

Adolescent Services

What is the program enhancement that can intensify the impact of high-impact practices in family planning?

Incorporate adolescent-friendly service delivery elements into existing contraceptive and health services.

Background

Most women around the world begin sexual relationships between the ages of 15 and 19 and face significant challenges in obtaining services and information to protect themselves from unwanted pregnancy and sexually transmitted infections, including HIV (Bankole and Singh, 2003; UNFPA, 2014; Wellings et al., 2006). As the world's population of 15- to 19-year-olds continues to grow beyond 600 million, countries will need to meet increasing demand for contraceptive services and information that address their specific needs (UNDP, 2015).

Historically, programs have supported either stand-alone adolescent clinics that offer contraceptive services, or adolescent-friendly contraceptive services offered in a separate room or in an “adolescent corner” within an existing health facility (Senderowitz, 1999). These programs demonstrate mixed effects (Denno et al., 2015; Tylee et al., 2007). Additionally, scale-up has been challenging for many countries due to complexity of the programs, and resource requirements threaten their long-term sustainability (Hainsworth et al., 2014).

To inform the next generation of programs, experts in adolescent sexual and reproductive health were asked to propose a streamlined approach, based on learning to date, that would be both scalable and sustainable. Mainstreamed Adolescent-Friendly Contraceptive Services (AFCS) incorporate within existing contraceptive services those adolescent-friendly elements that have demonstrated effectiveness in stand-alone or separate-space models. These elements can be incorporated into a range of service delivery channels (i.e., facilities, mobile outreach, community-based



© 2013 Arturo Sanabria, Courtesy of Photoshare

Adolescents' Right to Health, Including Contraceptive Information and Services

According to the UN Convention of the Rights of the Child, adolescents enjoy the right to the highest attainable standard of health, including access to contraception information and services. Adolescents are also included in broader reproductive rights supported by a range of human rights treaties and conventions, which nearly all countries have ratified (Cook and Dickens, 2000; UNFPA, 2012; UN General Assembly, 1990).

distribution, pharmacies, or drug shops). Drawing from a variety of literature reviews, a number of common program elements were identified that can increase contraceptive use among adolescents (Bankole and Malarcher, 2010; Senderowitz, 1999).

Common **service delivery** elements include:

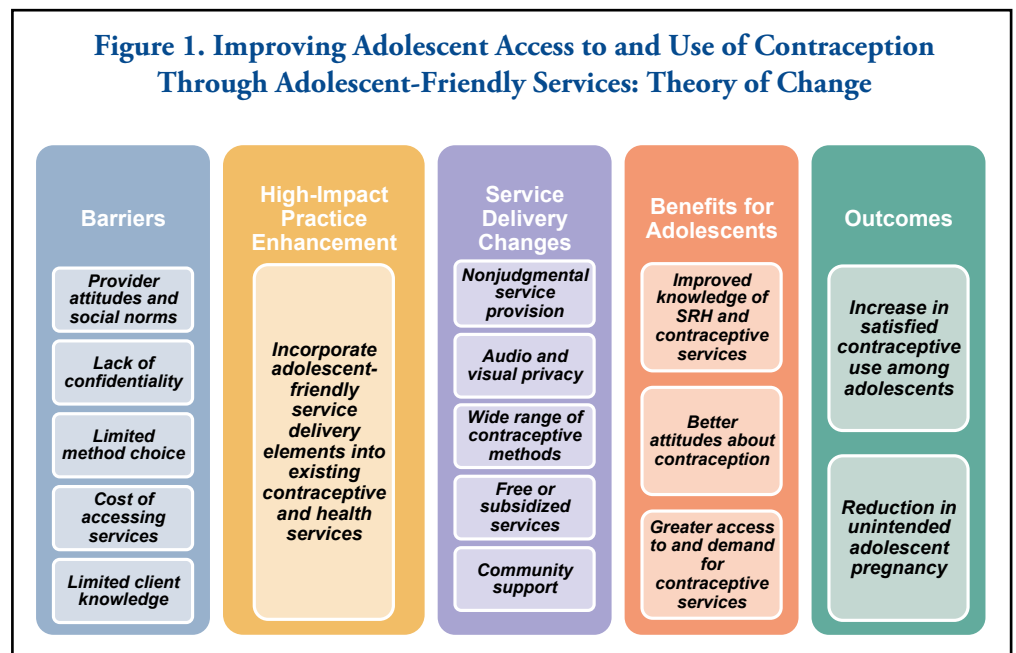
- **Training** and supporting providers to offer nonjudgmental services to adolescents
- Enforcing **confidentiality** and ensuring audio and visual **privacy**
- Offering a **wide range of contraceptive methods**
- Providing **free or subsidized** services

