IMPACTFUL ADOLESCENT FAMILY PLANNING PROGRAMS AT SCALE: NAVIGATING THE TRADE-OFFS

OCTOBER 2025

Melanie Yahner
Mary Phillips
Meghan Cutherell
Farahat Bello

Save the Children.

A360

psi

EXECUTIVE SUMMARY

Adolescent pregnancies are risky for girls and their babies, and limit education and livelihood opportunities. We know what works to reduce adolescent pregnancy: a wealth of evidence pinpoints the importance of approaches such as engaging families and communities to shift norms, aligning family planning (FP) with girls' aspirations, providing quality and adolescent-responsive services, and integrating FP into other services.

However, 21 million adolescents become pregnant each year, the challenge being the expansion of proven practices reaching more adolescents. All too often, projects deliver results that are not scaled beyond small pilot areas or sustained within government systems. Scalable programming requires trade-offs as programs must make difficult decisions between impactful interventions and those that can be scaled. For example:

- Should we insist on interventions being implemented with fidelity to tested models, or support adaptation in ways that may support scale but diminish impact?
- Should we intensify interventions with families and communities to shift social norms, or keep interventions light-touch to facilitate scale?
- Do we invest limited resources in building adolescents' agency to seek FP services, or in improving the quality of FP services for which there is low demand?

This brief explores trade-offs using lessons from adolescent FP programs in Ethiopia, Nigeria, Kenya, Bangladesh, and Tanzania. As socio-cultural and health system contexts will shape the feasibility of implementation, potential to produce impact, and scalability, these examples are not meant to be prescriptive. Rather, we provide guiding questions for implementers, donors, and governments to consider when designing and implementing programs that balance impact and scale.

Adolescent pregnancy is a large-scale challenge that calls for large-scale solutions: we must prioritize interventions that can produce impact at scale. At the same time, it is important to carefully weigh the trade-offs between impact and scale.

INTRODUCTION

Despite decades of global progress to reduce adolescent pregnancy, 21 million adolescents become pregnant each year, with nearly half unplanned (Guttmacher). Most pregnancies among adolescents are in low-and middle-income countries (LMICs) and take place in the context of marriage (UNFPA, 2022). Pregnancies are especially dangerous for adolescent girls and their newborns and have a lasting impact on girls' education, income-earning potential, and mental health.

Adolescent girls and their babies are more likely to experience complications than women aged 20-24 (WHO). An adolescent mother has a one-in-five chance of having another birth within two years (UNFPA, 2022). Closely spaced pregnancies further increase risks, including for preterm birth, low birthweight, small for gestational age infants, and newborn mortality (Pimentel et al; Kozuki et al).

Progress on reducing adolescent pregnancy has been uneven. Major variations exist between and within geographies, with some sub-populations of adolescents and some regions and countries having rates of early pregnancy well above regional or national averages (Melesse et al). Contraceptive use is significantly lower among populations of married adolescents than among married women aged 20-24. Adolescent pregnancy is higher among girls with low educational attainment and/or of low economic status, leading to increasing and continuing inequalities (Chung et al.; Yakubu et al.; Neal et al.). To address these gaps and reach in-need adolescent girls with family planning services, effective, high-quality programs at scale are needed.

WE KNOW WHAT ADOLESCENTS NEED, AND WHAT IMPACTFUL FAMILY PLANNING PROGRAMS FOR ADOLESCENTS LOOK LIKE

Adolescent girls and young women (AGYW) face unique barriers to contraceptive uptake, calling for additional and targeted strategies. While the specific barriers that shape access often vary by context and girls' individual circumstances, common barriers encompass gender and social norms and a lack of access to services that respond to their needs. Girls and young women are less likely to be familiar with, or be comfortable seeking health services, especially contraceptive services, at facilities than older women (Chandra-Mouli et al.). Married adolescent girls often experience restrictions on movement that limit their ability to move freely in the community, especially during the postpartum period. Unmarried girls may have more mobility in some contexts but are often unwilling to disclose sexual activity due to stigma. AGYW rarely self-identify a desire to use family planning, as it is perceived as appropriate only for women who already have children. Misconceptions about contraception mean that girls may consider it risky to their health and future fertility (Sedlander et al.).

