TECHNICAL GUIDANCE ON YOUTH-FRIENDLY PAC

Recognizing that unsafe abortion is a major contributor to maternal mortality, particularly for young women, the Postabortion Care (PAC) Consortium[1] is pleased to introduce *Technical Guidance on Youth-Friendly PAC*. This document is intended to be used by program managers and technical staff to improve the quality and access to life-saving PAC services for adolescents. Drawing on the body of literature on youth-friendly services and unsafe abortion among adolescents and on Consortium members' youth programming experience, the Youth-Friendly PAC Working Group examined the special needs of adolescent PAC clients. Using the PAC Consortium's *Essential Elements of Postabortion Care: An Expanded and Updated Model*[2] as a framework, the Working Group developed recommendations for making existing PAC services more youth-friendly. Monitoring and evaluation measures were also included so that managers and staff can ensure that PAC services offered to young people[3] are meeting their various needs.

I. Why Focus on Adolescents Within PAC Programs?

Adolescence, defined by the World Health Organization as a stage of development between the ages of 10-19, is a time marked by great physical and psycho-social change and a move toward independence from parents and caretakers. Adolescents account for 1/5 of the world's population and approximately 87% live in developing countries, where the legal indications for abortion may be highly restricted (for example, in cases of rape and incest or to protect the life and health of the woman).[4,5] Although practices differ by region and culture, more young people are engaging in pre-marital sexual behavior, which is linked to the trend of both women and men marrying at later ages. This results in a longer period of time during which sexual activity and pregnancy can take place outside of marriage, which in many settings is unsanctioned. These trends are sure to continue, as social changes that influence these behaviors increasingly are underway throughout the world. Such changes include people's access to different forms of media and new ideas, urbanization, migration, changes in traditional communication channels through which adults pass on information and guidance to young people, increased educational

Different Kinds of Adolescents

Adolescents are not a homogeneous group and are comprised of young women and men who are:

- At different stages of physical and psycho-social development
- In-school and out-of-school
- Married and unmarried
- HIV-, HIV+, or without knowledge of their HIV status
- Ethnic minorities
- Of different sexual orientations (heterosexual, homosexual and bi-sexual)
- Commercial sex workers or street youth
- Living in poverty
- Orphans or vulnerable youth

[1] The organizations that participated in the PAC Consortium Youth Friendly PAC Working Group included Pathfinder International, Ipas, Family Health International, CATALYST Consortium, IPPF, IntraHealth, and JHPIEGO

[2] PAC Consortium Community Task Force, Postabortion Care Consortium. 2002. *Essential elements of PAC: An expanded and updated model.*

[3] Adolescents comprise the 10 to 19 year age group, while youth usually refer to those between the ages of 15 and 24, and young people includes both youth and adolescents. "Youth," "young people" and "adolescents" will be used interchangeably in this document.

[4] UNFPA. 2003. *State of world population 2003. Making 1 billion count: investing in adolescents' health and rights*. New York: UNFPA.

[5] de Bruyn, M. and S. Packer. 2004. *Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling, and Clinical Care*. Chapel Hill, NC: Ipas.

opportunities for girls and women, and opportunities for young men and women to interact socially and vocationally.[6]

Young people often are more vulnerable to unwanted pregnancy and unsafe abortion due to their psycho-social development, power and gender imbalances vis-à-vis adults and males, poverty, sexual abuse and coercion, as well as traditional/cultural values that prevent or limit access to sexual and reproductive health (SRH) information and services. Less than 5% of the poorest young people use modern contraceptive methods and 1/3 of women in developing countries give birth before the age of 20.[7,8]

Due to the cultural and religious sensitivities surrounding abortion, it is difficult to determine the exact incidence of abortion. However, it is estimated that as many as 4.5 million adolescent women seek an abortion each year.[10,11,12,13] Of these, 40% are conducted under unsafe conditions and 95% of all unsafe abortions take place in developing countries, where abortion is legally restricted or highly inaccessible.13 An analysis of data on unsafe abortion by age indicates that the age pattern differs markedly from region to region. For example, the proportion of women aged 15–19 years in Africa who have had an unsafe abortion is higher than in any other region of the world and almost 60% of unsafe abortions are among women under the age of 25. This contrasts with Asia where 30% of unsafe abortions are among women less than 25 years and Latin America and the Caribbean where 42% of unsafe abortions are among women less than 25 years.[14]

