SCALING AND SUSTAINING ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMS IN THE PUBLIC SECTOR IN SUB-SAHARAN AFRICA

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ABOUT SPRING IMPACT

Spring Impact is a global non-profit on a mission to scale social impact. Spring Impact works directly with mission-driven non-profits and funders around the world, supporting them to scale and sustain social impact. Spring Impact has extensive experience in global health, having worked with over 200 social enterprise and non-profit clients in over 40 countries globally, more than a third of which focus on health services. Spring Impact has applied its thinking and expertise to programs integrating into public health systems to help ensure sustainability.

ABOUT THE WILLIAM AND FLORA HEWLETT FOUNDATION

The William and Flora Hewlett Foundation is a nonpartisan, private charitable foundation that advances ideas and supports institutions to promote a better world.

For more than 50 years, the foundation has supported efforts to advance education for all, preserve the environment, improve lives and livelihoods in developing countries, promote the health and economic well-being of women, support vibrant performing arts, strengthen Bay Area communities and make the philanthropy sector more effective.

ACKNOWLEDGEMENTS

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GLOSSARY

ADOLESCENTS/YOUTH
Individuals in the 10-19 years old age group (as defined by WHO)

CSOS
Civil society organizations

SUSTAINABILITY
Long-term continuous impact, likely reliant on some level of sustained implementation and funding

ASRH
Adolescent sexual and reproductive health

KPIS
Key performance indicators

SCALE
Increasing the impact of an innovation to better match the size of the social problem it seeks to address

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EXECUTIVE SUMMARY

Governments are instrumental to the sustainable scale-up of health services in their country. The delivery of full-coverage healthcare services in a country often requires deep collaboration between civil society and the public and private sectors. While each stakeholder has a role to play, the global move towards universal healthcare has increased governments' mandate to ensure access to quality services for their population; and in many places, subsidized public services are the most accessible option for marginalized groups.[1]

As such, many health-focused CSOs are pivoting their activities towards supporting governments to meet their health services goals, rather than delivering programs in parallel.[2] But there still remain questions about how to do this effectively and sustainably.

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> ❝❝ ASRH is an interesting lens to explore the challenge of how CSOs can work in partnership with governments to achieve sustainable scale of healthcare programs

Adolescent sexual and reproductive health (ASRH) is a critical need to address. Despite a growing global adolescent population, particularly in Sub-Saharan Africa, and the long-term individual and societal effects of risky adolescent sexual behavior,[3] ASRH has historically been an underinvested part of healthcare.[4] ASRH programs tend to be particularly complex, as a range of social, cultural, political and economic factors influence the sexual and reproductive health of adolescents.[5] International CSOs, multilateral and bilateral funding agencies and private foundations have historically supported, and continue to support, governments and CSOs in low- and middle-income countries to implement ASRH programs.[6] ASRH is therefore an interesting lens to explore the challenge of how CSOs can work in partnership with governments to achieve sustainable scale of healthcare programs.
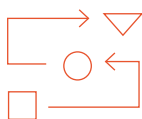
PURPOSE AND METHODOLOGY
With the support of the William and Flora Hewlett Foundation, Spring Impact embarked on this research to answer two questions:

1 How have CSO-led ASRH programs in Sub-Saharan Africa achieved scale through the public sector?

2 Have these programs been sustained through public sector systems after official project implementation has ended, and if so, how?

Spring Impact determined CSO-led programs as those where the CSO played the lead role in development and oversight of the program, even if implemented in partnership with government.

1 World Bank group, World Health Organization 'Tracking Universal Health Coverage: 2017 Global Monitoring Report' (Geneva: WHO, 2017).

2 Smith, J., Buse, K., Gordon, C. 'Civil Society: The catalyst for ensuring health in the age of sustainable development' Globalization and Health, 12 (40) (London: BioMed Central, 2016); Langsam, K., Martin, E., Worsham, E. Leveraging Government Partnerships for Scaled Impact (North Carolina: Scaling Pathways, 2018).

3 Branson, N., Byker, T. 'Causes and consequences of teen childbearing: Evidence from a reproductive health intervention in South Africa' Journal of Health Economics, 57 (London: Elsevier, 2018).

4 Morris, J., Rushwan, H. 'Adolescent sexual and reproductive health: The global challenges' International Journal of Gynecaology & Obstetrics, 131 (1) (London: Elsevier, 2015).

5 Svanemyr, J., Amin, A., Robles, O.J., Greene, M.E. 'Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches' Journal of Adolescent Health, 56 (1) (London: Elsevier, 2015) pp.s7-s14

6 Chandra-Mouli, V. et al 'Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights', Journal of Adolescent Health, 56(1). (Elsevier, 2015)

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Through its extensive work on scaling impact, Spring Impact has observed that conversations about sustainability often focus on how an intervention will be sustained financially when donor funding ends, rather than considering what is needed for sustained impact. Within ASRH a shift to focus on sustained impact would mean ultimately judging sustainability on whether adolescents continue to access high-quality services, and whether critical indicators, such as reductions in teenage pregnancy, are maintained or improved. However, it can be assumed that in the majority of cases sustained impact will rely on sustained program implementation, which in turn requires sustained funding and resourcing. For this research Spring Impact therefore sought to understand sustainability through three distinct lenses: the impact that has been sustained, the program activities that continue to be implemented, and the funding that continues to be allocated by national or local governments and other non-governmental entities.

We analyzed four Sub-Saharan African ASRH programs, through literature reviews, stakeholder interviews and reviews of national data. These programs and their project dates were:

- Programa Geração Biz (PGB), Mozambique, 1997–2013
- National Adolescent Friendly Clinic Initiative (NAFCI), South Africa, 1999–2006
- Pathfinder's Reproductive Health/Family Planning and Integrated Family Health Project (IFHP), Ethiopia, 2005–2016
- Ghana Adolescent Reproductive Health Project (GHARH), Ghana, 2014–2017

All four programs were multi-year, multi-stakeholder and largely externally donor-funded. Leading CSOs developed partnerships with each country's Ministry of Health from the start. All four intended for government ownership of the program in the long-term, with some aspects of public sector implementation and funding.

The research team also conducted a review of existing sector literature and interviewed experts in the field including ASRH CSOs and their implementing partners, ASRH funders, public health officials and public health researchers.[7] In developing the conclusions and recommendations, Spring Impact supplemented the research findings with wider knowledge and experience of providing scale-specific technical assistance to CSOs and their stakeholders within ASRH and beyond.

7 Please see the appendices for a full list of stakeholders interviewed and literature reviewed.

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KEY FINDINGS

The case studies demonstrate there are examples of CSO-led ASRH programs that have achieved impact and significant scale through the public sector in Sub-Saharan Africa in the last decade. The research team noted five common key success factors that contributed to this success:

1 The program was introduced at a moment of opportune context and timing

2 Governments and end-users were involved from the outset, and the CSO ensured ongoing input from each stakeholder group during design and implementation of programs

3 Efforts were made to embed the programs into government processes and systems

4 CSOs provided technical support to governments to build capacity to support long-term implementation of the programs

5 Roll-out was a measured process

These key success factors broadly mirror those from established frameworks and literature on how to scale healthcare, particularly ASRH programs.[8]

The research team then explored the question of whether these programs had been sustained after official implementation had ended—considered, again, through the lenses of impact, sustained program implementation and ongoing funding. They found that a number of years on, none of the programs' intended impact had been sustained to the same level and none had achieved the sustainability goals as originally set out.

Where implementation of program activities continued, CSOs or other stakeholders were typically driving it rather than the public sector, even though the intention was for government implementation. In the cases where the public sector was driving implementation, delivery was inconsistent (e.g. some areas were implementing, while others were not), or piecemeal (e.g. some components of the programs were implemented, while others were not). Additionally, funding continued to come largely from external donors, rather than being financed out of the country's own budget.

At Spring Impact we have observed that it is often presumed that the reason programs fail to be sustained through the public sector is because government funding is not available. Certainly, the lack of sustainable, protected funding for ASRH in the case study programs was a key reason why their impact was not successfully sustained. However, there are a number of other contributing factors, which we believe reflect that more could have been done to fully consider a realistic path to sustainability. These include:

- ongoing implementation was piecemeal, so not all essential components of the program were sustained
- program costs were not possible to sustain within government budgets
- the process of transitioning to government systems was not fully supported or was carried out too quickly
- governments struggled to take on some of the more innovative and nuanced programmatic components

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8 These include: ExpandNet, World Health Organization 'Practical guidance for scaling up health service innovations' (Geneva: World Health Organization, 2009); Worsham, E., Langsam, K., Martin, E. Leveraging Government Partnerships for Scaled Impact (North Carolina: Scaling Pathways, 2018).

RECOMMENDATIONS & CONCLUSIONS

Our research recommendations apply to CSOs, donors, governments and the sector as a whole to consider how they adjust their approach to work more practically towards sustainability of impact in a shifting, resource-constrained public-sector context. Complementing existing frameworks on how to bring programs to scale, our focus is on sustainability.[9] We hope this can contribute to the wider conversation on sustainability of public sector ASRH programming and global health initiatives as a whole.

FOR GOVERNMENT ACTORS:

Governments should be in the driving seat of health policy planning for their country. To ensure programming will ultimately lead to impact at scale, governments need to engage in sustainability planning—being clear about their national strategy and plans, the role they want to play in the future (e.g. whether they intend for ongoing implementation through the public sector or plan to steward it in other ways), and the support required to achieve this. Our recommendations for government actors are:

1. Protect policies and resources required for ASRH

2. Share your country or region's objectives and KPIs, in terms of health priorities and impact as well as local resource mobilization, to support progress towards these goals

3. Participate in program design and sustainability planning from the outset, being ambitious but realistic about the role government will play in implementation and funding in the future

4. Be transparent about what support is needed to achieve the 'end game' e.g. support to build capacity for sustainable adaptation

5. Ensure outcomes at scale can be tracked, linking back to the original objectives and KPIs
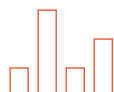
FOR CSOS:

CSOs should recognize governments as mutual partners and co-designers of a program's sustainability strategy. In considering where they can play a role CSOs need to focus on where their strengths and influence can best be employed, for example, up-skilling government and shifting behaviors of government providers. A sustainability strategy that considers the wider eco-system and stakeholders should guide CSOs' activities.

