

Unspoken Rules:

How Culture and Stigma Shape Young
People's Contraceptive Choices in Africa

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1.Executive Summary

This youth-led continental study synthesises findings from a trilogy of interconnected papers that each delve into critical aspects of youth development in Africa. The research explores: (1) Meaningful Youth Participation in governance and policymaking; (2) Youth Entrepreneurship and Green Jobs; and (3) Sexual and Reproductive Health and Rights (SRHR). Conducted across 14 African countries and implemented by 27 young researchers, the study amplifies diverse youth perspectives gathered through surveys, focus groups, and key informant interviews. The findings underscore persistent systemic barriers, financial exclusion, misaligned education systems, sociocultural stigma, bureaucratic constraints, and political tokenism that impede young people's ability to contribute to sustainable development. Key insights reveal strong youth interest in entrepreneurship as a pathway to economic independence, emerging but limited awareness of green jobs, widespread myths and stigma hindering SRHR uptake, and largely symbolic participation in formal decision-making spaces.

The trilogy proposes cross-cutting recommendations: expanding youth-friendly finance and entrepreneurship education; institutionalising youth representation with enforceable accountability; scaling comprehensive, culturally sensitive SRHR education and services; and leveraging digital platforms and intergenerational dialogue to amplify youth co-creation. These evidence-based recommendations are aligned with the AU–EU Joint Vision for 2030 and aim to transform youth insights into impactful policy and programming, recognising young Africans as active co-designers of their futures rather than passive beneficiaries.

Thus, this paper spotlights Sexual and Reproductive Health and Rights (SRHR), a fundamental aspect of youth well-being and empowerment in Africa. For comprehensive insights into related areas, readers are encouraged to explore the accompanying papers focusing on Meaningful Youth Participation <https://restlessdevelopment.org/?s=research> and Youth Entrepreneurship <https://restlessdevelopment.org/?s=research>, which together offer a holistic understanding of the challenges and opportunities facing youth across the continent.



2. Research Design and Methodology

This study is a continental youth-led research initiative that employed a mixed-methods, participatory design grounded in Restless Development's six-step youth-led methodology. The overarching aim of the research was to inform advocacy priorities guiding regional and cross-continental efforts related to the AU-EU partnership, with a particular focus on identifying the needs, obstacles, and priorities of young Africans under the AU-EU Joint Vision for 2030, which emphasises investment, peace, health, climate action, and youth inclusion (African Union and European Union, 2022).

A systematic literature review informed the identification of three key thematic areas: meaningful youth participation in policymaking, youth-led entrepreneurship, and sexual and reproductive health and rights (SRHR). These areas were selected to address identified gaps and challenges, and to contribute evidence for continental Youth Power Hackathons focused on youth-led accountability, campaigning, and advocacy.

Overall Objective: To explore the role of meaningful youth participation in policymaking, youth-led entrepreneurship, and reproductive health initiatives in advancing Africa's socioeconomic development.

Specific Objectives

- Analyse how youth participation in policymaking and implementation contributes to socioeconomic development in African countries.
- Investigate the contribution of youth-led entrepreneurship to economic growth and diversification.
- Examine the influence of cultural and societal norms on access to and use of modern contraceptive methods among young adults.

- Propose strategies to accelerate youth participation in decision-making on reproductive health, entrepreneurship, and public policy for sustainable development.

Data collection occurred across 14 countries,^[1] and was conducted in English, French, and Arabic to ensure inclusivity and cultural sensitivity. The research team, comprised of 27 young researchers, co-designed research instruments, led fieldwork, and ensured contextual appropriateness throughout the process. Data collection methods included 98 focus group discussions (n=955), 151 key informant interviews with civil society representatives, business leaders, and healthcare professionals, and 1,463 survey responses (722 women, 741 men) as indicated by Table 1. The targeted age for the research is 15-35 years.

Country	Female	Male	Prefer not to say	Grand Total
Burkina Faso	52	81	7	140
Burundi	33	74	2	109
Cameroon	49	43	17	109
Ghana	50	55		105
Kenya	46	54	2	102
Nigeria	91	57		148
Senegal	20	15		35
Sierra Leone	45	49	7	101
South Sudan	55	60	1	116
Tanzania	52	54	1	107
Tunisia	19	18		37
Uganda	46	74	12	132
Zambia	92	15		107
Zimbabwe	72	43		115
Grand Total	722	692	49	1463

Table 1: Survey reach disaggregated by gender

Qualitative data were analysed inductively using NVivo software to identify emergent themes, while quantitative data were summarised using descriptive statistics in Excel. Ethical safeguards were rigorously implemented, including obtaining informed consent, ensuring confidentiality, using age-appropriate approaches, and carefully addressing power dynamics, particularly in SRHR-related contexts.

[1] Burkina Faso, Burundi, Cameroon, Ghana, Kenya, Nigeria, Senegal, Sierra Leone, South Sudan, Tanzania, Tunisia, Uganda, Zambia, Zimbabwe

Limitations

While the study acknowledges limitations such as uneven rural coverage and its cross-sectional design (which limits causal inference). Digital data collection and local partnerships helped mitigate this gap; the cross-sectional design limited causal analysis, focusing instead on associations and trends. Additional funding would enable broader geographic representation and longitudinal exploration. The tri-lingual, youth-led approach strengthens its validity by centring lived experiences, enhancing triangulation, and generating actionable evidence to inform AU–EU policy and youth-centred programming. This approach not only ensures the inclusion of diverse voices but also enhances the relevance and applicability of the findings for policymakers and stakeholders alike, ultimately contributing to more effective and youth-responsive interventions.



1. Introduction

African youth face numerous health risks, including high rates of HIV/AIDS infection and limited access to sexual and reproductive health services. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is a key legal document adopted by the African Union in 2003 to promote women's rights across the continent. A primary focus of the Protocol is on SRHR, emphasising women's autonomy over their reproductive health choices, including access to contraceptives. Article 14 explicitly affirms women's rights to control their fertility, select any contraception method, and access family planning education. It also requires state parties to provide sufficient, affordable, and accessible health services, especially for women in rural areas, and to authorise medical abortion in specific cases such as sexual assault, rape, incest, and situations where pregnancy threatens the mother's mental and physical health or her life or the life of the foetus.

