

# Scale-up of Adolescent Contraceptive Services: Lessons From a 5-Country Comparative Analysis

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**Background:** Poor sexual and reproductive health outcomes among adolescents aged 10–19 years are indicative of the barriers this group faces in accessing health services and highlights a gap in the availability of appropriate services, including adolescent-friendly contraceptive services (AFCS). The HIV Investment Framework identifies contraceptive services as an entry point for HIV counseling, testing, and treatment, and as a component of HIV prevention. To effectively meet the needs of adolescents, greater understanding of effective scale-up strategies for adolescent-friendly services is needed.

**Methods:** The authors conducted a retrospective analysis of AFCS scale-up experiences in Ethiopia, Ghana, Mozambique, Tanzania, and Vietnam using the ExpandNet/World Health Organization framework for systematic scale-up. The authors analyzed the type of scale (expansion or institutionalization), dissemination and advocacy, organizational process, costs and resource mobilization, and monitoring and evaluation.

**Results:** The analysis showed that all programs simultaneously pursued expansion and institutionalization, contributing to sustainable scale-up. Advocacy complemented by intensive capacity building at all levels of the health system contributed to adoption of AFCS in national and district work plans and budgets as well strengthening collection of age-disaggregated data.

**Discussion:** To achieve scale-up of AFCS, the authors identified the importance of institutionalization and expansion in tandem for synergy and reinforcement, empowering adolescents to be agents of

change and hold government accountable to its commitments, and strengthening health systems to sustain AFCS.

**Conclusions:** This article contributes to a growing body of evidence around scale-up of AFCS, which can inform the implementation and sustainable scale-up of HIV and other services for adolescents.

**Key Words:** adolescents, adolescent-friendly services, contraception, HIV, scale up, sexual and reproductive health

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## INTRODUCTION

To accelerate progress in the global HIV response, the HIV Investment Framework, which was developed in 2011, set the agenda for HIV investments and programming for the next decade.<sup>1</sup> Implicit in the HIV Investment Framework is the role of contraceptive service delivery, as an entry point for HIV counseling, testing, and treatment and as a component of HIV prevention, particularly with regard to condom use and prongs 1 and 2 of prevention of mother-to-child transmission.<sup>1–3</sup> Adolescents, particularly girls, aged 10–19 years are a priority group whose vulnerability to early and unintended pregnancy and sexually transmitted infections, including HIV, is exacerbated by limited power because of age and gender inequality.<sup>3,4</sup> In sub-Saharan Africa, and South Central and Southeast Asia, 68% of sexually active adolescent women (aged 15–19 years) have an unmet need for contraception.<sup>5</sup> Women are considered to have an unmet need for modern contraception if they are sexually active [married or unmarried], do not want to have a child in the next 2 years or ever, are fecund, and are not using a modern contraceptive method. Adolescents' unmet need represents a gap in coverage and access to sexual and reproductive health (SRH) services but also relates directly to challenges in HIV prevention. Young people (aged 15–24 years) represent one-third of new HIV infections; of these, 38% are among adolescents aged 15–19 years.<sup>6</sup> Fifty-seven percent of the 2.1 million adolescents living with HIV globally are female.<sup>6</sup>

Poor SRH outcomes among adolescents are indicative of the myriad barriers this group faces in accessing health services and highlights a gap in the availability of appropriate services, including contraceptive services. Adolescent-friendly contraceptive services (AFCS)—defined by the World Health Organization (WHO) as those that are equitable, accessible, acceptable, appropriate, and effective (including

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provision of a wide range of methods)—can mitigate these barriers.<sup>7</sup> Therefore, to meet the SRH needs of the world’s 1.2 billion adolescents,<sup>8</sup> it is essential to scale up AFCS. However, there are challenges to this, including the need to cultivate and maintain the political will necessary to prioritize services for adolescents and the time to build adolescents’ capacity to advocate for their own needs and rights. Over the past 2 decades, there has been analysis of a number of successful experiences scaling up services for adolescents more broadly, yet more evidence and analysis are needed to advance understanding of effective scale-up strategies for adolescent services, and AFCS in particular.<sup>9–13</sup> To this end, this article analyzes AFCS scale-up experiences in 5 programs—in Ethiopia, Ghana, Mozambique, Tanzania, and Vietnam—and draws lessons to inform implementation and sustainable scale-up of HIV and other services for adolescents in line with the HIV Investment Framework.<sup>3</sup>