Investments that contribute to building an **enabling environment** for adolescent programming often include: ensuring **legal rights, policies, and guidelines** that respect, protect, and fulfill adolescents’ human rights to contraceptive information, products, and services regardless of age, sex, marital status, or parity; addressing norms and fostering **support among communities** and parents for adolescents to access contraceptive information and services; and addressing **gender norms**.

Taken together, these seven elements of adolescent-friendly contraceptive services, encompassing service delivery and enabling environment aspects, need to be considered to increase adolescent uptake of contraception. Based on experience from implementing stand-alone and separate-space AFCS, streamlining these elements into existing contraceptive services has the potential to be both cost-effective and scalable, expanding the reach of existing programs and improving access to high-quality contraceptive services for adolescents (see Figure 1).

This brief focuses on the elements of AFCS that are typically implemented within a service delivery setting. It describes how mainstreaming AFCS can address key challenges for contraceptive programs, discusses the existing evidence of adolescent-friendly elements, outlines key issues for planning and implementation, and identifies knowledge gaps. This brief does not fully cover elements that contribute to the enabling environment for adolescent programming, which are addressed more completely in other High-Impact Practice (HIP) briefs, such as the briefs on [health communication](#) and [policy](#).

AFCS has been identified as an **enhancement** to high-impact practices in family planning by the HIP technical advisory group. An “enhancement” is a practice that can be implemented in conjunction with HIPs to further intensify the impact of the HIPs. While there are some initial experiences implementing mainstreamed AFCS, more research and documentation is needed to better understand the potential and limitations of this approach. For more information about HIPs, see <https://www.fphighimpact-practices.org/overview>.



Which challenges can AFCS help countries address?

Studies consistently show that sexually active adolescents (married or unmarried) face many barriers to obtaining contraceptive services and products to prevent pregnancy—whether to delay, space, or limit pregnancy (Abdul-Rahman et al., 2011; Bankole and Malarcher, 2010; Biddlecom et al., 2007; Chandra-Mouli et al., 2014; Decker and Constantine, 2011; Glinski et al., 2014; Godia et al., 2014; Sidze et al., 2014; Tylee et al., 2007). Addressing these barriers within programs and policies is likely to improve the quality of services for all people who need contraception and is of particular importance to adolescents. These barriers are well documented and include:

Provider biases. Providers who believe that adolescents should not be sexually active or that contraception may inhibit future fertility may refuse to serve young people, or they may restrict access to certain contraceptive methods (Warenius et al., 2006; Wood and Jewkes, 2006). For example, in one survey in India, a third of doctors, more than half of nurses, and more than two-fifths of midwives stated they would deny oral contraceptives based on age, and nearly half of doctors said they would deny injectables based on age (Calhoun et al., 2013). In Ethiopia, nearly half of surveyed providers reported negative attitudes about providing contraception to unmarried adolescents (Tilahun et al., 2012).

Lack of confidentiality and privacy. Studies with adolescents from a range of countries including Mongolia, Vanuatu, and Zimbabwe indicate that confidentiality and privacy are very important concerns with accessing contraceptive services (Erulkar et al., 2005; Kennedy et al., 2013; Sovd et al., 2006). In Malawi, in a national representative sample of sexually active adolescents aged 12 to 19, more than 20% of females and 10% of males stated their privacy was not respected, which they perceived as a barrier to accessing services (Biddlecom et al., 2007).

Few contraceptive options. Adolescent programs often focus on provision of barrier methods (mostly condoms) and other short-acting contraceptives. Long-acting reversible contraceptives (LARCs) are often not presented as options for adolescents (Eke and Alabi-Isama, 2011). This restriction is usually due to provider bias or lack of awareness that age and parity are not contraindications for any method, according to the World Health Organization's medical eligibility criteria for contraceptive use (WHO, 2015). Users of short-acting methods, particularly adolescents aged 15 to 19, are more prone to contraceptive failure than users of LARCs (Blanc et al., 2009).

