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Informal Policies in Reproductive Health Programmes: A Systematic Review

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Abstract

Reproductive health programmes are often guided by formal policies and institutional frameworks; however, their implementation and outcomes are significantly influenced by informal policies embedded within sociocultural norms, institutional practices, and discretionary behaviours of frontline actors. Despite their importance, informal policy systems remain underexplored in reproductive health research. This systematic review examined how informal policies shape reproductive health programmes, implementation processes, and service delivery outcomes. A PRISMA-guided systematic review design was employed. Literature published between 2000 and 2025 was retrieved from PubMed, Scopus, Web of Science, JSTOR, Google Scholar, African Journals Online (AJOL), CINAHL, and ProQuest, alongside grey literature from international organizations and policy agencies. After screening and eligibility assessment, 24 studies met the inclusion criteria and were analyzed using thematic narrative synthesis. The findings revealed that informal governance and street-level bureaucracy were dominant influences on reproductive health implementation. Frontline health workers, local administrators, traditional leaders, and religious actors frequently exercised discretionary authority that shaped access to family planning, maternal health, and adolescent sexual and reproductive health services. Sociocultural norms, patriarchal systems, and religious beliefs functioned as unofficial policy structures regulating



reproductive health seeking behaviour and service acceptance. The review also identified substantial policy-practice gaps, where formally progressive reproductive health policies were weakened by provider bias, weak accountability systems, political interference, and institutional constraints. Community stakeholders and civil society organizations played important roles in mediating programme legitimacy and implementation. The review concludes that informal policies are central determinants of reproductive health programme outcomes. Effective reproductive health governance therefore requires integrating formal policy frameworks with sociocultural realities, stakeholder engagement, and implementation-level governance dynamics.

Keywords: Formal policies, Reproductive health, Institutional frameworks, Regulation.

Introduction

Reproductive health remains a central component of global public health and development, particularly in low- and middle-income countries (LMICs), where disparities in access to quality reproductive health services persist. Since the adoption of the Programme of Action at the International Conference on Population and Development (ICPD) in 1994, many countries have implemented reproductive health policies and programmes aimed at improving maternal health, family planning, and sexual health outcomes (Busse et al., 2022). However, despite policy reforms and programmatic expansion, implementation gaps remain significant, particularly in resource-constrained settings where informal systems often complement or substitute formal health services (Busse et al., 2022). In many developing countries, healthcare delivery operates within a pluralistic system consisting of both formal and informal structures. Informal health systems encompass unregulated or semi-regulated actors, community-based networks, traditional practitioners, and non-governmental service arrangements that operate outside formal regulatory frameworks. These actors play a substantial role in healthcare delivery, particularly among marginalized populations and communities with limited access to formal health facilities (Sen, G. and Ostlin, P. 2023). The reliance on informal systems is particularly evident in reproductive health programmes, where traditional birth attendants, patent medicine vendors, and community health volunteers frequently provide maternal and family planning services.

Informal policies refer to unwritten rules, practices, norms, and decision-making processes that shape program implementation outside formal legislative or institutional frameworks. These policies emerge through social relationships, community expectations, and institutional practices rather than official guidelines or regulatory mandates (Crawford *et al.*,

2025). Informal policies often influence how reproductive health programmes are delivered, accessed, and sustained within communities. They may include informal referral mechanisms, community mobilization strategies, traditional health practices, or unofficial financial arrangements within health systems. The persistence of informal policies in reproductive health programmes is closely linked to structural weaknesses in formal health systems (Crawford *et al.*, 2025). In many LMICs, inadequate infrastructure, shortages of skilled health personnel, limited funding, and weak governance structures create gaps in service delivery. These gaps are frequently filled by informal providers who deliver essential services, particularly in rural and underserved areas. Informal providers often operate independently of the formal health system, which can lead to fragmented service delivery, inconsistent quality of care, and limited accountability mechanisms (Busse et al., 2022).

Despite these challenges, informal health systems play a critical role in improving access to reproductive health services. In many communities, informal providers are more accessible, culturally acceptable, and affordable than formal healthcare facilities. They often maintain strong social relationships with community members, enabling them to influence health-seeking behavior and promote service utilization (Okpani and Okpani, 2024). Informal providers are deeply embedded within local communities and are frequently trusted sources of health information and support (Onwujekwe *et al.*, 2025). In reproductive health programmes, informal policies frequently shape maternal health practices, family planning decisions, and adolescent reproductive health behaviors. For example, informal community norms may determine whether women seek antenatal care, deliver in health facilities, or use modern contraceptive methods. In some settings, informal social networks and cultural beliefs influence reproductive decision-making more strongly than formal health policies. These informal dynamics can either facilitate or hinder the effectiveness of reproductive health programmes (Bolarinwa *et al.*, 2025).