**METHODS**

The authors identified experiences scaling up AFCS in low- and middle-income countries in Africa and Asia that were supported by United Nations Population Fund (UNFPA) and/or Pathfinder International, and that had intentionally scaled up AFCS to at least 20 service delivery points and expanded to more than 1 province/region. (“Province/region” denotes the geopolitical zone below national and above district levels.) Restricting the review to scale-up efforts supported by UNFPA and/or Pathfinder ensured access to process documentation and service delivery data.

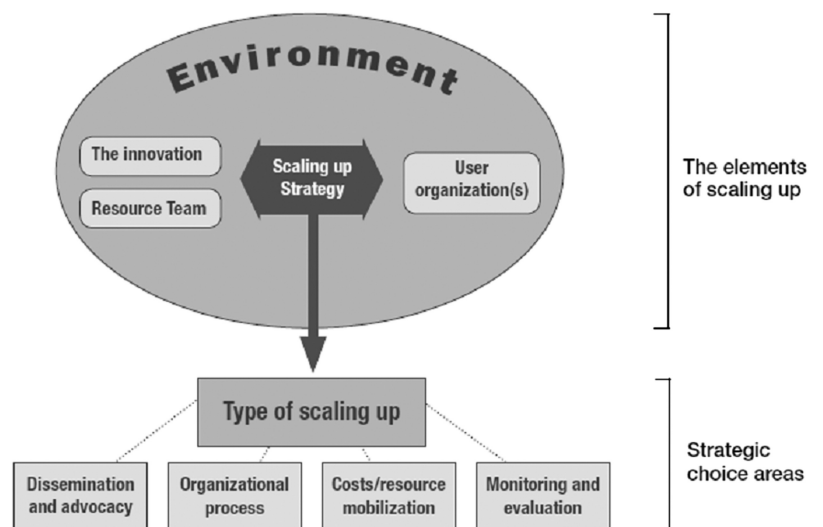
The authors identified 5 programs in Ethiopia,<sup>14</sup> Ghana,<sup>15–17</sup> Mozambique,<sup>18,19</sup> Tanzania,<sup>17,20,21</sup> and Vietnam<sup>22–24</sup> that had achieved the defined level of scale. The authors examined service delivery data, internal and external reports, evaluations, and relevant gray literature concerning the programs. Data were supplemented by experiences of program and technical staff, including several of the authors, who provided technical support during the AFCS scale-up (Gwyn

Hainsworth; Callie Simon; Julio Pacca; Worknesh Kereta; Carla Silveira; Bao Ngoc Le).

**Analytical Framework**

A retrospective analysis of the AFCS scale-up experience was conducted using the ExpandNet/WHO framework (Fig. 1).<sup>25</sup> This framework outlines a systematic approach to planning for and managing scale-up processes and focuses on the strategy for scaling up an innovation. Based on extensive literature review and international experience, the framework identifies 5 elements of scale-up: the *innovation*, defined as a package of interventions that are new or perceived as new in a given setting; the *user organization*, which implements the innovation, can be a government ministry, nongovernmental or faith-based organization (NGO or FBO), private-for-profit entity, or a coalition; the *resource team* that tested the innovation and/or provides technical support to the scale-up process; the *social, political, economic, and institutional environment* in which scale-up occurred; and the *scaling-up strategy* used to establish the innovation in policies, programs, and service delivery.<sup>26</sup> The interaction between these first 4 elements affects the scale-up strategy, which includes 5 strategic choice areas: type of scale (ie, expansion, institutionalization, diversification, or spontaneous), dissemination and advocacy, organizational process, costs and resource mobilization, and monitoring and evaluation (M&E) (Table 1). Each of these other strategic choices must be made according to the type of scale-up being pursued.

It should be noted that the ExpandNet/WHO framework is one of several scale-up frameworks recently put forward and is frequently cited in the literature.<sup>27</sup> Like other analytic tools, it facilitates a systematic analysis of a situation. However, such a framework presents a structured view of complex processes, and retrospective application of the framework may not fully capture the nuances of a scale-up experience. Space limitations prevent full presentation of the framework, including the principles that guide it.



