THE POLITICS OF GLOBAL POLICY FRAMES: REPRODUCTIVE HEALTH AND DEVELOPMENT IN GHANA

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INTRODUCTION

Until recently, adolescent and youth health have largely been neglected or considered secondary in relation to maternal and child health, a development that has been attributed to the lack of understanding regarding the health and development challenges that confront young people, as well as the fragmented nature of global governance. [1,2,3] In retrospect, it is also widely acknowledged that global commitments to fulfilling the targets set out in the Millennium Development Goals (MDGs) somewhat undermined the capacity of government and other actors to meet the needs of young people.[4] In 2015, the United Nations announced the Sustainable Development Goals (SDGs) – a global policy agenda that established the framework for the consequent development of two adolescent-friendly protocols, namely (1) the updated Global Strategy for Women's, Children's, and Adolescents' Health (hereinafter "The Global Strategy"), and (2) the Global Accelerated Action for the Health of Adolescents (AA-HA!). These global policy instruments largely account for the increased attention given to young people's health. But in what ways has the issue of adolescent and youth health been addressed at global, national, and sub-national levels, and to what extent do global policy frames affect policy development and reproductive health outcomes for young people?

Drawing on two important adolescent-focused programmes in Ghana – the Adolescent Health and Development Programme (ADHD), and the Ghana Adolescent Reproductive Health Programme (GHARH), this article examines the complex dynamics of issue framing to explain why these initiatives produced divergent outcomes. In the context of this study, implementation success is broadly defined to encompass processes and outcomes that positively reflect the values and objectives of an intended policy initiative, a position that is reflected by the GHARH programme. Importantly, the discussion highlights the merits of an integrated ideational policy discourse in the context of ongoing debates about young people's reproductive health. Although this ideational strategy is not without controversies, the discussion stresses the need to understand framing research not only in terms of agenda-setting, but also from a policy implementation perspective. Against this backdrop, it is worth emphasizing that policy implementation in itself is a matter of framing and discursive strategy. Some scholars have suggested that the link between ideas and policy-making outcomes is better illuminated by paying particular attention to institutional conditions and how specific actors affect the policy process with their ideas, as well as the discursive mechanisms by which policy ideas are translated into practice [5,6]. Our analysis is situated within this broader understanding.

The politics of ideas and global discursive processes has attracted attention from scholars over the years[7,8,9,10,11,12]. By looking at the ADHD and GHARH initiatives from an ideational perspective, this article responds to the call for further research concerning the impact of issue framing on vulnerable and marginalized populations[13]. Specifically, it seeks to identify and examine the core policy frames that provide substantive currency to adolescent and youth health and, most importantly, their intersections with the

trajectories of national politics. To better understand the divergent outcomes of the ADHD and GHARH programmes, the discussion is also situated within larger debates in human rights, which we discuss in more detail in a later section.

There is general consensus among scholars that the success or otherwise of a policy frame depends on a number of factors – the power of ideas used to portray the issue, the power resources of the actors, and the character of the political or institutional context, among others[14,15,16]. This article draws on the existing literature with the view to providing a nuanced understanding of the complexities and politics of global frames, and the environmental factors that shape policy initiatives. Ghana merits attention because it has responded quite well to the global call for comprehensive health programming that aligns with the new development agenda, with adolescent health as a centerpiece of the development discourse [17] (WHO 2017). Moreover, Ghana has been a leader in reproductive health and family planning across the West African sub-region over the past decades [18].

METHOD

This article is based on qualitative research conducted in Ghana from January – June 2017. The research draws on primary and secondary materials including global and national health policy documents, published books, journal articles, local newspapers, and other relevant health reports. A series of semi-structured interviews were conducted with individuals centrally involved with the ADHD and GHARH programmes at the national, regional, and district levels. The respondents include officials at the National Population Council (NPC), Ghana Health Service (GHS), Ghana Education Service (GES), and the National Youth Authority (NYA). Interviews were also conducted with leading officials of the Palladium Group (formerly Futures Group Europe), who constitute the primary implementing and oversight body of the GHARH Programme. Lastly, interviews were held with non-governmental organizations (NGOs) such as MAP International and Planned Parenthood Association of Ghana (PPAG), as well as young people aged 10-24 years. Overall, sixty (60) participants were involved in the study, and with permission from respondents, the interviews were audio recorded and later transcribed for analytical purposes. Discourse analysis and process tracing served as the main instruments for data analysis. This article presents only one segment of the data generated through this research effort.

