STRIVE
Tackling the structural drivers of HIV

Social norms

TECHNICAL BRIEF
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What is the issue?

A number of structural inequalities and harmful practices are associated with increased HIV vulnerability. The concept of social norms provides a way to understand what sustains these practices and structures. By addressing problematic norms, it is possible to challenge these structures and thus reduce HIV risk.

Social norms, especially gender-related social norms, can sustain harmful practices and unjust relations, with serious effects on people's health. Gender-related social norms define what is expected of a woman and a man in a given group or society; they are both embedded in institutions and nested in people's minds. They play a role in shaping women's and men's (often unequal) access to resources and freedoms, thus affecting women's and men's voice, agency and power[1]. Empirical evidence suggests the influence of social norms on various health-related actions (drinking alcohol[2], condom use [3], child marriage[4], sexual violence [5] and intimate partner violence[6]). Structural drivers of HIV are influenced by (and influence) social norms. The STRIVE consortium examines the ways in which norms intersect with other drivers and health-related issues in low and mid-income countries to increase the risk of HIV infection.

DEFINITION

In STRIVE's work to conceptualise social norms and how they operate, the consortium has adopted this definition:

Social norms are one's beliefs about:

1. what others in one's group do, and

2. the extent to which these others approve of something.

These beliefs influence people's actions and decisions, including those that affect their own and other people's health.

Because they operate at a population or community level, there is a comparative advantage for the HIV field in working on social norms. Interventions that seek to change relational practices might fail if they target individuals in isolation. By contrast, social norms offer a framework that can be operationalised to achieve change in collective practices, where these changes require shifting shared beliefs and actions. Substantial evidence demonstrates that social norms can specifically influence a variety of HIV-related behaviours. Prior research on HIV and social norms has mostly focused on four aspects of the norms/HIV nexus:

- condom use and sexual risk behaviour,
- drug injection and needle sharing,
- willingness to seek HIV testing, and
- access to and response of health services.

However, norms can also influence upstream factors that affect individuals' vulnerability to HIV, including:

- women's ability and willingness to leave abusive relationships,
- the ability of young people to resist alcohol advertising and promotion,
- the degree to which girls receive parental support to complete secondary school, and
- the impact of stigma on individuals' willingness to disclose their status.

What have we learned?

Social norms are unwritten rules that regulate acceptable behaviour in a group. Certain norms can increase HIV-associated risk, as well as other sexual outcomes. They can, for instance, increase risk of transmission by reducing condom use, or increase vulnerability by increasing likeliness of sexual violence. Conversely, taking norms into account can increase intervention effectiveness, for example by working to encourage a shared sense that protective practices are acceptable and appropriate in a particular group or society.

Where social norms intersect with other HIV-related factors, effective interventions should integrate a norms perspective in their implementation toolkit. Not all norms are equal, however: they can have different strengths as they intersect with these other factors.

The STRIVE research consortium concludes that, rather than designing interventions that exclusively target social norms, designers of programmes and study interventions should dedicate time to understanding in-depth the social and cultural context and, from there, help people devise strategies that integrate an appropriate normative component when necessary.

1 **Key finding:** Social norms are unwritten rules that regulate acceptable, appropriate and obligatory actions in a given group or society.

In order to understand and, ultimately, shift harmful social norms, a shared, standard definition is necessary. STRIVE has worked to conceptualise what social norms are and how they operate.

Social norms are unwritten rules that regulate behaviour in a group. Certain norms, especially gender-related social norms, can sustain harmful practices and unjust relations with serious effects on people's health. Social norms can increase HIV-associated risk as well as other sexual outcomes. They can, for instance, increase risk of transmission by reducing condom use or increase vulnerability by increasing the likeliness of sexual violence.

Many definitions of social norms exist in the literature. The definition coming from social psychology – norms as belief about others – seems helpful for practitioners designing and implementing health promotion interventions.

STRIVE has adopted this definition: Social norms are one's beliefs about what others in one's group do, and the extent to which these others approve of something. These beliefs influence people's actions and decisions, including those that affect their own and other people's health.

People comply with social norms for several reasons, and no single theory or explanation can address all of them. Key reasons for compliance include:

- the desire to obtain social rewards and avoid punishment,
- the desire to be part of a group, and
- coercion into compliance by power-holders.