**FIGURE 1.** The ExpandNet/WHO framework for scaling up. Reproduced with permission from the WHO.

**TABLE 1.** Strategic Choice Areas, ExpandNet Framework\*

Type of scale	Institutionalization: adoption of the innovation through political, policy, budgetary, regulatory and other health systems changes Expansion: replication or roll out of the innovation in the same geographic area and to new geographic places, or to cover more population Diversification or grafting: testing and adding a new innovation to one that is in the process of being scaled up Spontaneous: diffusion of the innovation without deliberate guidance
Dissemination and advocacy	Communication, knowledge transfer, and technical assistance to user organization and/or to influence policy reform to support the adoption of AFCS
Organizational processes	Management of the scale-up process related to pace, logistical coordination, and involvement role of stakeholders
Costs and resource mobilization	Assessment of costs and ensuring sufficient financial, human, and logistical resources for the scale-up process
M&E	Use of data to inform the scale-up process and understand its outcomes

\*WHO and ExpandNet, 2010.

To enable a comparative analysis of the 5 programs' scale-up experiences using the framework, the authors identified common data points (e.g., number of provinces/regions where AFCS was scaled up; number of AFCS facilities; number of adolescent service visits; and national and regional policies, guidelines, and standard operating procedures). However, the review was limited by existing data breadth and quality, and to the information contained in reports, evaluations, and other programmatic documents because some programs had been closed for several years. Although there were sufficient data to substantiate that all 5 programs achieved scale-up through both expansion and institutionalization, it was not possible to link these programs to population-level impact on service utilization. In 3 cases, studies were conducted on the programs' impact, and select data are presented here. In the other 2 pro-

grams, collection of these data could not be performed within the timelines and program budgets (Table 2).

## RESULTS

Based on the ExpandNet framework, the analysis identified that the user organizations in all 5 programs were government ministries; additional user organizations varied by program (Table 3). The resource teams consisted of Pathfinder International and/or UNFPA, representatives of the user organizations, and, in some cases, youth and health advocates.

### The Innovation: AFCS

In all 5 programs, contraceptive services tailored to adolescents were nonexistent or limited, thus requiring adaptation of AFCS to local contexts. In Ethiopia, Vietnam, and Mozambique, the innovation's adaptation and subsequent piloting was initiated by the resource teams in partnership with the user organizations. In Ghana and Tanzania, the user organizations sought to scale up AFCS from 4 pilot sites in Ghana and 5 in Tanzania. In all 5 programs, the pilot experience informed decisions about streamlining AFCS for scale-up. While contextual differences informed the design of AFCS, all programs provided AFCS as part of a broader adolescent-friendly service package that subscribed to WHO's above-mentioned definition. The following key characteristics of AFCS were emphasized: privacy and confidentiality; use of trained, nonjudgmental providers; availability of a full range of methods; free or subsidized services; and adolescent involvement in design, implementation, and quality improvement of services.<sup>7,28-31</sup> To reach more adolescents, AFCS were offered by the public sector in partnership with the private sector and/or through multiple service delivery channels (e.g., pharmacies in Vietnam, workplace satellite clinics in Ghana, and community-based distribution in Ghana, Tanzania, Ethiopia, and Mozambique). Four programs created community support and generated demand for AFCS through peer educators, youth groups, and community sensitization workshops; whereas the fifth, Vietnam, used social marketing and mass media to generate demand. In 3

**TABLE 2.** Selected Results From Ghana and Tanzania Population-Based Surveys\*,<sup>17</sup>

Country	Gender	Condom Use at First Sex		Condom Use at Last Sex		Consistent Condom Use		Modern Contraceptive at First Sex		Modern Contraceptive at Last Sex	
		Exposed (%)	Unexposed (%)	Exposed (%)	Unexposed (%)	Exposed (%)	Unexposed (%)	Exposed (%)	Unexposed (%)	Exposed (%)	Unexposed (%)
Ghana†	Male	41	41	56	55	33	34	43	42	59	56
	Female	48‡	37‡	41‡	34‡	17‡	12‡	50‡	40‡	49‡	42‡
Tanzania†	Male	44‡	24‡	65	65	28‡	14‡	43‡	22‡	67	68
	Female	54‡	33‡	54‡	30‡	25‡	15‡	56‡	37‡	64‡	39‡

\*Williams T, Mullen S, Karim A, et al. African Youth Alliance Program in Ghana, Tanzania, and Uganda: Impact on Sexual and Reproductive Health Behavior Among Young People Summary Report. Rosslyn, VA; 2007.

