Review article

Scaling-up Normative Change Interventions for Adolescent and Youth Reproductive Health: An Examination of the Evidence

Gabrielle Nguyen, M.P.H. a,*, Elizabeth Costenbader, Ph.D. b, Kate F. Plourde, M.P.H. b, Brad Kerner, M.P.H. a, and Susan Igras, M.P.H. c

a Department of Global Health, Save the Children, Washington, DC
b Global Health, Population, and Nutrition, FHI 360, Durham, North Carolina
c Institute for Reproductive Health, Georgetown University, Washington, DC

Article history: Received May 17, 2018; Accepted January 3, 2019
Keywords: Adolescents; Youth; Reproductive health; Scale-up; Normative change

ABSTRACT

Adolescent and youth reproductive health (AYRH) outcomes are influenced by factors beyond individual control. Increasingly, interventions are seeking to influence community-level normative change to support healthy AYRH behaviors. While evidence is growing of the effectiveness of AYRH interventions that include normative change components, understanding on how to achieve scale-up and wider impact of these programs remains limited. We analyzed peer-reviewed and gray literature from 2000 to 2017 describing 42 AYRH interventions with community-based normative change components that have scaled-up in low/middle-income countries. Only 13 of 42 interventions had significant scale-up documentation. We compared scale-up strategies, scale-up facilitators and barriers, and identified recommendations for future programs. All 13 interventions addressed individual, interpersonal, and community-level outcomes, such as community attitudes and behaviors related to AYRH. Scale-up strategies included expansion via new organizations, adapting original intervention designs, and institutionalization of activities into public-sector and/or nongovernmental organization structures. Four overarching factors facilitated or inhibited scale-up processes: availability of financial and human resources, transferability of intervention designs and materials, substantive community and government-sector partnerships, and monitoring capacity. Scaling-up multifaceted normative change interventions is possible but not well documented. The global AYRH community should prioritize documentation of scale-up processes and measurement to build evidence and inform future programming.

© 2019 Society for Adolescent Health and Medicine. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

IMPLICATIONS AND CONTRIBUTION

Little evidence exists on how to integrate normative change efforts into AYRH programs at scale, outside of pilot efforts. This review examines the scale-up processes of 13 documented, successful AYRH interventions with significant normative change components and provides evidence and guidance for programmers seeking to scale-up these unique interventions.

Adolescents (aged 10–19 years) and youth (aged 15–24 years) make up one-quarter of the world’s population and represent the largest cohort of young people in history [1]. Adolescents and youth (aged 10–24 years) face a multitude of reproductive health risks that, if not managed, will have consequences that follow them into adulthood. Early pregnancy and child marriage are a reality for millions, curtailing educational and vocational opportunities and contributing to intergenerational cycles of poverty [2]. Young people are still forming individual abilities, capacities, intentions, and agency. As such, they...
are susceptible to the influence of surrounding social systems that dictate social position and norms, the perceived attitudes or behaviors that are considered acceptable in a social group [3]. Structural barriers including lack of access to health services and economic assets further compound these factors [4].

Because adolescent and youth reproductive health (AYRH) outcomes and behaviors are influenced by the social norms outside of individual control, many believe that interventions to address AYRH must look beyond individual behavior change and seek to shift the negative normative environments that affect adolescents’ well-being [5,6]. For example, a prevalent social norm in many countries is that girls should leave school, get married, and have children early. Shifting or replacing these norms with norms that value gender equity and girls education is likely to enable girls to delay marriage and childbearing. The global health community is increasingly integrating these community-focused normative change activities, defined as “strategies designed to catalyze communities to challenge existing social norms” [7], into broader health programs. However, despite an increase in interest and implementation of these interventions, they are still a nascent area with little explicit guidance for program practice, measurement, and evaluation. As such, there remains a dearth of evidence on how best to foster normative change at scale to reach a larger population and thus achieve wider impact. Indeed, despite significant interest in scaling pilot interventions, little is known about how best to incorporate a norms focus into AYRH programs, demonstrate effectiveness of norms change or, subsequently, scale-up the normative change components of these interventions.

In 2015, the U.S. Agency for International Development awarded the Passages project to a consortium of organizations led by the Institute for Reproductive Health at Georgetown University to support development and testing of scalable approaches to foster social norms that support safe reproductive health (RH) behaviors among adolescents and youth, including delaying pregnancy and spacing subsequent births. To better understand the available evidence on the scale-up of normative change interventions for AYRH, members of the Passages project conducted a review of the current evidence base. The results are summarized here.

**Literature Review**

**Methodology**

In 2015, the Passages project Scale-up Task Team, led by Save the Children and Institute for Reproductive Health, conducted an exploratory literature review of the existing peer-reviewed and gray literature that describes the implementation or evaluation of AYRH interventions with normative change components that were in the process of, or had achieved, scale-up [7]. Combinations of terms, from three main domains—normative change, scale-up, and AYRH interventions—were used to identify relevant literature from three open-access, multidisciplinary research databases that provided access to a wide range of publications: Google Scholar, ScienceDirect, and JSTOR [6]. Relevant literature identified from these three databases was supplemented with additional literature identified through consultation with subject-matter experts. In total, 50 documents describing 42 interventions met the criteria for this initial broad review [7]. Findings from this initial review, summarized in a separate report [7], describe the community-based normative change interventions that were operating at scale to catalyze communities to challenge existing social norms that reinforce harmful attitudes and behaviors that lead to poor AYRH outcomes.

Subsequently, as described in Figure 1, we conducted a second “phase” of review, which focused on interventions from the initial 42 that could offer insight into scaling-up AYRH normative interventions. The conceptual understanding of scale-up applied throughout the initial report and this review was guided by the ExpandNet scale-up framework [8], the scale-up strategy that has been employed by the Passages project. ExpandNet defines scale-up as “deliberate efforts to increase the impact of successfully tested health innovations …to benefit more people and to foster policy and program development on a lasting basis” [8]. ExpandNet categorizes organizations with expertise in intervention implementation as “resource organizations” and the organizations that are expected to replicate the intervention at a larger scale as “user organizations.” Since many of the identified interventions did not provide documentation of scale-up efforts, this second review retained only 13 interventions for further analysis. Interventions were included in this review if they documented both their normative change components and scale-up efforts, and if they fit the inclusion/exclusion criteria detailed in Figure 1. We then searched project websites between February 2017 and April 2017 to identify additional scale-up documentation on the 13 interventions. As a team, we reviewed the available literature and participated in meetings to reach consensus on common themes, and conclusions were extracted from the interventions. The documentation from both search phases was analyzed to (1) examine common characteristics of normative change interventions that were scaled-up; (2) explore scale-up processes employed; and (3) identify factors that facilitated or inhibited scale-up. While it was our original intent to document the intervention components that contributed to normative change, and how these specific components were scaled-up, it was often unclear in the documentation which components were explicitly responsible for normative change outcomes. In addition, it is unlikely that one component acts in isolation of other components to foster normative shifts. As a result, our analysis documents characteristics of and scale-up processes employed by interventions that included normative change components rather than characteristics directly attributable to normative change components.