Theories of social norms offer several explanations of how norms influence behaviour. Much current work in social norms theory posits sanctions as the primary motivator. That is: people comply with the norm because they anticipate social rewards for doing so and social punishments for not complying. But many pathways to compliance exist. In a review of the social norms literature, Bell and Cox[11] identify four such motivations:

1. uncertainty (e.g. I don't know how to act, so I mimic what others do)
2. identity (e.g. I show membership in a given group by adopting their rules)
3. reward (e.g. I seek social rewards and try to avoid social punishment by complying with the norm);
4. enforcement (e.g. I am forced to comply with the norm)

Existing evidence

Many different theories of social norms exist, scattered across a number of disciplines and offering varying definitions. In the past, social norms have been understood as clusters of attitudes (the 'sum' of the personal attitudes that members in a group hold). Another strand of literature suggests , instead, that social norms are people's beliefs about other people's behaviour and attitudes, for instance one girl's belief that girls do not carry condoms with them, and that those who do are seen as sexually promiscuous. Social norms can be contrary to people's own attitudes: one person might have a preference for X (I would like to carry a condom) and believe others have a preference for Y (others would disapprove of me carrying a condom). This mismatch between personal attitudes and social norms might extend to a whole group, to the point that everyone in the group might have a preference for X and believe everyone else has a preference for Y, a phenomenon commonly referred to as 'pluralistic ignorance'[7-9]. However, that is not always the case: norms and attitudes might also be aligned, so that not only does everyone think that they would be sanctioned for carrying a condom, but they might also feel personally that it is wrong to use one[10].

Multi-faceted theories about social norms have been reviewed in general[11,13],and introduced in relation to health science in particular[14,15], while theory and measurement are covered in a practical manual widely used by those working in social norm change.[16] STRIVE has contributed to and built on these efforts to achieve a unified and practical approach to social norm change.

Some common frameworks are limiting in that they restrict norms influence to interdependent behaviours (where all actors have an interest in all other actors complying with the norm). However, STRIVE evidence suggests that norms can still play an important role in facilitating or delaying social change, even when they do not make the major contribution[17].

STRIVE findings

Field practitioners would benefit from a simple theory of social norms to help them develop effective intervention strategies as well as integrating working measures into their monitoring and evaluation frameworks. This simple theory would need to take into consideration the different ways in which norms can exert influence on both interdependent and independent behaviours[12]. Recognising this need, STRIVE has outlined the ways in which existing theory can help design better interventions. This report translates recent insights into advice that can be operationalised[1].

Among other things, the report examines opportunities for cross-fertilisation between gender theory and social norm theory, suggesting that, while social norms theory offers a clear structure to define and measure gender norms (understood as people's shared expectations of men's and women's acceptable behaviour), gender theory can help make sense of the power relations that shape and activate those norms.

The report also reviews the conditions that activate or shape the strength of a norm, concluding that specific contextual clues can trigger people's awareness of the presence of a norm. These could be exploited by interventions that want to increase the strength of a norm in a particular setting (for instance in a school, where adolescents are having their first romantic encounters, or in a hospital, where people seek help for HIV).

2 **Key finding:** In research, monitoring and evaluation practices, it is important to capture social norms adequately in order to design change interventions and to track norms change over time.

To monitor and evaluate an intervention, any attempt at measuring norms should be based on solid qualitative evidence; not doing so would risk collecting meaningless data or misinterpreting data. Diagnosing norms for appropriate intervention design requires collecting qualitative evidence of the type of norms that are sustaining behaviour. For this purpose, vignettes and participatory techniques can be particularly appropriate. While refined tools and techniques to measures norms do exist, measuring a social norm X can be as simple as asking participants if others usually do X, and if others would approve or disapprove of someone doing X.

Identifying the operating norms up front is critical to focus programmatic efforts on the right issue and/or to enable practitioners to adapt the programme. In STRIVE research studies, for instance, we learned how different (and sometimes contrasting) norms can interact to drive people's practices. For example, in the Samata study in India, we learned that norms around girls' sexual conduct might act as a barrier to their going to school. In another study – Samvedana Plus, also in India, we discovered an unusual situation, where the pressure to beat a wife was so strong that some men would over-report domestic violence, particularly to their friends.

Choosing the correct strategy for data analysis is also important. The analysis of social norms can be greatly improved by disaggregating data at the level of the smallest possible cluster, while retaining statistical power. This enables researchers to understand critical patterns in the social norms held by different groups in a given region. Data aggregated at, for instance, national level might hide important differences in the norms held by people living in different geographical, social or cultural settings. It is important to note that most existing global datasets – the Demographic Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), World Values Survey (WVS), for instance – do not include specific measures of norms. Researchers interested in identifying norms within these datasets are currently testing potential proxies. It is hoped that future datasets will include measures of key normative beliefs, compatible with the global nature of these datasets.