Financial barriers. Adolescents are unlikely to have control over financial resources to pay for transportation and service fees to access services (Michaels-Igbokwe et al., 2014). Studies with youth ages 15 to 24 in many low- and middle-income countries, such as Brazil, China, India, Kenya, Nigeria, and Uganda, found that cost is a barrier for accessing contraceptive, reproductive health, or health services (Bankole & Malarcher, 2010; Santhya et al., 2014; Warner et al., 2013). A survey of youth of the same age group in Myanmar found that fewer than one in five could afford reproductive health services (Thin Zaw et al., 2012).

Legal and policy barriers. A number of studies document legal and policy-related barriers including laws that do not allow contraception for adolescents and lack of knowledge among providers and adolescents themselves of the legal rights of adolescents to obtain contraception (Apland, 2014; Cook & Dickens, 2000; IPPF, 2014; Jaruseviciene, et al., 2006; Jaruseviciene et al., 2014; Levy et al. 2001; UNESCO et al., 2013). For example, in a study in Uganda, 38% of public and private providers stated that they required a consent form either from a parent, a spouse, or both for clients under 18 years of age requesting contraceptives (Nalwadda et al., 2011).

Gender norms. Gender norms that idealize sexual ignorance for girls and sexual prowess for boys are found globally and can impede young people's access to information and services and their ability to negotiate sexual relationships (Gay et al., 2012; Santhya & Jejeebhoy, 2015). Providers often reinforce these inequitable gender norms by refusing to provide unmarried adolescent girls with contraception even when requested (Chandra-Mouli et al., 2014). Married adolescent girls often face different gender-related barriers due to their social isolation, lack of power, limited mobility, and pressures to prove fertility by becoming pregnant early and often (Adams et al., 2013; Greene et al., 2014; Singh et al., 2014). As a way of upholding these social and gender norms, providers may not provide contraception to married adolescent girls or restrict long-acting methods until they have had a child (Greene et al., 2014; Speizer et al., 2000). Young men are expected to be knowledgeable about sex, making it difficult for them to seek information, and they may also face structural barriers to accessing services, which are typically targeted to women (Barker et al., 2007; Kuene et al., 2004; UNFPA, 2000).

Failure to address issues such as women's lower social status, economic dependence and limited agency, transactional sex as an important economic resource for young girls, and social norms of masculinity was identified as one reason a large service delivery improvement effort in Tanzania failed to demonstrate an impact on contraceptive use among young people (Doyle et al., 2011; Wight et al., 2012).

What is the impact?

Of six studies that assessed contraceptive use among adolescents post-AFCS intervention compared with a similar unexposed or control group, five found a statistically significant increase in contraceptive use among females exposed to or in the intervention group compared with females in the unexposed or control group (see Table 1). All these programs targeted both males and females, including individuals aged 15 to 19. While all programs included some AFCS elements discussed in this brief, only some included all of them. (In some countries, there may not have been a need to address all seven AFCS elements, for example, if certain elements were already in place.) The one study that did not find a statistically significant increase was in Nicaragua among a generalized population of voucher receivers. However, when the Nicaragua study population was disaggregated, findings indicated that voucher receivers in the school-based intervention group were more than twice as likely to report contraceptive use as school-based non-voucher receivers (Meuwissen et al., 2006). Of the five studies that reported male contraceptive use separately, only the program in China showed a significant increase in male contraceptive use (Lou et al., 2004).

In addition to programs included in Table 1, evidence from India, Mozambique, Tanzania, and Zimbabwe demonstrates a positive effect of AFCS programming on adolescent contraceptive use (Chandra-Mouli et al., 2015; Chandra-Mouli et al., 2013; Kanesathasan et al., 2008; Kim et al., 2001). Findings from these studies are consistent with other literature reviews, which conclude that effective adolescent programs usually involve investments in service delivery and enabling environment elements (Denno et al., 2015; Ehlers, 2003; Gottschalk & Ortalyi, 2014; Hainsworth et al., 2014; Hindin & Fatusi, 2014; Kesterton & de Mello, 2010; Williamson et al., 2009).

