SEXUAL REPRODUCTIVE HEALTH: A REVIEW OF THE CONTRACEPTIVE USE AND POSTPARTUM CARE FOR ADOLESCENTS

AN OVERVIEW FROM KENYA, GHANA AND SOUTH AFRICA

FEBRUARY 2025

Advancing women's health in Africa

Coalition for Women's Health in Africa (COWHA) _cowha www.cowha.net #cowha

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Key Abbreviations

COC	Combined Oral Contraceptives
COWHA	Coalition of Women's Health in Africa
EC	Emergency Contraceptives
FP	Family Planning
IUDs	Intrauterine Devices
LAM	Lactational Amenorrhea
MCPR	Modern Contraceptive Prevalence Rate
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
NSCC	Non-Subsidized Contraceptives
PAC	Post-Abortion Care
POP	Progestin Only Pill
PPC	Postpartum Care
SDM	Standard Days Method
SRH	Sexual Reproductive Health

Executive Summary

i. Problem overview

Adolescent pregnancy is a significant public health concern in Africa, particularly in Kenya, Ghana, and South Africa as the number of pregnancies remains high as compared to the world average. Between 2015 and 2019, a significant percentage of pregnancies among women aged 15-49 in Kenya (61 percent), Ghana (56 percent), and South Africa (65 percent) were unintended, with adolescent girls disproportionately affected (75). Of these, a considerable proportion ended in unsafe abortions: 38 percent in Kenya, 36 percent in Ghana, and 37 percent in South Africa.

In 2023, adolescent girls accounted for 17 percent of all pregnancies in Kenya, totaling approximately 254,000 cases. In Ghana, 10.6 percent of adolescent girls became pregnant, resulting in 102,673 pregnancies. In South Africa, adolescent pregnancies reached 150,000 (approximately three percent). The high number of early pregnancies is because adolescent girls lack appropriate information knowledge and access to preventive solutions exposing them to risks such as unplanned pregnancies, unsafe abortions, Sexually Transmitted Infections (STIs), including HIV, dangerous childbirth, subsequent complications, and mental health issues. These risks translate into increased adolescent mortality, disrupted education, and financial strain ultimately increasing the levels of poverty. Similarly, maternal-related conditions remain one of the top causes of death among adolescent girls aged 15-19 years in Kenya, Ghana, and South Africa.

Significant measures need to be put in place to reinforce existing efforts of reducing early pregnancies and their complications in these countries.

ii. The aim of the study

COWHA has embarked on a situational analysis study to access contraceptive use and postpartum care (PPC) among adolescent girls in Kenya, Ghana, and South Africa. The study explores potential solutions and opportunities for addressing existing challenges and disparities in postpartum Care and contraceptive use among adolescent girls in the three countries. The outcomes of the study aim to serve as an evidence base for further awareness creation and advocacy towards a more enabling environment for adolescent girls in relation to contraceptives and PPC.

iii. The methodology

This desk review adopted a scoping review approach using research data sources from grey literature, global and Pan-African organizations reports, women's health-related organizations in Africa, and local governments. The steps followed include topic identification, defining research sources, collecting, combining, and refinement of data and finally reporting and documenting.

iv. Key findings

Population and fertility rates

- Out of COWHA's three focus countries, Kenya has the highest percentage of girls aged 10-19 (24 percent), followed by Ghana (21 percent) and South Africa (17 percent).
- Fertility rates in the countries are divided as follows: Kenya (3.19), Ghana (3.4), and South Africa (2.29).
- The birth rates per 1,000 adolescent girls are: Kenya (64), Ghana (64), South Africa (61), world average (42).

Contraceptive use

- The most used Family Planning (FP) methods in Kenya, Ghana, and South Africa are implants, condoms and injectables.
- The demand (percentage of women that expresses the need and or wish) for contraceptives among women aged 15-49: Ghana (65.3 percent), Kenya (76 percent), South Africa (79 percent).
- The total domestic government expenditures on FP are USD 5 million (Ghana), USD 32 million (Kenya), and USD 90 million (South Africa). Kenya and Ghana are heavily dependent on donor funding for the domestic government expenditure on FP.
- The supply of FP commodities is mainly conducted through public-sector distribution methods.
- The use of contraceptives among adolescents in Ghana and Kenya remains controversial and a sensitive area of concern. In South Africa, the age criteria for a girl to be provided with contraceptives (including condoms) is 12 years; but with proper clinical screening, advice, and management. The age criteria by which a person can be sterilized in South Africa is 18 years.

Postpartum Care

- Many adolescent girls in Kenya and Ghana lack access to PPC, especially in rural areas. 30 percent and 21 percent of deliveries are done by unskilled workers in Kenya and Ghana respectively.
- South Africa has better health infrastructure for PPC as compared to Kenya and Ghana. Only three percent of deliveries are made by unskilled workers in the country.
- Skilled health personnel are scarce in rural areas of Kenya and Ghana, resulting in reduced access for women in terms of quality PPC.
- When adolescent girls choose to abort pregnancies, it is because of the following cross-cutting challenges; the desire to continue education or to protect future aspirations, to avoid the stigma of teenage pregnancy, poverty, rape, incest or transactional sex, unprotected sex, use of drugs, and medical reasons.
- Adolescent girls choose unsafe abortion methods because of the following cross-cutting challenges; lack of knowledge and access to safe abortion services, socio-economic conditions as a perceived influence for unsafe abortion practices, abortion perceived religious and cultural taboo, stigma of unplanned pregnancy, avoiding parental/guardian disappointment and resentment, lack of knowledge of the legal status of abortion, limited access to safe places and enabling environment, and desire for secrecy.

Abortion laws

- In Kenya, abortion is legal if the life or health of the woman is in danger. In March 2022, the Kenyan High Court affirmed abortion as a fundamental right and ruled that arbitrary arrests were illegal. However, the ambiguities in the past are still present, creating fears amongst both medical professionals and women which has disabled access to transparent and quality abortion services. Often, women have to turn to backstreet clinics in order to receive care.
- In Ghana, abortion is legal in cases of rape, incest, health

risks, and/or fetal malformation.

- In South Africa, abortion is legal upon request up to 12 weeks of gestation, under specific conditions these can be extended up to 20 weeks of gestation. These conditions can be for example if the continued pregnancy would significantly affect the pregnant person's social and economic circumstances, if continued pregnancy poses a risk of injury to the pregnant person's physical or mental health, there is a substantial risk that the fetus would suffer from a severe physical or mental abnormality, or the pregnancy resulted from rape or incest.

Key FP 2030 Government targets committed

Country	Targets
Kenya	• Reduce the unmet need for family planning for all women from 14 percent (2023) to 10 percent by 2030 • Reduce pregnancy among adolescent girls (15-19 years) from 14 percent (2023) to 10 percent by 2025 • Increased domestic financing for family planning commodities to cover 100 percent of the demand by 2026
Ghana	• Increase government financial commitment to procure 20 percent of Ghana's FP commodities needs by 2030, addressing the decline in funding from development partners • Reduce the unmet need for contraception among sexually active adolescents from 57 to 30 percent by December 2030
South Africa	• Strengthen FP services to ensure access • Emphasize on FP with a link to prevention of STIs • Target the teenage population via focused interventions and education • Development of Standard Operating Procedures for health workers in relation to FP • NB. No clear indicators or numbers mentioned as compared to Ghana and Kenya

Existing challenges: Contraceptive use

Country	Targets
Cross-cutting challenges	• Healthcare system-related challenges • Social and cultural barriers • Personal and psychological factors • Educational and informational gaps • Policy and legal constraints • Economic barriers • Need for more subsidized/ free contraceptives • High rate of discontinuation of contraceptive use among 15–19-years adolescents
Kenya	• Contraceptives are not in the National Health Insurance Fund (NHIF) package for secondary students • Limited offering of contraceptive solutions by the private health sector in rural/remote areas of the country • The Ministry of Health (MoH) Directive states that availing contraceptives to minors is illegal. In addition to minors being punishable by law if found using contraceptives • High unmet demand for contraceptives • Counterfeit contraceptives that have entered into the market and are widely available • Stalling of the Reproductive Health Bill 2019 which aimed to legalize the use of contraceptives among adolescent girls
Ghana	• The private sector is largely excluded from access to subsidized family planning commodities, accreditation, and Ghana Health Service's (GHS) supervision limiting wider access to contraceptives using private sector channels • High unmet demand for contraceptives • Data management issues: inaccurate or incomplete data on contraceptive usage, stock levels, and demand can hinder effective supply chain management
South Africa	• High unmet demand for contraceptives • Contraceptive stock-outs in the country

Existing challenges: Postpartum Care

Country	Targets
Cross-cutting challenges	• Social factors and stigma such as lack of community support, religious objections, and fear of prosecution
Kenya	• The stalling of the Reproductive Health Bill 2019 • Restrictive abortion law • Post-Abortion Care (PAC) is not included under the country's NHIF
Ghana	• Restrictive abortion law • Only less than 20 percent of the providers of PAC have met the criteria for basic or comprehensive care
South Africa	• Non-existing public health package for PPC

v. Conclusion

Opportunities to increase contraceptive use and improve PAC exist around education and outreach, accessibility, support systems, and policy advocacy as outlined in under potential solutions and opportunities section.

And address the issue of unintended pregnancies; the increase in contraceptive use, and Postpartum care needs to be prioritized. Increasing access to a variety of contraceptive methods for adolescents can help prevent unintended pregnancies and their associated health complications. Postpartum care includes both post-partum and PAC. Boosting postpartum care services specifically targeted towards adolescent mothers is crucial to reducing second and more pregnancies during their time of being an adolescent. Effective care provides essential support and monitoring during this vulnerable period, improving health outcomes for both mothers and their newborns.

Study Background

COWHA has embarked on a situational analysis study to access contraceptive use and PPC among adolescent girls in Kenya, Ghana, and South Africa. The study aims to give a local context and insights into the below aspects.

1. Assess contraceptive use among adolescent girls
2. Assess PPC among adolescent girls
3. Explore potential solutions and opportunities for addressing existing challenges and disparities in PPC and contraceptive use among adolescent girls in the three countries
4. Develop recommendations, which COWHA can take up in the future, for improving contraceptive access, utilization, and PPC outcomes for adolescent girls

The findings inform COWHA's advocacy efforts to improve policies and access to Sexual and Reproductive Health (SRH) services for adolescents, identify opportunities for partnerships with stakeholders, and develop programs to address the challenges and gaps identified. By addressing these gaps, COWHA can help reduce unintended pregnancies, improve maternal health outcomes, and empower adolescent girls. This study also enhances the knowledge base on adolescent SRH in Africa, further supporting COWHA's mission.

Methodology

The desk-review adopted the below procedural steps.

