SEXUALLY ACTIVE.

Strength: **Very strong**

In both Caraga and BARMM, adolescent girls are often forced by their parents to get married to their sexual partner when they find out they have been sexually active, and especially in the event of pregnancy. In Lanao, BARMM, some are even forced to marry as soon as parents discover that they are in a relationship. According to a female government leader from BARMM, 'Moro people do not want to be in disgrace. It is part of the tradition that we should not [cause] embarrassment [to our family] in the community.'

These results complement Nisa and AMDF's (2009) finding that in BARMM, 'many consider early marriage as a protection against *zina* (unlawful sexual intercourse) and perceive it to be a way of keeping with the *Sunnah* (custom and practice of the Islamic community).' Furthermore, CEFM is reinforced by the CMPL in BARMM, where girls can get married at the onset of puberty. In Caraga, where the legal age of marriage is 18, girls are still forced to marry their sexual partners after a period of living together.

While adolescent girls are sanctioned once their sexual activities and pregnancy are known, in Caraga it is becoming more acceptable for young couples to live together (live-in) in the event of pregnancy. In some instances, participants shared that this provides women and girls with more time to think before getting married.

40 Anderson et al., 2013, p. 5.

1.5. NORMS AROUND FAMILY PLANNING: PARENTS SHOULD AND TYPICALLY DO DECIDE FOR YOUNG PEOPLE.

Strength: **Strong**

In BARMM, participants shared that parents not only should, but typically do, decide when and to whom their children get married and they make decisions related to FP. This norm is reinforced by the *RH Law*, which requires minors to acquire parental or guardian consent before accessing SRH information and services. A service provider in BARMM explained: 'I think they didn't need that consent before. Now, for those below 18 years old [even married], they have this consent paper that needs to be signed should they apply for family planning.'

While parental/guardian consent is required by the law, some key influencers exhibited positive deviance by supporting couples to make their own decisions. For instance, a Muslim religious leader in Marawi City shared, 'Kids may seek help from the parents on which decision is better, but the couple will still have to decide in the end if they wish to go for it or not. My daughter doesn't want to be like me who had a lot of kids.' This behaviour helps challenge norms regarding parents' influence on the FP of young people.

NARRATIVE 2: Gender norms around ideal men/women and FP decision-making

The second dominant narrative to emerge from the findings across both regions relates to participants' traditional notions of masculinity and femininity. 'Ideal' women are described as submissive and nurturing homemakers and girls as obedient and decent, while men are seen as strong, decisive, and ultimately responsible for providing economic and financial security for their families.

Women and girls seen to transgress these norms faced strong social sanctions, including divorce by their husbands and families forcing girls into marriage. Rooted in existing systems of power and patriarchy, these inequitable gender norms also translate into women having limited control over their labour, bodily integrity, and FP decision making. Four norms were diagnosed in this narrative.

2.1. WOMEN SHOULD BE SUBMISSIVE AND NURTURING, AND LOOK AFTER THEIR CHILDREN AND HOME; MEN SHOULD BE STRONG AND DECISIVE AND PROVIDE ECONOMIC AND FINANCIAL SECURITY.

Strength: **Strong**

Key gender norms around ideal characteristics, and roles and responsibilities for men and women arose from the discussions in both BARMM and Caraga. Ideal women were characterized as submissive, emotional, obedient, nurturing, with their primary responsibility being to look after their children and home. Ideal men were described as strong and decisive, primarily responsible for providing for their families, and as ultimate decision-makers in their households. Ideal girls and boys were similarly described as being obedient to their parents and respectful. However, ideal girls were often characterized as being emotional ('crybabies'), whereas this was seen as an unacceptable trait for boys, suggesting discriminatory notions of masculinity and invulnerability. Additionally, it was specifically noted that 'girls should not have boyfriends,' whereas this was not a stated expectation of boys.

2.2. MEN SHOULD AND TYPICALLY DO DECIDE ON FP USE.

Strength: **Medium**

A key norm held by men, health service providers and, to a lesser extent, women in Caraga and BARMM, is that men should and typically do make decisions on FP, which prevents women from exercising control over their SRH. Although it was sometimes noted that decisions related to FP should be made by both men and women, men were seen as the ultimate authority. In Lanao del Sur,

BARMM, when asked what would happen if women decided to go to the health centre without their husband's permission, strong social sanctions were noted, such as 'separation, the man must be mad.' On the other hand, in the event that men would go against women's FP preferences, women were said to 'have no choice.' CEFM was noted as a key factor exacerbating these unequal power dynamics that limit women's and girls' influence over FP decision making.