> In Nigeria, the Society of Gynecologists and Obstetricians estimates that about 10,000 or 50% of the Nigerian women who die annually from unsafe abortion are adolescents and that abortion complications are responsible for 72% of all deaths among women under 19 years of age.[9]

Young women are more apt than older women to delay seeking an abortion as well as resort to cheaper and unsafe providers due to denial or unawareness that they are pregnant, fear of their parent's reaction, and/or lack of financial resources to obtain an abortion, all of which increase their risk of complications, including death. Also, they frequently delay seeking care for abortion-related complications once they occur. As a result, adolescents are more likely to suffer serious complications from unsafe abortion relative to other groups. In addition, very young adolescents also have higher rates of spontaneous abortion (i.e., miscarriage).[15,16,17,18,19]

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[6] Senderowitz, J. Hainsworth, G. and Solter, C. 2003. *A Rapid Assessment of Youth Friendly Reproductive Health Services.* Technical Guidance Series, No. 4. Watertown, MA, Pathfinder International.
[7] Ibid
[8] deBruyn, M. and S. Packer. 2004. Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling, and Clinical Care. Chapel Hill, NC: Ipas.
[9] Raufu, A. November 2002. *Unsafe Abortions Cause 20,000 Deaths a Year in Nigeria.* British Medical Journal. 325:988.
[10] Treffers, P. December 2002. *Issues in Adolescent Health and Development: Adolescent Pregnancy.* WHO/FCH/CAH/02.08 & WHO/RHR/02.14. Geneva, WHO.
[11] United Nations General Assembly. *Report of the Round Table on Adolescent Sexual and Reproductive Health and Rights: key future actions.* Available: http://www.unfpa.org/webdav/site/global/shared/icpd/rtable1.pdf
[12] Alan Guttmacher Institute (AGI). 1998. *Into a New World. Young Women's Sexual and Reproductive Lives,* New York: AGI.
[13] Pathfinder International. 1998. *Insights from Adolescent Project Experience,* Watertown, MA: Pathfinder.
[14] World Health Organization (WHO) 2004. *Unsafe abortion, Fourth edition, Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000.* Geneva, WHO.
[15] McCauley, A. and Salter, C. 1995. *Meeting the needs of young adults.* Population Reports, Series J, No. 41. Baltimore: John Hopkins School of Public Health, Population Information Program.

Service Barriers and Definition of Youth-Friendly Services

Adolescents are less willing and able to seek both family planning services to prevent unwanted pregnancy and unsafe abortion or to seek PAC services in the case of an unsafe abortion, for the following reasons:

- National laws and policies restricting access to services based on legal age and/or marital status
- Inconvenient hours of facility operation
- Lack of transportation
- High cost of services
- Limited understanding of their bodies and conception
- Little knowledge of available services and their location
- Belief that the services are not intended for them
- Concern that the staff will be hostile or judgmental
- Concern that services lack privacy and confidentiality and fear that their parents might learn of the visit
- Fear of medical procedures and contraceptive methods, including side effects
- Embarrassment at needing or wanting services
- Shame, especially if the visit follows sexual coercion or abuse[20]

To address these barriers to care for adolescents, the PAC Consortium seeks to both improve the quality of PAC services so that they better meet the unique needs of adolescent clients and to increase adolescent women's access to these services. "Access" refers to comprehensive services that are affordable and located in places that are easily accessible to adolescents, that the language and words used during adolescents' care is understandable and meaningful to them, and that policies exist and are implemented that eliminate social and service barriers for adolescents.

The concept of "youth-friendly" services addresses both quality and access issues. Although there are variations on the definition of youth-friendly services, in general, youth-friendly services are defined as services that attract, adequately and comfortably meet the health care needs of, and retain adolescent clients. Youth-friendly PAC services are those that:

- Offer privacy and confidentiality.
- Employ specially trained providers who deliver services in a non-judgmental manner, are comfortable communicating with young people on sensitive topics, and support informed choice.
- Are affordable or free for adolescent clients.

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[16] WHO. 1997. *Postabortion family planning: a practical guide for programme managers*. Geneva: WHO.
[17] Shawky, S. and Milaat, W. 2000. *Early teenage marriage and subsequent pregnancy outcomes.* Eastern Mediterranean Health Journal. Volume 6, Issue 1. Cairo: WHO Eastern Mediterranean Regional Office
[18] Advocates for Youth. 2005. *Youth's reproductive health: Key to aceiving the millennium development goals at the country level.* Washington DC: Advocates for Youth.
[19] International Institute of Population Studies. 1995. *National family health survey: MCH and family planning.* Bombay: IIPS.
[20] Senderowitz, J. Hainsworth, G. and Solter, C. 2003. *A Rapid Assessment of Youth Friendly Reproductive Health Services.* Technical Guidance Series, No. 4. Watertown, MA, Pathfinder International.