**Results**

**Intervention characteristics**

Table 1 summarizes the 13 interventions included: a brief description of their primary target populations and outcomes and information about where, when, and with whom they were carried out. As shown in the table, most of the interventions were implemented in Africa (n=10), and most lasted longer than 5 years from initial implementation to scale-up (n=11). In fact, the Tostan program reported a time frame of nearly 30 years over which it has been scaling-up (and adapting) its initial intervention [38]. Given our selection criteria, all 13 interventions primarily targeted adolescents and youth and engaged secondary audiences in various normative change activities. These secondary audiences were the wider community (n=13), parents
and family members (n=9), health providers (n=5), teachers (n=4), and cultural or community leaders (n=3). As all 13 interventions were focused on addressing AYRH, the most common target outcomes that the interventions sought to improve were RH knowledge, attitudes, and behaviors among adolescents. Although all the interventions were selected because of their community-level normative change components, only 11 of the 13 interventions explicitly mentioned measuring attitudes, beliefs, or behaviors among community members as one of their primary outcomes.

Table 2 provides a breakdown of the specific components implemented by each intervention as well as the type of key individual or community-level outcomes that each intervention measured. Community-level refers to activities that target groups in communities other than the primary target group of adolescents or youth whose behavior or health outcomes the program is seeking to shift. Thus, community-level outcomes measure change in secondary populations, such as parents, teachers, or health providers. All 13 interventions applied a multicomponent approach and implemented at least three intervention components. Many included curriculum-based family life education (n=4), peer education and support (n=5), or the creation of adolescent safe spaces (n=10). Social and behavior change communication activities, from interpersonal communication to mass media campaigns, were also popular (n=10). The mass media campaigns often accompanied community-level activities to expand an intervention’s reach and mobilize action in communities [27,32,36,41]. All 13 interventions encouraged community dialog on norms and AYRH topics through community group engagement activities. Many interventions also included structural components that aimed to strengthen youth-friendly health services (n=6) to improve access to quality services and to address policy through advocacy with government stakeholders (n=7). Some interventions also built the capacity of local partners (i.e., government and nongovernmental organizations [NGOs]) to manage intervention components, as part of their scale-up and sustainability efforts (n=9).

Significant improvements in RH knowledge, attitudes, and skills among adolescents were reported by all interventions, and improvements in behavior changes, such as use of contraception, school attendance, and marriage rates, were reported for 11 interventions. Documentation from MEMA kwa Vijana, PRACHAR, and Tostan measured changes in biological health outcomes, but only PRACHAR and Tostan demonstrated improvements in outcomes, such as reduced pregnancy rates and incidence of sexually transmitted infections [22,25,38].

Although only 11 of the interventions described efforts to target a normative outcome in their intervention design, all 13 interventions measured changes in the attitudes, beliefs, or behaviors of the secondary populations, thereby acknowledging the influence of the secondary populations’ attitudes or norms on AYRH outcomes. Although not specified in Table 2, the interventions that measured the attitudes and beliefs of the secondary populations measured three types of change: attitudes toward AYRH topics and behaviors (n=11), gender-equitable attitudes (n=9), and acceptance or incidence of gender-based violence (n=7).

Scale-up strategies

Table 3 summarizes the application of frequently used scale-up strategies: (1) expanding to a larger geographic region, (2) expanding to more user organizations (to achieve greater reach or depth), (3) adapting program content and range of services offered, (4) adapting program design to reach new populations,
Table 1
Description of 13 AYRH interventions with normative components that included scale-up phases

| Intervention | Region/country (bolded countries indicate pilot sites) | Time frame (from testing to scale-up phases) | Intervention description (primary population and outcomes targeted) | Secondary populations reached* |
|--------------|--------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------|--------------------------------|
| 1. African Youth Alliance (AYA) [9–11] | Botswana, Ghana, Tanzania, and Uganda | 2000–2005 | Primary population: in-school and out-of-school boys and girls (ages 10–24) Target outcomes: improve RH knowledge, attitudes, and behaviors (including modern contraceptive use and self-efficacy in negotiating condom use) and reduce STI and HIV/AIDS transmission | Parents, teachers, community and religious leaders, health providers, policymakers, and general community |
| 2. Gender Roles Equality and Transformation (GREAT) [12–15] | Uganda | 2010–2017 Scale-up: 3 years | Primary population: unmarried boys and girls (ages 10–19), newly married or parenting adolescents, and their communities Target outcomes: improve RH knowledge, attitudes, and behaviors; promote gender-equitable attitudes and behaviors and reduce incidence of sexual and gender-based violence | Parents, health providers, community health workers, and general community |
| 3. Geração Biz [16,17] | Mozambique | 1999–2010 Scale-up: 10 years | Primary population: in-school and out-of-school youth (ages 10–24) Target outcomes: improve RH knowledge, attitudes, and behaviors (modern contraceptive use); reduce incidence of early or unintended pregnancies; and improve gender-equitable norms | Parents, teachers, health providers, and general community |
| 4. Ishraq Program [18] | Egypt | 2001–2013 Scale-up: 9 years | Primary population: out-of-school girls (ages 12–15) Target outcomes: improve RH knowledge and behaviors; improve health-seeking behavior; increase rates of school enrollment and attainment; delay early marriage and childbearing; increase girls' self-confidence; and improve gender-equitable norms | Parents of adolescent girls, general community, and teachers |
| 5. Kenya Adolescent Reproductive Health Project [19–21] | Kenya | 1999–2008 Scale-up: 2 years | Primary population: in-school and out-of-school boys and girls (ages 10–19) Target outcomes: improve RH knowledge, attitudes, and behaviors; reduce school dropout rates; improve community and parental acceptance of AYSRH | Parents, teachers, health providers, government stakeholders, and general community |
| 6. MEMA kwa Vijana [22–24] | Tanzania | 1998–2008 Scale-up: 4 years | Population: primary school (grades 5–7) students (ages 10–15) Target outcome: improve RH knowledge, attitudes, and behaviors; increase contraceptive and youth-friendly service use; and reduce STI/HIV incidence | Parents, teachers, government and ministry officials, and general community |
| 7. PRACHAR [19,25,26] | India | 2001–2012 Scale-up: 7 years | Primary population: unmarried adolescent boys and girls, young married couples, and pregnant and postpartum women (ages 12–24) Target outcomes: improve RH knowledge and behaviors; delay age of marriage and age at first birth; increase contraception use and healthy birth spacing; and improve gender-equitable norms | Parents and in-laws of adolescents and young couples, community leaders, general community, and health providers |
| 8. Program H & Program M [27,28] | Brazil, Bolivia, Colombia, Mexico, Peru, Jamaica, Nicaragua, and India | 1999–2010 Scale-up: 7 years | Primary population: in-school and out-of-school youth; unmarried and married youth; and lesbian, gay, bisexual, transgender, or queer youth (ages 14–24) Target outcomes: improve RH knowledge, attitudes, behaviors; reduce incidence of gender-based violence; reduce drug use; improve couples' communication; and improve gender-equitable attitudes Program M added to reach women in 2003, then Entre Nos multimedia campaign added to complement and reach wider community | General community |
| 9. SASA! Raising Voices [29–31] | Uganda | 2008–2012 Scale-up: 3 years | Primary population: youth (ages 15–24) and adult women and men Target outcomes: improve attitudes, behaviors, and norms related to gender inequality, gender-based violence, and HIV risk | Community leaders and general community |