Existing evidence

Few researchers and practitioners have so far measured norms systematically as they intersect with gender and health-related choices in low and mid-income countries.[18,19] A meta-analytical review lists some exceptions in the field of adolescent sexual and reproductive health.[20] Since researchers in health have mostly measured individual attitudes and clustered them as norms, norms measurement remains a field in need of further refining.

STRIVE findings

A STRIVE report presents field measures used by practitioners and scholars for both research and monitoring and valuation purposes.[18] Authors found vignettes particularly useful in both diagnosing and measuring norms. They recommend (as above) disaggregating data to the smallest cluster possible, as groups of people that influence norms might be small.

Insights from STRIVE suggest that, even when no norms are directly sustaining a given behaviour, it might still important to address other, related norms that might work as contributing factors to (rather than sole drivers of) the given behaviour. For instance, even though there might not be a norm such as "girls are not supposed to get tested for HIV", there might be norms around women's mobility ("women are not supposed to leave the household alone") that might contribute to low levels of testing.

Finally, evidence from STRIVE suggests that questions at too high a level of abstraction might be misleading and prime for bias. Concrete questions that make use of examples from people's lives are more likely to generate meaningful answers. For example, "do you think men and women should share household chores?" is more likely to elicit information than "Do you believe in gender equity?"

3 **Key finding:** Not taking social norms into account in designing an intervention can increase harm.

Interventions that aim to empower people (for example, girls) to resist social expectations can increase conflict between them and power-holders. When vulnerable groups advocate for their rights and equality, their actions will be much more successful if their social network (as well as other key influencers and decision-makers) are supportive of these claims. Otherwise, if existing decision-makers hold discriminatory norms, rights claims might backfire, generating resistance and further suffering. Interventions that aim to shock the population about the high prevalence of a harmful behaviour might increase its prevalence, too. A media campaign showing that only 5% of the female population gets tested for HIV, for instance, might create the belief that getting tested is a bad idea, that others don't do it, and that they would disapprove of me doing it.

Social norms interventions do not exclusively aim at changing harmful norms. When there is no social norm sustaining a harmful behaviour, practitioners can help people create a new positive norm. For instance, when there is no norm around getting tested for HIV, an intervention might aim to increase people's positive feedback to those who do get tested.

Effective change strategies have to extend beyond just changing norms, taking into account the whole framework of factors that contribute to sustaining a harmful behaviour.

Existing evidence

An analytical review by Miller and Prentice[21] identifies the three most common strategies used in the field to change social norms.

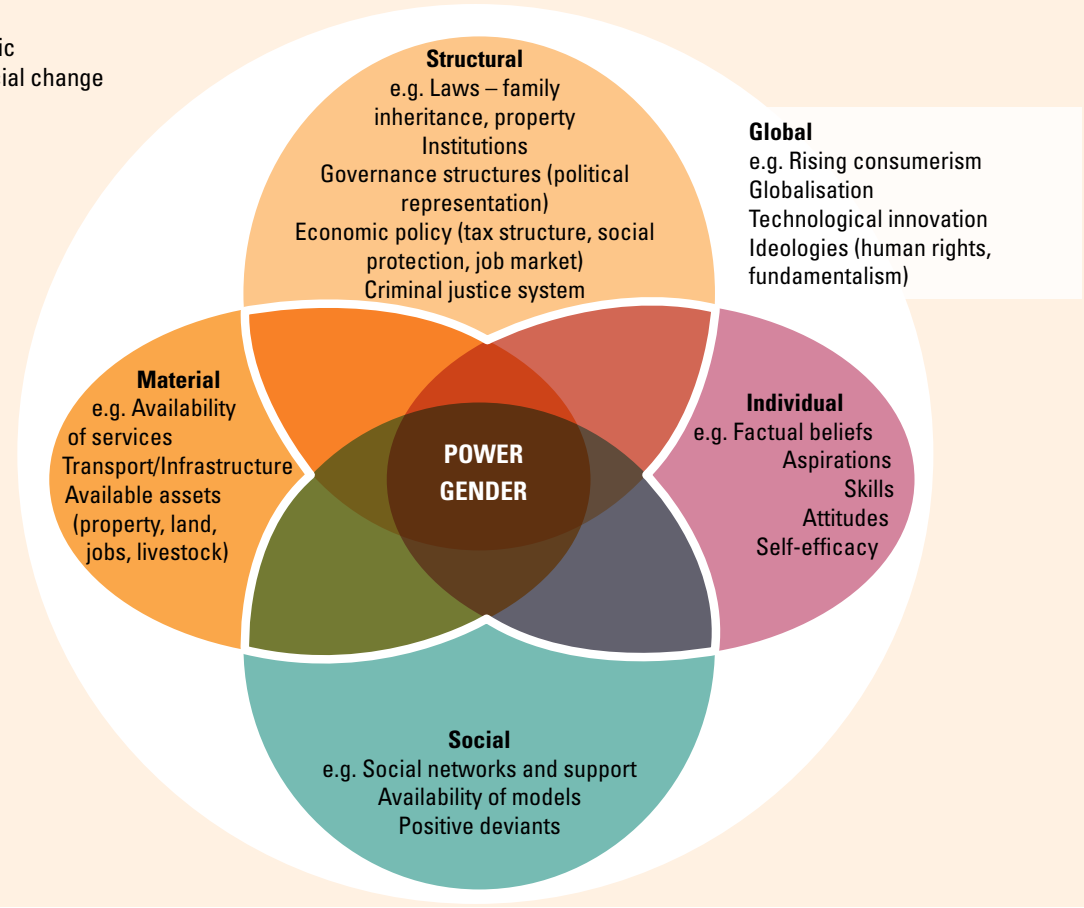
1. 'Social norms marketing' aims at correcting people's misperceptions about the prevalence of harmful practice. This strategy was widely used in US schools, with the display of messages such as "80% of students in this university only drink one beer on Saturday night", with the objective of inducing the remaining 20% to reduce their drinking patterns. The strategy was used for a variety of practices (from smoking to sexual aggression), with mixed evidence of its effectiveness [22].
2. 'Personalised normative feedback' sends individuals a message rating their performance against that of their peers. This approach was famously used to reduce electricity consumption by sending each household a letter showing how much energy they were consuming compared to their neighbours[23].
3. Focus group discussions gather participants in small numbers to change norms within the group and then motivate others around them, eventually changing the harmful norm in their network[24, 25].

