

What is the program enhancement that can intensify the impact of High Impact Practices in Family Planning?

Apply a **systems approach**ⁱ to make existing contraceptive services *adolescent-responsive*, i.e. responsive to the needs and preferences of adolescents.

Background

Adolescence, defined by the World Health Organization (WHO) as ages 10 to 19, is a time of tremendous physical, cognitive, and social change [1] and when many people initiate sexual activity [2]. Adolescents need a range of supports to remain well, to transition safely into adulthood, and to adopt lifelong healthy behaviors; a key support is access to contraceptive information and services [3, 4]. However, many countries continue to invest in interventions that are ineffective at increasing contraceptive use (e.g., youth centers), demonstrate mixed effects (e.g., peer education), or are challenging to sustain and bring to scale (e.g., separate spaces for young people within health facilities) [5-9]. This contributes to poor sexual and reproductive health outcomes. For example, about half of all pregnancies among adolescent females (15–19 years) in developing regions being unintended [10]. With 1.25 billion adolescents, increasing to 1.35 billion in 2050 [11], and countries striving to achieve universal health coverage [1, 12], health systems must go beyond piecemeal approaches to institutionalize service delivery that acknowledges adolescents as distinct from other age groups and addresses the barriers that limit adolescents' access to and use of contraception (Figure 1) [13-24].

i A systems approach refers to incorporating evidence-based elements throughout all components of the health system, rather than implementing isolated interventions. For example, an adolescent-responsive systems approach would include job descriptions, core competencies for providing technically sound nonjudgmental and confidential services to adolescents in pre-service and in-service training, and performance reviews, rather than solely running trainings with service providers.

Figure 1: Barriers to access and use of contraceptive services for adolescents



LAWS AND POLICIES

Laws often police adolescent sexuality and policies can prevent provision of contraception to unmarried adolescents or to those under a certain age.



GENDER AND SOCIAL NORMS

Social and gender norms that stigmatize unmarried adolescent sexuality, legitimize coercive sex, pressure married girls to prove their fertility, and limit girls' mobility and agency can hinder adolescents from seeking services.



MISCONCEPTIONS AND LACK OF KNOWLEDGE

Adolescents may be less informed about their bodies, contraception, and different methods than adults, and hold misconceptions about contraceptives and their effect on fertility or pleasure, which limit contraceptive use.



FINANCIAL BARRIERS

Adolescents often have fewer financial resources than adults, which can reduce access to contraception, especially in settings where contraception is not subsidized or free.



LACK OF PRIVACY AND CONFIDENTIALITY

Facilities may not be equipped or services delivered in a way that ensures privacy and confidentiality—a key concern of adolescents.



PROVIDER BIAS

Due to personal beliefs, social norms and structural factors, providers may refuse to serve adolescents, restrict their access to certain methods, or treat them in a judgemental manner that deters them from seeking services.

There is evidence that adolescent-friendly services, when well-designed and well-implemented, can help increase access to and use of contraception [25]. However, traditional models of specialized service delivery for adolescents have proven difficult to sustain and scale (Box 1). Establishing adolescent-responsive contraceptive services (ARCS) is emerging as a more scalable and sustainable way to meet adolescents' needs for contraceptive information and services. The term *adolescent-responsive contraceptive services* signals an evolution from traditional stand-alone models of adolescent-friendly services towards a *systems approach to making existing contraceptive services adolescent-responsive* by incorporating elements with demonstrated effectiveness for increasing adolescent contraceptive use (Box 2) [4, 7, 12, 25-30]. A systems approach implies that policies, procedures, and programs across the entire health system are adapted to respond to the diverse needs and preferences of adolescents.

Box 1: Separate space models have proven difficult to sustain and scale

In an attempt to respond to adolescents' concerns around stigma, privacy, and confidentiality, many programs and/or countries have implemented adolescent friendly services using separate space models (e.g., offering adolescent friendly services in a separate room within an existing health facility) [8]. However, separate space models have proven difficult to sustain and scale, due to staff and resource shortages and low utilization of available specialized services, among many other constraints [9].