(continued on next page)
| Intervention                                                                 | Time frame (from testing to scale-up phases) | Scale-up populations reached | Region/country (bolded is where the pilot occurred or through replication in new countries)                                                                 | Region/country (broadly: multiple countries to reach new populations) | Intervention description (primary population and outcomes targeted)                                                                                                                                                                                                 |
|----------------------------------------------------------------------------|---------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10. Sesto Sentido (part of Tostan)[29,38]                                   | 2000–2005                                   | General community           | Malawi, Zimbabwe, South Africa, Guinea, Malawi, Lesotho, Mozambique, Kenya, and South Africa (KARHP); and PRACHAR) were each piloted and scaled-up to multiple countries by user organizations[27,32]; two interventions were piloted in one country and then replicated in new countries by user organizations[i.e., SASA; Raising Voices, Tostan][29,38]; and two were implemented as pilot interventions in multiple countries from the beginning, scaling-up through different partners in each country[i.e., AYA, Southern African Regional Social and Behavior Change Communication Project][20,36]. |                                                                                                                                                                                                 | The most common scale-up strategy was to increase the number and capacity of user organizations during and after pilot implementation to create wider networks of organizations with the capacity for broad reach and impact. For example, PRACHAR built the capacity of local NGO and government partners as user organizations at every stage of its planned expansion through a “learning-by-doing” approach, building skills beyond those related to reproductive health topics. The resource organization held classroom orientations, conducted field exposure visits, and provided support to build the competencies of the user organizations’ staff in project management, budgeting, and monitoring[25]. |
| 11. South Africa Regional Program[36,37]                                    | 2007–2011                                   | General community           | Malawi, Zimbabwe, South Africa, Guinea, Malawi, Lesotho, Mozambique, Kenya, and South Africa (KARHP); and PRACHAR) were each piloted and scaled-up to multiple countries by user organizations[27,32]; two interventions were piloted in one country and then replicated in new countries by user organizations[i.e., SASA; Raising Voices, Tostan][29,38]; and two were implemented as pilot interventions in multiple countries from the beginning, scaling-up through different partners in each country[i.e., AYA, Southern African Regional Social and Behavior Change Communication Project][20,36]. |                                                                                                                                                                                                 | The most common scale-up strategy was to increase the number and capacity of user organizations during and after pilot implementation to create wider networks of organizations with the capacity for broad reach and impact. For example, PRACHAR built the capacity of local NGO and government partners as user organizations at every stage of its planned expansion through a “learning-by-doing” approach, building skills beyond those related to reproductive health topics. The resource organization held classroom orientations, conducted field exposure visits, and provided support to build the competencies of the user organizations’ staff in project management, budgeting, and monitoring[25]. |
| 12. Dostan (Community Health and Education Program)[38]                      | 1988–present                                | General community           | Malawi, Zimbabwe, South Africa, Guinea, Malawi, Lesotho, Mozambique, Kenya, and South Africa (KARHP); and PRACHAR) were each piloted and scaled-up to multiple countries by user organizations[27,32]; two interventions were piloted in one country and then replicated in new countries by user organizations[i.e., SASA; Raising Voices, Tostan][29,38]; and two were implemented as pilot interventions in multiple countries from the beginning, scaling-up through different partners in each country[i.e., AYA, Southern African Regional Social and Behavior Change Communication Project][20,36]. |                                                                                                                                                                                                 | The most common scale-up strategy was to increase the number and capacity of user organizations during and after pilot implementation to create wider networks of organizations with the capacity for broad reach and impact. For example, PRACHAR built the capacity of local NGO and government partners as user organizations at every stage of its planned expansion through a “learning-by-doing” approach, building skills beyond those related to reproductive health topics. The resource organization held classroom orientations, conducted field exposure visits, and provided support to build the competencies of the user organizations’ staff in project management, budgeting, and monitoring[25]. |
| 13. Young Empowered and Healthy Initiative (YEHIA)[38]                      | 2004–2013                                   | General community           | Malawi, Zimbabwe, South Africa, Guinea, Malawi, Lesotho, Mozambique, Kenya, and South Africa (KARHP); and PRACHAR) were each piloted and scaled-up to multiple countries by user organizations[27,32]; two interventions were piloted in one country and then replicated in new countries by user organizations[i.e., SASA; Raising Voices, Tostan][29,38]; and two were implemented as pilot interventions in multiple countries from the beginning, scaling-up through different partners in each country[i.e., AYA, Southern African Regional Social and Behavior Change Communication Project][20,36]. |                                                                                                                                                                                                 | The most common scale-up strategy was to increase the number and capacity of user organizations during and after pilot implementation to create wider networks of organizations with the capacity for broad reach and impact. For example, PRACHAR built the capacity of local NGO and government partners as user organizations at every stage of its planned expansion through a “learning-by-doing” approach, building skills beyond those related to reproductive health topics. The resource organization held classroom orientations, conducted field exposure visits, and provided support to build the competencies of the user organizations’ staff in project management, budgeting, and monitoring[25]. |
| 14. Action for Sexual and Reproductive Health (ASRH)[39]                    | 2011–2013                                   | General community           | Malawi, Zimbabwe, South Africa, Guinea, Malawi, Lesotho, Mozambique, Kenya, and South Africa (KARHP); and PRACHAR) were each piloted and scaled-up to multiple countries by user organizations[27,32]; two interventions were piloted in one country and then replicated in new countries by user organizations[i.e., SASA; Raising Voices, Tostan][29,38]; and two were implemented as pilot interventions in multiple countries from the beginning, scaling-up through different partners in each country[i.e., AYA, Southern African Regional Social and Behavior Change Communication Project][20,36]. |                                                                                                                                                                                                 | The most common scale-up strategy was to increase the number and capacity of user organizations during and after pilot implementation to create wider networks of organizations with the capacity for broad reach and impact. For example, PRACHAR built the capacity of local NGO and government partners as user organizations at every stage of its planned expansion through a “learning-by-doing” approach, building skills beyond those related to reproductive health topics. The resource organization held classroom orientations, conducted field exposure visits, and provided support to build the competencies of the user organizations’ staff in project management, budgeting, and monitoring[25]. |

Table 1 Continued

As reflected in Table 3, 11 of the 13 interventions employed more than one of these strategies to achieve wider impact. One intervention, MEMA Kwa Vijana, lacked documentation related to the scale-up of its normative change components. However, the intervention was included in the review because it used a normative change strategy during pilot implementation and documented the scale-up of all activities besides the normative activity. Although the African Youth Alliance (AYA) intervention was implemented in four countries, the only scale-up documentation on the normative components available was specific to implementation in Uganda[12]. Interventions expanded geographically, either in the same country where the pilot occurred or through replication in new countries. The extent of geographic expansion varied. Four interventions [i.e., Gender Roles, Equality and Transformation [GREAT]; Ishraq; Kenya Adolescent Reproductive Health Project [KARHP]; and PRACHAR] were each piloted and scaled-up to additional districts within the same country[13,18,19,25,39]. Six interventions scaled-up internationally. Program H and Sexto Sentido were piloted in one country and then replicated in new countries by user organizations[27,32]; two interventions expanded within the pilot country first, and then replicated in new countries by new user organizations [i.e., SASA; Raising Voices, Tostan][29,38]; and two were implemented as pilot interventions in multiple countries from the beginning, scaling-up through different partners in each country [i.e., AYA, Southern African Regional Social and Behavior Change Communication Project][20,36].