This norm was also held by duty bearers in BARMM. Despite the law stipulating that FP services and information can be provided to women over the age of 18 without the consent of family members, in Lanao it is common for health service providers to ask for the consent of the husband. 'For the girls, when they visit health centres, they need to come with their husband. The consent of the husband is [needed],' an Oxfam partner explained.

Moreover, if a woman decides on FP methods, she and her husband face social sanctions from community leaders. A male community leader from Caraga shared, 'I would say he's "under the *saya*" (henpecked husband) [laughter]. He couldn't contradict his wife's decision.'

For the community members in Caraga, norms around FP decision making are shifting particularly among the youth: 'Today's generation is different. There are certain laws and information… before women were scared of men.' It was also shared that a woman's decision over her own body is important: 'I think the woman should decide because she will ensure her health.'

2.3. NORMS AROUND DOWRY THAT TREAT WOMEN AS A COMMODITY.

Strength: **Medium**

In BARMM, participants shared that men give the dowry to the woman before marriage and prices are typically negotiated by the family depending on the woman's status. As one participant said, 'the bigger the dowry, the more valuable the wife is.' A key norm that emerged was that in exchange for the dowry, women are expected by both families to relinquish control over their labour, bodily integrity and decision making.

A participant from BARMM shared,

> Although the man was much older [than the woman], the parents approved [the marriage]. Then he did not get her virginity. For more than a month, [she] ignored her husband. She just said, 'I'll return the dowry, I'll return the expenses.' It's like that. If the woman doesn't agree [to have sexual intercourse], the dowry will be returned.

Interestingly, in the sense-making workshop, men disagreed that this was a negative norm. For them, dowry is part of the ritual and is not harmful. On the other hand, women agree that the norms around dowry are harmful to women.

The conflict in BARMM has strengthened gender norms around the lower value or worth of women and girls as compared to men and boys, related to the practice of dowry. An Oxfam partner shared, 'In Maranao, dowry is really expensive. But after the [Marawi] siege, it has become a joke for the men that women can be purchased 3 for 100 [pesos].'[41] This is due to severe conditions in the region, especially the lack of access to food and shelter. In this case, conflict was seen as a driver of negative norm change, exacerbating conditions of women and girls from poor households.

2.4. POLYGAMY IS COMMONPLACE WHEN WOMEN CANNOT BEAR CHILDREN.

Strength: **Strong**

In BARMM, participants noted that polygamy is common and an acceptable sanction towards women who cannot bear a child. Men, as well as the wider community, primarily blame women when a couple is unable to bear a child. A service provider in Lanao shared, 'There's one couple, she tried her

41 100 Philippine pesos are equivalent to $2.50 CAD.

best to get pregnant but she couldn't. So, when they broke up, the community blamed her because she always prioritized her career.' When childbearing is not possible for a couple, the husband is entitled to look for another woman to marry, and hence, polygamy becomes a sanction. In the sense-making workshop, a male participant shared that this is not a sanction but a religiously driven practice, howeverr female participants agreed that it is a sanction.

While polygamy is common in BARMM, it is no longer being practiced in Caraga due to the *Revised Penal Code* of the Philippines. A female participant from Caraga said, 'Before [men] could marry two to three wives. But today, this is no longer allowed [by the law]. We already know that having more than one wife is adultery, and it is prohibited. Religion is also an influence on why tribal people no longer practice having more than one wife. Many cultures now have changed.' However, when couples were unable to have children, women are still seen by the community as the one primarily responsible.

2.5. LOVE MARRIAGE AS A POSITIVE DEVIANCE IN FP AND DECISION-MAKING.

Strength: **Very strong**

In BARMM and Caraga, it was shared by participants that husbands are more willing to listen to their wives and make joint decisions related to FP when a couple gets married out of love. A community member from Lanao, BARMM shared, 'If they love each other, of course the woman would ask, she will ask to the man, "how many kids do you want?" But if they don't love each other, only the man is decisive, the man only.' Love marriage provides women the power over her own decisions, including FP.

A female respondent from Agusan shared, 'My husband is my first love. I am not arranged'. More and more women are becoming decisive of whom and when to marry. A female religious leader from Lanao shared, 'It was because they already saw what happened before. Kids married at a young age don't get along well.'

Furthermore, in some cases CEFM is seen in a negative light. 'At present, when parents push their children in early marriage, they destroy their children's future,' a community member from Maguindanao shared. However, the recognition that love marriage is a positive deviance doesn't undermine the reality that women and girls are still vulnerable to violence, whether the marriage is forced or out of love.