Supporting AGYW's contraception use to delay their first pregnancy until they are ready, and to space subsequent pregnancies requires addressing these barriers. Evidence from the past decades shows that effective adolescent family planning programs share several key characteristics:

- **Shifting norms:** Engaging families and communities to support girls' decision-making and reduce stigma.
- **Building demand:** Aligning FP with girls' dreams for their future, tackling myths, and strengthening agency.
- **Strengthening services and systems:** Providing confidential, non-judgmental, adolescent-responsive care and the full FP method mix.
- **Providing tailored counseling:** Helping AGYW to connect FP to their lives by supporting consistent use, method switching, and addressing "first-timer" concerns through longer/multiple counseling sessions and one-to-one contact.
- **Integrating services:** Linking FP with other health and non-health services for seamless support that meets girls' needs.

IF WE KNOW WHAT WORKS FOR ADOLESCENTS, WHAT STOPS US FROM SCALING IMPACTFUL SOLUTIONS?

What we need is the rapid scaling of effective interventions to increase access to family planning for adolescent girls and young women.

While there is no shortage of small, donor-funded programs that yield positive results, these efforts often struggle to scale. In aiming to address the complex barriers that AGYW experience, many interventions are too complex, expensive, or reliant on external resources to be sustained within public sector systems.

For long-term impact, family planning interventions must be designed from the outset to be scalable and sustainable within the constraints of government systems. ExpandNet, a global network focused on scaling health innovations, recommends that scale be planned from the beginning by ensuring that interventions are feasible within the local health system's financial and human resources, as simple as possible, and tested under real-world conditions. ExpandNet emphasizes that trade-offs are often necessary to enable this scalability.[1] In this brief, we explore some of these trade-offs based on real-world experience scaling adolescent family planning programs in multiple LMICs.

1 Throughout this brief, we use "scalable" to encompass potential for expansion to reach more adolescents in more geographies, AND for institutionalization into government systems in line with ExpandNet guidance.

UNDERSTANDING THE TRADE-OFFS BETWEEN IMPACT AND SCALABILITY

When designing adolescent family planning interventions, implementers face a fundamental tension between the desire to maximize impact versus the need to ensure scalability. While we all want programs that are both impactful and far-reaching, the reality is that this requires compromise.

It can be helpful to visualize these tensions using a quadrant framework that maps interventions across two dimensions: impact and scalability.

Figure 1: The Impact-Scalability Trade-Off Quadrant

	HIGH IMPACT	LOW IMPACT
High Scalability	**The goal:** Programs that governments can sustain and scale while still delivering real results.	**The risk of over-simplification:** Highly scalable but lacking enough depth to shift behavior or needs.
Low Scalability	**The "graveyard of pilot projects":** Effective but too complex, costly, or donor-reliant to replicate or sustain. (Spicer et al.)	**Avoid entirely:** Programs that do little and reach few.

Many pilot interventions land in the bottom left corner, deeply impactful but too expensive, complex, or resource-dependent to grow. This is especially true for adolescent reproductive health programs, which often require intensive support to shift norms, reach marginalized girls, or deliver nuanced counseling. To reach the top left corner, programs that are both impactful and scalable, implementers must make intentional, context-aware trade-offs. These may involve simplifying program components, adjusting delivery models, or leaning more heavily on existing government platforms.

However, you need to be cautious: make too many trade-offs, or choose the wrong ones, and programs risk drifting into the top right: scalable but ineffective. These are the interventions that may reach many but fail to deliver meaningful outcomes for the girls they're meant to serve.

To achieve sustainable impact for adolescents, interventions that are both highly scalable and highly impactful, it is imperative to balance the changes that will improve family planning uptake for young women against what is feasible for government to sustain with quality.

This brief focuses on these trade-offs, which we define *as intentional choices between competing priorities*—impact and scalability—recognizing that shifts toward scalability often lead to compromises in impact. Drawing on examples from five countries through the A360 and Connect initiatives (see Boxes 1 and 2), we explore decisions made to support scale and the implications for impact.