Urbanization and population growth have further intensified reliance on informal health systems, particularly in informal settlements and peri-urban communities. Residents of such communities often face barriers to accessing formal health services, including financial constraints, transportation challenges, and social stigma. As a result, they frequently rely on informal providers for reproductive health services, even when formal services are available (Van Belle, 2024). Informal policies within these settings may determine service pricing, referral pathways, and service delivery practices. Another important dimension of informal policies in reproductive health programmes is the existence of informal financial arrangements within health systems (Okpani and Okpani, 2024). Informal payments defined as payments made outside official service fees



are common in many healthcare settings and may influence service quality, provider behavior, and patient satisfaction. These payments may be requested by healthcare providers or voluntarily offered by patients to secure faster or better services (Binyaruka *et al.*, 2022). Such practices represent informal policy mechanisms that shape health service delivery and access.

The integration of informal health systems into formal reproductive health programmes has become a growing priority for policymakers and global health organizations. The World Health Organization and other international agencies increasingly recognize the importance of engaging informal providers in health system strengthening efforts. Strategies such as training, supervision, and referral systems have been proposed to improve coordination between formal and informal health systems and enhance service quality (Onwujekwe *et al.*, 2025). However, the regulation of informal health systems remains a complex challenge. Strict regulation or prohibition of informal providers may reduce service availability, particularly in rural areas where formal healthcare infrastructure is limited. For example, policies banning traditional birth attendants in some countries have been associated with unintended consequences, such as increased home deliveries without skilled assistance (Chinkhumba *et al.*, 2025; Okonofua, 2023). This highlights the need for balanced approaches that recognize the role of informal systems while ensuring quality and safety in reproductive health services. In addition, the growing emphasis on universal health coverage (UHC) and health system integration has increased attention to the role of informal policies in reproductive health programmes (Van Belle, 2024). Informal sector workers and underserved populations often face difficulties accessing health insurance schemes due to irregular income and lack of formal employment structures. These challenges reinforce reliance on informal health systems and underscore the importance of understanding informal policy mechanisms in reproductive health service delivery (Barasa *et al.*, 2025).

From a research perspective, systematic reviews of informal policies in reproductive health programmes are essential for synthesizing existing evidence and identifying gaps in knowledge. Although numerous studies have examined reproductive health policies and service delivery, relatively few have focused specifically on informal policy mechanisms and their impact on reproductive health outcomes. Evidence regarding the effectiveness, sustainability, and integration of informal health systems remains fragmented and context-specific (Bolarinwa *et al.*, 2025). Moreover, methodological limitations in existing studies have hindered the development of comprehensive policy frameworks for integrating informal systems into formal reproductive health programmes (Onwujekwe *et al.*, 2025). Understanding informal policies in reproductive health programmes is therefore critical for

improving service delivery, strengthening health systems, and achieving global reproductive health goals. Informal policies influence program implementation, resource allocation, and community engagement, particularly in settings where formal health systems face structural constraints (Okpani and Okpani, 2024). By systematically reviewing existing evidence on informal policies in reproductive health programmes, researchers can provide policymakers and stakeholders with insights into effective strategies for integrating informal systems into formal health frameworks. Ultimately, addressing informal policies in reproductive health programmes requires a holistic approach that recognizes the interconnected roles of formal institutions, community networks, and socio-cultural practices (Crawford *et al.*, 2025). Such an approach is essential for improving reproductive health outcomes, reducing maternal and neonatal mortality, and promoting equitable access to quality reproductive health services in developing countries. Hence, the aim of this systematic review of existing evidence on informal policies in reproductive health programmes.

Methodology

Research Design

This study employed a systematic review design to comprehensively examine existing evidence on informal policies in reproductive health programmes. Systematic reviews are rigorous, transparent, and reproducible methods for identifying, appraising, and synthesizing evidence from diverse sources to address clearly defined research questions. Given the complexity of informal policies often embedded in social norms, institutional practices, unofficial governance structures, and implementation realities this review adopted a narrative and thematic synthesis approach rather than statistical meta-analysis.

This design was considered appropriate because studies on informal reproductive health policies frequently vary in conceptual frameworks, methodological approaches, sociopolitical contexts, and reporting formats, making quantitative pooling unsuitable. The review therefore integrated qualitative, quantitative, and mixed-method evidence to generate a structured understanding of how informal policies influence reproductive health programming, service delivery, stakeholder interactions, and outcomes across different settings (Baumeister & Leary, 1997).

The methodology was guided by Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) principles to ensure transparency in study identification, screening, eligibility assessment, and inclusion.

Review Questions



The review was guided by five key research questions. First, it examined the types of informal policies and practices that influence the design and delivery of reproductive health programmes across different contexts. Second, it explored how these informal policies shape the design, implementation, and outcomes of reproductive health interventions. Third, the review investigated the key actors and stakeholders involved in the development, negotiation, interpretation, and enforcement of informal reproductive health policies. Fourth, it examined the sociocultural, political, institutional, and economic factors that facilitate or constrain informal policy processes within reproductive health programmes. Finally, the review assessed the strategies that have been effective in aligning informal policies and practices with formal reproductive health policy goals and in improving programme implementation and outcomes.