Despite the Protocol's comprehensive provisions, its implementation varies significantly across African nations, mainly due to different ratification timelines, which affect the speed and scope of subsequent national law reforms. As a result, early ratifiers such as Ghana and Nigeria have shown more rapid alignment with the Protocol by enacting legislation on domestic violence and gender equality. In contrast, recent or pending ratifications, like those in South Sudan and Burundi, demonstrate slower progress and ongoing challenges (African Union, 2023).

Recent studies underscore significant disparities in modern contraceptive prevalence rates (CPR) across African nations, reflecting varied access to and utilisation of family planning services. For instance, a comprehensive analysis of 20 African countries revealed an overall modern contraceptive use prevalence of 26%, with rates ranging from 6% in Guinea to 62% in Zimbabwe (Ahinkorah et al., 2020). This variation suggests that while some countries have made substantial progress in promoting contraceptive use, others continue to face considerable challenges, as indicated by Figure 1 below.

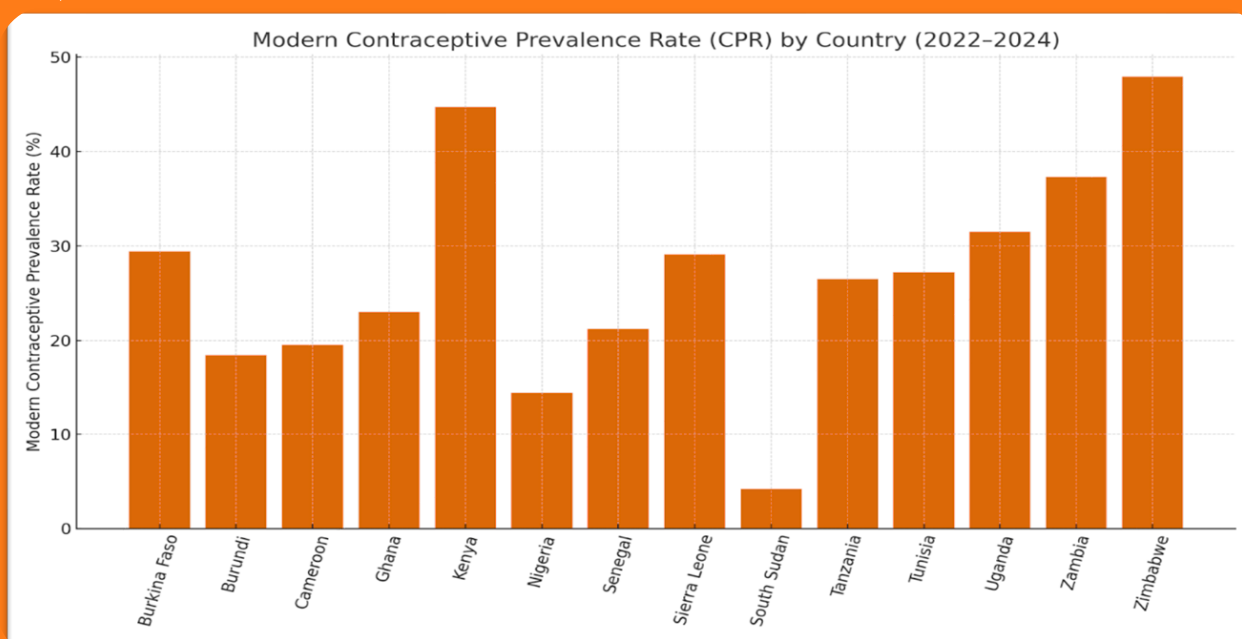


Figure 1: Data from Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).

The factors influencing these disparities are multifaceted. Economic constraints, limited availability of contraceptive methods, cultural and religious opposition, and inadequate education about family planning contribute to low contraceptive use in many regions. Additionally, gender-based barriers and societal norms often impede women's access to and decision-making autonomy regarding contraceptive use (Ahinkorah et al., 2020).

2. The impact of cultural and societal norms on the accessibility and use of modern contraceptive methods.

Cultural and societal norms are pivotal in shaping young adults' access to and utilisation of modern contraceptive methods across Africa. These norms influence perceptions, attitudes, and behaviours related to sexuality and reproductive health, often creating barriers that restrict young people's ability to seek information and services. As highlighted in recent studies, these norms sustain myths, stigma, and opposition, thereby significantly impeding progress toward universal SRHR access for youth (UNFPA, 2020).

Contraceptive prevalence rates (CPR) among married women aged 15–49 vary significantly across African countries. Figure 2 summarises the percentage of married women in this age group using any method of contraception and modern methods specifically.

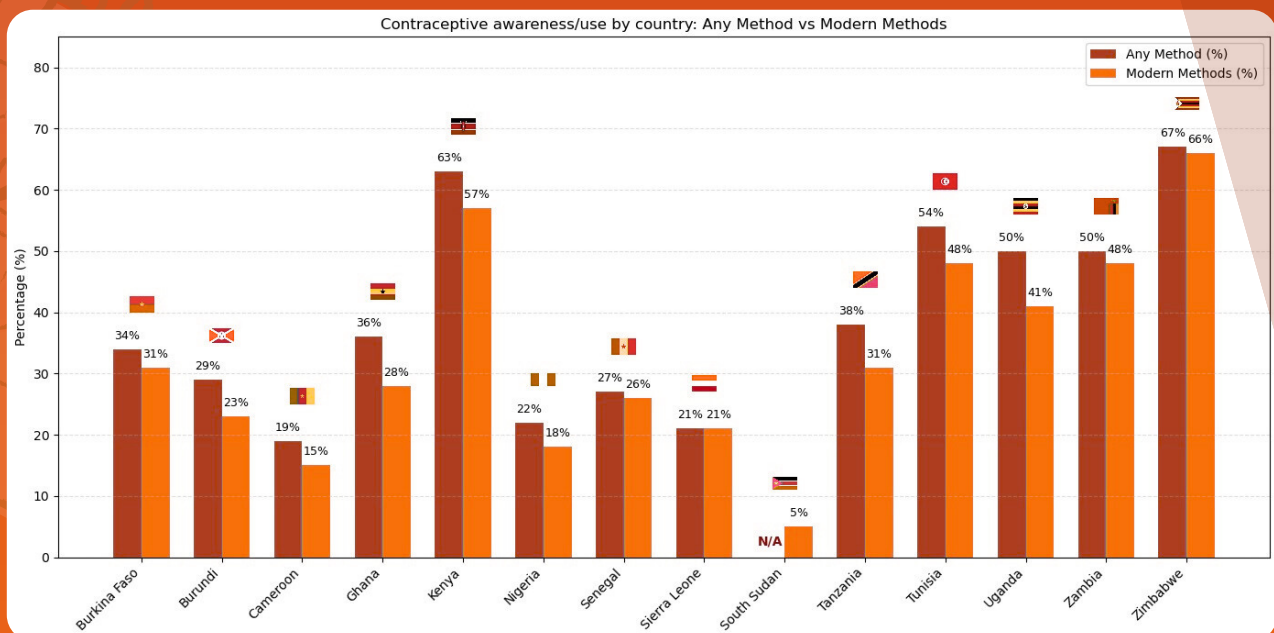


Figure 2: Percentage of women aged 15–49 using any method of contraception and modern methods (Source: <https://www.prb.org/>)