The study area for the research was Sunyani, which is the administrative capital of the Brong Ahafo region.[i] It was selected as the initial site for the research because the GHARH intervention primarily focused on the Brong Ahafo region. The region was selected as the focal point of GHARH intervention due to the high rates of adolescent pregnancy, as well as recognized gaps and demand in sexual reproductive health services among young people across the region[19]. Interviews were also conducted with Palladium

[i] Ghana is comprised of sixteen administrative regions, and Brong Ahafo lies in the middle part of the country. Research suggests that fertility rates are relatively high in the Brong Ahafo region due to low literacy level. As part of efforts to strengthen Ghana's decentralization system and foster equitable development, six new regions were created following a referendum held on December 27, 2018, thus altering the former ten regional administrative boundaries. Following the regional restructuring, the Brong Ahafo region has been divided into three separate regions, namely Brong Ahafo, Bono East, and Ahafo.

and government officials in the Greater Accra region of Ghana, the national capital. Ethical clearance was obtained from the University of Guelph Research Ethics Board (Canada) and the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (Ghana). Due to ethical considerations regarding this study, the specific study locations are confidential. It should, however, be emphasized that all research participants identified in this article explicitly consented to the use of their full name for the purpose of this study.

The remainder of the paper is structured as follows: The first section provides a brief overview of the trajectory of adolescent health within the context of global politics. The second section provides, a contextual overview of the health landscape in Ghana, with particular focus on the policies and programmes that have been adopted over time to deal with the health challenges faced by young people. The third section includes a comparative overview of the ADHD and GHARH initiatives. The fourth section entails a critical analysis of the core frames embedded in the SDGs, the Global Strategy, and the AA-HA! Framework, which provides deep insight into the complexities and analytical tensions surrounding the discursive construction of adolescent health. The remaining three sections of the paper will discuss the opportunities and constraints associated with the GHARH programme, and will provide focused analysis that offers a conceptual understanding of the intricacies of an integrated ideational policy discourse. The conclusion weaves these different strands of discussion together, and integrates these strands with some final thoughts on framing and policy implementation.

HEALTH IN THE GLOBAL CONTEXT: THE CASE FOR ADOLESCENT AND YOUTH HEALTH DEVELOPMENT

It has been widely recognized that young people have received inadequate support in terms of social policies and programme interventions; as a population, they have been neglected or ignored. The WHO[20], reports that adolescents are generally perceived to be healthy due to the low death rates of this age group vis-à-vis child or adult populations. However, this perception has been dispelled in light of new evidence, which suggests that urgent response is required to confront the challenges and health inequities faced by adolescent and youth populations[21].

Although the MDGs delivered tangible progress in terms of meeting global and regional targets, empirical evidence reveals that the benefits were unevenly distributed across the global communit.[22] Further, a wide category of marginalized, disadvantaged, and vulnerable people had been left behind in the development discourse. The realities of the global and domestic environments, therefore, created momentum and set the global stage for policy action on adolescent and youth health. In structural terms, the global policy window for adolescent and youth health opened after the adoption of the SDGs, with its landmark slogan, "leave no one behind." SDG #3 specifically addresses the adolescent and youth population, and identifies the need to ensure and promote healthy lives and well-being for all at all ages.

As a significant departure from earlier global development commitments, adolescents, women and children have been strategically positioned at the forefront of the global development agenda. In line with this reasoning, the Global Strategy (2015)[23] proposes that, "the survival, health and well-being of women, children and adolescents are essential to ending extreme poverty, promoting development and resilience, and

achieving the SDGs" (p. 12). Within this context, the Global Strategy was launched in September 2015 to complement the SDGs in the global effort to improve the health and well-being of young people, a development that resulted in the subsequent adoption of the AA-HA! Framework.

CONTEXTUAL OVERVIEW OF ADOLESCENT AND YOUTH HEALTH IN GHANA

Ghana has demonstrated a significant level of commitment to improving adolescent and youth health over the past few years. Although gaps and challenges remain, the state recognizes the youth as critical assets in the national development agenda. As such, the revised National Population Policy[24] places emphasis on the general welfare and special needs of the youth. Several policies and programs have been established over time to confront the challenges faced by young people. Examples of such policies, programs, and strategies include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), National Population Policy [25], National Health Policy, National Reproductive Health and Service Policy and Standards, National Youth Policy, Ghana Adolescent Reproductive Health Policy, National Gender and Children Policy, National Condom and Lubricant Strategy (2016 – 2020), Ghana Family Planning Costed Implementation Plan (2016 – 2020), ADHD and GHARH programmes, and more recently the Adolescent Health Service Policy and Strategy (an initiative that emerged from the GHARH intervention).

While these policies, programs, and strategies have varied objectives and goals, they share certain commonalities. A significant point of convergence is the goal towards enhancing the general quality of life of young people, which ultimately boils down to effective policy delivery within an institutional context that facilitates their transition towards productive adulthood. As noted in the Adolescent Reproductive Health Policy, comprehensive and effective health programming could help to avert the wasting of the lives of young people[26]. More broadly, these national policies, programs, and strategies harmonize under the understanding and recognition of health as a human rights issue, the advancement of which leads to empowerment, wealth creation, and overall well-being.