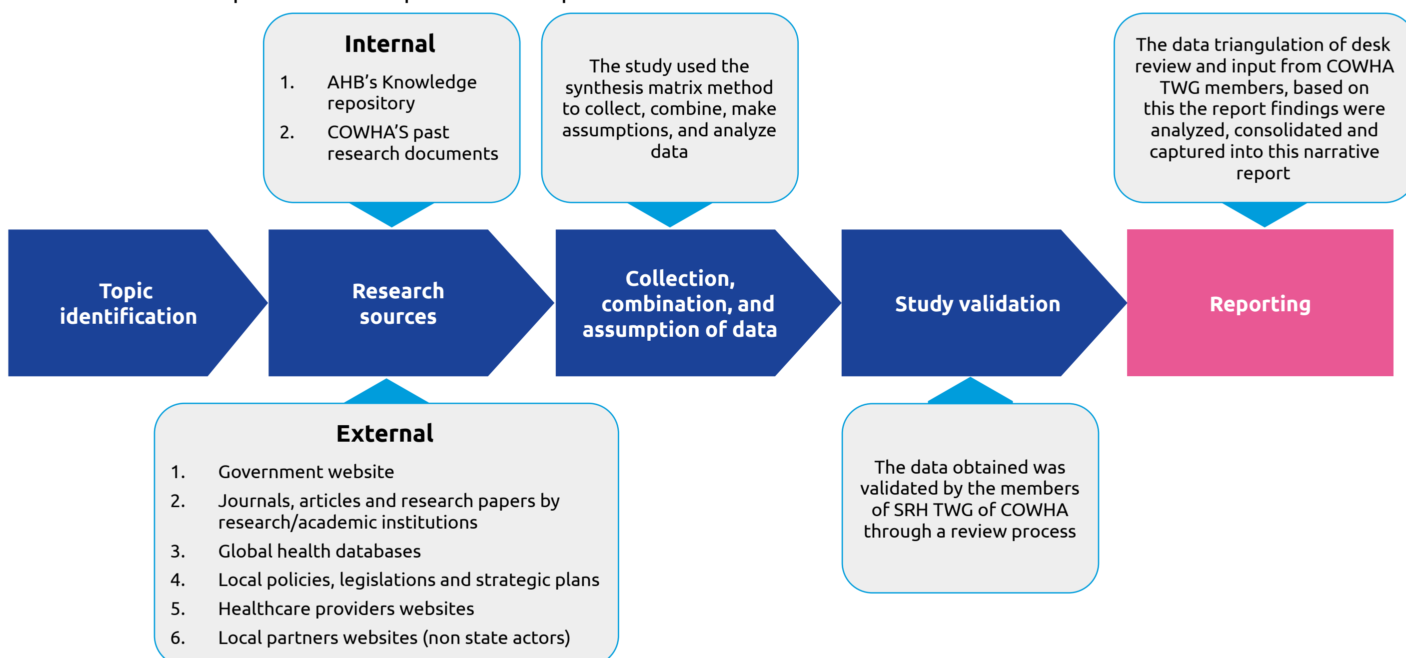


Figure 1: Study methodology

Study Limitations

While this study provides valuable insights into contraceptive use and PPC for adolescents in Kenya, Ghana, and South Africa, the below limitations must be acknowledged.

1. Cross-country comparisons were limited by the lack of uniform data and information available from secondary sources.
2. Limited scope of data and information as the study relied on a desk review approach only which may not be comprehensive or deep enough to address specificities in our research questions.
3. Out-of-date information: The study relied on the most current or updated sources of information, sometimes the information was several years old, which may not reflect the most current situation.
4. Lack of control over and inconsistencies in data quality as various sources used different research and data handling methodologies. However, having this in mind, the data obtained went through a series of reviews and confirmations, adding the years and data reference for justification.

1.0: Introduction

1.1: Key general demographics in Africa

Africa remains a diverse continent with a population of 1.49 billion people. In 2021, the female population represented 50.14 percent of the region's total population.
This continental number is comparable to the situation in Kenya, Ghana, and South Africa. On the continent, women give birth to four children on average. The fertility rates in Kenya, Ghana, and South Africa are 3.19, 3.4, and 2.29 respectively (1).

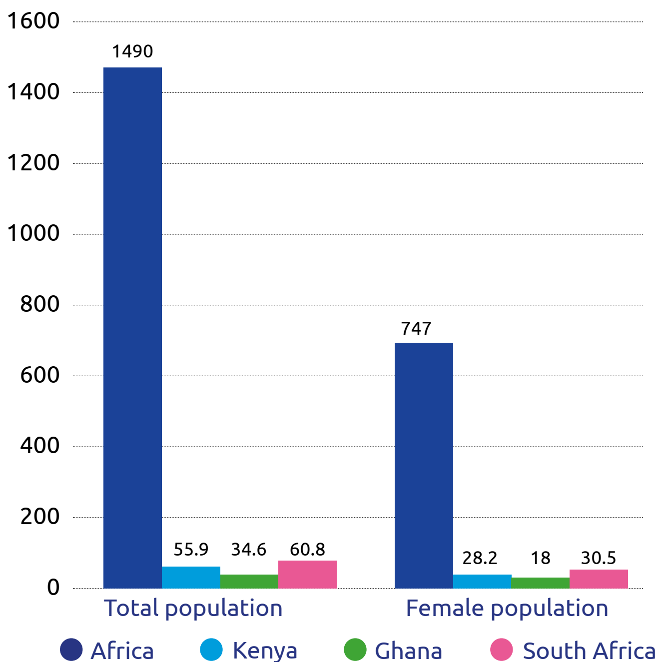


Figure 2: Female population (Kenya, South Africa, and Ghana)

Across Kenya, Ghana, and South Africa, the median (average) age ranges from 19 years in Kenya to 27 years in South Africa. In all three countries, females generally live longer than males. Life expectancy for females ranges from 65 years in South Africa to 66 years in Ghana, while life expectancy for males ranges from 60 years in South Africa to 62 years in Ghana (2,3).

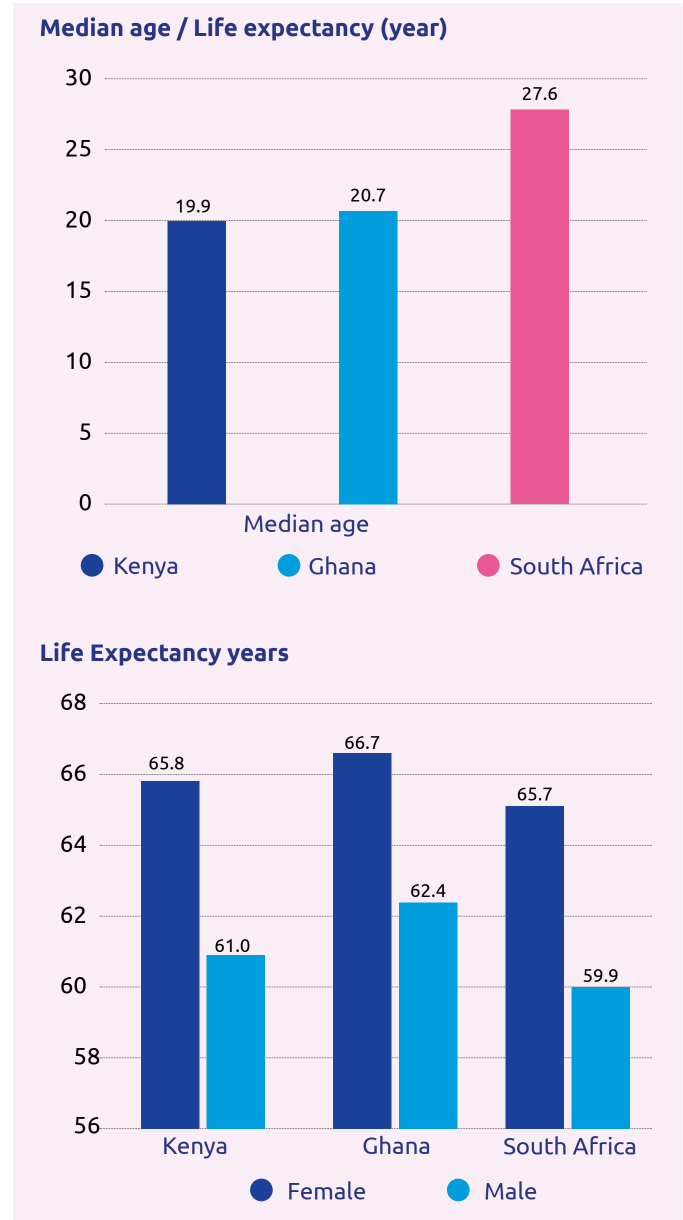


Figure 3: Median age/life expectancy – Kenya, Ghana and South Africa

1.2: Adolescent girls in Kenya, Ghana, and South Africa

"Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19 years. It is a unique stage of human development and an important time for laying the foundations of good health and wellbeing. To grow and develop in good health, adolescents need information, including age-appropriate comprehensive sexual health information; opportunities to develop life skills; access to quality health services plus effective, safe, and supportive environments. They also need opportunities to meaningfully participate in the design and delivery of interventions to improve and maintain their health". (4)

Numbering over 226 million, adolescents in Sub-Saharan Africa (SSA) make up the largest proportion of the adolescent population of the world. The number of adolescents will continue to grow as fertility rates in the region remain high (4). In 2021, about 132 million adolescent girls aged 10–19 years lived in the African Region covering 22 percent of the total female population in the region (5).

Out of the total female population per country in Kenya, Ghana, and South Africa, Kenya has the highest percentage of girls aged 10-19 years (24 percent), followed by Ghana (21 percent) and South Africa (17 percent) as shown in the below diagram (6).

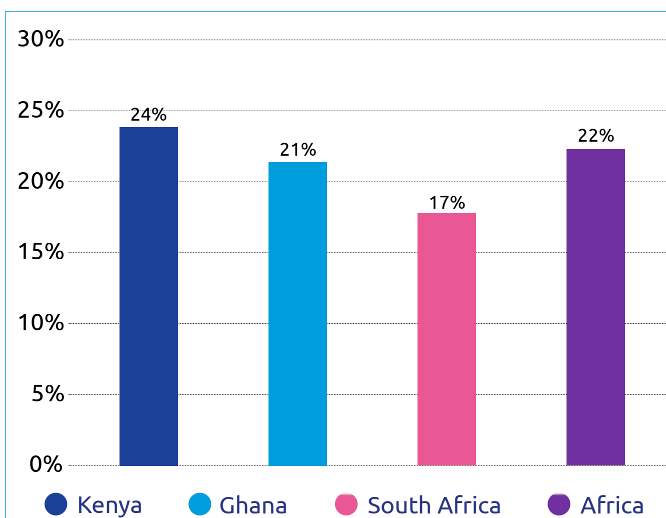


Figure 4: Percentage of adolescent girls (10-19 years) per country's total female population

1.3: Adolescent pregnancy: A health concern in Kenya, Ghana, and South Africa

Approximately 16 million adolescents aged 15–19 years old give birth each year in developing regions, including Africa. Another million girls younger than 15 years old also give birth annually (7). In Low and Middle-Income Countries (LMIC), complications of pregnancy, childbirth, and abortion are estimated to be among the leading causes of death for girls aged 15–19 years old. The higher prevalence among adolescents of hypertensive disorders of pregnancy and the higher risk of their babies having low birth weight (LBW) and/or being born prematurely have also been reported in numerous studies from both high and low-income countries (7).

Adolescent pregnancy is a significant public health concern in Africa, and in COWHA's focus countries Kenya, Ghana, and South Africa. The rate of birth per 1,000 among adolescent girls remains high in Kenya - 64, Ghana - 64, and South Africa - 61 as compared to the world's average – 42 (8) (9). Maternal-related conditions remain one of the top causes of death among adolescent girls aged 15-19 years. The critical postpartum period – the first six weeks after childbirth– is often neglected, especially for young mothers. Reasons for this are multiple: limited or difficult access to quality healthcare services due to geographic distance, quality concerns or lack of financial means and lack of awareness.

To mitigate increased adolescent pregnancies, contraceptive use, and PPC need to be prioritized and incorporated into the care cycle of delivery and increasingly adopted, especially for adolescent girls who have given birth because they are at higher risk for post-delivery complications and new unplanned pregnancies. Increasing access to a variety of contraceptive methods for sexually active adolescents can help prevent unintended pregnancies and their associated health complications. PPC includes both postpartum and PAC. Boosting PPC services specifically targeted towards adolescent mothers is crucial. Effective care provides essential support and monitoring during this vulnerable period, improving health outcomes for both mothers and their newborns. In addition, the reasons and mitigations for this focus are actionable and relatively simple to implement in advocacy efforts and strategies where adolescents can champion the gaps and share success stories on how these gaps can be overcome.

"Contraception or birth control is the prevention of ovulation (stopping the ovaries from releasing eggs) or prevention of fertilization of an egg by a sperm (conception) or the prevention of attachment of a fertilized egg to the lining of the uterus (implantation)".(10)

2.0: Contraceptive Use Among Adolescent Girls in Kenya, Ghana, and South Africa

Contraceptive methods can be classified into reversible and permanent methods as shown in the below diagram.

Contraceptive methods

Natural Methods

- Lactational Amenorrhea Methods
- Fertility awareness methods
- Withdrawal methods

Reversible Methods

LARC
- Copper T intrauterine device (IUD)
- Implant

User dependent
- Birth control patch.
- Birth control shot(injection)
- Vaginal ring
- Combined oral contraceptive (COC)
- Condoms
- Diaphram or cervical cap
- spermicide

Emergency Contraception

- Emergency contraceptive pill
- Copper IUD as an emergency contraception

Permanent Methods

Female sterilization
- Tubal ligation

Male Sterilization
- Vasectomy

Figure 5: Contraceptive methods

The total demand for contraception includes both met needs and unmet needs.