Figure 2 provides an overview of the use of modern contraceptives among young and adult women, indicating a relatively low use of modern methods compared to traditional methods with countries such as South Sudan reporting as little as 5%. The average across all countries is 32%. This indicates a significant gap in modern contraceptive use, underscoring the need for strategies to improve access and uptake among young people.

2.1 Cultural and societal norms and how they impact accessibility

The influence of cultural and societal norms significantly affects young people's access to contraception and reproductive health information in Africa. These norms shape attitudes and behaviours that either facilitate or hinder access to SRHR services.

One key issue is the limited access to formal education on contraception. Findings from the cross-country youth-led research show that 67% (34% female, 31% male, 2% did not specify gender) of respondents reported receiving formal education on contraception and reproductive health, while 33% had not. A gender comparison indicates that more females (69%) than males (66%) have received formal education. This data highlights both progress and ongoing gaps in SRHR education, particularly among youth populations in the Global South. According to UNFPA (2020), cultural barriers hinder many adolescents and young people from navigating early sexual and reproductive choices, who lack accurate, age-appropriate information, which can increase vulnerabilities and misinformation (UNFPA, 2020)

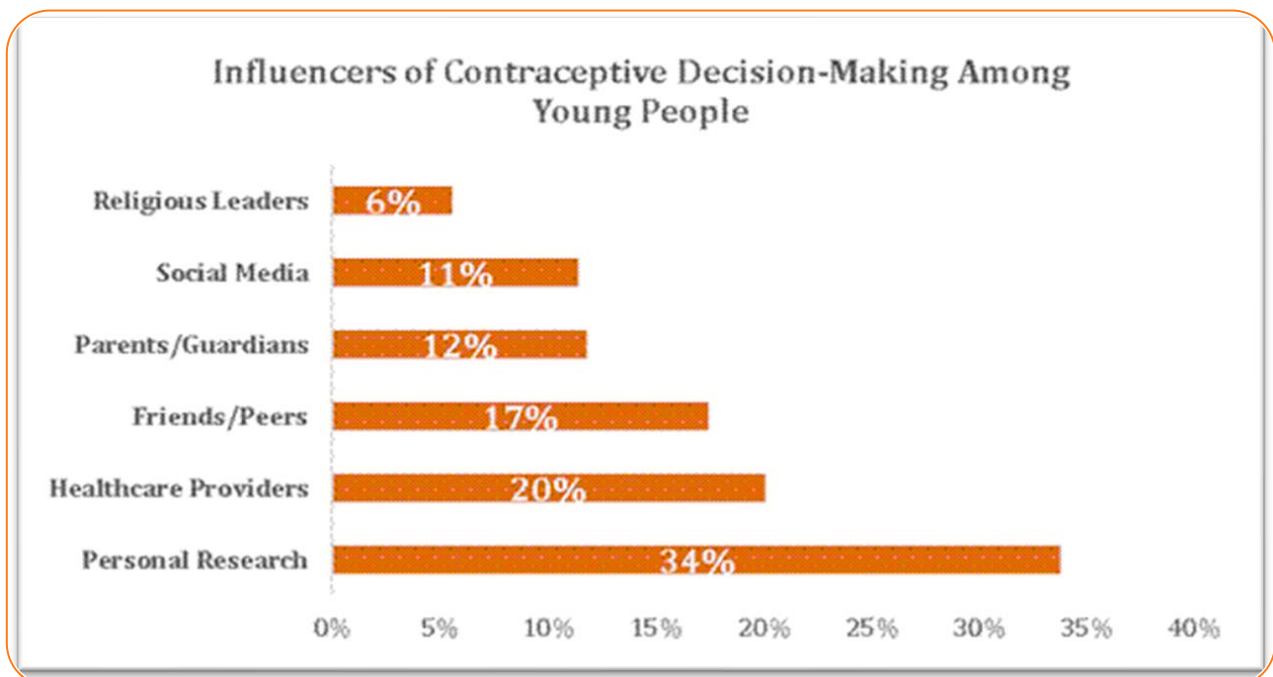


Figure 3: Influencers of contraceptive use among young people (Source: Survey Data)

Figure 3 illustrates what young people use when deciding on contraceptive choices. It highlights that many young individuals base their decisions about which contraception to use primarily on personal research rather than relying on professional healthcare guidance or educational resources.

Although self-reliance is beneficial, this tendency can be seen as a positive trait, demonstrating independence and resourcefulness; however, it also raises concerns about the quality and accuracy of the information relied upon. The lack of professional guidance may lead to misunderstandings about various contraceptive options, their effectiveness, potential side effects, and the implications of choices on reproductive health.

Table 2 provides a comprehensive analysis of each variable categorised by gender. This breakdown reveals distinct influences and trends that affect females and males individually. It offers valuable insights into how various factors uniquely impact each gender, highlighting the primary influences for both groups. For females, healthcare providers are the primary source of support, and for males, they are heavily reliant on religious leaders.

Influencers of Young People's decision on using contraceptives	Female	Male	Other
Personal Research	52%	45%	35
Healthcare Providers	53%	46%	2%
Friends/Peers	38%	59%	4%
Parents/Guardians	51%	45%	5%
Social Media Religious	50%	42%	9%
Leaders	32%	67%	1%

Table 2: Influencers of young people's decisions on contraceptive use, disaggregated by gender

While family members and peers appear to be the predominant influencers, religious leaders exert a more modest yet notable influence, especially among males. According to Agha (2010) and Biddlecom (2009), cultural and religious norms often shape reproductive health choices and behaviours. These findings align with broader literature that underscores the complex role of religion in sexual and reproductive health. Religious teachings and leaders usually communicate messages about abstinence and fertility that can impact attitudes towards contraceptive use (Agadjanian, 2013; Izugbara et al., 2021). However, such influence may sometimes contribute to hesitancy or misconceptions about modern contraceptive methods, particularly in conservative communities.