†In Ghana and Tanzania, an endline survey was conducted in program implementation and control areas; 17- to 22-year-olds (unmarried or recently married) were sampled using a stratified cluster sampling methodology. The data above reflect the analysis of respondents in the intervention area based on exposure. Respondents were classified as having exposure if they recalled exposure to at least 3 activities and no exposure if they recalled no activities.

‡Statistically significant difference between exposed and unexposed.

**TABLE 3.** Five-Country Scale-up Overview\*

Countries	User Organization†	Scale-up Timeframe	Program Under Which Scale-up Was Pursued	Expansion: Number of AFCS Sites, Geographic Coverage, and Service Use‡	Institutionalization: Types of Policies, Guidelines, and Systems Influenced by Intervention During Scale-up
Ethiopia	Federal Ministry of Health and local NGOs	2005 to present	Reproductive Health/Family Planning Project (2005–2008); Integrated Family Health Program (2008 to present)	163 AFCS sites in 6 of 9 regions in Ethiopia Number of service visits (2009–2013): 1,570,927	National ASRH guidelines and policies Other national strategies and plans include ASRH National in-service provider training curriculum and network of trainers AFCS included in national and participating regional and district work plans and budgets
Ghana	Ghana Health Services and Ministry of Health, Nursing and Midwifery Council of Ghana, Christian Health Association of Ghana, Planned Parenthood Association of Ghana, and other local NGOs	2000–2005	African Youth Alliance (2000–2005)	65 AFCS sites in 20 of 110 districts in 5 of 10 regions in Ghana Number of service visits among 10- to 19-year-olds (fourth quarter of 2003 to first quarter of 2005): 141,224§	National ASRH guidelines and policies Other national strategies and plans include ASRH National pre- and in-service provider training curricula, tools, and network of trainers AFCS included in participating district work plans and budgets Age-disaggregated data collection within HMIS AFCS integrated within private sector and participating NGO/FBO delivery systems
Mozambique	Ministry of Health, Ministry of Education, Ministry of Youth and Sports, and local NGOs	1999–2009	Program Geração Biz	244 AFCS sites in 119 of 128 districts in all 11 provinces of Mozambique Number of service visits (2000–2008, 2 quarters of 2009, 2010, and 2011): 2,467,458	National ASRH guidelines and policies adopted Other national strategies and plans include ASRH National in-service provider training curriculum; school-based ASRH curriculum, tools, and network of trainers AFCS included in national and provincial work plans and budgets Age-disaggregated data collection within HMIS Multisectoral committees established
Tanzania	Marie Stopes Tanzania, Dar City Council/Infectious Disease Center, University of Dar es Salaam, The Family Planning Association of Tanzania, Ministry of Health Zanzibar (Unjuga and Pemba Island), Ministry of Health Mainland and relevant district councils, and local NGOs	2001–2005	African Youth Alliance	58 sites in 11 of 129 districts in 8 of 30 regions in Tanzania, including Pemba Island Number of service visits (2003–2004): 216,719	National ASRH guidelines and policies Other national strategies and plans include ASRH National in-service provider training curricula, tools, and network of trainers AFCS included in participating district work plans and budgets

(continued on next page)

TABLE 3. (Continued) Five-Country Scale-up Overview\*

Countries	User Organization†	Scale-up Timeframe	Program Under Which Scale-up Was Pursued	Expansion: Number of AFCS Sites, Geographic Coverage, and Service Use‡	Institutionalization: Types of Policies, Guidelines, and Systems Influenced by Intervention During Scale-up
Vietnam	Ministry of Health	2004–2010	Reproductive Health Projects	28 sites in 17 of 63 provinces in Vietnam Number of service visits (2007–2010) among 10- to 19-year-olds: 37,494¶	National ASRH guidelines and policies Other national strategies and plans include ASRH National in-service provider training curriculum, tools, and network of trainers

\*Data from this table are drawn from the following list of references: Ref. 14, 15, 17, 18, 20, and 22.

