Breaking the Silence: Factors Associated with Perceived Social Norms Regarding Sexual and Reproductive Health Among Adolescent Students in Monastic Schools, Myanmar

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Abstract

This study assessed perceived SRH social norms, SRH knowledge, and associated factors among adolescent students in monastic schools in Myanmar. Data were drawn from the 2016 baseline survey of the Integrated Multi-Sectoral Approach (IMSA) project, involving 870 students aged 11–18 years from eight monastic schools in Magway Region. Perceived descriptive and injunctive SRH social norms were measured and analyzed using ANOVA and multiple linear regression. The mean perceived social norms score was 33.9 (SD = 5.3; range: 17–50), with lower scores indicating more favorable perceived social norms. Good knowledge of puberty was reported by 56.2% of students. Higher education (β = -1.49, p < .01) and receiving SRH education from peer educators (β = -1.71, p < .01) were significantly associated with more favorable perceived social norms. Better SRH knowledge was associated with more favorable perceived social norms, although the association was not statistically significant (β = -0.315, p = .386). Strengthening comprehensive sexuality education (CSE) by addressing unfavorable social norms and improving access to accurate, age-appropriate SRH information through trained teachers and peer educators may promote more favorable SRH-related social norms among adolescents. Future research should evaluate the long-term effects of CSE interventions on social norms.

Keywords

Adolescents; marginalized groups; Monastic schools; Myanmar; perceived social norms; sexual and reproductive health

Introduction

Social norms, defined as individuals' perceptions of which behaviors are typical and acceptable within a given context, are powerful drivers of behavior among adolescents (Cislaghi & Shakya, 2018). Positive or favorable social norms are societal attitudes, expectations, or behaviors considered desirable and appropriate within a particular cultural or social context. In sexual and reproductive health (SRH), these norms promote open communication about sexual health, respect for diverse identities, acceptance of safe sexual practices, and equitable access to comprehensive SRH information and services. Favorable social norms can positively influence individual behaviors, strengthen adolescents' self-confidence, and empower them to assert their rights (Berhane et al., 2019). In contrast, negative or unfavorable social norms refer to attitudes, expectations, and behaviors that are harmful or restrictive. These unfavorable norms can suppress open discussion, limit access to essential SRH information and services, discourage adolescents from seeking sexual health and contraceptive information, and stigmatize certain behaviors or identities, such as premarital sex (Cislaghi & Shakya, 2018; Jewkes et al., 2009).

Power inequalities and gender norms underpinning social norms significantly influence adolescent SRH outcomes (Cislaghi & Shakya, 2018; Malhotra et al., 2019). Social and cultural expectations often reinforce inequitable gender roles, with young women expected to be chaste and modest. These expectations may limit educational opportunities, lower school attendance, and restrict access to healthcare, particularly among girls in monastic schools (Phyu & Han, 2021; Swe et al., 2022). Studies in Myanmar also suggest that social and cultural norms influence the delivery of SRH education in monastic schools, thereby limiting access to accurate and comprehensive SRH information (Swe et al., 2022). These constraints may increase the risk of unintended pregnancies, sexually transmitted infections, and gender-based violence (Rolleri, 2013). Religious and cultural factors further shape these outcomes and may contribute to variations across communities. Therefore, understanding the interplay among social norms, power dynamics, and cultural and religious influences is essential for promoting positive SRH outcomes among adolescents.

Over the past decade, Myanmar has made significant progress in developing and implementing adolescent sexual and reproductive health (ASRH) policies and strategies; however, challenges remain in their effective implementation. Young people continue to face social and cultural barriers to accessing accurate SRH information and services (UNFPA, 2022). Community and cultural factors, including restrictive social and gender norms, hinder adolescents' ability to access rights-based SRH information and services and increase their vulnerability to unintended pregnancies, sexually transmitted infections, and gender-based violence (Rolleri, 2013; UNFPA, 2021b). These challenges further contribute to health inequities among adolescents in Myanmar.

Identifying the social norms that influence adolescents' SRH in Myanmar is critical given the persistent burden of poor SRH outcomes. Silence surrounding SRH-related issues and deeply rooted social and gender norms are particularly common among adolescent girls in marginalized groups, including those in religious institutions. A mixed-methods study conducted among adolescent girls in monastic schools found substantial gaps in knowledge about puberty, reproductive anatomy, fertility, and menstruation, with many participants reporting that they felt unprepared for menarche and expressed a need for more comprehensive SRH information (Swe et al., 2022). These findings suggest that adolescents in

monastic schools may have limited access to accurate SRH information, with cultural taboos and inadequate educational support contributing to misinformation and insufficient knowledge about SRH (Swe et al., 2022). Such silence may perpetuate harmful social norms and practices that reinforce gender inequality and increase the risk of gender-based violence, thereby undermining girls' rights (Lundgren & Amin, 2015). Breaking this silence and addressing harmful social norms are therefore essential for improving SRH outcomes among adolescents in Myanmar.

Despite the evident impact of social norms on adolescents' SRH outcomes, research on the relationships among socio-ecological factors, SRH knowledge, and perceived social norms remains limited. This study, therefore, addressed three research questions: (1) What is the prevalence of favorable perceived social norms regarding SRH among adolescent students in monastic schools in the Magway Region of Myanmar? (2) What are the levels of SRH knowledge and sources of SRH information among these students? (3) What factors are associated with perceived social norms regarding SRH among adolescent students in monastic schools?

