NATIONAL GUIDELINE FOR FAMILY PLANNING SERVICES IN ETHIOPIA

Federal Democratic Republic of Ethiopia

Ministry of Health

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Foreword

We are only a few years away from the year 2015, the time by which 189 nations, including Ethiopia, pledged to achieve the eight Millennium Development Goals (MDGs). The Federal Government of Ethiopia has undertaken several developmental measures toward the achievement of these goals, of which the growth Development Plan(GTP) is notable.

The Federal Ministry of Health (FMOH) developed and launched the 20-year rolling Health Sector Development Program (HSDP), which has currently reached its fourth stage—HSDP IV—with its prime priorities being maternal health, neonatal and child health, HIV and AIDS, tuberculosis, and malaria.With the implementation of the Civil Service Reform Program, considerable achievement has been made in transforming customer-based care throughout the health system. Moreover, review of the implementation of HSDP I, II, and III has indicated that substantial progress has been achieved in the implementation of primary health care through the expansion of the Health Extension Program (HEP) and through capacity building in human resource and health care facilities. However, there still is concern on the progress for MDG 5—improving maternal health—including family planning service coverage.

The FMOH has undertaken an initiative for measures to reduce maternal mortality through the provision of clean and safe delivery at the HEP level, skilled delivery and emergency obstetric care at the facility level, and, most important, family planning at all levels of the health care system. It is obvious that meeting 100% of unmet need for modern contraceptive methods will have an immediate impact in decreasing unintended pregnancies whose outcome could be postpartum hemorrhage or unsafe abortion, both which are major causes of maternal mortality. Thus, the FMOH has undertaken an initiative to scale up insertion of the subdermal hormonal implant Implanon by Health Extension Workers, along with provision of misoprostol for prevention of postpartum hemorrhage.

This Guideline document was developed with the objective of creating an enabling environment for the implementation of HSDP IV and the subsequent attainment of all MDGs in general—and MDG 5 in particular. I believe that this guideline, along with a standardized training manual and the revised Reproductive Health Strategy, will gear the implementation of HSDP IV toward the fulfillment of the MDG milestone. To this end, it is imperative that government organizations, non-governmental organizations, civil society organizations and the private sector make a concerted effort in making the necessary commodities and services available.

Finally, I would like to congratulate all those who expended their time, knowledge, and logistical support in realizing this document, and call for a more strategic and concerted effort in its implementation, along with close monitoring and evaluation of its impact.

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List of Acronyms

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
AAU-MF	Addis Ababa University, Medical Faculty
ART	antiretroviral therapy
BCC	behavior change communication
BPR	business process reengineering
BTL	bilateral tubal ligation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CPR	contraceptive prevalence rate
CYP	couple-year of protection
DHS	Demographic and Health Survey
ECP	emergency contraceptive pills
EPI	Expanded Program on Immunization
FGAE	Family Guidance Association of Ethiopia
FGC	female genital cutting
FMOH	Federal Ministry of Health
FP	family planning
GBV	gender-based violence
GMP	General Medical Practitioner
GTP	Growth and Transformation Plan
HCT	HIV counseling and testing
HDA	Health Development Army
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HO	health officer
HSDP	Health Sector Development Program
HTP	harmful traditional practices
ICPD	International Conference on Population and Development

IEC	information, education, and communication
IUCD	intrauterine contraceptive device
LAM	lactational amenorrhea method
LMIS	Logistics Management Information System
MCH	maternal and child health
MDG	Millennium Development Goal
MEC	Medical Eligibility Criteria
NGO	nongovernmental organization
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PLWH	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
RH	reproductive health
ROC	reproductive organ cancer
SDM	standard days method
STI	sexually transmitted infection
TFR	total fertility rate
UNFPA	United Nations Population Fund
VCT	voluntary counseling and testing
WHO	World Health Organization

Contents

1. Background

1.1. Health, population (demographics), and development

1.1.1. Population

The population of Ethiopia totals nearly 79.5 million people, of whom 83.8% live in rural areas and 16.2% are urban. Women and men constitute 49.5% and 50.5% of the total population, respectively. Ethiopia's population is young, averaging 17 years of age. The population density is 67.9/km^2 (Office of the Population Census Commission, 2010).

Life expectancy at birth is 55.4 years for women and 53.4 years for men (Health and Health related indicators 2009/2010, FMOH). Average household size is 4.8 people, with the urban population having a smaller mean household size (4.2) than the rural population (4.9) (Central Statistical Agency [Ethiopia] and ORC Macro, 2006). The dependent population amounts to 52.8% of the total population (Office of the Population Census Commission, 2010).

Women aged 15–49 years constitute 23.4% of the total population. Children under age 5 account for 12.2% of the population, and 42.6% of the total population is under 15 years of age. Adolescents aged 10–19, young people aged 15–24, and youth aged 10–24 make up 26.0%, 20.6%, and 34.7% of the total population, respectively (Office of the Population Census Commission, 2010).

Infant and under-5 mortality are showing a decreasing trend. The infant mortality rate is 77 infant deaths per 1,000 live births, and the child mortality rate is 50 deaths per 1,000 live births, giving an under-5 mortality rate of 123 per 1,000. With a crude birthrate of 35.7 births per 1,000 population and a crude death rate of 13.2 deaths per year per 1,000 population, the annual rate of natural increase is 2.6% (Central Statistical Agency

[Ethiopia] and ORC Macro, 2001; Central Statistical Agency [Ethiopia] and ORC Macro, 2006;and Health indicators 2008/2009, FMOH).

Ethiopia's per-capita income is US$330 (World Bank, 2010). With a decrease in fertility, there is a period in which the productive segment of the population is expected to increase, with proportional economic growth. This phenomenon, called the "demographic bonus," is likely to occur in Ethiopia in the near future as a result of well-organized family planning (FP) programs and services.

1.1.2. Health

The potential health service coverage is 90%, yet per capita for health service utilization per year is 0.3% (Health and Health related indicators 2008/2009, FMOH). Health service delivery in Ethiopia follows a three-tier system: the *Primary Health Care Unit* (PHCU), which consists of five satellite health posts, one Health Centre, and a Primary Hospital to serve areas of 5,000, 25,000 and 100,000 population, respectively; a *General Hospital,* which serves an area of 1 million people; and a *Specialized Hospital,* which serves an area of 5 million population. The cadres of health care providers range from Health Extension Workers (HEWs), who carry out their duties at the community and health-post levels, to medical specialists.

The Health Policy of Ethiopia boldly states that the health needs of women and children deserve particular attention. The policy recommends decentralizing services and "enriching the concept and intensifying the practice of family planning for optimal family health and planned population dynamics" (Government of Ethiopia, 1993).

The total fertility rate (TFR) in Ethiopia is 4.8 lifetime births per woman (EDHS 2011). The contraceptive acceptance rate is 56.2%. The contraceptive prevalence rate (CPR) among married women is 13.9% in 2005 and 32% in 2008 (Central Statistical Agency [Ethiopia] and ORC Macro, 2006; Health and Health related indicators 2008/2009, FMOH, L10K study). Though improving, antenatal care attendance, the institutional delivery rate, and postpartum care coverage are still low, at 67.7%, 18.4%, and 34.3%,

respectively. The percentages of children under 1 year of age covered by child pentavalent and measles immunization are 81.6% and 76.6% (Health and health related indicators 2008/2009, FMOH).

Adult HIV prevalence in 2009/2010 is estimated to be 2.4%, with higher prevalence among women (2.6%) than among men (1.7%). In 2008–2009, the number of people who ever accessed antiretroviral therapy (ART) had reached 152,472 (Health and health related indicators 2008/2009, FMOH**)**.

1.2. Historical background and progress of FP programs in Ethiopia

Modern FP services in Ethiopia were pioneered by the Family Guidance Association of Ethiopia (FGAE), which was established in 1966. FGAE's first FP services were provided from a single-room clinic run by one nurse. FGAE's programmatic activities and services gradually spread all over the country, with a network of eight branches, 18 clinics, 26 youth centers, 740 community-based reproductive health (RH) service outlets, 242 outreach sites, six marketplace sites, and eight workplace sites. The ministry of health (MOH) also began to enhance the effort through provision of maternal and child health (MCH) and FP services in health facilities. Since 1980, the MOH further expanded its FP services through cyclic country support programs by the United Nations Population Fund (UNFPA) and other stakeholders.

Following Ethiopia's adoption of a Population Policy in 1993, local and international institutions partnered with the government in expanding FP programs and services. The National Office of Population was then established to implement and oversee the strategies and actions related to the Population Policy.

In 1996, the FMOH released *Guidelines for FP Services in Ethiopia* to guide stakeholders, as well as to expand and ensure the quality of FP services. In this guideline, the FMOH designated new outlets for FP services in addition to the preexisting facility-based and outreach FP services. Moreover, other policy and

strategic documents have emphasized integration and the linkage of FP services with other RH services, to enhance FP utilization.

Knowledge of FP has increased to 87% among currently married women. However, FP use is still lagging, at 13.9% in 2005—though a recent survey with representative samples from Ethiopia's four most populous regions demonstrated the CPR to have reached 32% there (The L10K Project, 2009). This can for the most part be attributed to the FMOH's new Health Extension Program (HEP), which has worked to increase access to preventive and promotive health services, including FP services at the community and household levels.

At the international level, several milestones have left footprints in population, women's status, RH, and FP. In 1994, the International Conference on Population and Development (ICPD) focused on the close link between population, sustained economic growth, and sustainable development. ICPD recommended actions to help couples and individuals to meet their reproductive goals.

1.3. Current RH status of the Ethiopian population

1.3.1. Status of women in Ethiopia: Socioeconomic and gender perspectives

"*The state shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited*." (The Constitution of the Federal Democratic Republic of Ethiopia, Art 35.4) (Federal Democratic Republic of Ethiopia, 1995)

The Federal Democratic Republic of Ethiopia has declared its commitment to gender equality, equity, and empowerment of women by stipulating the rights of women in its Constitution, by issuing the Women's Policy of Ethiopia and revising the Family Law and the Criminal Law. It established the machinery for facilitating and monitoring the mainstreaming of gender issues in the development process. The Government has also incorporated gender issues in different national policies

including the social, health, education and training, HIV/AIDS, population and in other sector policies.