BOX 1

ADOLESCENTS 360

In 2016, Adolescents 360 (A360), a project of Population Services International, worked alongside adolescent girls to co-design interventions aimed at increasing the relevance of, access to, and use of contraceptive services. Across its three priority geographies, A360's interventions tap into girls' aspirations and position contraception as a tool that can support them in pursuing their life goals. These interventions support public health systems to deliver high-quality, adolescent-responsive services at the community level. In its second investment phase, starting in 2020, A360 transitioned from the direct implementation of these interventions to a technical assistance (TA) provider, supporting the sustainable scale-up of these aspirational ASRH models through public sector health systems. This scale-up process supported three interventions across three countries:

In Ethiopia, Smart Start uses financial planning as an entry point to elicit discussions with married adolescent girls and their husbands around delaying and spacing births. Smart Start is delivered by Health Extension Workers (HEWs) and is fully integrated within the national Health Extension Program (HEP). Under the leadership of the Ethiopian MOH and with TA from PSI Ethiopia, Smart Start has been scaled to over 9,500 health posts across seven regions in Ethiopia.

In northern Nigeria, Matasa Matan Arewa (MMA) integrates contraceptive service delivery concepts around skill-building and family health and stability. MMA engages girls' key influencers - particularly their husbands and religious and traditional leaders - with messages that build an enabling environment for their contraceptive use and decision-making. The Nigerian MOH, with support from Society for Family Health (SFH) Nigeria, has scaled MMA to over 1,450 primary health centers (PHCs) across four states in northern Nigeria.

In Kenya, Binti Shupavu engages girls in dynamic goal-setting sessions to position contraceptive use as relevant to achieve their aspirations and delivers opt-out contraceptive counseling during these sessions to remove stigma for girls accessing services. The Kenyan MOH is implementing Binti Shupavu with TA from Population Services Kenya (PSK) across 402 health facilities in four counties in Kenya.

BOX 2

CONNECT

Connect (2019-2025), implemented by Save the Children, designed and tested streamlined "enhancements" to government and project platforms to support PPFP adoption among first-time mothers aged 15-24. Connect leveraged larger-scale USAID projects to test two models of more scalable interventions in Bangladesh and Tanzania. Over iterative pilot (2020-2022) and scale-up (2022-2024) phases, Connect evaluated the impact and cost-effectiveness of these enhancements and supported institutionalization into government systems.

In Bangladesh, Connect worked only to strengthen existing government community and facility-level interventions, without introducing project-dependent approaches. Connect supported a community health worker (CHW) cadre—Family Welfare Assistants (FWAs)— to conduct targeted home visits using a risk-screening algorithm, distribute invitation cards to encourage first-time mothers to access facility services, and provide a Mother-Baby Booklet as a take-home resource. In public health facilities, Connect introduced a pre-discharge counseling checklist to improve counseling and care. In total, Connect trained 1,345 health providers, and FWAs conducted 54,381 home visits to first-time mothers.

In Tanzania, Connect strengthened 559 community support groups for pregnant and breastfeeding mothers, implemented by Lishe Endelevu to:

1. Improve inclusion of first-time mothers;
2. Integrate 4 PPFP-focused games, and
3. Support CHWs to conduct home visits to counsel on PPFP and nutrition, refer for facility PPFP, and provide FP refills.

CHWs enrolled 5,712 first-time mothers into groups in 62 villages and conducted 4,301 home visits. Connect supported the Ministry of Health in developing and rolling out a Gender and Respectful Care on-the-job training package

NAVIGATING TRADE-OFFS ALONG THE PATH TO SCALE

Planning for scale is not a one-time decision; it's a series of strategic choices made before and throughout implementation. This section organizes common trade-offs encountered in adolescent family planning programs when designing for scale and implementing the intervention. We present decisions that require balancing ambition with feasibility using examples from A360 and Connect, including decisions made, the rationale for those choices, and lessons learned. This brief does not seek to be prescriptive in how implementers should design for scale or how they should respond to each of these questions. Rather, we strive to guide implementers to recognize the trade-off questions that must be considered.

TRADEOFF 1: INVEST IN DEMAND GENERATION OR STRENGTHENING SERVICE PROVISION?

In its most stark variation, this trade-off is a decision about whether to invest in generating demand for services that do not exist or are of poor quality or strengthening services that no one demands. In most contexts, investments in both empowering adolescents to seek services and strengthening the health system's ability to deliver those services are needed. Yet to fully invest in both is likely outside the realm of existing budgets and scope, so programs often have to choose where best to place limited resources.