Previous studies on adolescent sexual and reproductive health have highlighted the importance of considering both behavioral and socio-ecological factors in examining adolescents' sexual intentions and decision-making. The Theory of Planned Behavior suggests that attitudes influence behavioral intentions, perceived social norms, and perceived behavioral control (Ajzen, 1991). In addition, the socio-ecological model emphasizes that adolescents' attitudes, perceptions, and behaviors are shaped not only by individual factors, but also by interpersonal relationships, community environments, and broader institutional influences (Bronfenbrenner, 1979). Together, these theoretical perspectives provide a useful framework for examining how individual- and community-level factors, together with SRH knowledge, are associated with perceived social norms regarding SRH among adolescents.

This study applies Bronfenbrenner's Socio-ecological Model (SEM), as adapted by Cislaghi and Heise (2018), to examine how individual, interpersonal, community, institutional, and societal factors are associated with perceived social norms regarding SRH among adolescents. This framework provides a comprehensive understanding of how adolescents' SRH attitudes and beliefs are shaped by across multiple socio-ecological levels, including peers, educators, and broader socio-cultural contexts (Bronfenbrenner, 1979; Cislaghi & Heise, 2019; Pulerwitz et al., 2019). Applying this framework also helps identify potential entry points for contextually appropriate interventions to promote positive SRH outcomes among adolescents.

Methods

Study design and participants

This study used data from the baseline school-based survey of the Integrated Multi-Sectoral Approach (IMSA) project conducted by Burnet Institute Myanmar. The baseline survey was conducted across eight monastic schools (five post-primary and three middle monastic schools) in Magway Region, Myanmar, covering grades 5 to 10. The monastic schools were selected using a purposive sampling method based on accessibility, engagement, and support from school principals. Monastic schools generally cater to two primary groups of students:

novices exploring religious life while receiving formal education within the monastic school, and lay students (ordinary students) from the local community seeking formal education offered by the monastic schools. In monastic schools, SRH education is commonly delivered through life skills-based education (LSE) sessions, which may cover topics related to puberty, reproduction, contraception, relationships, HIV, and sexually transmitted infections. Depending on the school context and available resources, SRH information may be delivered by teachers, healthcare providers, or trained peer educators through classroom-based or outreach education sessions.

For the baseline survey, all students aged 11 years or older who were enrolled in Grade 5 or above, including both novices and lay students, were eligible and invited to participate. In the baseline survey, 1,428 students participated, based on the number present on the day of data collection. Students completed anonymous self-administered questionnaires to ensure privacy and encourage more open responses to sensitive SRH-related questions. The present study included adolescent students aged 11–18 years enrolled in grades 7–10 who completed all relevant sections of the questionnaires in the baseline survey. Students from Grades 5 and 6, who did not answer sexual and reproductive health-related questions in accordance with the guidelines of the Myanmar Ethics Review Board (Burnet Institute, 2020), were excluded from the analysis. In total, 870 adolescent students comprised the final study sample.

The baseline survey was approved by the Alfred Health Human Research Ethics Committee, Australia, and the Department of Public Health Ethics Research Committee, Myanmar. To conduct the baseline survey in the Magway region, Myanmar, the necessary permissions were obtained from the education and health authorities at the national, regional, and township levels, as well as from the monastic school system. Parental or guardian consent was obtained from adolescents younger than 18 years. Eligible adolescents whose parents or guardians had provided permission were also asked to provide written informed consent or assent to participate voluntarily in the survey. All collected data were treated confidentially (Burnet Institute, 2020).

This study received ethical approval from the Institutional Review Board of the Institute for Population and Social Research, Mahidol University (COA No. 2023/04-076).

Study measures

A structured self-administered questionnaire adapted from the WHO tools and guidelines, the existing LSE curriculum, and relevant literature was used in the original baseline survey. The questionnaire included sections on socio-demographic characteristics, SRH knowledge, attitudes and beliefs related to SRH, and sources of SRH information. The questionnaire underwent pre-testing and refinement to ensure clarity, relevance, and comprehensibility for study participants. The survey collected data on variables relevant to the objectives of the present study and served as the basis for the secondary data analysis.

Perceived social norms: In the present study, perceived social norms were assessed using individual attitudes and beliefs related to SRH as proxy indicators of social norms. As the secondary dataset did not include direct measures of reference-group expectations or community-level norms, the study focused on perceived social norms derived from adolescents' attitudes and beliefs related to SRH rather than direct measures of collective social norms. Although individual attitudes are conceptually distinct from social norms, they may provide insight into the prevailing normative environments where direct measurement

of group-level social norms is not feasible (Mackie et al., 2015; Storey & Kaggwa, 2009). Mackie et al. (2015) suggested that when direct measurement is unavailable, perceived social norms may be approximated using individuals' subjective beliefs about socially acceptable behaviors or common practices. Similar approaches were applied in previous studies, including Storey and Kaggwa (2009), which used reported individual attitudes as proxy indicators of collective attitudinal norms.