NARRATIVE 3: FP and contraceptive use

While the provision of contraceptive methods, both traditional and modern, have been mandated by the *RH Law* and other national and local level policies to ensure universal access to SRH services, the demand for, access to, and use of FP services and contraception is limited due to norms around fertility and condom use, family size and modern contraceptives. In BARMM and Caraga, four norms were identified.

3.1. FERTILITY NORMS SYNONYMIZE MARRIAGE WITH CHILDBIRTH: A WOMAN SHOULD GIVE BIRTH RIGHT AFTER HER MARRIAGE.

Strength: **Very strong**

In BARMM and Caraga, a majority of both men and women stated that women should give birth right after marriage. A male community leader from Caraga shared, 'If you decided to get married, you should be ready to have children. If you still don't want to have children, you better not marry.' A female respondent in Lanao, BARMM had similar views: 'Pregnancy... would be the direction anyway [after marriage].'

Furthermore, participants shared that married couples using contraceptive methods before having their first child was considered unacceptable, citing religious reasons. A female government leader from BARMM said, '[Contraception] prior to first pregnancy is prohibited in Islam. If you want to use contraceptives, you should give birth first then

use birth spacing. But it is forbidden for us to have FP. It is haram,' revealing how conservative religious beliefs are often used to justify this norm.

Across the regions, some married women and girls are deciding when to have a child and do not give birth right after marriage. During the sense-making workshop a male leader from BARMM shared, 'There are empowered married women who prioritize their studies and career before having a child.' Also, while having a child is expected right after marriage, there are parents who are positive exceptions, listening to what their children want to do before having a child.

3.2. FERTILITY DESIRES AND PROCREATION: A LARGE FAMILY SIZE IS COMMON AND SOCIALLY DESIRABLE.

Strength: **Strong**

In BARMM and Caraga, it is expected and accepted for couples to have large family sizes regardless of socio-economic status, age of women, and health consequences. In Caraga, there is a strong descriptive norm that most people have large family sizes. Participants from Caraga shared that in their communities, large family size (even up to 10 or more) is common and is referred to as *'do-re-mi'* or bearing children one after another without spacing. Representatives from the Regional Health Unit in Lianga shared that couples would not plan at all, which was articulated as 'come what may.' According to a *datu* (community leader) in Cagwait, having many children is accepted in the community, even if living in poverty. He explained, 'In our community, some would say, "If a worm is able to live, how much more a human who has hands and feet. All you need is hard work and perseverance."'

In BARMM there is a strong injunctive norm that couples should have large families and it is desirable to do so. This is further reinforced and shaped by socio-political factors, such as strengthening family ties and political standing, as well as religious beliefs (see next section on influencing factors). Maranao participants in Lanao said they were expected by their family and wider community to 'multiply.' For them, the more family members a clan has, the more voters they can have, which will ensure their political power in the province.

As a result of improved access to education, participants shared that people are beginning to learn the practical challenges of having many children without spacing and some couples have started using contraceptive methods. In Caraga, through the active advocacy campaign of the government institutions led by the Department of Health (DOH), Commission on Population (PopCom) and civil society, couples have started to use modern methods, such as IUD, pills and implants. An Indigenous leader from Caraga shared, 'Before, the concept of family is having a lot of children, the better. Now, the wellness of the mother is being considered [and] the idea of a better future.'

In BARMM there is evidence that this descriptive norm is weakening, although slowly. A duty bearer from BARMM shared, 'We are eight siblings in the family. But our view in the past was different. We have smaller families now.'

3.3. CONTRACEPTION AND BIRTH SPACING SHOULD NOT BE USED AS THEY ARE UN-ISLAMIC, AND AN INTERFERENCE WITH GOD'S WILL.

Strength: **Medium**

In BARMM, a strong norm hindering the use of contraceptives that is upheld by conservative religious beliefs is that they are un-Islamic and interfere with God's will. An *Iman* (religious leader) stated, 'If you are using a condom and pills for the women, you're like a murderer that kills millions and millions of human beings. It is not allowed to use contraceptives in Islam. You would have a sin to God. You'd die. That's your punishment.'

A community member also cited this conservative religious belief as a reason for disagreeing with contraceptive use: 'I have a cousin who wants birth spacing. She got sick after that. Her husband

got mad because she is taking over the decisions instead of letting Allah do it.' This, however, goes against the progressive *fatwa* supporting the use of contraceptive methods that religious leaders noted some are following. During the sense-making workshop, male participants from BARMM disagreed on the prevalence of this norm because of the *fatwa*, while female participants agreed that the norm was still widely held.