†User organizations named are the primary service delivery organizations. Because of the number of local implementing partners conducting outreach and community mobilization, the authors do not include the name of each partner.

‡Unless otherwise noted, service statistics represent young people aged 10–24 years and a variety of SRH services offered at health facilities as part of adolescent-friendly health services. Given data limitations, the authors did not include service delivery statistics from peer educators/providers.

§Data reported are from 34 of the 58 AFCS sites.

||Data from 2000 to 2009 is from Program Geração Biz management information system maintained by Pathfinder International in collaboration with Ministries of Health, Youth and Sports, and Education, and UNFPA. Data from 2010 and 2011 is from MOH official PGB annual report (which began as part of transition to full national ownership). The data reported in the national annual report from 2011 includes 3 quarters of reported data and 1 quarter of projected data.

¶In Vietnam from 2007 to 2010, 251,365 10- to 24-year-olds sought SRH services.

programs, linkages were established between AFCS and school-based life skills and SRH education implemented by ministries of education.

### Scale-up Strategy

During the implementation process, each program primarily pursued 2 types of scale-up—expansion and institutionalization—and made strategic choices about dissemination and advocacy, organizational processes, cost and resource mobilization, and M&E of AFCS. The addition of HIV care and treatment to the service package in Mozambique represented a third type of scale-up: diversification.<sup>32</sup> The strategic choices differed depending on the type of scale-up being pursued (ie, expansion or institutionalization) but for brevity these are described together below.

### Type of Scale

On examining the type of scale pursued by each program, we found that all had strong components of both expansion and institutionalization (Table 3). AFCS was expanded to new sites and provinces/regions to increase service coverage, although the degree of expansion differed among the programs—from national scale in Mozambique where 244 AFCS sites were established in all 11 provinces to Vietnam where AFCS were scaled up to 28 sites in 17 of the country's 63 provinces.<sup>18,22</sup> The expansion process ranged from 4 to 12 years across the 5 programs; expansion was phased and gradual to ensure lessons were incorporated as scale-up occurred (Table 4). Regarding institutionalization, all 5 countries developed adolescent health strategies and included references to adolescent-friendly services in key policies (e.g., national AIDS strategic plans, poverty reduction strategies). Additionally, ministries of health developed and/or revised guidelines, curricula, and tools to support AFCS delivery, and AFCS was included to varying degrees in existing government work plans and budgets.

### Dissemination and Advocacy

In all 5 countries, initial political will to address adolescent sexual and reproductive health (ASRH) was a driver for scale-up. To increase key stakeholders' support and ownership of AFCS, resource teams made strategic advocacy and dissemination decisions building on formal commitments that came in the form of memoranda of understanding and clear agreements with the resource team. Advocacy was pursued through national ASRH working groups, coordinating committees, and civil society coalitions. Some results from this targeted advocacy include the removal of restrictions for long-acting methods for unmarried, nulliparous adolescents in Vietnam.<sup>33</sup> Resource teams advocated with ministries of health to address health system gaps that could undermine AFCS delivery (e.g., commodity security); however, actors working on health systems strengthening more broadly were not adequately engaged to address the full range of health system barriers to AFCS provision (e.g., human resource allocations). In 4 programs, specific efforts were made to build adolescents' capacity as advocates to influence policymaking and to play leadership roles in adolescent-related programming. This helped cultivate larger youth movements and increased accountability of government and private service delivery organizations.

To institutionalize AFCS, advocacy was complemented by technical support and dissemination of tools and curricula needed for AFCS provision. In all 5 programs, national in-service training curricula, job aids (e.g., adolescent contraceptive counseling cue cards), facility assessment tools, and supervision checklists for adolescent-friendly health services, including AFCS, were developed and disseminated. Frequently, user organizations adapted these curricula and tools from existing Pathfinder and UNFPA materials, expediting the process. Dissemination was facilitated by learning tours to other countries and by visits to pilot/model AFCS sites by health system staff and government decision-makers. National and regional networks of trainers in adolescent-friendly health services were created in all 5 countries to

