Adolescent-Responsive Contraceptive Services

Institutionalizing adolescent-responsive elements to expand access and choice

APPENDIX

This table highlights how select HIPs have been made more adolescent-responsive. While these do not illustrate a full systems approach to adolescent-responsive contraceptive services as described in the accompanying HIP enhancement brief, they can be considered a starting point.

Table 1: Illustrative examples of how ARCS elements can enhance HIPs

HIGH-IMPACT PRACTICE	ADAPTATIONS FOR ADOLESCENTS	OUTCOME
Immediate Postpartum Family Planning (IPPFP) *Proactively offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility [1].*	Kenya [2]: • Providers trained to offer contraceptive counseling and services to adolescents during antenatal care and before discharge. • Quality improvement introduced to address systemic barriers.	27% (N=94) of adolescent mothers who received IPPFP began a contraceptive method compared to 4% (N=7) of adolescent mothers who received standard care [2].
Postabortion Family Planning *Proactively offer voluntary contraceptive counseling and services at the same time and location where women receive facility-based postabortion care (PAC) [3].*	Ethiopia [4]: • Providers trained to offer adolescent clients postabortion contraceptive counseling and a full range of methods, including LARCs.	In intervention facilities, 38% (n= 4,472) of PAC clients under age 25 left with a LARC compared with 25% (n=7,267) in control facilities [4].
Family planning and immunization integration *Proactively offer family planning information and services to women in the extended postpartum period during routine child immunization contacts [5].*	Malawi [6]: • Contraceptive information and methods offered to adolescent mothers during routine child immunizations. • Forms revised to collect age-disaggregated service data.	From the end of 2018 through January 2020, 8% (N=2,555) of immunization clients reached with contraception were under age 18, and 49% were aged 19-25 [6]. This example demonstrates that integrating FP into immunization services has the potential to reach adolescent mothers who want to space but may be reluctant to seek stand-alone contraceptive services. It is a step in the right direction to respond to the needs of adolescent mothers, who are less likely to seek PPFP services compared to all women of reproductive age [7].

HIGH-IMPACT PRACTICE	ADAPTATIONS FOR ADOLESCENTS	OUTCOME
Social franchising *Organize private providers into branded, quality-assured networks to increase access to provider-dependent contraceptive methods and related services [8].*	Madagascar [9, 10]: • Social franchise providers trained to offer SRH services to low-income youth • Vouchers for free services to offset financial barriers • Targeted demand generation.	More than 1.4 million youth received SRH services (including contraception) between 2001 – 2018 [9-11], and an evaluation showed an increase in young family planning clients after training. This example illustrates how social franchises can serve as a platform to integrate *adolescent-friendly* elements (including competency-based provider training, vouchers and linking to demand generation) to better respond to the needs of adolescents. The positive trends in Madagascar were not sustained after the voucher scheme and demand generation activities ended [10], thus reinforcing that provider training alone is insufficient to establish ARCS.
Community Health Workers (CHWs) *Integrate trained, equipped, and supported CHWs into the health system [12].*	Niger [13]: • *Relais* (volunteer CHWs) trained to counsel and refer married adolescents for contraception during household visits.	Contraceptive use increased by 22% after one year among married adolescents reached by trained *relais* as compared to the control [13].
Mobile outreach services *Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods [14].*	Senegal [15]: • ***Community partnerships*** developed, including with youth associations. • Mobile services provided at schools, and other locations frequented by adolescents. • Providers trained on respectful care for adolescents. • Age- and sex-disaggregated data collected and used in service delivery planning and management.	The adolescent-responsive model saw more adolescent clients when compared to the standard outreach model (53%, N= 1121 vs. 24%, N=829 in 2019) [15].

HIGH-IMPACT PRACTICE	ADAPTATIONS FOR ADOLESCENTS	OUTCOME
Drug shops and pharmacies *Train and support drug-shop and pharmacy staff to provide a wider variety of family planning methods and information to adolescents [16].*	Studies including one from Kenya [17] show that pharmacies are often an appealing source of contraceptive methods for adolescents because: • They are located where adolescents live, work, and spend time. • They are open at convenient times for adolescents and services are offered quickly. • They offer relative privacy compared to public health facilities.	Among male and female adolescents and youth aged 18 - 24 who were sexually active and used modern contraception at last sex, 59% (n=154) surveyed obtained their method from a pharmacy, with young women slightly more likely than men to obtain their method at a pharmacy [17].

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