- Met need is the percentage of sexually active women who are currently using contraception.

- The unmet need for contraception is defined as the proportion of sexually active women who want to delay or stop childbearing but are not using contraception(11).

Among the 1.9 billion women of reproductive age, (15-49 years) worldwide in 2019, 1.1 billion needed FP; of these, 874 million were using modern contraceptive methods, and 164 million had an unmet need for contraception (12). The proportion of the need for FP satisfied by modern methods, Sustainable Development Goals (SDG) indicator 3.7.1, has stagnated globally at around 77 percent from 2015 to 2022. However, in SSA the number increased from 52 percent in 2015 to 58 percent in 2022 (13).

IUDs (161 million) and the birth control pill (150 million) are the most common used modern FP methods globally. Other modern methods have fewer users globally – injectables (72 million), implants (25 million), and male sterilization (17 million). Among traditional methods, 33 million women rely on the rhythm/calendar method, and 53 million on withdrawal (Coitus interruptus) (12).

The most common type of modern contraceptives used in Africa are injections (39.4 percent), condoms (17.5 percent), and implants (26.5 percent) (14). SSA is the only region globally, where injectables are the dominant method with a prevalence of 9.6 percent among women of reproductive age. An explanation for this might be the lower accessibility of quality healthcare services, where an injectable lasts longer which does not require a woman to visit a clinic for a "refill" too often, reducing the risk of encountering stock-outs, saving travel time and finances.

The prevalence of contraceptive use among sexually active adolescent girls in SSA is 25.4 percent, as per a cross-sectional study completed. The study shows that over 90 percent of the 25 countries studied had less than 50 percent contraceptive use among sexually active adolescent girls. Adolescent girls with higher education are eight times more likely than those with no formal education to use contraception. When compared to single adolescent girls, married adolescent girls are 66 percent less likely to use contraceptives. Adolescent girls with two or more children are seven times more likely than those without a child to use contraceptives (15). However, differences in specific cultural and community situations do persist.

Ghana

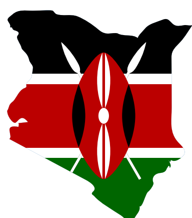
The use of modern contraceptive methods by women aged 15–49 years increased from five percent in 1988 to 28 percent in 2022. This is due to increased knowledge awareness, and access to contraceptives. The use of traditional methods (commonly abstinence and withdrawal) increased a little bit during this time (eight percent in 1988 and nine percent in 2022)(16).

For modern contraceptives, among all women of reproductive age, injectables (6 percent) and implants (5.3 percent) are the most used methods. Adolescents mostly use condoms, injectables, withdrawal, or implants (17). Young people value contraceptive methods for effectiveness (70 percent), no risk of harming health (31 percent) nor future fertility (26 percent), ease of use (20 percent), and no effect on menstruation (19 percent) (18).

In Ghana, the total demand for contraceptives amongst women aged 15-19 is 65.3 percent. The unmet need for FP amongst women aged 15-19 years is 31 percent. The below table shows an outline of the percentage use of contraceptives among 15-19-year-olds (19).

Method	Percentage of use
Any method	34.3
Any modern method	27
Female sterilization	0
Male sterilization	0
IUDs	0
Injectables	4
Implants	12
Pills	2.1
Male condom	4.3
Emergency contraception	0.7
Standard Days Method (SDM)	0.4
Lactation amenorrhea method (LAM)	3.4
Any traditional method	7.3
Rhythm	3
Withdrawal	3.3
Other	1
Not currently using	65.7

Table 1: The percentage use of contraceptives among amongst 15-19-year-olds in Ghana



Kenya

"The use of modern methods of FP among women aged 15-49 years has increased over time, from 18 percent in 1989 to 57 percent in 2022 with the use of traditional methods remaining relatively stable over the last three decades at about six percent". Albeit numbers from other sources might be inconsistent with this data, the above is what the Kenyan Demographic and Health Survey 2022 reports.

Out of the 70 percent of sexually active unmarried women (including adolescents), who use a method of FP; 59 percent use a modern method. The most popular type of FP method for sexually active women is the male condom (20). Reasons for this are the flexibility and visibility in use, easy access to purchase and the fact that the use prevents STIs.

In Kenya, 76 percent of women aged 15-49 years have a demand for FP; 38 percent prefer to space-out (delay) births, and another 38 percent prefer to limit (stop) births.

Since 2003, trends in contraceptive use have revealed a huge increase in uptake among women aged 15–24 years; with the use of long-term methods having increased fourfold. Among young women, 62 percent use modern methods, which is high considering the non-promoting attitude of the Kenyan government. However, the rate of contraceptive discontinuation is high among this group; with age and method of contraception being identified as the two significant determinants of discontinuation (21).

The below table shows an outline of the percental use of contraceptives among sexually active women, including adolescents, in Kenya (22).

Method	Percentage of use
Any method	70
Any modern method	59
Injectables	16
Male condom	20
Pills	6
Implants	11

Table 2: The percentage use of contraceptives amongst sexually active unmarried women, including adolescents, in Kenya

South Africa

In South Africa, 60 percent of sexually active women aged 15-49 are using contraception, and almost all of them are using a modern method. The use of modern methods of contraception by sexually active women is relatively high throughout the country, ranging from 51 percent in the Free State to 65 percent in KwaZulu Natal.

The most used contraceptive methods are injectables (Three months, 18 percent, and two months, seven percent) and male condoms (16 percent). The use of modern methods increases with education, from 44 percent among sexually active women with no education to 62 percent among sexually active women with more than secondary education (23).

About 19 percent of sexually active women aged 15-49 have an unmet need for contraception. The total demand including unmet need for contraceptives is 79 percent. The prevalence of contraceptive use among active adolescent girls in South Africa is 59.8 percent (14).

The below table shows an outline of the percentage use of contraceptives among sexually active women aged 15-49, including adolescents, in South Africa (21).

Method	Percentage of use
Any modern method	59
Injectables	25
Male condom	16
Pills	7
Implants	4
Female sterilization	6
Other modern method	2

Table 3: The percentage use of contraceptives amongst sexually active women aged 15-49 in South Africa

2.1: Cross-cutting factors influencing contraceptive use among adolescent girls in Kenya, Ghana, and South Africa

The use of contraceptives among adolescent girls is influenced by various factors:

- Accessibility barriers, such as lack of availability and affordability, significantly hinder their ability to obtain contraceptives.
- Fear and misconceptions about the effects and safety of contraceptive methods further decrease their usage.
- Knowledge and empowerment play a critical role, as informed and confident adolescents are more likely to utilize contraception effectively. Individual factors, including personal beliefs and health considerations, also shape contraceptive choices.
- Additionally, social and cultural factors, encompassing societal norms and peer influences, largely impact adolescents' attitudes toward contraception. In addition to stigma, discrimination and provider behaviour.

Category	Factor
Accessibility barriers	• Stockouts • Limited options for contraceptive methods • Long waiting times • Lack of privacy and confidentiality
Fear and misconceptions	• Fear of side effects • Myths and misconceptions
	» Weight gain is a major concern for women considering hormonal birth control - A lot of research has gone into this and has not demonstrated a consistent effect of contraceptives on weight gain. » Coils and pelvic infections - Women considering using coils often ask if they will be more prone to pelvic infections. Coil does not increase the risk of acquiring pelvic infections. » Libido - research shows that most women on hormonal contraceptives report no changes in Libido. A small portion may report reduction, but this may be connected to an emotional connection with the partner, levels of stress, and hormonal fluctuations. » Infertility - women are also worried if the method will make them infertile or will delay conception. No contraceptive method other than sterilization causes infertility.
Knowledge and empowerment	• Education and awareness • Assessing the right method
Individual factors	• Poverty (ability to afford contraception) • Easily concealed methods (desire for discretion) • Number of children (greater likelihood of using contraception with more children) • Media influence (exposure to family planning information)
Social and cultural factors	• Religious beliefs • Parental hindrance • Stigma • Negative attitudes of healthcare providers • Peer/friends/boyfriends support of contraceptive

Table 4: Cross-cutting factors influencing contraceptive use among adolescent girls in Kenya, Ghana, and South Africa (23) (16) (23) (24)

2.2: The funding and supply chain of contraceptives

The FP commodities, including contraceptives, are mainly procured using the public sector means which are largely funded by donors in Kenya, South Africa, and Ghana. The private health sector remains a key contributor to the supply of these commodities at the country level. Below is more in-depth information on the funding and supply of contraceptives per country.

Kenya

The supply of free-to-patient or subsidized contraceptives in the public sector is provided by the national procurement body, Kenya Medical Supplies Agency (KEMSA). At KEMSA, public facilities are given priority for commodities, however, private facilities may also access these at no cost, when available, if they are registered with a Master Facility List number and provide monthly service reports using MoH registers.

Contraceptives through KEMSA are paid through defined sources of financing (via donors and the national government). The main payers of family planning are the Government of Kenya, the United Nations Population Fund (UNFPA), the United Kingdom (UK), the United States Government (USG), the Bill and Melinda Gates Foundation (BMGF) and the World Bank (Global Financing Facility (GFF) (26). In the financial year 2019/2020, the Government of Kenya accounted for 27 percent of the country's FP commodity funding as shown in the below pie chart.

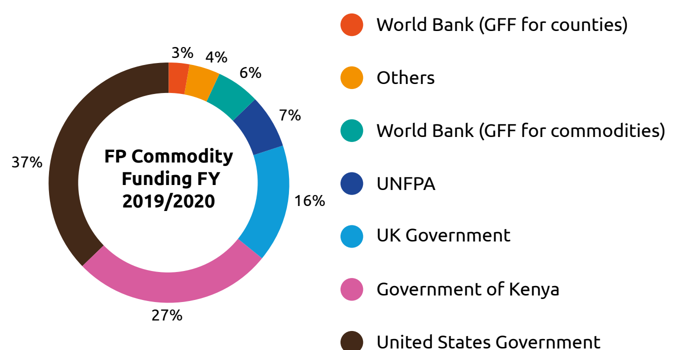


Figure 6: Kenya's FP commodity funding FY 2019/2020

In 2022, the global FP funding from donor organizations covered USD 1.35 billion. This represents a decline of USD 129 million since 2021, when it was USD 1.48 billion, and marks the lowest level of funding since 2016 (27). Donor contributions have been declining because of declining global funding commitments as LMIC governments are expected to take a greater share of the responsibility for financing healthcare. In 2024, the Kenyan government is expected to cater for 80 percent of the FP budget as donor funds will

have significantly decreased. The country is required to increase its domestic funding for FP commodities to cover 100 percent of the requirements by 2026 (26). This has not happened and the sustainability of FP commodities is at risk. Consumers in Kenya may be forced to purchase their family planning methods out-of-pocket or forego the services entirely. Costly contraceptive methods that depend on donor support, such as implants, may become less available.

In 2022, the total government expenditure on FP was USD 32 million. This means that on average USD 0.14 is spent on FP per person. To ensure the sustainability and continuation of FP services, the Government of Kenya and development partners have entered an Memorandum Of Understanding (MOU) for the government to gradually increase its funding for FP commodities in preparation for donor exit by 2026. As an LMIC, Kenya has declared FP commodities as strategic and thus there is a need to ensure full domestic financing. To do this, the government will have a ring-fenced budget allocation for FP commodities and engage with key decision-makers to advocate for FP as a development agenda, ensure timely disbursement and efficient utilization of allocated funds, push for Medium Term Expenditure Frameworks (MTEFs) engagement and participation, and implement an annual resource flow monitoring (28).

In 2019, The UNFPA supported the Ministry of Health (MoH) Kenya and KEMSA in building a responsive and resilient supply chain through the development of an early warning and alert system for reproductive health commodities and other essential medicines. The commodity security alert system proactively tracks monthly consumption data to advise on overstocking and understocking, thereby minimizing stock-outs, wastage, and expiries.