Furthermore, the sources from which young people access contraceptive information reflect societal attitudes. The research indicated that digital platforms are the primary source of information among youths, enabling anonymous learning and avoiding open discussions. In contrast, interpersonal sources like friends (9%) and family (5%) are less frequently mentioned, likely due to cultural taboos surrounding open conversations about sexuality and contraception (UNICEF, 2021).

Although 78% of youth reported some level of access, 10% still find contraceptives "not accessible," and 12% are uncertain, as indicated by Figure 4. These findings suggest that although a significant majority experience moderate to high access, gaps persist.



Accessibility of Contraceptives

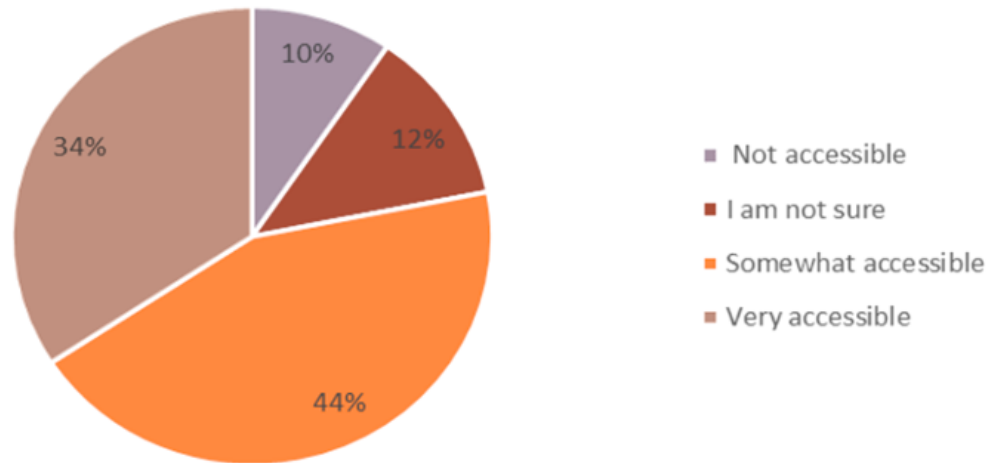


Figure 4: Accessibility of contraceptives (Source: Survey data)

Cross-country analysis in Figure 5 reveals notable gender and country-level disparities in contraceptive accessibility among young people. In most countries, males report higher access than females, as seen in Burundi (68% vs. 30%) and Burkina Faso (58% vs. 37%). However, Zambia and Zimbabwe deviate from this trend, with female access significantly higher (86% and 63%, respectively) than male access (14% and 37%, respectively). Countries like Kenya, Nigeria, and Tanzania show relatively balanced access, while South Sudan and Tunisia maintain similar rates for both genders. Respondents who preferred not to disclose gender remain minimal, peaking at 16% in Cameroon.

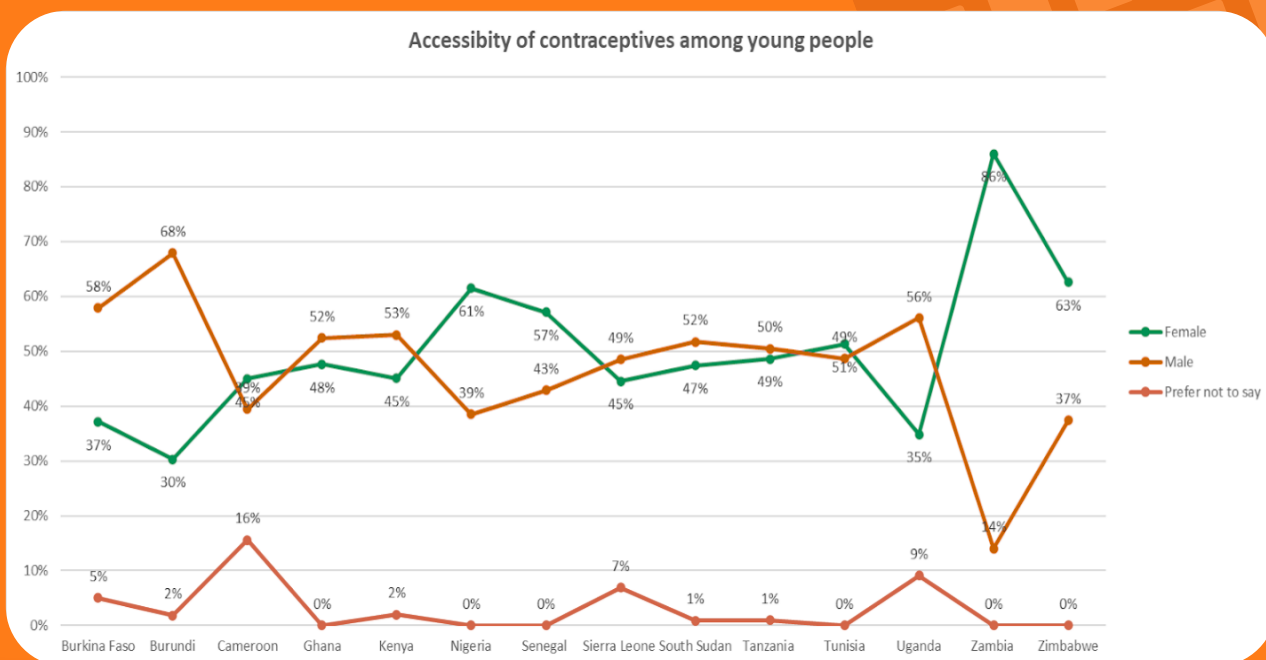


Figure 5: Accessibility of contraceptives disaggregated by country and gender

Moreover, misconceptions about contraceptives remain prevalent; 72% (38%F, 34M) of respondents confirmed the existence of myths as illustrated in Figure 6. The data in Figure 5 show that misconceptions are most common among respondents aged 20–29, with 25–26% answering “Yes.” These age groups also comprise the largest portion of the sample, each representing 36%. The 30–34 group, comprising 21% of the sample, exhibits a moderate prevalence of misconceptions (16%). In contrast, only 5% of the 15–19 age group (just 6% of the sample) report misconceptions. “No” responses are lowest in the youngest group and slightly higher among older participants