Search Strategy

A comprehensive and systematic search strategy was developed to identify relevant literature published between 2000 and 2025. This time frame was selected to capture contemporary developments in reproductive health governance, policy implementation, and health systems strengthening, particularly in relation to informal institutional practices.

Searches were conducted across multiple electronic databases to ensure multidisciplinary coverage of public health, policy studies, sociology, and development literature. The databases included: PubMed/MEDLINE; Scopus; Web of Science; JSTOR; Google Scholar; ProQuest; African Journals Online (AJOL); and CINAHL. Search terms were developed using Boolean operators and keyword combinations tailored to each database. Core search terms included: informal policy, street-level bureaucracy, informal governance, reproductive health programme, sexual and reproductive health, maternal health, family planning, health systems, policy implementation, community norms and institutional practice, low- and middle-income countries, Africa, specific country names where relevant.

Inclusion and Exclusion Criteria

The inclusion criteria were developed to capture studies that provided relevant evidence on the role of informal policies and practices in reproductive health programmes. Eligible studies included those addressing informal policies, informal institutional practices, or unofficial governance mechanisms related to reproductive health. The review considered studies focusing on reproductive, maternal, sexual, and family planning health services. Both empirical and policy-oriented evidence were eligible, including qualitative, quantitative, and mixed-methods studies, as well as policy analyses, programme evaluations, and credible grey literature. To ensure temporal relevance, only studies published between 2000 and 2025 and

available in English were included. Studies were also required to examine stakeholder roles, implementation dynamics, or policy-related outcomes within reproductive health programmes.

Studies were excluded where they focused solely on formal policies without examining informal structures, practices, or governance mechanisms. Clinical reproductive health studies were excluded when they had no clear relevance to policy development, implementation, governance, or programme delivery. Editorials, opinion papers, and commentaries that did not provide empirical or substantive policy evidence were also excluded. Non-English publications were excluded where a reliable translation was unavailable. In addition, duplicate studies and publications for which the full text could not be accessed were excluded from the review.

Study Selection Process

The study selection process followed a PRISMA-informed four-stage procedure. During the identification stage, relevant records were retrieved through systematic searches of electronic databases, grey literature sources, and manual citation tracking of relevant publications. The retrieved records were then screened by reviewing their titles and abstracts to exclude studies that were clearly unrelated to the review objectives. During the eligibility stage, the full texts of potentially relevant studies were obtained and assessed against the predefined inclusion and exclusion criteria. Finally, at the inclusion stage, studies that satisfied all eligibility requirements were selected for the final synthesis. This structured process helped to ensure that the selection of studies was systematic, transparent, and consistent with the objectives of the review.

Data Extraction

A standardized data extraction framework was developed to ensure the systematic and consistent capture of relevant information from each included study. The framework captured key bibliographic information, including the author(s) and year of publication, as well as the country or region in which the study was conducted. Information on the study objectives, design, and methodology was also extracted, alongside details of the specific reproductive health programme or service area examined. Particular attention was given to identifying and describing the type and nature of informal policies, practices, or governance mechanisms reported in each study.

The extraction framework further captured information on the key stakeholders involved, including government institutions, non-governmental organisations, healthcare providers, communities, religious leaders, and other relevant actors. Data were also extracted on the social, political, cultural, and economic factors influencing informal policy processes, as



well as the challenges and facilitators affecting programme implementation. Information on programme outcomes, policy implications, major conclusions, and recommendations was also recorded. This structured approach enhanced consistency and comparability across the included studies while facilitating the systematic organization and subsequent thematic synthesis of the evidence.

Quality Appraisal

Methodological quality of the included studies was assessed using appropriate critical appraisal tools according to study design. The Critical Appraisal Skills Programme (CASP) tools were used to assess qualitative studies, while the Joanna Briggs Institute (JBI) critical appraisal tools were applied to cross-sectional and mixed-methods studies. The assessment focused on the clarity of study objectives, methodological rigour, appropriateness of sampling procedures, validity and reliability of the data, transparency of the analytical methods, and relevance of the findings to the review questions. Studies demonstrating insufficient methodological quality were either excluded from the final synthesis or, where their findings were considered potentially informative, interpreted with appropriate caution. This approach helped to strengthen the credibility and reliability of the evidence included in the review.

Data Synthesis

A thematic narrative synthesis approach was employed in accordance with the framework proposed by Popay et al. (2006). This approach was considered appropriate because of the anticipated heterogeneity in study designs, populations, settings, policy contexts, and outcome measures across the included studies. The synthesis involved three main stages. First, a preliminary synthesis was conducted by organizing the included studies according to the type of informal policy or practice, reproductive health domain, geographical region, and stakeholder group. This facilitated the identification of recurring patterns, similarities, and differences across the evidence base.