The perceived social norms scale was adapted from a set of attitude- and belief-related questions in the original questionnaire. The scale included three domains: relationships (13 items), contraception (13 items), and HIV/AIDS (6 items). The internal consistency of the 32-item scale was assessed using Cronbach's alpha, which indicated good reliability ($\alpha = 0.87$). Example items included; "It is all right for unmarried boys and girls to hold hands" and "A boy's respect for a girl diminishes if she willingly engages in sexual activity with him" (relationships); "Contraception encourages young people to have sex" and "preventing pregnancy is a woman's responsibility" (contraception); and "I would stop spending time with a friend if I knew they had HIV" (HIV/AIDS).

Drawing on descriptive and injunctive norm concepts and considering the available data, responses were coded to generate a perceived social norms score. Responses for positive items were coded as agree = 0, "don't know" = 1, and disagree = 2, while reverse coding was applied for negative items (agree = 2, "don't know" = 1, disagree = 0). Higher scores indicated more unfavorable perceived social norms regarding SRH, whereas lower scores indicated more favorable perceived social norms. Total scores ranged from 0 to 64. The "don't know" category was retained in the analysis because it may reflect uncertainty, limited knowledge, ambiguity regarding prevailing social expectations, or discomfort discussing sensitive issues. Accordingly, these responses were treated as an intermediate category between agreement and disagreement rather than as missing values.

Level of SRH knowledge: SRH knowledge was assessed using items from the original baseline questionnaire, which was developed based on WHO tools and guidelines, the existing LSE curriculum, and relevant literature. The questionnaire assessed SRH knowledge across six constructs: puberty, reproductive organs, pregnancy prevention, contraception, HIV, and sexually transmitted infections (STIs). Each item had three response options: "true", "false", and "don't know". Each correct response was assigned one point, whereas incorrect or "don't know" responses received a score of zero (Vongxay et al., 2019). Knowledge of contraceptive methods was scored as 2 = heard of and know how to use, 1 = heard of but don't know how to use, and 0 = never heard of. SRH knowledge levels were classified using the sample mean as the cut-off point. Students with above-mean scores were classified as having good SRH knowledge, whereas those with below-mean scores were classified as having low SRH knowledge (Brunelli et al., 2022).

Sources of SRH information were assessed across three components: (1) types of SRH educators, (2) SRH topics learned in monastic schools, and (3) frequency of SRH education sessions. Types of SRH educators referred to the main providers of SRH education in the selected monastic schools. They included teachers, healthcare providers, peer educators, or those who received no SRH education from any provider.

Disability status: Self-reported disability status was assessed using the Washington Group Short Set of Questions (Madans et al., 2011), which measures functional difficulties across six domains: seeing, hearing, walking, remembering or concentrating, self-care, and communication. Responses were categorized as "no difficulty", "some difficulty", "a lot of

difficulty", and "cannot do at all". For analysis, disability status was grouped into two categories: 0 = "no difficulties" and 1 = "at least one form of difficulty", which included respondents reporting "some difficulty", "a lot of difficulty", or "cannot do at all" in at least one functional domain.

Data analysis

Descriptive, bivariate, and multiple linear regression analyses were performed to examine the associations between individual factors, SRH knowledge, community-level factors (type of SRH educators and sources of SRH information), and perceived social norms among students while controlling for potential confounding variables, such as age, gender, and education level. Two multiple linear regression models were estimated. Model 1 included the main explanatory variables, while Model 2 additionally incorporated SRH knowledge level to assess whether the associations between perceived social norms and the explanatory variables changed after adjustment for SRH knowledge. The selection of explanatory variables was guided by the study objectives and the results of the bivariate analyses. Comparing the two models also allowed for the assessment of the potential role of SRH knowledge in the associations between the explanatory variables and perceived social norms.

Missing values were observed for the variable "types of SRH educators" and affected 25.9% of the study sample. These missing values primarily occurred among students who reported not receiving SRH education in monastic schools and therefore did not identify a specific source of SRH education. To examine the potential impact of these missing values on the study findings, a sensitivity analysis was conducted, following recommended approaches for evaluating the robustness of results under alternative assumptions about missing data (Little & Rubin, 2019). Missing responses were recoded as "no teachers," "no healthcare providers," or "no peer educators," respectively, based on the assumption that students who did not receive SRH education were not exposed to these educator types. The results were then compared with complete-case analyses in which observations with missing values were excluded. Similar results were observed across the different approaches, indicating that the study findings were not substantially affected by the handling of missing data. All analyses were performed using IBM SPSS version 18 and Stata version 18.

Results

This section presents the characteristics of the study participants and the results of the descriptive, bivariate, and multivariable analyses of factors associated with perceived social norms regarding sexual and reproductive health (SRH).

Of the 1,428 students who participated in the original baseline survey, 870 met the eligibility criteria and were included in the present analysis. Table 1 presents the characteristics of the study participants(N = 870). The average age of the students was 14.4 years. Students aged 14–18 years comprised the majority (68.9%) of the study population, whereas 31.1% were aged11– 13 years. Female students accounted for 60.3% of the sample, and male students 39.7%. The largest proportion of students was in Grade 7 (27.7%), followed by Grade 9 (26.3%), Grade 8 (24.6%), and Grade 10 (21.1%).

