Scaling Contraceptive Service Delivery for Adolescents in Ethiopia: The Case of Smart Start

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Introduction

In Ethiopia, adolescent girls ages 15 to 19 make up an estimated 6% of the total population, most of whom reside in rural areas (1), and 17% of whom are married (2). Ethiopia has a high percentage of teenage pregnancies (13%) which has remained unchanged over decades with the majority (83%) occurring within marriage (3). Despite high (98.4%) awareness of family planning among married adolescents, the adolescent contraceptive prevalence rate (CPR) is lower (36.5%) compared to CPR for all women of reproductive age (41.4%). This is due to multiple factors including individual preference, cultural norms, poor socioeconomic position, underuse of SRH resources (information, counseling, and services), and other factors resulting in grave pregnancy outcomes (4). The Rapport Building, Exploring, Decision Making, and Implementing the Decision (REDI) framework is used for counseling all women as per the Guideline for Family Planning Services in Ethiopia, but the low rates of family planning use among married adolescents mean a different strategy is required. In 2017 a new approach, called Smart Start, which positions contraception as an asset to support financial stability and is delivered through the health extension worker cadre, was piloted. An external evaluation of the pilot showed an increase in mCPR among adolescents of 5.1% and increases in the use of long-acting reversable contraceptives (LARCs), as well as knowledge, attitudes, and practices surrounding contraception (5). These results prompted the Ministry of Health in Ethiopia to scale-up the program to reach married adolescent girls across the country. The Ministry set a goal to expand Smart Start to 12,000 health posts across Oromia, Amhara, Tigray, Southwest Ethiopia, Central Ethiopia, South Ethiopia, Sidama, Somali, and Afar regions between 2022-2025, representing 72% of all health posts in these regions. This paper examines the impact of scaling up this counseling and service delivery approach on utilization of contraceptive methods by married adolescents in Ethiopia between January 2022 – March 2024. If accepted, the authors would provide updated analysis through Q1 2025.

Methods

An interrupted time series design was employed to collect data from government health management information systems (HMIS) across 4,555 sample health posts in Ethiopia for the period from January 2021 to March 2024. In Ethiopia, sampled facilities scaled up the approach in two waves (wave 1 - starting January 2022 and wave 2 - starting January 2023). HMIS data collected included contraceptive uptake (new and continuing users) among adolescent girls ages 15-19. Analysis segmented this data into three distinct phases (Figure 1):

1. Pre-implementation phase: the months prior to activation of the approach in sampled sites.
2. Early scale-up phase: the six months immediately after activation.
3. Mature scale-up phase: the remaining months after activation until March 2024**.**

Data were retrieved from the HMIS for all regions, cleaned manually and analyzed. Data anonymity preserves confidentiality.

Results

Smart Start was progressively scaled from 1,038 health posts in May 2021 to 9,335 health posts in March 2024. The 26,000 Health Extension Workers (HEWs) trained on the approach reached 372,465 new users and 298,535 continuing users of contraception.

Sampled sites reached on average 7,170 users per month during the pre-implementation phase, equating to between one to two users per health post per month (Figure 1). In early scale-up, average reach among the same sites increased by 36% to 9,776 users, or two users per health post, per month. Average reach increased further in the mature scale-up phase to 12,537 users, or three users per health post per month. Performance trends were influenced by the facilitation of an acceleration period, involving increased accountability and support for the implementation approach, which occurred in October-November 2022. During this time, monthly reach increased nearly sevenfold through concentrated engagement from the MOH and technical assistance partner.