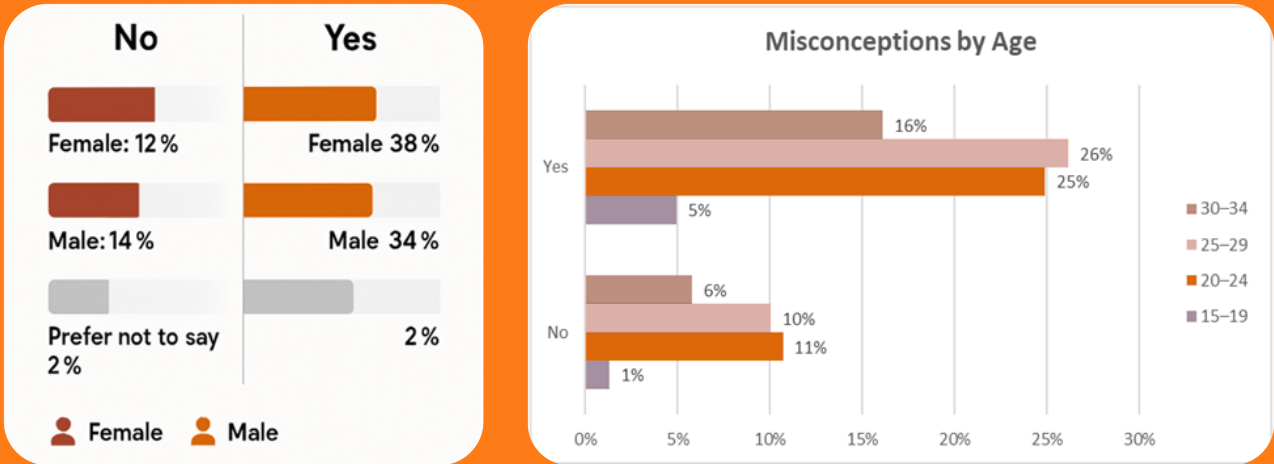


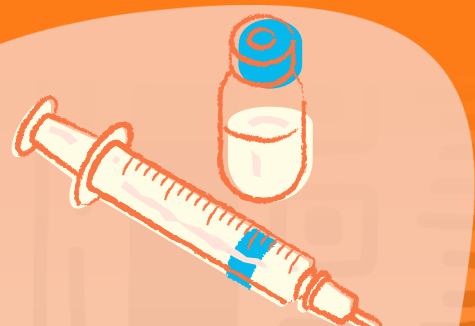
Figure 6: Misconceptions by gender and age

This data demonstrates that misconceptions exist among both males and females, primarily affecting the 20–29 age group. This may be attributed to the fact that many in this age group are independent and often enrolled in higher education. This finding may explain why most respondents reported relying on personal research when deciding which contraceptive to use.

Figure 7 shows perceived misconceptions. These are often culturally entrenched beliefs and reinforced by misinformation spread through social networks and digital media, reflecting how societal narratives shape perceptions and influence behaviours (Kassa et al., 2020). Additionally, cultural and religious opposition play a crucial role. Many communities and religious groups label contraceptive use as immoral or sinful, leading to community and parental resistance. This is evident in countries like Kenya and Tunisia. Kenya is a ‘catholic nation’, which affects access to condoms, while in Tunisia, conversations surrounding sexual and reproductive health and rights (SRHR) are often viewed as sensitive and taboo. This cultural stigma can create barriers to public dialogue, education, and access to essential health services,



Figure 7: Perceived misconceptions by young people



ultimately impacting individuals' understanding and management of their sexual and reproductive health. The avoidance of such topics reflects deep-rooted societal norms and values, making it challenging to address SRHR-related issues constructively.

Societal norms influence young people's comfort levels in discussing contraception with their families. While some youths are very comfortable, 32% still feel "not comfortable at all," highlighting the ongoing presence of cultural taboos and intergenerational communication challenges. Young people aged 25–29 are the most comfortable discussing contraceptives with family, with the highest percentage feeling "very comfortable. Comfort levels tend to increase with age, with the 30–34 group showing relatively high comfort compared to the youngest group (15–19), who are least likely to feel comfortable engaging in such discussions.