3.4. CONDOMS SHOULD NOT BE USED AS THEY DO NOT SEXUALLY SATISFY MEN.

Strength: **Strong**

Across the region, a strong social norm was rooted in men's sense of sexual pleasure and entitlement; condoms were seen as an unacceptable form of contraception because 'they don't satisfy men.' A respondent from BARMM shared, 'The community tells him don't use a condom, because like eating you won't be able to savour its real taste'. Among couples who use modern methods of contraception, women use pills or IUD, putting the sole burden of contraceptive use on women. This norm is also being justified using conservative religious beliefs fuelled by misinformation that men can get an illness from condoms. As a male respondent from BARMM shared, 'In Islam, men are not allowed to use condoms. The story is that millions were killed [by them].'

While the use of condom is not accepted across the region, there is evidence of norm change among the younger generation of men with working wives. A female service provider from BARMM shared, 'There are also men whom I have interviewed who want to use FP methods. They are already the ones initiating or inquiring about it, such as about the use of condoms. They really want to.'

NARRATIVE 4: VAWG as an acceptable response to women who are transgressing their roles

Supplementing the second narrative on gender norms around gender roles and FP, the fourth narrative reveals how VAWG becomes an acceptable response to women who transgress their roles by seeking FP services without their spouse's consent or by refusing sex.

4.1. MEN CAN ABUSE THEIR WIVES IF WOMEN SEEK FP SERVICES OR ADVICE WITHOUT THEIR KNOWLEDGE OR PERMISSION

Strength: **Medium**

Participants shared that domestic violence was seen to be an acceptable punishment in the community for women who defied the gender norm around men's decision-making authority over FP, by seeking advice or services without their permission. A male government leader from BARMM explained, 'It will lead to domestic violence because it is still not accepted. It is okay to use contraceptives, but in our culture, women are prohibited without permission from their husbands.'

4.2. SEXUAL ASSAULT AND MARITAL RAPE ARE AN ACCEPTABLE BEHAVIOUR BY MEN IF THEIR WIVES REFUSE TO HAVE SEX WITH THEM.

Strength: **Medium**

In both regions, women and girls shared their own and others' experiences of assault upon refusing to have sex with their partners. A female participant from Caraga shared an incident she had witnessed: 'One early morning, the wife came out with only a towel. She refused to have [sex] with her husband and was punched by her husband on [her breast and vagina]. I asked her, "What happened?" She replied by showing me her bruises.'

Photo credit: PB Miranda – Oxfam 2019

A male tribal leader from Caraga also explained,

> Actually, having a family is not the first thing we were thinking about when we decided to get married. It was our sexual urges… Sometimes force is inevitable when the man can't get what he wants. But the usual reason why couples fight, based on the cases reported to us, is her refusal to have sex. I think that's the primary reason for domestic violence.

In the sense-making workshop, both men and women disagreed with norms around marital rape as accepted behaviour. For them, there is no rape between couples because women should always respect and fulfil their husbands' wishes. However, when asked whether a woman who wants to refuse sex, but cannot, would feel violated, female participants agreed. A female service provider in BARMM shared, 'Women don't know that there is such thing as marital rape, right? Because what men say is that women should be submissive for you to reach heaven. So even if the woman is already tired, she will still force herself [to submit to her husband].'

Girls who have experienced CEFM are even more vulnerable to violence, as they tend to have limited knowledge of their SRHR, and less power and control than their husbands. In cases of CEFM, women and girls are more vulnerable to domestic violence, which, in some instances, are even supported by the girl's family. A female service provider from BARMM who experienced CEFM shared that after their wedding, she was forced to sleep with her husband: '[My father would lock our door]. My husband and I didn't even know each other's names – you should know each other! I felt the chills when we shared the bedroom for the first time.'

4.2 INFLUENCING FACTORS

The social and gender norms described in the previous section are further exacerbated or challenged by six influencing factors at the material, institutional, social and individual levels.

CONFLICT

Participants shared how conflict leads to greater incidences of early marriage and early pregnancy in their communities. In BARMM, there are some cases where families would resolve conflict through the marriage of their children. For example, when a family discovers that their child is pregnant, marriage would be a way of avoiding *rido* (violent inter-family or clan conflict). A community member from Lanao shared, 'We need to be calm so there would be no *rido*. They should be married immediately.' This supports the norm around early marriage, wherein CEFM becomes an acceptable sanction towards adolescents who get pregnant or are sexually active.