Second, relationships between informal policies and reproductive health programme outcomes were explored across different contexts. Particular attention was given to contextual factors that could influence these relationships, including gender norms, governance systems, donor influence, provider discretion, and community power structures. This stage helped to explain how and why informal policies and practices influenced programme design, implementation, and outcomes in different settings. Third, the robustness of the evidence was assessed by examining the strength, consistency, and credibility of findings across the included studies, taking into consideration methodological quality and contextual differences.

The synthesis generated several overarching themes, including informal governance and decision-making, cultural and religious norms, provider discretion and street-level implementation, community influence and social legitimacy, policy-practice gaps, and resource allocation and institutional adaptation. These themes provided a framework for integrating findings across diverse studies and for understanding the mechanisms through which informal policies and practices shape reproductive health programmes and their outcomes.

Ethical Considerations

As this study was based exclusively on the secondary analysis of published and publicly accessible materials, formal ethical approval was not required. Nevertheless, established ethical standards for conducting evidence synthesis were observed throughout the review process. All sources were accurately cited and referenced to acknowledge the contributions of the original authors and prevent plagiarism. The findings of the included studies were represented faithfully without distortion, selective reporting, or misinterpretation. Particular attention was given to avoiding plagiarism and ensuring that evidence was not selectively presented to support predetermined conclusions. In addition, methodological decisions, including the study selection, data extraction, quality appraisal, and synthesis processes, were reported transparently to enhance the credibility, reproducibility, and integrity of the review.