Many of the study reports included little or no detail on the degree of implementation or on intermediate results. Therefore, it is unclear which elements specifically contributed to observed increases in contraceptive use. It is also important to note that half of the studies included in Table 1 were implemented at small scale and in most cases were not sustained.

Table 1. Results From Selected Programs Implementing a Variety of AFCS Elements

Country, Setting, Target Population (Reference)		Modern Contraceptive Use Post-Intervention	
		Unexposed/Control	Exposed/Experimental
China peri-urban, unmarried, sexually active females and males ages 15–24 (Lou et al., 2004)	Females	48%	90%**
	Males	42% ¹	88%** ¹
Ethiopia rural, married females and males ages 12–24 (Erulkar & Tamrat, 2014)	Females	57% ²	69% ³ 71% ⁴
	Males	NA ⁵	NA ⁵
Ghana married and unmarried females and males ages 10–24 (Williams et al., 2007) ⁵	Females	42% ⁶	49%* ⁶
	Males	NSS ⁶	NSS ⁶
Nicaragua urban, males and females ages 12–20 (Meuwissen et al., 2006)	No difference observed in contraceptive use between voucher receivers and non-receivers		
Tanzania married and unmarried females and males, ages 10–24 (Williams et al., 2007) ⁵	Females	39% ⁶	64%* ⁶
	Males	NSS ⁶	NSS ⁶
Uganda married and unmarried females and males, ages 10–24 (Williams et al., 2007) ⁵	Females	42% ⁶	59%* ⁶
	Males	NSS ⁶	NSS ⁶

*Reported as statistically significant with no p value.

** p < .001.

NSS = not statistically significant.

¹ Uses contraception regularly.

² Ever use of contraception.

³ Ever use of contraception among the wives-only intervention group.

⁴ Ever use of contraception among the couples intervention group.

⁵ Although the program targeted both females and males, contraceptive use was reported for females only.

⁶ Modern contraceptive use at last sex, reported for married or recently married 17- to 22-year-olds.

Interventions with insufficient evidence of impact on adolescent’s contraceptive use:

- **Youth clubs** and **youth centers** that provide contraceptive services may not be cost-effective and do not reach the intended target groups (Chandra-Mouli et al., 2015b; Denno et al., 2015; Zuurmond et al., 2012).
- Benefits of **peer educator** programs are typically limited to those trained as peer educators (Chandra-Mouli et al., 2015b; Harden et al., 2001; Kim & Free, 2008; Tolli, 2012).

How to do it: Tips from implementation experience

Conduct a needs assessment to identify the most effective approaches to reaching sexually active adolescents with contraceptive services. Formative research and monitoring data should be disaggregated to identify specific needs and preferences of different adolescent groups. Take into account where adolescents currently go to access contraceptive commodities and services and who has unmet need. Sub-populations may demonstrate preferences for specific channels, such as the public or private sector, clinics, or pharmacies.

Use multiple service modalities to reach a wider range of adolescents. Such approaches can include static facilities (both public and private), community-based distribution, mobile outreach services, pharmacies and drug shops, informal settings, schools, or workplace-based services.

Train providers to offer adolescent-friendly services. Include AFCS elements into pre-service training for providers. This inclusion can reduce the need for in-service training while ensuring recent graduates have basic competencies in adolescent health and contraceptive service delivery. While training is a core and necessary element in effective AFCS programs, it is not sufficient on its own to change provider behavior (Denno et al., 2015). Training should include providing nonjudgmental information and services; accurate information on medical eligibility criteria for adolescent contraceptive use; legal policies and rights of adolescents to services and information; values clarification on adolescent sexuality; and skills on how to communicate with adolescent clients.

Use a whole-clinic approach to training on AFCS. This approach will help ensure adolescent-friendly care is not invested in only one provider and that adolescents do not experience resistance from support staff, such as an intake nurse or pharmacist.