In both BARMM and Caraga, there is an entrenched and persisting conflict. Participants highlighted the effect of the 2017 Marawi Siege (in BARMM), the bloodiest and most destructive military operation since the World War II that displaced 98% of the area population.[42] Participants shared that due to the siege, an increase of early marriage in Lanao occurred. Girls and boys marry to have a green card, which serves as a requirement to be registered in the list to receive aid. As the displaced population resort to marriage as a perceived solution to the impact of conflict, negative norms associated with CEFM are also reinforced. There is also limited availability of SRH services as a result of the conflict.

On the other hand, participants reported that the conflict had resulted in more active contraceptive use, as couples recognize the risks involved with having children given the unstable environment.

As a respondent from Caraga shared: 'It is very difficult to have many children at the height of armed conflict, where many are displaced... I think it is very important to have [FP].'

POVERTY

In both regions, poverty drives CEFM and hinders access to SRH information and services. While CEFM is seen primarily as a sanction against women and girls who are sexually active or pregnant, it is also being driven by economic challenges as parents marry off their daughters as a way out of poverty. As a service provider from BARMM shared, 'There are practices where a parent will submit their children for early marriage to lessen the financial burden of the family.' In the process, the young wife will face further negative norms as she builds her family life, particularly through the transactional nature of the dowry system.

Moreover, poverty also exacerbates norms that hinder access to SRH information and services. Those with resources can visit doctors, but poor communities face difficulties in accessing needed services, especially those living in remote areas with limited SRH services available.

RELIGION

In BARMM, different ethnic groups (Maranao in Lanao; Maguindanaon in Maguindanao) and individuals interpret Islam differently. In terms of access to SRH information and services, some community members and religious leaders share fundamentalist and conservative beliefs, while others hold more progressive views. A participant from BARMM shared, 'I do not believe that birth-giving must be controlled. The couple must not have control because it's in the Koran.' This individual insight is a conservative interpretation of Islam, which aims to justify the restricted access to SRH information and services.

Despite the different interpretations of Islam by the individuals and the ethnic communities, participants would frequently state that their practice of Islam is based on Koran, and not an individual or a particular community interpretation.

42 Fonbuena, 2018

EDUCATION

Across both regions, education plays a big role in challenging norms around early marriage, contraceptive use, and decision-making. For example, those who go to schools tend to prioritize their career goals and prepare for the future before entering marriage. An Oxfam partner for BARMM, the Al-Mujadilah Development Foundation Inc (AMDF), explained that better access to education has led to a decrease in CEFM in their area. A community leader from Caraga also shared, 'If the children are preoccupied with something to do like going to school, most likely they won't think about getting married at an early age. But if they are bored, they would likely consider to get married.' Moreover, education empowers women and girls to decide on their bodies.

TECHNOLOGY

According to the participants in BARMM and Caraga, technology can serve both as a beneficial and harmful tool for norm change. From a positive lens, a community member from BARMM explained how technology could be an educational tool that gives people a wider perspective:

> With technology, practically speaking, parents want their children to be well educated for them to get prepared in their personal lives, like getting married. Nowadays, it is commonly shown on TV how women are burdened. Women want knowledge and education so that when they are no longer together with their husband, they have stable work and can defend themselves.

On the other hand, it is important to understand how technology affects people's lives and how to use it effectively to challenge negative norms that hinder SRHR. For instance, 'fake news' or misinformation about contraceptive use is rampant in the community, according to a service provider from Marawi City, BARMM.

4.3 INFLUENCERS

Participants identified five key influencer groups, whose opinions matter most to people in the community, and who influence decisions related to access to SRH information and services, contraceptive use, marriage, pregnancy, and VAWG. The degree and nature of each group's influence are discussed below.

PARENTS

Across the region, parents play a significant role in their children's decision-making on marriage and family life, including the marriage arrangements, childbearing, and the contraceptive methods to be used.

CEFM is driven by parents and not the children themselves. A participant from Caraga shared, 'For me, children are obliged to follow their parents because they fear that their parents might get mad at them. Even if they do not like each other, they have no choice but to [marry and] grant their parents' desires.' Moreover, parents exert a strong influence on their children's decision-making after marriage because, according to a participant from BARMM, 'In our culture, even if you already have a spouse, you still need to [listen to] your parents… they are more knowledgeable.'

RELIGIOUS LEADERS

In BARMM, Muslim religious leaders highly influence community members' decisions involving SRH information and services, and contraceptive use. According to a male participant from Lanao, 'Because the *ulama* (Islamic scholars) said it, this is the truth.' Muslim religious leaders can play a greater role in guiding decision-making with regards to SRH and contraceptive use than service providers who are trained to advise on such matters. When asked about religious leaders, a female service provider explained that 'they are more influential [on FP]. The health workers just advise about what should be done to improve reproductive health.'