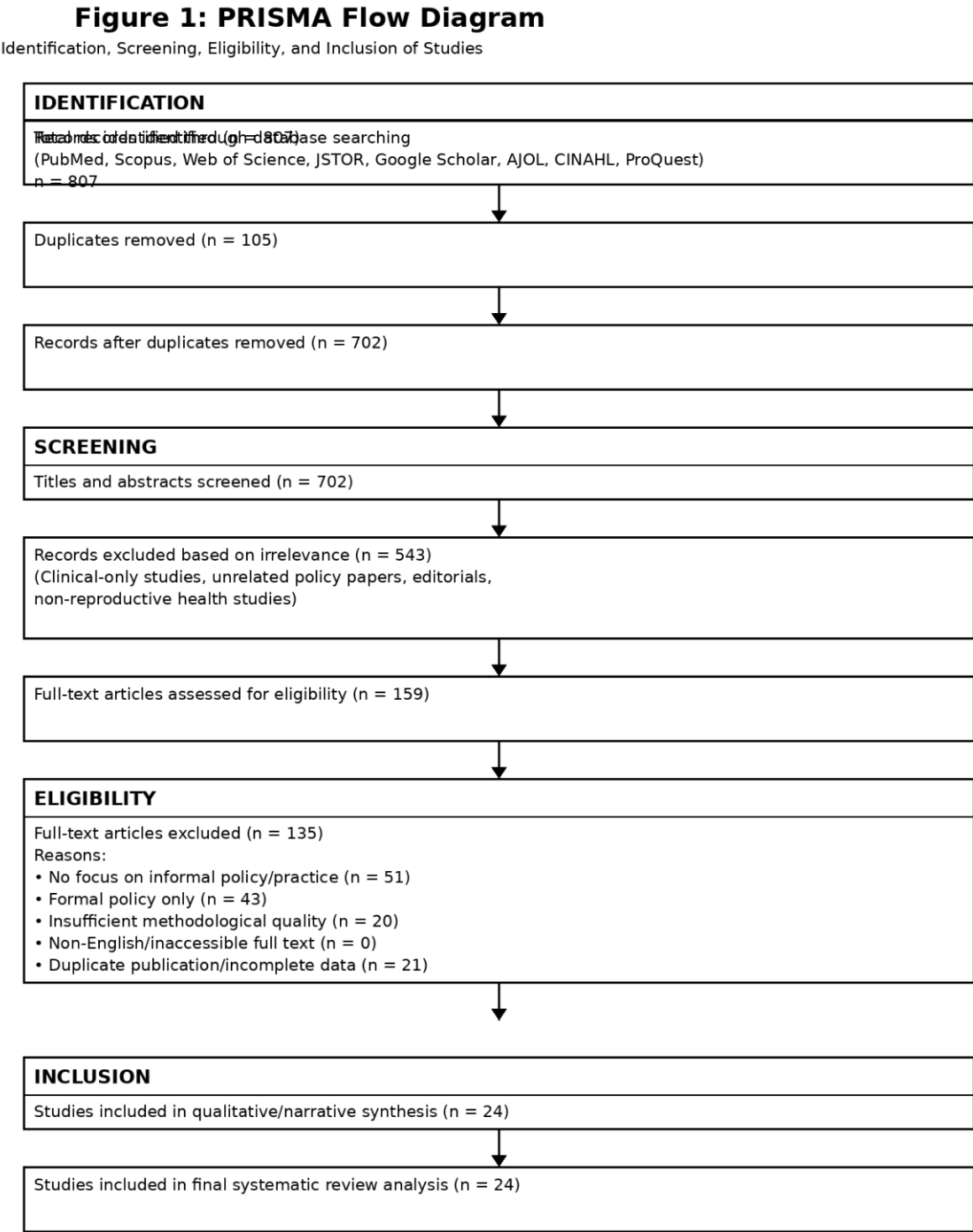


Figure 1: PRISMA Flow Diagram showing steps taken to arrive at selected studies

Results

Prisma Study Selection Summary For Included Studies On Informal Policies In Reproductive Health Programmes

Table 1 presents the systematic process used to identify, screen, and select studies for inclusion in this review. A total of 807 records were initially identified from multiple academic databases, reflecting a broad evidence base on reproductive health and policy-related issues. Following duplicate removal (13.0%), 702 unique studies remained for title and abstract screening. The large proportion of records excluded at the



screening stage (77.4%) indicates that although reproductive health literature is extensive, relatively few studies explicitly addressed informal policy dimensions, unofficial governance systems, or sociocultural structures relevant to this review. Of the 159 full-text articles assessed for eligibility, 84.9% were excluded, primarily because they focused on formal policy

structures, lacked emphasis on informal practices, or failed to meet methodological quality standards. Ultimately, only 24 studies (15.1% of full-text reviewed studies) were included in the final synthesis. This substantial narrowing demonstrates both the specificity of the review focus and the limited direct scholarship on informal policies in reproductive health programmes.

Table 1: PRISMA Study Selection Summary for Included Studies on Informal Policies in Reproductive Health Programmes

PRISMA Stage	Description	Number of Records (n)	Percentage (%)
Identification	Records identified through database searching	807	100.0
Identification	Duplicates removed	105	13.0
Screening	Records after duplicates removed	702	87.0
Screening	Records excluded after title/abstract screening	543	77.4
Eligibility	Full-text articles assessed	159	22.6
Eligibility	Full-text articles excluded	135	84.9
Inclusion	Studies included in qualitative/narrative synthesis	24	15.1
inclusion	studies included in final systematic review	24	15.1

characteristics of included studies (n = 24)

Table 2 summarizes the geographical, methodological, and programmatic characteristics of the 24 studies included in the review. Geographically, nearly half of the studies (45.8%) were conducted in Sub-Saharan Africa, indicating that this region represents the strongest body of evidence on informal reproductive health policy processes. This dominance likely reflects the complex interaction of formal health systems with pluralistic governance structures, sociocultural norms, and community power systems common in many African contexts. South Asia (25.0%) also contributed substantially, particularly in relation to sociocultural mediation of reproductive health, while Latin America (16.7%) emphasized reproductive rights and implementation tensions. Methodologically, qualitative studies accounted for 50.0% of included studies, highlighting the socially

embedded, context-specific, and relational nature of informal policy systems, which are often better captured through qualitative inquiry. Mixed-method studies (29.2%) provided a broader understanding of both implementation processes and measurable outcomes, while quantitative studies were less common (20.8%), likely due to the difficulty of operationalizing informal systems through standardized metrics.

In terms of programme focus, family planning emerged as the most frequently studied area (33.3%), followed by maternal health (25.0%) and adolescent sexual and reproductive health (20.8%). This distribution suggests that informal policy influences are particularly salient in reproductive domains where cultural, religious, and gender norms strongly shape service access and utilization.



Table 2: Characteristics of Included Studies (n = 24)

Variable	Category	Frequency (n)	Percentage (%)	Analytical Interpretation
Geographic Region	Sub-Saharan Africa	11	45.8	Dominant representation due to reproductive governance challenges in pluralistic systems
	South Asia	6	25.0	Strong focus on sociocultural policy mediation
	Latin America	4	16.7	Emphasis on reproductive rights implementation
	Other LMICs	3	12.5	Limited but diverse contextual contribution
Study Design	Qualitative	12	50.0	Most suitable for exploring informal systems
	Mixed Methods	7	29.2	Balanced contextual and outcome analysis
	Quantitative/Cross-sectional	5	20.8	Less frequent due to complexity of informal policy measurement
Programme Focus	Family Planning	8	33.3	Most common due to social norm interactions
	Maternal Health	6	25.0	Focus on provider discretion and access
	Adolescent SRH	5	20.8	High sensitivity to informal norms
	Community RH Interventions	3	12.5	Grassroots governance emphasis
	Gender/Reproductive Rights	2	8.3	Policy-practice rights tensions

Major Thematic Findings On Informal Policies In Reproductive Health Programmes

Table 3 highlights the major themes that emerged across the 24 studies and demonstrates the pervasive role of informal systems in reproductive health programming. Informal governance and street-level bureaucracy were the most dominant

themes (87.5%), indicating that frontline health workers, local administrators, and unofficial actors often function as de facto policymakers whose discretionary decisions substantially shape implementation outcomes. Similarly, policy-practice gaps (83.3%) were highly prevalent, revealing that formal reproductive health policies frequently diverge from actual



practice due to local institutional realities. Hence, sociocultural norms (79.2%) and institutional constraints (75.0%) also emerged strongly, underscoring the influence of patriarchal systems, religious authority, weak accountability, and political interference on programme delivery. Community stakeholder influence (70.8%) and provider bias (66.7%) further demonstrate that reproductive health programmes are embedded within broader social governance systems, where implementation is negotiated through local actors and values.