ARCS is an “enhancement to high-impact practices in family planning” as identified by the HIP Technical Advisory Group. An enhancement is a practice that can be implemented in conjunction with HIPs to further intensify their impact. For more information about HIPs, see <https://fphighimpactpractices.org/>. For examples of how HIPs can be enhanced through the inclusion of adolescent-responsive elements, please see the ARCS Appendix document available on the HIPs website noted above. This brief focuses on service delivery aspects of ARCS and does not discuss other investments that support adolescents' use of contraception or that reduce adolescent births, such as girls' education, community engagement, engaging men and boys, or social marketing, which are addressed in other HIP briefs [31-35].

Box 2: A systems-approach to adolescent-responsive contraceptive services

A systems-approach to adolescent-responsive contraceptive services includes the following evidence-informed elements:

WHO HEALTH SYSTEMS BUILDING BLOCKS: Evidence-informed elements for adolescents

Health Information Systems	Service Delivery	Access to essential medicines	Health Workforce	Financing	Leadership/ Governance
Age and sex-disaggregated data available*	Information and services available where and when adolescents can access them; audio and visual privacy ensured; confidentiality ensured; services linked to demand generation	Full contraceptive method mix offered, including emergency contraception and long-acting reversible contraception	Competent providers offer technically sound nonjudgmental and confidential services	Services are free or subsidized	Adolescents involved in service design, implementation and monitoring*

*Although current evidence does not show a direct contribution of these two elements to increased contraceptive use, it does show that they are grounded in good public health practice and are important for adolescent-responsive service delivery [4, 12, 30].

What is the impact?

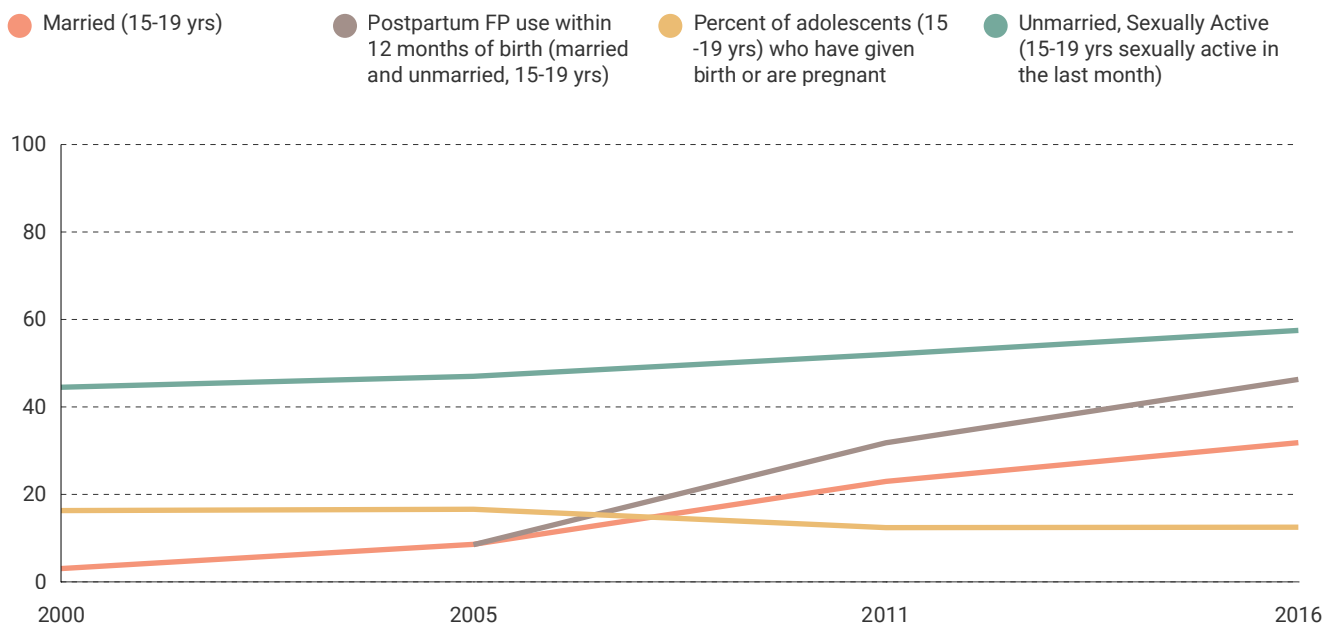
Evidence is accruing that investing in ARCS can improve adolescent contraceptive use [36-39], and Ethiopia and Chile are showing promising results. Specific actions taken by the government of Ethiopia included:

- The development of policies that supported adolescent access to contraceptive information and services, regardless of age, parity, or marital status [40];
- Changing health management information systems (HMIS) to collect age- disaggregated data for key indicators;
- Training and supervising health service providers;
- Using a variety of service delivery models and/or providers (health extension workers) to reach adolescents;
- Offering free contraceptive services;
- Providing a broad range of methods;
- Refurbishing health facilities; and
- Institutionalizing administrative decision making at the local level and linking service provision with community engagement and women’s empowerment activities [41-46].

An adaptive management style and involvement of key stakeholders, including non-governmental organizations (NGOs) and professional associations, facilitated the adoption of these actions and policies [41]. While it is not possible to attribute the relative contribution of these actions to increases in adolescent contraceptive use, Ethiopia has reported consistent increases in contraceptive uptake among all sexually active adolescents and fewer adolescent births (Figure 2) [47-49].

The Chilean government’s 10-year strategy (2011–2020) implemented a five-pronged systems-approach that trained health service providers; created adolescent-friendly spacesⁱⁱ in primary health centers; offered the full method mix; improved outreach and referrals; and created a legal framework that articulated stakeholder responsibilities. A monthly register gathered adolescent-specific data. Human and financial resources were sustained throughout the 10-year period and coordination mechanisms were maintained [41]. Advocacy and publicity highlighted the strategy’s positive outcomes, which helped to alleviate public resistance to providing contraception to adolescents.

Figure 2: Modern contraceptive use among adolescent girls aged 15-19, Ethiopia, by study year, percent



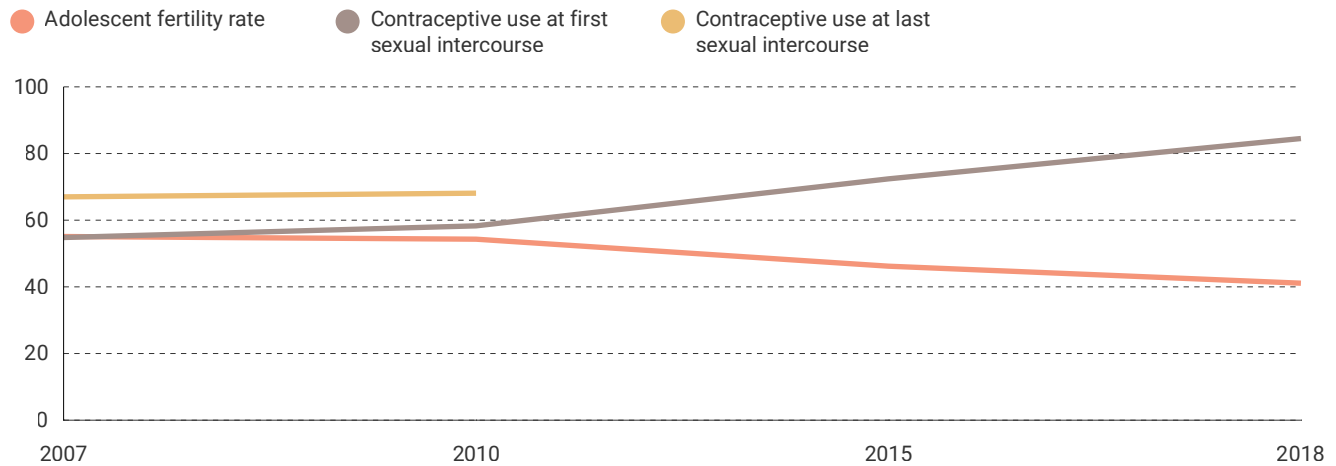
Source: Ethiopia DHS 2005, Ethiopia DHS 2011, Ethiopia DHS 2016)

ii The term adolescent-friendly is used here, as this was the official term used by Chile’s Ministry of Health when referring to these spaces (“espacios amigables para la salud de adolescentes”).