Photo credit: April Bulanadi – Oxfam 2019

Moreover, in the role-playing around VAWG in the FGDs, participants shared how issues related to domestic violence are resolved through the advice of religious leaders. Even after seeking guidance from family, community leaders, teachers and service providers, the participants ultimately listened to the *ulama*.

FRIENDS

In BARMM and Caraga, where women and girls are not free to discuss their SRH experiences with their parents, they often turn to trusted friends. A female service provider from Caraga shared, 'A girl couldn't tell her parents about what she wants. She will tell it to her close friends. Usually, her peers will influence her.' However, more often than not, their knowledge on SRH is limited as young people in general have limited access to SRH information and services.

DUTY BEARERS AND SERVICE PROVIDERS

Duty bearers and service providers influence SRH decisions of the community, both in Caraga and BARMM. While some of them hold institutional norms that hinder access to SRH, particularly towards young people, some also support the provision of SRH information to young people. A female service provider from BARMM shared, 'I believe that it is important to engage adolescents and educate them about SRH.' Their work and encouragement to use SRH services in the community, including among young people, is vital to challenge the negative norms and to increase access. A female service provider from Caraga said, 'In our community, we do not have any knowledge. The factor that could [improve this] are *barangay* (village) health workers.'

TRADITIONAL LEADERS

In Caraga, the influence of traditional leaders has diminished throughout the years due to the integration of settlers from other parts of the country into Indigenous communities in Mindanao. However, according to a participant from Maguindanao, their influence remains in BARMM: 'There are *datu* (leaders) in the past who arranged their children for early marriage so that they can multiply.' Similarly, male participants insisted that 'to be considered great and powerful, the tribe leader should have plenty of children.' This demonstrates how the childbearing practices and beliefs of traditional leaders have a significant influence on communities.

A tribal leader shared that traditional contraceptive methods have always been practiced in their community: 'There's a natural way for the couple not to have a child. A masseur can massage the belly of a woman or give her herbal medicine to prevent her pregnancy.' That such an FP practice exists facilitates the acceptance of other FP methods introduced by the government. However, some would insist that this traditional method is more effective and believe that modern methods that come from outside their communities have adverse side effects.

BUILDING STRATEGIES FOR NORMS CHANGE 5

As explained in this study, social norm change is critical to ending CEFM and VAWG, and to increase access to SRH information and services; women and girls who are knowledgeable of their SRHR and have access to services can avoid the risks and threats of further vulnerabilities and violence. This section shares opportunities for social norm change, according to the research findings and the strategies adopted by the *Creating Spaces* and *SHE* projects.

5.1 PROMOTING POSITIVE NORMS

To build strategies for norm change, research participants and Oxfam partners, UnyPhil and AMDF, identified the key norms that are most influential. Four key norms were identified by both groups (males and females), and these were ranked in terms of influence based on criteria detailed in the Annex. These key norms fall under the four major narratives, are connected, and reinforce each other:

KEY DISCRIMINATORY NORMS

1. Sexuality and chastity: women and girls (even men and boys) who engage in sexual activities before marriage are immoral
2. CEFM as a sanction for adolescents who get pregnant or are sexually active
3. Women and girls who experienced CEFM are more vulnerable to VAWG
4. Fertility norms synonymize marriage with childbirth: a woman should give birth right after her marriage

Love marriage was also highlighted as a positive deviance that has influence in challenging these norms.

POSITIVE NORMS

The participants then collectively strategized on how to foster social norm change. Oxfam staff and partners flipped the negative norms into positive norms and designed the following key messages:

1. Child marriage and teenage pregnancy harm your health.
2. *Aral, hindi kasal.* (Education not marriage)
3. Child marriage exposes girls to higher risk of violence.
4. A woman has the right to decide when she wants to get married and when she wants to have children.
5. 'I must be able to choose when to get married and to whom.'
6. *Sa pagsasamang may respeto, madali ang pagpaplano.* (Respect within the relationship is key in FP.)

Following this study, these messages should be tested for their effectiveness among target audiences in the communities, and then improved accordingly to be used for community advocacy and campaign activities.

5.2 THE ROLE OF INFLUENCERS IN CHANGING NORMS

Participants shared recommendations on how norms can be shifted by identifying the role of influencers, and connecting with positive outliers, individuals and groups. As Heise and Manji (2016, p. 2) noted, 'To shift social norms, interventions must create new beliefs within an individual's reference group so that the collective expectations of the people important to them allow new behaviours to emerge.'