II. ESSENTIAL ELEMENTS OF PAC

Comprehensive PAC services as defined by the PAC Consortium are comprised of five elements of care:

- **Community and service provider partnerships** for prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs;
- **Counseling** to identify and respond to women's emotional and physical health needs and other concerns, including contraception;
- **Treatment of incomplete and unsafe abortion** and complications that are potentially life-threatening;
- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or practice birth spacing; and
- **Reproductive and other health services** that are preferably provided on-site or via referrals to other accessible facilities in providers' networks.

The specific needs of adolescent clients and recommended actions as they relate to each of the essential elements are further explored below.

Community and Service Provider Partnerships

Community-service provider partnerships, comprised of community members (youth, parents, teachers, community and religious leaders, men and women), adult and youth lay health workers, traditional healers, and formally trained service providers, can facilitate community dialogue on sensitive issues (e.g., adolescent sexual activity, sexual abuse or coercion, and unwanted pregnancy) and create an enabling environment to support the provision of needed SRH information and contraceptive services to young people. These partnerships not only play a vital role in the prevention of unintended pregnancies and unsafe abortion and but also can increase access to sustainable high quality PAC services for young people. Such partnerships provide an opportunity for community input on the quality of PAC services for adolescents as well as how services are best organized. Placing PAC within a larger context such as safe motherhood or adolescent SRH may encourage greater community participation.

While community involvement is a necessary ingredient to sustainable comprehensive PAC services, in some cases it may hinder the provision of comprehensive PAC services, especially in communities where influential leaders and community members hold very conservative views about adolescent sexuality, pregnancy outside of marriage, and abortion. Although the ideal is to form community-provider partnerships, it is important that program managers and providers are realistic about the extent to which they can involve the community. In challenging situations, they may need to look for allies beyond the traditional community leaders and work with community women's groups or traditional birth attendants. Taking incremental steps and developing solid alliances is important to working with the community.

Creating partnerships among stakeholders requires a range of innovative strategies in which young people must play an active and ongoing role. Programs may have to first work with adolescents to help them build skills so they can participate as equals. In addition, it may be necessary to sensitize

adult partners so that they respect and encourage adolescents' perspectives and participation. Strategies to create community-provider partnerships can include:

- Conducting community meetings and discussion groups in which a range of stakeholders, including different cohorts of youth, participate. Skilled facilitation is needed so that no one group or perspective dominates the discussion. In some cultural contexts, it may be necessary to work separately with men and women. The aim of such activities should be to develop strategies for positive change, including ways to support young women who experience unwanted pregnancy and unsafe abortion and need PAC services.
- Developing spaces in which like-minded stakeholders meet to develop proposals for improving information and services available to young people. Youth-developed proposals are particularly important in fomenting change.
- Holding informational and skills-building workshops that help people to understand the issues of pregnancy, contraception, abortion, and postabortion care and provide opportunities to build youth-adult partnerships to address these issues in non-judgmental ways.
- Conducting communication campaigns that engage the talents of young people and help to disseminate messages about the challenging topics of sexuality and reproductive health throughout the community, linking these themes with experiences that are relevant to youth, including poverty, inequality, unequal access to power and decision-making, and gender-based violence.
- Capitalizing on existing youth programs and interventions to strengthen community-provider linkages. Community interventions such as peer education have great potential to help prevent unwanted pregnancies and unsafe abortion by providing SRH information and non-clinical contraceptive methods. They also can refer young women in need of PAC services and provide youth feedback about the quality of services.
- Working with schools to address the need for SRH education and life skills. Teachers and school headmasters can be mobilized to prevent unwanted pregnancy and unsafe abortion by educating young people on how to make healthy choices and protect themselves. They can also play an important role in recognizing signs of unsafe abortion and referring for needed PAC services.

Community-service provider partnerships that encourage youth participation in all stages of service delivery, including formation, communication, implementation, and monitoring can result in innovative ways to deliver services to young people that meet their range of needs.

The following sections outline the basic youth-specific components that should be included in the other four elements of PAC. There are some components however that apply to the overall PAC visit, these are described below.