THE ADHD AND GHARH PROGRAMMES IN COMPARATIVE PERSPECTIVE

This section provides an overview of the ADHD and GHARH initiatives with attention to the actors and context that informed the implementation of both programs. Ghana is signatory to several global treaties and conventions that recognize the right to health, and this mechanism has been instrumental in pushing young people's reproductive health issues and rights to the forefront of the national policy agenda. The GHARH programme emerged in response to difficulties faced by the ADHD programme and, specifically, its failure to yield the expected health outcomes for young people. The challenges that undermined the ADHD initiative include the lack of information, education, and communication (IEC) materials from the Ghana Health Service (GHS), inadequate regional support for the programme, poor coordination and supervision, minimal orientation for service providers, insufficient funding from the government, among others [27].

The ADHD programme was established in 2001 and implemented by GHS, while coordination of the program remained within the ambit of the NPC. The GHARH initiative, on the other hand, is a three-year Department for International Development, DFID,-funded project (£11.3 million UK aid) implemented by the Palladium Group (an international NGO), in partnership with the Government of Ghana (GoG) and other relevant partners (Jan 2014 – March 2017).[ii] Through a multi-sectoral approach, the project was instituted to improve reproductive health and educational outcomes for adolescents and youth in all 27 districts in the Brong Ahafo region, with support from four significant collaborative national agencies –NPC, GHS, GES, and the NYA. Five selected non-governmental organizations (NGOs) were also engaged as implementing partners for the project – Hope for Future Generations (HFFG), Map International, PPAG, Women in Law for Development in Africa (WiLDAF), and Institute of Social Research and Development (ISRAD).

Similar to the ADHD initiative, the GHARH programme aimed at improving national efforts towards the fulfillment of MDG #5 (i.e., improving maternal health), with the ultimate goal of reducing the adolescent pregnancy burden and maternal mortality rates among young people aged 10-24 years. Perhaps the most striking aspect of the GHARH programme is its adaptation to the exigencies of the global policy environment, specifically in relation to the adoption of the SDGs, the Global Strategy, and the AA-HA!, which ultimately served as the overarching framework for policy intervention. Certainly, this 'layering' mechanism effectively demonstrates the dynamic character of Ghana's policy landscape, and also draws attention to the role of ideas in the policy process [28,29,30,31]. As explained by Baumgartner, Jones, and Mortensen[32], new policy images are emotive appeals that hold the potential to attract new participants. Importantly, the broad character of the SDGs relative to the MDGs, as well as emergence of new actors is a key difference in the policy environment that helps to explain the contextual landscape that structured the implementation of the GHARH and ADHD programmes respectively.

To achieve the core objectives of the GHARH programme, Palladium sought to strengthen the capacity of the government and implementing partners in relation to efficient implementation, management, and effective delivery of adolescent sexual and reproductive health programmes. At this point, it should be emphasized that capacity building is a crucial mechanism that highlights the connections between ideas and policy-making outcomes. Drawing insight from Schmidt[33], we will demonstrate in the following sections how the dynamics of "coordinative" and "communicative" discourse translate into what we refer to as the ideational-implementation nexus (p. 310). While the GHARH programme draws on global ideational protocols, it is important to reiterate that it also rests on existing national policies and strategies – an arrangement that illustrates how the success of global policy frames are dictated by national politics and legitimation mechanisms.

[ii] The Department for International Development (DFID) is one of Ghana's key bilateral donors. DFID has supported the nation with millions of dollars in aid towards the goals of eradicating poverty and improving social infrastructure over the past decades.

MAKING THE CASE: FRAMING FOR ADOLESCENT HEALTH

The Sustainable Development Goals (SDGs) are generally agreed to constitute an improvement over their predecessor, the Millennium Development Goals (MDGs) for two main reasons. First, they are more broadly conceived and focused on underlying causes of poverty, disease, and inequality, rather than on specific indicators and their measurement. And second, they are articulated in global terms and not directed exclusively at developing countries. As noted, adolescent health is captured by SDG #3, "Ensure healthy lives and promote well-being for all at all ages." The topic addressed in this paper, reproductive health for adolescents, is also the focus of SDG #5, "Achieve gender equality and empower all women and girls." Each goal identifies a number of problems, some intractable and others more amenable to change, and provides evidence of either progress toward the goal or barriers to its achievement. All goals adopt the language and perspective of human rights, which is to say that they acknowledge universal, global norms and standards to be fundamental to development. However, the goals also try to reconcile this foundation with the need to pay close attention to context and cultural differences. To some extent, this produces frame conflict between the meta-cultural human rights frames and the various action frames for development[34], although the main argument that we are advancing in this paper is that frames should not compete with each other; rather, framing strategies should be integrative and multiple. We also want to emphasize that we understand frames to constitute both cognitive predispositions[35] and political strategies[36].