However, a lot need to be done to improve the status of women in the community. The family system is patriarchal, with dominance by men and the elderly. Gender discrimination starts from birth. Decision making in the household is dominated by men.

It is well-known that women's education delays marriage and first birth, increases FP use, improves partner communication, and advances women's status in the community. Although girls' enrollment in school has significantly increased in Ethiopia, there still is a difference in favor of boys. Gross enrolment rate (GER) for girls at primary level increased from 53.8 percent in 2002/03 to 85.1 percent in 2006/07, while GER for boys increased from 74.6 to 98.0 during the same period. Though the gender gap is narrowing, there still is a gender disparity at primary level. The gender disparity gets wider at higher level of the educational system (see below).The linear projections to gender parity in secondary and tertiary levels indicate possible divergence from the path to the MDG goal due, primarily, to the dismal performance in the 90s.

Gender Parity Index in Secondary and Tertiary levels

	1991	1999	2000	2001	2002	2003	2004	2005	2006	2007
Gender Parity Index in secondary level enrolment	**0.75**	**0.68**	**0.67**	**0.66**	**0.62**	**0.57**	**0.57**	**0.6**	**0.63**	**0.67**
Gender Parity Index in tertiary level enrolment	**0.22**	**0.23**	**0.28**	**0.27**	**0.36**	**0.34**	**0.34**	**0.32**	**0.32**	**0.34**

Data Source: MDG country report, 2010, MOFED

Besides, opportunities to continue schooling are disproportionately more limited for girls than for boys. Moreover, employment is lower for women than for men. In addition, exposure to the mass media, though generally low, is higher among men.

Knowledge about FP and about HIV is higher among men than among women. Knowledge among all women about any method of contraception is 86.1%, compared with 91% among all men. The average number of contraceptive methods known is 2.7 among women, compared with 3.6 among men. Yet women bear most of the burden of using FP methods: Male-dependent or male-dominated contraceptive methods account only for 1.1% among the 13.9% CPR. This is despite better knowledge about male-

dependent methods than about female-dependent methods (Central Statistical Agency [Ethiopia] and ORC Macro, 2006).

Early marriage is common in Ethiopia. Among women aged 25–29 at the time of the 2005 survey, 61.7% had been married by 18 years of age. In addition, 12.7% of 15–19-year-olds were already married by age 15. (This is despite the fact that the legal age at marriage in Ethiopia is 18 years.) Among adolescents aged 15–19, 20.4% had had a live birth by age 18. Nearly half (46.1%) of women aged 20–24 in 2005 had given birth before they were 20 years old (Central Statistical Agency [Ethiopia] and ORC Macro, 2006).

Because of the low status of women, the practice of abduction, rape, and other biological and traditional reasons, adult prevalence of HIV is twice as high among women as among men. Nearly 90% of women have heard about AIDS, compared with 96.6% of men. Similarly, knowledge of how to prevent HIV transmission is higher among men than among women (Central Statistical Agency [Ethiopia] and ORC Macro, 2006).

Harmful traditional practices (HTPs) are prevalent in Ethiopia. Nearly three-quarters of women (74.3%) were victims of female genital cutting (FGC). Approval of continuing the practice of FGC declined from 59.7% in 2000 to 31.4% in 2005—despite a constitutional right (Art. 16) of protection from bodily harm. Physical violence by an intimate partner is reported by 49% of women. Wife-beating is justified by 81% of women. Nearly 8% of women were married by abduction (Central Statistical Agency [Ethiopia] and ORC Macro, 2006). Furthermore, in some areas, sexual violence by an intimate partner is reported by 59% of women (WHO, 2005). One in five ever-widowed women is dispossessed of property (Central Statistical Agency [Ethiopia] and ORC Macro, 2006).

There is a need to change women's status in the community. Recognizing the low status of women, the Government of Ethiopia has established constitutional rights, laws,

directives, and strategies to empower women. However, realizing these rights calls for collective action from all stakeholders.

1.4. Maternal mortality and morbidity

The death of a mother is a tragic loss, not only for the family but also for the community and the country at large. Mothers are a productive segment of the population. The chance of a child's surviving and pursuing an education is limited if the mother is dead. In Ethiopia, the maternal mortality ratio has dropped from 1,068 maternal deaths per 100,000 live births in 1990 to 871 per 100,000 in 2000 (Central Statistical Agency [Ethiopia] and ORC Macro, 2001) and to 673 per 100,000 in 2005 (Central Statistical Agency [Ethiopia] and ORC Macro, 2006). A recent World Health Organization (WHO) estimate shows that the maternal mortality rate has dropped to 470 per 100,000 live births (WHO, 2010). Maternal deaths accounted for 21% of all deaths among women aged 15–49 in 2005 (Central Statistical Agency [Ethiopia] and ORC Macro, 2006).

For every maternal death, there are 25–40 serious complications related to pregnancy and childbirth that limit the quality of life of women who survive the ordeal (Royston & Armstrong, 1989). Most of these complications require repeated clinic visits and numerous medications and procedures for relief or cure, with enormous cost to the health care system. One of the cheapest method of preventing these unnecessary deaths and the suffering of women is the provision of FP services.

1.5. Trends in TFR and CPR in Ethiopia

Ethiopia has set its own goals for population, which are articulated in the population policy and HSDPIV as a TFR of 4.0 and a CPR of 65% by 2015. The population size has increased by five and one-half times in a little over a century, from 11.5 million in 1900 to 74 million in 2007. The demographic transitions in Ethiopia are characterized by an initial slow growth at a rate of less than 1.5% per annum until the 1940s, followed by acceleration between 1955 and 1995 up to 3%, after which the annual growth rate

declined slowly to the current level of 2.6%. The population doubling time currently is estimated to be 23 years.

The increase in population size is mainly the result of two very important demographic events: the gradual decline in the crude death rate over the last four decades, from around 30 per 1,000 to about 15 per 1,000; and the maintenance of the crude birth rate at between 40 and 50 births per 1,000 from 1960 to 2000. The country's TFR increased over three decades, from about six lifetime births per woman to 7.7 in the 1990s, after which it gradually declined to 4.8 by 2011 (Central Statistical Agency [Ethiopia] and ORC Macro, 2006). Although the urban TFR started declining as early as 1984 and was half of the rural TFR by 2000, the decline in rural TFR has not only lagged behind but has also been small, having dropped by only one birth in a decade. Another problem is that couples in Ethiopia rely more on short-term methods of contraception than on long-acting and permanent methods.

In conclusion, the TFR is still high, implying further rapid population growth in the years ahead. This will require quite concerted activity to increase the country's CPR and also shift the method mix to a greater emphasis on long-acting and permanent FP methods.

2. Policy Environment

The Ethiopian Government is a signatory to several international conventions or charters and declarations, including those arising from the 1987 Safe Motherhood Conference in Nairobi; the 1990 World Summit for Children; the 1994 ICPD; and the 1995 Fourth World Conference for Women. Ethiopia is also one of the signatories of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and of the Millennium Declaration.

Over the past 20 years, the Government of Ethiopia has followed up on its international commitments by adopting and implementing a series of policies and national strategies aimed at creating the necessary conditions for all Ethiopians to have access to basic social services, as well as ensuring women's human, economic, and political rights and their full participation in the development process.

The Constitution of Ethiopia, in Article 35, clearly states "Women shall… have equal right with men.… Laws, customs, and practices that oppress or cause bodily or mental harm to women are prohibited…. To prevent harm arising from pregnancy and child birth and in order to safeguard their health, women have the right of access to family planning information, education, and capacity." (Federal Democratic Republic of Ethiopia, 1995)

The National Health Policy states its main objective as to ensure provision of "comprehensive and integrated primary health care in a decentralized and equitable fashion" (Government of Ethiopia, 1993). The major emphasis is on health promotion and on prevention, focusing on communicable diseases, nutritional disorders, and environmental health problems, without neglecting essential curative activities. The policy states that maternal health and child health deserve due consideration. The National Health Policy emphasizes intersectoral collaboration, particularly with regard to family health and population planning.

The National Population Policy's overall objective is to harmonize the rate of population growth with economic development and thereby improve the welfare of the people (Transitional Government of Ethiopia, 1993). Within the context of current development strategies in Ethiopia, all of the eight targets set in the population policy directly or indirectly relate to FP, of which two are most applicable to this document:

- Reducing the current TFR to approximately 4.0 by the year 2015
- Increasing the CPR to 65% by the year 2015

The **Health Sector Development Plan (HSDP)** is a 20-year effort to achieve universal access to essential primary health care services by 2010 (FMOH, 2010). Designed to serve as a framework for technical and financial support to the health sector, the program is aimed at providing and extending access to primary health care services, enhancing the quality of such services, and improving health sector management. It is part of the government's 20-year investment program, and its overall objective is to improve people's health status, and thereby improve the productivity of the population; decrease people's household expenditures on health, thereby increasing opportunities for these resources to be invested productively; and contribute to the alleviation of poverty and support socioeconomic development.

The **National Reproductive Health Strategy** of the FMOH gives due emphasis to FP. **Under this section, the document** states that the goal of FP is to reduce unwanted pregnancies and enable individuals to achieve their desired family size. To **achieve** this overall objective, the strategy sets the following as action points:

- Delegate to the lowest service delivery level possible the provision of all FP methods, especially long-acting and permanent methods, without compromising safety or quality of care.
- Increase access to and utilization of quality FP services, particularly for married and unmarried young people and those who have reached desired family size.
- Create acceptance of and demand for FP, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth.

The HSDP harmonization manual agreed upon by partners working in the area of health invites all partners to work together to achieve the national targets through the concept of one plan, one budget, and one national target/report.