The recommendations below have been developed into a 'government end game tool', provided to accompany this report, intended as a stepwise tool to guide organizations in developing their own government sustainability strategy. Our recommendations for CSOs are:

1. Put impact first in your definition of scale and sustainability, focusing on what is needed to achieve sustained impact

2. Challenge yourself to be lean and question which parts of your program need sustaining

3. Start with an 'end game' vision of how each program component will be sustained and work backwards to consider the actions that can be taken towards that

4. Consider your role in the 'end game', and what role you are well-suited to play in the short and medium term

5. Consider how to create a balanced partnership, questioning how you can be a true partner to government

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9 For publications on how to bring innovations to scale, please see Worsham, E., Langsam, K., Martin, E. Leveraging Government Partnerships for Scaled Impact (North Carolina: Scaling Pathways, 2018), and ExpandNet, World Health Organization, Practical guidance for scaling up health service innovations (Geneva: World Health Organization, 2009), as well as Spring Impact's Social Replication Toolkit (https://toolkit.springimpact.org/Home).

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FOR FUNDERS:

Funders continue to be important players in global health programming. Funders can be extremely influential in encouraging positive behavior but, conversely, can sometimes create barriers by incentivizing unhelpful or even harmful behavior, or structuring grants or investments in ways that do not support sustainable impact at scale. Our recommendations for funders are:

1 Support CSOs to be specific and realistic about sustainability

2 Adjust funding models to better support sustainable impact at scale

3 Recognize where trade-offs may be needed in pursuit of sustainable impact

4 Ensure young people and communities are engaged in program design, but that innovation also responds to the constraints of government systems

5 Advocate for ASRH within international spheres, and, in partnership with CSOs, to national governments

6 Help to build a library of stories and evidence base on sustainability

FOR ALL STAKEHOLDERS:

CSOs, governments and funders can all take individual action to work together more effectively, but ultimately it is only through collaboration that we will achieve sustainable impact at scale of public sector ASRH programming and wider global health initiatives. Further recommendations for all stakeholders are:

1 Consider sustainability through the three lenses of impact, implementation and funding

2 Work together to devise, refine and adapt sustainability plans

3 Agree clear expectations for Monitoring & Evaluation (M&E) activities, including after official project implementation ends

4 Work together to consider how dynamic programming can be sustained over time

5 Continue to champion the rights of adolescents and the need for ASRH

Our recommendations set out clear actions each stakeholder can take to consider how better to support systematic and sustainable scale of ASRH interventions, recognizing that each stakeholder brings their own distinctive strengths. However, these are just a starting point. What remains central is that these issues will only be tackled, and sustainability achieved, if as a sector we hold ourselves and others to account on how we are pursuing sustainable impact at scale.

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CONTEXT AND INTRODUCTION

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CONTEXT

Governments are instrumental to the sustainable scale-up of health services in their country.

The delivery of full-coverage healthcare services in a country often requires deep collaboration between civil society and the public and private sectors. While each stakeholder has a role to play, the global move towards universal healthcare has increased governments' mandate to ensure access to quality services for their population; and in many places, subsidized public services are the most accessible option for marginalized groups.[10] As such, many health-focused civil society organizations (CSO) are pivoting their activities towards supporting governments to meet their health services goals, rather than delivering programs in parallel.[11] But from our work we have seen that many CSOs have questions about how to do this effectively and sustainably.

Adolescent Sexual and Reproductive Health (ASRH) is critical to address but programs are complex and typically delivered in partnership with international CSOs.

There are 1.2 billion 10-to-19-year-olds globally, the largest adolescent population in history.[12] Sub-Saharan Africa is the region with the largest projected relative growth, with adolescents expected to increase by 44% between 2015 and 2030.[13] Adolescents face particular sexual and reproductive health risks. They are particularly vulnerable to unintended pregnancies, unsafe abortions, maternal death, sexual abuse and sexually transmitted infections, including human immunodeficiency virus (HIV).[14] Risky sexual behaviors and reproductive health problems in adolescence can have educational and economic consequences into adulthood and for subsequent generations[15], resulting in long-term impacts on the individual, their families and communities. While recent decades have seen improvements in adolescent mortality rates, its pace has not matched gains made in other areas such as child health.[16]

> ❝❝ ASRH programs tend to be particularly complex, as a range of social, cultural, political and economic factors influence the sexual and reproductive health of adolescents.

10 World Bank group, World Health Organization 'Tracking Universal Health Coverage: 2017 Global Monitoring Report' (Geneva: WHO, 2017).
11 Smith, J., Buse, K., Gordon, C. 'Civil society: The catalyst for ensuring health in the age of sustainable development' Globalization and Health, 12 (40) (London: BioMed Central, 2016); Langsam, K., Martin, E., Worsham, E. Leveraging Government Partnerships for Scaled Impact (North Carolina: Scaling Pathways, 2018).
12 United Nations Population 2030 (New York: UN, 2015).
13 Ibid.
14 Denno, D. et al, 'Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support', Journal of Adolescent Health, 56(1) (London: Elsevier, 2015).
15 Branson, N., Byker, T. 'Causes and consequences of teen childbearing: Evidence from a reproductive health intervention in South Africa', Journal of Health Economics, 57. (London: Elsevier, 2018), pp. 221–235.
16 Denno, D. et al, 'Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support', Journal of Adolescent Health, 56(1) (London: Elsevier, 2015); Morris, J., Rushwan, H. 'Adolescent sexual and reproductive health:

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However, ASRH programs tend to be particularly complex as a range of social, cultural, political and economic factors influence the sexual and reproductive health of adolescents.[17] ASRH programs are typically characterized by the following:[18] However, ASRH programs tend to be particularly complex as a range of social, cultural, political and economic factors influence the sexual and reproductive health of adolescents. ASRH programs are typically characterized by the following:

Supply of high-quality, adolescent-friendly reproductive health services (including services to prevent, diagnose and treat sexually transmitted infections and HIV/AIDS, and counseling on family planning)

Training, mentorship and supervision for healthcare providers to provide adolescent-friendly services

Free provision of services and commodities to adolescents

Adolescent empowerment activities to build their social assets

Relationship-building activities, such as peer education, to influence adolescents' behaviors

Community sensitization activities to creative positive social norms for adolescents on sexual and reproductive health behaviors, which may include improving adolescent—adult linkages

Dynamic programming, including ongoing engagement with adolescents throughout program design, planning, implementation and evaluation[19]

Advocacy to promote adolescent-focused policies/systems, health system accountability and/or to secure increased funding for ASRH

These activities typically require coordination across government ministries and depend on each other for maximum impact on adolescents' sexual and reproductive health.[20]

International CSOs have been involved with sexual and reproductive health programming in Africa, providing technical and financial assistance, since its establishment in the 1970s.[21] Specifically for ASRH programs, international CSOs, multilateral and bilateral funding agencies and private foundations have supported, and continue to support, governments and CSOs in low- and middle-income countries to implement ASRH programs.[22]

As such, adolescent sexual and reproductive health (ASRH) services are an interesting lens through which to explore the challenge of how CSOs and governments can work together more effectively to achieve sustainable scale of healthcare programs.

17 Svanemyr, J., Amin, A., Robles, O.J., Greene, M.E. 'Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches' Journal of Adolescent Health, 56 (1) (London: Elsevier, 2015).

18 World Health Organization 'WHO recommendations on adolescent sexual and reproductive health and rights' (Geneva: WHO, 2018); Family Planning High-Impact Practices (HIP) 'Adolescent-friendly contraceptive services: Mainstreaming adolescent-friendly elements into existing contraceptive services' (Washington, DC: USAID, 2015); and interviews (names included in Appendix A); Simon, C., Benevides, R., Hainsworth, G., Morgan, G., Chau, K. 'Thinking outside the separate space: A decision-making tool for designing youth-friendly services' (Washington, DC: Evidence to Action Project/Pathfinder International, March 2015).

19 Many interviewees cited this as an element required for effective adolescent programming.

20 Viner, R., Ozer, E., Denny, S., Marmot, M., Resnick, M., Fatusi, A., Currie, C. 'Adolescence and the social determinants of health' The Lancet 379: 1641–52 (Online: Lancet, 2012).

21 Garenne, M. 'Family planning and fertility decline in Africa: From 1950 to 2010' Family Planning DOI: 10.5772/intechopen.71029 (online: https://www.intechopen.com/books/family-planning/family-planning-and-fertility-decline-in-africa-from-1950-to-2010, 2018).

22 Chandra-Mouli, V. et al 'Twenty years after international conference on population and development: Where are we with adolescent sexual and reproductive health and rights' Journal of Adolescent Health, 56 (1) (Elsevier, 2015).

PURPOSE AND NEED

With support from the William and Flora Hewlett Foundation, Spring Impact embarked on this research to answer two questions:

1   How have CSO-led ASRH programs in Sub-Saharan Africa achieved scale through the public sector?

2   Have these programs been sustained after official project implementation has ended, and if so, what enabled them to do so?

Spring Impacted determined CSO-led programs as those where the CSO played the lead role in development and oversight of the program, even if implemented in partnership with government.

Through its extensive work on scale, Spring Impact has observed that sustainability considerations often focus on how an intervention will be sustained financially when donor funding ends, rather than considering what is needed for sustained impact. Within ASRH a shift to focus on sustained impact would mean ultimately judging sustainability on whether adolescents continue to access high-quality services, and whether critical indicators, like reductions in teenage pregnancy, are maintained or improved. However, it can be assumed that, in the majority of cases, sustained impact will rely on sustained program implementation, which in turn requires sustained funding and resourcing. For this research Spring Impact therefore sought to understand sustainability through three distinct lenses: the impact that has been sustained, the program activities that continue to be implemented, and the funding that continues to be allocated by national or local governments and other non-governmental entities.