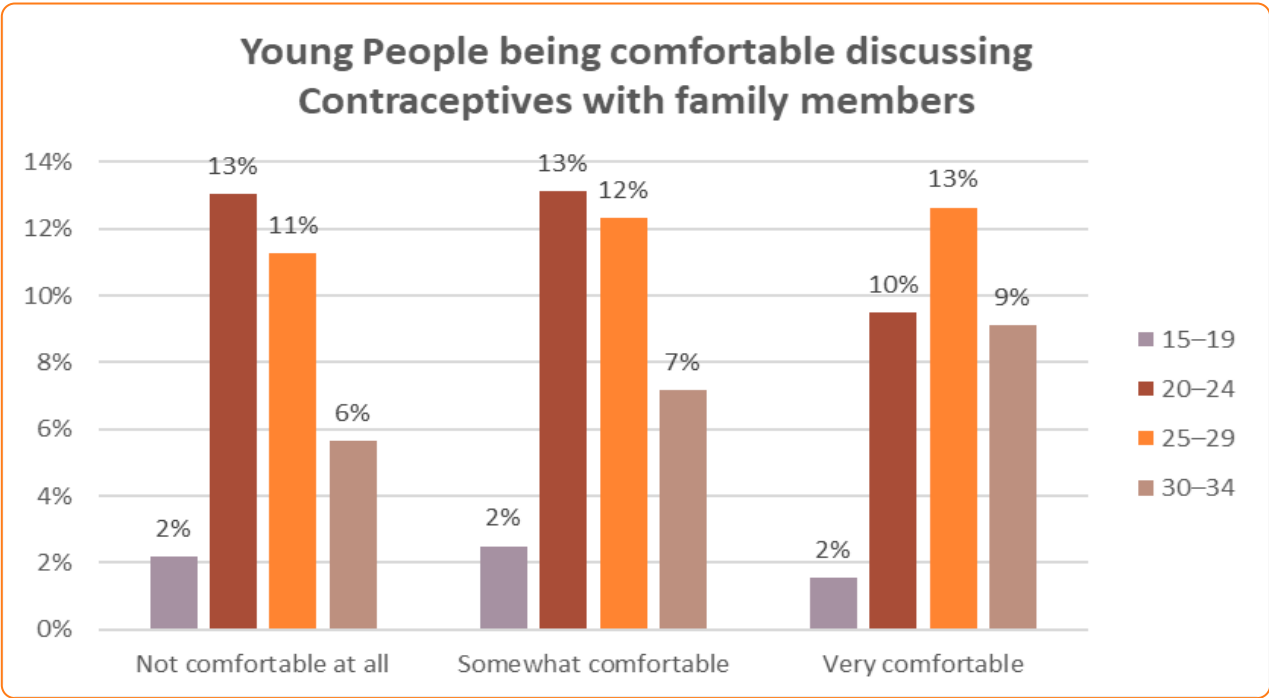


Figure 8: Comfort of young people discussing contraceptives with family members

Literature indicates that comfort in discussing contraceptive methods with family members tends to increase with age. Adolescents aged 15–19 often exhibit reluctance to engage in such discussions, influenced by cultural norms and fear of disapproval. In contrast, adults in midlife exhibit a greater level of confidence when addressing their own contraceptive needs as well as those of their children (Higgins et al., 2021). Nevertheless, a significant proportion of youth report feeling at least somewhat comfortable initiating conversations on this topic, suggesting a shift in family dynamics, likely facilitated by enhanced access to SRHR education and online dialogue platforms (UNFPA, 2020).



3. Cultural and societal norms and their impact on modern contraceptives

Access to Sexual and Reproductive Health (SRH) services is essential for ensuring individuals' rights to health, autonomy, and well-being (World Health Organisation, 2019). It helps reduce maternal mortality, prevent sexually transmitted infections, and support family planning (UNFPA, 2021). Ensuring universal access to SRH services is crucial for achieving gender equality and sustainable development (UN Women, 2020).

In many African contexts, deeply rooted cultural and societal norms shape perceptions of sexuality and reproductive health, often creating formidable barriers that impede young people's access to and use of modern contraceptives (Katz, 2014). These norms are not merely passive beliefs but active forces that govern behaviours, influence policy, and reinforce social hierarchies that restrict open dialogue and informed decision-making about contraception.

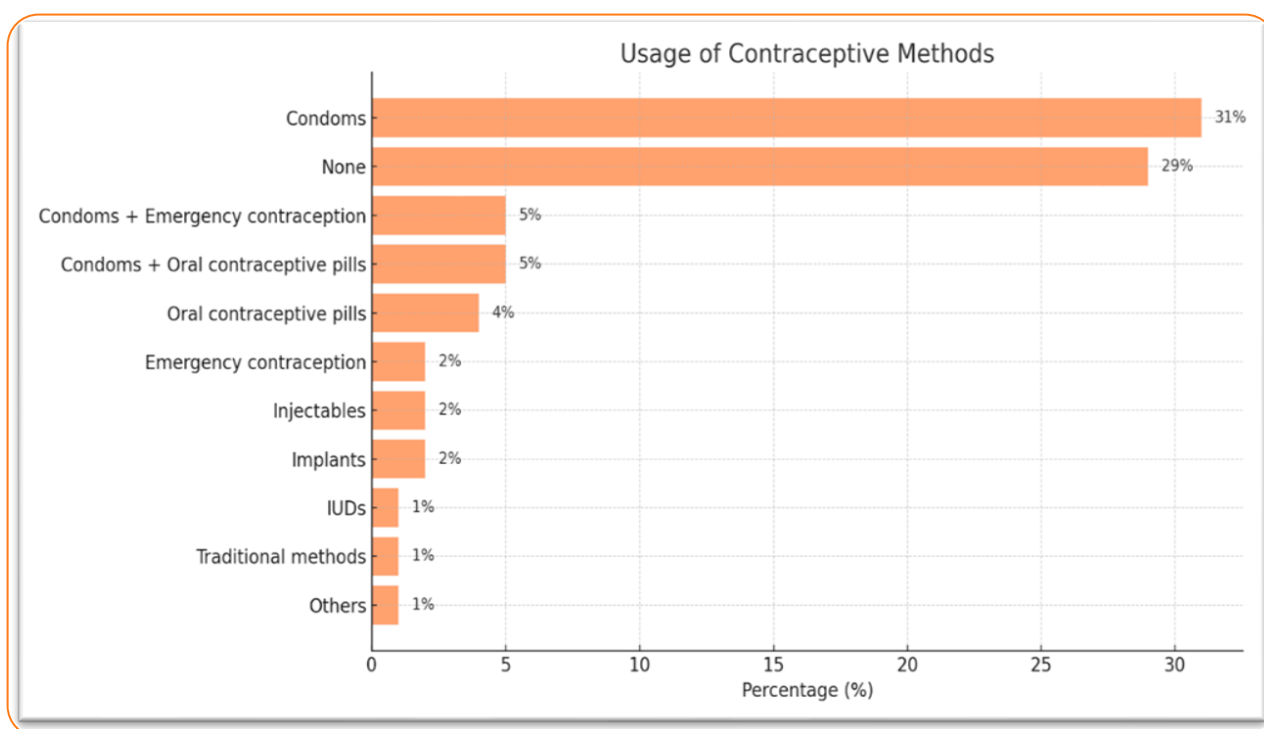


Figure 9: Usage of contraceptive methods among young people (Source: Survey data)

Figure 9 indicates a low uptake of modern contraceptives among young people. This data shows a strong reliance on condoms and a concerning number of individuals not using any contraceptive method. Modern contraceptive combinations (like pills + implants) are almost absent, which could indicate either low access, awareness, or preference.

The use of modern contraceptives has been affected by social and cultural norms; in many communities, discussing sexual health or using contraception is taboo, viewed as morally inappropriate or shameful, especially for unmarried youth. Religious and cultural narratives frequently equate contraception with promiscuity or moral failure, reinforcing the idea that young people should abstain entirely or face social censure. Young women face heightened scrutiny and moral judgment, making their access to contraception fraught with social risks.

The research data indicated that many communities require spousal or parental permission for young women to access contraceptives, rooted in norms that prioritise female chastity and control female sexuality. Conversely, young men often remain excluded from SRHR education and services, reinforcing gender inequalities and limiting shared responsibility for reproductive health. This gendered double standard perpetuates environments where contraceptive use remains clandestine and stigmatised.