The first frame that gives shape to global initiatives for adolescent health is human rights. This is evident in the SDGs, as noted above, and also in the Global Strategy and AA-HA! Framework. Regarding progress toward SDG #5, the UN reports that, "Gender inequality persists worldwide, depriving women and girls of their basic rights and opportunities"[iii]. The 2017 progress report for SDG #3 emphasizes that "Preventing unintended pregnancies and reducing adolescent childbearing through universal access to sexual and reproductive health care is crucial to the health and well-being of women, children and adolescents." While the former makes explicit reference to women's rights, the latter suggests the need for universal access to "sexual and reproductive health services," which is itself framed in politically charged, controversial language. Reference to "sexual and reproductive health" represents a discursive shift away from longstanding (and less politically controversial) commitments to maternal and child health (see, for instance, Johnson 2016[37]: 6-10; more on this below). In any case, the 2017 SDG reports for goals #3 and #5 provide consistent evidence of the same universalist, human rights frame. Human rights are embedded in the SDGs as standard commitments to UN sponsored activities. In other words, they are not employed by UN agencies so much as they are fundamental to UN consciousness and therefore serve as a meta-cultural narrative. However, there is also a strategic, action-oriented dimension to the linking of development goals and human rights commitments. The human rights frame signals individuals' rights to a minimum standard of living, dignity, gender justice, and self-determination at the same time that it highlights states' responsibilities to their citizens.

[iii] https://sustainabledevelopment.un.org/sdg5

The WHO's Global Strategy also states that human rights are of paramount importance in achieving health goals. In its updated strategy document, it indicates that:

> *This Global Strategy is much broader, more ambitious and more focused on equity than its predecessor. It is universal and applies to all people (including the marginalized and hard-to-reach), in all places (including crisis situations) and to transnational issues. It focuses on safeguarding women, children and adolescents in humanitarian and fragile settings and upholding their human rights to the highest attainable standard of health, even in the most difficult circumstances*[iv].

Further, the introduction makes clear that, "The updated *Global Strategy* includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 Agenda. By helping adolescents to realize their rights to health, well-being, education and full and equal participation in society, we are equipping them to attain their full potential as adults" (p. 5; see also fuller articulation on p. 37). However, this commitment is significantly different from the SDG commitment to human rights. The Global Strategy develops a three-pronged approach to addressing women's, children's, and adolescent health. The approach is structured with three objectives: Survive, Thrive, and Transform. The first element, "Survive" attends primarily to the standard concerns of maternal and neonatal health and survival. The final two – Thrive and Transform – are more clearly focused on adolescents.

The second predominant frame is that of development. In the documents under consideration here, development is conceived in both cultural and economic terms. Regarding the former, attention to cultural specificity is a challenge to the human rights frame, as cultural differences and their practice either contradict human rights guarantees outright, or merely frustrate their realization in practice. Regarding the latter, "sustainable development," refers to both economic growth and the strengthening of financing mechanisms for health care. All three global initiatives, the SDGs, the Global Strategy, and AA-HA!, combine cultural and economic elements in their development frames. The SDGs are the most expansive in their approach to development, and integrate well development and human rights considerations. The SDGs identify the specific underlying causes of inequality and premature death and make these preconditions to development the focus of the global initiative. In other words, the SDGs do not just pay attention to gender inequity, poverty, child marriage, FGM as development-related issues, rather the SDGs are themselves commitments to these socio-cultural phenomena.

The SDGs articulate the goals of reducing poverty, improving health, reducing child and maternal deaths, empowering women, and so on, without justifying them in economic terms. The goals are stated as independent imperatives, intrinsically worthwhile, and not of instrumental value (i.e., worthy of pursuit because they will improve economic performance). Workforce participation and economic growth are included as a separate goal (#8), and not directly connected to all other goals. However, the goal of poverty alleviation is central to the Agenda and is highlighted in the preamble to the 2030 Agenda for Sustainable Development: "The importance of context cannot be overstated: the specific details of each action in different settings will depend on political

[iv] www.wec-globalstrategyreport-200915.pdf , p. 11

environments, power dynamics, economics, religion, social norms and factors affecting health literacy and care-seeking behaviors among women, children and adolescents[v]." In short, the language of development is broadly presented throughout the SDG Knowledge Platform. Interestingly, the Global Strategy and AA-HA! initiatives were developed in response to the SDG agenda, yet both interpret that agenda in different ways.