Although less dominant, cultural adaptation strategies (58.3%) and stakeholder collaboration (62.5%) were identified as important facilitators, suggesting that aligning formal policy goals with local informal structures can improve programme legitimacy and effectiveness. Collectively, the findings confirm that informal policies are not peripheral influences but central determinants of reproductive health outcomes.

Table 3: Major Thematic Findings on Informal Policies in Reproductive Health Programmes

Major Theme	Frequency Across Studies (n=24)	Percentage (%)	Key Analytical Insights
Informal Governance / Street-Level Bureaucracy	21	87.5	Frontline provider discretion significantly shaped implementation outcomes
Sociocultural Norms as Policy Drivers	19	79.2	Community, religious, and patriarchal systems functioned as unofficial policy frameworks
Community Stakeholder Influence	17	70.8	Traditional leaders, NGOs, and local actors mediated programme legitimacy
Policy-Practice Gaps	20	83.3	Formal reproductive policies often diverged from implementation realities
Provider Bias and Discretion	16	66.7	Personal beliefs and institutional culture altered service access
Cultural Adaptation Strategies	14	58.3	Contextual adaptation improved programme acceptance
Stakeholder Collaboration	15	62.5	Multi-level engagement enhanced implementation effectiveness
Institutional Constraints / Weak Accountability	18	75.0	Corruption, weak oversight, and political interference undermined policy goals

Informal Governance Structures and Street-Level Bureaucracy in Reproductive Health Programmes

Table 3a provides detailed evidence that informal governance structures significantly shape reproductive health service delivery. Frontline provider discretion was the most frequently reported dimension (21 studies), demonstrating that healthcare providers often selectively interpret or adapt programme implementation according to personal, moral, or

sociocultural considerations. This finding positions providers as informal policymakers whose decisions can either enable or restrict access beyond formal policy provisions.

Service access variation across regions (20 studies) further indicates that implementation outcomes are heavily influenced by localized governance ecosystems rather than national policy uniformity alone. Religious and traditional gatekeeping (18 studies) and local administrative influence (17



studies) also emerged prominently, revealing that reproductive health implementation is often mediated by unofficial authority structures at both community and institutional levels. Overall, the table illustrates that reproductive health programming is

profoundly shaped by decentralized, informal power structures, suggesting that successful policy implementation requires engagement with subnational governance realities.

Table 3a: Informal Governance Structures and Street-Level Bureaucracy in Reproductive Health Programmes

Dimension	Key Findings	Frequency Across Studies (n=24)	Analytical Interpretation
Frontline provider discretion	Health workers selectively interpreted or modified programme implementation based on personal, moral, or cultural beliefs	21	Street-level actors functioned as informal policymakers, often determining actual service delivery beyond formal guidelines
Local administrative influence	Facility managers and local bureaucrats shaped programme priorities unofficially	17	Institutional authority at subnational levels significantly mediated policy implementation
Religious and traditional gatekeeping	Community and faith leaders influenced access to reproductive services	18	Informal authority structures often superseded official reproductive health frameworks
Service access variation	Differences in implementation occurred across regions despite uniform national policies	20	Reproductive health outcomes were shaped by localized informal governance ecosystems

Sociocultural Norms as Informal Policy Drivers

Table 3b demonstrates that sociocultural norms function as powerful informal regulatory systems within reproductive health programmes. Patriarchal norms were the most dominant factor (19 studies), reflecting how gendered power relations frequently constrain women's reproductive autonomy and influence access to services. Religious beliefs (18 studies) and community expectations (17 studies) also played substantial roles, indicating that social legitimacy often supersedes formal reproductive rights

frameworks in many studies. Adolescent reproductive restrictions, although slightly less frequent (15 studies), reveal particularly strong normative barriers for young people seeking sexual and reproductive health services. Moral and cultural narratives around adolescent sexuality often create disproportionate restrictions, even where formal policies are supportive. These findings emphasize that reproductive health programmes are deeply embedded in sociocultural systems, where informal norms may either reinforce or undermine formal policy objectives depending on contextual alignment.