Positive outcomes included a decrease in the birth rate among adolescents aged 15-19:

- From 55.1 births per 1,000 women in 2007 to 41.1 births per 1,000 women in 2018;
- A 51% reduction in the proportion of births to mothers under the age of 19 between 2000-2017; and
- A 30% increase in reported contraceptive use at first sexual intercourse between 2007 and 2018 (Figure 3) [41, 50-53].

Figure 3: Modern contraceptive use among all adolescents aged 15-19, Chile, 2007-2018, percent



Sources: [1]INJUV. Quinta Encuesta Nacional de Juventud. Santiago, Chile: Instituto Nacional de la Juventud; 2007. [2]INJUV. Sexta. Encuesta Nacional de Juventud. Santiago, Chile: Instituto Nacional de la Juventud; 2010. [3]Dides C, Fernández C. (Ed.). Salud Sexual Salud Reproductiva y Derechos Humanos en Chile. Estado de Situación 2016. Santiago de Chile: Corporaci Miles; 2016. [4]INJUV. Novena Encuesta Nacional de Juventud. Santiago, Chile: Instituto Nacional de la Juventud; 2019.

Note: The estimates for contraceptive use at first and last sexual intercourse are for all adolescents and not disaggregated by sex (sex-disaggregated data for this age group was not available in the National Youth Surveys for the respective years).

Other sectors implemented complementary efforts, showcasing the value of including ARCS within multi-sectoral adolescent programming.

Although Ethiopia and Chile have not fully addressed the complete list of elements listed in Box 2, their results illustrate how a systems approach to providing ARCS can contribute to improving contraceptive uptake. When an adolescent-responsive lens is intentionally and systematically applied across the health system, the resulting system is stronger and is better able to sustain quality services at scale (Box 3).

Box 3: Lessons from Chile, Ethiopia, and Uruguay

The Governments of Chile, Ethiopia, and Uruguay have systematically invested in adolescent sexual and reproductive health. Each country developed its own approach to scale up adolescent responsive sexual and reproductive health services, and the following points were commonalities in their efforts [37, 41]:

- Dedicated advocates created momentum for scale-up
- Supportive policies enabled the development and implementation of evidence-informed interventions
- The essential intervention package was simplified to the extent possible to facilitate scale-up
- Communication around scale-up was clear and directive
- Adequate resources were allocated
- The scale up effort was effectively managed
- Scale-up execution was systematic and pragmatic
- Relevant stakeholders were actively engaged and contributed to sustainability
- Assessments and periodic reviews enabled the adaptive management of programs, and effectively communicated successes
- Ongoing advocacy ensured sustained integration across policies, programs, strategies, services, and indicators

How to do it: Tips from implementation

This is a non-exhaustive list of tips for implementing ARCS. The tips are associated with WHO’s Health Systems Building Blocks to illustrate how to apply a systems approach to ARCS [54]. A systems-approach will involve the implementation of these actions *and* will analyze and coordinate the relationships between them. Because this brief addresses contraceptive service delivery for adolescents, most tips are supply side related. Demand side tips can be found in other HIP briefs [31, 33-35].

Ensure an enabling policy and legal environment for contraceptive provision to adolescents