The majority of students were lay students (74.7%), whereas the remaining 25.3% were novice students (monks or nuns). Overall, 13.7% of students reported at least one form of difficulty. Approximately 56.2% of students demonstrated good knowledge of male and female-related puberty; however, knowledge of reproduction, HIV, and pregnancy prevention among students was comparatively lower than that of the other SRH topics. Only 45.9% of students demonstrated good knowledge of HIV transmission, common signs and symptoms, and HIV prevention. Overall, 51.1% of students had above-mean SRH knowledge scores (good SRH knowledge), whereas 48.9% had below-mean scores (low SRH knowledge). Teachers were the most commonly reported providers of SRH education during life skills class (69.1%), followed by healthcare providers (13.9%) and peer educators (11.4%). However, 25.9% of students reported not receiving any SRH education in their monastic schools. Based on the students' reports, puberty-related information was the most commonly covered topic during the life skills classes (56.4%), followed by HIV/STIs (52.2%). Overall, 48.7% of students reported receiving SRH education regularly (daily, 2–4 times per week, or once per week) in the classroom (Table 1).

Table 1: General Characteristics of the Study Population (*N* = 870)

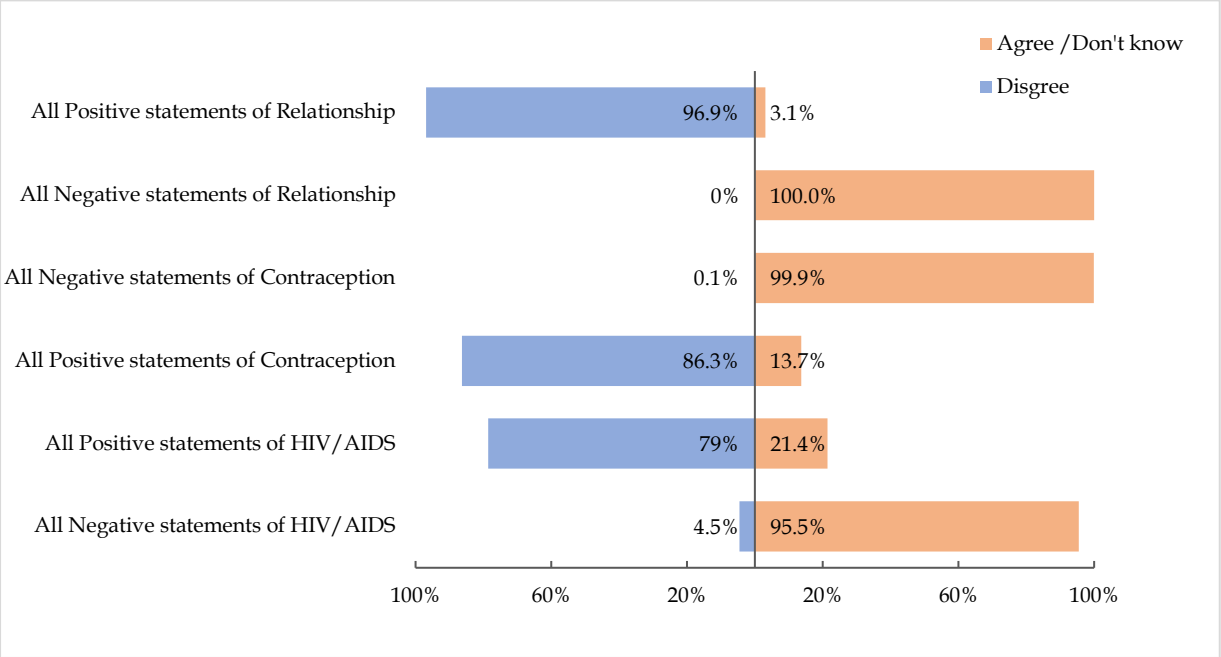
Characteristics	Frequency (%)	Mean of Perceived Social Norms Score Mean ± SD	*P* value
Age groups			
11-13 years	271 (31.1%)	34.30 ± 4.99	.147
14-18 years	599 (68.9%)	33.74 ± 5.42	
Mean ± SD	14.4 ± 1.43	- 0.030 [a]	.363
Gender			
Male	345 (39.7%)	33.59 ± 5.72	.156 †
Female	525 (60.3%)	34.12 ± 4.99	
Education level (Grade)			
Grade 7	241 (27.7%)	34.72 ± 4.91	**.030***
Grade 8	214 (24.6%)	33.30 ± 4.99	
Grade 9	229 (26.3%)	33.84 ± 5.62	
Grade 10	186 (21.4%)	33.66 ± 5.62	
Types of students			
Novice (monks or nuns)	220 (25.3%)	34.52 ± 4.83	**.048***
Lay students	650 (74.7%)	33.70 ± 5.43	
Students' residence type			
Students lived at the boarder in monastery	279 (32.1%)	34.14 ± 5.23	.390
Students attended from community	591 (67.9%)	33.81 ± 5.32	
Disability Status			
No	751 (86.3%)	33.61 ± 5.21	**.000*****
At least one form of difficulty	119 (13.7%)	35.82 ± 5.44	
Learning about reproductive health education (life skills) from:			
Teachers	601 (69.1%)	34.02 ± 5.44	.370
Healthcare providers	121 (13.9%)	34.31 ± 5.45	.368
Peer educators	99 (11.4%)	32.78 ± 5.26	**.024***
No one teaching SRH education	225 (25.9%)	33.46 ± 4.97	.139
Reported SRH topics learned at monastic schools			
Puberty	491 (56.4%)	34.15 ± 5.38	.133
HIV & STIs	454 (52.2%)	34.07 ± 5.49	.369
Reproduction and Pregnancy	238 (27.4%)	34.02 ± 5.68	.721†
Relationships	204 (23.4%)	34.51 ± 5.24	.065