The five-year Growth and Transformation Plan (GTP) not only aims to attain rapid economic growth (14.9% per annum), but also seeks to ensure the expansion of quality health services and education to attain the MDGs and ensure the welfare of youth and women through capacity building and good governance

In summary, the constitution, health-related policies, and strategies in Ethiopia cover all major grounds and offer all necessary provisions, creating an enabling environment for the management of population dynamics in the interest of sustainable development, and the FP program is given due consideration. The Business Process Reengineering (BPR) effort and other quality improvement process initiatives being undertaken by the government will further facilitate activities for meeting the unmet need for FP.

3. Rationale for Family Planning Services

"***To prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right to FP education, information, and capacity.***" (The Constitution of the Federal Democratic Republic of Ethiopia, Article 35.9) (Federal Democratic Republic of Ethiopia, 1995)

3.1. Health benefits

"Family planning saves [the] lives of women and children and improves the quality of life for all. It is one of the best investments that can be made to help ensure the health and well-being of women, children, and communities.'" (WHO, 1995)

FP reduces mortality and morbidity from pregnancy and childbirth. Spacing childbirth at intervals of three to five years significantly reduces maternal, perinatal, and infant mortality rates. Use of FP prevents the depletion of maternal nutritional reserves and reduces the risk of anemia from repeated pregnancies and births.

Pregnancy and childbirth pose special risks for some groups of women—adolescents, women older than 35, women with more than four previous births, and women with underlying medical diseases. It is estimated that if all of these high-risk pregnancies were avoided through the use of FP, 25% of maternal deaths could be prevented (Royston & Armstrong, 1989). Moreover, unwanted pregnancy can lead to unsafe abortion, with its resultant short-term and long-term complications, including death. Suffering and deaths from complications of unsafe abortion can be prevented with the use of FP.

Apart from limiting and spacing births, FP methods have other, non-contraceptive benefits. If properly and consistently used, the condom provides protection from sexually transmitted infections (STIs), including HIV. The lactational amenorrhea method (LAM) provides special nutritional benefits to the infant and protects the infant from infections. In addition, LAM establishes mother-child bonding early in life, the

benefits of which continue through later life. It also reduces the risk of breast cancer in the mother.

3.2. Social and economic benefits

Individual: Pregnancy and childbirth pose a risk to the life of the woman. Repeated pregnancies and childbirth limit women's education, employment, and productivity, resulting in low status in the community, with a resulting poor living standard. FP enables women to pursue an education, to attain a better employment opportunities.

Family: Increased family size leads to income- and resource-sharing. Having too many pregnancies close together can entail early weaning, with consequent high levels of infant morbidity and mortality, as well as the high cost of alternative infant feeding options. In addition, children in such families tend to be underfed, ill-housed, and undereducated, culminating in future unemployment and being a burden to the family and the community at large. The death of a mother results in the disruption of the family.

Community and national: Increase in population size leads to an increased ratio of people to land, as well as reduced production and income, with consequent increased migration to urban areas. Furthermore, increased population size results in poor social services, poor education, compromised women's empowerment, an increase in the nonproductive segment of the population, deforestation, and overconsumption of resources (which aggravates poverty).

Global: Uncontrolled population growth intensifies famine, war, and migration, which are collectively termed "demographic entrapment" (King, 1993). Moreover, deforestation, erosion, and resource depletion and global warming are consequences of the population explosion.

All of these individual, family, community, and global effects of uncontrolled population growth can be minimized through strong FP programs and services that respect the

rights and informed decisions of women and men. FP is one of the most powerful health interventions with which to achieve MDGs.

3.3 Meeting individuals'/couples' fertility needs

Meeting individuals' fertility needs promotes women's right to choose whether to be pregnant and when to be pregnant. Furthermore, meeting individuals' fertility needs is essential if women are to achieve sexual and reproductive health and rights. Besides, meeting fertility needs is one of the tools for empowering women and attaining the MDGs.

4. Goals and Objectives of the Family Planning Guideline

4.1. The need for an FP policy guide

The Government of the Federal Democratic Republic of Ethiopia has committed itself to the achievement of the eight MDGs. MDG No. 5 addresses improvement in maternal health. The targets of MDG No. 5 are reducing maternal mortality by 75% and achieving universal access to RH services by the year 2015. Beyond the MDGs, the Ethiopian government strongly believes that FP is one of the key strategies to improving maternal health and bringing about development. Hence,

Cognizant of the need to coordinated FP programs and services in the country to ensure standardized, high-quality, client-centered, broad-reaching FP services that recognize the various levels of care, from the PHCU to the central referral hospitals;

Considering the distinct needs of underserved and special segments of the population for cultural, clinical, and gender- and age-specific FP programs and services;

Recognizing the ever-developing FP program approaches, including the HEP, issues of method mix, and development of the Medical Eligibility Criteria (MEC) for FP use;

Understanding the importance and relevance of the integration of FP services with other RH services, information, education, and communication (IEC) and behavior change communication (BCC) activities, FP commodity supply chain management, the health management information system, and coordinated partnership in FP programs and services;

Being aware of the fact that the 1996 FP guideline is out of date with current developments and the need to address new targets and directions; and

Being mindful of the significance of FP programs and services in the overall socioeconomic development of the country,

The Ethiopia FMOH has developed this FP guideline. The guideline has been developed with close consideration of and reference to the Ethiopian Constitution,

relevant policies, strategies, guidelines, and legal documents, scientific evidence, as well as international treaties, declarations, conventions, and covenants.

4.2. Commitment of FMOH

The commitment of the FMOH is reflected both in the achievements obtained so far and in the strategic plan for the future. In recent years there have been unprecedented increases in CPR and in utilization of antenatal care, skilled birth attendants, and postpartum care. Moreover, the number of maternal deaths has decreased. The first of the four major areas in Strategic Objective I of HSDP IV is to improve the health of mothers, neonates, children, adolescents, and youth. In this context, HSDP IV has set bold targets of reducing the maternal mortality ratio to 267 deaths per 100,000 live births and increasing usage of skilled birth attendants to 60% and CPR to 65% by 2015.

One strategy for achieving MDG No. 5 and the objectives of HSDP IV is to expand the provision of quality FP services. Collective activities by the government and other stakeholders contributed to an increase in the CPR from about 3% in the 1970s to 14% in 2005 and to 32% in 2008. The FMOH affirms that this leadership and collaboration will be strengthened more to achieve the HSDP IV targets that are in line with the MDGs.

4.3. Objectives of the FP guideline

This FP guideline has been developed to fulfill the following objectives:

- Guide FP programmers and implementers at government, nongovernment, and bilateral and multilateral organizations, and at private-sector as well as charity and civic institutions.
- Serve as a guide to all cadres of health care providers directly or indirectly involved in the provision of FP services, including for pre-service and in-service training.
- Set standards for FP programs and services.
- Standardize various components of FP services at all levels.

- Expand and improve the quality of the FP services to be offered.
- Direct integration of FP services with other RH services.
- Be used as a general directive and management tool.

4.4. Users of the FP guideline

The users of this guideline are:

- Policy makers
- Health managers
- FP program coordinators and managers at all levels
- All cadres of health care providers and instructors at health training institutions
- FP researchers, monitors, and evaluators
- Donors, other stakeholders, and implementers of FP programs in the government, nongovernment, and private sectors

5. Family Planning Services

5.1. Definition of FP

“Family planning” is defined as the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility.

FP is a means of promoting the health of women and families and is part of a strategy to reduce the high levels of maternal, infant, and child mortality. People should be offered the opportunity to determine the number and spacing of their own children. Information about FP should be made available, and access to FP services should be actively promoted for all individuals desiring them.

5.2. Service eligibility

Any reproductive-age person—male or female, regardless of marital status—is eligible for FP services, including information, education, and counseling.

5.3. Range of services to be offered in FP

The following services shall be offered at each level of the health system, in accordance with Tables 1 and 2:

- Counseling
- Provision of contraceptive methods
- Screening for reproductive organ cancers
- Prevention, screening, and management for STIs, including HIV
- Prevention and management of infertility

5.3.1 Counseling

Counseling is an important task of service providers. All clients have to be counseled to assist them in making an informed, voluntary choice and decision regarding fertility and contraception. Information should be provided regarding all methods of contraception, their advantages, and their expected side effects, as well as the steps to be taken if and when clients have side effects. Knowledge of the common misconceptions about each method is an added advantage to the counselor, and efforts should be made to address clients' concerns and fears about specific methods. FP workers should ensure confidentiality and privacy for potential clients. After receiving counseling on all available methods, clients should be helped to make an informed decision. See the REDI counseling flow chart in the annex.

5.3.2 Provision of contraceptive methods

The contraceptive mix in Ethiopia will consist of the following commodities and methods:

- Natural FP methods:
  - Abstinence
  - Fertility awareness–based methods, such as the standard days method (SDM), rhythm (calendar) method, two-days method, cervical mucus (Billings ovulation) method, sympto-thermal method
  - Lactational amenorrhea method (LAM)
  - Withdrawal
- Modern FP methods:
  - Male and female condom, diaphragm and other barrier methods
  - Vaginal contraceptives (foam, tablet, and jelly)
  - Emergency contraceptives
  - Progestin-only pill
  - Combined oral contraceptive
  - Injectable contraceptive
  - Implant
  - Intrauterine contraceptive device (IUCD)

- Bilateral tubal ligation (BTL)
- Vasectomy

For the convenience of clients, an FP service provider can prescribe 13 cycles of pills at a single visit for one year of use. Similarly, 48 condoms can be dispensed (for three months use) at a single visit, and the client should be informed that he or she can come for more if these run out before the next appointment day. For long-acting and permanent methods, detailed follow-up instruction should be provided at the first visit.

While respecting clients' rights and supporting informed decision making, as well as ensuring that method-mix is central to quality FP services, the FP program should focus on highly effective contraceptive methods, with a particular emphasis on long-acting and permanent methods. Dual protection should be strongly recommended to all clients at risk of infection with STIs, including HIV.

5.3.3 Screening for reproductive organ cancers

FP offers a unique opportunity to screen and teach the client to do self-examination for some of the reproductive organ cancers (ROCs). Health care workers should teach all clients to regularly do breast self-examination. Where facilities exist, women should be encouraged to have an annual Pap smear or have visual inspection of the cervix using acetic acid (VIA) or Lugol's iodine solution (VILI) at a health center. Health Extension Workers should educate women and their families about ROCs and about the benefits of screening.