PROGRAM EXAMPLE: A360

Adolescents 360 had a mandate to increase contraceptive uptake among adolescent girls, so our initial focus was on building demand for contraception by increasing the relevance of family planning for this audience. In all geographies, the project referred girls to existing service providers available through the primary healthcare system. However, we quickly found gaps in the health systems that limited girls' ability to act on their desire to start using contraception, such as—provider bias, commodity stock-outs, and a lack of training on long-acting reversible methods, among others. We knew we had to expand to strengthen service delivery but wanted to define a scope that was manageable and aligned with our focus on adolescent contraceptive uptake. Using results from quality audits, we identified the highest priority gaps and areas for intervention, including enhancing quality of method counseling and supporting commodity forecasting and last-mile distribution. Over time, with additional funding and a stronger system for demand creation, we have been able to expand the scope of service-side support.

The trade-off: *We diverted funding and attention from demand creation for adolescents to strengthen service quality to ensure that contraceptive demand could be met with quality services. Staying in the highly effective and highly scalable quadrant required a careful balance of remaining focused on building demand among adolescent clients while addressing the most critical service-side barriers.*

What we've learned: For adolescent family planning programs, some level of demand creation is essential. However, it's neither effective, nor ethical to refer girls to places with poor quality service. Align the approach with the context and analyze the most relevant gaps to make targeted investments that support your program goals.

TRADEOFF 2: SIMPLE OR HOLISTIC?

On the one hand, this trade-off explores whether to offer individual girls robust, multi-sectoral programming to address the root causes of issues. On the other hand, it considers whether to develop focused, single-issue interventions that offer less robust support but are more likely to be scalable and sustainable. Adolescent girls' contraceptive decisions are shaped by intersecting barriers, poverty, gender norms, early marriage, and misinformation. Multi-layered, cross-sectoral interventions that address these root causes (e.g., combining SRH with economic empowerment) can lead to longer-lasting outcomes for girls. However, such complexity requires significant coordination, often across multiple ministries, which can limit the feasibility of implementation at scale. Simpler, health-sector-focused models are easier to adopt and replicate but may overlook the underlying drivers of adolescent pregnancy—limiting their long-term impact.

PROGRAM EXAMPLE: A360

During A360's co-design process with girls in southern Nigeria, they expressed that they wanted support that went beyond health to include economic and poverty reduction programs. The intervention was initially designed to teach girls basic income-generating skills, such as soapmaking, beading and the provision of education on contraceptive methods. This was not only attractive to the girls but also served to make the program more appealing to their gatekeepers, such as mothers and husbands. However, the program was not resourced to offer girls robust economic support, and as we increasingly looked to government to take over implementation, it was clear that the health system did not have the mandate, nor the capacity, to sustain the skills classes. This component was dropped, which meant compromising both on what the girls said they wanted from programming and the limiting of the scope of services the program could offer them. Nonetheless, it ensured the program could continue to strengthen contraceptive service delivery, the core program outcome, and the one with the greatest readiness for government adoption. A360 has been able to sustain multi-sectoral programming in only one of its four program geographies: in northern Nigeria, a series of four soft skills and knowledge-building classes has been institutionalized and scaled alongside the core package of contraceptive services. This was possible because of strong multi-sectoral coordination, available resources, and favorable community structures. Optimal settings for successful multi-sectoral, scaled programming, however, are limited.

Trade-off: *Multi-sectoral components respond to adolescents' needs and desires and shouldn't be immediately discounted in a scale-up process. Yet, to stay highly effective and highly scalable, A360 has often had to drop the more complex elements of its interventions related to income generation. This made it easier to make the case for government scale but did reduce the domains in which the program supported girls.*

What we've learned: There is no perfect model. Simple interventions are often essential for scale and increased program reach, but it can be heart-wrenching to reduce program offerings or knowingly ignore girls' needs for more robust offerings. Programs should be clear about their goals from the beginning and identify early on the minimum amount of necessary components to drive real change. Complexity should be built only where the context demands it and the system can support it. More insight and innovation on how to scale complex, multi-component programs for girls are required.

TRADEOFF 3: BREADTH VS. DEPTH OF ENGAGEMENT?