Characteristics	Frequency (%)	Mean of Perceived Social Norms Score Mean ± SD	*P* value
Sexual Health	183 (21.0%)	34.32 ± 5.80	.277†
Contraception	106 (12.2%)	34.37 ± 5.57	.344
SRH education in life skills class			
No SRH education	225 (25.9%)	33.46 ± 4.97	.052
Rarely	221 (25.4%)	33.51 ± 5.12	
Regular	424 (48.7%)	34.36 ± 5.53	
Level of SRH knowledge [1]			
Puberty			
Below-mean score	381 (43.8%)	33.99 ± 5.01	.683
Above- mean score	489 (56.2%)	33.85 ± 5.51	
Reproductive organs			
Below-mean score	487 (56.0%)	33.94 ± 4.97	.848 †
Above- mean score	383 (44.0%)	33.87 ± 5.67	
Contraception			
Below-mean score	431 (49.5%)	33.84 ± 4.97	.693 †
Above- mean score	439 (50.5%)	33.98 ± 5.61	
Pregnancy prevention			
Below-mean score	471 (54.1%)	33.83 ± 5.22	.632
Above- mean score	399 (45.9%)	34.01 ± 5.39	
HIV			
Below-mean score	471 (54.1%)	34.10 ± 5.19	.244
Above- mean score	399 (45.9%)	33.68 ± 5.41	
STIs			
Below-mean score	420 (48.3%)	33.83 ± 5.12	.656
Above- mean score	450 (51.7%)	33.99 ± 5.46	
Overall level of SRH knowledge			
Below-mean score	425 (48.9%)	34.08 ± 4.90	.358 †
Above- mean score	445 (51.1%)	33.75 ± 5.65	
Score of Perceived Social Norms (Mean ± SD)			
Relationship	15.2 ± 2.9		
Contraception	13.1 ± 3.1		
HIV/AIDS	5.6 ± 2.7		
Total	870 (100%)	**33.91 ± 5.3**	

*Note: *p < .05, **p < .001, ***p < .001; † Robust test (Welch ANOVA) was used due to the violation of homogeneity; [a] Correlation Analysis: Pearson's correlation coefficient was conducted.*

Figure 1 presents the students' self-reported attitudes and beliefs regarding relationships, contraception, and HIV/AIDS.

Figure 1: Students' Responses to Positive and Negative Statements on Relationships, Contraception, and HIV/AIDS



Overall, 96.9% of students reported disagreeing with or being uncertain about at least one positive statement concerning relationships, whereas none disagreed with any of the negative statements. Similarly, only a small proportion of students (13.7%) agreed with positive statements about contraception, while nearly all (99.9%) agreed with negative statements. For HIV/AIDS-related statements, a considerable proportion of students (78.6%) reported disagreement with or uncertainty about the positive statements, whereas only 4.5%disagreed with the negative statements. The overall mean perceived social norms score regarding SRH was 33.9 (SD = 5.3) (Figure 1). Among the three domains, the highest mean perceived social norms score was observed for relationships, followed by contraception and HIV/AIDS. The association between individual characteristics, community factors, the level of SRH knowledge, and perceived social norms was tested using analysis of variance (ANOVA), following assessment of the homogeneity of variances. The results are presented in Table 1.

Novice students (monks or nuns) exhibited significantly more unfavorable perceived social norms than lay students, $F(1, 868) = 3.94$, $p = .048$. Female students had slightly more unfavorable perceived social norms regarding SRH than male students; however, there was no statistically significant difference in mean perceived social norms scores between genders ($p = .156$). Post hoc tests indicated that students in Grade 7 had significantly more unfavorable perceived social norms compared with those in Grade 8, $F(3, 866) = 2.99$, $p = .030$. Students who received SRH education from peer educators had significantly lower mean perceived social norms scores than those who did not receive SRH education from peers ($F(1, 643) = 6.74$, $p = .024$). The mean score of perceived social norms among students with below-mean SRH knowledge scores (low SRH knowledge) was slightly higher than that of students with above-mean SRH knowledge scores (good SRH knowledge). However, there was no statistically significant difference in perceived social norms according to the level of SRH knowledge ($p > .05$) (Table 1).

Table 2 presents the results of the multiple linear regression analyses. Model 1 included the main explanatory variables, whereas Model 2 additionally adjusted for SRH knowledge.

Model 1 identified several significant individual- and community-level factors associated with perceived social norms, including education level (grade), disability status, and receiving SRH education from peer educators ($p < .05$). After incorporating SRH knowledge into Model 2, the overall model fit did not substantially change compared with Model 1.