Confidence in Contraceptive Decision-Making Among Young People

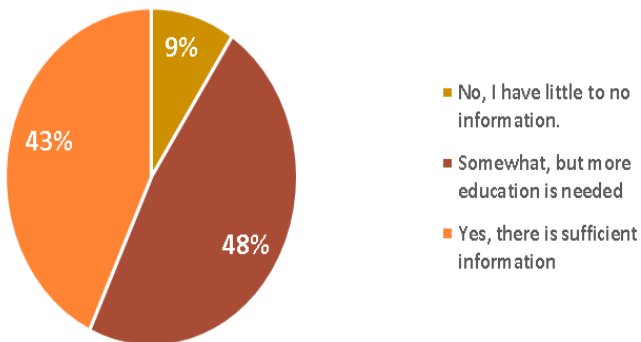


Figure 10: Young people's confidence in contraceptive decision making

The existing norms have contributed to low confidence in contraceptive decision-making among young people, with only 43% of the young people indicating they have sufficient information to make an informed decision, as indicated by Figure 10.

Male respondents exhibited slightly higher confidence in their knowledge, with 47% reporting having "sufficient information," compared with 41% of female respondents. Conversely, women expressed a greater need for additional education: 50% reported needing "more education," compared with 44% of men.

Both genders reported an equal likelihood of feeling entirely uninformed (9%). The lack of confidence significantly impacts young people's ability to access sexual and reproductive health and rights (SRHR) services. Many young individuals may feel hesitant or anxious about seeking these services due to fears of judgment, lack of information, or insufficient support systems. The lack of confidence among individuals significantly contributes to the misunderstandings and misconceptions highlighted in this report. This uncertainty can lead to distorted perceptions and misguided beliefs, which ultimately affect how information is interpreted and acted upon.

These norms influence not only individual attitudes but also shape the entire ecosystem of access, impacting education, health service delivery, peer and family interactions, and policy frameworks. Deeply ingrained cultural and religious beliefs act as gatekeepers, defining what is considered acceptable and permissible, often at the expense of young people's reproductive autonomy (Ouhid et al, 2023). This research revealed that schools' curricula focus primarily on abstinence and are influenced by community opposition tied to conservative values, which further limits the accessibility and use of comprehensive SRHR services.

Moreover, the research revealed that while over half of young respondents 53% have not felt judged or shamed for seeking or using contraceptives, nearly one-third 29% report experiencing some form of stigma, whether from family members, peers, or society at large. This significant share highlights the enduring presence of moral and cultural narratives that discourage open discussion and autonomous decision-making regarding SRHR. Additionally, 17% of respondents indicated that they have never used contraceptives, a data point that may reflect no sexual activity or early-stage sexual activity, limited access, or internalised stigma discouraging use.

3.1 Barriers to Accessing Contraceptives and SRHR Services

Despite global commitments to improve youth access to contraceptive and sexual and reproductive health and rights (SRHR) services, many young people in Sub-Saharan Africa continue to face complex and overlapping barriers.

Access to contraceptive and SRHR services is a fundamental human right and a critical component of youth empowerment, public health, and sustainable development (UNFPA, 1994; UN, 2015). In many African countries, adolescents and young adults encounter numerous barriers rooted in misinformation, cultural norms, policy gaps, and systemic limitations. The data represent the most frequently reported barriers across the selected countries.

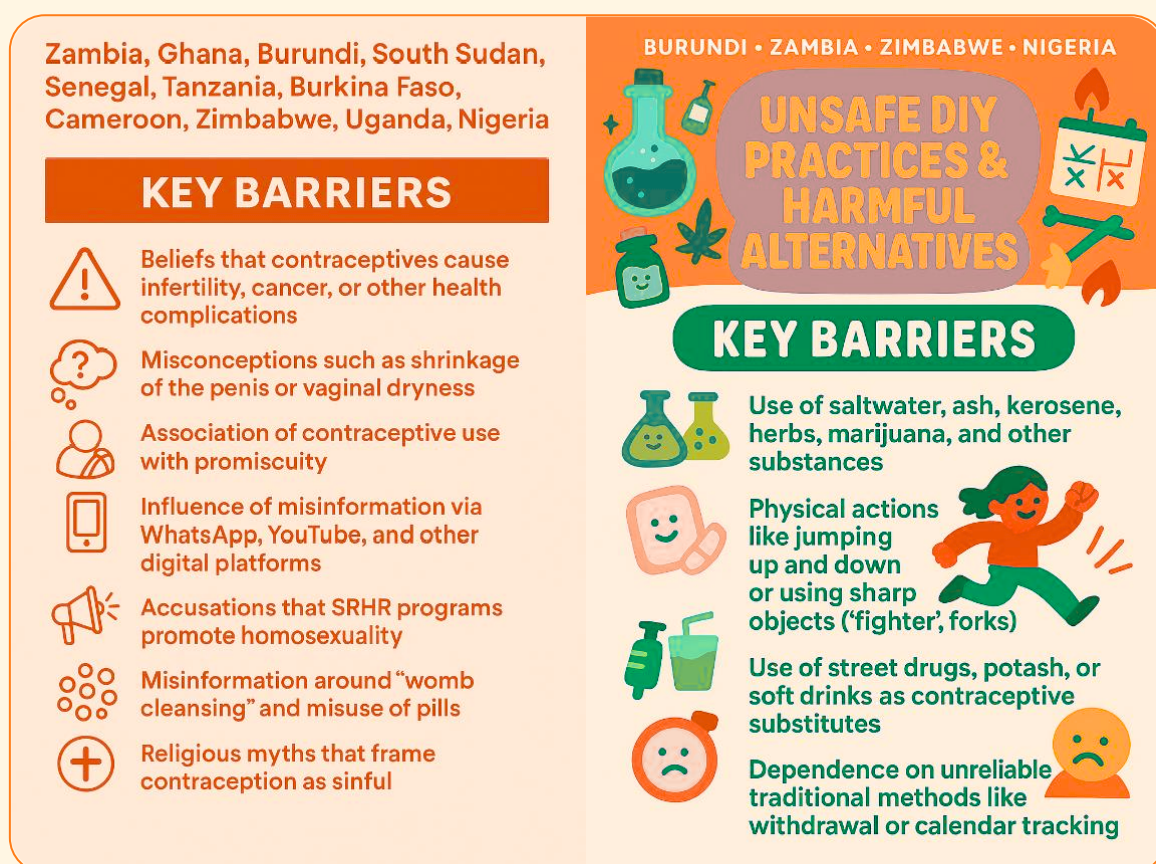


Figure 11: Summary of barriers faced by young people across different countries.