Table 3b: Sociocultural Norms as Informal Policy Drivers

Dimension	Key Findings	Frequency Across Studies (n=24)	Analytical Interpretation
Patriarchal norms	Male-dominated decision-making restricted women's reproductive autonomy	19	Gendered social structures operated as powerful informal policy systems
Religious beliefs	Religious doctrines influenced contraceptive use, adolescent sexuality, and service acceptance	18	Faith-based norms frequently shaped reproductive policy implementation



Community expectations	Collective norms regulated acceptable reproductive behavior	17	Social legitimacy often outweighed legal policy frameworks
Adolescent reproductive restrictions	Youth sexual health services were constrained by moral and cultural narratives	15	Adolescents faced disproportionate barriers due to normative control

Role of Community Stakeholders and Intermediaries

Table 3c highlights the central role of community stakeholders as intermediaries between formal reproductive health policies and local implementation realities. NGOs and civil society organizations were the most frequently identified actors (18 studies), often serving as bridges between policy frameworks and community needs through advocacy, education, and service

delivery support. Traditional leaders (16 studies) were also highly influential, particularly in shaping legitimacy and social acceptability. Faith-based organizations (15 studies) played dual roles, functioning either as facilitators or barriers depending on ideological orientation, while women’s and community groups (14 studies) enhanced contextual responsiveness through grassroots engagement.

Table 3c: Role of Community Stakeholders and Intermediaries

Stakeholder Category	Roles and Contributions	Frequency Across Studies (n=24)	Analytical Interpretation
Traditional leaders	Community mobilization, legitimacy, norm enforcement	16	Traditional authorities were central to programme acceptability
NGOs and civil society	Advocacy, service delivery support, awareness creation	18	NGOs often bridged formal policy and community implementation
Faith-based organizations	Moral framing, support or resistance to interventions	15	Religious institutions could facilitate or constrain programme uptake
Women’s/community groups	Peer education, trust-building, resource coordination	14	Grassroots structures enhanced contextual responsiveness

Policy-Practice Gaps in Reproductive Health Programming

Table 3d reveals persistent disconnects between formal reproductive health policy design and practical implementation. The most prominent gap was the formal-versus-implementation disconnect (20 studies), demonstrating that progressive reproductive policies frequently fail to achieve intended outcomes due to implementation barriers. Weak accountability

systems (18 studies) and resource constraints (17 studies) were major structural contributors, reinforcing the dominance of informal systems when formal oversight is limited. Provider bias (16 studies) and political or local interference (13 studies) further illustrate how discretionary authority and political economy factors reshape policy implementation on the ground. These findings suggest that policy effectiveness depends not solely on legislative quality but on institutional capacity, governance coherence, and contextual adaptation.



Table 3d: Policy-Practice Gaps in Reproductive Health Programming

Gap Dimension	Key Findings	Frequency Across Studies (n=24)	Analytical Interpretation
Formal vs implementation disconnect	Progressive policies often poorly translated into practice	20	Policy design alone was insufficient without implementation alignment
Provider bias	Personal or institutional beliefs restricted service provision	16	Informal discretion altered policy intent
Weak accountability systems	Limited oversight allowed inconsistent implementation	18	Governance failures reinforced informal policy dominance
Resource and institutional limitations	Funding shortages and infrastructure gaps shaped practical adaptations	17	Structural constraints encouraged unofficial coping mechanisms
Political/local interference	Subnational politics altered programme delivery priorities	13	Political economy factors influenced operational realities

Discussion

This systematic review provides compelling evidence that informal policies are central to the functioning, implementation, and outcomes of reproductive health programmes. Across the 24 studies included, informal governance structures, sociocultural norms, community stakeholder influence, and policy-practice gaps consistently emerged as dominant forces shaping reproductive health systems. These findings reinforce broader health systems scholarship that formal policy frameworks alone are insufficient to explain programme performance, particularly in low- and middle-income countries (LMICs), where unofficial institutions, social norms, and implementation discretion often determine real-world outcomes (Sheikh et al., 2024).

Informal Governance and Street-Level Bureaucracy in Reproductive Health

A major finding of this review is the prominence of informal governance and street-level bureaucracy, identified in 87.5% of included studies. This aligns strongly with Lipsky’s (2020) foundational theory of street-level bureaucracy, which argues that frontline workers effectively become policymakers because they exercise discretion in interpreting and implementing formal rules. In reproductive health, this review demonstrates that healthcare providers frequently shape access to contraception, maternal health services, and adolescent sexual and reproductive

health (SRH) based on personal values, religious beliefs, institutional culture, and local expectations.