Table 2: Multiple Linear Regression Results for Factors Associated with Perceived Social Norms

Factors	Model 1		Model 2	
	β [se.]	p *value*	*β [se.]*	*p value*
Age (years)	0.141 [0.219]	.520	0.148 [0.220]	.500
Gender				
Female	Ref.		Ref.	
Male	-0.576 [0.381]	.131	-0.556 [0.382]	.146
Education level (Grade)				
Grade 7	Ref.		Ref.	
Grade 8	-1.485 [0.520]	**.004****	-1.474 [0.520]	**.005****
Grade 9	-1.187 [0.653]	.069	-1.166 [0.653]	.075
Grade 10	-1.397 [0.908]	.124	-1.382 [0.909]	.129
Type of Students				
Novice (monk or num)	Ref.		Ref.	
Lay students	-0.382 [0.465]	.411	-0.372 [0.465]	.424
Students' residence type				
Live at boarder in monastery	Ref.	Ref.	Ref.	Ref.
Attend from community	-0.821 [0.480]	.088	-0.822 [0.480]	.088
Disability Status				
No	Ref.		Ref.	
At least one form of difficulty	2.021 [0.540]	**.000*****	2.044 [0.541]	**.000*****
Types of SRH educators [a]				
Teachers	-1.160 [0.955]	.225	-1.138 [0.955]	.234
Health care providers	0.675 [0.618]	.274	0.646 [0.618]	.296
Peer educators	-1.708 [0.609]	**.004****	-1.708 [0.611]	**.005****
No one teaching RH education [b]	-		-	
SRH Topics learning from monastic schools [b]				
Puberty	0.325 [0.520]	.532	0.356 [0.521]	.495
Reproduction and Pregnancy	-0.294 [0.505]	.561	-0.298 [0.505]	.555
Contraception	0.344 [0.660]	.602	0.340 [0.660]	.607
Relationship	0.725 [0.465]	.119	0.695 [0.466]	.136
Sexual Health	0.417 [0.531]	.433	0.459 [0.533]	.390
HIV & STIs	-0.035 [0.485]	.943	-0.036 [0.485]	.941
Frequency of SRH education in the class				
No RH education	Ref.		Ref.	
Rarely	0.420 [1.141]	.713	0.376 [1.142]	.742
Regular	1.734 [1.193]	.147	1.727 [1.194]	.148
Level of SRH knowledge				
Below-mean score	-	-	Ref.	
Above-mean score	-	-	-0.315 [0.364]	.386
Constant	33.23	**.000*****	34.56	**.000*****
N	870		870	
R^2	0.061		0.062	

Factors	Model 1		Model 2	
	β [se.]	**p** *value*	*β [se.]*	*p value*
Adjusted R^2	0.040		0.040	
F	2.912		2.803	
AIC	5,355.757		5,356.987	
BIC	5,455.896		5,461.894	

*Note: se: Standard Error; N: No. of observations; AIC, BIC: To evaluate and compare the models based on the goodness of fit and complexity; [a] Multiple responses with "Yes/No" Binary variables; [b] Excluded due to multicollinearity; *p < .05, **p < .01, ***p < .001; Note: Negative coefficients indicate more favorable perceived social norms (lower scores), while positive coefficients indicate more unfavorable perceived social norms (higher scores).*

Similar findings were observed in Model 2, where students in higher grades (Grades 8–10) and those who received SRH education from peer educators had significantly lower perceived social norms scores than students in lower grades and those who had not received peer education ($p < .05$). Interestingly, students with good SRH knowledge had lower perceived social norms scores than those with low SRH knowledge; however, this association was not statistically significant ($p = .386$). In both regression models, students with at least one form of functional difficulty had approximately 2.04 points higher perceived social norms scores than students without functional difficulties ($p < .001$).

Lastly, the study found that male students, lay students, students from the community, and those who received SRH education from teachers, and those who learned about reproduction, pregnancy, and HIV/STIs through life skills classes in monastic schools tended to have lower perceived social norms scores after controlling for the other variables in the models; however, these associations were not statistically significant ($p > .05$).

Discussion

This study aimed to quantify perceived social norms regarding SRH and identify associated factors among students in monastic schools. The findings revealed a high prevalence of unfavorable perceived social norms, with the most pronounced unfavorable social norms related to relationships, potentially indicating the influence of underlying gender norms. The study also showed that students in higher grades tended to exhibit more favorable social norms regarding SRH. Despite the relatively small number of students with disabilities, adolescents with disabilities demonstrated more unfavorable perceived social norms than those without disabilities. Additionally, the study found that exposure to peer education on SRH was associated with more favorable social norms, highlighting the important role of peers in shaping adolescents' social perceptions.

The study found that students in monastic schools exhibited unfavorable perceived social norms regarding SRH, with an overall mean score percentage of 53%. The relationship domain had the highest mean score percentage (63%), suggesting that students' attitudes and beliefs may reflect harmful gender norms and contribute to unhealthy relationship dynamics. For instance, the majority of students demonstrated acceptance of unhealthy practices in relationships and contraception, such as agreeing with statements that "a boy's respect for a girl diminishes if she willingly consents to engage in sexual activity with him", "forcing a girl to have sex is justified if the boy loves her", and "carrying condoms and preventing pregnancy are the women's responsibility". These findings are consistent with those of Berhane et al.

(2019), who reported more unfavorable attitudes regarding women's rights in relationships and contraception use among adolescent girls in Ethiopia. Similarly, inequalities in access to and utilization of SRH education and services between men and women have been identified in Myanmar (Baek et al., 2024; Thin Zaw et al., 2013). Together, these findings suggest that promoting respectful relationships and equitable access to SRH education and services is essential for addressing persistent harmful gender stereotypes in Myanmar.