The SDGs are the most directly concerned with the cultural dimensions of development, namely the contextual factors that contribute to high rates of adolescent pregnancy, domestic violence, FGM, child marriage, and HIV infection. These are acknowledged in both the Global Strategy and the AA-HA! document, although both tend to focus preponderantly on economic rather than cultural dimensions of adolescent health (ill health as the basis for multi-level, multi-sectoral action). For example, concerning cultural factors, the Global Strategy emphasizes that, "the importance of context cannot be overstated: the specific details of each action in different settings will depend on political environments, power dynamics, economics, religion, social norms and factors affecting health literacy and care-seeking behaviors among women, children and adolescents."[38] However, there is consistent and equally forceful reference to the theme of economic development. To this point, the Global Strategy report states, "If countries in demographic transition make the right human capital investments and adopt policies that expand opportunities for young people, their combined demographic dividends could be enormous. In sub-Saharan Africa, for example, they would be at least US$500 billion a year, equal to about one third of the region's current GDP, for as many as 30 years."[39] The entire second chapter of the Global Strategy is dedicated to the theme of investment as one of the primary benefits of improving the health of women, children, and adolescents. This may raise some red flags concerning the existence of neo-liberal predicates, which is to say that the strategy directs itself to adolescent health not as a matter of fulfilment of human rights but as a means of bolstering preparedness of future adults/ productive citizens for participation in the market. Further, the report resolves to, "Identify context-specific needs—including barriers to realizing rights—and promote access to essential goods, services and information. Expand age-appropriate opportunities for socioeconomic and political participation. Ensure that these activities are funded in country plans and budgets" (Global Strategy page 59, point 2).

The Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation – Summary (hereinafter "the AA-HA! document"), is similarly dedicated to economic justifications for development. This document does not make extensive reference to human rights (for brief mention exceptions, see pages 4 and 18). There is an acknowledgment on page 4 that "Adolescents have the fundamental right to health," although this is not cast as a reason for "investing" in adolescent health. Further, the document is not primarily focused on development, although it does describe its purpose as achieving the SDGs (vii) and aligning with Global Strategy commitments. To be sure, the AA-HA! document is an implementation guide rather than a grand visioning strategy. Therefore, it is more oriented toward practice (in the realms of both development and health administration), which is dependent on robust partnerships with constituents (adolescents), communities, government stakeholders and decision makers from different sectors, technical support agencies, and donors.

[v] https://sustainabledevelopment.un.org/post2015/transformingourworld

In the AA-HA! document, the imperative for attention to adolescent health is framed as an investment that brings "a triple dividend" (p. 4, 17, and throughout the document). The health benefits that will accrue from improved attention to adolescent well-being and survival include benefits "for adolescents now… for adolescents' future lives… [and] for the next generation" (4). In addition, the document claims that "investments in adolescent health reduce present and future health costs and enhance social capital" (4). The language of investment is both admirably pragmatic and dubiously instrumental. The language of investment is a sound strategy for convincing governments, political leaders, and policy makers to fund health programs for adolescents. Because revenues and funding sources are limited, it is important to advocate, in whatever language resonates, for the prioritization of vulnerable and often excluded or invisible groups (such as adolescents). However, as Pretice[40] explains, the economic reframing of complex social justice issues often "sidesteps the problem of social inequality" (p. 692). Moreover, "the business case [for childcare or health care] builds an ideological/ conceptual bridge to contemporary wealth production, not to social transformation" (2009: 693). In other words, the case for investing in adolescent health focuses on future economic returns and minimizes the complexities of persistent socio-economic inequalities, endemic poverty, and patriarchy.

The third frame to be considered here is that of adolescent health. While this seems to be a simple descriptive branding of an important policy focus, it is more complex than that. The shift in focus on maternal and child health to adolescent health as a separate but related health domain, is a strategic rhetorical shift, which might or might not possess any potential for change in health outcomes. There is longstanding criticism of the maternal and child health commitments. These criticisms are well explained elsewhere[41,42,43]. Suffice it to say that the focus on maternal health rather than women's health or sexual and reproductive health suggests a pronatalist, conservative bias toward protecting women as mothers. Further, maternal health conveniently tends to ignore the important yet politically divisive issue of abortion[44]. And finally, maternal and child health seem fused in ways that further emphasize the pronatalist bias and thereby marginalize both women and children as independently vulnerable populations.