The trade-off is whether to focus only on young women or also engage their key influencers (partners, mothers, and mothers-in-law).

Supporting adolescent girls' contraception use often requires more than just individual outreach; it means shifting the attitudes and behaviors of those around them. This is particularly true for married girls, who may need approval from husbands or mothers-in-law, and for unmarried girls navigating stigma or secrecy. Close engagement with influencers, particularly through social and behavior change (SBC) strategies, can unlock contraceptive access for girls whose choices are highly restricted and support long-term behavior change.

However, health systems are often not equipped to deliver intensive SBC programming. Many frontline workers, including CHWs or health extension workers, are influenced by the same restrictive norms as the communities they serve, and lack the time, skills, or mandate to engage with families, partners, or communities. Training and supporting these cadres to implement SBC effectively is often left to donor-funded projects, which cannot be sustained at scale. Programs must decide whether to make concerted, targeted efforts that reach fewer people but address key barriers or adopt light-touch approaches that are easier to scale but may not reach those facing the highest barriers.

PROGRAM EXAMPLE: A360

In Ethiopia, couples valued joint contraceptive decision-making, but men's work schedules clashed with health worker availability. A360 piloted husband group sessions, which boosted uptake and satisfaction but proved unsustainable, as they required overburdened staff to mobilize and counsel men on weekends. While contraceptive use was higher among couples where both husband and wife were reached by the program, data showed adolescents still adopted contraception at relatively high rates even without husband engagement. The approach was therefore dropped for scale.

In northern Nigeria, however, husband engagement was essential. Married girls face severe restrictions and little autonomy, making male buy-in critical. A360 partnered with Ward Development Committees to train Male Interpersonal Communication Agents, who reach men in everyday settings and engaged religious leaders to align contraception with faith. This scalable model has reached over 600,000 husbands across four states.

The trade-off: *In this case, arriving at a highly scalable and highly effective intervention meant offering the minimum viable components for contraceptive uptake based on the local context. In Ethiopia, the intervention was effective without direct male engagement, while male engagement was required in Nigeria.*

What we've learned: Not every setting requires intensive SBC to achieve impact, but in restrictive contexts, it may be non-negotiable. Programs should match the depth of engagement to the depth of the barrier. Where structural constraints are high, find scalable ways to reach influencers, whether through community platforms, local actors, or cost-effective group models.

TRADEOFF 4: UNIVERSAL VS. TARGETED PROGRAMMING?

When designing for scale, programs must decide whether to aim for broad, universal reach--serving all groups—or to target specific sub-populations who face higher barriers and risks—such as AGYW, and specific groups like married and parenting AGYW. Universal approaches can generate political buy-in, streamline integration into health systems, and accelerate coverage. However, universal coverage is rarely achieved, and may result in overlooking those who need the most support.

Targeted approaches, such as focusing on married adolescents, first-time mothers, or girls out of school, allow for tailored strategies and closer engagement. These approaches are often more effective in reaching those most vulnerable to early pregnancy. However, they may require more effort per client, attract less political support, and appear slower or more limited in reach, especially in early phases.

PROGRAM EXAMPLE: CONNECT

Connect, for example, focused on first-time mothers, an especially vulnerable group for early and repeat pregnancy. This targeted approach enabled the program to tailor counseling, messaging, and outreach strategies. However, some stakeholders at all levels of the health system raised concerns about targeting. Some frontline health workers were hesitant to offer extra support to select community members, when their mandate was to serve the whole community. Similarly, national-level decision-makers felt that focused attention to sub-groups was not needed in light of the government's goals of improving coverage for all. In some cases, stakeholders expressed concern that focused support for young mothers could encourage early childbearing.

The trade-off: *Focusing on first-time mothers and married girls has potential for high impact, but risks shifting to the low-scalability quadrant unless stakeholder buy-in to the potential contribution to national strategies is secured.*

What we've learned: Resources must be focused on those who need them; universal programming will not diminish inequities. Targeting is required to drive equity and impact. Programs should start with a clear rationale for who they serve and why, and anticipate that they may need to invest time in supporting government and partners to see the value in strategic targeting. Over time, designs may have to evolve either expanding reach or sharpening focus as they scale through government systems.