Spring Impact was inspired to carry out this research by its work with Marie Stopes Zambia (MSZ). Spring Impact is supporting MSZ's innovative partnership with the Zambian Ministry of Health (ZMOH), which has the goal to refine an ASRH program that can be rolled out across the Zambian public sector. This partnership provides a way of scaling MSZ's lessons from the human-centered design (HCD) process across the ZMOH's existing network, enabling the HCD insights to deliver impact at scale. In searching for examples of similar programs that had been successfully sustained at scale, it became clear that there were few examples and scant practical advice for the MSZ team, creating a challenge when planning their approach. This report, in part, serves to plug the information gap and instigate conversation around scaling and sustaining ASRH programs.

It is hoped that these insights and recommendations will inform other CSOs (and their stakeholders) working to design, scale and sustain these types of programs through the public sector. While this research was approached through an ASRH lens, its conclusions can be applied to other programs in both the health and non-health sectors where CSOs and governments are working together to achieve sustainable scale, particularly those addressing complex challenges like ASRH.
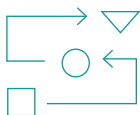
METHODOLOGY

The conclusions of this report are based on an analysis of four ASRH programs delivered in Sub-Saharan Africa, which was carried out in 2018–2019. The programs were selected for analysis as they were regarded in initial interviews and research as positive examples of scale through the public sector. All four intended for government ownership of the program in the long-term, with some aspects of public sector implementation and funding. Official project implementation (i.e. when CSOs were formally supporting activities through donor-funded projects) for all four programs had ended at the time of analysis, enabling the research team to consider what had been sustained. We also chose programs that were of sufficient size to have documentation available, and where some of the program team or stakeholders were available for interview.

The research team gathered information on these programs through literature reviews, stakeholder interviews and reviews of national data. These programs and their project implementation dates were:

- Programa Geração Biz, Mozambique, 1997–2013
- National Adolescent Friendly Clinic Initiative, South Africa, 1999–2006
- Pathfinder's Reproductive Health/Family Planning and Integrated Family Health Project (IFHP), Ethiopia, 2005–2016
- Ghana Adolescent Reproductive Health Project, Ghana, 2014–2017

To complement the case studies, the research team conducted a review of existing sector literature and interviewed experts in the field, including ASRH CSOs and their implementing partners, ASRH funders, public health officials and public health researchers.[23]

In developing its conclusions and recommendations, Spring Impact supplemented the research findings with wider knowledge and experience of providing scale-specific technical assistance to CSOs and their stakeholders within ASRH and beyond.

23 Please see the appendices for a full list of stakeholders interviewed and literature reviewed.

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CASE STUDIES

This section provides an overview of the four programs analyzed for this report, their respective journeys to scale and what sustainability looks like following their official project end.

All four of the following case studies were multi-year, multi-stakeholder and largely externally donor-funded. All four intended for government ownership of the program in the long-term, with some aspects of public sector implementation and funding. The programs reached varying levels of scale, the largest being PGB, reaching 83% of all public health facilities in Mozambique, and the smallest being GHARH, reaching all districts in one province and three districts in another.

The key success factors and information shared here are not exhaustive; they represent what the Spring Impact researchers found most insightful across all four programs.

1 PROGRAMA GERAÇÃO BIZ[24] (PGB)

Country	Mozambique
Project dates	1997–2013
Program objectives	To provide adolescents and youths with sexual and reproductive health information, preventative services against HIV/AIDS and sexually transmitted infections, and specialized services in the case of HIV infection.

Main program components

- Provision of youth-friendly services in public health facilities and youth-friendly spaces
- In-school peer educators and teachers that provided sexual and reproductive health education in secondary schools and referred adolescents to services
- Community-based educators that provided health education and referred adolescents to services

Key stakeholders and roles

- Ministry of Health, Ministry of Education, Ministry of Youth and Sports and their provincial, district and community counterparts: co-design and implementation
- The United Nations Population Fund (UNFPA) and Pathfinder International, a global non-profit organization that focuses on reproductive health, family planning, HIV/AIDS prevention and care, and maternal health: technical support and fundraising
- Local CSOs: local implementing partners

Primary funder(s)

- Danish International Development Agency
- Norwegian Agency for Development Cooperation
- Swedish International Development Cooperation Agency
- Trocaire
- Government of Mozambique

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JOURNEY TO SCALE

Objective for scale and sustainability:
full government implementation and funding by 2011 (building from 20% of program activities paid for by government during the scale-up).

Peak level of scale:
coverage in 83% of districts across all 11 provinces.

Impact at scale:
a program evaluation in 2011 showed the proportion of respondents who used contraception was somewhat higher among those who had been exposed to PGB (57%) compared to the overall study population (53%) and knowledge of modern contraceptive methods was higher among those exposed to PGB—possibly indicating a positive intervention effect. Demographic and Health Surveys show an overall reduction in adolescent fertility from 1997 to 2003; fertility among urban adolescents aged 15–19 decreased from 175 to 143 births per thousand adolescents.[25] However, a 2017 paper asserts that, despite 18 years of implementation, the program did not result in significant overall improvement of SRH outcomes.[26]

SUSTAINABILITY

Sustainability of program implementation
Implementation has only been sustained in five of the 11 provinces. Pathfinder International is no longer involved, but the UNFPA continues to support ministries with implementation, including continued advocacy to build ASRH into ministries' planning processes.

Sustainability of funding
The current implementation is funded by the UNFPA. The UNFPA is currently supporting the Ministry of Youth and Sports to mobilize donors, including the World Bank, for continued, and expanded, delivery of the PGB.

Sustainability of impact
We were unable to source any more recent ASRH data than the surveys cited above, and therefore it is difficult to conclude whether the same level of impact has been maintained five years on.

PGB has resulted in greater political support for ASRH issues across ministries. The demand for ASRH service provision continues across provincial ministries, but the struggle is in raising the resources and capacity to provide it. There also appears to be greater support and appetite for multisectoral working to address other health issues. The change in government in 2006/7 dismantled some of the approaches PGB had been working on, but overall there is still increased support for ASRH.

24 Information and insights for this case study are based on interviews with a key project stakeholder from UNFPA, and the following documents: Chandra-Moulli, V., 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?' Reproductive Health 12 (12) (London: BioMed Central, 2015); Rodrigues da Silva, L. 'Communication strategies of adolescent sexual and reproductive programmes in Mozambique: The cultural challenges of programa Geração Biz' Open Access Journal of Public Health, 2 (3) (Scient Open Access, DOI https://doi.org/10.4172/2161-0711-C1-027 2018); and Hainsworth, G, Engel, D.M., Simon, C., Rahimtoola, M., Ghiron, L.J., 'Scale-up of adolescent contraceptive services: Lessons from a 5-country comparative analysis' Acquir Immune Defic Syndr, 66 (5) (Philadelphia: Lippincott, Williams & Wilkins, 2014) pp.s200-s208.
25 ICF, 2015, The DHS Program STATcompiler, funded by USAID. http://www.statcompiler.com. January 26 2020.
26 Rodrigues da Silva, L. 'Communication strategies of adolescent sexual and reproductive programmes in Mozambique: The cultural challenges of programa Geração Biz' Open Access Journal of Public Health, 2 (3) (Scient Open Access, DOI https://doi.org/10.4172/2161-0711-C1-027, 2018).

2 NATIONAL ADOLESCENT FRIENDLY CLINIC INITIATIVE[27] (NAFCI)

Country South Africa

Project dates 1999–2006

Program objectives NAFCI aims to improve the quality of adolescent health services at the primary care level and to strengthen the public sector's ability to respond appropriately to adolescent health needs.

Main program components

- Accreditation standards for public health facilities, including youth-friendly spaces, Chill Rooms, and an essential package of basic clinical sexual and reproductive services
- Accreditation is through:
  - A clinic self-appraisal
  - A quality improvement process involving training nurses and staff, equipping facilities and providing publicity for the facilities
  - An external assessment, leading to a gold, silver or bronze accreditation
- Through the loveLife program, a trained peer educator, groundBREAKER, is assigned to each public health facility. Alongside peer education and support, groundBREAKERS represent the needs of young people on the clinic's internal quality improvement team, assist with quality assessments and are involved in outreach activities

NAFCI is one component of loveLife, a high-profile media campaign targeted principally at 12–17 year olds and aimed at changing sexual behavior. Print and media activities covered radio, television, magazine, newspapers and advertising. Community outreach activities ranged from in-school programs, a helpline and Y-Centres (educational, recreational and sexual health service points), among others.

Key stakeholders and roles

- Reproductive Health Research Unit, an academic research and training unit of the University of Witwatersrand: development and initial implementation and project management of the NAFCI program
- Department of Health: co-design and eventually management and implementation of NAFCI
- The Health Systems Trust, The Planned Parenthood Association of South Africa and NGO Advocacy Health Initiatives: consortium of existing health service organizations responsible for implementation of the larger loveLife campaign

Primary funder(s)

- Henry J. Kaiser Family Foundation
- Global Fund to Fight AIDS
- Tuberculosis and Malaria
- Bill and Melinda Gates Foundation
- Government of South Africa
- Additional local funding sources

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JOURNEY TO SCALE

Objective for scale and sustainability:
Full handover of implementation, management and funding from NAFCI to government.

Peak level of scale:
In 2010, 500 clinics or 12% of public clinics were NAFCI-accredited.

Impact at scale:
Evaluations report mixed results: a 2005 analysis of 212 externally assessed clinics showed a majority complied with 80-90% of NAFCI's standards for youth-friendly services.[28] However, a further evaluation in 2006 reported that youth-friendly services were not being implemented at the selected facilities surveyed, as they lacked training and the physical space. However, a recently published 2018 study that used data from 2000 to 2010 found living near a NAFCI clinic during adolescence delayed childbearing, substantially lowering the likelihood of early teen childbearing.[29]

SUSTAINABILITY

Sustainability of program implementation
NAFCI accreditation standards have been incorporated into the Department of Health's youth-friendly services standards, and therefore continue to exist. However, research and stakeholder interviews imply that assessments and accreditations have been discontinued. groundBREAKERS are still attached to clinics, although in many cases, because there is no longer a dedicated adolescent-specific nurse at the clinic that the groundBREAKER reports in to, they often complete administrative tasks such as filing or making copies of documents rather than assisting with quality assessments or delivering outreach activities. The Chill Rooms continue to be a space where adolescents are received by groundBREAKERS before seeing a nurse. Chill Rooms are managed by loveLife.