The most common scale-up strategy was to increase the number and capacity of user organizations during and after pilot implementation to create wider networks of organizations with the capacity for broad reach and impact. For example, PRACHAR built the capacity of local NGO and government partners as user organizations at every stage of its planned expansion through a “learning-by-doing” approach, building skills beyond those related to reproductive health topics. The resource organization held classroom orientations, conducted field exposure visits, and provided support to build the competencies of the user organizations’ staff in project management, budgeting, and monitoring [25].

To facilitate scale-up in new contexts, five interventions adapted activities, increasing the depth of services provided, to better meet needs of new user organizations and communities. The KARHP, for example, tested a streamlined package of activities that included successful components of its intervention during adaptation, and then added additional community outreach and income-generation activities to better support its target populations, based on feedback from the community[19]. Two interventions also adapted activities to reach new primary populations. In the case of Ishraq, the resource organization added two additional program components requested by the communities; a parallel life skills and sexual reproductive health program for adolescent boys and services for older female graduates who needed support to transition into the formal schooling system[18].

Seven of the interventions documented efforts to work with government ministries to be institutionalized into the public sector. The implementing organizations did so by delegating responsibilities for managing at least one component of the intervention to a relevant government entity. In these cases, to ensure the impact observed during the pilot could be replicated...
Table 2
Strategies utilized and key outcomes measured by included interventions

| Intervention components | Adolescent and youth outcomes | Secondary population attitudes, beliefs, or behaviors | Normative change findings or results |
|-------------------------|-------------------------------|---------------------------------------------------|---------------------------------|
|                         | FLE Peer education and support, Adol. safe spaces, SBCC, CGE, HSS, Capacity-building of user orgs, Policy and advocacy, RH knowledge, attitudes, skills, or intentions, Behavior change, Biological health outcomes | | |
| 1. AYA* [9–11]         | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | No explicit evaluation of norms. Implied change due to improved supportive ARH policies and support for ARH and YFHS among community members, parents, and AY. |
| 2. GREAT [12–15]       | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved gender-equitable norms among community members, parents, and AY. |
| 3. Geração Biz [16,17]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + | 0 | No explicit evaluation of norms. Implied change among health providers due to improved quality and use of YFHS. Implied gender norms did not significantly change among AY. |
| 4. Ishraq Program [18]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved gender-equitable norms among participants, parents, and community leaders. |
| 5. Kenya ARH Project [19–21] | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved parent-child discussions on SRH and norms related to discussing ARH topics among community members. |
| 6. MEMA kwa Vijana [22–24] | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + | 0 | Improved norms related to discussing SRH with AY among teachers and health workers. Implied change due to increased community support for FLE for unmarried AY. |
| 7. PRACHAR [19,23,26]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved norms to delay child marriage and childbearing among AY and support from parents. |
| 8. Program H & Program M [27,28] | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved gender-equitable norms among community members and AY. |
| 9. SASA! Raising Voices [29–31] | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + | + | No explicit evaluation of norms. Implied improved gender-equitable and SRH norms related to GBV among community members and AY due to reduction in GBV and more equitable behaviors and attitudes among community members. |
| 10. Sexto Sestido [32–35] | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved gender-equitable norms and norms related to sexuality among community members and AY. |
| 11. South Africa Regional SBC Communication Program [36,37] | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] + + + | | Improved gender and SRH norms related to gender equity, GBV, and HIV |

(continued on next page)
| Intervention components | Adolescent and youth outcomes | Secondary population outcomes | Normative change findings or results |
|-------------------------|-------------------------------|------------------------------|----------------------------------|
| FLE peer education and support | Improved gender norms related to FCM to reduce FGM prevalence among community members and parents | Improved FCM prevalence among community members and parents | + |
| Addi, safe spaces | Behavior change | Attitudes, beliefs, or behaviors | + |
| SRHC | Policy and advocacy | Attitudes, beliefs, or behaviors | + |
| CGE | RH knowledge, attitudes, skills, or intentions | Attitudes, beliefs, or behaviors | + |
| STI and HIV prevention, and so forth; secondary population attitude/beliefs/behaviors | Attitudes or behaviors related to gender equity, gender-based violence, and female genital mutilation | + |

| 12. Tostan | Improved gender norms related to FCM to reduce FGM prevalence among community members and parents | Improved FCM prevalence among community members and parents | + |
| 13. YEAH | Gender-based violence | Gender-based violence | + |

Factors facilitating and challenging scale-up processes

Across the reviewed literature, we identified four categories of factors that were mentioned as facilitators or challenges to scale-up success: (1) resource needs, (2) intervention design, (3) partnerships for sustainability, and (4) monitoring and evaluation (M&E) systems and data. Distribution of the documentation of these factors across interventions is depicted in Table 4. In some cases, it was difficult to distinguish whether the facilitators and challenges discussed were related to the success of implementation generally or to the scale-up process more specifically.

Resource needs. Eight of the interventions identified the need for financial and human resources to support scale-up. In most instances, the documentation referenced financial resources as a facilitator to scale-up as resource organizations supported user organizations to incorporate activities into their operational budgets. The development of low-cost materials was also cited as a facilitator to scale-up. For example, SASA! was able to reduce the financial burden among user organizations by providing free online program materials and tools, but because it did not have staff who could monitor the use of materials, the organization could not ensure fidelity to the intervention's core components [39]. GREAT's “low-investment approach” design of a toolkit and activities that could be adopted by existing community groups limited the financial burden placed on user organizations to replicate activities, enabling them to leverage their own resources to integrate GREAT's activities into existing initiatives [12].
Human resources were most often identified as facilitators when resource organizations successfully built the capacity of user organization staff to ensure program fidelity and manage activities. Tostan, for example, mentors and trains user organizations to manage activities in their own communities to support scale-up [39]. In addition to ensuring the technical capacity of staff in user organizations, many resource organizations supported staff to examine and reflect upon their own values and norms [39]. For instance, documentation of the PRACHAR project stressed the importance of training project staff and volunteers to reflect on their own norms, to be empowered to take action and build their commitment to the project’s objectives [22]. Not surprisingly, a lack of financial or human resources was often cited as a challenge to scale-up efforts. High staff turnover among user organizations, mentioned by three interventions, required resource organizations to invest additional time and financial resources to train new staff [12,16,18].