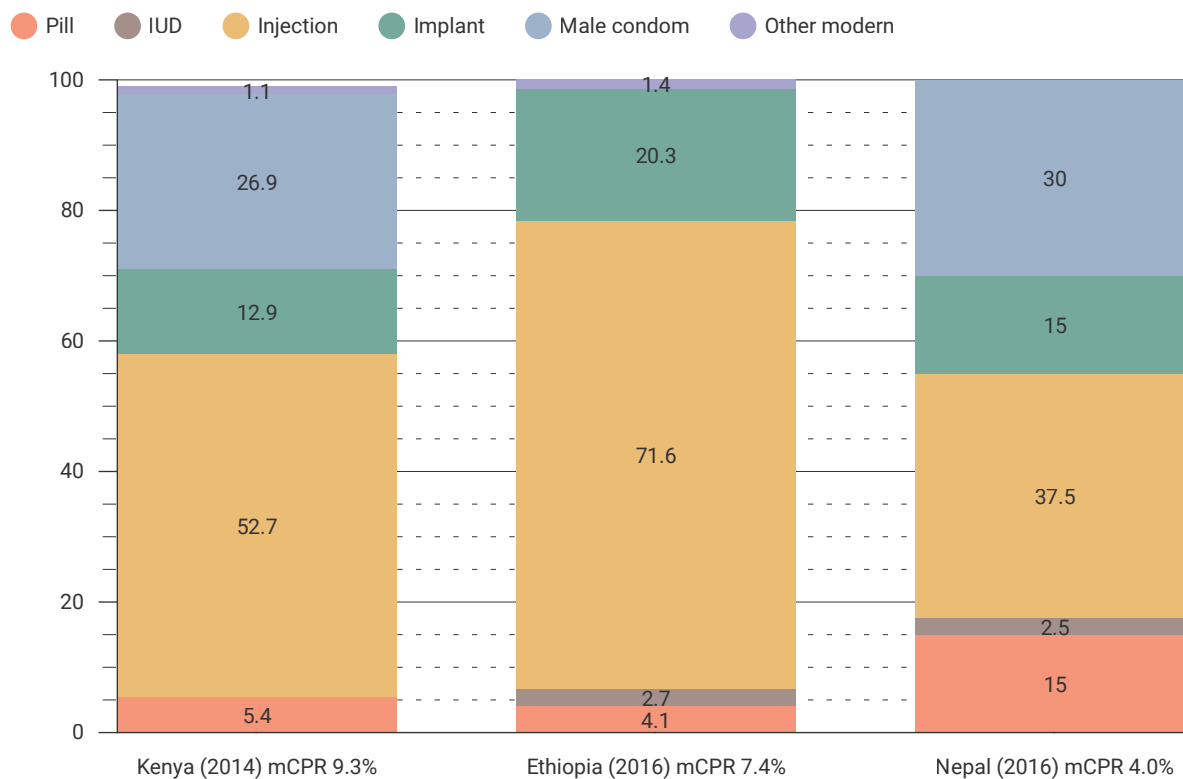
Service Delivery

Access to essential medicines

Leadership and Governance

- » Support the development, revision, and implementation of laws, policies, and service delivery guidelines that clearly state that all adolescents can obtain accurate, comprehensive sexual and reproductive health information, support in decision-making from a qualified health professional, respectful treatment, and voluntary choice of a full range of contraceptive methods regardless of age, marital status or parity [42, 55-60]. Figure 4 shows method mix data from Kenya, Ethiopia, and Nepal highlighting that adolescents will use a variety of methods, including long-acting reversible contraception (LARCs), when offered a full range of contraceptive methods [49, 61, 62].
- » Ensure copies of relevant laws, policies, guidelines, and adolescent-friendlyⁱⁱⁱ service standards where they exist are widely available. Provider trainings and follow up support at facility level should reflect these legal rights, policies, guidelines, and standards [63, 64].

Figure 4: Modern method mix among all women ages 15-19 from recent DHS surveys, percent



*Note: other methods include female condoms, LAM, IUD

iii The term *adolescent-friendly* is used here, as most countries continue to use this term when referring to national services standards.