The focus on adolescents is both much needed and somewhat mystifying. Both the Global Strategy and the AA-HA! document provide compelling justifications for the isolation of adolescents as a group of particular concern. The SDGs speak directly to the need to focus on adolescents as a vulnerable group. For example, SDG #3 mentions the distinct sexual and reproductive health needs of this population, and SDG#5 speaks to the challenges of achieving gender equity and empowerment for girls, whereas SGD#8 emphasizes the labour rights violations and employment needs of adolescents. In the introduction to the Global Strategy, it is stated that, "for the first time, adolescents join women and children at the heart of the Global Strategy. This acknowledges not only the unique health challenges facing young people, but also their pivotal role alongside women and children as key drivers of change in the post-2015 era. By investing in the right policies and programmes for adolescents to realize their potential and their human rights to health, education and full participation in society, we can unleash the vast human potential of this "SDG Generation" to transform our world" (11). Similarly, the AA-HA! document makes clear that, "adolescents are not simply old children or young adults. This deceptively simple observation lies at the heart of the Global Accelerated Action for the

Health of Adolescents (AA-HA!): guidance to support country implementation – which reflects the coming of age of adolescent health within global public health" (foreword, iv).

However, despite the apparent uniqueness of adolescents as a population, there might be more intergroup variation than the updated focus suggests, much of which is still attended to by other global frames. The clearest example of this is the domain (and frame) of maternal health, an area of concern that does not abate in significance under the new frameworks. The SDGs and Global Strategy make abundantly clear that maternal health, related to a wide variety of causes from child marriage to lack of access to medical care, is a major health threat for all women. The AA-HA! document, which is focused exclusively on adolescent health, reveals that the leading cause of death for girls from 15-19 years of age is "maternal conditions" (6), which indicates the precarity of both age and gender. It is possible, given the emphases on maternal health in all three sets of global commitments, that the rhetorical framing of "adolescent health" will necessitate continued attention to the more conventional action frame of "maternal health."

While we have isolated these three frames – human rights, development, and adolescent health – for analytical purposes, the documents and strategies themselves suggest an integrated approach. We endorse this suggestion, but caution that without explicit and careful attention to individual frames and their components, the political and policy implications of integrated initiatives are obscured. We agree with the admonition of the Global Strategy, which declares that:

> *Only a comprehensive human rights-based approach will overcome the varied and complex challenges facing women's, children's and adolescents' health. To succeed, countries and their partners will have to take simultaneous action in nine interconnected and interdependent areas: country leadership; financing for health; health systems resilience; individual potential; community engagement; multisector action; humanitarian and fragile settings; research and innovation; and accountability* (p. 48).

The complexity of this endeavor cannot be overstated. It is enormous, and deserving of increased global resources and attention. It is our intention in this paper to demonstrate this position through the case of adolescent health and multi-level initiatives for adolescent reproductive health in Ghana.

IMPLEMENTING THE GHARH PROGRAMME: FRAMING AND STRATEGIES

Implementation failure or success is contingent on a number of factors, and as suggested by Schmidt[45], it is worth paying attention to the dynamics of the coordinative and communicative discourses. On the one hand, the coordinative discourse speaks to the construction, elaboration, and justification of policy by actors primarily at the center of the policy sphere (i.e., elected officials, civil servants, experts, etc.). On the other, the communicative discourse involves the presentation and legitimation of policy ideas and programs developed in the coordinative discourse to the general public. To better understand the variation in program outcomes – that is, the ADHD and GHARH – we examine the strategies employed by Palladium in advancing their program objectives. It should be noted that although Palladium operated largely as a grant provider, the

organization exercised primary oversight over the implementation of the GHARH programme, while the NPC served as the coordinating unit.

To overcome the key challenges identified in the ADHD programme (i.e., issues of coordination, supervision, advocacy materials etc.), Palladium first sought to coordinate agreement among policy actors in the policy sphere. As such, a key feature of the intervention speaks to the concept of strategic partnership and multi-sectoral implementation. In contrast to the ADHD programme, the GHARH initiative involved a more robust set of policy and implementing actors. Arguably, the emergence of new actors partly contributed to the success of the GHARH intervention. Through sustained engagement with DFID, NPC, GHS, GES, NYA, NGOs, and other relevant stakeholders and implementing partners, a comprehensive strategy was adopted to guide the implementation of the GHARH programme. Of course, the need for concerted action in the context of multi-level governance has gained significant currency in policy and health discourses over the past few years, particularly in response to the complex challenges of modern governance[46,47,48].

In essence, the structural framework adopted for implementation required the need for all key actors to understand the fundamental purpose of the intervention and their specific role both within the policy and implementation streams. As pointed out by the Team Leader, it was important for all the partners to come to a common understanding and agreement prior to the implementation of the GHARH intervention.[vi] By looking at the structural context through the lens of the ideational-implementation nexus, one notices that to ensure effective intervention, implementation in itself had to be understood more broadly in terms of its ideational properties – that is, the institutional values (human rights, development, and adolescent health) that defined Palladium's mandate, and upon which the GHARH programme was predicated. As should be clear by now, the ADHD initiative failed to yield the expected outcomes due to poor understanding of this ideational mechanism. As we discuss in more detail below, the capacity building initiatives undertaken under the GHARH intervention were fashioned to reflect the ideational position adopted at the outset.