The market for non-subsidized contraceptives in Kenya is small and may be, currently, insufficient to play a significant role in strengthening the sustainability of the FP market, if current market conditions persist (29). Non-subsidized contraceptives contribute to only two percent of the total contraceptive volume, and are largely dominated by emergency ECs and COCs. ECs are distributed in limited quantities by KEMSA, together with donor-implementing partners Population Service International (PSI) and DKT International. Non-subsidized contraceptives are usually supplied to the market by organizations such as DKT International, PSI, Marie Stopes International (MSI), and private pharma distributors (30).

About 50 percent of public sector contraceptive users receive these at no-cost (31). Pharmacies are restricted by regulation from administering injectable contraceptives. However, they source huge quantities of other subsidized products from KEMSA.

The ability to pay for contraceptives remains a challenge as 38.6 percent of the population lives below the poverty line of USD 1.90 a day (32), this is why free or subsidized contraceptives are needed. More than eight in ten of the people living below USD 1.90 a day rely on the public sector for family planning solutions. More attention is needed to target subsidies to the poorest and ensure government facilities are well-equipped to cope with lost user fee revenue.

The current NHIF's in-patient package includes surgical FP procedures while the out-patient package includes long- and short-acting methods of FP. A secondary school student package has also recently been introduced which does not include contraception but does allow students to be linked to Linda Mama for free maternity care. Neither of these schemes adequately addresses FP services and prevention of pregnancy (33). We hope more for inclusion and coverage for contraceptive services for adolescents in the new social health insurance scheme (SHIF). FP remains less covered by private health insurance (as approved by the employer) as it is not classified as a medical need but considered as a lifestyle decision. Most contraceptive users are forced to purchase them out of pocket when the free ones from the public healthcare facility get exhausted.

Below are the key statistics regarding public and private sector contributions to the FP market (34).

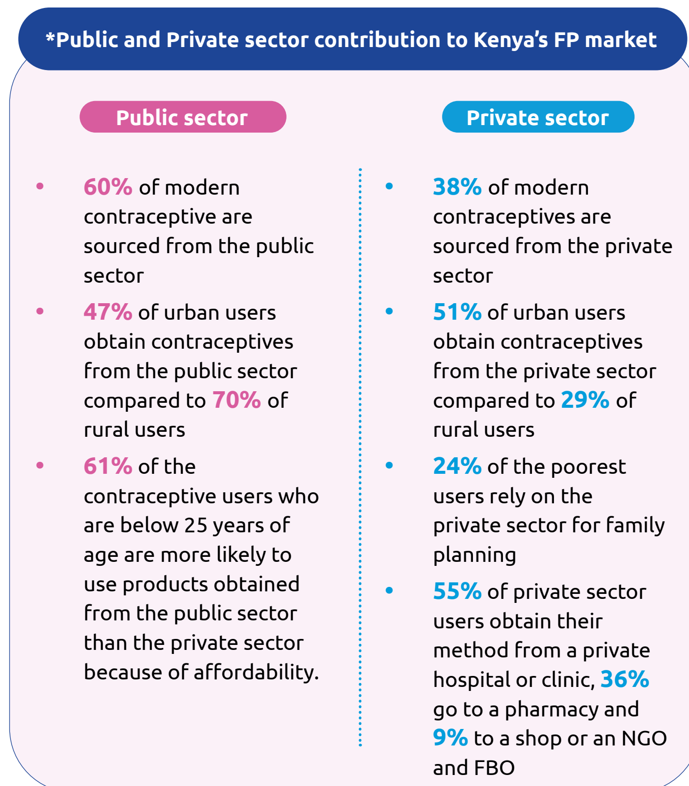


Figure 7: Public and Private sector contributions to Kenya's FP market

**Please note that the inconsistencies in comparisons are due to the limited availability of data across the three priority countries in this study.*

Ghana

In Ghana, the procurement of medical products is conducted by the Procurement Unit of the Ghana Health Service (GHS), monitored and supervised by the Public Procurement Authority. Procured medical products are stored in the Central Medical Stores which are then supplied countrywide through regional medical stores. The main sources of FP commodity funding are the Government of Ghana, UNFPA, and United States Government, and the Government of the United Kingdom.

The private sector has historically been excluded from procurement planning for national FP efforts. Private-sector facilities purchase commodities directly from commercial suppliers. The method mix provided in private facilities is more limited than in public facilities, particularly for long-acting reversible methods. Less than a quarter of private facilities offer IUDs or implants, and less than a third provide injectables (35).

In the context of Ghana's progression to middle-income status, the country must increasingly fund health services from domestic resources. The country has a dedicated budget line for essential health commodities including contraceptives and has included modern contraceptive methods in the National Health Insurance Scheme (NHIS)

benefit package. The current percentage of funding from government domestic financing ranges from 25 percent to 33 percent (36). There is a continued call for Ghana to increase domestic funding for FP commodities to ensure commodity security and maintain gains made in modern contraceptive use. In 2022, the domestic government expenditure on FP was USD 5 million (37). This means that on average USD 0.57 is spent FP per person.

In 2026, Ghana aims to achieve a ten percent target for FP commodity procurement and by 2030 achieve a 20 percent target for FP commodity procurement (38).

Below are the key statistics regarding public and private sector contributions to the FP market (39).

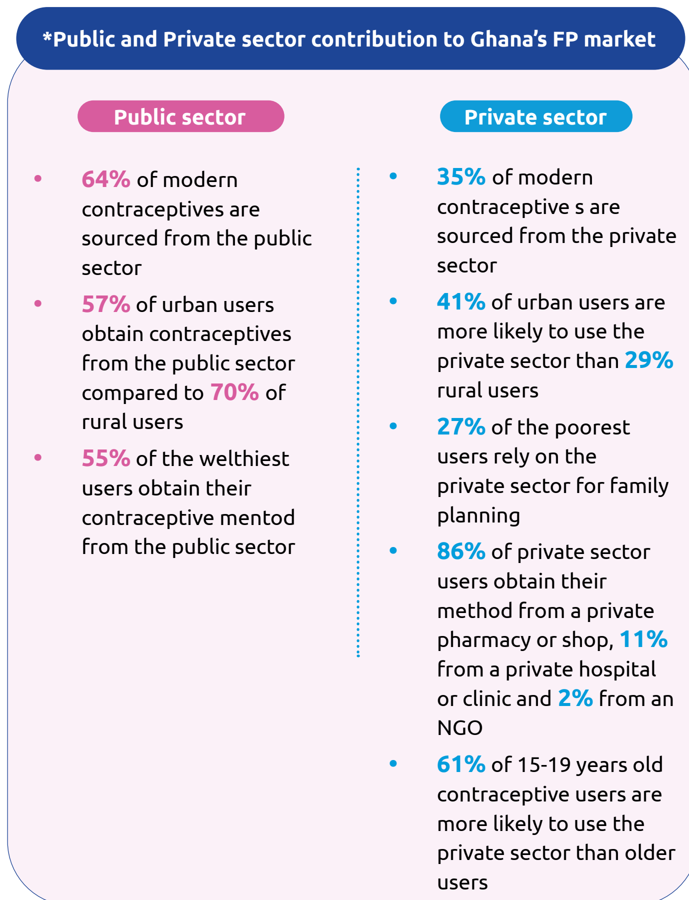


Figure 8: Public and Private sector contributions to Ghana's FP market
**Please note that the inconsistencies in comparisons are due to the limited availability of data across the three priority countries in this study*

South Africa

In South Africa, the FP supply chain is multi-faceted within both the government system and the private sector. South Africa is an upper- middle income country and the government remains the main contributor for the FP commodity funding. In September 2017, the end of the global support as a LMIC for the supply of oral and injectable contraceptives to public sector facilities in South Africa was associated with considerable supply disruption, impacting not only the public sector but also the private sector (40). The government remains the main funder for contraceptives, but funding gaps exist to date. The base cost of contraceptive use in South Africa is USD 90 million per annum as per 2018 estimates (41). This is approximately one percent of the government's national health budget. This means that USD 1.48 is spent on FP per person per annum.

Below are the key statistics regarding public and private sector contributions to the FP market (42).

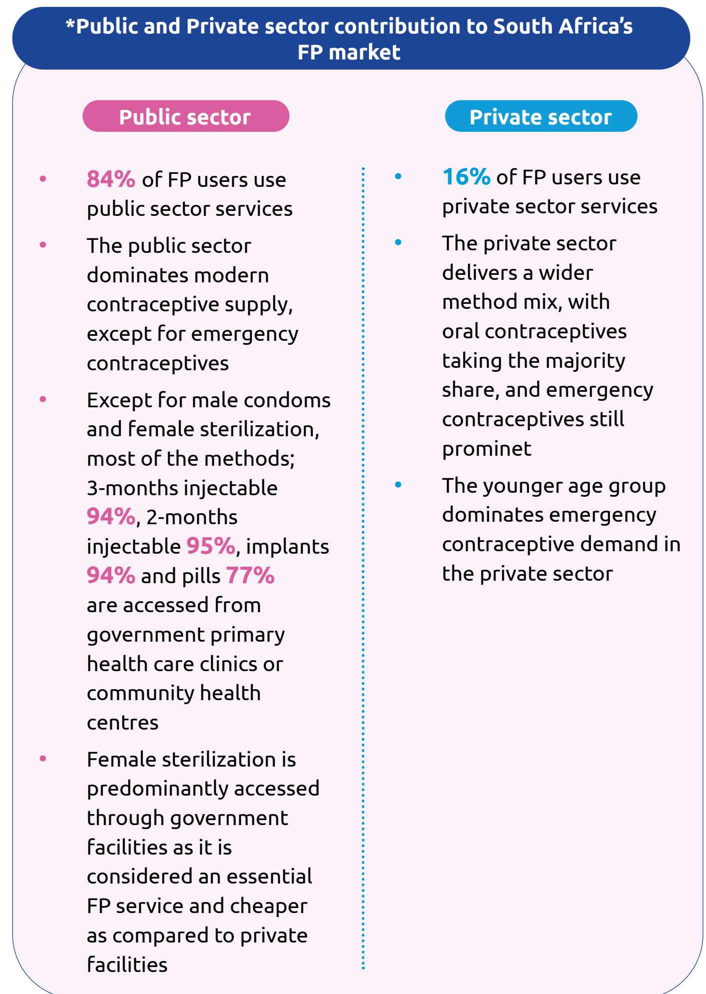


Figure 9: Public and Private sector contributions to South Africa's FP market
**Please note that the inconsistencies in comparisons are due to the limited availability of data across the three priority countries in this study.*

Contraceptive stock-outs have been a challenge in South Africa. Out of 6.9 percent of clinic stockouts, 40 percent cover contraceptives. Out of these, the most reported shortages are injectable contraception, at 81 percent, and oral contraception at 15.9 percent (43). The USAID global funded supply chain project, GHSC-PSM, recently funded a study on oral and injectable contraceptives in South Africa. The study concluded that contraceptive security in South Africa "can be enhanced by a broad method mix, a deliberate attempt to attract a range of suppliers of similar, if not identical, products, and ongoing support to women and the healthcare workforce regarding the availability and advantages of different methods"(40).