Intervention design. Intervention design appeared to play a key role as both a facilitator and an impediment to scale-up. Seven interventions noted the content or structure of their intervention as a facilitator of scale-up. The KARHP and GREAT are two such examples. Both planned for and developed implementation toolkits or guidance materials during pilot implementation, which later facilitated scale-up through user organizations [12,18].

Four interventions cited a need to further modify intervention design during the scale-up phase as a challenge. In some cases, the intervention activities implemented during the pilot phase were too costly for user organizations to continue or replicate. For example, in response to concerns that the SASA!’s community mobilization process was difficult and costly, it created nonmonetary incentives to engage volunteers for the project. The nonmonetary incentives took the form of capacity-building opportunities as well as the ability to obtain recognition from peers for serving as change agents in the community [39]. Such adaptability of intervention activities was also mentioned by three interventions as a facilitating factor to scale-up. PRACHAR and Ishraq both noted that the ability to adapt activities, either to better address community needs or to simplify processes, facilitated scale-up [13,22].

Partnerships for sustainability. Partnerships with and support from community groups and government stakeholders were the most frequently mentioned facilitators of scale-up. Documentation from 10 interventions noted that community engagement and support for the AYRH interventions facilitated not only pilot implementation efforts but also the scale-up process by fostering trust and ownership among the organizations that would become user organizations in the expansion process. Tostan, for example, noted that their success in building the necessary critical mass needed for social change was achieved through capacity building of and support from the local committees through conducting village meetings during pilot implementation [8]. Other activities to engage community stakeholders

---

**Table 3**

| Intervention name                  | No. of interventions utilizing this strategy | Expanding to a larger geographic region in-country or replication in new countries | Expanding to more user organizations (e.g., local NGOs/community-based organizations, or international NGOs) | Adapting program design to increase depth and scope of the services offered | Adapting program design to reach new primary populations | Institutionalizing the intervention into the public sector |
|------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| AYA [9–11]                         | 11                                         | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| GREAT [12–15]                      |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Geração Biz [16,17]                |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Ishraq Program [18]                |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Kenya ARH Project [19–21]          |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| MEMA iwa Vijana [22–24]            |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| PRACHAR [19,25,26]                 |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Program H & Program M [27,28]      |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| SASA! Raising Voices [29–31]       |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Sexto Sentido [32–35]              |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| South Africa Regional SBC          |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Communication Program [36,37]      |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| Tostan [38–40]                     |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |
| YEAH [41,42]                       |                                            | ☑️                                                                                 | ☑️                                                                                                              | ☑️                                                                                                                               | ☑️                                                                                                                            | ☑️                                                                                                             |

ARH = adolescent reproductive health; AYA = African Youth Alliance; GREAT = Gender Roles, Equality and Transformation; SBC = social and behavior change; YEAH = Young Empowered and Healthy Initiative.

Blank = available program documentation did not mention the category as a scale-up strategy utilized.

* Available documentation specific to scale-up experience in Uganda.
Table 4
Factors identified as facilitators or challenges to scale-up efforts of normative strategies of each of the 13 included interventions

| Resource needs | Intervention design | Partnerships for sustainability | Monitoring and evaluation systems and data |
|----------------|---------------------|---------------------------------|------------------------------------------|
|                | Financial resources | Intervention design | Adaptability of programming | Community support and engagement | Government support and ownership | No. interventions that cited a facilitating factor | No. interventions that cited a challenging factor |
| No. interventions that cited a facilitating factor | 7 | 4 | 7 | 10 | 9 | 7 |
| No. interventions that cited a challenging factor | 5 | 5 | 4 | 3 | 3 | 2 |

**Facilitators**

**AYA** [9–11]

- Advocacy and partnerships with Uganda Kingdoms led to select Kingdoms securing financial resources to take on project initiatives.
- Communities (including religious institutions) participated in all stages of programming, building capacity to analyze and address AYRH issues.

**GREAT** [12–15]

- Used a “low-investment approach” design and user organizations could leverage financial resources to integrate GREAT components into existing programming.
- Received positive support from community members; active and early engagement with potential user organizations helped build local ownership and sustainability of GREAT components.

**Challenges**

**AYA** [9–11]

- No challenges to scale-up documented.
- Building capacity of staff to understand own gender norms supported community-level work, building sustainability of activities. Resource organization prepared for transition as implementer to capacity builder, provided mentoring to user organizations to lead activities.

**GREAT** [12–15]

- The Community Action Cycle component was difficult for user organizations to understand and required repeated trainings and capacity-building initiatives.
- Not enough community participation necessary to achieve wide diffusion and reach the tipping point for social normative change.

**Facilitators**

**Geração Biz** [16,17]

- User organizations could continue activities through integrating program costs into operating budgets.
- Local user organizations expressed interest and could integrate program costs into operating budgets.

**Challenges**

**Geração Biz** [16,17]

- Existing village health teams were overworked and resource organizations experienced high staff turnover.
- User organizations needed capacity building from the resource organization to support M&E system.
| Challenges | Resource needs | Intervention design | Partnerships for sustainability | Monitoring and evaluation systems and data |
|------------|----------------|---------------------|-------------------------------|---------------------------------------------|
| Costs to implement across sectors and at various administrative levels were substantial | Financial resources | Human resources | Intervention design | Partnerships for sustainability | Monitoring and evaluation systems and data |
| High staff turnover, requiring follow-up and additional technical assistance from the resource organization. Gender inequity among peer educators and inadequate gender sensitivity training may have affected program effect on social normative change | Content and structure | Adaptability of programming | Community support and engagement | Government support and ownership |
| M&E systems were inconsistent across provinces, requiring significant time and support from resource organization | |

3. Ishraq Program [18]

**Facilitators**

- Created steps to integrate graduates into formal schooling and existing systems
- Activities easily fit into government systems and initiatives
- Local communities maintained support and demand for project to continue and were very involved in community activities
- Government ministries involved in design and implementation; increased attention to improving AYRH
- Rigorous M&E system allowed for effective learning and implementation of adjustments to streamline activities

**Challenges**

- Cost of providing continued support to graduates needed to be raised from local funds
- Graduates aged out of formal program and required additional support
- Lack of government legal records and documentation for graduated girls made it difficult to access public services

**4. Kenya ARH Project [19–21]**

**Facilitators**

- Costing activities helped to identify essential program components for replication and MOH could leverage resources to integrate activities in existing initiatives
- Availability of implementation tools and guidance documents facilitated transition to user organizations
- Local community expressed high demand and was very engaged with community activities
- Supportive government policies brought attention to project and integration of various intervention components into MOH initiatives
- Strong pilot data and dissemination showcased evidence and generated buy-in to adapt and refine for scale-up

**Challenges**

- Lack of sufficient resources for all components
- High turnover of relevant staff required high level of continued external technical assistance and additional retraining