The ideational and discursive component of the GHARH initiative is important for two reasons. First, to ensure successful implementation, Palladium had to frame the GHARH programme in ways that not only captured the interest of implementing agencies and partners, but also ensured that the appropriate environment had been created for the various actors to engage the initiative with the requisite knowledge and capacity to deliver on the goals of the programme. Indeed, this was a major failing of the ADHD programme. As we argue, capacity building is an ideational mechanism through which policy ideas are translated into action. Second, capacity building was an ideational strategy intended to link the coordinative and communicative streams. In other words, both the coordinative and communicative discourse helped to legitimate the GHARH programme, and to create a fertile environment for effective policy intervention.

As part of its capacity building strategies, Palladium trained not less than 7,000 people, which includes staff of NPC, GHS, GES, NYA, peer educators, service providers, among others. [vii] Capacity building was aimed towards the need to shift attention away

[vi] Interview with Team Leader of Palladium, Mr. David Logan, Ghana, March 13, 2017
[vii] Interview with Mr. Bashiru Adams (Overall Monitoring and Evaluation Coordinator on the GHARH project), Ghana, May 10, 2017.

from the traditional practice of using general practitioners to handle adolescent health issues (interview with a senior policy official, Accra, 2017). As pointed out by a technical consultant, capacity building was essential because it had been taken-for-granted in many institutions. [viii] Another key aspect of capacity building was that Palladium developed a mobile application for service providers to enhance their interaction with adolescent health resource persons. This strategy was to help bridge the knowledge and service gap between service providers and experts specifically trained in the area of adolescent health, and to help identify the core reproductive and development issues faced by adolescents.

The GHARH intervention, as a rights-based and development initiative, was also embedded with awareness creation, sensitization, and community mobilization. This allowed for information empowerment among the adolescent and youth cohort in the region. It is estimated that not less than 400,000 young people were reached across the region. About 600 school health clubs were also established across the region to provide education and counseling services to young people. Palladium's flagship project in terms of capacity building draws attention to what is popularly referred to as "adolescent health corners". These adolescent-focused health centres were established specifically to expand health service delivery by providing "safe spaces" or adolescent-friendly services for young people in the region. Overall, 54 adolescent health corners were established across the region, with two facilities in each district (this comprises new and refurbished centres). It is worth pointing out that although the ADHD programme championed the concept of health corners, evidence suggests that most of the established corners were fraught with functionality and integrity issues [49]. Arguably, Palladium's reinvention of the health corners can be interpreted as a symbolic effort at shifting the discourse on adolescent pregnancy from the sphere of intentional cause to institutional responsibility.[ix]

Generally, these corners provide counseling services, STI diagnosis, family planning, psychiatric care, antenatal and post-natal care, as well as comprehensive abortion services and referrals for young people. Field visits to two health corners revealed a significant patronization of health services by young people in the region. Overall, it is estimated that about 51,426 young people were reached with sexual reproductive health (SRH) services and information by the GHARH-supported corners[50]. Notably, these corners have been furnished with recreational games such as scrabble, checkers, ludo, and cards that are designed to sustain the interest of young people who visit the health corners. Generally, the field research revealed that some of the young people frequent the health corners merely to play, and this generates opportunities for the health practitioners to educate them, as well as gradually introduce them to the health services offered at the facilities.

Finally, another innovative strategy introduced by Palladium is the television drama series entitled 'You Only Live Once' (YOLO). This educational programme was designed to help young people make sound reproductive health choices, and has been very popular among the youth since its introduction. Perhaps by harnessing the power of the current technological revolution, Palladium was able to engage a broader section of the youth population through interactive media platforms such as Facebook, Twitter, Instagram, and YouTube. Indeed, the drama series was ranked in 2017 as the most

[viii] Interview with Mr. Jacob Larbi, Ghana, Feb. 08, 2017.

[ix] For further detail, see Deborah Stone, *Policy Paradox: The Art of Political Decision Making* (New York: W.W. Norton & Company, Inc, 2012).

influential radio and television program on social media[51]. It is worth emphasizing that while television programmes such as 'YOLO' are not new to the Ghanaian media landscape, YOLO is unique in terms of its packaging as part of a broader interventionist programme and linkage with the adolescent health corners. Overall, an interesting takeaway from these initiatives is that when young people are effectively engaged, they respond positively to health interventions targeted at them.

A DISCURSIVE AGENDA: TOWARDS AN INTEGRATED IDEATIONAL POLICY DISCOURSE

To better understand the dynamics and utility of an integrated ideational policy discourse, which we propose in this article, it would be useful to first situate the discussion within the broader context of debates in human rights. As we argue, a key part of the puzzle that helps to explain why the ADHD programme failed to yield the expected outcomes, and yet has received little attention, speaks to the lack of a unifying global frame and consistent appeal to the human rights norms. It is worth highlighting that the ADHD initiative was developed and implemented within the context of the MDGs.