5.3.4 Education on, screening for, and treatment of STIs

All clients should be given information on STIs, including HIV. These diseases should be described clearly, using local terms, where they exist. Clients should be informed about the symptoms of STIs, the methods of prevention, how they are treated, and, in the event of suspected diseases, where clients can obtain examination and treatment.

If a client is found to have an STI, it should be managed according to the national guideline for the management of STIs, using the syndromic approach.

5.3.5 Prevention and management of infertility

Management of infertility is expensive, requiring sophisticated services. More than 80% of female infertility is due to infections. The role of FP is mainly in STI prevention, through promotion of responsible sexual behavior, use of condoms, screening and treatment, counseling, referral, and seeking of services, when indicated. If a client presents with infertility, information on where to get services should be provided.

5.3.6 Integration of FP and other RH services

In Ethiopia there are good starts regarding integration of services which should be considered at all levels of the health care delivery system. Integration of FP with other RH service delivery is cost-effective and enables maximum utilization of health care services in one visit.

5.3.6.1. HIV counseling and testing (HCT)

HCT services can be good entry points for FP services, and vice versa. Both HIV and unwanted pregnancy are consequences of unprotected sex. Hence, clients attending HCT clinics and clients seeking FP services are sexually active people. Integrating HCT and FP service delivery is cost-effective and enables maximum utilization of health care in one visit. Health care workers who provide services for people living with HIV (PLWH) and FP clients have knowledge and counseling skills. With minimum input, both types of providers can provide services to clients seeking HCT and FP services at one stop.

The HIV/AIDS Policy and Guidelines for Voluntary Counseling and Testing for HIV (FMOH. 2007a), the Guidelines for Prevention of Mother-to-Child Transmission of HIV (PMTCT) (FMOH. 2007b), antiretroviral therapy, and treatment for opportunistic infections in Ethiopia recommend that basic FP information and services should be

incorporated into these services for all clients, regardless of their HIV serostatus. The feasibility and success of integration of FP services with HIV and AIDS care and support has been demonstrated in the country.

5.3.6.2 Education about, screening for, and treatment of STIs

Because of the disturbance and unpleasant manifestations of STIs, people tend to seek treatment for STIs promptly. In such patients, as unprotected sex is the culprit of the STI, the need for FP is evident. Health care providers who use the syndromic approach in the management of STIs should educate and counsel clients about high-risk behavior and should promote dual protection. Partner notification and treatment in syndromic management of STIs creates an opportunity for male involvement in FP. Dual protection should be strongly recommended to all clients at risk of STIs and HIV infection.

5.3.6.3. Comprehensive abortion care, antenatal care, delivery care, and postpartum care

A woman seeks abortion or postabortion care largely because of unwanted pregnancy. One of the elements of comprehensive abortion and postabortion care is provision of FP counseling and services based on free and informed choice. Abortion and postabortion care may be the first encounter of a woman with the health system, so providers should utilize this opportunity to counsel women and provide FP services. The *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* recommend that a woman should be provided with the choice of contraception immediately after abortion. If a woman comes for a repeat abortion, then the health system has failed in preventing unwanted pregnancy (FMOH, 2006.).

FP counseling should be part of focused antenatal care (ANC) services. Though fewer than 10% of all deliveries occur in an institution and receive postpartum care, it is imperative that all women who give birth at health facilities should be counseled on FP and informed about the availability of FP services.

5.3.6.4. Child health, immunization, and other RH services

Child health and immunization services create a good opportunity for the provision of FP information and counseling. Furthermore, programs that address HTPs, gender-based violence (GBV), prevention and management of infertility, screening for gynecological malignancies, family life education, and other RH services create opportunities for FP services. Hence, these services should be utilized to address issues related to FP.

5.3.6.5. Family life education

Family life education helps prepare young people for the transition to adulthood. In-school programs can result in positive behavior changes. FP issues need to be addressed in such curricula.

6. Family planning service strategies

Currently, it is estimated that 90% of the Ethiopian population has access to modern health services. The recently implemented BPR has introduced a three-tier system for health service delivery characterized by a *PHCU* consisting of five satellite Health Posts, one Health Centre, and a Primary Hospital to serve populations of 5,000, 25,000 and 100,000, respectively; a *General Hospital* that serves 1 million people; and a *Specialized Hospital* that serves 5 million population.

All health institutions in Ethiopia—rural and urban, hospitals, health centers, health posts, and both government-operated or private—shall provide FP services. FP services shall be delivered through the following service delivery modalities:

- Community-based services
- Facility-based services
- Social marketing
- Outreach services

6.1 Family planning services, by level of care

The provision of FP services is dependent upon the integration of services throughout the health care system, starting from the community level to specialized referral hospitals. In addition to outpatient clients, FP counseling and services should be made available to postpartum women, postabortion women, and individuals with special needs.

All health workers providing FP services should have contraceptive clinical and counseling skills.

Table 1 is a summary of the types of recommended services to be rendered and the types of providers who should be staffing the different levels of care. The skill level and task analysis by provider are summarized in Table 2.

Table 1. Organization of services, by level of care

Level of facility	Type of health personnel available	FP services
Health post	Health Extension Workers	• Counsel on FP and other RH issues • Counsel on natural FP methods • Provide injectables • Insert Implanon • Refer to health center for other long-acting and permanent methods • Do planning based on local data
Health centre	Health Officers (HOs), Midwives, Clinical Nurses, Public Health Nurses, Laboratory Technicians	The above activities, plus: • Conduct general physical and pelvic examinations, including VIA/VILI • Insert and remove implants • Insert and remove IUCD • (Where a trained GMP/HO is available), provide tubal ligation and vasectomy • Manage complications and side effects • Provide syndromic management of STIs • Provide HCT, including care • Train community-level workers and junior health professionals in FP • Conduct monitoring and facilitative supervision
Primary Hospital	Non physician clinicians, GMPs, HOs, Midwives, Clinical Nurses, Public Health Nurses, Laboratory Technicians	The above activities, plus: • Provide permanent methods of contraception • Receive referrals • Manage complications and side effects • Do work-ups for infertility
General and Referral hospital	Obstetrician-Gynecologists, GMPs, HOs, Midwives, Clinical Nurses, Public Health Nurses, Laboratory Technicians	The above activities, plus: • Manage infertility • Manage complicated STIs • Manage complications and side effects of contraceptive methods • Manage ROCs • Perform research

Table 2. Service organization of private facilities, NGOs, institutions of higher learning, and work-based facilities, by level of care

Level of facility	Type of health personnel available (minimum)	FP services
1. Lower clinic	1 Clinical or General Nurse (Diploma) 1 Lab. Technician	• Counsel on FP and RH • Distribute male and female condoms, oral contraceptives, (including ECPs), and injectables
2. Medium clinic	1 GMP/HO 1 Clinical Nurse At least 1 Lab. Technician	The above, plus: • Tubal ligation and vasectomy*
3. Higher-level clinic	1 Specialist/GMP (Head) 1 Specialist/GMP 1 Nurse At least 1 X-ray technician	The above, plus: • Management of complications and side effects
4. Specialized clinic (ob-gyn)	At least 1 Ob-gyn specialist 1 X-ray technician 1 Lab.technician 1 Midwife/Nurse	• All methods of FP
5. General and Specialized Hospital (MCH)	Variable types and numbers of professionals (including specialists)	• All methods of FP

Table 3. Task analysis for provision of FP

Task	Provider's category				
	Obstetrician-gynecologist	GMP	HO, Nurse, Midwife	Midwife, clinical nurse at diploma level	HEW
Client assessment					
• History taking	✓	✓	✓	✓	✓
• Physical examination	✓	✓	✓	✓	X
• Bimanual pelvic exam	✓	✓	✓	✓	X
• MEC	✓	✓	✓	✓	✓
Counseling	✓	✓	✓	✓	✓
Provision of FP services, by method					
• Natural methods	✓	✓	✓	✓	✓
• Condoms	✓	✓	✓	✓	✓
• Pills	✓	✓	✓	✓	✓
• Emergency contraceptives	✓	✓	✓	✓	✓
• Injectables	✓	✓	✓	✓	✓
• Implanon	✓	✓	✓	✓	✓*
• Other implants	✓	✓	✓	✓	X
• IUCD	✓	✓	✓	✓	X
• BTL	✓	✓*	✓*	X	X
• Vasectomy	✓	✓*	✓*	X	X
Other RH services					
• Syndromic management of STIs	✓	✓	✓	✓	X
• Management of complicated STIs	✓	✓	✓	X	X
• Cancer screening	✓	✓	✓	✓	X
• Treatment of ROCs	✓	X	X	X	X
• Management of infertility	✓	X	X	X	X
Pain medications					
• Nonnarcotic analgesics	✓	✓	✓	✓	✓
• Narcotic analgesics	✓	✓	✓	X	X
• Local anesthesia	✓	✓	✓	✓	✓*
Management of complications and side effects	✓	✓	✓	✓	✓^
Follow-up care	✓	✓	✓	✓	✓
Universal precautions	✓	✓	✓	✓	✓
Integration of FP and other RH services	✓	✓	✓	✓	✓
Instrument processing	✓	✓	✓	✓	✓
IEC/BCC	✓	✓	✓	✓	✓
Recording and reporting	✓	✓	✓	✓	✓
Training junior health professionals and community health workers	✓	✓	✓	✓	✓

Key;

✓ = Roles expected to be performed by the category

✓ *= Roles expected to be performed by the category after additional in-service training

✓^ = Reassurance and analgesics for mild side effects and refer

X = Roles not expected of the category

6.2 Outreach

Outreach: An FP outreach program is when an FP team arranges on its own a service provision program at health posts or kebele in its catchment area. Such programs are regular and happen at fixed intervals (e.g., every month or quarterly).

Mobile Outreach: A mobile outreach program is when an FP team provides long-acting and permanent methods at the health post or health center level. The FP team is organized at the higher level. Such programs are not regular and are need-based.