TRADEOFF 5: IMPLEMENT THROUGH EXISTING STRUCTURES AND TOUCHPOINTS, OR CREATE TAILOR-MADE STRUCTURES?

Existing government and community health structures offer limited opportunities for close engagement with AGYW, household influencers, and communities. Implementers must decide whether to work within these structures, accepting potential trade-offs in impact, or introduce project-specific activities that may be effective but unsustainable without external funding. For instance, some projects use donor-funded outreach workers who can implement interventions more flexibly and consistently, yet this model ends with project funding. Meanwhile, government CHWs are often under-resourced and overburdened, balancing government duties with those of non-government initiatives.

PROGRAM EXAMPLE: A360

In Ethiopia, A360 first engaged a paid "Smart Start Navigator" who spent six weeks in each community supporting Health Extension Workers (HEWs) to identify girls and provide them with initial family planning counseling. While highly effective, this model was too costly to scale. Instead, the program engaged with the Women's Development Association (WDA), a volunteer network linking households to health services, to support HEWs in client identification. Where WDAs are active, this works well. However, their limited reach makes it harder in weaker areas, hampering per-site productivity compared to the pilot. Still, adolescent client flow remains higher than pre-implementation levels, and the model is scalable nationwide without added service delivery costs.

PROGRAM EXAMPLE: CONNECT

Connect introduced "sensitization visits" in Bangladesh, where first-time mothers and their families visited health facilities to familiarise themselves with services and providers. Facilitated by providers and local leaders, the visits were well received but required project funding for transport and were not part of providers' responsibilities. Sustaining them would have required local government to manage and fund travel, so the approach was not continued. Connect ultimately worked with salaried government community health workers, the Family Welfare Assistants (FWAs), whose roles include home visits to all mothers. Supporting FWAs to improve visit timing and coverage for young first-time mothers offered potential for national scale-up. However, while coverage improved in treatment areas, few first-time mothers were reached, and no impact on family planning adoption was seen. A qualitative study showed that FWAs faced high vacancies, heavy workloads, and limited flexibility, meaning that despite the system's scalability, it did not enable effective service delivery.

The trade-offs: *Working with government CHWs ensured scalability, but with limited resourcing, programs risk falling into the scalable-but-ineffective quadrant. Removing an unsustainable program element may have lessened impact, but improved scalability.*

What we've learned: Designing solely for impact often leads to interventions that government systems cannot sustain. To prevent impactful activities from ending with donor funding, programme designers must consider what is realistically feasible within government systems. However, adolescents remain a high-need group that existing health services often fail to reach effectively, requiring additional resources to drive change. The challenge lies in identifying the minimum viable inputs and finding ways to redirect existing resources toward adolescent services, which may require some experimentation to achieve balance.

TRADEOFF 6: REQUIRE FIDELITY TO THE MODEL OR SUPPORT ADAPTATION

This trade-off is between strict fidelity to intervention design, which requires intensive oversight but increases the chance of replicating pilot outcomes and openness to adaptation. In turn, this risks program drift but reduces oversight demands and allows interventions to evolve with local preferences or simplify complexity. Pilots often benefit from heavy implementer oversight, especially when tied to research. Having said that, such oversight becomes costly and impractical at scale or under government ownership, making shifts in program approaches responding to implementation context more likely.

PROGRAM EXAMPLE: CONNECT

In the process of forming community support groups during scale-up, some CHWs in Tanzania recruited young mothers who did not meet the defined eligibility criteria for first-time mothers. This included some mothers older than 24, and others with two or more children. While some CHWs had misunderstood the recruitment criteria during the orientation, others were reluctant to exclude anyone who wanted to join the groups. Connect identified a need to clarify the written standard operating procedures for the groups and to discuss recruitment challenges in refresher training sessions. In this case, the evolution of the approach to include additional participants did not undermine the aims of the intervention but underscores that approaches may evolve away from the original intent in response to contextual realities, misunderstandings, or to facilitate implementation.

The trade-off: *Allowing adaptation may improve scalability through simplification but risks reducing impact if fidelity to core elements is not maintained.*

What we've learned: Careful attention to challenges and adjustments that arise during small-scale implementation is essential. An adaptive management approach is important to evolving tools and approaches in response to challenges. However, implementers must identify the core aspects of the intervention and implementation approach so that those aspects can be emphasized in training and supervision.