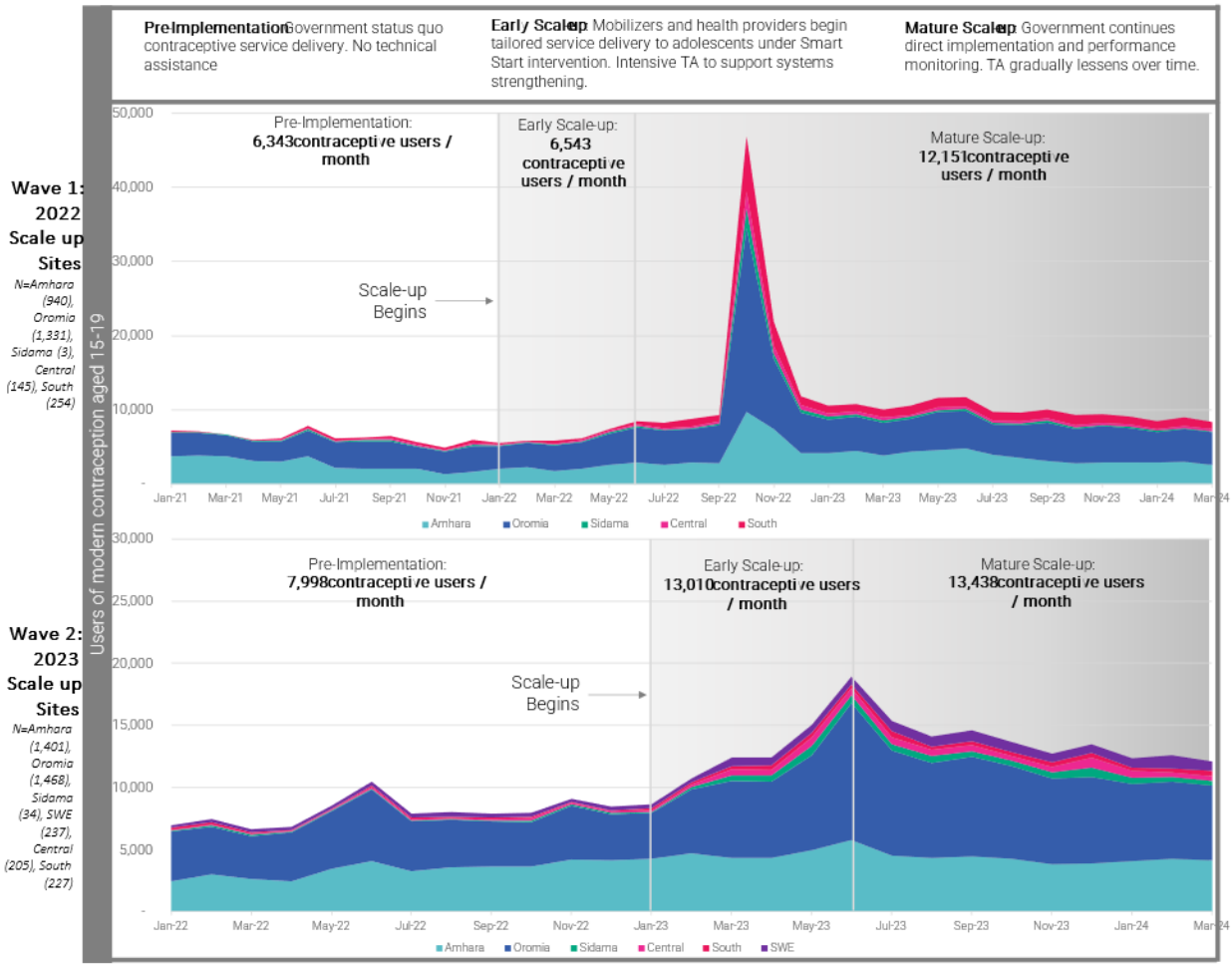

Figure 1. Contraceptive uptake among adolescent girls ages 15-19 by scale-up phase.

Discussion:

This study demonstrates that the scale-up of Smart Start generated substantial increases in contraceptive uptake among adolescents aged 15-19 in sampled sites. Positive shifts in contraceptive uptake were greatest when additional focus was applied to the scale-up efforts through the acceleration period. Although contraceptive uptake dropped after the level of focus declined, uptake remains higher in the mature phase than before scale-up begins, suggesting that the MOH has shifted practice and norms in a sustained way. Questions remain about how best to sustain this impact over the long-term and institutionalize the practices introduced. Other studies showed client -centered counselling tools improve counseling outcomes positively. One -study that take McCormack's seminal framework (6) that identified six distinct domains of patient/ client-center counseling, including fostering the provider-client relationship, a reciprocal exchange of information between clients and providers, the need for providers to recognize and respond to their clients/patients' emotions, managing uncertainties the client may

experience, making decisions, and facilitating self-management. It showed that one of the FP counselling tools, a Smart Choice assessment tool that aims to improve contraceptive counselling aid by making the counselling session more comprehensive, better tailored to the patient's need and preferences, and by increasing the patient's ability to have an active role in contraceptive decision-making (7). The introduction of family planning program that aims to improve demand generation including among married adolescents requires integration of the intervention to the health system if it is to be Instuitionalization and scaled up (8). Another study of metanalysis on key structural interventions for adolescent contraceptive use that have been evaluated in low- and middle-income countries. The study searched eight academic databases, relevant websites and s 2016 evidence gap map and screened references based on set inclusion criteria. This study screened 6993 references and included 40 unique intervention evaluations, reported in 138 papers, this study showed that poverty reduction/economic empowerment interventions were the most common structural intervention, followed by interventions to increase schooling and those aiming to change social norms will have positive outcome for contraceptive use among married adolescents in low and middle income countries that supported tailored innovative counselling to empower married adolescents(9).

Conclusion and recommendation

Smart Start counselling approach when implemented in the context of integration with the public health system increases access and utilization of contraceptive methods by married adolescents, The government of Ethiopia should contextualize the approach based on regional setup for reaching more needy married adolescents

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