Sustainability of funding
Since NAFCI's transition to government, the Government of South Africa has funded it. There are also a number of externally funded initiatives to reinstate the NAFCI standards, including the Bumb'ingomso Project in Buffalo City, funded by DGMT and implemented by Beyond Zero.

Sustainability of impact
Nine years after the NAFCI program was handed over to the South African government, a 2015 evaluation found no evidence to demonstrate that facilities providing youth-friendly services provided a more positive experience to clients, predominantly due to healthcare workers' attitudes.[30] A 2018 study similarly found that youth-friendly assessments in public healthcare facilities did not meet the criteria for youth-friendly service provision.[31]

The NAFCI standards continue to be part of the National Department of Health's youth-friendly services standards. There is continued prioritization of ASRH services and numerous national programs have been developed following NAFCI. In 2016 a national campaign for adolescent girls and women was launched, comprising a comprehensive package of interventions that uses youth-friendly services as an approach to promote access to services and information.

27 Information and insights for this case study are based o: interviews with key project stakeholders and the following documents: Ashton, J., Dickson, K., Pleaner, M., 'Evolution of the national adolescent-friendly clinic initiative in South Africa' (Geneva: WHO, 2009); Branson, N., Byker, T., 'Causes and consequences of teen childbearing: Evidence from a reproductive health intervention in South Africa', Journal of Health Economics, 57, (London: Elsevier, 2018, pp. 221-235); Geary, R. S., Webb, E. L., Clarke, L., Norris, S. A. 'Evaluating youth-friendly health services: Young people's perspectives from a simulated client study in urban South Africa' Global Health Action, 8 (1), 26080 DOI:10.3402/gha.v8.26080 (2015).; James, S. et al 'Assessment of adolescent and youth friendly services in primary healthcare facilities in two provinces in South Africa' (London: BioMed Central, 2018).
28 Ashton, J., Dickson, K., Pleaner, M. 'Evolution of the national adolescent-friendly clinic initiative in South Africa' (Geneva: WHO, 2009).
29 Branson, N., Byker, T. 'Causes and consequences of teen childbearing: Evidence from a reproductive health intervention in South Africa' Journal of Health Economics, 57 (London: Elsevier, 2018, pp.221–235).
30 Geary, R. S., Webb, E. L, Clarke, L., Norris, S. A. 'Evaluating youth-friendly health services: Young people's perspectives from a simulated client study in urban South Africa' Global Health Action, 8 (1) 26080 (DOI:10.3402/gha.v8.26080, 2015).
31 James, S. et al 'Assessment of adolescent and youth friendly services in primary healthcare facilities in two provinces in South Africa' (London: BioMed Central, 2018).

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3 PATHFINDER INTERNATIONAL THROUGH THE REPRODUCTIVE HEALTH/FAMILY PLANNING (RH/FP) AND INTEGRATED FAMILY HEALTH PROJECT (IFHP)[32]

Country	Ethiopia
Project dates	2005–2016
Program objectives	To promote an integrated model to strengthen family planning, reproductive health and maternal and child health services for rural and hard-to-reach populations. The ASRH component, delivered by Pathfinder International Ethiopia, specifically aimed to reduce barriers to service uptake among young people and improve their healthcare-seeking behaviors.

Main program components

For the ASRH/Pathfinder International delivered component:
- Advocacy for ASRH and youth-friendly services in national, regional and woreda (district) health policies, budgets and plans, and integrating youth-friendly services into the public health system more broadly
- Awareness-raising activities for parents, young people and community leaders, led by healthcare providers and peer educators, to create a supportive environment for the program
- Provider counseling and ASRH service provision at youth-friendly facilities to increase sexual reproductive health knowledge, skills and healthcare-seeking behavior of young people

IFHP was the follow-on to an existing Pathfinder project—Reproductive Health/Family Planning (RH/FP)—that began in 2005. RH/FP was a maternal and neo-natal child health program that worked closely with the Federal Ministry of Health.

Key stakeholders and roles

- Pathfinder International, a global non-profit organization that focuses on reproductive health, family planning, HIV/AIDS prevention and care and maternal health, and John Snow Inc, a global public health research and consultancy: project management, technical assistance and capacity-building for regional program and cluster offices, public health facilities and peer educators
- Federal Ministry of Health and its regional (Regional Health Bureaus) and local (zonal and woreda) level counterparts: service delivery at public health facilities, and management of peer educators and youth-friendly health service provider training

Primary funder(s)

- USAID
- Korean International Cooperation Agency

JOURNEY TO SCALE

Objective for scale and sustainability:
to make the case for government support for ASRH services.

Peak level of scale:
248 sites across six (out of the nine) woredas (districts).

Impact at scale:
over five million adolescents received services throughout the project. At the time of scale-up, the National Health Management Information System did not provide age-disaggregated data, so no attributable impact data is available. Although not necessarily demonstrating causation, the Ethiopian Demographic Health Survey shows use of contraception among all women aged 15-19 increased from 1.3% to 7.4% from 2000 to 2016.[33]

SUSTAINABILITY

Sustainability of program implementation
Following the official end of IFHP in 2016, its activities were phased out by way of 'Transform', a Pathfinder-led primary healthcare project delivered in partnership with the Federal Ministry of Health.[34] Its ASRH-specific activities are similar to IFHP but, in line with changing global practices, its focus is on mainstreaming ASRH activities.[35] It builds on the same structures established by IFHP—for example peer educators—and is already in 300 facilities and scheduled to scale to another 130 facilities. Pathfinder continues to work with the government to advocate for continued ASRH prioritization in health-planning processes. It is not clear whether government delivery of IFHP's activities would have continued without Transform.

Sustainability of funding
Pathfinder's Transform project, which seeks to improve public primary healthcare services—including services for adolescents—in partnership with the Federal Ministry of Health, is funded by USAID.

Sustainability of impact
We were unable to source any more recent ASRH outcomes data, given it has only been two years following the official end of IFHP. However, where previously there was public sector resistance to provision of ASRH services, post-IFHP, there has been a dramatic increase in support for ASRH issues across government. The widescale reach of the ASRH component of the Transform project indicates the willingness of the government to provide ASRH services, but it is yet to be proven whether these services will be able to be successfully transitioned to government at the end of the project.

32 Information and insights for this case study are based on interviews with a key project stakeholder from Pathfinder International Ethiopia and the following documents: Pathfinder International, 'Bringing youth-friendly services to scale in Ethiopia' (Massachusetts: Pathfinder International, 2012); UNICEF, Ethiopian Ministry of Women and Children Affairs Ethiopia Children Fact Sheet 2018 (New York: Unicef, 2018) p.9; Hainsworth, G. et al 'Scale-up of adolescent contraceptive services: Lessons from a 5-country comparative analysis' Acquir Immune Defic Syndr, 66 (5) (Philadelphia: Lippincott, Williams & Wilkins, 2014) pp.s200–s208.
33 Central Statistical Authority/Ethiopia and ORC Macro, 2001; Ethiopia Demographic and Health Survey, 2000; Addis Ababa, Ethiopia: Central Statistical Authority/Ethiopia and ORC Macro; Central Statistical Agency (CSA) [Ethiopia] and ICF 2016; Ethiopia Demographic and Health Survey, 2016: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF.
34 See Transform project website for more information: https://www.pathfinder.org/projects/transform-primary-health-care/
35 These changing global best practices were referenced in our interviews and in publication such as Simon, C., Benevides, R., Hainsworth, G., Morgan, G., Chau, K. 'Thinking outside the separate space: A decision-making tool for designing youth-friendly services' (Washington, DC: Evidence to Action Project/Pathfinder International, March 2015).

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4 GHANA ADOLESCENT REPRODUCTIVE HEALTH PROJECT[36] (GHARH)

Country	Ghana
Project dates	2014–2017
Program objectives	To reduce the rate of sexual activity before the age of 18 and increase the proportion of adolescents using a modern contraceptive method.

Main program components

- Provision of free adolescent-friendly services and commodities through youth corners and outreach clinics delivered through public health facilities
- Awareness-raising events and community mobilization activities including distribution of informational materials, social media campaigns and a television series, You Only Live Once (YOLO), that advises and directs adolescents on the challenges they face in their sexuality.
- Sexuality education in schools, including resources for teachers and the facilitation of school health clubs
- Provision of technical assistance to support the multiple national stakeholders in implementing and coordinating the program

Key stakeholders and roles

- Palladium (previously the Futures Group), an international advisory and management business: project manager and technical advisor
- National Population Council, a statutory body that advises the Ghanaian government on population matters: project coordinator
- Ghana Health Service's Family Planning Division, Ghana Education Service and their regional/district counterparts: education and service delivery; and
- Local CSO partners: community mobilization

Primary funder(s)

- UK Department for International Development

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JOURNEY TO SCALE

Objective for scale and sustainability:
to expand and sustain ASRH services—as implemented during GHARH—across Ghana, in line with the recent adolescent health policy. The goal was for future funding and implementation to be taken over by the Ghana Health Service and Ghana Education Service.

Peak level of scale:
all 27 districts in the Brong Ahafo Region and three in the Ashanti Region, out of a total of 216 districts in Ghana; total of 54 youth corners and 546 school health clubs.

Impact at scale:
between 2014 and 2017, there was an 84% increase in the number of new adolescent users of modern family planning methods in project regions. In Brong Ahafo, the percentage of adolescent girls who became pregnant dropped from 9.3% in 2014 to 8.4% in 2017.[37]

SUSTAINABILITY

Sustainability of program implementation
The project ended in 2017. In 2019, implementation of all program components had continued, although not comprehensively. Components that continued include:
- Some youth corners continued to be staffed.
- There was some continuation of school health clubs and community meetings, though this was typically as a result of the personal commitment of the nurses, school teachers or community members.
- The YOLO television series continued to be sustained, implemented by another CSO—USAID Communicate for Health Project—and the series is aired by the private sector.
- Some community mobilization had been sustained by local CSOs, where it fit with their existing programming priorities.
- A mobile app to support providers in supplying ASRH information and services had been launched, and some informational materials developed.