**TABLE 4.** Phases of Scale-up (Expansion)

<b>Ghana</b>			
<b>Phase 1 (2000–2001)</b>	<b>Phase 2 (2002)</b>	<b>Phase 3 (2003–2004)</b>	
Consensus building; stakeholder buy-in	AFCS introduced in 19 sites in 3 regions	Expansion to 65 AFCS sites in 5 regions	
<b>Tanzania</b>			
<b>Phase 1 (2001)</b>	<b>Phase 2 (2002)</b>	<b>Phase 3 (2003–2004)</b>	
Consensus building; stakeholder buy-in	11 AFCS sites introduced in 4 regions	Expansion to 58 AFCS sites in 8 regions	
<b>Vietnam</b>			
<b>Phase 1 (2004–2006)</b>	<b>Phase 2 (2007–2008)</b>	<b>Phase 3 (2009–2011)</b>	
Consensus building; learning trip to Thailand; pilot of 5 AFCS sites in 3 provinces	Expansion to 19 AFCS sites in 7 provinces	Expansion to 28 AFCS sites in 17 provinces	
<b>Ethiopia</b>			
<b>Phase 1 (2005–2007)</b>	<b>Phase 2 (2008–2009)</b>	<b>Phase 3 (2010–2011)</b>	<b>Phase 4 (2012–2014)</b>
Site ready assessment; learning trip to Mozambique; consensus building; pilot in 20 AFCS sites in 4 regions	Expansion to 64 AFCS sites in 4 regions	Expansion to 115 AFCS sites in 6 regions	Expansion to 163 AFCS sites in 6 regions; transition to government
<b>Mozambique</b>			
<b>Phase 1 (1999–2000)</b>	<b>Phase 2 (2000–2005)</b>	<b>Phase 3 (2005–2008)</b>	<b>Phase 4 (2008–2012)</b>
Consensus building; needs assessments; pilot introduced to 12 sites in Maputo city and 1 province	Expansion to 83 sites in 7 provinces and Maputo city	Expansion to 244 AFCS sites in 10 provinces and Maputo City	System strengthening and capacity building for full transition to government; continued multisectoral coordination

rapidly roll out service provider training. Throughout implementation, all programs cultivated government champions from district to national levels to support scale-up.

**Organizational Process**

Organizing the scale-up process involved decisions about stakeholder involvement, program design and adaptation, establishing actors’ roles and expectations, and determining the pace for scale-up. In the 5 programs, the public sector scaled up AFCS by integrating AFCS into existing public health facilities. Given the context of health system decentralization and relatively weak health systems, the resource teams provided significant technical and management capacity building to district-, regional-, and central-level authorities. In all programs, AFCS scale-up was systematic, with planned annual targets for expansion and clear site selection criteria considering facility type and extent of geographic expansion, including potential to reach large numbers of adolescent clients.

**Costs and Resource Mobilization**

Strategic choices made about resource mobilization and containing costs during scale-up included the use of existing health facilities, resource diversification, and capacity building for resource management and advocacy. In all programs, scale-up was supported partially or wholly by donor funding that enabled the initial expansion and institutionalization of AFCS. In some instances, the resource team worked with the government to combine funding streams and bring on new donors to cover new service expansion initiatives. In

Ethiopia, this entailed combining 2 subsequent USAID-funded projects with similar objectives and mobilizing private funding. In Mozambique, new donors supported the expansion of coverage to new provinces and further adaptations to the innovation (e.g., integrating HIV services into the ASRH package during scale-up).

With sustainability as a goal, all programs conducted advocacy to include AFCS within national, regional, and district budgets and work plans, or in the case of NGO partners within their existing programs and budgets. Success varied by program, with the greatest in Mozambique and Ethiopia, where the resource team simultaneously conducted advocacy and strengthened government partners’ capacity to include AFCS in budgets and work plans.

In Mozambique, the resource team calculated program costs and cost per adolescent served and then based on these costs provided districts with budget estimates for AFCS and level of donor contribution to secure proportionate government contributions for AFCS. Incorporation of AFCS within district budgets then fed into the national budget. Costing data were also used to demonstrate how costs per person would decrease over time due to economies of scale as a way of advocating for service expansion to an additional province.