STRIVE findings

A STRIVE paper (Cislaghi and Heise: Eight pitfalls of normative interventions, under review) pinpoints common pitfalls dangers that practitioners face in designing interventions that include a social norms perspective. These include:

- Conflating social norms and personal attitudes (that is, thinking of these two constructs as being the same);
- Focusing exclusively on contrasting norms and attitudes (I would like to get tested for HIV but that's not acceptable), while norms and attitudes can also be aligned (etting tested for HIV is not acceptable, and I wouldn't like to do that anyway);
- Overlooking protective norms that practitioners might leverage (for instance norms of protecting your family from disease and adversity);
- Assuming social norms are the sole driver of harmful practices, while they may instead be a factor contributing to the harmful practice to a smaller or larger extent, depending on the context (intersecting with, for instance, institutional and material factors); and

Figure 1: A dynamic framework for social change



- Confusing the prevalence of a social norm with its influence – that is, a norm may be widely held but have limited power when, for instance, it influences actions carried out in privacy.

Some initiatives treat norms in isolation, investing in norm-change as the sole means to shift a particular behaviour. However, insights from STRIVE work on norms suggest that norm change should be embedded within a framework of action that addresses other individual, social, material and structural factors.[12,18] As shown in Figure 1, these factors need to be taken into account not only individually, but also – and more importantly – in the ways they interact and overlap in contributing to sustaining the harmful practice of interest.

What is the impact?

STRIVE's work has contributed to research and interventions on social norms, and to funding to pursue them. An influential three-day STRIVE workshop on social norms in January 2013[26] brought together conceptual thinkers, programmers and practitioners, intervention evaluators and funders to:

- explore the utility of applying a social norms perspective to intimate partner violence, child marriage and other social issues,
- catalyse a dialogue between practitioners who are seeking to transform norms and thinkers who are developing and testing social norms theory, and
- build capacity to incorporate a social norms perspective when designing programmes and to capture shifts in norms as part of programme evaluation.

A number of initiatives were seeded as a result of this workshop, while resources, available from the STRIVE site, continue to be widely used.

Conceptual work on social norms has fed into STRIVE research into specific structural factors contributing to HIV vulnerability, including harmful and gender-specific alcohol advertising and use, keeping girls in school, intimate partner violence against sex workers and shifting harmful gender norms through sport with boys and girls.

