

This document is intended to lead program managers, planners, and decision-makers through a strategic process to identify the most effective and efficient investments for improving the sexual and reproductive health of young people. It was developed as part of a review and technical consultation on adolescent sexual and reproductive health and reflects the deliberation of experts.*

Throughout the steps below, *programmatic responses should address the diversity of adolescents and their needs. Monitoring data should be disaggregated into meaningful categories such as age, marital status, and other key characteristics that are relevant to the context to ensure program beneficiaries are the intended recipients.*

Step 1: Know your adolescents.

Adolescence is a time of many changes, from physiological and biological changes to social, psychological, and developmental changes, and a time when most young people begin exploring sexuality and relationships.

Consequently, an individual's need for sexual and reproductive health information, education, and services can change rapidly during adolescence.

In order to ensure programming best meets the needs of young people, consider the following questions:

- Which adolescents are having sex?
- What percentage of young people begin having sex at age 14, 15, 16, etc.?
- Are young people having sex within the context of marriage or not?
- What is the level of coerced sex among this group?



Unmarried girls, ages 15 to 19, attend a Pathfinder International training about adolescent sexual and reproductive health. © 2017 Paula Bronstein/Getty Images/Images of Empowerment

Step 2: Understand the underlying drivers of adolescent pregnancy.

Decision-makers often assume that the vast majority of adolescent pregnancies are unintended. While unintended pregnancy is a serious issue among adolescents, decision-makers may underestimate the social pressures and other complexities that often lead girls to seek motherhood as a way to prove fertility and establish an accepted role in society.

In contexts where rates of wanted fertility are high, consider structural interventions that invest in adolescent girls' and young women's education and human capital and that provide alternatives to marriage and

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motherhood. Evidence-based interventions include conditional and unconditional cash transfer programs that support keeping girls in school and investments that promote young women's economic empowerment. (See HIP brief on [Educating Girls](#) and the Evidence Summary on [Economic Empowerment](#).)

Step 3: Create a supportive environment.

Young people often face social and cultural norms that actively discourage access to sexual and reproductive health services and information. Ensure policies are in place and are enforced to facilitate access to services and information for all young people and to avoid restricting access based on non-medical attributes such as marital status, parity, or age. Work with community leaders, schools, and families to reduce stigma around adolescent sexuality and to promote supportive attitudes about sexual and reproductive health care-seeking behavior among adolescents.

Invest in gender transformative activities that promote respectful relationships, empower young women to protect themselves, and teach young men to be supportive partners. Support efforts to improve communication between parents and adolescents, especially very young adolescents (10–14 years old) before they become sexually active.

Step 4: Reach young people with information.

All young people need access to comprehensive sexual and reproductive health information. Where participation in formal education is nearly universal, especially at upper primary and secondary school levels, and school systems are strong, school-based comprehensive sexuality education can serve as a useful platform for providing accurate information, dispelling myths, imparting life skills, and linking and referring adolescents to services.

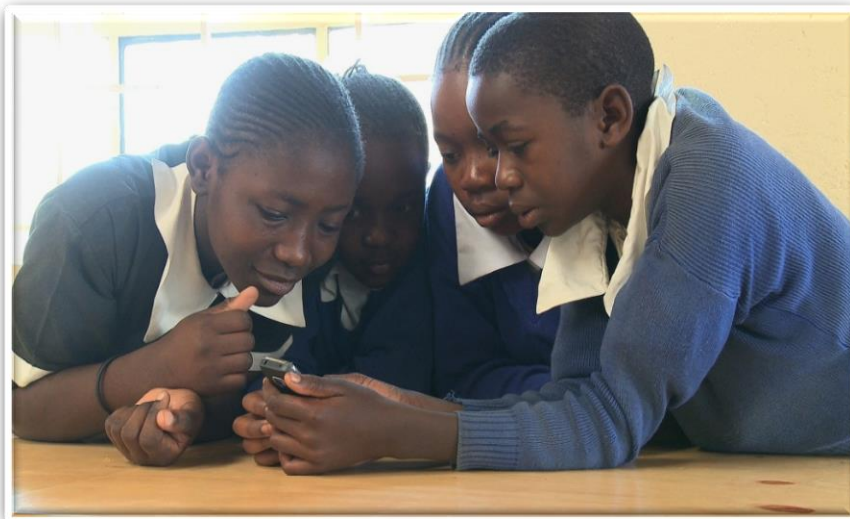


Photo: USAID

In many settings, young people, especially girls, are not in school. These young people may be reached through mass media, comprehensive health communication campaigns, or community outreach campaigns. As more young people become digitally connected, mHealth applications offer another channel to reach young people through text messaging or other social media platforms. (See HIP brief on [mHealth](#).)

Some adolescents, such as those who are married or who live in extreme poverty, may be socially isolated and lack access to mass media. These individuals may be better served through community-led social behavior change communication. (See HIP brief on [Community Group Engagement](#).)

Step 5: Reach sexually active young people with contraceptive services.

Seven elements of adolescent-friendly service delivery and enabling environment need to be considered to increase adolescent uptake of contraception. 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. **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**, and
- 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**.

Before investing in adolescent-friendly contraceptive services (AFCS), consider **where young people currently go** to access contraceptive commodities and services. Disaggregate adolescent populations to identify preferences. Some groups may prefer specific channels, such as the public or private sector, clinics, or pharmacies.

Clinic-Based Services: AFCS can be offered as part of any health service. Incorporating the principles of AFCS into **postabortion care**, HIV screening, treatment, and care services, antenatal and postnatal care, and **immunization services** (which may be used by young mothers) is likely to increase coverage and contraceptive uptake among adolescents in places where these services are frequented by adolescents. (See HIP brief on *Adolescent-Friendly Contraceptive Services*.)



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Alternative Channels of Service Delivery: Consider expanding high-quality contraceptive provision beyond clinics through **drug shops and pharmacies** or informal settings. In areas where young women's mobility is restricted, consider supporting community-based family planning distribution by **community health workers (CHWs)** or community-based distribution agents who are acceptable to adolescents. **Mobile outreach services** can expand access to a wider range of methods that may not be available in remote settings.

Step 6: Reduce financial barriers to contraceptive services.

Young people often have limited power over financial decisions and resources. Therefore, all programs should have some means for young people to access services and contraceptives free or at highly subsidized rates.

Social marketing can provide highly subsidized products through a wide range of outlets and distributors. Socially marketed programs that intend to reach adolescents should develop targeted marketing and distribution strategies for this population.

Vouchers may also reduce financial barriers to services and expand contraceptive options, including access to long-acting reversible contraceptives, although the evidence of these programs is limited. Contraceptive vouchers also expand access to the private sector, which may be preferred by adolescents, particularly among unmarried girls and where community norms do not accept sexual activity among young people.

Interventions with insufficient evidence of impact on adolescents' contraceptive use:

- **Youth clubs** and **youth centers** that provide contraceptive services may not be cost-effective and do not reach the intended target groups.[†]
- Benefits of **peer-education** programs are typically limited to those trained as peer educators.

For more information on HIP briefs and on the work of the HIP partnership, please refer to the *High Impact Practices in Family Planning* website at www.fphighimpactpractices.org or contact the team at fhip@k4health.org.

The HIP partnership develops briefs that synthesize the evidence and provide experiential learning on how to implement selected HIPs. High Impact Practices are endorsed by:

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[†] Chandra-Mouli V, Lane C, Wong S. What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. *Glob Health Sci Pract.* 2015;3(3):333-340. Available from: <http://dx.doi.org/10.9745/GHSP-D-15-00126>