**Monitoring and Evaluation**

Age- and sex-disaggregated data are essential to determine adolescents’ access to services and retention for care. However, in the beginning of the scale-up process, 4 countries did not have a national health management information system (HMIS) that supported age-disaggregated data by age cohorts

10–14, 15–19, and 20–24. Therefore, in all countries but Ghana, the resource team conducted advocacy to influence the design of HMIS. In the interim, programs used modified data collection forms to enable greater understanding of adolescent service usage patterns by age cohort. Information collected included sex, age, method mix, and whether service visits were new or revisits as an indicator of retention for care.

The programs all faced challenges in maintaining quality as service delivery sites expanded, particularly because AFCS depends heavily on respectful, unbiased provider attitudes and behaviors. Therefore, programs built in mechanisms to support monitoring of service quality and use of monitoring data to inform program decisions. In Tanzania and Ghana, mystery clients were employed, whereas in Vietnam and Mozambique, client exit interviews were conducted. Results from both methodologies found a high level of client satisfaction in Tanzania, Mozambique, and Vietnam, with more mixed results in Ghana.<sup>15,18,20,24</sup> Adolescent clients identified gaps in the provision of a full range of services beyond contraception and instances of negative provider attitudes. In Mozambique and Ethiopia, quarterly review meetings were also held among district and regional health authorities, health facility staff, and peer educators, using a set of guided questions to review monitoring data and address gaps in quality. When a quality decline was identified in Mozambique, assessment and certification procedures were established to help ensure a minimum level of quality among master trainers in the national training networks and at AFCS sites.

In 4 programs, monitoring was complemented by either internal or external evaluations of AFCS scale-up. In Vietnam and Mozambique, these evaluations were conducted at various intervals during scale-up, informing subsequent phases and guiding strategic choices. In Vietnam, the evaluation of the first phase of AFCS implementation showed that commune-level facilities reached a limited number of adolescents (on average 33 adolescent visits per month); therefore, they decided to establish AFCS at higher volume reproductive health centers.<sup>24</sup> Although the monitoring of the expansion process in all 5 programs was well-documented (e.g., evaluations, operations research, data on numbers of sites and service visits), the institutionalization process was not consistently and systematically documented.

## DISCUSSION: LESSONS FROM SCALE-UP

Analysis using the ExpandNet/WHO Framework revealed strengths, challenges, and gaps in AFCS scale-up in the 5 countries. The lessons that emerged can inform future scale-up efforts to expand adolescents' access to and use of HIV and other services referenced in the HIV Investment Framework. Successful scale-up requires national, regional/provincial, and district government commitment to the scale-up process and making decisions at the onset about the extent of scale the country will pursue to achieve its goals.

In all programs, an emphasis on both expansion and institutionalization created important synergies that contributed to sustainable scale-up of AFCS. The supportive policy environment cultivated as part of institutionalization laid the foundation for expansion of services, whereas expansion led

to greater service usage by adolescents and generated momentum that spurred adolescents and civil society to hold governments accountable for fully operationalizing adolescent health policies. Timing played a significant role in solidifying this synergistic relationship; to generate momentum, it was critical that service roll out happened soon after the policy environment was created. As expansion proceeded, additional steps to institutionalize AFCS (e.g., dissemination of technical expertise, tools, and curricula) were essential for efficient scale-up, achievement of economies of scale, and sustainability of AFCS. In Mozambique, once a solid foundation had been laid in terms of both expansion and institutionalization, diversification was an effective way to address a broader range of adolescent health needs.

A unique factor in AFCS scale-up is that adolescents have less of a political voice and their needs are often overlooked by policy-makers and decision-makers; therefore, extra steps are required to engage adolescents and elevate adolescent health issues as a priority. In 4 programs, adolescents played a crucial role in advocating with community leaders, governments, and civil society for the establishment and scale-up of AFCS. As peer educators, they generated demand for AFCS and served as a bridge between the community and health facility, providing information and nonclinical contraceptive methods and making referrals for clinical services. Although the analysis showed that peer educators and other adolescent-led interventions were critical enablers of AFCS use, the challenges of retention and performance must also be considered when planning for scale-up.

All 5 programs chose to use pilot or previously established model sites as a mechanism for advocacy, learning, and dissemination. Using pilot/model sites allowed adolescents and health providers to see successful AFCS implementation and created learning opportunities for newly trained AFCS providers. For district- and regional-level decision-makers, these sites helped foster goodwill and political commitment to expanding AFCS.