REFERENCES

1. Cislaghi, B., K. Manji, and L. Heise, Social norms and gender-related harmful practices. Theory in support of better practice. 2018, STRIVE: London.
2. Halim, A., P. Hasking, and F. Allen, The role of social drinking motives in the relationship between social norms and alcohol consumption. *Addict Behav*, 2012. 37(12): p. 1335-41.
3. Peterson, J.L., et al., Perceived condom norms and HIV risks among social and sexual networks of young African American men who have sex with men. *Health Educ Res*, 2009. 24(1): p. 119-27.
4. Lee-Rife, S., et al., What Works to Prevent Child Marriage: A Review of the Evidence. *Studies in Family Planning*, 2012. 43(4): p. 287.
5. Berkowitz, A., The Social Norms Approach to Violence Prevention, in Young Men as Allies in Preventing Violence and Abuse: Building Effective Partnerships with Schools, A. Berkowitz, et al., Editors. 2003, FVPF.
6. Beyer, K., A.B. Wallis, and L.K. Hamberger, Neighborhood environment and intimate partner violence: a systematic review. *Trauma Violence Abuse*, 2015. 16(1): p. 16-47.
7. Miller, D.T. and C. McFarland, Pluralistic ignorance: When similarity is interpreted as dissimilarity. *Journal of Personality and Social Psychology*, 1987. 53: p. 298-305.
8. Hines, D., R.N. Saris, and L. Throckmorton-Belzer, Pluralistic Ignorance and Health Risk Behaviours: Do College Students Miperceive Social Approval for Risky Behaviours on Campus and in Media. *Journal of Applied Social Psychology*, 2002. 32(12): p. 2621-2640.
9. Halbesleben, J.R.B., A.R. Wheeler, and R.M. Buckley, Everybody Else is Doing it, So Why Can't We? Pluralistic Ignorance and Business Ethics Education. *Journal of Business Ethics*, 2005. 56: p. 385-398.
10. Cislaghi, B. and L. Heise, Theory and Practice of Social Norms Interventions: Eight Common Pitfalls. under review.
11. Bell, D.C. and M.L. Cox, Social Norms: Do We Love Norms Too Much? *Journal of Family Theory Review*, 2015. 7(1): p. 28-46.
12. Cislaghi, B. and L. Heise, Four avenues of normative influence. *Health Psychology*, 2018.
13. Young, H.P., The Evolution of Social Norms. Annual Review of Economics, 2015. 7(1): p. 359-387.
14. Reid, A.E., R.B. Cialdini, and L.S. Aiken, Social Norms and Health Behaviour, in Handbook of Behavioural Medicine, A. Steptoe, Editor. 2010, Springer: New York. p. 263-271.
15. Chung, A. and R.N. Rimal, Social Norms: A Review. Review of Communication Research, 2016. 2016(4): p. 1-28.
16. Mackie, G., et al., What are Social Norms? How are they measured? 2015, UNICEF and UCSD: New York.
17. Cislaghi, B. and L. Heise, Using social norms theory for health promotion in low-income countries. *Health Promot Int*, 2018.
18. Cislaghi, B. and L. Heise, Measuring Gender-related Social Norms: Report of a Meeting, Baltimore Maryland, June 14-15, 2016. 2017, London: LSHTM.
19. FHI360 and IRH, Learning Collaborative Background Reader. 2016, Georgetown University: Washington DC.
20. Van de Bongardt, D., et al., A Meta-Analysis of the Relations Between Three Types of Peer Norms and Adolescent Sexual Behaviour. *Pers Soc Psychol Rev*, 2015. 19(3): p. 203-34.
21. Miller, D.T. and D.A. Prentice, Changing Norms to Change Behaviour. *Annu Rev Psychol*, 2016. 67: p. 339-61.
22. Lewis, M.A. and C. Neighbors, Social norms approaches using descriptive drinking norms education: a review of the research on personalized normative feedback. *J Am Coll Health*, 2006. 54(4): p. 213-8.
23. Pellerano, J.A., et al., Do Extrinsic Incentives Undermine Social Norms? Evidence from a Field Experiment in Energy Conservation. *Environmental and Resource Economics*, 2016. 67(3): p. 413-428.
24. Cislaghi, B., D. Gillespie, and G. Mackie, Expanding the Aspirational Map, in Human rights education : theory, research, praxis, M. Bajaj and N. Flowers, Editors. 2017, University of Pennsylvania Press: Philadelphia. p. ix, 353 pages.
25. Abramsky, T., et al., Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Medicine*, 2014. 12(122).
26. STRIVE workshop on social norms theory and practice: http://strive.lshtm.ac.uk/news/strive-workshop-social-norms-theory-and-practice-resources-available-download

More information: http://strive.lshtm.ac.uk/themes/gender-norms-and-violence

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STRIVE research consortium

A DFID-funded research programme consortium, STRIVE is led by the London School of Hygiene & Tropical Medicine, with six key research partners in Tanzania, South Africa, India and the USA. STRIVE provides new insights and evidence into how different structural factors – including gender inequality and violence, poor livelihood options, stigma, and problematic alcohol use – influence HIV vulnerability and undermine the effectiveness of the HIV response.

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