One of the reasons for low utilization of long-acting and permanent FP methods is difficult geographic access or unavailability of the service at a nearby health service outlet. Hence, the outreach or mobile outreach program is meant to cover those households where the distance from nearest health center is a limiting factor. Outreach services should include FP IEC, counseling, and services integrated with other MCH activities, including the Expanded Program on Immunization (EPI).

6.3 Social marketing

Social marketing is a strategy that promotes, distributes, and sells contraceptives at affordable price through existing commercial channels. Social marketing promotes FP services through multimedia IEC.

Social marketing is already being used for the promotion and sales of condoms, pills, and injectables. Other FP commodities (e.g., emergency contraceptives pills [ECPs]) can be distributed through social marketing, which complements the services that are rendered in the public, private, and NGO health institutions. Social marketing also involves pharmacies, drug stores, and rural drug vendors.

6.4 Workplace-based services

FP services at the workplace have the benefit of accessing an easy-to-reach, known population of workers. It potentially saves employees time, minimizes lost productivity, and has the benefit of reaching more male targets.

Ministries that have health facilities (e.g., Trade and Industry, Agriculture, Energy and Mines, Transport, and Communications), including factories, are encouraged to run FP services. Facilities at workplaces must be registered by the FMOH and must function based on the staffing and facility standards of the FMOH.

6.5 School-based services

Provision of Sexual and reproductive health services including FP services in school settings and in institutions of higher learning have the benefit of accessing an easy-to-reach and known population of youth. Student clinics in these academic institutions not only provide young people with objective information on sexuality and responsible sexual behaviors, but they also can offer opportunities for offering HIV testing, STI prevention and early management, and FP services.

School based interventions should include building the capacity of health providers working in student clinics, and equipping the clinics with necessary materials, equipment and supplies. In addition, it should involve establishing and /or strengthening referral arrangement between student clinics and health facilities(Hospitals and health centers) for FP services that are not offered in the student clinics.

Prevention of unwanted pregnancy should be a main component of the intervention in schools. The intervention should use various strategies tailored towards the need and status of in school youth. Such strategies should include,

- Peer education
- Mini media
- Youth dialogue
- Talk shows

- Edutainment and infotainment
- Radio programs
- Debates
- Drama/ theater (forum theatre)
- IEC/BCC materials development and distribution
- Student clubs

6.6 Role of NGO and private sector in FP program

The FMOH recognizes the important role and contribution of NGOs and the private sector to health. HSDP IV recognizes the proactive involvement of NGOs and the private sector, which "... significantly complement the public sector's capacity to tackle public health problems" (FMOH, 2005). NGOs will partner with FMOH and shall continue to take part in FP programs, as depicted in the harmonization manual of the HSDP.

7. Services for clients with special needs

7.1 Adolescents and youth

"*Limited knowledge of sexual physiology, early marriage, limited use of contraceptives, limited access to reproductive health information, and girls' limited agency over [their] sex lives all contribute to the high rate of unwanted pregnancy.*" National Adolescent and Youth Reproductive Health Strategy (FMOH, 2006)

Fewer than 10% of married girls aged 15–19 years use any modern FP method. Almost one-third (31.1%) of adolescents experienced an unwanted or mistimed live birth (Central Statistical Agency [Ethiopia] and ORC Macro, 2006), indicating limited access to FP services or access to less youth-friendly services.

Unmarried and married youth may have different sexual, FP, and other SRH needs. FP services can create an opportunity to discuss STIs, HIV, GBV, and other SRH issues. Because of ignorance and psychological and emotional immaturity, adolescents' and youths' compliance with the use of FP methods may not be optimal. Considering these facts:

- FP services need to be youth-friendly—i.e.
  - There should be friendly procedures to facilitate easy and confidential registration, short waiting times, swift referrals, and consultations available with or without an appointment.
  - Providers should be competent, with good communication skills, motivated and supportive, informative, and responsive to questions and concerns.
  - Such services should be affordable, offer privacy, should maintain confidentiality, and should be conveniently located, with convenient working hours.
  - Adolescents should be involved in planning and service delivery.
  - Such programs should have comprehensive service packages and ways of increasing access with outreach and peer-to-peer services.

- Providers should have evidence-based guidelines and services with a management information system.
- The minimum service standards for adolescent and youth RH should be observed.

- Adolescents prefer RH services to be under one roof. Hence, all efforts should be made to provide FP and other RH services in youth centers and student clinics of higher learning institutions.
- IEC/BCC messages should be gender and age oriented and should recognize the special needs of adolescents and youth.
- Good counseling and support is particularly essential. Ensuring privacy and confidentiality is particularly important in addressing the FP needs of adolescents and youth.
- Married adolescents require FP services to delay and space childbirth.
- Unmarried adolescents may have more than one sexual partner, behavior that predisposes them to STIs more than older people. Hence, dual use of FP methods should be included in counseling sessions.
- Youth who are not sexually active should get information and education on FP.
- As casual and forced sex is more prevalent among youth than among older people, provision of ECPs and condoms to youth in advance is recommended.

All contraceptives can safely be used by adolescents. However, specific attributes of the different FP methods for use by adolescents should be discussed during counseling.

7.2 People Living with HIV

Dual protection is critical in reducing transmission of STIs and HIV. For PLWH, dual method use helps to prevent transmission of HIV to an uninfected partner. In addition, dual method use helps PLWH to avoid acquiring other strains of HIV that could be drug-

resistant. For the HIV-negative client, dual method use prevents the sexual transmission of HIV and other STIs from an infected partner.

The fertility intentions of PLWH are varied. The Guidelines for Prevention of Mother-to-Child Transmission in Ethiopia recommend respect for the right of all women to decide their number and timing of children, regardless of HIV status. Avoiding unwanted pregnancy in HIV-positive women using FP is one of the four prongs of PMTCT.

ART services are widely available in the country. The service provides an opportunity to discuss FP and other RH matters. Regardless of their use of ART, PLWH can start and continue to use most contraceptive methods safely. Considering these realities:

- PLWH have equal rights to found a family and bear and rear children.
- Health care workers should provide them with information on various FP methods.
- Dual protection should be part of FP counseling.
- HIV-positive women should be informed about the implications of pregnancy, and prevention of pregnancy should be encouraged.
- Use of hormonal contraceptives in all HIV-positive women, regardless of ART use, is recommended, because the benefit to be obtained from using contraceptives outweighs the potential risk of unwanted pregnancy. However, it should be known some antiretroviral drugs affect the bioavailability and efficacy of hormonal contraceptives.
- Health care providers working in ART clinics should inform and educate PLWH about the prevention of unwanted pregnancy and the use of FP.
- Services should be provided under one roof.

7.3 Survivors of sexual violence

Sexual violence is a public health problem and a violation of human rights. Sexual violence is associated with numerous physical, psychological, and emotional consequences. Unwanted pregnancy is one of the complications of sexual violence.

Hence, emergency contraception should be provided for all victims of completed rape who are at risk of pregnancy.

ECPs and the IUCD are the two recommended types of emergency contraception. Whenever prepackaged ECPs are not available, oral contraceptives can be substituted. There are no known medical conditions for which ECP use is contraindicated. Considering these facts:

- ECPs should be provided for all survivors of rape who are at risk of pregnancy and who present within five days of the assault.
- The IUCD can be used as emergency contraception if the woman presents within seven days of the sexual assault or chooses the IUCD as a long-term FP option.
- If the survivor/victim presents more than seven days after the assault, she should be informed about safe abortion services.

7.4 Persons with disability, including mental disability

The ability to make an informed choice may be compromised in persons with disability, including mental disability. The ability of the person with disability to use an FP method in a timely way should also be considered. In view of these:

- Counseling and informed decision should involve parents, or next of kin, or guardians, depending on the degree of the mental disability. In the absence of these caretakers, the provider may decide, in the best interests of the client with serious mental disability, on a method choice.
- Some drugs that are used to treat mental disorders affect the bioavailability and efficacy of hormonal contraceptives. Hence, alternative methods of contraception should be considered.
- As much as possible, FP methods that do not seriously demand user compliance (e.g.IUCD, implants, surgical methods) should be encouraged, to ensure efficacy.

8. Advocacy, Communication, and Social Mobilization for Family Planning

IEC combines strategies, approaches, and methods that enable individuals, families, groups, organizations, and communities to play an active role in achieving, protecting, and sustaining their own health. Embodied in IEC is the process of learning that empowers people to make decisions, modify behaviors, and change social conditions. Activities are developed based upon needs assessments, sound educational principles, and periodic evaluation, using a clear set of goals and objectives.

BCC is the process of educating, persuading, and disseminating information to people to positively influence their behavior patterns and enable them to take actions that will enhance their RH status.

The aims of the IEC /BCC in FP are:

- To increase awareness and use of FP/child spacing methods and other relevant RH services
- To promote client-provider interaction

8.1. Communication channels

For effective IEC/BCC, a multimedia approach should be used. BCC messages should be correct, precise, timely, audience-specific (age, gender, educational level, marital status), and culturally sensitive and acceptable. The message should be clear and easily understandable.

The target groups should include:

- Policy makers
- Health care providers

- Opinion leaders, religious bodies
- Women
- Men
- Adolescents and youth
- Communities
- Media personnel, partner organizations

8.2. Contents of IEC/BCC messages and activities

The contents of IEC/BCC messages and activities should recognize the knowledge, experience, socioeconomic characteristics, customs, and traditions of the community. The contents should include, but not be limited to:

- Benefits to the mother, to the child, to the family, to the community, and to the world
- Where services are available
- Characteristics of FP methods
- Clients' rights: to information, access to quality services, choice, safety, privacy, confidentiality, dignity, comfort, continuity of services, and opinion
- Related RH issues—STIs/HIV, pregnancy, parenthood, ROCs, infertility
- Dispelling of rumors and misconceptions

8.3. Media and opportunities for IEC/BCC

All available channels and outlets should be used to ensure that coordinated IEC/BCC messages and activities reach the target populations. The channel of choice for IEC/BCC activities should be based on the target audience and the local availability and acceptability of the channel. They may include:

- Newspapers, magazines
- Radio, television, sonic screens
- Leaflets, brochures, posters
- Banners, billboards
- Schools
- Marketplaces
- Home visits
- Youth and anti-HIV/AIDS clubs
- Workplaces
- Kebele, community meetings

- Cultural festivals
- Panel discussions, debates
- Demonstrations, drama, songs
- Cinemas, theatre
- Internet

In addition, use of role models, actual clients/cases, and influential leaders of the community should be considered.