Results of this analysis suggest the importance of examining the strengths and weaknesses of the health delivery system in each country and planning for scale-up accordingly. As much as possible, investments to address gaps in basic service delivery should be made before adding adolescent-friendly components. In the 5 experiences, some of the foundational challenges included low-quality contraceptive services for all clients, with some methods unavailable due to untrained providers or the unavailability of commodities, weak supervision systems, and the inability to make informed management decisions because of lack of age-disaggregated data. As a result, AFCS scale-up required unanticipated investments to ensure that basic contraceptive services were in place before addressing the specific needs of adolescents, restricting the degree and speed of expansion.

Scale-up of AFCS is important; however, services must be sustained over time to achieve better health outcomes. After the initial externally funded programs ended, the degree of AFCS sustainability varied across the countries. Factors that influenced sustainability included the: degree of expansion; extent of institutionalization, especially regarding the

establishment of systems to support AFCS delivery, incorporation of AFCS into relevant budget lines, and integration of AFCS into pre-service curricula; and the level of adolescent engagement. As AFCS provision is contingent on trained staff, turnover can undermine sustainability, stressing the importance of incorporating AFCS into pre-service and alleviating the need for ongoing in-service training. In Mozambique, level of scale and corresponding numbers of trained providers helped mitigate the effects of staff turnover, as trained staff were often transferred to another AFCS facility. National-level scale also created greater visibility of services, making them harder to dismantle. In addition, the systems created to support national-level scale (e.g., a network of trainers) and budget allocations dedicated to AFCS helped maintain the presence of services. Strong adolescent and youth engagement also held government accountable for sustaining services even when a change in ministerial leadership led to a weakening in political will regarding AFCS.

Any scale-up process requires assessing costs and mobilizing resources. Concerted attention was placed on building capacity for and including AFCS within national and regional/provincial budgets and work plans to help sustain services once external funding ended. Governments creatively leveraged multiple funding streams to provide comprehensive services and worked to include adolescent-focused services in budget allocations and commitments. However, with the exception of Mozambique, costing estimates for AFCS were unavailable, constraining both the resource teams' ability to advocate and the governments' ability to make adequate budget allocations.

Although data informed decisions throughout the scale-up process, M&E of AFCS posed significant challenges in all countries, largely because of the lack of age-disaggregated data within the existing HMIS. As countries scale up adolescent services referenced in the HIV Investment Framework, it will be important to engage with development partners and stakeholders involved in broader health system strengthening efforts to revise national HMIS. In addition, all 5 experiences demonstrate that collecting and routinely examining service quality data is critical to ensuring fidelity to the innovation during expansion.

The analysis found a gap in the documentation of the processes and milestones of institutionalization, particularly compared with the quantity of data collected on expansion. Although capturing data related to institutionalization can be less straightforward, it should be valued equally and must be part of any scale-up process. Failure to systematically track institutionalization can result in insufficient attention and resources dedicated to this type of scale by the resource team, user organizations, and external funders. Furthermore, it limits the ability to monitor the progress and quality of institutionalization efforts and to take corrective actions.

## CONCLUSIONS

The scale-up of AFCS in these 5 countries marks an important step forward in meeting adolescents' contraceptive needs. However, there remains much to do. Adolescents continue to bear a disproportionate burden of poor SRH out-

comes, including HIV incidence. Significant investments must be made in scaling up integrated SRH services and interventions for adolescents, including the package of services prioritized in the HIV Investment Framework. The learnings from this analysis—such as the importance of pursuing both institutionalization and expansion of services for adolescents, empowering adolescents as agents of change, and strengthening health systems, including age-disaggregated HMIS, to sustain adolescent-friendly service delivery—should be used to inform future scale-up strategies. Furthermore, the analysis identified challenges to scaling up services for adolescents that governments, development partners, and donors must collaboratively address. These include the challenge of incorporating services for adolescents in national budget lines, reliance on external funds to catalyze scale-up of services for adolescents, lack of international donor commitments to this population, and need to identify new strategies to reach the most vulnerable adolescents at scale. We conclude that the ExpandNet/WHO framework is useful for retrospective and comparative review, but is more useful when applied at program outset to ensure a systematic approach to scaling-up.

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