ADDITIONAL TRADE-OFF QUESTIONS

The above list is not exhaustive. In addition to the detailed examples above, other trade-off questions include:

1. **Material design: All the bells and whistles, or bare bones?** Beautifully designed tools printed on high-quality paper can make AGYW feel that they have been invested in and can be a source of pride for implementers. Yet reducing investment in design and printing (such as using lower-quality paper) is less costly and can result in more AGYW being reached.

2. **Public or private facilities?** AGYW may find that services in private facilities are higher quality and more welcoming than those in public facilities. Nevertheless, in many settings, even if the private sector provides a large share of health services, private health facilities are loosely networked, if at all. This impedes the ability to scale and sustain interventions. While public health facilities are often under-resourced, the national public health system provides more opportunities to scale and sustain interventions.

3. **Easiest to reach or hardest to serve?** Programs may choose to work in geographies in which improving adolescent contraceptive uptake may be relatively straightforward: stable, high-population areas, with high contraceptive prevalence among the general population. This may require fewer resources and lead to more rapid change. However, this approach risks leaving behind AGYW who may be the most vulnerable, such as, AGYW living in conflict prone, low-density areas, with low overall contraceptive prevalence. Working in areas with the poorest indicators, however, requires more resources and may result in a smaller geographic footprint and more modest overall impact.

4. **Top-down or bottom-up advocacy?** Scaling programs requires embedding them into national policies, guidelines, and budgets with the support of senior influential leaders. This requires strategic, repeat engagement and advocacy at the national level. Changes at this level are resource-intensive and can take years to achieve but can catalyze widespread impact. At the same time, local stakeholders such as village and regional leaders are tasked with implementing national policy and often hold budgets that can support health activities and health service improvement. Local leaders can facilitate the implementation and sustainability of community activities if they are supportive and see alignment with their own goals and priorities. Even so, building widespread local support necessitates reaching many more individuals, which is also resource and time-intensive.

5. **External or government priorities?** Donors and implementing partners often align intervention strategies with global or donor priorities to leverage proven practices, avoid known pitfalls, fill evidence gaps, or rapidly access funding. Still, government endorsement is essential to sustainability and can "fast track" geographic expansion. Nonetheless, governments may prioritize differently, balancing other factors such as available domestic resources, severity of need, and sensitivities around adolescent contraceptive use, which can require trade-offs. Government ownership is key to sustainability, but trade-offs in design and content can risk reducing effectiveness—the top left square in our quadrant above.

CONCLUSION

The current and future generations of adolescents need impactful programs that meet their needs. We know a great deal about what is needed for impactful programming for adolescents. We also know that small, complex interventions that cannot be scaled will not reach the many adolescents that need them. We must move towards programs that are designed both for impact and for scale.

Even though in most settings no intervention is both perfectly scalable and perfectly impactful, navigating trade-offs is inevitable, and quite often difficult. In designing for scale, implementers must carefully identify potential trade-offs in the context and monitor to understand the implications on reach and impact. This brief aims to elucidate trade-off decisions that must be considered.

It is important to note that many trade-offs reflect gaps in existing health systems. We also need substantial investments in health systems strengthening at the facility and community levels. Government systems cannot deliver impactful interventions unless they are sufficiently resourced to support coverage and quality.

What we have learned across these five settings pinpoints the importance of context in shaping both potential for impact and potential for sustainability. Varied health system contexts can result in vastly different challenges in implementing and sustaining even seemingly similar interventions.

Many underlying drivers of adolescent pregnancy are far beyond the scope of the health system to address, with gender inequality and poverty remaining the two major ones. Wanting to make progress on these issues is part of what drives programs to develop such robust interventions. These are what get dropped in going to scale. More creativity and partnership are required to continue working holistically for girls.

ADDITIONAL INFORMATION AND RESULTS

Connect: https://resourcecentre.savethechildren.net/collection/the-connect-project
A360: https://a360learninghub.org/

RECOMMENDED CITATION

Yahner M, Phillips M, Cutherell M, and Bello F. Impactful adolescent family planning programs at scale: Navigating the trade-offs. Washington, DC: Save the Children and Population Services International; 2025.