The multitude of barriers across these countries significantly hinders young people’s use of modern contraceptives. Health-related fears, such as concerns about infertility, cancer, weight changes, and vaginal irritation, are compounded by mistrust in official health messages and negative attitudes from healthcare providers, leading to reluctance in seeking contraceptive services. Social stigma, judgment, and gender norms further discourage contraceptive use; young people fear disapproval from family, community, and health workers, with girls facing heightened scrutiny and boys often excluded from SRHR education.

Structural challenges such as high costs, stockouts, long travel distances, and a lack of youth-friendly, private service points reduce the availability and appeal of contraceptive options, especially in rural and underserved areas.

Educational gaps, including the absence of comprehensive SRHR curricula and neglect of boys and young men in programming, further diminish awareness and informed decision-making. Coupled with limited policies and trained providers, these factors collectively reduce young people's confidence and willingness to use modern contraceptives, ultimately impacting contraceptive uptake and reproductive health outcomes. They also lead to the use of unsafe and unreliable 'Do it yourself (DIY)' methods, such as the use of saltwater, ash, marijuana and physical activity to avoid pregnancy.

4. Key Strategies to Advance SRHR for Young People in Africa

Advancing sexual and reproductive health and rights (SRHR) for young individuals in Africa necessitates a comprehensive, youth-centred approach that addresses both structural and social barriers. A foundational step in this endeavor is expanding access to accurate, age-appropriate, and contextually relevant information.

Expanding Education

This entails integrating comprehensive sexuality education into formal school curricula and supporting informal learning initiatives through community outreach. Such educational efforts must be rights-based, culturally sensitive, and facilitated by trained professionals with institutional support from schools and local organisations.

Besides classroom teaching, it is vital to reach young people, especially those who are out of school, through digital platforms and peer-led outreach. Making sure that SRHR information is engaging, visually attractive, and available in local languages can greatly improve youth engagement and trust.

Improve SRHR service delivery.

Enhancing the availability and accessibility of contraceptive services represents another critical priority. This objective requires expanding youth-friendly clinics, mobile outreach initiatives, and subsidised health programmes, particularly in underserved regions where services are fragmented or non-existent. Strengthening the supply chain is essential to ensure the consistent availability of contraceptives and other vital SRHR commodities. Innovations such as self-care options, including self-injectable contraceptives and telemedicine, can empower young individuals to take control of their reproductive health with increased privacy and autonomy.

Use of multimedia

Strategic behavioural change communication using storytelling, participatory media, and trusted, relatable messengers can effectively challenge harmful myths, stigma, and misinformation that obstruct contraceptive use. These misconceptions are often spread through digital platforms such as WhatsApp and YouTube, as most young people (31%) rely on the internet as their primary source of information.

Engage communities

At the community level, engaging families, guardians, and influential leaders is vital to creating supportive environments for adolescents. Providing targeted training and resources for parents, traditional leaders, and faith-based institutions can help reduce stigma and create safe spaces for intergenerational dialogue. These discussions are critical for dispelling shame, challenging harmful norms, and fostering positive attitudes toward adolescent SRHR.



Youth Empowerment

Youth empowerment must remain a focus of all interventions. This involves equipping young people with essential life skills to make informed and confident decisions about their sexual and reproductive health. Mentorship programmes, youth-led safe spaces, and digital platforms that provide verified content can all help to build youth agency. Moreover, young people should be recognised as key stakeholders, not just beneficiaries, in SRHR programmes, ensuring their voices influence the design, delivery, and evaluation of services to improve relevance and effectiveness.

Ultimately, all SRHR strategies should be grounded in robust evidence and informed by adaptive learning. Disaggregated data by age, gender, location, and other identity markers should better inform programming that reflects the diverse experiences of youth. Institutionalising feedback mechanisms and youth-led accountability structures will facilitate continuous service improvement. Longitudinal research and monitoring systems are essential for tracking the impact of interventions and supporting sustained, systemic change.

5. Recommendations

Recommendations	AU-EU Joint Vision Pillar(s)
1. Expand access to comprehensive sexuality education and youth-friendly SRHR services via schools, digital platforms, and peer-led models	Health & Education
2. Invest in youth-friendly clinics, mobile outreach, and innovative self-care SRHR solutions, particularly for underserved groups	Health & Education
3. Engage families, faith leaders, and communities to de-stigmatise SRHR and foster supportive intergenerational dialogue	Health & Education

6. Conclusion

Research findings show that cultural and societal norms greatly affect young people's access to and use of modern contraceptives in Africa. Although policies like the Maputo Protocol (African Union, 2003) and the African Youth Charter (African Union, 2006) have promoted SRHR, these norms still influence sexual behaviour and reproductive decisions.

Improvements in contraceptive access are observed in countries such as Kenya, Zimbabwe, and Zambia; however, disparities persist, where stigma and gender expectations restrict youth agency. For instance, modern contraceptive use varies from 5% in South Sudan to 66% in Zimbabwe (Ahinkorah et al., 2020), highlighting both healthcare access inequalities and deeply rooted cultural attitudes towards sexuality and gender.

The study highlights how culture and religion create barriers to open discussions about contraception, especially within families. It reveals that 32% of young people feel “not comfortable at all” discussing contraceptive use with family, reflecting generational and moral obstacles. In many communities, sexuality is regarded as shameful, with contraceptive use seen as a sign of promiscuity, particularly for unmarried women.

This not only restricts information but also enforces gendered double standards, where young men face less scrutiny than young women, who risk stigmatisation for asserting control over their reproductive choices. These expectations align with patriarchal norms that prioritise female chastity and modesty, limiting women’s access to modern contraceptives without fear of judgment.

Religious and cultural beliefs can greatly influence contraceptive use, differing according to community interpretation. In countries such as Kenya and Tunisia, strong religious influences—Catholicism and Islam, respectively—often hinder discussions on contraception (Agadjanian, 2013; Izugbara et al., 2021). Religious leaders can either reinforce restrictive views or promote more progressive approaches, depending on the context.

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