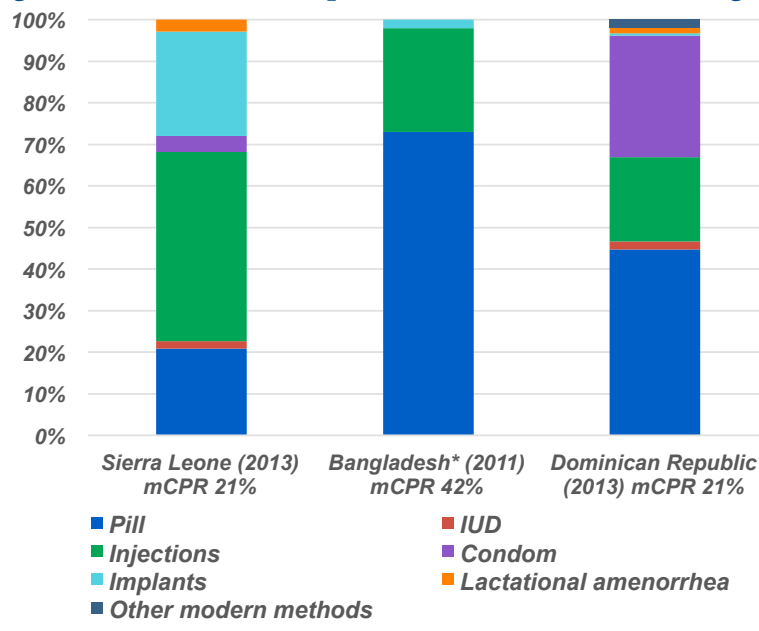
Reinforce training through supportive supervision, job aids, and mentorship to change provider attitudes and behaviors. Supportive supervision tools and provider job aids can be helpful to enforce rights-based programming.

Enforce confidentiality and ensure audio and visual privacy. Take various steps to increase client confidentiality such as: safe storage of client records, nondisclosure of adolescents' health information without their permission; minimizing nonessential interruptions by other facility staff or clients during service provision; and reinforcing the importance of client confidentiality as part of AFCS training. Various measures can be taken to help maintain audio and visual privacy, such as using a private counseling room, using consultation rooms with doors and window curtains, partitioning the waiting areas so that adolescent clients do not have to mix with adult clients, and not conducting history taking and screening in public.

Tailor health communication to the needs and interests of adolescents. Consider where and from whom adolescents get information on sexual and reproductive health. Engage young people in developing messaging and in identifying appropriate channels for communication. (See also the [Health Communication](#) and [Digital Health](#) HIP briefs).

Offer a full range of contraceptive options. Figure 2 shows method mix among 15- to 19-year-old females in Bangladesh, the Dominican Republic, and Sierra Leone. Modern contraceptive use among adolescents in these three countries ranges from 21% to 42%. The data illustrate that adolescents will use a variety of methods, including highly effective LARCs when offered a full range of contraceptive methods (AAP, 2014; Committee on Adolescent Health Care, 2012; WHO, 2015).

Figure 2. Modern Contraceptive Method Mix for Females Aged 15-19



*Bangladesh data are among married women only. Data Source: STATcompiler (www.statcompiler.com/).

Provide no-cost or subsidized services. All programs should have some means to provide services and contraceptives free or at highly subsidized rates. Programs have used a variety of approaches to accomplish this including subsidized services as part of a social franchise model, social marketing, or vouchers, or as part of a cost-recovery scheme (Denno et al., 2015). Programs that intend to reach adolescents should develop targeted marketing and distribution strategies for this population.

Provide an enabling environment by ensuring legal rights and supportive policies related to provision of contraceptive services for adolescents. Clear guidelines that support health professionals to provide services and information to adolescents are critical for expanding adolescents' access to services. For legal rights and adolescent-related health policies to be operationalized at the service delivery level, the facility should have copies of relevant service delivery policies and standards (e.g., adolescent-friendly service provision standards where they exist) and providers should be well oriented on their use as part of AFCS training or staff updates. In addition, supervision checklists should reflect key provisions of these policies, and supervisors should reinforce their application during supervision visits (Greifinger & Ramsey, 2014; Senderowitz et al., 2002).

Link service delivery improvements with activities that build support within communities. Interventions directed at influencing the sexual and reproductive health behaviors of adolescents are significantly enhanced where there are complementary interventions for parents, providers, religious leaders, and other influential adults who can foster a supportive environment in health facilities, schools, religious places of worship, and in homes (Futures Group International, 2005; Gottschalk & Ortayli, 2014; Kesterton & de Mello, 2010). Effective sexuality education guidelines (UNESCO, 2009a; UNESCO, 2009b) can ensure adequate knowledge by adolescents to access services (Todesco & Gay, forthcoming 2015).