8.4. Male involvement

There are numerous and plausible reasons to involve men in FP activities and services. The family system is patriarchal. Men are the breadwinners in most families and are the decision makers at all levels. Men remain fertile for a longer period of life, are more involved in polygamous relationships, are more mobile, and are risk takers. Besides, men have better access to information and are more knowledgeable about FP methods. Nevertheless, the burden of FP is on women.

Men should be addressed in FP programs and services as users, promoters, and decision makers. Therefore, the following should be considered to ensure male involvement:

- Improve couples' communication regarding fertility and FP, so that decisions reflect the needs and desires of both men and women
- Ensure that FP services address the specific needs of men and are made male-friendly.
- Provide men with information that enables them to responsibly participate in FP use and decision making.
- Encourage men to accompany their partners on FP visits.
- Encourage and help to develop men as responsible adults and parents, so they can play an important role in preventing unwanted pregnancy and STIs. Men's cooperation is essential to stopping the spread of STIs, including HIV.
- Make information on FP, STIs/HIV, and other RH issues available to men through various formal and informal channels, including places of work and recreation.
- Involve men in the design and implementation of FP and RH services and allow them to express the ways in which they can be encouraged to take more responsibility.

8.5. Community involvement

The community should be made aware of the overall benefits and availability of FP services. FP programs and services, including IEC/BCC activities, should respect the customs and traditions of the community. Community involvement is key to dispelling rumors and misconceptions, and thereby developing ownership of FP programs by the community for successful and sustainable outcome.

The Government of Ethiopia has initiated an innovative strategy; the health Development army(HDA)),which aims to foster community ownership. The health development army provides the platform to promote family planning (FP) and reproductive health (RH) in the community. Partners working on FP and RH should work with HEW's and the primary health care unit staff to improve the knowledge of health development team leaders. Furthermore, FP and RH issues should be recognized as priorities and be discussed on regular basis during community dialogues at the health development teams.

9. Contraceptive supplies and management

9.1 Logistics management information system

The current pipeline has five levels. Products flow from the central Pharmaceutical Fund and Supply Agency (PFSA) down to the regions; from the regions to the zones (where they exist), then to woredas, and finally to the service delivery points. Information flow follows the same line, but from the service delivery point upward.

Health facilities are expected to send monthly logistics management information system (LMIS) reports to their respective woredas. At the woreda level, these reports should be compiled and sent to the zones (regions); from the regions, the reports go to the central-level quarterly. Using these reports, the higher level is expected to resupply the lower level of the system with the required FP commodities.

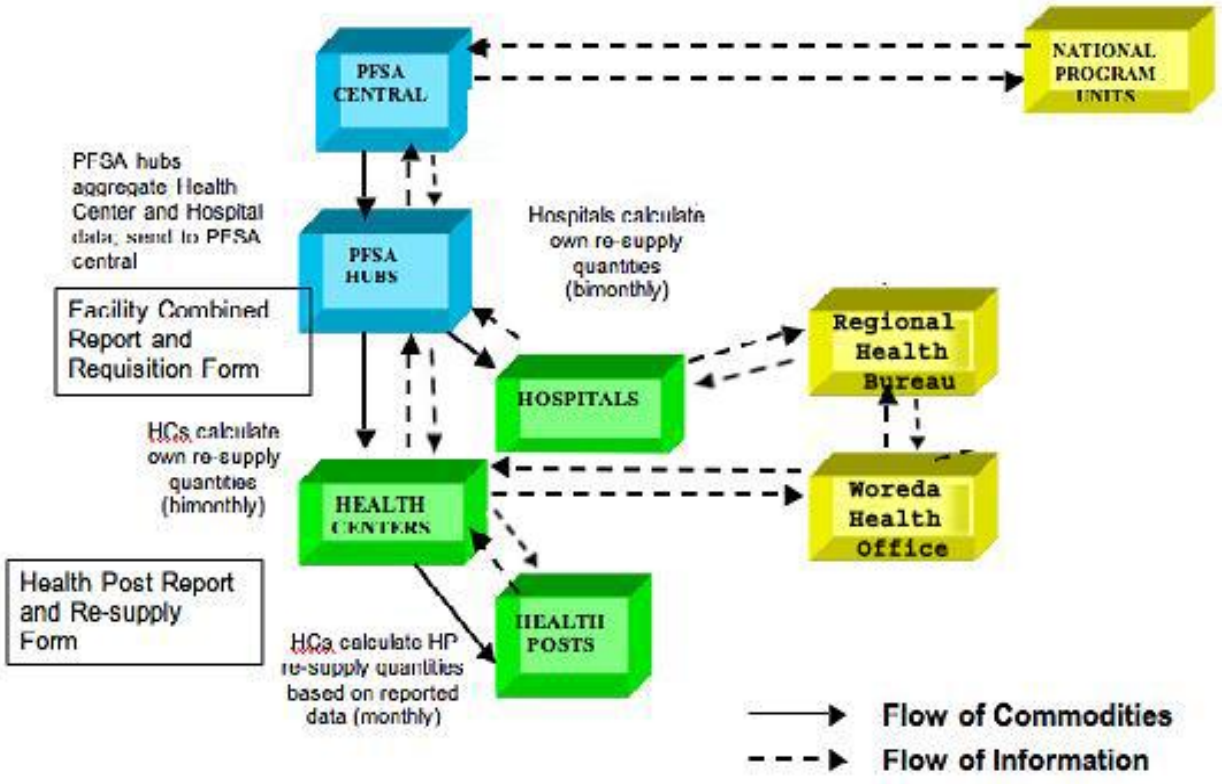
In 2007, a new LMIS was designed, and according to this system, the PFSA is expected to deliver health commodities directly to health facilities and collect LMIS reports from the health facilities. The new LMIS, which is expected to be functional at the end of 2011, is designed in such a way that logistics information is collected and reported for decision making on resupply planning, as shown below:

- A combined order and report form should be completed by Health Centres and Hospitals and sent to the PFSA for order processing every other month. The Health Centre order should include the commodity requirements of the Health Posts.
- A copy of the Health Centre report and order and a copy of each Health Post report should be sent to the Woreda Health Office for management and supervision purposes, and a copy of the Hospital report and order is also sent to the Regional Health Bureau for the same reason.
- The Woreda Health Office should aggregate logistics data from the Health Centres and send aggregated reports of logistics data to the Regional Health Bureau.

- The PFSA resupplies the health facilities with the required contraceptive commodities, based on the reports collected from health facilities and feedback from the Regional Health Bureaus.

The overall information system also includes a mechanism for higher levels to provide "feedback" to the respective lower levels. In the feedback reports, facilities will be able to see how they are performing compared with other facilities in their geographic area.

Figure 1: Flow of Commodities and Information



9.2 Forecasting

Forecasting is used to estimate the quantities of each product that a program will dispense to users for a specified period of time. It is the only way to ensure that programs order the amount of each type of contraceptive that clients are likely to use. Forecasting is done at the central level, where procurement usually takes place, and it is often done by logistics and program managers. Forecasting ensures the sustainable availability of contraceptives and other RH commodities.

To ensure regular and reliable forecasts for all essential drugs and contraceptives, the PFSA is taking concrete actions to build its internal capacity for forecasting. Gaining this experience is critical for the sustainability of the FP program in forecasting.

Contraceptive needs should be forecast at least annually and should be reviewed every six months. Whenever there is a change of the forecasting assumptions about client preferences or policy, the forecasting body should conduct a thorough review of the existing forecasts and adjust the trends. Forecasting should always be done using as many data sources as possible. The contraceptive forecasting methods used are:

- The consumption method (logistics forecasting)
- The demographic method (population-based forecasting)
- The service statistics method (service data forecasting)

9.3 Procurement

Contraceptive procurement should be done in accordance with the acceptable quality, safety, and efficacy, and at the right time and in the right quantity, as specified in the procurement plan. An efficient procurement system means that contraceptives are available at the best possible cost to both programs and customers. The government’s procurement system must be sufficiently robust and flexible to respond to evolving commodity needs.

The PSFA is accountable for the procurement of contraceptives and other essential drugs. Thus, besides building its capacity on procurement, the agency is working closely with donors

to ensure that the requested quantities are procured and delivered in a timely manner and that the procurement satisfies the national need for contraceptives.

9.4 Warehousing and storage

Warehousing and storage, which are basic parts of the contraceptive management system, are more than just shelving products. It is important to make storage guidelines and/or posters available in all storage facilities, to ensure implementation of proper storage procedures. Warehouses should operate according to the standard storage guideline, and there must also be ways to ensure the implementation of the good storage principles at all levels. A physical inventory should be taken at least every year at all levels.

9.5 Transport and distribution

A system of regular deliveries to health facilities is being designed by the PFSA. Health facilities will be grouped based on their geographic locations, and delivery routes will be designed for efficient transportation of health commodities. The health facilities will submit their resupply requests, and each facility will be scheduled to receive delivery of FP commodities every two months.

9.6 Inventory control procedures

A combination of inventory control systems (push and pull) is in place for RH commodities at the central and regional levels, with set maximum and minimum stock levels. Established guidelines for maximum and minimum stock levels are available at all levels for FP commodities. Contraceptives should be in full supply (i.e., there should be enough stock at all times and at all levels of the logistics pipeline to anyone who wants to use them).

Every facility should use the necessary inventory control tools, such as Bin Cards and Stock Record Cards, and these tools should always be updated.

9.7 Ordering and reporting

The Logistics Requesting and Reporting Form is used for both requesting products and reporting. Health facilities should fill the combined Reporting and Requesting Form and send it to the PFSA every two months for refill. Based on the report, the PFSA should deliver the necessary FP commodities to the respective health facilities.

Health posts are expected to send their summary report to their respective health centers; they will get resupplied based on the report from the health center on monthly basis.