This finding is supported by Lehmann and Gilson (2023), who observed that frontline health workers often adapt policies according to cultural pressures, thereby mediating service delivery outcomes. Similarly, Erasmus and Gilson (2025) found that provider discretion in LMIC health systems can either facilitate adaptive implementation or perpetuate inequities. In reproductive health, such discretion becomes particularly consequential because issues like contraception, abortion, and adolescent sexuality are deeply moralized. The present review therefore expands existing literature by showing that informal provider power is not merely an implementation variable but a structural policy force. Furthermore, the review’s evidence that local administrators, traditional leaders, and faith actors often supersede formal policy authority echoes Cleaver’s (2022) concept of “institutional bricolage,” where official systems are reshaped by informal local practices. This suggests that reproductive health programmes are not implemented through formal bureaucratic channels alone but through hybrid governance arrangements that combine official and unofficial authority systems.

Sociocultural Norms as Informal Policy Systems

The review found that patriarchal norms, religious doctrines, and community expectations function as de facto policy systems regulating reproductive behaviour. This finding



aligns with social norms theory, which emphasizes that deeply embedded cultural expectations often govern health behaviours more powerfully than formal law (Cislaghi & Heise, 2024). Across the reviewed studies, patriarchal structures restricted women's reproductive autonomy, while religious and communal norms frequently determined the acceptability of family planning, adolescent SRH, and maternal health interventions. These patterns are consistent with Sen and Ostlin (2025), who argue that gender inequality is a fundamental structural determinant of reproductive health disparities. Likewise, Cornwall et al. (2025) observed that reproductive rights frameworks often fail when they do not adequately engage with prevailing sociocultural institutions. This review contributes to the literature by framing these sociocultural systems not merely as "barriers" but as informal policy architectures that actively regulate programme implementation. For adolescents, the review's finding that youth reproductive access is disproportionately constrained by moral narratives is also supported by Hindin and Fatusi (2024), who documented how social stigma and moral regulation significantly reduce adolescents' ability to access SRH services in sub-Saharan Africa. Thus, informal policies around morality and sexuality may undermine formally progressive adolescent health strategies.

Community Stakeholders as Governance Intermediaries

This review also underscores the dual role of community stakeholders traditional leaders, NGOs, faith organizations, and women's groups—as both facilitators and gatekeepers. This finding supports Gilson's (2023) trust and governance framework, which emphasizes that health systems legitimacy often depends on social relationships beyond formal institutions. NGOs and civil society organizations were frequently found to bridge policy and practice gaps through advocacy, awareness, and contextual adaptation, a pattern also reported by Shiffman (2025) in global reproductive health governance. However, the review also demonstrates that community stakeholders may reinforce restrictive norms. This duality reflects the findings of Campbell and Cornish (2024), who argue that community participation can be transformative only when power structures are critically engaged. Faith-based organizations, for example, may enhance programme legitimacy but can also constrain reproductive rights depending on theological orientation. Thus, community engagement cannot be assumed to be inherently progressive; rather, stakeholder influence must be analyzed politically and institutionally. This review therefore advances literature by highlighting stakeholder systems as informal governance ecosystems rather than simply programme partners.

Policy-Practice Gaps and the Limits of Formalism

One of the most significant findings is the widespread policy-practice gap identified in 83.3% of studies. Formal reproductive health policies were often progressive in design but inconsistently implemented due to weak accountability, provider bias, sociocultural resistance, and political interference. This mirrors Walt and Gilson's (2024) policy triangle framework, which emphasizes that policy outcomes are shaped not only by content but by actors, context, and process. The review's findings suggest that many reproductive health reforms fail because they overemphasize legislative design while underestimating informal implementation systems. Similar concerns have been raised by Sheikh et al. (2023), who argue that health policy implementation in LMICs is often mediated by hidden institutional norms. Likewise, George et al. (2025) found that governance failures in maternal health frequently stem from unofficial institutional practices rather than policy absence. This has major implications for reproductive health governance: policy success depends not simply on "what is written" but on "how systems behave." Therefore, integrating political economy analysis, social norms assessment, and implementation science is essential.

Implications for Theory and Policy

Collectively, this review supports an expanded governance perspective in reproductive health that recognizes informal policies as structurally embedded determinants of health outcomes. Traditional policy analysis often privileges formal institutions, yet this review demonstrates that reproductive health systems function through overlapping formal and informal architectures. This aligns with North's (2023) institutional theory, which distinguishes between formal rules and informal constraints as coexisting governance systems. For policy and practice, this means reproductive health interventions should move beyond legal reform and incorporate: Sociocultural systems mapping; Stakeholder power analysis; Frontline provider behavioral interventions; Community negotiation strategies; Accountability strengthening. Without such integration, formal reproductive health policies risk implementation failure despite technical soundness.

Conclusion

This review indicates that informal policies are not peripheral or secondary influences but fundamental governance structures shaping reproductive health programme outcomes. Informal governance systems may either facilitate adaptive implementation or reproduce exclusion, depending on the culture. The findings therefore challenge reproductive health scholarship and policymaking to move beyond formal policy frameworks toward a more politically, socially, and institutionally grounded understanding of programme implementation. Future reproductive health reforms should explicitly recognize and



strategically engage informal systems if they are to achieve equitable, context-responsive, and sustainable outcomes.

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