Pay attention to gender and social norms to ensure successful investments in AFCS. Adolescent girls will access contraception in settings where gender norms have been transformed to allow girls to know about sexual and reproductive health and to feel empowered to access services (McCleary-Sills et al., 2012). Adolescent boys will access contraception in settings where boys feel some sense of responsibility to plan pregnancies (Barker et al., 2010).

Priority Research Questions:

1. Does mainstreaming AFCS increase contraceptive uptake among the intended population of adolescents?
2. What is the cost-benefit of mainstreaming AFCS?
3. Can effective mainstreamed AFCS be scaled-up and sustained?

Tools and Resources

Thinking Outside the Separate Space: A Decision-Making Tool for Designing Youth-Friendly Services helps program designers select and adapt appropriate youth-friendly service delivery models. Available from: <http://www.e2aproject.org/publications-tools/pdfs/thinking-outside-the-separate-space-yfs-tool.pdf>

Making Health Services Adolescent-Friendly: Developing National Quality Standards for Adolescent Friendly Health Services provides step-by-step guidance on developing quality standards for providing health services to adolescents. Available from: http://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/

Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators presents a framework that links community involvement interventions to desired adolescent health outcomes. Available from: <http://www.unfpa.org/resources/community-pathways-improved-adolescent-sexual-and-reproductive-health>

Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients contains a user guide, eight instruments, and a framework for analyzing and reporting on data collected to analyze the quality of adolescent health services. Available from: http://www.who.int/maternal_child_adolescent/documents/fch_cah_9789241598859/en/

References

A complete list of references used in the preparation of this brief can be found at:

<https://www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/>

For more information about HIPs, please contact the HIP team at fphip@k4health.org.

Suggested citation:

High-Impact Practices in Family Planning (HIPs). Adolescent-friendly contraceptive services: mainstreaming adolescent-friendly elements into existing contraceptive services. Washington (DC): USAID; 2015. Available from: <https://www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/>

Acknowledgments: This document was written by Jill Gay, Gwyn Hainsworth, Karen Hardee, and Shawn Malarcher. Critical review and helpful comments were provided by Michal Avni, Regina Benevides, Doortje Braeken, Jimmie Braley, Kimberly Cole, Maureen Corbett, Liz Creel, Laurette Cucuzza, Jen Drake, Ellen Eiseman, Sarah Fox, Kate Gilles, Rena Greifinger, Jim Griffin, Rachel Hampshire, Ann Hirschey, Laura Hoemeke, Laura Hurley, June Hutchings, Roy Jacobstein, Niranjala Kanesathasan, Rebecca Kohler, Joan Kraft, Cate Lane, Pauline Lee, Judy Manning, Erin Mielke, Stembile Mugore, Danielle Murphy, Constance Newman, Rachel Okun-Kozlowicki, Tanvi Pandit-Rajani, Leslie Patykewich, Anne Pitzer, Jen Pope, Shannon Pryor, James Shelton, Tabitha Sripipatana, Sara Stratton, Julie Taft, Caitlin Thistle, Mary Vandenbroucke, Gracey Vaughn, Chandra-Mouli Venkatraman, Defa Wane, Kelsey Wright, and Sylvia Wong.

This HIP brief is endorsed by: Abt Associates, Bill & Melinda Gates Foundation, CARE, Chemonics International, EngenderHealth, FHI 360, Georgetown University/Institute for Reproductive Health, International Planned Parenthood Federation, IntraHealth International, Jhpiego, John Snow, Inc., Johns Hopkins Center for Communication Programs, Management Sciences for Health, Marie Stopes International, Palladium, PATH, Pathfinder International, Planned Parenthood Global, Population Council, Population Reference Bureau, Population Services International, Public Health Institute, Save the Children, U.S. Agency for International Development, and University Research Co., LLC.

The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of HIP briefs, which are viewed as summaries of evidence and field experience. It is intended that these briefs be used in conjunction with WHO Family Planning Tools and Guidelines: http://www.who.int/topics/family_planning/en/.