Employ a variety of sectors and channels, to reach different adolescent segments

Service Delivery

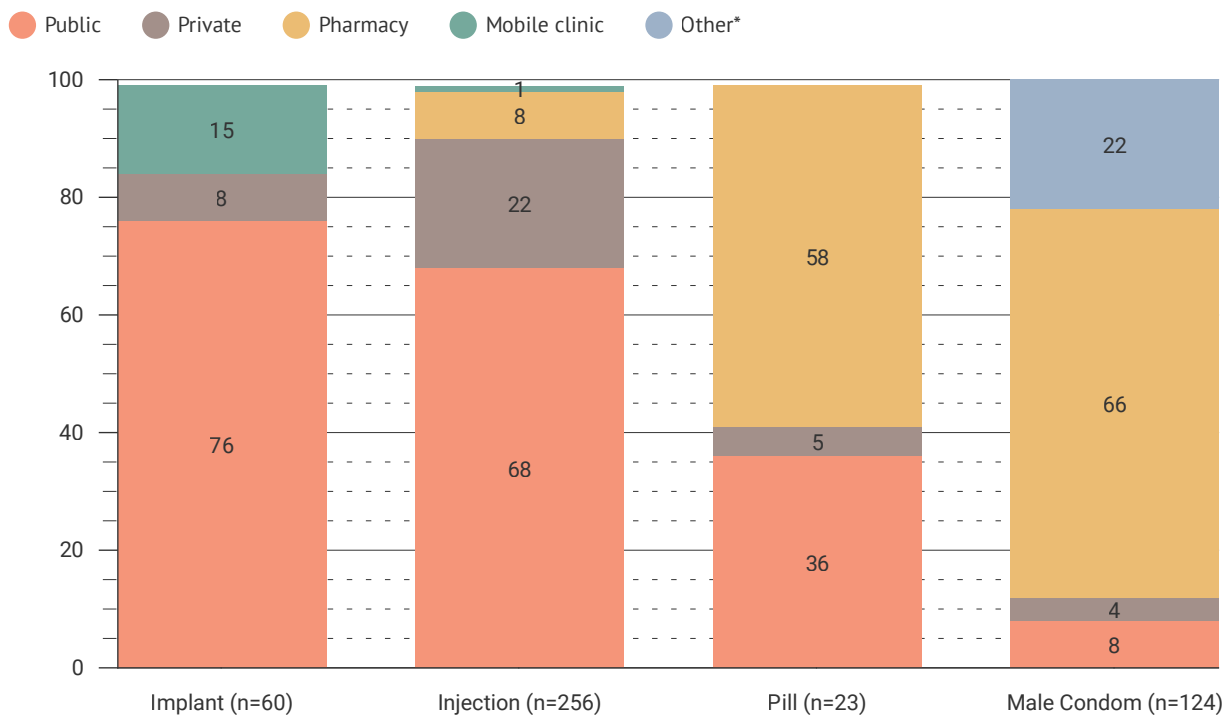
- » Use different channels to reach a wider range of adolescents, taking into consideration adolescents' needs and preferences, as well as the types of methods that can be provided through each channel. These include public and private-sector facilities, community-based distribution, mobile outreach services, pharmacies and drug shops, and school- or workplace-based services. Figure 5 shows an example from Kenya on the importance of offering adolescents a range of channels to obtain contraception [61].
- » Integrate contraceptive products and services into other health services, especially services that adolescents readily seek (e.g., HIV and MNCH) —this can be especially important from an equity perspective to reach certain adolescent segments (e.g., first-time parents, adolescent boys, etc.).
- » Consider promising new modalities, especially relevant in the context of COVID-19, such as self-care models (e.g., self-injection of DMPA-SC) [65, 66], and direct-to-consumer models (e.g., digital platforms to provide counseling and home delivery of methods) [67, 68]. Also, provide over the counter access to emergency contraception and oral contraceptive pills.

Link ARCS with social and behavior change interventions that address adolescent-specific cognitive, cultural, and social challenges and barriers

Service Delivery

- » Link multi-sectoral demand side and gender-transformative community-engagement efforts to ARCS, including through strong referral networks [7, 31, 33, 34, 69-77].

Figure 5: Method source by current method, all users ages 15-19 years, Kenya DHS, percent



*Other methods include female condoms, LAM, IUD.

Total sample size of all users ages 15-19 is 463, and n=the number of users for the method.