PARENTS

As children lack awareness of the consequences of their actions, including sexual engagement, opening up with their parents will be helpful in addressing the risks of early pregnancy that may lead to CEFM. 'Parents should let their children open up to them and share their experiences,' UnyPhil staff shared. The Oxfam *Creating Spaces* project activities on family conversations, which are being implemented in BARMM, may help strengthen discussions on SRHR and on the discriminatory norms identified.

Parents and especially fathers who exhibit positive deviance with respect to CEFM, contraceptive use, and women's SRHR, could be supported to promote their beliefs to challenge negative norms within their communities to make visible the changes that are happening (addressing descriptive norms) and the benefits of defying norms (addressing injunctive norms). Young males and females whose beliefs challenge gender and social norms could also be empowered through greater awareness raising, education, and the consistent access to information on SRHR.

RELIGIOUS LEADERS

The *fatwa* that encourages access to SRH information and services was signed in 2003, and yet many Muslim religious leaders are not aware of it. Oxfam partner AMDF recommended that service providers share their knowledge of SRH with progressive religious leaders as an entry point into the religious community. Positive deviance among Muslim religious leaders is vital in changing norms and behaviours in communities where their opinions and advice matter. Identifying positive deviance among religious leaders and linking with them could be a pathway to norms change. These progressive religious leaders could be mobilized to educate community members and positively influence conservative, influential religious leaders.

FRIENDS

Given that children and youth will mostly open up about their SRH experiences to their friends, it is important to address the lack of SRH knowledge through peer-to-peer activities involving young people. When young people become knowledgeable of their SRH, the negative consequences associated with sexual engagement can be mitigated, such as early pregnancy that can result in CEFM.

DUTY BEARERS

There are laws in the country that ensure universal access to SRH information and services, such as RH Law, Anti-VAWC Law, and the Magna Carta of Women. Duty bearers and service providers should be held accountable to implement these laws. They also require more education on how discriminatory gender norms impede on the full implementation of these laws. Building networks with duty bearers and sharing information on SRHR, CEFM and VAWG is essential to building strategies on norms change.

TRADITIONAL LEADERS

Traditional (tribal) leaders are part of Consultative Advisory Bodies (CAB) headed by the Department of Education for the implementation of the Indigenous People's Education Program. As members of the CAB, they address issues concerning youth in community schools. Concerns about SRHR, CEFM, and VAWG should be shared with this group.

5.3 SHIFTING NORMS AROUND SRH INFORMATION AND SERVICES, CEFM AND VAWG

In order to reduce CEFM and VAWG, and increase access to SRH information and services, *Creating Spaces* (CS) and *SHE* projects implement strategies to shift social norms that sustain these practices through changing people's attitudes, beliefs, norms, and behaviours. The projects engage key community actors to promote positive gender norms.

CS has engaged national legislators in proposing to amend the CMPL, stipulating that the marrying age across all communities and religions should be 18 years old and above. The projects engage duty bearers and service providers to ensure that the laws and policies are fully implemented to promote the rights of women and girls. The projects also mobilize youth leaders, women and girls, and men and boys to raise awareness within their communities on the consequences of CEFM and VAWG, and to promote SRHR. *Creating Spaces* partners also conduct family conversations so that young people and parents can openly discuss SRH experiences. Lastly, they engage media and disseminate messages that will promote positive norms. The purpose of this study was to build on the existing CS and *SHE* project efforts and strategies for social norm change through a better understanding of the most relevant social norms and influencers to focus on to promote SRHR, and challenge CEFM and VAWG.

Photos credit: Vina Salazar– Oxfam 2019

6 CONCLUSION

The Philippines was ranked eighth in the 2018 Global Gender Gap Report, which calculates the gap between women and men in four key areas (health, education, economy and politics) to gauge a country's state of gender equality.[43] One of the attributes of this high ranking is the number of laws and policies in the country that promote women's rights; this includes access to SRH as well as the elimination of VAWG. However, years after the enactment of these laws, enforcement remains weak. This report demonstrates that having these laws in place is not enough to ensure women's and girls' rights, including SRHR, because of persevering discriminatory social norms held by community members and duty bearers who play a key role in implementing the laws.