Female students tended to have more unfavorable perceived social norms than male students. These findings are consistent with two previous studies conducted in Myanmar, which found that girls generally held more unfavorable attitudes or perceived norms regarding premarital sex than boys (Oo et al., 2011; Thin Zaw et al., 2013). In religious educational settings, girls may encounter greater pressure, judgment, and stigmatization related to SRH because of prevailing societal expectations and gender. Furthermore, evidence from Myanmar suggests that adolescent girls attending monastic schools face challenges in accessing accurate reproductive health information. Many of these girls receive incorrect or incomplete information because of prevailing social taboos, cultural beliefs, and behavioral restrictions (Swe et al., 2022).

Students with disabilities had more unfavorable perceived social norms regarding SRH than their non-disabled peers. To date, a growing body of evidence suggests that individuals with disabilities often face stigma, discrimination, and various barriers that hinder their access to SRH information and services (Ahumuza et al., 2014; Ganle et al., 2020; Michielsen et al., 2012). Young people with disabilities have reported challenges in accessing SRH information and utilizing SRH services, including contraception and gynecological consultations. Despite expressing a need for these services, they frequently encounter significant barriers and rely on others for support when seeking care from service providers (Burke et al., 2017). These barriers may contribute to limited understanding, misconceptions, and negative attitudes toward SRH (Ahumuza et al., 2014; Ganle et al., 2020). Consequently, adolescents with disabilities may face difficulties in making informed decisions and accessing appropriate SRH services, potentially affecting their overall health and well-being (Burke et al., 2017; Ganle et al., 2020). Several studies have underscored the importance of improving access to accurate SRH information and services for adolescents with disabilities (Ahumuza et al., 2014; Burke et al., 2017; Ganle et al., 2020). However, the findings related to disability in the present study should be interpreted with caution because disability status was classified into two categories and did not distinguish between different types or levels of disability severity. Further research is needed to better understand the needs and barriers experienced by students with disabilities in monastic school settings.

Students who received peer education on SRH-related topics exhibited more favorable perceived social norms than those who did not. Similar findings were reported in Nigeria, where peer education sessions contributed to significant improvements in knowledge, attitudes, and opinions regarding STIs, HIV, HIV-related stigma, and condom use among adolescents and young people (Akuiyibo et al., 2021). Previous studies have also shown that peer educators can effectively transfer knowledge to their peers through interactive activities that facilitate behavior change, while students who received HIV prevention education from peers reported a significant reduction in stigma (Bagnall et al., 2015; Brown et al., 2012; Michielsen et al., 2012; Ogul & Sahin, 2024). Adolescents may find it easier to connect with their peers and discuss sensitive topics than with adults, thereby enhancing communication and learning (Barbagallo & Boon, 2012; Brown et al., 2012; Döring et al., 2017; Ogul & Sahin, 2024). However, evidence regarding the effectiveness of peer education in improving broader SRH outcomes remains mixed (Chandra-Mouli et al., 2015; Medley et al., 2009). Nevertheless,

the findings of the present study suggest that peer educators may play an important role in promoting more favorable perceived social norms regarding SRH among adolescents.

Novice students (monks or nuns) demonstrated significantly more unfavorable perceived social norms than lay students. Similar observations have been reported in other religious settings. For example, a study in Zimbabwe reported that some nuns were hesitant and uncomfortable discussing sexual and reproductive health information (Mudzimu, 2021), while a study in Thailand found that young women residing in Catholic nun-operated boarding houses as part of nonformal education programs were less likely to engage in premarital sex than those not participating in similar programs (Tangmunkongvorakul et al., 2012). Although the reasons underlying the observed differences between novice and lay students could not be determined in the present study, previous literature suggests that religious and educational environments, including the unique environment and moral code of monastic life, may influence adolescents' exposure to SRH information and services and, consequently, their perceptions of SRH. In Buddhist culture, novices may return to lay life (Preeda, 2020). In Bhutan, engaging monasteries in delivering life skills-based education (LSE) training on SRH has yielded positive outcomes within the monastic community and society, highlighting the potential value of strengthening SRH education in religious settings. These initiatives have been associated with broader improvements in SRH indicators, including reduced maternal mortality, increased contraceptive use, and a higher proportion of skilled birth attendance (UNFPA, 2021a).

Students with good SRH knowledge tended to report more favorable perceived social norms than those with lower SRH knowledge; however, the association was not statistically significant. Similar findings were reported in Nigeria, where women with greater knowledge of contraception were more likely to exhibit positive attitudes toward contraceptive use, aligning with prevailing social norms (Babalola et al., 2015). Likewise, a study conducted in Indonesia found that adolescent boys with greater SRH knowledge exhibited higher levels of body satisfaction and experienced less guilt regarding their sexuality than adolescent girls (Kågesten et al., 2021). However, the association between SRH knowledge and social norms may be influenced by various factors, including the availability and accessibility of SRH information and services, as well as cultural beliefs (Decker et al., 2021; Thin Zaw et al., 2013; Wakjira & Habedi, 2022). Although the association was not statistically significant in the present study, the broader evidence highlights the importance of providing accurate and reliable SRH information, as accurate knowledge is essential for promoting positive behaviors and informed decision-making in the context of SRH.