2.3: Policy and regulatory frameworks for contraceptives in Kenya, Ghana, and South Africa

Country	Policy Framework	FP commitments by 2030 (43)
Kenya	• FP services fall under the Reproductive and Maternal Health Services Unit (RMHSU), Division of Family Health, MoH. • The 6th edition of the National Family Planning Guidelines for Service providers prioritizes the following areas towards universal access to family planning services; 1. advocacy for family planning services including post-pregnancy family planning, 2. FP Commodity security, 3. demand creation, 4. focus on adolescents, the youth, and vulnerable populations, 6. integration of FP services into HIV and other programs, 7. capacity strengthening, and 8. monitoring and evaluation for FP services. • The MoH Kenya, through the "Delivering Sustainable and Equitable Increases in Family Planning in Kenya" (DESIP) program funded by the Foreign, Commonwealth & Development Office (FCDO), aims to revise the review of the 6th Edition of National Family Planning guidelines of 2018 in 2024. The DESIP programme seeks to ensure greater and more equitable access to and uptake of FP services in 19 (Wajir, Garissa, Mandera, Samburu, Isiolo, Marsabit, Kilifi, Lamu, Kwale, Tana River, Mombasa, Baringo, Narok, Kajiado, West Pokot, Elgeyo Marakwet, Turkana, Migori and Homa Bay) priority counties in Kenya, with the following as its key output: Greater availability of FP commodities, greater demand for FP commodities, sustainability of the private sector, and improved and sustainable national ownership (45). • The National Adolescent Sexual and Reproductive Health policy (ASRHP), 2015 aims to enhance the SRH status of adolescents in Kenya and contribute towards the realization of their full potential in national development. Through the policy, the government aims to increase the contraceptive prevalence rate for any contraceptive method among adolescent women (15-19 years) by 55 percent and condom use at sexual debut to 80 percent by 2025 (46).	• Increase modern contraceptive prevalence rate (mCPR) for married women from 58 percent to 64 percent by 2030. • Reduce unmet need for FP for all women from 14 percent to 10 percent by 2030. • To ensure the sustained availability of FP commodities to the last mile. • To enhance the capacity of human resources for health (HRH) to provide FP information and services while also focusing special attention on the under-served, vulnerable, and hard-to-reach population including populations in humanitarian/emergency situations. • Reduce pregnancy rate among adolescent girls (15-19 years) from 14 percent to 10 percent by 2025 • Transform social and gender norms to improve male engagement in FP and eliminate social-cultural barriers to FP service utilization. • Improve availability and utilization of quality FP data for decision-making. • Increased domestic financing for FP commodities to cover 100 percent of the requirements by 2026.
Ghana	• At the national level, the health governance in Ghana is split into two; The MoH Ghana and GHS. • The MoH in Ghana sets policies and guidelines for healthcare delivery, including FP. It provides strategic direction for FP programs, ensuring alignment with national health objectives. • GHS plays a central role in coordinating and implementing FP programs in Ghana. It oversees the procurement, distribution, and monitoring of contraceptives to health facilities across the country. GHS also provides training and support to healthcare workers involved in FP services that fall under the Reproductive and Child Health Department, Family Health Division (FHD), GHS. Its vision is to improve the health status of mothers, children, adolescents, young people, women, and men of reproductive health through equitable access to appropriate, comprehensive, quality and cost-effective reproductive health information, education and services. • All individuals and couples including adolescents in Ghana are eligible for FP services according to the National Reproductive Health Service Policy and Standards 2014 (47).	• By the end of 2030, all persons of reproductive age in Ghana will have equitable and timely access to quality FP information, commodities, and services. • Implement the roll-out of FP under the National Health Insurance Benefits Package, increasing the number of districts currently providing FP on NHIS to 75 percent by September 2027 and 100 percent by 2030. • Increase government financial commitment to procure 20 percent of Ghana's FP commodities needs by 2030, addressing the decline in funding from development partners. • Increase the mCPR among currently married women or women in a union from 30 percent in 2020 to 44.4 percent by the end of 2030, through expanded method choice, improved service delivery, and enhanced data management. • Reduce unmet need for contraception among sexually active adolescents from 57 percent to 30 percent by December 2030, by promoting reproductive health education, strengthening partnerships, and improving access to FP services. • Develop and implement a targeted social and behavior change communication plan that focuses on rights-based FP, aiming to provide correct and consistent information to promote FP adoption.

Country	Policy Framework	FP commitments by 2030 (43)
South Africa	• FP services are linked with the HIV/AIDs, TB and Maternal & Child Health programmes of the National Department of Health. According to the Revised National Contraception Clinical Guidelines (2019), the age criteria for a child to be provided with contraceptives including condoms is 12 years but with proper clinical screening, advice, and management. The age criteria for which a person can be sterilized is 18 years. Young people can safely use any contraceptive method.	• Strengthen FP services to ensure widespread access and improved quality of care throughout South Africa. • Emphasize the importance of using both contraception and measures to prevent STIs to ensure dual protection. • Develop and implement standardized operating procedures for community health workers, clinic nurses, and midwives to effectively promote and provide FP services. • Targets the teenage population through tailored interventions and comprehensive reproductive health education to reduce the rates of teenage pregnancies. • Launch a comprehensive school health program, particularly for girls, to provide information on reproductive health rights, FP, contraception, and safe sexual practices.

2.4: Key emerging issues/trends on contraceptive use among adolescent girls

While access to contraceptives for young women has gradually improved in Kenya, Ghana, and South Africa, in recent years and months new challenges, issues, and trends have emerged. The below table shows some of the key issues and trends in contraceptive use among adolescent girls.

Country	Emerging Issues/Trends
Kenya	• Minors in Kenya can be punished by jail time according to law if found using contraceptives. The MoH in 2022 indicated that giving contraceptives to minors is illegal. This contradicts the Children's Act in the guidelines or in the National Adolescent Sexual and Reproductive Health Policy (NASRHP) which has no clauses indicating that it is criminal to provide contraceptives to minors (48). • Adolescents must seek consent from their parents/guardians, or the parent/guardian must be present before the contraceptive is administered as per the existing Children Act, 2022. • The reproductive health bill of 2019 has been put on hold for further discussion following its second introduction in the Parliament in 2020. The Bill provides a legal framework to support increased access to reproductive health services, including contraceptives and to legalize abortion among adolescents in Kenya (49). • In 2021, the Kenya Institute of Curriculum Development (KICD) dismissed civil advocacy to introduce comprehensive sex education in Kenyan schools, stating that it is unconstitutional as school children are minors and cannot make their own decisions on sexual consent. The country still lacks a proper framework to guide the required parental consent for students to receive sex education (50). **Percent Distribution of Married and Sexually Active Unmarried Adolescents Women Aged 15-19 by Modern Contraceptive Use** 2003 KDHS: Sexually Active Unmarried 25.9; Married 16.4 2008/09 KDHS: Sexually Active Unmarried 24.7; Married 19.6 2014KDHS: Sexually Active Unmarried 49.3; Married 36.8 2022 KDHS: Sexually Active Unmarried 43.8; Married 36.9 Sexually active unmarried women 15-19 years who use modern contraceptives Women 43.8% *Figure 10: Trends in the use of modern contraception among adolescents source: (51)*
Ghana	• Ghana under the expansion of the NHIS included long-term contraception methods such as the injection, implant, and coil which will be available at no cost to the user at the point of use, eradicating out-of-pocket costs (52).
South Africa	• South Africa is facing a shortage of birth control stock at public health facilities. In 2022, stock-outs of contraceptives represented 40 percent of all medicine stock-outs reported (53). • South Africa has been using first-in-kind vending machines for contraceptives, HIV kits, pregnancy tests, as well as sanitary towels in the Eastern Cape at Mthatha Ultra City. This initiative is targeting girls and women of childbearing to increase access to sexual reproductive health and HIV prevention services. These vending machines will carry a variety of oral contraceptives and emergency contraceptives/morning-after pills and HIV prevention, such as HIV self-testing kits, lubricants, male and female condoms, pregnancy tests, and sanitary towels (54).

3.0: Postpartum Care for Adolescent Girls

3.1: Postpartum care (PPC) and its importance

The post-pregnancy period also called the postpartum or postnatal period, is the first six weeks (42 days) after pregnancy and delivery of a baby. The post-pregnancy period can also include the post-abortion period. During this time, the mother's body returns to its pre-pregnancy state (55).

PPC is defined as care given to the mother and her newborn baby immediately after the birth of the placenta and for the first six weeks of life.

PAC includes any, or all, of the following, as needed or desired: Follow-up care after abortion, incomplete abortion, management of non-life-threatening complications: infection and haemorrhage, post-abortion contraception and according to the WHO abortion care guideline. Abortion can either be spontaneous or induced through medical procedures. Consistent care is required on both occasions. Abortion can be unsafe when self-managed or induced by unskilled professionals which can bring about complications such as incomplete abortion, haemorrhage, infection, uterine perforation, anesthesia-related complications, and uterine rupture (56). In line with international human rights law and medical best practice, post-abortion care should always be provided regardless of whether abortion is restricted in a particular setting.

Effective PPC is needed to provide support to the child-bearer, prevent, provide early diagnosis and treat complications, refer to specialized care, when necessary, support exclusive breastfeeding (in case of parity and life-birth), offer counseling and service provision for contraception and the resumption of the sexual activity.

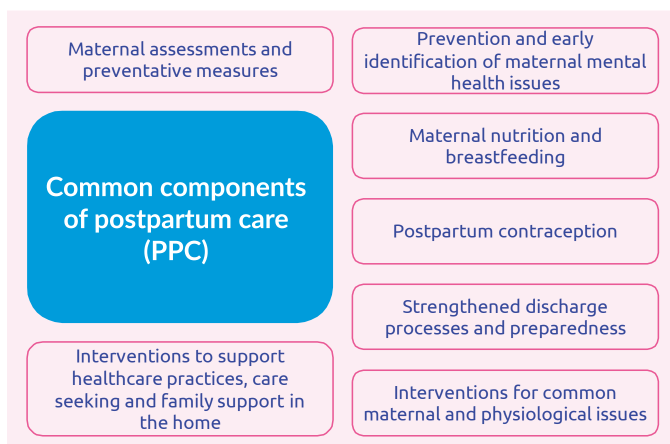


Figure 11: Key components/elements of PPC (57)

What can occur during the post-pregnancy period?

After childbirth, a mother can expect to have some physical changes and symptoms, but they are usually mild and temporary. Severe health issues are rare. Nonetheless, the doctor, hospital staff members, or health care plan usually sets up a program of follow-up office or home visits.

The most common complications after childbirth include postpartum hemorrhage - may occur soon after delivery but may occur up to six weeks later, uterus infection, bladder and kidney infections, breast infections, problem with breastfeeding, and depression (65). As earlier on mentioned, post-abortion complications may include incomplete abortion, haemorrhage, infection, uterine perforation, anesthesia-related complications, and uterine rupture.

3.2: Maternal mortality during the postpartum period in SSA

In 2009, the African Union launched the Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) with the theme "Africa cares: No woman should die while giving life". CARMMA's operations are derived from key priority areas enshrined in the 2005 African Union's policy framework for the promotion of sexual and reproductive health and rights in Africa and the Maputo Plan of Action (2006). CARMMA focuses on three key areas which are: Public information and advocacy, encouraging achievements and strides made in some countries in reducing maternal mortality and seeking to replicate them, and intensifying actions aimed at reducing maternal and infant mortality. The campaign mobilizes increased political commitment and action to reduce maternal mortality in countries with high rates. CARMMA was initially envisioned as a ten-year campaign but in 2021, a new phase was launched and is scheduled to continue till 2030.

Similarly, the WHO developed the Ending Preventable Maternal Mortality (EPMM) Global initiative. The initiative has established new coverage targets and milestones that need to be achieved by 2025 if the SDGs are to be met, which include.

- 90 percent of pregnant women attend four or more antenatal care visits (towards increasing to eight visits by 2030)
- 90 percent of births to be attended by skilled health personnel
- 80 percent of women who have just given birth to access postnatal care within two days of delivery
- 60 percent of the population to have access to emergency obstetric care within two hours of travel time
- 65 percent of women can make informed and empowered decisions regarding sexual relations, contraceptive use, and their reproductive health

Globally, the main causes of maternal mortality are complications of unsafe abortion (8 percent), embolism (3 percent), hemorrhage (27 percent), hypertension (14 percent), sepsis (11 percent), others direct and indirect complications (10 and 28 percent) respectively (58).

SSA has a maternal mortality rate of 545 per 100,000 live births. It accounted for 70 percent of global maternal deaths in 2020. Most of the maternal deaths occur during the postpartum period as compared to during pregnancy or labor and delivery; approximately two-thirds of maternal deaths occur in the postpartum period(59).

Despite more women delivering in health facilities, which is known to improve outcomes due to appropriate and timely access to skilled care, many women are still at high risk of death. The postpartum period receives much less attention than pregnancy or childbirth. However, the period after birth still poses substantial risks to mothers and can result in significant maternal morbidity and mortality. Among women who die in the postpartum period, 80 percent of deaths occur within the first week after delivery. Women who do deliver in health facilities are typically discharged within 24 hours without further follow-up, resulting in a gap in care during a high-risk period (60).