This research sought to shed light on social norms and other factors that influence the extent to which girls and women in BARMM and Caraga, particularly those subjected to CEFM and VAWG, are able to access SRH information and services. It revealed the shared beliefs, attitudes and perceptions embedded in but also challenging existing systems of patriarchy and unequal power relations in BARMM and Caraga. It was able to bring to light new evidence of the lived realities of women and girls living in BARMM and Caraga using an innovative Social Norms Diagnostic Tool, and by applying a gender-transformative research methodology grounded in feminist principles which saw participants not as passive participants but as active agents of change. The participants identified 15 discriminatory social norms that were diagnosed, articulated, and unpacked for the first time within BARMM and Caraga, to demonstrate how they hinder SRHR and perpetuate CEFM and VAWG. One of the strongest and most prevalent norms informing the behaviours of communities as well as service providers in a way that restricts women and adolescent girls access to SRH information and services was that women and girls who are sexually active before marriage are 'immoral'. Across both BARMM and Caraga, participants also shared how child early and forced marriage was seen by parents to be an acceptable response to finding out their children have been sexually active and especially in the event of adolescent pregnancy. Fertility norms were also widely held where participants in both regions felt that couples should have children right after marriage and that larger families are common and socially desirable. The report also highlights how these norms also interact with and are reinforced or weakened by a range of influencing factors including conflict, poverty, conservative religious beliefs, education and technology.

The research also provided insights into positive outliers and allies representing key opportunities for norm and behaviour change. These include for stance progressive religious leaders in BARMM who don't share this belief and are supportive of contraceptive use as well as younger men who are more supportive of sharing family planning decision-making and using contraceptives such as condoms.

The research methodology and findings contribute to the *Creating Spaces* and *SHE* projects and other similar initiatives in the conflict-affected areas of BARMM and Caraga that seek to shift harmful social norms. We also hope the evidence will enable or inspire other organisations seeking to design SRH or VAWG prevention strategies, particularly in conflict-affected contexts, to embed a social norms approach. For sustainable and transformative norm change, SRH interventions must be embedded in an evidence-based understanding of existing norms, who influences them and how they can be challenged . We also hope these findings and the research methodology will inspire further normative research following a feminist participatory approach which leverages the collective engagement of researchers, duty bearers, women's rights advocates, community leaders, women and girls, and other influencers are encouraged.

43 World Economic Forum, 2018

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ANNEXES

A. RESEARCH PROCESS

PROCESS AND TIMELINE	KEY RESULTS
Literature and Data Review: January to April 2018	Social norms and other factors that influence SRHR, CEFM and VAWG were reviewed and analyzed. The review identified the research focus and knowledge gaps.
Design of research tool: May to June 2018	Partners shared their inputs in the Social Norms Diagnostic Tool and suggested mechanisms on how it will be delivered effectively. The content of the tool was translated into local languages and a delivery guide was created.
Preparation for data collection: June to July 2018	Training of field research team ensured that the team thoroughly understood the research objectives and content. Research ethics were also discussed during the training to ensure that the team abided by the international and national ethical guidelines as well as Oxfam safeguarding policies. Participants in the participatory exercise were identified by Oxfam partners and the field coordinator.
Data collection: August to October 2018	In the participatory exercise, two facilitators took the lead in delivering the tool, and they were co-facilitated by Oxfam partners. The data collection was performed in local languages and ensured cultural sensitivity. Informed consent was drawn from the participants. For those who are below 18 years old, informed consent was signed together with parents/ guardians. Confidentiality and anonymity were ensured to the participants.
Data encoding and analysis of data: November 2018-March 2019	A thorough reading of the transcript was done to see patterns and trends that emerged and these were initially coded manually. The data was coded with the support of computer-assisted qualitative data analysis software, NVivo Pro 2012. In examining and analyzing the codes and its relationship with each other, fifteen norms that hinder access to SRH and perpetuate CEFM and VAWG were diagnosed.
Sense-making Workshop: April 2019	Nine out of 78 participants of the participatory exercises in BARMM and Lanao were chosen to participate in the sense-making workshop based on their diverse background, with a particular attention to religious and traditional leaders, service providers and young people. Partners from AMDF and UnyPhil also participated in the workshop. Participants ranked the norms based on their influence and relevance to the *Creating Spaces* project. They also identified how norms can be changed, and the roles of the influencers in building strategies for change.

B. NORMS RANKING

QUESTIONS	HIGH	MEDIUM	LOW
How widely accepted is this social norm in BARMM? Does an average person in BARMM follow this norm?			
How much of an influence does this norm have on women and girls' demand for/ ability to access SRH?			
How much of an influence does this norm have on the behaviour of reference groups?			
Do people in BARMM personally believe this to be true but still behave in a way that contradicts their belief?			
How strong is the 'punishment' for violating the social norm? Does the person who goes against the norm face a backlash?			
How realistic and achievable would it be to mobilize communities across different contexts to shift this norm successfully?			
How easy would it be to involve a range of stakeholders in shifting this norm?			
How critical is addressing this norm to ending CEFM and VAWG?			

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