(continued on next page)
| Table 4 | Continued |
|---------|-----------|
| **Resource needs** |
| Financial resources | Human resources |
| **Intervention design** |
| Content and structure | Adaptability of programming |
| **Partnerships for sustainability** |
| Community support and engagement | Government support and ownership |
| **Monitoring and evaluation systems and data** |
| --- | --- | --- | --- | --- |
| 5. MEMA kwa Vijana [22–24] | Scale-up of normative components not documented |
| Facilitators | Building capacity of local NGO staff and community members who led activities to understand own norms and internalize their role as change agents enhanced performance | Adaptable activities and systems to respond to the needs of community and user organizations | Communities were engaged in activities; consistent partnerships with local user organizations from the start fostered commitment | Rigorous M&E data showed evidence of project impact, which generated local support and demand |
| Challenges | Multiple components were too large for public sector, requiring refinement/adaptation |
| 6. PRACHAR [19,25,26] | |
| Facilitators | |
| Resource organization budgeted for capacity building of user organizations as part of scale-up efforts and made materials available at no cost | |
| Challenges | Recruitment and commitment of participants due to competing priorities was difficult |
| 7. Program H & Program M [27,28] | |
| Facilitators | Resource organization | Developed materials for user organizations to adopt and made them readily available | Communities showed strong interest and engagement and built capacity of user organizations as part of activities and program costs | Initiated early engagement with government stakeholders and supported government to integrate project activities into ongoing initiatives | Rigorous data and results from adaptations in multiple countries demonstrated programs’ effectiveness |
| Challenges | |
| 8. SASA! Raising Voices [29–31] | |
| Facilitators | Discussion leaders were unpaid volunteers but still showed commitment and engagement; the resource organization made online trainings and program materials available to user organizations at no cost | Program addressed social norms of staff and volunteers first, empowering them to take action and building their commitment to community mobilization activities | Intervention focused on empowerment rather than negative behaviors | Developed an open-source toolkit that is publicly available and freely distributes supplementary materials and online trainings | Messages diffused outside of target population showing strong interest among participants; community advocacy activities built support among user organizations | Fostering relationships with and support from local government leaders built interest and support of activities | M&E tools developed are easy to use and strong impact demonstrated |
| Resource needs | Intervention design | Partnerships for sustainability | Monitoring and evaluation systems and data |
|----------------|--------------------|---------------------------------|--------------------------------------------|
|                |                    |                                 |                                            |
| Financial resources | Human resources | Content and structure | Adaptability of programming | Community support and engagement | Government support and ownership |                                 |
| Challenges | Short-term donor cycles cited as a barrier to achieving the long-term normative change necessary to replicate impact at scale | Difficult to monitor use of freely available materials to ensure fidelity to core components | Community mobilization process can be difficult and costly | Available availability of telenovela episodes and group discussion materials for user organizations | Strong partnership and support from civil society organizations that became user organizations; target populations generated demand for program | Supportive policy environment with government ownership |
| 9. Sexto Sentido [32–35] Facilitators | | | | | |
| Challenges | No challenges to scale-up documented | | | | |
| 10. South Africa Regional SBC Communication Program [36,37] Facilitators | Resource organization accounted for costs related to capacity building and mentoring of user organization staff | Resource organization mentored and built capacity of user organizations to manage program and understand underlying norms | Content avoided focus of negative behavior; focus on noncombative manner reinforced women’s empowerment messages | Community showed enthusiasm for activities; inclusion of capacity-building activities with local user organizations built local ownership | Eventually gained support from government bodies that made public declarations to end female genital cutting |
| Challenges | Difficult to find local residents to serve as facilitators, increasing program costs | Some content was too difficult for facilitators to discuss, leading to changes in core program components and messages | The complexity of female genital mutilation norms in countries where practice is universal made it difficult to initiate behavior change | Opposition from some community and religious leaders; lack of community participation without tangible incentives | Some countries faced challenges gaining support from government stakeholders at start |
| 11. Tostan [38–40] Facilitators | | | | | |
| 12. YEAH [41,42] Facilitators | | | | | |

Blank = available program documentation did not mention the category as a facilitator of their scale-up effort.

ARH = adolescent reproductive health; AYA = African Youth Alliance; AYRH = adolescent and youth reproductive health; GREAT = Gender Roles, Equality and Transformation; M&E = monitoring and evaluation; MOH = Ministry of Health; SBC = social and behavior change; YEAH = Young Empowered and Healthy Initiative.

*a* Available documentation specific to project scale-up experience in Uganda.
included participatory activities to identify and address local AYRH issues, consultations with stakeholders to inform intervention design, and establishing mechanisms to receive and share data with communities about ongoing activities.

Advocacy and partnerships with government stakeholders were also noted by implementers as a facilitator to scale-up. Documentation from nine interventions mentioned that partnerships with government ministries at local or national levels and capacity-building activities with government partners supported pilot implementation and eventual scale-up efforts. AYA, Geraçao Biz, Ishraq, and Project H either implemented through government partners from the start, or began collaborating with them early on during implementation, to integrate activities into government systems and ensure activities aligned with government strategic priorities. In turn, this built ownership of programming and intervention results before “handover” to the government. AYA in Uganda engaged policymakers and community leaders, including representatives of four Kingdoms, in all phases of intervention design. The project also partnered with the Kingdoms to implement the community-level activities, which translated into the Kingdoms adopting supportive AYRH policies in their agendas and securing funding to continue the initiatives started by the resource organization [25].

Notably, interventions that mentioned community or government support as a facilitator to scale-up also mentioned lack of support as a challenge to scale-up. Five of the interventions identified lack of community or government support or adaptability as a challenge. For instance, the KARHP noted that despite substantial interest from the government to adopt supportive AYRH policies, because of the complex budgeting and planning process, the resource organization still struggled to integrate activities into the government system and had to adapt activities to accommodate systems, underscoring that supportive policy environments alone do not facilitate the sustainability of intervention impact [18].

Monitoring and evaluation systems and data. The monitoring and use of data was mentioned as a facilitating factor for scale-up by seven of the interventions. Notably, the interventions that identified M&E capacity as a facilitator were often interventions that demonstrated evidence of impact during the pilot phase. PRACHAR and the KARHP noted that the availability of evaluation data showing intervention impact from pilot implementation, particularly regarding the importance of the normative components, provided the evidence needed to generate buy-in from user organizations [19,20]. Several interventions faced challenges related to the M&E capacities of user organizations, which in some cases were unable to replicate the M&E systems developed by the resource organizations. For instance, Geraçao Biz found that the M&E capacity across scale-up locations was inconsistent. To address this, the intervention conducted periodic evaluations to improve the M&E system, which was designed to be adaptable and thus could easily be integrated into the systems of varying capacity [16].