Today, the language of human rights is often used as strategic leverage to push for political and social goals embedded in principles of social justice, equity, and human dignity[52,53]. Central to the present discussion is the normative advancement of human rights protocols within the context of global development and national health discourses. While the utility of the human rights frame is beyond question, a number of studies suggest that it may not necessarily be an effective ideational instrument in addressing the rising tide of reproductive injustice, inequality, and poor maternal health outcomes [54,55,56,57,58].

Ghana has various resolutions and policies on adolescent health, which are all remarkably inspired by, and grounded in the human rights ideology. Within this context, the outcome of the ADHD programme should be understood as a framing issue, especially given that sexual and reproductive health in itself is defined and largely approached in the Ghanaian context with a rights-based framework, as reflected by Ghana's National Reproductive Health and Service Policy and Standards[59]. If the above ideational premise is flawed, then we argue that the rights-based approach is not enough. Indeed, privileging the human rights frame constrains broader discourses around which policy action can be crystallized. Undoubtedly, the relative success of Palladium in implementing the GHARH programme lies in part on its ability to employ broader strategies that link human rights approaches with other substantive action frames underpinning adolescent health, while recognizing the overarching institutional settings for effective intervention.

While the idea of framing is not without difficulties, Schon and Rein [60] demonstrate the utility of integrative and multiple framing strategies, particularly in the context of program design and implementation. In what they metaphorically describe as "design rationality," the designer (collection of actors) is constantly engaged in a discursive conversation with his or her materials (policy object and external environment), a complex political process that leads to new opportunities or problems, as well as strategies (p. 167). In line with this reasoning, we maintain that an integrated ideational policy discourse provides important reference points for the discursive construction of adolescent health in ways that augment our understandings of health politics in both the global and national spheres.

So, if the language of rights, development, partnership, inclusion, among others, are to translate into meaningful change on the ground, a variegated ideational lens cannot be overemphasized. Rather than privilege the human rights frame over other substantive health ideologies, an integrated ideational policy discourse provides a multidimensional language that allows state and non-state actors to draw on an array of policy tools, options, networks, and resources to produce transformative social change, while appreciating contextual environmental realities and constraints. Of course, a one-size-fits-all ideational platform raises critical and legitimate questions about potential competition between frames. But to assume that every context presents equal or similar socio-political or institutional challenges is unwarranted, if not misleading. Indeed, what one may consider as competing frames in one context could present opportunities in a different venue. It goes without saying that conflicting frames are not immune to resolution[61]. The challenge, then, for policy makers, health programmers, and other stakeholders is to figure out innovative strategies of combining the strengths of the various substantive frames without sacrificing the core values of adolescent health.

Ultimately, the frames that animate the SDGs, Global Strategy, and AA-HA! generate a series of puzzles, yet can be considered complementary, and provide theoretical tools for better understanding of the power of ideas in shaping the trajectory of global and national politics. However, an integrated ideational policy discourse, as we have noted, also requires a critical appreciation of the dialectic value of individual frames.

CONCLUSION

The aim of this article has been to advance understanding on why some policies yield better outcomes and initiatives than others with similar goals. Drawing on Ghana's experience with two significant adolescent reproductive health initiatives (i.e., ADHD and GHARH programmes), we examine why these interventions produced very different outcomes. In contrast to the ADHD initiative, we argue that the advantage of shifts in global thinking about adolescent health, coupled with innovative strategies, helped Palladium structure the GHARH programme in ways that contributed to implementation success. In view of the collaborative nature of the GHARH project, it seems the specific elements and structure of partnership arrangements have implications for policy implementation.

As we have argued, frames hold significant currency in terms of reconstructing policy problems, but could also translate as rhetorical instruments that hold empty promise. Therefore, the need to consider the various dimensions of the policy frame, as well as the nature of the contextual environment, and how they may facilitate or constrain social change cannot be overemphasized. Importantly, the analysis draws our attention to the inextricable link between ideas and policymaking outcomes, and the need to appreciate policy implementation as a matter of framing and discursive strategy.

In the context of institutional constraints and ongoing debates about the complex challenges of adolescent health, we suggest that an integrated ideational policy discourse is relevant for movement towards transformative health service delivery in a lower middle-income country (LMIC) context. Against this backdrop, government ownership and commitment to adolescent health initiatives cannot be overemphasized. We argue that while the ADHD and GHARH programmes offer useful comparative insights into the dynamics of policy framing, it is also the case that such a comparison encourages thinking

beyond agenda setting to include elements of policy implementation, as well as policy sustainability.

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