The WHO recommendations for postpartum care include continuous care in a healthcare facility for up to 24 hours and further postpartum clinical examinations at 48-72 hours, 7-14 days, and 6 weeks after birth.

"According to the WHO, A skilled birth attendant is an accredited health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (i.e. uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of women and neonates for complications."

Skilled health personnel is lacking especially in rural areas in both Kenya and Ghana with 30 percent and 21 percent of deliveries being attended by unskilled health personnel. South Africa has met the EPMM goal of ensuring 90 percent of births are performed by skilled health personnel. Seeking PPC two days after delivery remains an issue of concern that needs to be addressed in Kenya, Ghana, and South Africa.

Country	Percentage of deliveries by skilled health personnel	Post-pregnancy care
Kenya	70 percent	78 percent of women seek PPC within two days of delivery and 20 percent do not come for PPC within 41 days of delivery
Ghana	79 percent	The rate of postnatal visits is 71 percent
South Africa	97 percent	84 percent of women seek PPC within two days of delivery and 16.4 percent do not come for PPC within 41 days of delivery

Table 5: Percentage of deliveries by skilled personnel and PPC (59)

Within the postpartum period, obstetric complications are the primary cause of direct maternal deaths worldwide. Complications such as hemorrhage, hypertension, and sepsis account for 62.4 percent of maternal deaths in SSA. Each of these complications has identifiable warning signs that, if noticed early, are likely to result in improved maternal outcomes. Therefore, ensuring knowledge of warning signs of complications is a key strategy in improving complication management outcomes and reducing deaths resulting from delays in seeking or inadequate care. The use of portable ultrasounds in the most remote areas, could help with much of this. It has been tested in Kenya, but not scaled.

Since the year 2000, Ghana has significantly managed to reduce the maternal mortality ratio (MMR) as compared to Kenya and South Africa. MMR remains high in Kenya (61) main reasons have been limited access to quality healthcare, and high MMR rates in North and East Africa regions.

Country	Maternal mortality (2000)	Maternal mortality (2020)
Kenya	564	530
Ghana	499	263
South Africa	173	123

Table 6: Maternal mortality ratio per 100,000 live births in Kenya, Ghana, and South Africa

Maternal-related conditions remain one of the top causes of death among adolescent girls aged 15-19 years in Kenya and Ghana. Adolescent pregnancy is particularly dangerous and imposes more complications as adolescent girls' bodies are still maturing, and their organs may not be fully developed to handle the demands of pregnancy and childbirth. This increases the risk of complications such as pre-eclampsia, excessive bleeding, and infections. Others include the risk of preterm birth and increased need for cesarean sections.

Country	Adolescent girls (10-14 years)	Adolescent girls (15-19 years)
South Africa	• Diarrheal diseases • HIV/AIDs • TB • Lower respiratory infections • Interpersonal violence	• HIV/AIDs • TB • Lower respiratory infections • Self-harm • Interpersonal violence
Ghana	• Diarrhoeal diseases • HIV/AIDS • Malaria • Road injury • Meningitis	• HIV/AIDs • Malaria • TB • Maternal conditions • Road injuries
Kenya	• Diarrhoeal diseases • HIV/AIDS • Malaria • Road injury • Meningitis	• Diarrheal diseases • HIV/AIDs • TB • Maternal conditions • Road injuries

Table 7: Top causes of death among adolescent girls aged 10-19 (60)

3.3: Birth rates among adolescent girls: Kenya, Ghana, and South Africa

The rate of births amongst adolescent girls aged 15-19 in Kenya has been significantly reducing since 2010 though the number remains high. In Ghana and South Africa, the rate has slightly reduced. The birth rate in the three countries was almost equal in 2021(62). However, immense efforts to reduce the rate of births are needed.

In 2023, adolescent girls contributed to 17 percent of total pregnancies in Kenya. This is approximately 254,000

pregnancies. In the same year, 10.6 percent (102,673 pregnancies) of adolescent girls got pregnant in Ghana. Adolescent pregnancies in South Africa stood at 150,000 (8)(9)(63).

Country	Rate of birth per 1,000 among adolescents (15-19 years) (2010)	Rate of birth per 1,000 among adolescents (15-19 years) (2021)
World	Unknown	42
Kenya	101	64
Ghana	68	64
South Africa	67	61

able 8: Birth rates among adolescents: in Kenya, Ghana, and South Africa

3.4: Policy and regulatory framework in relation to PPC

Country	Policies & guidelines
Kenya	• In Kenya, PPC falls under the Department of Family Health under the MoH. • Guidelines for Postnatal Care to Mothers and Newborns 2016 outline a model in practice for maternal and newborn health comprised of targeted postpartum and post-abortion care. • The National Reproductive Health Policy 2022-2032 aims to reduce maternal morbidity and mortality due to obstetric hemorrhage, sepsis, hypertensive disorders, obstructed labor, and post-abortion complications and to improve reproductive health outcomes among adolescent girls and young women.
Ghana	• In Ghana, PPC falls under the Family Health Division under the GHS. • Ghana Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Strategic Plan 2020-2025 aims to offer all people in Ghana timely access to high-quality RMNCAH&N services.
South Africa	• In South Africa, PPC falls under the Directorate of the Maternal, Child, and Adolescent Health (MCAH) under the National Department of Health. • Guidelines for maternal care 2016 guide health workers in providing obstetric, surgical, and anesthetic services for pregnant women in district clinics, health centres, and district hospitals. It recommends various steps in postnatal care, including potential emergencies and how to prevent and treat options in case of occurrence. • South African Maternal, Perinatal, and Neonatal Health Policy aims to reduce maternal, perinatal, and neonatal morbidity and mortality rates by 50 percent by 2030, in line with the SDGs. The policy focusses on the reproductive lifecycle from pre-conception in preparation for safe motherhood, the antenatal period, the fetus, delivery, and through the neonatal and postnatal periods, including access to post-delivery contraception.

Table 9: Policies and guidelines for PPC in Kenya, Ghana, and South Africa

3.5: Unintended pregnancies and abortions and among adolescent girls: Kenya, Ghana, and South Africa

The WHO defines abortion as pregnancy termination prior to 20 weeks' gestation.

Unintended pregnancies disrupt the lives of all women of reproductive age, regardless of their marital status. In the African continent, the trauma and stigma associated with unintended pregnancies disproportionately affect teenage girls and young women, and as such, vast numbers of them resort to unsafe abortion to evade shame and exclusion.

Adolescent girls tend to end pregnancies based on their desire to continue education or to protect future aspirations (e.g. desire to give birth when married), to avoid the stigma of teenage pregnancy, poverty, rape, incest or transactional sex, unprotected sex, use of drugs, and medical reasons.

When women face unintended pregnancy and do not have access to safe abortion care, some are forced to resort to unsafe abortion methods, putting their health and lives at risk. The WHO's definition of unsafe abortion is as follows: "An abortion is unsafe when it is carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (64)." The least safe conditions are when an abortion is carried out by untrained people using dangerous or invasive methods. As a leading cause of maternal deaths, unsafe abortion can be devastating to women, their families, and communities.

Adolescent girls comprise a considerable proportion of annual abortion deaths worldwide, with 15 percent of all unsafe abortions taking place among girls under 20 years of age. Each year, an estimated 3.2 million unsafe abortions. Consequences of unsafe abortions include life-long injuries, severe disability, heavy bleeding, damage to internal organs, or loss of the ability to become pregnant in the future. In addition to the physical aspects mentioned above, most mothers face psychological crises. In other words, the basis of their physical disorders in unwanted pregnancy is their attitude, emotions, and anxiety. Unwanted pregnancy leads to a negative outlook towards pregnancy (65).

Adolescent girls choose unsafe abortion methods because of the following cross-cutting factors; lack of knowledge and access to safe abortion services, unfavorable socio-economic conditions, religious and cultural influences, stigma of unplanned pregnancy, avoiding parental/guardian disappointment and resentment, lack of knowledge of the legal status of abortion, limited access to safe places and enabling environment, and desire for secrecy (66).

3.6: The legal status of abortion in Kenya, Ghana, and South Africa

Country	Legal status
Kenya (67)	Abortion in Kenya is regulated by Article 26(4) of the Constitution of Kenya (2010), which states that abortion is not permitted unless, in the opinion of a trained health professional, there is a need for emergency treatment, or the life or the health of the mother is in danger, or if permitted by any other written law. Criminal enforcement of the penal code has led Kenyan women and girls to face harassment, as well as wrongful arrest and prosecution. Healthcare providers are also reluctant to provide safe care while the penal code remains in place, even in emergencies. In 2022, the High Court of Kenya in Malindi affirmed that abortion is a fundamental right under the Constitution of Kenya. The landmark ruling also held that arbitrarily arresting and prosecuting patients seeking abortion care or health care providers offering abortion services is illegal.
Ghana	The abortion law in Ghana was amended in 1985, and it states that an abortion performed by a qualified medical practitioner is legal if the pregnancy is the result of rape or incest or if the abortion is performed to protect the woman's mental or physical health, or when there is a malformation of the fetus. The GHS provides safe abortion and post-abortion care services at its facilities within the context of the Ghana Abortion Law and the policy document that provides guidelines on the provision of these services. Hence safe abortion services on medico-social grounds as permitted by the law are not readily available in national health institutions. Some aspects of the law still appear implicit and may hamper the implementation of safe abortion services in the country (68).
South Africa (69)	The Choice on Termination of Pregnancy Act of 1996 gives women the right to request termination of pregnancy up to and including the 12th week of pregnancy and under certain circumstances between the 13th and 20th week of pregnancy by a certified nurse practitioner or medical doctor. This makes Abortion in South Africa legal on request. In 2004, an amendment was added to make termination of pregnancy services more available for women. This amendment allowed for any health facility that has a 24-hour maternity service to offer first-trimester abortion services.

Table 10: Abortion law status in Kenya, Ghana, and South Africa 3.06: The rate of abortion (Age bracket 15-49 years)

3.7: The rate of abortion (Age bracket 15-49 years)

The rate of unintended pregnancies is high is Kenya, Ghana, and South Africa, and this remains skewed disproportionately among young girls. Over 50 percent of unintended pregnancies in these countries are aborted and mostly using unsafe abortion methods as shown in the visual below.

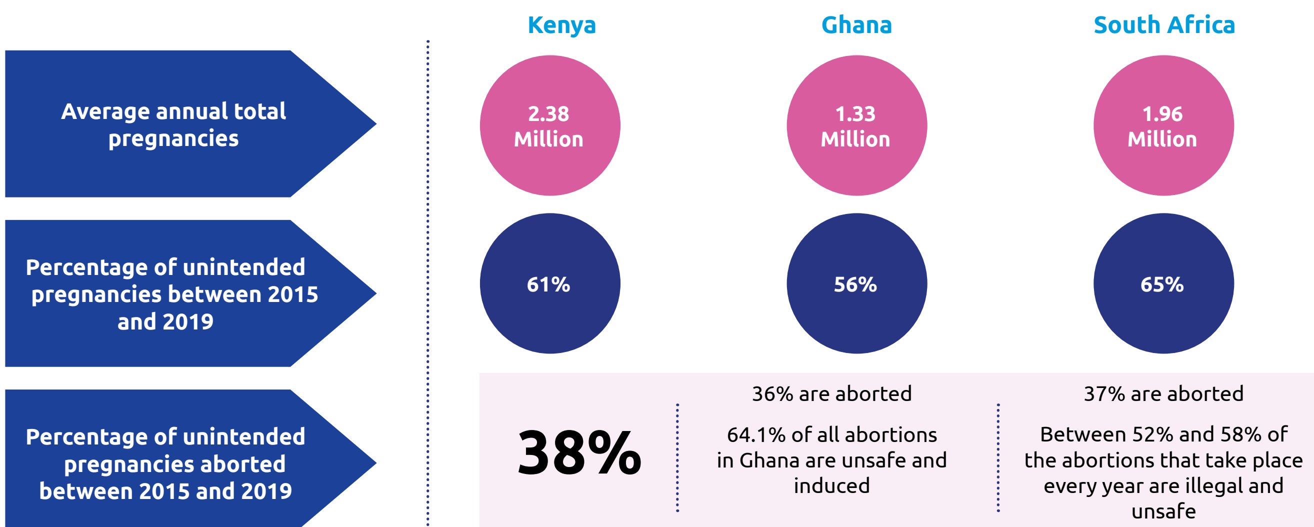


Table 11 :The rate of abortions in Kenya, Ghana, and South Africa (70) (71) (72)

"The persisting stigma and false narratives about abortion in the public domain and criminal justice system has put the lives of more Kenyan women and girls on the line," said Evelyne Opondo, Senior Regional Director for Africa, Center for Reproductive Rights. "They are afraid of seeking safe and legal abortion for fear of prosecution even in situations where terminated pregnancy is the result of rape. Abortion stigma violates the rights of women and girls to access health, psychosocial support, and freedom from cruel, inhumane, and degrading treatment "(73).