Discussion

This exploratory review of peer-reviewed and gray literature pertaining to the scale-up of normative change interventions for AYRH identified only 13 interventions that both met our definitions of normative change and scale-up and provided documentation of their scale-up efforts. The 13 interventions we analyzed used a variety of scale-up strategies across diverse contexts and time frames with different scale-up goals. As the language on scale-up and normative change varied, and the interventions were multifaceted, it was difficult to separate which components contributed specifically to normative change and to assess how normative change outcomes were evaluated. Despite these limitations, we discerned many elements common to scale-up success and several unique considerations for the scale-up of normative change interventions.

Many of the interventions planned for scale-up during the pilot phase, citing early preparation as a critical factor in their success for later expansion and institutionalization. This preparation took many forms. Some resource organizations developed a strategic scale-up plan, while others sought to ensure community and government stakeholder buy-in through advocacy and early engagement. Many interventions incorporated measures to align intervention components with government policies, systems, or NGO platforms so that the interventions could be easily integrated into existing programs. Other organizations budgeted capacity-building activities for user organizations to independently implement the interventions over time. Unique to normative change interventions, working with staff to identify and clarify their own norms and roles as change agents was emphasized by many as a critical component to successful implementation and scale-up.

Social norms are highly contextual. Thus, program adaptability was highlighted across the reviewed literature as a facilitator of scale-up. Interventions identified for this review were almost always adapted when scaled-up in new contexts. Guidance documents and tools, combined with capacity building of user organizations, were identified as critical supports to maintain fidelity of the core normative change components during scale-up.

The complexity and use of M&E systems was also cited by about half of the interventions as important for guiding scale-up efforts. When scale-up involved cross-organizational monitoring, it was useful for multiple organizations to share core indicators. Often, however, monitoring systems developed for pilot implementation needed to be adapted or simplified to accommodate new contexts and organizational systems during scale-up.

We note that the development of tools and the adaptation of systems often require significant initial investment and is likely to add to intervention timelines. Indeed, since changing social norms requires changing the beliefs of many individuals, the time frame for reaching tipping points and demonstrating effectiveness of normative change efforts is likely to require longer than the standard three- to five-year time frames of most health-focused projects. Advocacy is needed to increase awareness of these longer term resource needs, especially if normative change at scale is the ultimate goal.

Although all but one of the interventions documented a change in the attitudes, beliefs, or behaviors of individuals in the larger community, clear measures of normative change outcomes were notably lacking from the documents reviewed. In most cases, documentation alluded to the assumption that the mechanisms of norms change were effective due to changes in health outcomes, but norms change itself was rarely evaluated. Documentation of efforts to confirm findings and assess normative change with communities was lacking as well. The articulation and measurement of social norms need to be given considerably more attention. This includes being more explicit about what norms are expected to change and about how norms change will be monitored over time during pilot implementation.
and under scale-up conditions. To this latter point, careful M&E is needed to ensure that the normative change mechanism inherent in norms-focused activities continues to operate at scale. Currently, for instance, it is unclear how much interventions can be adapted before effectiveness must be re-evaluated. Unfortunately, documentation of how to monitor the normative change components of AYRH interventions is sorely lacking. Simple indicators and adaptable approaches to measuring normative change at scale are needed [3,44].

We note the following limitations. Our review did not include information about ongoing scale-up activities. The lack of a common language when referring to normative interventions or scale-up made it difficult to ascertain if challenges or facilitators were related to scale-up or to the implementation of the pilot itself. As mentioned previously, documentation of the scale-up process of normative change strategies, even among the interventions included in our review, was limited. Most of the reviewed documentation of challenges or facilitators focused on describing elements of the strength of the intervention itself and whether impact was achieved. Projects tended to provide minimal description or analysis of their scale-up experiences, and even less description of the process of scaling-up their normative change strategies specifically. Documentation regarding measurement and evaluation of normative outcomes, whether during pilot or while operating at-scale, was also lacking.

Summary and Implications

The ability to scale-up community-based normative change interventions is commonly questioned. However, the 13 interventions included in this review demonstrate that the scale-up of multicomponent community-based normative change interventions is feasible. They also show that the scale-up of such interventions requires planning and considerations that are distinct from those required for the scale-up of traditional behavior change approaches because they seek to influence change at both individual and community level and are highly contextual to complex social environments. The success of scaling normative change interventions is facilitated by planning for scale-up from the beginning, even before evidence of effectiveness indicates an intervention is worthy of going to scale.

The few interventions included in this review and the scant documentation of scale-up processes highlight the need for more research and evaluation, as well as better articulation and documentation of scale-up and lessons learned. In addition, greater shared learning across the many organizations that are implementing normative change interventions is needed to improve measurement and analysis of normative change and scale-up, to ultimately ensure sustained impact of these initiatives. Building the evidence base for effective approaches for shifting social norms and creating enabling environments for behavior change at scale is crucial if the field is to meet the large and growing RH needs of adolescents. Despite the need for more evidence, the insights gleaned from this review provide an important starting point to inform future normative change programming for AYRH and have broad applicability to other health sectors.

Acknowledgments

The authors would like to acknowledge the technical contributions of Stephanie Oum at Save the Children for her work on the initial literature review on normative change interventions for AYRH going to scale, from which the conceptualization of this article was derived. This article was prepared as part of the Passages project.

Funding Sources

This article and the Passages project are made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. AID-OAA-A-15-00042.

References

[1] UNFPA. The state of world population 2014 - The power of 1.8 billion. New York, NY: UNFPA; 2014.
[2] UNFPA. Motherhood in childhood: Facing the challenge of adolescent pregnancy. New York, NY: UNFPA; 2013.
[3] Mackie G, Monetti F, Shalaya H, et al. What are social norms? How are they measured? San Diego, CA: 2015. https://www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf. Accessed October 1, 2018.
[4] Amin A, Chandra-Mouli V. Empowering adolescent girls: Developing egalitarian gender norms and relations to end violence. Reprod Health 2014;11:75.
[5] Svanemyr J, Amin A, Robles Oj, et al. Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches. J Adolesc Health 2015;56:57–14.
[6] Mmani K, Sabherwal S. A review of risk and protective factors for adolescent sexual and reproductive health in developing countries: An update. J Adolesc Heal 2013;53:562–72.
[7] Institute for Reproductive Health, Georgetown University and Save the Children. Scaling up normative change interventions for adolescent and youthsexual and reproductive health - Literature review findings and recommendations. Washington, DC: Institute for Reproductive Health, Georgetown University and Save the Children for the U.S. Agency for International Development (USAID); 2016.
[8] ExpandNet Secretariat and World Health Organization. Nine steps for developing a scaling-up strategy. Geneva, Switzerland: World Health Organization; 2010.
[9] Williams T, Mullen S, Karim A, et al. Evaluation of the African Youth Alliance Program in Ghana, Tanzania, and Uganda - Summary report. Rosslyn, VA: JSK Research and Training Institute; 2007.
[10] Daniels U. Improving health, improving lives: Impact of the African Youth Alliance and new opportunities for programmes. Afr J Reprod Health 2007; 11:18–27.
[11] JSI Research & Training Institute Inc. Evaluation of the African Youth Alliance Program in Tanzania - impact on sexual and reproductive health behavior among young people. Rosslyn, VA: JSI Research & Training Institute, Inc; 2007.
[12] Community pathways to improved adolescent sexual and reproductive health: A conceptual framework and suggested outcome indicators. Washington, DC and New York, NY: Inter-Agency Working Group (IAWG) on the Role of Community Involvement in ASRH; 2007.
[13] Georgetown University’s Institute for Reproductive Health. The Gender Roles, Equality and Transformations (GREAT) project: From pilot to scale. Washington, DC: Institute for Reproductive Health; 2017.
[14] Georgetown University’s Institute for Reproductive Health. GREAT Project endline report. Washington, DC: IRH/Pathfinder International/Save the Children: 2016.
[15] Georgetown University’s Institute for Reproductive Health. The GREAT project - Results brief. Washington, DC: IRH/Pathfinder International/Save the Children; 2018. http://irh.org/wp-content/uploads/2015/07/GREAT_Results_Brief_global_07.10.8.5x11.pdf. Accessed October 3, 2018.
[16] Hainsworth G, Zilhao I, Badiana R, et al. From inception to large scale: the Geraçao Biz Programme in Mozambique. Geneva, Switzerland: World Health Organization; 2005.
[17] Chandra-Mouli V, Gibbs S, Badiana R, et al. Programa Geração Biz, Mozambique: How did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve? Reprod Health 2015; 12:12.
[18] Selim M, Abdel-Tawab N, Elsayed K, et al. The Ishraq Program for out-of-school girls: From pilot to scale-up. Cairo: Population Council; 2013.
[19] Evelia H, et al. From pilot to program: Scaling up the Kenya adolescent reproductive health project. Washington, DC: Frontiers in Reproductive Health, Population Council; 2008.
[20] Evelia H, Wanjeru M, Obare F, et al. Ten years of the Kenya Adolescent Reproductive Health Project: What has happened? Nairobi, Kenya: APHA II OR Project in Kenya/Population Council; 2011.