Overall PAC visit

It is important to review national laws, health policies, and standards and guidelines around PAC services. In most cases, the legal framework is supportive of PAC services and providers should be aware that it is their responsibility to provide confidential and quality services to all women, even adolescents.

The adolescent client should be asked who they would like to have involved in their care (e.g., partner, friend, a caring adult, or parents). The provider should then include them in ways that will be supportive to the adolescent client during the procedure and in the recovery process.

Privacy and confidentiality should be stressed for all clients, particularly adolescent clients who face additional stigma due to their age and the fact that in many cases they are not married or in a formal union. Where feasible, a separate waiting room for youth clients can provide a sense of privacy and alleviate fears of being seen by adult community members.

A common barrier to seeking PAC services is the fear of negative provider attitudes. Therefore providers should be sensitized through training and supervision that all PAC clients deserve and have the right to the same treatment and standard of care regardless of whether their abortion was induced or spontaneous. Providers should also be aware that sexual coercion or violence, which is common among adolescents in many contexts, may be the cause of the unwanted pregnancy and subsequent abortion. In these cases, they should also remember that the younger the adolescent, the higher the chance that the sexual offender is a close relative or a direct family member, which has implications with regard to confidentiality, the client's overall care, and referral needs.

Facilities and providers need to be extremely sensitive to the length of the facility stay when providing services to adolescent clients. Adolescents are often supervised by either their parents or their schools, and may not be able to stay away for long periods of time without explanation, which can be a barrier to seeking services. If adolescents are aware that they will receive discreet, timely PAC services, they may be more likely to seek those services.

Counseling

For some adolescents, the PAC visit may be their first time they have come to a health facility for a reproductive health service. Many adolescents may not have adequate knowledge about conception or how to prevent a future unwanted pregnancy, and they may have questions regarding other SRH issues. The provider should maximize the opportunity of the PAC visit to address multiple SRH needs and provide information on: (1) what to expect during treatment or procedures, (2) any medication or drugs, (3) complications and when to return to the facility, (4) contraception, (5) sexually transmitted infections (STIs)/HIV prevention and (6) SRH decision-making and (7) condom negotiation.

When counseling adolescent clients, it is important to remember that:

- Counseling should be tailored to the specific needs and characteristics of each young person since "adolescents/youth" are not a homogeneous group. Differences in age, developmental stage, educational/literacy level, and marital status all affect the counseling session, including what types of information should be provided and how to effectively communicate the information.
- Adolescents may be more fearful and less likely to have the support of family members or partners than older PAC clients. Therefore a supportive and empathetic approach is needed.
- Young people often are less informed and rely on information from their peers, which may be incorrect, therefore myths and rumors need to be addressed.

- Adolescents may not discuss their real problem or concern at the beginning of the counseling session. Providers must allocate more time and special care to counseling adolescent clients including ensuring two-way communication and being patient.
- Providing verbal support and explaining what is happening during the treatment procedure when women are conscious throughout the process can serve as an important means of pain management.
- Additional support can be provided through peer counseling or lay counseling programs. See below under *Referral for Other RH Services*.

During **counseling**, the provider should:

- Provide clear and simple information on what to expect during physical exam, treatment, and any other procedures. Describe the pain and/or discomfort that the adolescent might feel during treatment during uterine evacuation and offer pain management options, including supportive accompaniment by a friend or partner if the client desires.
- Encourage the adolescent client to talk about her feelings regarding the abortion. Remember these feelings are often mixed, and the provider may help the adolescent elaborate her loss, clarify her thoughts regarding the pregnancy and abortion, and plan when to become pregnant again, if she desires. Be clear about the immediate return of fertility, and discuss all contraceptive options for her and her partner. See below under *Postabortion Family Planning* for more information.
- Screen for sexual abuse and gender-based violence (GBV). If providers are required to report cases of sexual abuse or GBV to law enforcement authorities, discuss with the adolescent how this will be addressed. Providers must be trained beforehand and a screening protocol for GBV must be in place to ensure that providers discuss this issue in a confidential and empathetic manner, and respond appropriately when GBV is disclosed.
- Screen for STIs/HIV and help the client assess her risk of STIs/HIV. Dual protection to prevent unintended pregnancy and STIs/HIV should be emphasized.
- Give clear instructions on any follow-up care, including any needed medications, and discuss post-treatment danger signs and symptoms that would require the client to immediately return to the facility. Give clients the name of a contact person, such as the attending physician or nurse in charge who can be reached night or day, in case they need to return to the clinic.