Recommendation for policy implication

Based on the findings of this study, strengthening Comprehensive Sexuality Education (CSE) programs in monastic schools and other school settings serving adolescents should place greater emphasis on addressing unfavorable social norms related to relationships, contraception, and HIV/AIDS. Given the high prevalence of these unfavorable norms among students in monastic schools, efforts should focus not only on improving SRH knowledge but also on promoting respectful relationships, gender equality, and informed decision-making by providing accurate, age-appropriate SRH information. Considering that teachers were the primary source of SRH education for most students, strengthening teachers' capacity to deliver accurate, age-appropriate, and gender-sensitive SRH education may help promote more favorable social norms among adolescents. The findings also suggest that greater

attention should be given to students with disabilities, who were more likely to report unfavorable perceived social norms regarding SRH. Ensuring equitable access to SRH information and education for students with disabilities may contribute to more inclusive learning environments and improved SRH outcomes.

Empowering peer educators may be a valuable component of SRH interventions. Although only a small proportion of students reported receiving SRH education from peer educators, exposure to peer education was associated with more favorable perceived social norms. Therefore, peer education may serve as a complementary approach to strengthening SRH education within monastic schools. Further research is needed to better understand the implementation and effectiveness of peer education interventions, including their influence on adolescents' SRH knowledge, attitudes, and perceived social norms.

Collaborative efforts among educational authorities, monastic school principals, teachers, community members, and other relevant stakeholders are crucial for addressing these issues. Emphasis should be placed on integrating social norms-related content into SRH education to promote respectful relationships, gender equality, and informed decision-making among adolescents.

A key recommendation for future research is to conduct qualitative studies to explore social and gender norms that shape adolescents' SRH perceptions and behaviors. Such studies could provide deeper insights into adolescents' lived experiences, perceptions, and the social and cultural contexts influencing SRH. Furthermore, future quantitative studies should consider using more comprehensive measures of social norms rather than relying on proxy indicators. Incorporating measures of collective norms could enhance understanding of how social and community factors influence SRH outcomes beyond the individual level. These approaches may provide a more comprehensive understanding of social dynamics and inform targeted interventions and policies to improve adolescent SRH outcomes at the community level. As this study primarily focused on the direct relationships between variables, future research should investigate potential mediating and moderating factors that influence perceived social norms regarding SRH. Examining these factors could improve understanding of the mechanisms through which individual-, social-, and community-level factors interact within the socio-ecological context.

Strengths and limitations

This study has several limitations. First, perceived social norms were measured using proxy indicators derived from adolescents' attitudes and beliefs regarding SRH-related issues because direct measures of injunctive and descriptive norms were not available in the secondary dataset. Therefore, this measure may not fully capture broader community- or society-level normative environments. Second, the purposive selection of participating monastic schools may have introduced selection bias and limited the generalizability of the findings to other monastic schools in the Magway Region and Myanmar. In addition, the exclusion of Grade 5 and Grade 6 students for ethical reasons limited the representation of younger adolescents, who may be at an important stage in the development of SRH-related attitudes and perceptions. Third, due to the limitations of the available data, the study was unable to include several potentially important factors identified in the socio-ecological model, such as family dynamics, economic status, social and peer networks, access to healthcare services, and the availability and accessibility of youth-friendly SRH clinics, all of

which may influence adolescents' perceived social norms regarding SRH. Fourth, the study employed a cross-sectional design with self-report measures, which may limit the validity of the findings.

Furthermore, the cross-sectional design limits the ability to establish causal relationships between perceived social norms and the independent variables, as the observed associations may be influenced by reverse causality or unmeasured confounding factors. Therefore, further research is needed to explore these relationships, including potential causal pathways. Despite these limitations, this study makes a noteworthy contribution to the existing literature by shedding light on the potential influence of SRH knowledge and individual- and community-level factors in shaping perceived social norms regarding SRH among adolescents in religious educational settings. By acknowledging the complex interplay between perceived social norms, individual characteristics, community factors, and SRH knowledge, this study provides evidence that may inform targeted interventions aimed at promoting positive SRH outcomes among adolescents from diverse social groups.

Conclusion

In conclusion, addressing unfavorable social norms related to SRH is crucial for improving SRH outcomes among adolescents. Promoting more favorable social norms can support healthy behaviors and informed decision-making, thereby contributing to the overall well-being of adolescents and their communities. The findings of this study affirm the value of continued efforts to strengthen and expand school-based CSE programs by addressing specific knowledge gaps, harmful gender and social norms, and ensuring equitable access to accurate SRH information. Given that teachers were the primary source of SRH education, strengthening their capacity to deliver age-appropriate and gender-sensitive SRH education may help foster more favorable social norms among adolescents, while peer education may serve as a complementary approach to support SRH learning. Future research should explore factors that influence perceived social norms regarding SRH and investigate the potential impact of SRH education programs on shifting these norms. By breaking the silence surrounding SRH-related issues and challenging harmful social norms, a more supportive environment can be created to promote positive attitudes and healthy SRH practices among adolescents, especially those from marginalized groups.

Author’s note

This article is an abridged version of the first author’s master’s thesis at Mahidol University. It includes descriptive findings that were presented at the 14th International Graduate Students Conference on Population and Public Health Sciences (IGSCPP).

Ethical approval

The Burnet Institute, which managed and conducted the original dataset, has officially approved access to the dataset, “the Integrated Multi-Sectoral Approach (IMSA) To Improve the SRH of Adolescents in Magway, Myanmar: Baseline Survey,” as confirmed by this study.

Additionally, the research protocol for this study was reviewed by the Institutional Review Board of the Institute for Population and Social Research of Mahidol University (IPSR-IRB, COE No. 2023/04-076).

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