10. Quality of care in family planning

RH programs face increasing pressure to provide quality, customer-oriented services. Both the ongoing health sector reform process in countries worldwide and the comprehensive RH agenda from the 1994 ICPD have pushed many FP programs to move away from demographic targets and toward an emphasis on the quality of the services they provide to meet their clients' holistic reproductive and other primary health care needs.

International studies show that clients are deeply concerned about the quality of the FP services they receive (Barnett & Stein, 1998) and confirm the relationship between improved quality and utilization of services (Finger, 1998). FP service providers in general need to adopt quality improvement strategies to improve client satisfaction, increase use and safety of services, and positively affect reproductive and general health.

Quality in health care is often defined as providing client-centered services and meeting clients' needs (Berwick, Godfrey, & Roessner, 1990). The quality improvement process is an effort to continuously do things better until they are done right the first time and every time. Quality services are those that meet the needs of clients (or customers) and are provided in a manner consistent with accepted standards and guidelines. The concepts that clients have rights and that staff have needs are internationally accepted as the basis for quality health care. Ethiopia has adapted the framework and hence all health care providers and partners need to adhere to the framework stated below:

10.1 The rights of clients

Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to RH and sexuality, and to health overall. Information and materials for clients need to be available in all parts of the health care facility.

Access to services: Clients have a right to services that are free/ affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no

inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Informed choice: Clients have a right to make a voluntary, well-considered decision that is based on options, information, and understanding. The informed choice process is a continuum that begins in the community, where people get information even before they come to a facility for services. It is the service provider's responsibility either to confirm that a client has made an informed choice or to help the client reach an informed choice.

Safe services: Clients have a right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service delivery guidelines, quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during the delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff's handling of clients' medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services, supplies, referrals, and follow-up necessary to maintaining their health.

10.2 The needs of health care staff

Facilitative supervision and management: Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients.

Information, training, and development: Health care staff needs knowledge, skills, and ongoing training and professional development opportunities to remain up to date in their field and to continuously improve the quality of services they deliver.

Supplies, equipment, and infrastructure: Health care staff needs reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services

11. Health management information system

FP records and reports are important tools for strategic planning, supervision, and monitoring. The Health Management Information System (HMIS) was put in place as of 2009. The HMIS is a primary source of data for monitoring. Two commonly used FP records are described in this chapter.

11.1. Client card

All clients seeking FP services need to have a client card. The client card records their socio-demographic and health history, the physical examination findings, and the client's current FP method. The follow-up section of the card records the history and physical examination findings at the time of the visit.

The client card provides information on past and current use of an FP method and the client's history of method switching (if any). It is an important tool for monitoring the quality of services, as it provides information on whether the client has been screened for his or her eligibility to use the method. It is useful for follow-up of clients. When the client cards are organized in a systematic way, it helps to track clients who discontinue methods.

11.2. Family planning register

This register records relevant information on all clients who receive service from a health facility. The FP register is kept in the FP room of the facility. The FP register should be completed by the provider at the time of service provision.

The register includes such information as the client's medical record number, sex, date of visit, counseling services received, contraindications for use of certain methods, method provided, number of visits, FP method used, and date of last visit (in case of condoms, combined oral contraceptives, and injectables). The register:

- Provides information on contraceptive use in a specified geographical area
- Is a useful tool for tracking clients

- Provides information on supplies of contraceptives

11.3. Referral form

Records of clients referred are obtained from the referral records. The referral record is in Annex 12.3 (page 63).

11.4. Supplies records

Records of contraceptive supplies are described in the section on contraceptive logistics (page 48).

11.5. Reports

FP reports provide information on the progress of the various indicators that have been identified by the FMOH. The report is an important tool for monitoring. The health facility should compile a monthly report and forward it to the woreda health office. A woreda health office is to compile all reports from all facilities in its catchment area monthly and to submit a report to the zonal health office, which in turn will summarize the report every three months for the regional health bureau. The regional health bureau then compiles the total contraceptive acceptor and the LMIS report and submits them to FMOH biannually.

11.6. Confidentiality of records and data use

Individual client records should be kept confidential. Records should not be accessible to unauthorized personnel. All data analysis has to be done without identifying individual clients.

12. **Annexes**

12.1. Family planning register

Family Planning Register

Identification			Family Planning and Contraceptive Services														
Personal information			Registration			Counsel and Screen					Fill app.		Clinical exam and contraceptive services provided				
Serial No.	MRN	Sex (M/F)	Reg. date (DD/MM/YY)	New acceptor at registration (√)	Repeat acceptor at registration (√)	HIV Test offered (√)	HIV Test performed (√)	HIV Test Result (R or NR or I)	HIV specific counseling / methods offered (√)	TT status checked (√)	Contraindication for hormonal method (√)	Contraindication for IUD (√)	Permanent method selected (TL or V)	Visit No.	Visit date (DD/MM/YY)	Contraceptive Provided	Remark/Appointment
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
														1			
														2			
														3			
														4			
														5			
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														5			

count new acceptors [ ] [ ] *count repeat acceptors*

Abbreviate type (Column 17) as follows:
***MaC** - Male Condom; **FeC** - Female Condom; **OC** - Oral Contraceptive*
***Inj** - Injectable; **EC** - Emergency Contraception **Diaph** - Diaphragm;*
***IUCD** - Intrauterine Contraceptive device **Imp** - Implant*

INSTRUCTIONS FOR FAMILY PLANNING REGISTRATION AT HEALTH CENTER / HOSPITAL

Register only (HC/Hospital-FPReg), kept in FP room, and completed by Family Planning Service Provider

Location information to be completed at front of register:

Region	Write the region where the facility is located
Woreda / Sub-City	Write the woreda/sub-city where the facility is located.
Kebele	If Health Post, write the name of the kebele where the Health Post is located.
Name of Health Facility	Write the name of the health facility where the FP services are provided.
Register begin date	Enter the date of the first entry in the register, written as (EC) Day / Month / Year (DD/MM/YY)
Register end date	Enter the date of the last entry in the register, written as (EC) Day / Month / Year (DD/MM/YY)

SN	Datum	Comments
	Identification: Personal information	
1	Serial Number	Sequential serial number in registration book; to be entered on client's registration card for later identification in register
2	Medical Record Number (MRN)	Unique individual identifier used on medical information folder, for HC and hospital.
3	Sex	**M = Male; F = Female**
	Family Planning services: Registration	
4	Registration date	Date client registered in this registration book, written as (EC) Day / Month / Year (DD/MM/YY)
5	New acceptor at registration	Tick if client is new acceptor at the time of registration. A new acceptor is someone who has not received a contraceptive method from a recognized program before registration.*
6	Repeat acceptor at registration	Tick if client is repeat acceptor at the time of registration. A repeat acceptor is someone who is not a new acceptor; in other words, a repeat acceptor has received a contraceptive method from a recognized program before registration.
	Counseling and screening	
7	HIV test offered	Tick if HIV test offered under provider initiated HIV counseling and testing guidelines
8	HIV test performed	Tick if client tested for HIV/AIDS.
9	HIV Test results	Enter **R** in red pen if test is **reactive**; **NR** in normal color of pen if test is **not reactive**; or **I** in normal color of pen if test is **indeterminate.**
10	HIV specific contraceptive counseling / methods offered?	Tick if HIV specific contraceptive counseling / methods offered.
11	TT status checked	Tick if TT status checked.
	Fill when applicable	
12	Contraindications for hormonal method	Tick if one of following conditions present - Breastfeeding baby < 6 weeks old - Bleeding /spotting between periods or after intercourse - Jaundice (abnormal yellow skin or eyes) - Smoke - Diabetes - Severe headache or blurred vision - Severe pain in calves, thighs or chest, or swollen legs (edema) - High blood pressure (history of) - Heart attack, stroke or heart disease (history of) - Breast cancer or suspicious (firm, contender, or fixed) lump in the breast - Taking drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampicin) - other

INSTRUCTIONS FOR FAMILY PLANNING REGISTRATION AT HEALTH CENTER / HOSPITAL

SN	Datum	Comments
	Fill when applicable	
13	Contraindications for IUD	Tick if one of following conditions present - Client (or partner) has other sex partners - Sexually transmitted genital tract infections (GTI) within the last 3 months or other chronic STI (eg HBV, HIV/AIDS). - Pelvic infection (PID) or ectopic pregnancy (within the last 3 months) - Heavy menstrual bleeding (twice as much or twice as long as normal) - Severe menstrual cramping (dysmenorrhea) requiring analgesics and/or bed rest. - Bleeding/spotting between periods or after intercourse - Symptomatic valvular heart disease - other
	Family Planning services: Clinical examination and contraceptive services provided	
14	Permanent contraception	If permanent method supplied, enter TL (for tubal ligation) or V (for vasectomy)
15	Visit No (1-5)	Visit number in current year
16	Visit Date	Date of visit, written as (EC) Day / Month / Year (DD/MM/YY)
17	Contraceptive provided	Contraceptive method a client chooses (record modern methods only) Abbreviate type as follows: **MaC Male Condom** **FeC Female Condom** **OC Oral Contraceptive** **Inj Injectable** **EC Emergency Contraception** **Diaph Diaphragm** **IUCD Intrauterine Contraceptive Device** **Imp Implant**
18	Remarks	Any additional suggestions, comments…follow up appointment

Monthly counts for service delivery:

At end of month, add

- the ticks for new and repeat acceptors (columns 5 and 6 to report on family planning acceptors (indicator A1.2)

Provider Initiated HIV Counseling and Testing (PIHCT) services are tallied as given, from columns 7, 8, and 9 on the Health Center / Hospital PIHCT Tally (HC/Hospital-PIHCTTally).

- Tests offered, tests performed, and positive tests are tallied by sex and age group (15-24 years and 25 years and older).

* JHPIEGO Glossary of General Family Planning Terms (*http://www.reproline.jhu.edu/English/6read/6gloss/glossfp.htm*) defines "**New (FP) Program User** (also known as **New [FP] Acceptor**)" as "Someone who receives family planning services from an agent of a FP program who has never received a contraceptive method from a recognized program before. The essence of a FP services within the context of a program is that clients are provided with counseling, physicals and exams (if required) and followup care, in addition to a method of contraception."