Sustainability of funding
Despite advocacy activities for increased funding, there has not been a sustained increase in domestic budget allocation for ASRH with the new government administration. There is no consistent allocation in district budgets for ASRH and therefore no dedicated government funding for continuation of GHARH's activities. However, the programmatic components that built on existing structures—e.g. nurses working at youth corners on certain days of the week—continue. Outside government, different stakeholders, particularly UNFPA, have funded select components of the program. For example, the mobile app and informational materials have external international donor funding from the West African Health Organization and UNFPA; YOLO is funded by the private sector and Communicate4Health (USAID); and select community mobilization activities are fundraised for by local CSOs, where it fits with their programming priorities.

Sustainability of impact
While there is some indication that there are lower pregnancy rates, stakeholders believed the rates are not as low as they were during the project. However, no data could be found to verify either of these claims.

Beyond the program, GHARH has had wider impact on ASRH issues nationally: ministries have seen the benefits of multi-sector working and are continuing to collaborate. In 2019, during Spring Impact's project visit, the Ghana Health Service and Ghana Education Service were working together to develop a comprehensive sexuality education curriculum to supplement the national school curriculum. A recent nutrition program for adolescent girls had also successfully used the coordination structures set up by GHARH to deliver folic acid in schools.

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36 Information and insights for this case study are based on in-person interviews with project stakeholders, Spring Impact's observations from visiting public health facilities and schools in Ghana, and UK Department for International Development, 'Project Completion Review 202819', Development Tracker (Online: https://devtracker.dfid.gov.uk/projects/GB-1-202819/documents, February 2018).
37 UK Department for International Development 'Project Completion Review 202819' Development Tracker (https://devtracker.dfid.gov.uk/projects/GB-1-202819/documents, February 2018).

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THEMES ON ACHIEVING AND SUSTAINING SCALE ACROSS THE CASE STUDIES

Considering the question of whether, and how, programs have achieved scale, the case studies demonstrate there are examples of CSO-led ASRH programs that have achieved impact and significant scale through the public sector in Sub-Saharan Africa in the last decade. Across the four programs, the research team noted five common key success factors that contributed to this success. These broadly mirror those from established frameworks—key among them the ExpandNet/WHO framework for scaling up.[38]

The research team then explored the question of whether these programs had been sustained after official implementation had ended—considered through the lenses of impact, sustained program implementation and ongoing funding. They found that a number of years on, none of the programs' intended impact had been sustained to the same level, and none had achieved the sustainability goals as originally set out. We propose a number of reasons why we believe this to be the case.

38 ExpandNet and the World Health Organization (WHO) have published several sector-accepted resources that guide country projects as they strategically plan and manage scaling-up processes. We have included the key ExpandNet/WHO resources reviewed in the bibliography.

KEY SUCCESS FACTORS FOR ACHIEVING SCALE-UP

At scale, most programs reported changes in behaviors due to program activities, and some reported tangible impact (e.g. contraceptive use increased).

The rigor of impact evidence across the programs, however, is inconsistent; many interviewees cited challenges in the monitoring and evaluation of the programs, and there is a paucity of publicly available data. Quantifying longer-term outcomes was also difficult, as the causal pathway of family planning and fertility remains difficult to identify amongst public health experts. Nonetheless, all programs reported, at a minimum, significant changes in behavior at scale. We identified common success factors across the programs that we believe enabled them to achieve this.

1   The program was introduced at a moment of opportune context and timing
All four programs were introduced to government at a time when there was a recognized need for ASRH services within local communities, making this a relevant public sector challenge to address. Local recognition took varying forms, such as research demonstrating the size of the issue or national policy formalizing commitment to ASRH, and converged with a time of prioritization and commitment from the global community. GHARH, for example, was introduced to provide district- and national-level support in implementation of the National Adolescent Health and Development strategy. Internationally, momentum and support for ASRH investment was high. Timing was particularly opportune for NAFCI and PGB, as they were part of the global movement for improving ASRH services that had been put on the agenda at the 1994 International Conference on Population and Development. This conference accelerated the call to action to governments and health systems to remove adolescents' barriers to SRH education and services, and spurred the development of these programs.

2   Government and end-users were involved from the outset, and the CSO ensured ongoing input from each stakeholder group during design and implementation of programs
For the most part, the programs and related policies were designed in partnership with government stakeholders and, where possible, designed in line with government policies. This ensured initial and ongoing buy-in and ownership from ministries. Clear roles and responsibilities were established from the outset, with systems set up for collaboration to account for the multi-sectoral and stakeholder program design.

Many of the innovations were also co-designed with young people, CSOs and community stakeholders. For example, representatives of youth and youth-serving organizations were key stakeholders in the conception of NAFCI's program guidelines and workshops were held with district-level and clinic staff to validate NAFCI's accreditation standards. As a result, the innovations were perceived to be engaging and exciting when they were first introduced. This was attractive to adolescents and motivating to providers who were excited about being part of a new initiative. GHARH also used operations research studies on adolescents' perspectives to inform the training for healthcare workers, the design of the youth-friendly corners and the decision to create the YOLO TV series and mobile application—among other programmatic components. As the programs scaled, many continued to bring the adolescent voice and dynamism to ensure its continued relevance and cultural acceptance at scale. Across all four programs, adolescents were consistently a vital part of service delivery, primarily as peer educators, leading to better engagement with the target group as they identified with the messages delivered.

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3 **Efforts were made to embed the programs into government processes and systems**

Each program resulted in the establishment of clear policy frameworks that prioritized ASRH. Programs were designed in line with new policies where possible; where policy frameworks were not in place, the program implementers advocated for the required changes to ensure integration into policies. For example, Palladium and DFID worked with the Government of Ghana to revise the national ARH Policy in 2016, the Adolescent Health Service Policy and Strategy for 2016–2020, and the NPC Strategic Plan for 2017–2024. These actions laid the foundation for continued prioritization and implementation of ASRH activities and therefore their programs.

Rather than creating new systems that would need to be transitioned to government to be sustained, the CSO sought to build on existing public sector systems. NAFCI streamlined program components within existing human resource, performance management and stock management processes. Pathfinder/IFHP succeeded in ensuring the curriculum for service providers included a section on ASRH and developed the National Planning Implementation and Evaluation Tools for Adolescent- and Youth-Friendly Reproductive Health Service Standards (2010). A number of programs sought to ensure compatibility of their programs with the local health information systems. In a few cases support was provided to the health ministries to disaggregate ASRH data from overall maternal and child health outcomes.

Funding relationships were set up to enable the eventual transition of financial flow from external donor to national government. In the case of the GHARH, DFID administered funds to the Government of Ghana, who then contracted the CSO. Funds also went directly to local government, who allocated funding based on work plans.

4 **CSOs provided technical support to governments to build capacity to support long-term implementation of the programs**

Providing technical support to build government capacity and ensure adequate transfer of skills to support ongoing implementation, beyond the program implementation period, was a key activity across all four programs. Pathfinder International Ethiopia, for example, paved the way for youth-friendly services through its support for the Ethiopian public sector, from piloting model sites to employing local officers to integrate program components into regional- and community-level work plans and budgets. GHARH worked through both national- and district-level structures to improve the capacity for prioritizing and managing ASRH services, embedding staff at all levels of government, dependent on the ministry's specific needs.

The programs also engaged other national stakeholders to provide technical support to the public sector. For example, GHARH and loveLife engaged local think tanks and universities to support in-program development and administer trainings. PGB ensured local leaders, youth associations and local partners had the capabilities to implement the program. This increased the credibility of the program locally but also sought to ensure a mechanism for ongoing implementation support if the CSO were no longer involved.

5 **Roll-out was a measured process**

The programs generally followed a measured and phased roll-out trajectory, starting with smaller pilot areas for testing before spreading nationwide, aided by codified documents and processes. For example, before rapidly scaling, Pathfinder/IFHP set up 20 pilot sites to serve as learning sites. Facilities and government officials interested in delivering ASRH services visited the original pilot sites to observe implementation. This served as a training tool, and also a way to get new facilities and officials excited.

- A number of commonalities across the programs during the roll-out were noted, including: cross-site learning and innovation for continued momentum, ownership and quality control at the local level
- Decentralized approaches to implementation and funding that allowed for local adaptation to, and ownership of, new contexts
- Clear documentation to communicate the intervention with use of checklists and other quality control measures/systemized materials for quality management and sustainability

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SUSTAINABILITY FOLLOWING PROJECT CLOSE

The research team then explored the question of whether these programs had been sustained after official implementation had ended—considered through the lenses of impact, sustained program implementation and ongoing funding. They found that a number of years on, none of the programs' intended impact had been sustained to the same level and none had achieved the sustainability goals as originally set out.

1 Inconsistent public sector implementation

We found that where the public sector became the sole implementer, delivery was inconsistent (e.g. some areas were implementing, while others were not), or piecemeal (e.g. some components of the programs were implemented, while others were not). In some instances, for example NAFCI, the training and support offered to facility staff was implied to have completely stopped. In others, delivery had been ad-hoc, rather than on the routine basis found elsewhere, such as antenatal care or antiretroviral therapy, whose importance is prioritized on a sustained basis.

Where the research team found sustained and systematic implementation of program activities, it was primarily in locations where CSOs continued to be involved, even though that was not the original intention. In the case of IFHP and PGB, following the official end of the projects, the CSOs continued to drive implementation of activities, and are still involved in delivery and technical assistance. In both countries, they have continued their advocacy efforts to keep adolescents on the national agenda.

On a smaller scale, some continued implementation could be seen where local practices had changed. Interviewees reflected a difference in community acceptance of ASRH in areas where significant emphasis was placed on engaging local gatekeepers and champions, or where the CSO had supported the same region for a continuous and significant period of time. For example, in the case of PGB, greater impact can be seen in regions with longer periods of UNFPA involvement. Interviewees noted that there were a handful of healthcare providers across programs whose mindset towards and passion for ASRH were sustained. Some continued to provide youth-friendly services and run community events, despite the end of formal program activities—GHARH being a key example. In addition, program components were sustained when they were built into existing health systems and structures. For example, in Ghana the nurses continue to staff youth centers at dedicated times of the week because it is part of their formal routine and the physical infrastructure is available.