[21] Askew I, Evelia H. Mainstreaming and scaling up the Kenya Adolescent Reproductive Health Project. Washington, DC: Frontiers in Reproductive Health Program/Population Council; 2007.

[22] Renju JR, Andrew B, Medard L, et al. Scaling up adolescent sexual and reproductive health interventions through existing government systems? A detailed process evaluation of a school-based intervention in Mwanza region in the northwest of Tanzania. J Adolesc Heal 2011;48:79–86.

[23] Renju J, Andrew B, Nyalali K, et al. A process evaluation of the scale up of a youth-friendly health services initiative in northern Tanzania. J Int AIDS Soc 2010;13:32.

[24] Renju J, Malokha M, Kato C, et al. Partnering to proceed: Scaling up adolescent sexual reproductive health programmes in Tanzania. Operational research into the factors that influenced local government uptake and implementation. Heal Res Policy Syst 2010;8:12.

[25] Wilder J, Masilamani R, Daniel E. Promoting change in the reproductive behavior of youth - Pathfinder International's PRACHAR project, Bihar, India. Watertown, MA: Pathfinder International; 2005.

[26] Rahman M, Daniel E. A reproductive health communication model that helps improve young women's reproductive life and reduce population growth: The case of PRACHAR from Bihar, India. Watertown, MA: 2010.

[27] Ricardo C, Nascimento M, Fonseca V, et al. Program H and Program M: Engaging young men and empowering young women to promote gender equality and health. Washington, DC: Pan American Health Organization; 2010.

[28] Barker G, Nascimento M, Segundo M, et al. How do we know if men have changed? Promoting and measuring attitude change with young men. Lessons from program H in Latin America. In: Ruxton S, ed. Gender. Equal. Men Learn. from Pract. Oxford, UK: Oxfam GB; 2004:147–61.

[29] Heilman B, Stich S. Revising the script - Taking community mobilization to scale for gender equality. Washington, DC and Kampala, Uganda: International Center for Research on Women and Raising Voices, 2016.

[30] Abramsky T, Devries K, Kiss L, et al. Findings from the SASA! Study: A cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. BMC Med 2014;12:122.

[31] Carlson C. SASA! Mobilizing communities to inspire social change. Kampala, Uganda: Raising Voices. Available at http://raisingvoices.org/wp-content/uploads/2013/03/downloads/resources/Unpacking_Sasa1.pdf. Accessed March 4, 2019.

[32] Solórzano I, Bank A, Peña R, et al. Catalyzing personal and social change around gender, sexuality, and HIV: Impact evaluation of Puntos de Encuentro's communication strategy in Nicaragua. In: Horizons Final Report. Washington, DC: The Population Council Inc.; 2008.

[33] Puntos de Encuentro. Impact data - Violence against women - Puntos de Encuentro. 2013. Available at: http://www.comminit.com/puntos_encuentro/content/impact-data-violence-against-women-puntos-de-encuentro. Accessed October 5, 2018.

[34] Lacayo V, Obregón R, Singh J. Approaching social change as a complex problem in a world that treats it as a complicated one: The case of Puntos de Encuentro, Nicaragua. Investig Y Desarro 2016;16:12–59.

[35] Bank A. Sexto Sentido. Available at: http://www.comminit.com/la/node/39415. Accessed July 24, 2017.

[36] Hutchinson P, Wheeler J, Silvestre E, et al. External evaluation of the Southern African Regional Social and Behaviour Change Communication Programme. New Orleans, LA: Tulane University; 2012. Available at: http://www.oecd.org/derec/unitedkingdom/Southern-African-Regional-Social-Behaviour-Change-Communication-Programme.pdf. Accessed October 5, 2018.

[37] Wallace-Karenga K. Mainstreaming HIV, AIDS and gender into culture: A community education handbook: Part I. Pretoria: SAfAIDS; 2005.

[38] Diop NJ, Faye MM, Moreau A, et al. The TOSTAN program evaluation of a community based education program in Senegal. Washington, DC: Population Council; 2004.

[39] Pathfinder International. PRACHAR: Advancing young people's sexual and reproductive health and rights in India. Watertown, MA: Pathfinder International; n.d.

[40] Tostan. Community empowerment program - Program structure. Available at: https://www.tostan.org/programs/community-empowerment-program/program-structure/. Accessed July 7, 2017.

[41] Health Communication Partnership. The December 2010 Health Communication Partnership (HCP) and the Young Empowered and Health (Y.E.A.H.) midterm evaluation survey report. Uganda. Kampala, Uganda: Health Communication Partnership; 2008. Available at: https://www.k4health.org/sites/default/files/HCP%20Midterm%20Survey%20Report.pdf. Accessed October 6, 2018.

[42] JHU Center for Communication Programs. The Health Communication Partnership Uganda final report. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health; 2012.

[43] High-Impact Practices in Family Planning (HIPS). Community engagement: Changing norms to improve sexual and reproductive health. Available at: http://www.fphighimpactpractices.org/briefs/community-group-engagement/. Accessed April 20, 2017.

[44] Cislaghi B, Heise L. Measuring gender-related social norms. Report of a Meeting, Baltimore, Maryland, June 15–16, 2016. 2016.