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Commentary

Scaling-up Norms-Focused Interventions for Adolescent and Youth Sexual and Reproductive Health: Current Practice and Reflections for Moving the Field Forward

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This commentary by the Learning Collaborative to Advance Normative Change Scale-up Community argues for the integration of norms-focused interventions into adolescent and youth sexual and reproductive health (AYSRH) initiatives for sustained behavioral impact at scale, offering a definition, evidence from successfully scaled norms-focused interventions, and remaining questions.

As indicated in the theory commentary, we expect social norms to have a particularly strong influence on adolescent/youth behavior during a period of physical and social change and development, including gender and sexuality [1]. Given limited social and economic power of young people, family members often influence sexual and reproductive health decisions about the age of first sex or early marriage. Even if families and government policies support different social norms, communities often continue to enforce traditional norms (as in early marriage). We argue that when norms are significant drivers of behaviors and decision-making, norms-focused interventions are more effective than purely individual-focused programming in sustaining behavioral outcomes [2].

What constitutes a norms-focused intervention has important implications for scale-up. No standard definition exists. For the LC, which focuses on interventions with significant community-based components: norms-focused interventions seek to improve AYSRH in part by transforming the social norms that prop up harmful health-related behaviors. They use an analysis of social norms, including whether there are any that are salient in driving that behavior, and are led by communities through a process of critical reflection, resulting in positive new norms rooted within the values of that group [3]. Conceptualization of social norms as social beliefs by Heise and Cislaghi suggests that norms exist on a spectrum of influence. Thus, normatively focused, AYSRH programs need to identify which norms are at play and how they interact with community contexts [4]. While recognizing interventions may be incremental in pushing normative boundaries, the widespread adoption of a new norm (and related behavior), or reduction of a harmful norm, ultimately defines successful scale-up in this case.

How might this play out in practice? An individually focused program addressing female genital cutting includes messaging and engages girls and parents in discussions on harmful health and social consequences of the practice. A norms-focused intervention would go further and more in-depth, for example, working with respected opinion leaders and influential reference groups to generate the social support needed for household behavior change. A norms-focused intervention would increase girl child and family outcomes through synergies created by community-level normative shifts. Success is not only measured as achieving widespread individual change but also as a function of a shift in broad community support, which implies a different project timeline and framework. Another distinguishing feature of norms-based AYSRH interventions is they challenge power structures. Programmers should expect some level of social pushback especially during scale-up as such challenges become widespread [5]. Implementing organizations have an ethical responsibility to not only monitor but ensure engagement of adult and socioinstitutional allies to mitigate pushback.

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While not all projects addressing social norms have significant community components, for those that do, recent reviews of social norms interventions going to scale via government and nongovernment organization channels [6,7] indicate they usually incorporate the following:

1. Initial design and later adaptations informed by an assessment of social context, of determinants and drivers of social and behavior change, and change capacities of receiving communities, with understanding of the relative weight of norms and other factors on behavior change;
2. A transferrable intervention package with articulated normative change mechanisms, underpinned by social justice and accountability principles, that can be monitored for implementation fidelity and emerging social pushback;
3. Resources for institutionalization with government through policies, protocols and guidance, and with influential community stakeholders through their approval and sanctioning roles;
4. Sufficient project duration and intensity to allow internalization of new norms;
5. Planned links to provider-friendly AYSRH services and social supports [8].

We illustrate the aforementioned scale-up considerations using the PRACHAR Project [9,10], which operated from 2001 to 2012, initially in Bihar State, with expansion into new Bihar districts and Haryana State. Eventually reaching 960 villages and 10 million people, over 11 years PRACHAR significantly increased age of first birth and increased contraceptive use (consideration #4 sufficient project duration). Implemented by Pathfinder International, with government and civil society partners, PRACHAR emphasized a scalable, multilayer, gender-integrated approach (#2 transferable package) to improving the sexual and reproductive health of youth in different life stages—unmarried, married, and first-time parents. PRACHAR researched social barriers—in Bihar and before scale-up in Haryana—and used this information to design strategies to challenge and alter norms related to early marriage and childbearing among youth and key community members-reference groups (#1 assessment of context and norms). Staff initiated state- and district-level consultations to elicit government approval and eventually activity engagement (#3 institutionalization). Dialogical, norms-questioning activities coupled with SRH and gender messages reached parents and in-laws of young people (#2 norms change mechanisms). Community leaders, including religious leaders in Haryana, were asked to speak out on the issues (#3 institutionalization). Locally recruited female and male change agents played norms-challenging roles. Over time in Bihar, the norms-focused task of female change agents were eventually shifted to Accredited Social Health Activitists (ASHA), the government frontline health workers (#2 norms change mechanisms; #3 institutionalization). Differing cultural contexts and political motivations influenced scale-up processes. In Bihar, a lack of political commitment (and possibly social pushback) to some aspects of the gender-aware features of PRACHAR (i.e., use of male change agents) led to that component left out, leaving the scaled up version of the program less able to address existing gender constraints and opportunities (#2 transferable package). In Haryana, the government was more supportive of involving men, as PRACHAR reinforced local gender-equity approaches (#1 assessment of context and norms; #3 institutionalization). Consequently, gender integration and its effects were part of the scale-up monitoring system (#2 fidelity assessment). Youth-friendly services sensitization in local facilities and through ASHA networks provided direct services (#5 planned links).

With renewed interest in incorporating norms-focused interventions within AYSRH programs going to scale, yet very limited process documentation and explicit evaluation of norms-focused interventions, fundamental questions such as (1) What intervention components are critical for success?; (2) What are the risks in undertaking norms-focused interventions?; (3) What are unintended effects or benefits?; and (4) Under what conditions are norms-breaking social movement interventions more or less effective than incremental interventions? remain unanswered.

Within interventions, we need to understand critical parameters: (1) What dose-response threshold and time is necessary to achieve normative change?; (2) How can we identify community capacity to engage with norms-focused interventions?; (3) What is the trade-off between depth and breadth, i.e., between less-scalable intensive, continuing efforts and more scalable time-bound efforts?; and (4) How do we measure cost-effectiveness?

Across interventions, we need experiential evidence and monitoring and evaluation to compare interventions and learn what is critical to success. Strong process documentation with standardized questions and case studies can create a base of knowledge that is helpful to program designers and implementers.

Finally, findings from the article on scale-up in this supplement [11] behoove us to focus on the *process* of scale-up: (1) How should we design for normative shifts given short funding rounds and changing thematic priorities? Are there situations where scale-up can lead to more harm than good and ethically should not be done?; and (2) How should we think of adaptation? At what point is an adapted intervention no longer the original intervention, and does it matter as long as normative shifts occur?

To conclude, this programming area is in its own adolescence—growing, changing, and developing. Many questions remain given its nascence; more, better documented models are needed. We have an ethical responsibility to communities and ourselves as external change agents to design scalable interventions that are appreciative of existing culture while engaging communities in pushing normative boundaries. Scale up of norms-focused interventions can be done, and the payoff for AYSRH will be substantial: wide-reaching, sustained positive normative environments that respond affirmatively to adolescents' health and well-being into adulthood.

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