3.8: Post Abortion Care (PAC) services

WHO outlines guidelines on safe abortion, the role of health workers in providing safe abortion care and post-abortion contraceptives, and medical management for abortion (74). The below table shows the level of access to PAC services in Kenya, Ghana, and South Africa.

Country	Access to PAC services
Kenya	• The provision of quality PAC in healthcare facilities in Kenya is low, with access hindered by legal restrictions on abortion. • There is limited evidence on the quality of care provided to patients with abortion complications in public health facilities in Kenya. • PAC guidelines were restricted from use for several years due to worry that the PAC guidelines would help individuals perform these services illegally and were just re-released in 2019 back to health facilities throughout the country. • PAC services – both complications and contraceptives- are not included under the country's National Health Insurance Fund.
Ghana	• In 2006, the GHS and the MoH developed protocols for comprehensive abortion care, which includes PAC. • Ghana's decentralized health system helps ensure that contraceptives and PAC services are routinely available at all levels of the public and private health service delivery systems. • Only less than 20 percent of PAC providing facilities meet all signal function criteria for basic or comprehensive PAC.
South Africa	• PAC services are legal and available. • They involve medical assessment by a healthcare provider for any complications, treatment if there are any complications, counselling to address emotional concerns, and methods to avoid unintended pregnancies in the future including access to FP options. • PAC services are provided by qualified and licensed Doctors, Midwives, and Nurses.

Table 12: The access to PAC services in Kenya, Ghana, and South Africa (75) (76) (77) (78) (79)

4.0: Potential Solutions and Opportunities for Addressing Existing Challenges and Disparities for Contraceptive Uptake Among Adolescent Girls in Kenya, Ghana, and South Africa

A: Cross-cutting Challenges	Potential Solutions and Suggested Interventions
Educational and informational gaps: limited education and awareness on modern contraceptives	1. Integrate SRH Education in school curriculums that cover contraception methods, benefits, and risks 2. Expand community outreach and awareness programs 3. Leverage digital platforms to share educational content, testimonials, and resources on contraception 4. Targeted communication to adolescents to address specific needs and concerns
Healthcare system-related challenges: stockouts, long waiting times at healthcare facilities, lack of privacy and confidentiality, negative attitudes of healthcare providers, assessing the right method	**Stockouts** 1. Improve national forecasting and procurement systems to predict demand and avoid stockouts 2. Partnerships with the private sector to create a wider network of contraceptive access points 3. Replicate efforts made by the UNFPA in supporting the MoH Kenya in building a responsive and resilient commodity supply chain systems 4. Ghana and Kenya can take lessons on how South Africa is using vending machines for contraceptives
	Long waiting times 1. Increase staffing levels at clinics, especially nurses trained in SRH services 2. Implement appointment systems to reduce waiting times 3. Explore alternative service delivery models like mobile clinics or outreach programs
	Lack of privacy and confidentiality 1. Designate dedicated spaces for SRH consultations within clinics plus Youth Friendly accreditation options 2. Train staff on the importance of privacy and confidentiality 3. Offer telemedicine consultations for contraception services where appropriate 4. Use peers to promote FP options (Youth Promotors), as being done in certain areas in Kenya
	Negative attitudes of healthcare providers 1. Conduct sensitization workshops for healthcare providers on FP services for adolescents 2. Address provider bias through training on client-centered care and informed choice
	Assessing the right method 1. Develop user-friendly decision-making tools to help girls choose the most appropriate method 2. Implement self-service options for obtaining certain contraceptives
Social and cultural barriers: parental hindrance, religious beliefs towards contraceptives, stigma, myths and misconceptions	**Parental hindrance** 1. Implement FP education programs that involve parents and adolescents 2. Develop age-appropriate information materials for parents on contraceptive benefits and safety
	Religious beliefs 1. Partner with religious leaders to clarify misconceptions about contraceptives and their compatibility with faith

A: Cross-cutting challenges	Potential Solutions and Suggested Interventions
	Stigma, myths and misconceptions 1. Launch community awareness campaigns using trusted voices and local media to dispel myths and misconceptions 2. Utilize peer education programs where trained young women share experiences and address misconceptions 3. Integrate sexual and reproductive health education into school curriculums to normalize contraceptive use 4. Partner with youth-focused organizations to spread accurate information through workshops and social media
Personal and psychological factors: fear of side effects, lack of peer/ friends/boyfriend's support of contraceptive, covert use of contraceptives, some methods are not easily concealed	**Fear of side effects** 1. Develop educational materials emphasizing the safety and common side effects of various methods 2. Leverage on existing health hotlines and other communication channels 3. Providers offer pre-counseling sessions to address individual concerns and provide personalized information. This can help manage anxieties and build trust.
	Lack of peer/friends/boyfriends' support system 1. Create safe spaces within clinics or youth centers for confidential discussions and peer support groups 2. Develop social media campaigns that normalize contraceptive use amongst young people
	Discreet and covert use of contraceptives 1. Increase access to discreet and user-friendly methods like injectables, implants, intrauterine devices (IUDs), or certain oral contraceptives 2. Explore offering discreet packaging or dispensing options for contraceptives at pharmacies 3. Address the underlying reasons for covert use through counseling and educational programs
Policy and legal constraints: prohibiting country laws on the use of contraceptives, lack of policies facilitating contraceptive provision in schools	1. Lobby for the revision of laws restricting access to contraceptives for adolescent, try to remove the politics from the discussions 2. Partner with legal advocacy groups to challenge unconstitutional or discriminatory laws 3. Hold governments accountable for fulfilling policy commitments on adolescent sexual and reproductive health 4. Advocate for policy changes to allow for SRH education for adolescents in schools 5. Develop model programs demonstrating the effectiveness of school-based interventions for contraceptive access 6. Advocate for policies allowing for adolescents to access contraceptives without mandatory parental consent in certain situations 7. Involve young people in policy discussions to ensure their needs and perspectives are considered 8. Utilize data and evidence-based research to advocate for effective policy changes
Economic barriers: cost of contraceptives	1. Advocate for government subsidies or public health insurance coverage for contraceptives 2. Implement targeted programs offering free or low-cost contraceptives to low-income adolescents 3. Partner with NGOs or private sector to establish social marketing programs for subsidized contraceptives 4. Explore innovative financing mechanisms like vouchers or social impact bonds for contraceptive access 5. Implement strategies to reduce transportation costs associated with clinic visits (e.g., vouchers for public transport) 6. Partner with youth-focused organizations to offer financial aid or microloans for contraceptive access 7. Educate girls and boys about various contraceptive methods and their associated costs 8. Train healthcare providers to discuss cost-effective options during counseling sessions

B: Kenya Specific Challenges	Potential Solutions and Suggested Interventions
Need for more subsidized/ for free contraceptives and including contraceptives to NHIF package for secondary students	1. Advocate for including essential contraceptives in the NHIF /SHIF package for secondary school students 2. Implement targeted government programs offering free or subsidized contraceptives to low-income adolescents 3. Partner with NGOs and private companies to establish social marketing programs for subsidized contraceptives
Limited offering by the private health sector in rural areas	1. Private sector capacity building in rural areas for contraceptive offerings
MoH Directive that giving minors contraceptives is illegal and minors are also punishable by law if found using contraceptives	1. Work with the MoH and relevant stakeholders to develop alternative, age-appropriate guidelines for contraceptive access by minors, considering maturity and decision-making capacity. Good area for COWHA to continue building on and working this out further (TWG)
High rate of discontinuation among 15–19-years adolescents	1. Create mechanisms for improved method choice and counselling 2. Health providers to adopt client-centered approach that includes open communication, active listening and addressing myths and misconceptions 3. Providers to offer alternative methods during counselling and emphasize that switching methods is normal
High unmet demand for contraceptives	1. Expand service delivery points and vending machines 2. Youth-friendly hours at clinics/facilities 3. Consider school-based initiatives 4. Drive public awareness to normalize contraceptive use among the adolescents 5. Offer cost friendly contraceptives
Counterfeit contraceptive drugs	1. Strengthen regulation and enforcement by Pharmacy and Poisons Board (PPB) 2. Harsh penalties for those involved in the production, distribution, and sale of counterfeit contraceptives 3. Implement stricter import controls and improve traceability mechanisms
Stalling of the reproductive health bill 2018	1. Revamp advocacy efforts for constructive discussion around the bill
C: Ghana Specific Challenges	**Potential Solutions and Suggested Interventions**
Need for more subsidized/ for free contraceptives	1. Implement targeted government programs offering free or subsidized contraceptives to low-income adolescents 2. Partner with NGOs and private companies to establish social marketing programs for subsidized contraceptives
The private sector is largely excluded from access to subsidized family planning commodities, accreditation, and GHS supervision	1. The government is highly advised to come up with a multi-tiered approach to integrate private sector into family planning through tiered subsidy programs, streamlining accreditation process, and Public - Private Partnerships (PPPs)
High rate of family planning method discontinuation among 15–19-years adolescents	1. Create mechanisms for improved method choice and counselling 2. Health providers to adopt client-centered approach that includes open communication, active listening and addressing myths and misconceptions 3. Providers to offer alternative methods during counselling and emphasize that switching methods is normal
High unmet demand for contraceptives	1. Expand service delivery points 2. Youth-friendly hours at clinics/facilities 3. Consider school-based initiatives 4. Drive public awareness to normalize contraceptive use among the adolescents 5. Offer cost friendly contraceptives
Data Management Issues: Inaccurate or incomplete data on contraceptive usage, stock levels, and demand can hinder effective supply chain management	1. Through partner collaboration, the government can incorporate a commodity supply chain system to monitor supply and use of the contraceptives

D: South Africa Specific Challenges	Potential Solutions and Suggested Interventions
Need for more subsidized/free contraceptives	1. Increased funding for FP by the government 2. Increase private sector support to the provision of subsidized/free contraceptives in the country 3. FP services fully included in the proposed national health insurance scheme
High rate of discontinuation among 15–19-years adolescents	1. Create mechanisms for improved method choice and counselling 2. Health providers to adopt client-centered approach that includes open communication, active listening and addressing myths and misconceptions 3. Providers to offer alternative methods during counselling and emphasize that switching methods is normal
High unmet demand for contraceptives	1. Expand service delivery points 2. Youth-friendly hours at clinics/facilities 3. Consider school-based initiatives 4. Drive public awareness to normalize contraceptive use among the adolescents 5. Offer cost friendly contraceptives
Contraceptive stock outs	1. Roll-out of vending machines for contraceptives across the country

5.0: Potential Solutions and Opportunities for Addressing Existing Challenges and Disparities for PPC Among Adolescent Girls in Kenya, Ghana, and South Africa

Challenges	Potential Solutions and Suggested Interventions
Cross-cutting challenges/areas of improvement for post-pregnancy (including post-abortion care) for adolescent girls	
Social factors and Stigma • Lack of community support • Stigma or fear of stigmatization by family members, providers, and the community in general • Fear of prosecution • Religious objections by some facilities and providers to abortion	1. Mobilization and awareness campaigns at the community level that normalize seeking PPC 2. Offer workshops for parents and guardians on how to provide emotional and practical support to their daughters after pregnancy 3. Advocate for anti-stigma messaging within healthcare facilities and communities, emphasizing the importance of non-judgmental care 4. Championing the rights of adolescent girls to access PPC without judgment 5. Push for legal frameworks that guarantee adolescents' right to confidential and safe PAC services 6. Partner with religious leaders to clarify the need for PAC and their compatibility with faith
Policy and Access • Prohibitive costs of PAC services • Lack of clear policy guidelines on PAC services • Facility policies that prevent mid-level health care workers to provide PAC • Adolescent-and youth-friendly PAC services are rare	1. Include PAC services on national health insurance schemes 2. Devise innovative ways of funding for cost-effective PAC services 3. Advocate for clear policies and guidelines on PAC services 4. Advocate for favorable provider policies for offering PAC services 5. Offering of adolescent and youth friendly PAC services by providers 6. Integration of PAC with the existing postpartum standards of care