GHARH approached the private sector as a route to sustainability for a component of its program. It outsourced YOLO, an exciting and wide-reaching ASRH-focused television series, to private television producers that continue to produce and air episodes.

2 Funding continues to be from external donor organizations

Many of the programs intended for the government to fund activities following the official project close. However, only a handful of regions and districts across the four countries have dedicated budget for ASRH services. Even in Ghana, where there is a National Adolescent Reproductive Health Program Unit, there is still no protected district funding for the continuation of all of GHARH's activities. Where there has been ongoing consistent implementation, it has been in situations where the implementing CSO has raised funds from external donors to continue delivery (e.g. additional training for teachers in sexuality education).

3 Impact not maintained at the same level

Data and outcomes monitoring was weak at the time of scale-up; and a number of years on, this continues to be the case.[39] Up-to-date adolescent reproductive health outcomes (e.g. fertility rate) or outputs (e.g. number of adolescents availing services) are not published externally or are difficult to find. Anecdotally, a number of stakeholders shared the view that impact has reduced following the official project close. This aligned with the little available data that was successfully sourced and the few evaluations that were available.

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39 Diaz, N., Heard, A., Rankin, K. 'Adolescent sexual and reproductive health: scoping the impact of programming in low- and middle-income countries' (New Delhi: International Initiative for Impact Evaluation, 2016).

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4   Increased support nationally for ASRH issues and multi-sector approaches

Although the public sector was unable to systematically take on the programs' implementation or funding, support for ASRH issues nationally dramatically increased, both within government but also across wider civil society. In South Africa, loveLife and NAFCI laid the foundations for subsequent improvements to the country's national Adolescent and Youth Friendly Services Model and ASRH campaigns. It also galvanized and provided a framework for other CSOs to implement youth-friendly services. For example, many of NAFCI's peer educators, or groundBREAKERS, have been nurtured to become part of 'Active Change Drivers', a network of socially conscious young people that drive change on issues such as gender-based violence. The policies, strategies and standards that were created during the programs still do exist at the national level. In Ethiopia, following Pathfinder/IFHP, it became mandatory for all providers to be trained in youth-friendly service delivery. In Ghana, a specific goal for adolescent health was included as part of the Ministry of Health's Family Planning 2020 commitments. Stakeholders reflected that there is now the will to implement ASRH across the public sector.

Government ministries have recognized the benefits of a multi-sectoral approach to adolescent issues and partnerships have continued. For example, building on the successes of Pathfinder/IFHP, comprehensive life-skills education, including sexuality education, is currently being integrated into secondary school curricula in Ethiopia and inclusion of comprehensive sexuality education in the national curriculum is underway in Ghana. This will help facilitate referrals from schools to health facilities for SRH services.

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REASONS WHY FULL IMPACT IS NOT SUSTAINED BY THE PUBLIC SECTOR

At Spring Impact we have observed that it is often presumed that the reason programs fail to be sustained through the public sector is because government funding is not available. Certainly, the lack of sustainable, protected funding for ASRH was a key reason why the impact of the case study programs was not successfully sustained. However, there are a number of other contributing factors, which we believe reflect that more could have been done to fully consider a realistic path to sustainability.

1 No sustained, protected funding for ASRH

The majority of the programs envisaged governments would be able to dedicate funding to continue implementation of program activities. However, for the most part, this did not happen.

Protected funding for ASRH in the midst of competing healthcare priorities is difficult. Even when there is dedicated ASRH funding, governments are still resource-constrained. For example, although Ghana has a national ASRH budget, its total health budget allocation per person, and as a share of the total government budget, has significantly declined since GHARH's inception in 2011.[40] Additionally, maintaining prioritization of ASRH is challenging. ASRH is preventive care, which Spring Impact has seen is often under-valued against curative care, as its impact is longer-term and difficult to quantify; and, often, some moral and political oppositions to the need for sexual health services for adolescents remain. ASRH is also often 'lumped in' with maternal and child health and general family planning services, which ignores recognition that the challenges of adolescents are distinct and need to be addressed in different ways. As such, when government administrations change, priorities can shift. For example, even though both PGB and GHARH secured ongoing commitment to ASRH programs across all levels from incumbent governments, the next administrations that took power were not as supportive of ASRH and did not dedicate specific resources to adolescents.

Even where budgets are not necessarily declining, ASRH programs are generally perceived to be expensive, which can make it difficult to ensure sufficient budget is allocated. Initially, they are often costly and time consuming to co-design because they require many consultations with different stakeholders. Because multiple ministries are involved at different levels (e.g. national and local), programming is resource-intensive to embed and maintain at each level. ASRH programs are multi-component and require allocation of staff across activities, ministries and levels. CSOs have also reflected that adolescents are also a difficult demographic group to access and persuade, and therefore require more resources for demand generation and community sensitization. ASRH programs are often implemented separately, rather than embedded into other health services for adolescents, which may also contribute to this perception.

National funding is not the only challenge for ASRH projects; they are also at the whims of changing international funding patterns. The implementation of policies such as the Global Gag Rule—which bans foreign NGOs which receive US federal funding from providing abortion services or referrals[41]—and pressures on international initiatives like the Global Fund to Fight AIDS, Tuberculosis, and Malaria—which faced funding shortfalls and waning political commitment from governments and international organizations[42]—also impacted the availability of funding.

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40 UK Department for International Development 'Project Completion Review 202819' Development Tracker (https://devtracker.dfid.gov.uk/projects/GB-1-202819/documents, February 2018).
41 Open Society Foundations, 'What is the Global Gag Rule?' (https://www.opensocietyfoundations.org/explainers/what-global-gag-rule, 2018).
42 The Global Fund Step Up the Fight (Geneva: The Global Fund, 2019).

2 Insufficient consideration of a realistic path to sustainability

There are a number of reasons impact was not sustained through the public sector that we believe might have been mitigated by more comprehensive sustainability planning on the part of the CSO and partners. These include:

- **Ongoing implementation was piecemeal, so not all essential components of the program were sustained**
Because a range of social, cultural, political and economic factors impact adolescents' sexual and reproductive health behaviors, there are a number of essential components of an intervention that must be functioning for full impact. In places where some program activities did continue, these did not result in the same level of impact, because the other essential programmatic components did not. With GHARH, nurses in the Brong Ahafo region are still allocated to the youth-friendly corner on certain days of the week, but in the absence of significant demand-generation activities and strong youth clubs, there are few adolescents that come to facilities for services. The lack of practice can also mean nurses are unable to maintain new skills in youth-friendly service delivery. This issue with piecemeal implementation is mirrored across other analyses of why ASRH services have not been sustained at scale.[43]

- **Program costs were not possible to sustain within government budgets**
All four case studies had significant program budgets, which meant that planned activities were often high resource and intensity, rather than designed to be suitable for government budgets. Although some consideration was given to costs—for example, IFHP tried to make the program leaner in later phases by using community resources for refurbishments—the programs remained too expensive for government to sustain at the same levels.

- **The process of transitioning to government systems was not fully supported or was carried out too quickly**
The programs presumed that aspects would be handed over to government, without full consideration of the support needed to enable this transition.

For example, for adolescents to feel comfortable confiding in healthcare providers and accessing ASRH services from them, these providers require soft skills that take mentorship and ongoing support to develop. Soft skills like youth-friendly service provision contrast with typical government quality assurance processes (e.g. stock management), which can be more routine and systematic. NAFCI's quality assessment process, when managed by loveLife, was perceived by clinics as an exciting drive for quality. When the public sector took it on, it lost its perceived excitement, and staff and young people regarded the assessment as performance management. Moreover, government training systems are typically set up so that one-off trainings are provided instead of ongoing mentorship and motivation, meaning that skills like youth-friendly service provision are not reinforced and solidified. Public sector staff turnover exacerbates this challenge, because even when providers are trained and mentored, when they move between facilities these gains can be lost.

Surfacing and discussing these challenges at an earlier point may have made it possible to factor this into the sustainability planning and technical assistance provided.

In addition, from Spring Impact's experience of working with a wide range of global organizations, alongside the interviews carried out for this research, a frequent reflection is that transition to government takes longer than expected, and that it is unlikely that all components can be handed over at once, which is often what happens due to time frames set by donor milestones.

For example, a factor cited for why the impact of NAFCI had not continued was its speed of transition to government: the Department of Health took over all implementation components at once, including internal and external assessments, quality assurance processes and capacity-building of clinic staff. Interviewees suggested that, despite a five-year capacity-building process, a phased and gradual transition would have led to better outcomes.

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43 Chandra-Mouli, V., Lane, C., Wong, S. 'What does not work in adolescent sexual and reproductive health: A review of evidence on interventions commonly accepted as best practices' Glob Health Sci Pract. 3(3):333-340 (http://dx.doi.org/10.9745/GHSP-D-15-00126, 2015).

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- **Governments struggled to take on some of the more innovative and nuanced programmatic components**
  Adolescents are constantly changing and require new and exciting programs to keep them engaged. Likewise, ASRH programs need to be dynamic to keep up with these changes, as shown by the growing uptake of human-centered design approaches.[44] This type of programming, with frequent adaption based on clients' needs, desires and lifestyles, requires new ways of working that can be difficult to sustain in a government setting. Additionally, government funding is often not sufficiently dynamic to adjust to iterative, innovative and potentially 'controversial' programming.

  For example, part of NAFCI's success in generating demand for ASRH services was due to loveLife's media campaigns. However, loveLife had trouble sustaining its initial ethos because its media campaigns were restricted to avoid inflammatory or controversial content when transferred to government. In these instances we believe it may have been more appropriate to consider some ongoing role for the private sector or civil society actors to ensure impact could be sustained.

44 World Health Organization 'WHO recommendations on adolescent sexual and reproductive health and rights' (Geneva: WHO, 2018).