Treatment of complications

While treatment of abortion complications is similar for both adult and adolescent clients, there are some additional aspects that should be considered when treating young people.

- Technical issues for adolescent clients include using a smaller speculum during exam and procedure, using misoprostol to facilitate cervical dilation/ripening, and additional attention to pain management.
- Because of the time sensitivity, adolescents should not be required to stay for 24 hours after the procedure as are many other PAC clients. An outpatient manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA) procedure is preferable to facilitate timely discharge, when this is clinically possible.
- Adolescents often wait longer before seeking an unsafe abortion. This has implications for the severity of complications and can influence the type of provider that can provide treatment as

well as the type of technology that can be used (e.g., MVA, EVA, dilation and curettage [D&C]/sharp curettage [SC], and/or misoprostol).

- In addition to the benefits of MVA or EVA associated with time considerations mentioned above, MVA or EVA is preferred by the World Health Organization over D&C for adolescents because severe complications are less likely.[21]
- Clinical procedures for using MVA, EVA, D&C, or misoprostol are often the same as for an adult client. However lack of knowledge of what to expect and limited emotional support from family can lead to increased anxiety and pain. Pain management, especially for nulliparous women, may require additional treatment strategies (e.g., cervical priming with medical compounds or light sedation during the procedure). Extra support to the youth client during the procedure and attention to pain management can also improve the client's overall PAC experience.
- During treatment, providers should take note of any other SRH problems (e.g., STIs) that are detected and make sure that the client receives appropriate care or referral.

Postabortion Contraceptive/Family Planning Services

As discussed earlier, the PAC visit may be the first time that an adolescent has ever accessed RH services and therefore it is imperative that the client receives postabortion contraceptive counseling and services. Because young people often do not return to the facility for follow-up care, it is important that contraceptive methods (at a minimum condoms) are available to adolescent clients before they are discharged from the PAC facility.

During postabortion contraceptive service provision, the provider should:

- Clarify the adolescent client's reproductive intentions at the outset. For those who want to become pregnant, emphasize the need to wait six months before becoming pregnant again.22 Assess and discuss physical and emotional readiness to become pregnant again (e.g., if the client is severely anemic or depressed).
- Remember that age is not a contraindication for any contraceptive method therefore adolescent clients should be offered a range of methods. However, the IUD is not recommended if infection is present and sterilization is usually not appropriate for adolescent clients.
- Discuss dual protection from both unwanted pregnancy and STIs/HIV in an integrated manner. Demonstrate proper condom use (for both male and female condoms) and ask the client to return the demonstration.
- Help the client learn how to negotiate condom use. Young people often do not possess the life and communication skills needed to negotiate using condoms with their partner.
- Remember that young people may need extra information and help in learning to use their method (e.g., linking daily activity to taking a pill) and may have different concerns than adult clients (e.g., weight gain or acne). In addition, young people may not have a safe place to keep a method (e.g., a packet of pills) so certain methods like injectables may be more acceptable to them.
- Use visual aids and youth-focused IEC materials to reinforce family planning messages.
- Where emergency contraceptive pills (ECP) are legal, include information about ECP in case of contraceptive method failure or unprotected intercourse, and provide an advance supply of

[21] WHO. 2003. *Safe abortion: technical and policy guidance for health systems.* Geneva: WHO.

ECP, if possible. If a prescription is needed to obtain ECP, provide the prescription so that clients have the method on hand in case of future unprotected sexual intercourse.

- If possible and the client desires, involve male partners in contraceptive counseling.

Provision of or Referral for Other Services

The PAC visit is often the first time a young person has attended a RH facility and as a result, she may need other SRH services beyond PAC. In addition, an adolescent who has been sexually abused or is in a vulnerable situation (e.g., a street child or an orphan) may need social services in addition to health services. As much as possible, direct provision of SRH and other health services should be provided at the primary facility that the adolescent client first visits. In many cases, adolescent clients may not return to the facility or will not go to the referred facility. However, when it is necessary to refer a client, the following points should be taken into consideration:

Types of Referral Services

- Sexuality education and/or SRH counseling and information
- HIV/AIDS counseling
- Voluntary HIV counseling and testing (VCT)
- STI testing/treatment
- Counseling/support for gender-based violence and sexual coercion
- Treatment, care and support for HIV positive youth
- Legal, emotional, and financial support for orphans and vulnerable children (OVC)