12.2 Consent form for voluntary surgical contraception

በፍላጎት የቀዶ ሕክምና ቤተሰብ ዕቅድ ደንበኞች
የሚሞላ መተማመኛ ቅጽ

እኔ ፊርማዬ ከዚህ በታች የሚገኝ ግለሰብ በቀዶ ሕክምና የእርግዝና መከላከያ ለማስደረግ ስለፈለኩ ከዚህ በታች የተዘረዘሩትን ነጥቦች ተረድቼ ተቀብያለሁ።

ይኸውም፤

1ኛ በቀዶ ሕክምና ከሚደረገው የእርግዝና መከላከያ ሌላ ጊዜያዊ የሆነ የእርግዝና መከላከያ ዘዴዎችን በመጠቀም ቤተሰቤን ማቀድ እንደምችል አውቃለሁ።

2ኛ ይህ በቀዶ ሕክምና የሚፈጸም የቤተሰብ ዕቅድ ዘዴ ነው። እንደማንኛውም የቀዶ ሕክምና ስርዐተ ደንብ ስለሚደረግ አንዳንድ መጠነኛ ችግሮች ሊከሰቱ መቻሉን ሐኪሜ ገልጸውልኛል።

3ኛ ዘዴው የዘለቂታ መሆኑ ሊታወቅ ይገባል ሆኖም ማንኛውም የቀዶ ሕክምና መቶ በመቶ ዋስትና ሊያሰገኝ አይችልም። ለጥቂት ደንበኞችም ላይሰራ ይችላል። የቀዶ ሕክምናው ውጤት ከሰመረ ተጨማሪ ልጆች ሊኖረኝ አይችልም።

4ኛ እኔው በእራሴ ፍላጎት ያለምንም ተጽእኖና ግፊት የተቀበልኩ ስለሆነ ቀዶ ሕክምናው ከመሰራቱ በፊት በፈለግሁ ጊዜ ሀሳቤን በመለወጥ ድርጊቱን ሳለመቀበል እችላለሁ። ሀሳቤንም በመለወጤ ምክንያት የሕክምና፤ የጤና፤ ሌሎች አገልግሎቶችና ጥቅሞች ላይነኩብኝ መብቴ የተጠበቀ ነው።

5ኛ ይህ የእርግዝና መከላከያ ዘዴ በግብረ ስጋ ግንኙነት ጊዜ የሚተላለፉ በሽታዎችን /ኤች አይ ቪን ጨምሮ/ እንደማይከላከልም ተረድቻለሁ።

---------- ----------
የደንበኛው ስም የደንበኛው ፊርማ/አሻራ

የሃኪም ወይም ስምምነቱ በደንበኛው
ተገልጋይ ፈቃደኝነት መፈጸሙን
ለማረጋገጥ የተወከለ ባለሙያ
ስምና ፊርማ

ቀን

12.3 Referral form

Federal Ministry of health

Referral form

Date _____

Medical record number_____

Referred to _____

Referring Institution _____

Name _____ age _____

sex_____

Address: region _____Woreda _____kebele _____ house number _____

Brief History:

Brief physical examination

Reason for referral _____

Name of the provider _____

Signature of the provider _____

……

Please use the following section for feedback

Referred to _____Referring Institution

_____

Feed back

Signature:

12.4 Couple-years of protection

A CYP is the estimated protection from pregnancy provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.

How is CYP calculated?

CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure. CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realized.

Method	CYP Per Unit
Oral contraceptives	13 cycles per CYP
Condoms	120 units per CYP
Female condoms	120 units per CYP
Vaginal foaming tablets	120 units per CYP
Depo-Provera injectable	4 doses (ml) per CYP
Noristerat injectable	6 doses per CYP
Cyclofem monthly injectable	13 doses per CYP
Copper-T 380-A IUCD	5.5 CYP per IUD inserted
Implanon implant	2.0 CYP per Implant
Jadelle implant	3.5 CYP per Implant
Emergency contraceptive pills	20 doses per CYP
Natural family planning (SDM)	2 CYP per trained, confirmed adopter
LAM	4 active users per CYP (or .25 CYP per user)
Sterilization (male and female)	12.5 CYP

12.5 Counseling guide

NEW CLIENT: REDI FP counseling steps

R - RAPPORT-BUILDING	
Greet client with respect	Welcome client; offer a seat; introduce yourself
Make introduction	Tell your name to the client and ask client's name
Assure confidentiality and privacy	Affirm to the client that the subject would not be disclosed to any other person unless she/he want to; ensure that there is nobody else is listening to the talk and looking at the procedure
Explain the need to talk about sensitive issues	Explain need to ask personal and some times sensitive questions
E – EXPLORATION	
Ask the reason for visit	About previous FP method use, whether she has already decided on a method, what s/he knows about FP methods
Explore client's knowledge about FP method/s/ and fill the knowledge gaps	Ask what she/he knows about the types of contraception and Provide information based on the gap about how to use, effectiveness, advantages, disadvantage and complications, protection against STI/HIV
Ask reproductive history and fertility plan	Pregnancy history and outcomes, number and age of children, Whether s/he wants more children, if she wants contraception, the nature of contraceptive protection desired (Duration, hormone/non hormone, etc)
Explore client's circumstances and relationships	Partner/spouse/family involvement and support for contraceptive use with particular emphasis on method(s) of interest; ability to communicate with the partner about FP decisions; history of violence and/or rape; other factors (socio-economic) that may influence contraceptive use, or use of method(s) of interest
Explore issues related to sexual life	Questions/concerns/problems client has about sexual relations/practices; nature of sexual relationships (frequency, regularity) that may affect contraceptive choice and use whenever important
Ask about STI/HIV knowledge/ history and help to perceive risk	Ask about knowledge, history of STI , any sign and symptoms on the client/ partner perceived risk of STI/HIV and explain the advantage of Dual protection to reduce the risk
Rule out pregnancy	Ask about date of last birth, Breast Feeding practice, last menstrual period and menstrual pattern , history of unprotected sex, recent abortion/miscarriage etc
Screen client for possible medical condition	Ask whether client has any known or suspected health problems: Cardiovascular (including high blood pressure), liver, reproductive cancer, bleeding/spotting between periods/after sex, severe anemia etc.
D - DECISION MAKING	
Help clients consider or remind the following before making decision:	1. Eligibility 2. side effects tolerance 3. STI/HIV risk protection 4. Potential barriers
Encourage to make her/his own decision	Reconfirm it is her/his choice, confirm that the decision is voluntary
I – IMPLEMENTATION	
Explain how to use method	When to start, how to use and where to obtain the method, S/E and their Mx, Warning signs. Explain the procedure if there is one.
Identify barriers to implement decision & develop strategies to over come barriers	Consider barriers like S/E, Partner r/n, cost and availability of method and deal with them like what to do with S/E, role of emergency contraceptive, options to switch , negotiation with partners, etc and provide written information (if any)
Make a follow-up plan	Timing of medical follow up or resupply ensure that client understood all information, remind the client to return or call whenever s/he has questions, concerns or problems

RETURNING CLIENT (WITH PROBLEM): REDI counseling steps

R - RAPPORT-BUILDING	
Greet client with respect	Welcome client; offer a seat
E – EXPLORATION	
Ask the purpose for visit	Returning client with no problem or with problem
Ask about satisfaction with current method	Check if client has any questions/concerns/problems, especially regarding side effects
Confirm correct method use	Ask the client to describe how she is using the method
Ask about changes in circumstances and sexual life; new medical conditions	Ask if she has any health problems recently, if she has changed partner, concerns that she might be exposed to STI/HIV (ask about dual method use) since last visit;
If there is dissatisfaction, explore the reasons and discuss for solution	• Side effects (managing side effects or switching to another method) • Incorrect method use (discuss how to use method and backup method correctly) • Suspected pregnancy (ask about client's and her partner's reaction to possible pregnancy, explain screening/testing to be done); discuss method options if pregnancy screening/tes are negative and options if result positive (e.g. ECP, if appropriate) • Warning signs (explain screening/other exams, test and treatment to be done and referral as needed) • Change in individual STI/HIV risk (help perceive her risk, dual method use). • Lack of partner or family support to use the method (discuss possible communication and other strategies that can help client continue with method)
D - DECISION MAKING	
Identify what decisions the client needs to confirm or make Encourage to make own decision	Continuing with current method, switching to another method discontinuing FP method, STI/HIV risk reduction/dual protection, complying with treatment Reconfirm her/his choice, confirm that the decision is voluntary
I – IMPLEMENTATION	
Help the client in implementing the decision: - Continue current method - Switch to another method - Discontinue the method Make a follow-up plan	• Help deal with the side effects • Provide the information and skills (especially for condoms) needed for correct use of the method • Help to get services they need or refer (pre-conception or antenatal care) • For clients wanted removal of Implant or IUD, explain removal procedure and respond to question. Timing of medical follow up or resupply, ensure that client understood all information, remind to return or call whenever s/he has questions, concerns or problems

RETURNING CLIENT (SATISFIED): REDI counseling steps

R - RAPPORT-BUILDING	
Greet client with respect	Welcome client; offer a seat
E – EXPLORATION	
Ask the purpose for visit	Ask what she/he feels about using the method
Ask about satisfaction with current method	Check if client has any questions /concerns /problems, especially regarding side effects
Confirm correct method use	Ask the client to describe how she is using the method (if it is administered by the client herself/himself)
Ask if there are changes in circumstances and sexual life; if she develops any medical problem	Ask if she has any problems regarding her health condition, if she has changed partner, concerns that she might be exposed to STI / HIV (ask about dual method use) since last visit;
D - DECISION MAKING	
Help client identify what services she needs during this return visit	Re supply Regular well women visit Follow up visit etc
I – IMPLEMENTATION	
Make a follow-up plan if, applicable Provide or refer for other services, if applicable	Timing of medical follow up or resupply, ensure that client understood all information, remind to return or call whenever s/he has questions, concerns or problems

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