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RECOMMENDATIONS FOR SUSTAINING PROGRAM IMPACT AT SCALE

Our research has shown that while it is challenging to achieve scale through the public sector, it is possible, and there are existing tools, frameworks and examples of ASRH programs that have managed to do so in the Sub-Saharan African context. However, sustaining the program's implementation, funding and impact through the public sector poses more challenges. The case studies show that for programs that were initially CSO-led, their delivery, funding and impact are rarely sustained once adopted by the public sector.

However, despite the complexity, governments are instrumental to the sustainable scale-up of ASRH services. We therefore challenge all those involved in program impact—CSOs, donors, governments and the sector as a whole—to consider how they might adjust their approach to work more practically towards sustainability of impact in a shifting, resource-constrained public sector context.

In this section, building on the research as well as Spring Impact's wider experience, we put forward initial recommendations for each group, with an emphasis on CSOs as the focus of this research. Complementing existing frameworks on how to bring programs to scale, our focus is on sustainability.[45]

45 These include: ExpandNet, World Health Organization 'Practical guidance for scaling up health service innovations' (Geneva: World Health Organization, 2009); Worsham, E., Langsam, K., Martin, E. Leveraging Government Partnerships for Scaled Impact (North Carolina: Scaling Pathways, 2018).

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> " Governments should be in the driving seat of health policy planning for their country

RECOMMENDATIONS FOR GOVERNMENT ACTORS:

Governments should be in the driving seat of health policy planning for their country as they are ultimately accountable for the health needs of their population. Governments often engage CSOs and partners as they develop health policies and recognize the need to involve them in the implementation of those policies, particularly on more complex programming like ASRH, or where it is advantageous to enable innovation outside of government structures and behaviors.

However, to ensure this will ultimately lead to impact at scale, governments need to engage in sustainability planning—being clear about their national strategy and plans, the role they want to play in the future (e.g. whether they intend for ongoing implementation through the public sector or plan to steward it in other ways), and the support required to achieve this.

1   Protect policies and resources required for ASRH
Champion ASRH within your country, recognizing the health and economic benefits of doing so. Acknowledge that adolescents have distinct challenges and needs, rather than grouping services into maternal health or general family planning. Secure adequate funding for these vital services and, where possible, ensure this budget is protected specifically for ASRH.

2   Share your country or region's objectives and KPIs to ensure progress towards these goals
Share your country or region's objectives and KPIs in terms of health priorities and impact, as well as local resource mobilization. Be open with partners about what will be needed for future government adoption in terms of evidence and costs. Enable CSOs to align outcomes tracking, for example if particular measures are needed for government reporting that the CSO may not have considered (e.g. HIV testing rates among boys, when the CSO is focused on family planning for adolescent girls). Where possible, identify and share what would be regarded as a reasonable 'price point' for a program for future government adoption, enabling the CSO to innovate and iterate towards that, even if there is more funding currently available from external donors.

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3 **Participate in program design and sustainability planning from the outset, being ambitious but realistic about the role government will play in implementation and funding in the future**

Work with CSO partners and funders to align around a shared vision of how a program will be sustained in the future—with clarity on the role government intends to play in terms of funding, implementation and overall oversight, including aspects such as M&E and quality assurance. Recognize that there are aspects where other partners may be better placed to play a role; for example, supporting ongoing program iteration to respond to the needs of adolescents, or where you may require ongoing technical support. Consider how you can form partnerships and governance structures that will enable sustained implementation, retaining government ownership even where external partners are driving implementation, for example through contracting or public–private partnerships. Ensure this vision is shared across the different ministries and levels of government that will be involved in funding and implementing programs.

4 **Be transparent about what support is needed to achieve the 'end game'**

Identify what you need from partners to achieve your 'end game' e.g. evidence, a cost-effective program, or support in building wider community acceptance. Seek support from actors to help you build the systems to address ASRH in the long-term, e.g. institutionalizing training for healthcare providers, rather than just providing one-off trainings. Consider realistic time-phasing for transition; there are likely to be aspects where you want to take over implementation sooner, and others where partner involvement may be required over a longer period.

5 **Ensure outcomes at scale can be tracked, linking back to the original objectives and KPIs**

Ensure government systems are able to track outcomes at scale, including disaggregation of data by age. Across the case studies in this research, the lack of outcomes data available at scale beyond official project implementation limits the ability to understand if, and where, impact has been sustained. There is a shared imperative across CSOs, funders and governments to better understand how to achieve sustainable impact at scale, so where possible make this data available to other actors.

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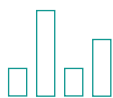
RECOMMENDATIONS FOR CSOS

CSOs should recognize governments as mutual partners and co-designers of a program's sustainability strategy. In considering where they can play a role, CSOs need to focus on where their strengths and influence can best be employed; for example, up-skilling government and shifting behaviors of government providers. A sustainability strategy that considers the wider eco-system and stakeholders should guide CSOs' activities.

1 Put impact first in your definition of scale and sustainability

The ability to sustain impact depends on your program having impact in the first instance. Many of the case studies struggled to prove outcomes before public sector transition, significantly complicating their ability to demonstrate outcomes following transition. Baseline data was not collected, nor were monitoring and evaluation systems always in place from the outset. Ensure you are collecting the right data as your program scales. You must have the data and evaluations that attribute your program activities to changes in behavior and/or outcomes. This needs to go beyond outputs (e.g. peer educators trained) to intermediate, and ideally long-term, outcomes (e.g. services availed, fertility rate). If long, costly evaluations such as randomized control trials are not feasible for your program, explore how more dynamic forms of impact measurement might be appropriate for your time frame and budget; for example, rapid cycle testing or lean data approaches to evaluations. Without program efficacy, there is no impact to be sustained. This is the fundamental first step.

The objective of sustainability is long-term, continuous impact. It may, but does not necessarily, mean the continued implementation of your program as is. Reframing your objective of sustainability as sustained impact will help you to consider your program as the means to achieve that, rather than continued implementation of the program as the goal in itself.

2 Challenge yourself to be lean

With intended impact as your guide, challenge yourself to question which parts of your program need sustaining. Although ASRH programs may require multiple components for impact, do not assume that your program must continue to be sustained as is. For example, when framing what it means to sustain community awareness events, use sustained demand for ASRH services as the outcome driving your decisions, rather than the continued funding and implementation of the same demand-generation activities you have been implementing. This will influence what you choose to carry on implementing and encourage you to think about sustainability in terms of impact, rather than just operations and finances. You may also be implementing activities that do not significantly contribute to the desired outcomes or provide sufficient value for the resources invested. Use existing impact data or commission evaluation studies to identify the key drivers of your program's impact, in relation to its cost.

> The objective of sustainability is long-term, continuous impact. It may, but does not necessarily, mean the continued implementation of your program as is

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3 **Be strategic—start with an 'end game' vision and work backwards to develop a realistic plan**

ASRH programs are complex and often require multiple components to be in place for full impact. Therefore, you need a sustainability plan for each essential component. As with a Theory of Change that considers the ultimate impact first and then the activities that contribute towards this, create an 'end game' of the sustainability vision for each programmatic component, and then the actions that can be taken towards that. Consider, for each essential component, how this will be realistically funded and implemented in the future, taking into account government resources and capacity available.

Be creative with this visioning—remember that government ownership does not need to automatically equal full public sector implementation. Consider other potential options, such as public–private partnerships or CSO contracting, and consider the long-term role you intend to play as a CSO. Create this vision in partnership with government to ensure that all stakeholders are aligned towards a shared vision.

With your long-term goal in mind, you can then co-create your plan for action with your government partners. Approaching your program on a per-component basis means you can develop a more achievable strategy for transitioning that accounts for the different nature, and therefore sustainability trajectories, of each activity. You can work closely with government to understand the components they have the interest and capabilities to take on first, as they will know best which components have the highest potential for government ownership in the short term, and likewise where more support will be needed from you as a CSO. For example, you might continue implementing and funding ASRH media campaigns as the government may want to focus its resources on providing ASRH services in its public health facilities. Be realistic about what the government can take on and how quickly that can happen. Be prepared to secure the necessary buy-in and resources you need to continue to deliver or support some of the program components—likely over a longer term than you may anticipate, as it can be a long and complex process to integrate new activities or workstreams within government systems.

4 **Consider your role in the 'end game', and what role you are well-suited to play in the short and medium term**

Consider your role in the 'end game', what you can do now to get there and how you can support other stakeholders—particularly government partners—to achieve their 'end game' vision too.

Consider the strengths you have as a CSO compared to your other stakeholders. CSOs tend to be agile, dynamic, able to access funds and take more risks. Reflect on the barriers in the way of achieving each component's end game. The following are potential roles for CSOs to take in the short, medium or long term:

Playing to CSO strengths:
- Program innovator: the continued success of ASRH programs is reliant on ongoing innovation to adapt to adolescents' changing needs. As governments are accountable for the careful use of public money, they are often seen as having a lower risk appetite for experimentation. The role of ongoing iteration and innovations can therefore be suited to CSOs. This includes using approaches like human-centered design, staying up to date with global best practice within ASRH programming and helping government to adapt implementation to donor priorities and their local context and environment
- Community-level behavior change: a shift in provider or community mindset towards the importance of ASRH services can serve as an enabler to sustainable change. CSOs can focus efforts towards changing the 'hearts and minds' of providers and community gatekeepers.
- Supporting government to access funding: funding is a barrier to sustained scale. CSOs can support government by accessing short- to medium-term funding for them, and/or capacity-building to enable them to do so
- Continued or shared implementation of specific program components: there are some components that government will likely be slower to take on, but that are critical to impact. Particularly in instances where multiple components must be in place for full impact, CSOs could continue implementation of some components to complement government-led components—for example, continued management and payment of peer educators

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Building government capacity:
- Building systems: CSOs can support governments to improve or build processes, systems and infrastructure that will encourage the longevity of ASRH activities[46]—for example, co-developing information management systems, embedding comprehensive sexuality education into education systems and building any physical infrastructure required
- Supporting transitioning of program components: some ASRH program components are more difficult to hand over to government; for example, multi-sectoral stewardship and working, training and quality assurance for youth-friendly services or ongoing youth-friendly content creation. CSOs could focus their efforts on determining how these can continue sustainably

Ongoing advocacy:
- Advocate for improved ASRH policies and funding: ongoing funding and commitment to adolescents is hard to maintain, yet it is one of the biggest determinants of sustainable scale. There needs to be continued support to government for improved policy and funding that brings out the youth voice in policymaking and builds and up-skills champions for ASRH across government. Youths inherently have less influence and power over policy, so CSOs will always have an important role in amplifying their voice, and should ensure continued time and resources towards these activities where possible

5 Consider how to create a balanced partnership

Recognize the power dynamics that often exist between CSOs, particularly when externally donor-funded, and government partners. Question your own role and how you can be a good partner to government, e.g. including government perspective from the beginning or challenging unrealistic funder expectations

RECOMMENDATIONS FOR FUNDERS:

Funders continue to be important players in global health programming, as resource-stretched governments struggle with competing priorities and are often restricted in their ability to accept risk and innovation. Funders can be extremely influential in encouraging positive behavior but, conversely, can sometimes create barriers by incentivizing unhelpful or even harmful behavior, or structuring grants or investments in ways that do not support sustainable impact at scale.