- When possible, refer adolescents to facilities that offer youth-friendly services or to facilities or organizations that are receptive to adolescent clients.
- Providers should take time and explain clearly to the adolescent client the purpose and importance of the referral. Adolescents generally have less familiarity and experience with different services, medical procedures, and their purposes.
- Referral cards or slips should note the type of service/counseling the adolescent client requires and can also be kept as part of record keeping between the primary site and the referral site. The card can also highlight the fact that this client is an adolescent and requires special attention and more expedient services/treatment.
- If possible, provide clients with easy to read and understandable materials that:
    - Explain the services they will obtain at the referral site..
    - Describe the client's right to confidential services.
    - Provide general information on SRH.
- Providers should be aware of community-based SRH services (e.g., peer providers, outreach services, non-traditional condom distributors, and youth-friendly pharmacies) and be willing to refer back to the community for services when appropriate. For example, an adolescent PAC client may need life skills, emotional support, and an on-going supply of condoms to exercise her decision to prevent future pregnancies and STIs/HIV. This type of on-going support may be more easily found through networks of peer providers or other youth programs.
- In some countries there are youth hotlines or websites on SRH, in such cases, the phone number or website address should be given to adolescent clients for more information.

III. Monitoring and Evaluation

OBJECTIVES	PROCESS AND RESULTS INDICATORS
1. Develop community and service provider partnerships that involve adolescents in defining needs related to YF PAC services and ways of addressing those needs	• Level of participation (# of adolescents, description of the roles they play, number of community meetings/dialogues where both youth and adults participate, description of the impact that youth participation makes in process and decision-making) in developing partnerships and defining the important issues to be addressed in the partnerships • Formal partnership agreements include explicit language about the needs of and services provided to adolescents
2. Provide counseling to all adolescents receiving PAC services	• % of adolescent women who receive counseling to address their health-related needs and concerns • % of adolescent women interviewed who state that their health needs and concerns were addressed by health facility staff • % of adolescent women whose counseling took place in a private and confidential manner (people could not see or overhear the adolescent during counseling, with or without parents or guardians, according to the adolescents' wishes) • Of the adolescent women who want their male partners to be involved in the counseling process, % who are counseled along with their male partners *(when he is available)*
3. Provide clinical treatment to all adolescents experiencing complications of unsafe abortion	• % of adolescent women treated per type of medical procedure (MVA, EVA, D&C/SC, misoprostol, or MVA/SC with misoprostol) • % of adolescent women treated who themselves gave verbal or written informed consent for the medical procedure
4a. Offer information to adolescent women (and their male partners when young women so desire) about the range of contraceptives available; 4b. Provide adolescents with the contraceptive method(s) they choose	4a. • % of adolescent women who received information about contraceptives (% per type of contraceptive) • % of adolescent women who received information about contraceptives without the previous consent of their parents or guardians • Of the adolescent women who want their male partners to be involved in the counseling process, % received information about contraceptive methods along with their male partners *(when he is available)* 4b. • Of the adolescent women who want contraceptive(s), % who receive any method before leaving the health facility • Of the adolescent women who want contraceptive(s), % who receive their desired method before leaving the health facility (denote type of method) • Of the adolescent women who want contraceptive(s), % who received method(s) without parental/guardian consent • % of adolescent women leaving the facility with a. male condom b. female condom (either as a sole method or in addition to a method)
5. Provide adolescents with other reproductive health services they need at the time of PAC or directly afterward	• % of adolescent women screened for gender-based violence, especially sexual violence (in their lives in general and as a cause of the pregnancy resulting in unsafe abortion) • % of adolescent women identified as having other SRH needs at the time of PAC services (by type of need identified) • Of the adolescent women identified as having other SRH needs, % who receive direct care in the same health facility • Of the adolescent women identified as having other SRH needs, % who are referred to other services for care

Conclusion

Efforts to make PAC services more youth-friendly not only can increase access to life-saving PAC but can also reduce the number of future unwanted pregnancies and help young people practice healthy SRH behaviors. Youth-friendly PAC should not be viewed as an additional service or intervention but rather a way of improving the overall quality of PAC services to meets the needs of all clients, including adolescents. Although the main focus of this document is adolescents, the discussion and recommendations are also pertinent to many young people between the ages of 20-24 years. The PAC Consortium hopes that this technical guidance will be useful and relevant to those who provide PAC services in the many countries where we work. Suggestions and feedback are always welcome; please contact the Youth-Friendly Working Group at info@pac-consortium.org. For additional information on PAC and adolescents, please see our website www.pac-consortium.org.