Improve providers' competency in providing ARCS

Health Workforce

- » Use whole clinic training that equips all providers and staff, including support staff, with the competencies necessary to offer respectful care, including contraceptive information, counseling, and products to adolescents [78]. This can build shared commitment to serving adolescents and complementary responsibilities for delivering ARCS.
- » Train small groups using low dose, high frequency training methodologies [79] that incorporate WHO's Core Competencies in Adolescent Health and Development for Primary Care Providers [80].
- » Reinforce training through job descriptions that reference quality standards, job aids, refresher training, mentorship, and supportive supervision [7, 81], as training alone is insufficient in changing provider behavior [7, 82, 83]. Complement trainings with interventions that address the individual, situational and social factors contributing to provider bias [23, 84]. This can include values clarifications exercises and creating a supportive environment for change without placing blame on providers, in addition to the dissemination of guidelines and mentoring mentioned earlier [84].

Collect and use data to design, improve, and track ARCS implementation

Health Information Systems

- » Use quantitative and qualitative data to determine the specific needs and preferences of different adolescent groups; identify who is not being reached with contraceptive services; and use a strategic approach to draw on evidence-based interventions that ensure adolescents clients are offered appropriate contraceptive services (See Adolescents: Improving Sexual and Reproductive Health of Young People: A Strategic Planning Guide) [34].
- » Review existing health information systems to collect, compile, and analyze age- and sex-disaggregated data [39, 85, 86].
- » Collect adolescent feedback. This can be done through exit interviews, self-administered questionnaires, digital platforms, mystery clients, or other approaches.
- » Include adolescent-focused indicators in quality improvement frameworks.
- » Review data at the facility, district, and national level to ensure that corrective action is taken, and resources are appropriately allocated [29].

Address financial barriers to adolescent contraceptive use

Financing

- » Include ARCS in universal health coverage (UHC) and national insurance schemes and/or use other approaches such as offering vouchers or offering subsidized services through social marketing, social franchising, and cost-recovery schemes [4, 7, 87].
- » Finance ARCS through national and sub-national budget allocations and distributions.

Support meaningful participation and leadership of adolescents

Leadership and Governance

- » Ensure that national policies are designed and implemented to acknowledge adolescents' rights to meaningful engagement and establish mechanism that facilitate adolescents' meaningful participation in the design, implementation, and monitoring of ARCS [29].
- » Support adolescents to effectively contribute to advocacy, governance, and accountability efforts [29, 88].

Measurement and Indicators

The following indicators can be used to measure and monitor countries' progress towards offering ARCS [89]. Indicators 1a and 1b should be measured and analyzed together to give a more complete picture of contraceptive service delivery to adolescents.

- 1a. Number and percent of health facilities that currently provide adolescent contraceptive services (measured by the percent of facilities that provided contraceptive services to at least one adolescent in the last 3 months).^{iv}
- 1b. Total number of contraceptive visits by clients under the age of 20 years.^v
2. Proportion of districts (or other geographic area) in which adolescents aged 15-19 years have a designated place in community accountability mechanisms^{vi} on access to and quality of health services. (The denominator is the number of districts with a community accountability mechanism in place, and the numerator is the number of them in which adolescents have a designated place.) [89]^{vii}

Priority Research Questions

1. What are the factors and system conditions that allow for adolescent-responsive contraceptive services to be scaled and sustained?
2. What actions have governments taken to integrate ARCS into UHC, and what were the results?
3. What social accountability mechanisms—including those that are led by adolescents—could increase contraceptive services' responsiveness to adolescents?

iv Performance Indicator Reference Sheet forthcoming.

v For countries that only collect FP data for 10 – 14 yrs. and 15 – 19 yrs., this indicator should be calculated by taking the sum of both age bands. For countries that collect FP data for 15 – 19 yrs., this indicator should be calculated by taking the sum of visits to 15 – 19 yrs.

vi Illustrative examples of community accountability mechanisms include: community audits, community score cards, monitoring citizen charters, public hearings, health committees at the district/ sub-district/ health facility levels, financial monitoring committees, public expenditure tracking surveys, school health management committees, and participatory research and evaluation.

vii This indicator is adapted from a forthcoming handbook on universal health coverage being developed by WHO and draws from evidence on social accountability, including Hurd et al. (2020).

References

A complete list of references used in the preparation of this brief can be found at: <https://www.fphighimpactpractices.org/briefs/adolescent-responsive-contraceptive-services/>

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For more information about HIPs, please contact the HIP team <https://www.fphighimpactpractices.org/contact/>

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