Challenges	Potential Solutions and Suggested Interventions
Service Delivery • Limited care within 42 days of delivery • Limited skilled health personnel for deliveries and PPC • Inadequate spaces for treatment that guarantee privacy	1. Explore alternative service delivery models like mobile clinics or outreach programs to reach adolescent mothers in remote areas or with limited mobility 2. Launch targeted campaigns to educate adolescent mothers about the importance of PPC 3. Capacity building for health personnel offering deliveries and PPC
Kenya	
The stalling of the reproductive health bill 2019	Revamp advocacy efforts for constructive discussion around the bill
Abortion in Kenya is legal only to preserve the pregnant person's health	Explore a partnership with legal experts and women's health organizations to explore strategic litigation challenging the restrictive legal framework around abortion in Kenya
PAC is not included under the country's National Health Insurance Authority	Advocate for the inclusion of PAC services under NHIF or new SHIF
Ghana	
Abortion in Ghana is legal only to preserve the pregnant person's health	Explore a partnership with legal experts and women's health organizations to explore strategic litigation challenging the restrictive legal framework around abortion in Ghana
Only less than 20 percent of the providers of SAC or PAC have met the criteria for basic or comprehensive care	Build capacity for PAC providers especially at the primary healthcare level
South Africa	
Non-existing package for PPC	Advocate for full inclusion of PPC under the proposed national health insurance scheme

6.0: Conclusion

This study has shed light on the availability of FP methods, PPC guidelines, and service accessibility and the consequences of early and unintended pregnancies among adolescents in Kenya, Ghana, and South Africa. It underscores the critical need for improved contraceptive demand creation, availability, and use especially during the post-pregnancy period. FP methods and services availability and inclusion in national policies will greatly contribute to the reduction of early pregnancies and unintended prevalence with a focus on PPC which is essential for better health outcomes among female adolescents in Kenya, Ghana, and South Africa. The socioeconomic benefits of reducing possible complications and improving the health outcomes of women and girls are immense, as adolescence is a critical stage for laying the foundation for lifelong health.

Adolescence is marked by vulnerabilities, especially in terms of sexuality, marriage, and childbearing. Many girls face coercion into unwanted sex or marriage, exposing them to risks such as unwanted pregnancies, unsafe abortions, STIs, including HIV, and complications during childbirth or the postpartum period. Increasing contraceptive use and PPC among adolescent girls can significantly mitigate these risks.

The post-pregnancy period is a critical yet often neglected phase in maternal health with many maternal deaths occurring during this time. In Kenya and Ghana specifically, the post-pregnancy period receives less attention than pregnancy or childbirth and it becomes even more limited for adolescent girls. This limited access directly leads to high rates of unsafe abortions and consequent complications, morbidity, and mortality.

Contraceptive use among adolescents remains controversial in Kenya and Ghana due to restrictive laws, and cultural taboos while South Africa has made strides in legalizing abortion, PAC, and contraceptive use for adolescent girls.

Key actions required include:

1. **Increase access to contraceptive services among adolescents**

This is essential for preventing pregnancies and mitigating related complications. Early parenthood carries social, economic, and health consequences, including an increased risk of HIV infection.

2. **Enhance PPC**

Focusing on adolescent girls to reduce the burden of teenage pregnancy, including access to safe abortions, and efficiently addressing associated health complications, ensuring healthier outcomes whether during post-abortion or postpartum periods.

3. **Adopt a multi-sectoral approach**

This involves policy and legal reforms, comprehensive PPC, capacity building for healthcare providers at different levels, robust family planning supply chain, community engagement, education, private sector involvement, and improved data management. These measures are vital for increasing contraceptive access and strengthening PPC.

In conclusion, addressing these critical areas through a collaborative and multifaceted approach will significantly contribute to better health, social, and economic outcomes.

7.0: Recommendations for COWHA

7.01: COWHA's mandate

COWHA is an innovative and unified platform dedicated to advancing the well-being of women and girls in Africa through multisectoral partnerships and collaboration. At its core, COWHA is a dynamic force, bringing together private and non-state organizations to create impactful solutions for equitable healthcare. COWHA aims to address the unique health needs of women in Ghana, Kenya, and South Africa, ensuring tailored and effective interventions.

COWHA stands on the below pillars that underpin its operational framework.

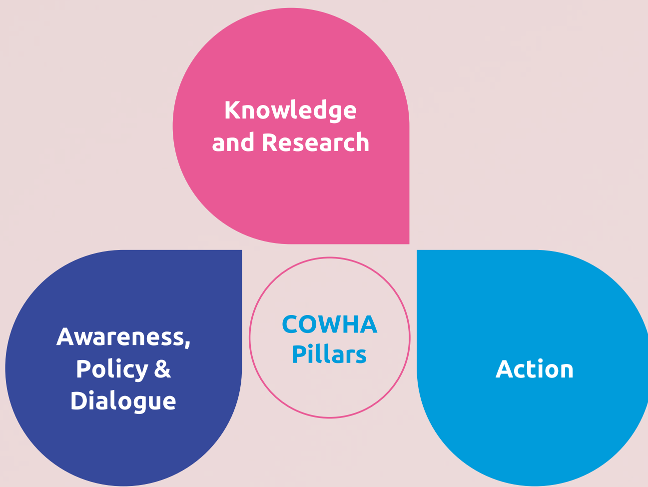


Figure 12: COWHA's mandate

7.02: Desk review study's importance to COWHA

The desk review on contraceptive use and PPC for adolescents in Kenya, Ghana, and South Africa is crucial for COWHA's mission of advancing women's well-being in Africa.

The findings inform COWHA's advocacy efforts to improve policies and access to SRH services for adolescents, identify opportunities for partnerships with stakeholders, and develop programs to address the challenges and gaps identified. By addressing these gaps, COWHA can help reduce unintended pregnancies, improve maternal health outcomes, and empower adolescent girls. This study also enhances the knowledge base on adolescent SRH in Africa, further supporting COWHA's mission.

7.3: Recommendations to COWHA - Contraceptive use for adolescent girls in Ghana, Kenya, and South Africa

Pillar	Recommendations	Potential stakeholders
Knowledge & Research	Disseminate desk review report on COWHA's website and its social media platforms.	COWHA & AHB
	Disseminate desk review report to COWHA members	COWHA Members
	Disseminate desk review report to key external stakeholders	Stakeholders in women's health in Africa
	Develop an adolescent-targeted leaflet (approved by MoH - with logos) on existing contraceptive methods, benefits, safety, and designated places to get them. This can be shared on social media and website. Youth advocacy groups can also help to share across. Examples of designated places include; high-end pharmacies, FP specialized health centres e.g. Jacaranda Hospital, and Gynecology sections (hospitals)	COWHA, COWHA members, MoH and youth advocacy groups.
Awareness, policy, and dialogue	Hold national sensitization/educational workshops for healthcare providers on FP services for adolescents. Specific key areas of discussion can be: 1. Dedicated places for FP consultations 2. Privacy and confidentiality 3. Standard procedure for pre-counseling sessions for adolescents 4. Adolescent friendly FP services 5. Provider policies regarding contraceptive use among adolescents 6. Country policies and laws on contraceptive use among adolescents	COWHA, COWHA members, healthcare providers, MoH, youth advocacy groups, child rights advocacy groups, law societies
	Lobby for the integration of SRH education into high school curriculum to normalize the use of contraceptives among adolescents	Kenya Institute of Curriculum Development, MoH, The National Council for Curriculum and Assessment (NaCCA) of Ghana, UNICEF, Ministries of Education, Gauteng Institute for Curriculum Development, UNESCO, MSI, AMNESTY International
	Help revive discussions around the Reproductive Health Bill 2019 in Kenya, which aims to legalize the use of contraceptives among adolescents	FIDA Kenya, KELIN, KMA, MSK, KMWA, NCPD, ICRH Kenya, FP2030
	Help strengthen the private health sector's role in FP planning in Ghana	MoH, GHS, CHAG, PHSDSAG, HFG, Marie Stopes Ghana, PPAG
	Push for a clear and legally right directive by the MoH Kenya on the use of contraceptives by adolescents	MoH, COWHA, ICRH Kenya, FIDA Kenya
	COWHA's comments on the revision of the 6th Edition of National Family Planning Guidelines 2018	DESIP Programme partners
	Lobby for the inclusion of essential contraceptives in the new SHIF package for secondary school students in Kenya	MoH, COWHA, SHIF, Healthcare Federations
	Develop a social media campaign that normalizes contraceptive use among young people. This can address specific concerns such as myths and misconceptions, fear of prosecution etc	COWHA
Action	Support in building capacity for the FP commodity supply system for the Central Medical Store of Ghana to monitor the supply and use of contraceptives	MoH Ghana, GHS, UNFPA, Central Medical Store
	Develop a business case paper for a potential roll-out of vending machines for contraceptives in Ghana, Kenya, and South Africa	COWHA
	Develop a model framework demonstrating the effectiveness of school-based interventions for contraceptive access in Ghana, Kenya, and South Africa	COWHA

Pillar	Recommendations	Potential stakeholders
	Help set up a network/union of private health partners for FP commodity supply at country levels to create a unified voice to address existing FP supply chain challenges from the private sector lens	Drugs regulators, manufacturers, distributors, healthcare providers, MoH, national drug stores, pharmacies, Reproductive Health Supplies Coalition

7.4: Recommendations to COWHA - PPC for adolescent girls in Ghana, Kenya, and South Africa

Pillar	Recommendations	Potential stakeholders
Knowledge & Research	Develop an adolescent-targeted leaflet (approved by MoH - with logos) on existing post-pregnancy care, benefits, safety, and designated places to get them. This can be shared on social media and website. Youth advocacy groups can also help to share across	COWHA, MoH, Youth advocacy groups
	Develop a series of anti-stigma social media posts emphasizing the importance of non-judgmental care for adolescent	COWHA
	Launch a social media campaign to educate adolescent mothers about the importance of PPC and expected standard of care	COWHA
Awareness, policy, and dialogue	Hold national sensitization/educational workshops on PPC for adolescents. Specific key areas of discussion can be: 1. Abortion and PAC 2. Privacy and confidentiality 3. Access to PPC 4. Contraceptive use during post-pregnancy 5. Provider policies regarding PPC among adolescents 6. Country policies and laws on PPC among adolescents	MoH, Healthcare Federations, Regulators, Hospitals, Patient Groups, Media, Law Societies
	Help revive discussions around the Reproductive Health Bill 2019 in Kenya, which aims to legalize abortion among adolescents	FIDA Kenya, KELIN, KMA, MSK, KMWA, NCPD, ICRH Kenya, FP2030
	Lobby for the inclusion of PPC services under the new SHIF in Kenya	SHIF, MoH, KHF, Marie Stopes Kenya, FIDA, ICRH, UNFPA
	Advocacy for policy/legal reforms to explore strategic litigation challenging the restrictive legal framework around abortion in Ghana	Ghana Center for Democratic Development, FIDA Ghana, The Third World Network-Ghana, PPAG, The Ark Foundation, Ghana Medical Association, Amnesty International, IPAS, MoH, GHS
	Lobby for full inclusion of PPC services under the proposed national health insurance scheme in South Africa	National Department of Health, Health Parliamentary Committee, SAMA, SHRC, FAMSA, SMRC
Action	Develop a pilot model for integrated care delivery (postpartum care and PAC) for Ghana, Kenya, and South Africa and create a roadmap for implementation together with stakeholders and lobby for the government buy-in	MoH, women's health groups, medical associations, healthcare facilities

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COWHA is an initiative from AHB which also serves as the secretariat and research lead at the Coalition.
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