1 Support CSOs to be specific and realistic about sustainability

Challenge CSOs and partners to communicate a specific vision of what public sector implementation looks like for their program, considering what is possible in terms of sustainability of implementation and funding, and the transition time frames for different program components. Recognize there may be a need for ongoing CSO involvement beyond the official program period, particularly for oversight, advocacy and evaluation.

Offer funding and support to CSOs to dedicate the time needed to develop this vision in collaboration with government partners. Support processes to ensure alignment of KPIs and evaluation metrics with government, including how these will be monitored after the official program end.

Where CSOs will provide technical assistance to government partners, challenge them to ensure this is done from the perspective of true capacity-building and knowledge transfer.

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46 Chandra-Mouli, V., Chatterjee, S., Bose, K. 'Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents?' Reproductive Health, 13 (10) (London: BioMed Central, 2016)

2 **Adjust funding models to better support sustainable impact at scale**
Provide upfront funding to build the systems for future scale and sustainability, recognizing that this will increase costs in the short term but with longer-term payback. If you ask for reporting on costs per beneficiary, enable partners to separate out the upfront costs, so that it does not misleadingly inflate the cost effectiveness of the program.

Provide flexible longer-term funding to help CSOs towards their sustainability objectives, including protecting grantees against unforeseen challenges, changing donor priorities and supporting longer-term evaluation of outcomes. Encourage CSOs to identify and communicate risks in advance and work collaboratively with them on mitigation strategies.

Consider the different transition speeds of different program components. Recognize that there may be tangible reductions in the funding required over time, but that some components, where there is less clarity on the path to sustainability, may require funding for a much longer period than is often expected. Consider when it may be appropriate to channel funds directly to governments. Hold grantees to account on how they are progressing towards their ultimate aims, for example, indications of increased government ownership.

3 **Recognize where trade-offs may be needed in pursuit of sustainable impact**
Funders can play a leadership role in helping CSOs and governments to navigate when trade-offs may be needed for long-term sustainability e.g. reductions in impact numbers in the short term while resources are directed towards creating sustainable systems for the future. As international priorities and trends around ASRH delivery change, funders can help to determine when programming should be adjusted e.g. in response to emerging best practice vs. when changes may jeopardize hard-won aspects of government ownership.

4 **Ensure young people and communities are engaged in program design, but that innovation also responds to the constraints of government systems**
Continue to champion participatory design, including the use of approaches like human-centered design. Ensure that innovation and design are focused within government systems from the start and are co-developed with government partners to ensure that new programs have the potential for future scale and sustainability.

5 **Advocate for ASRH within international spheres and to national governments**
All the case studies saw successful uptake as they were introduced at a time of both national and international focus on ASRH. Recognizing their influential position, donors can play an important role in ensuring sufficient prioritization of ASRH within international arenas, as well as partnering with local CSOs to advocate for supportive budgets and policies at a national government level.

6 **Help to build a library of stories and evidence based on sustainability**
Help to support research that seeks to understand how and when sustainability has been achieved, including supporting evaluations to take place beyond the official program implementation period. Support the documentation of success stories over time, helping to demystify the path to sustainability for others.

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RECOMMENDATIONS FOR ALL STAKEHOLDERS:

CSOs, governments and funders can all take individual action to work together more effectively, but ultimately it is only through continued conversation and collaboration that we will achieve sustainable impact at scale of public sector ASRH programming and wider global health initiatives.

1 Consider sustainability through the three lenses of impact, implementation and funding

The global health sector uses the terminology of sustainability to mean a wide variety of things, too often restricted to financial sustainability only. We propose that sustainability should be driven by the goal of sustainable impact, and therefore analyzed through the lenses of impact, program implementation and financial sustainability, recognizing the complexities of interaction between them.

2 Work together to devise, refine and adapt sustainability plans

CSOs, governments and funders all have a role to play in ensuring future sustainability of CSO-led programs. Align around a shared vision of what government sustainability would look like in the future, including the specific roles and responsibilities of different parties, such as future scale-up or ongoing innovation. This will enable each stakeholder to consider how to draw on its respective strengths in pursuit of that vision.

3 Agree clear expectations for M&E activities, including after official project implementation ends

Work together to consider how impact will be tracked beyond the official project end; for example, whether this will be made publicly available through government systems, or whether external evaluations will be carried out separately. As shown through this research, without this it is not possible to create a true picture of what impact has been sustained, and therefore whether public sector scaling approaches have been successful.

4 Work together to consider how dynamic programming can be sustained over time

While some program elements have a clear—if still challenging—path to sustainability, for others the route to sustainability is more complex. The need to ensure that programming remains dynamic to the needs of adolescents is one of these elements, and there has been insufficient consideration of how to support governments to sustain this way of working. We believe the sector should come together to think creatively about how capabilities of client-focused adaptation could be embedded or supported within governments.

5 Continue to champion the rights of adolescents and the need for ASRH

Recent years have shown that sexual and reproductive health rights, and the need for ASRH in particular, are always at risk of moral and political opposition. We therefore must all play a role in continuing to champion the rights of adolescents and the need for ASRH, without which the global commitments to the Sustainable Development Goals and Universal Health Care cannot be achieved.

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CONCLUSION

Despite the existence of many promising solutions, there continues to be high need for ASRH programs in Sub-Saharan Africa and across other low- and middle-income countries, with adolescents held back from achieving their full potential through early pregnancy or sexual disease.

The quest for sustainable public sector scale in ASRH and wider global health programming has long been a focus of research and discussion. However, analysis in this research demonstrates that many programs can achieve some impact at scale, given sufficient funding and resourcing of programs, but that sustainability is rarely achieved. Through this research we propose that the desired public health impact will only be achieved if sustainability—of impact, implementation and funding—is now brought to the forefront.

Our research provides recommendations for CSOs, governments and funders working to tackle this issue. There is an increasing move to put governments in the driving seat of planning development programming in their country, which includes being able to draw on successful innovations created by CSOs. CSOs have an important role to play in developing successful innovations and programs, but are increasingly moving to supporting governments to ensure these are successfully embedded at scale, rather than creating a parallel system of direct delivery. Many funders working in this space believe in the values of sustainable government adoption but are frustrated that this is rarely achieved.

Our recommendations set out clear actions each can take to consider how better to support systematic and sustainable scale of ASRH interventions, recognizing that each brings their own distinctive strengths. These include putting impact first in the definition of scale and sustainability, and breaking down programs into their component parts, with distinct and realistic transition plans for each component. What remains central, though, is that these issues will only be tackled, and sustainability be achieved, if as a sector we hold ourselves and others to account on how we are pursuing sustainable impact at scale.

> Sustainability will only be achieved if we hold ourselves and others to account on how we are pursuing sustainable impact at scale

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APPENDIX A: STAKEHOLDERS INTERVIEWED

We interviewed the following stakeholders, who shaped our insights and recommendations.

GHARH
- David David Logan, Ghana Health Adolescent Reproductive Project
- Leticia Appiah, National Population Council Ghana
- Alexandra Britton, Palladium Group
- Kaja Jurczynska, Palladium Group
- Angela Bortey, Ghana Health Service
- Luisa Hanna, Department for International Development, Ghana
- Robert Mensah, UNFPA Ghana
- Shamwill Issah, previous Health Advisor for DFID during the program
- The team also conducted interviews with national, provincial and district representatives from the Ghana Health Service and Ghana Education Service.

PGB
- Rita Badiani, Pathfinder International
- Emidio Sebastiao, UNFPA Mozambique

IFHP
- Worknesh Kereta, Pathfinder International Ethiopia

LOVELIFE/NAFCI
- David Harrison, previous CEO of loveLife
- Grace Matlhape, previous CEO of loveLife
- Sisanda Gaga, Beyond Zero

GENERAL
- Emily Bancroft and Jennifer Crouch, VillageReach
- Clarissa Brundage, Bill and Melinda Gates Foundation
- Venkatraman Chandra-Mouli, World Health Organization
- Claire Cole, Adolescent 360
- Temple Cooley, Packard Foundation
- Adesegun Fatusi, Paaneah Foundation, Academy for Health Development
- Mara Hildebrand, Children's Investment Fund Foundation
- Janet Holt, The William and Flora Hewlett Foundation
- Meggan Ireland, Last Mile Health
- Seema Jalan, United Nations Foundation
- Rebecka Lundgren, Georgetown University Medical Center
- Erin McGinn, Palladium
- Lydia Murithi and Reshma Trasi, Pathfinder International
- Isihaka Mwandalima, Pathfinder Tanzania
- Uzoamaka Osikhena, AMP Health
- Marina Plesons, World Health Organization
- Peter Schaffler and Claire Graham, Marie Stopes International
- Emily Sullivan, Family Planning 2020
- Amanda West, Mercy Corps
- Erin Worsham, Duke University
- Lindi van Niekerk, independent consultant
- Wendy Leonard, The Ihangane Project
- Gwyn Hainsworth, Bill and Melinda Gates Foundation

This report does not necessarily reflect the views of the stakeholders interviewed, or the organizations they represent. All conclusions are Spring Impact's.

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APPENDIX C: PHOTOGRAPHY

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