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Guideline Development Group

The federal ministry of health in Ethiopia has various technical working groups composed of members from different local and international organization, universities and research institutions. The Family planning technical working group is one of those organized under the FMOH maternal and child health directorate. This group discusses at a regular basis and advises the RMNCAH directorate on Family planning intervention updates, policy directions, advises the ministry on alignment of interventions at a national and regional level. Recently, the team has found the importance of revising the national family planning guideline

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Guideline development Process

The family planning guideline will be developed through a participatory approach, taking inputs from the family planning technical working group and technical advisory group. Experts in the federal ministry of health who are directly in place coordinating family planning interventions will be highly involved and their input and experiences will be documented and incorporated.

In this process, an individual consultant was recruited and desk review of TWG meeting minutes, literature reviews, review of policy documents, strategic documents and guidelines that need to be reviewed for the preparation of the guideline were identified and reviewed. Following which, a first draft of the FP guideline was developed and comments were gathered from the technical working group. Finally a two days’ workshop was organized and further inputs were gathered and incorporated accordingly to make the guideline complete.

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
PSA  Pharmaceutical 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
1. Executive Summary
2. Target audience

The intended audience for this guideline includes policymakers, family planning programme managers and the scientific community. Health professionals at all levels, in the public sector, private sector, teaching institutions and all other service delivery points can use it as a reference and guide for providing services. The guideline aims to provide guidance to national family planning and reproductive health programs in the preparation of manuals for delivery of contraceptive services. Below are the summarized lists of potential users of the guideline:

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

3. Background

3.1. Global Context

The global population is projected to increase from its current number of 7.6 to 9.9 billion in 2050, up 2.3 billion (29 percent increase) according to the 2018 projections by Population Reference Bureau (PRB). The major increase in the world population is expected to come from the developing world. In this regard, Africa’s current population of 1.28 billion is projected to reach 1.71 (33.6% increase) in 2030 and 2.58 (101.6% increase) billion in 2050 at 2.6% rate of natural increase. However, globally over the last four decades women are having fewer children, reducing from 4.7 children per woman in 1970 to an average of 2.4 children in 2018. In Africa, this reduction shows a 30% decline, from 6.7 to 4.6. This indicates that most African countries are still in the early phase of the fertility transition, which necessitates investment in women education and empowerment, expanding family planning services and similar other interventions.
In an effort to achieve a better future for all, SDG 3 has targeted to reduce maternal mortality ratio to less than 70 per 100,000 live births by 2030 and plans to ensure universal access to sexual and reproductive health-care services; including for family planning\(^1\). Progress toward achieving SDG target 3.7 will be assessed using indicator 3.7.1, which is specified as the proportion of reproductive age women who have their need for family planning satisfied with modern methods of contraception. Levels of demand satisfied by modern methods of more than 75 per cent are considered high, while values of less than 50 per cent are considered very low.

In 2017, for the group of 69 countries that are the focus of the Family Planning 2020 (FP2020) initiative, the percentage of demand for family planning satisfied with modern contraceptive methods increased from 59 per cent in 2000 to 68 percent. On the other hand, in Africa, the proportion of the demand for family planning satisfied with modern contraceptive methods increased from 41 per cent in 2000 to 56 percent in the same year\(^2\).

### 3.2. National Context

#### 3.2.1. Health System

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 is the lowest health service delivery unit. A *general hospital*, which serves an area of 1 million people, is the mid-level structure; and a *Specialized Hospital*, which serves an area of 5 million population, is the higher teaching and referral hospital. 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).

\(^1\) [https://www.un.org/sustainabledevelopment/health/](https://www.un.org/sustainabledevelopment/health/)
\(^2\) Family Planning 2020 [http://www.familyplanning2020.org/](http://www.familyplanning2020.org/). The global partnership focuses on 69 of the world’s poorest countries, including 41 countries in Africa as well as 22 in Asia, 4 in Latin America and the Caribbean and 2 in Oceania.
Ethiopia has been planning and implementing various long-term development plans across the past five decades. Currently it is implementing growth and transformation plan II, which is aligned with the global sustainable development goals. In this regard, the health sector has effectively implemented four phases of health sector development plans since 1997, which mainly focused on strengthening the primary health care unit and has documented best achievements in expanding preventive measures in the public health area. The increase in average life expectancy from 47.1 years in the 1990’s to 64.4 years in the 2015’s might be an evidence for the expansion of health system and improved living style in the country.

3.2.2. Historical background and progress of FP programs in Ethiopia

The Family Guidance Association of Ethiopia (FGAE), an affiliate member of the International Planned Parenthood Federation (IPPF), which was established in 1966 pioneered modern family planning services in Ethiopia. FGAE used to provide its’s first FP services in a single-room clinic run by one nurse. 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 collaborated 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 the first Guideline for FP Services in Ethiopia to guide stakeholders, as well as to expand and ensure the quality of FP services, which was revised in 2011. 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.

3.2.3. Current SRH status of the Ethiopian population

Because of Ethiopia’s commitment to improving reproductive health and family planning, the country has showed a remarkable progress; evidenced by a reduction of maternal mortality ratio and improvement in contraceptive prevalence rate. According to the latest EDHS estimate, the proportion of mothers dying per 100,000 live births has declined in Ethiopia from 871 in 2000 to 412 in 2016 (53% reduction providing an average of 3.5% reduction per year). Similarly, infant
mortality decreased from 97 deaths per 1,000 live births in 2000 to 48 deaths per 1,000 live births, indicating a 50.5% reduction. Whereas, TFR has declined from 7.7 children per woman in 1990, to 4.6 children per woman in 2016, which is still very high in rural women than urban women. A comparison of contraceptive prevalence rate also indicates that among currently married women in Ethiopia, it has increased steadily from 8 percent in 2000 to 36 percent in 2016. However, there is a significant variation among urban and rural communities and across different regions. Urban women are much more likely than their rural counterparts to use any method of contraception (52 percent versus 33 percent), while only 2 percent use FP in Somali compared to 56 percent in Addis Ababa. Similarly, the unmet need in family planning is gradually declining from 37% in 2000 to 22% in 2016 (EDHS, 2016). Long acting family planning methods have been emphasized in the last five years evidenced by increased availability of implannon at community level since 2009 and scale up of intrauterine contraceptive devices in hundreds of districts since 2010. According to the 2016 EDHS, Injectable and implants comprise 63.5% and 22.0% compared to the 72.4% and 10.3% in 2011, a very dramatic method shift in method mix. These achievements in the health sector can be attributed to the expansion of the Health Extension Program (HEP). Implementation of the package of family health, expanded training of health workers on FP and expansions on community demand creation for family planning services under the leadership of the federal ministry of health and the financial and technical support from partners and the donor agencies can be mentioned for the improved achievements in the reproductive, maternal and child health services.

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

Women play a critical role in Ethiopia. They are in all segments of society and undertake the majority of household related tasks. However, gender inequality remains a major barrier to human development. All too often, women and girls are discriminated against in health, education, political representation, and the labor market with negative consequences for development of their capabilities and their freedom of choice. This makes violence against women in Ethiopia is a concern from a human rights, economic and health perspectives posing challenges in achieving gender equality and women’s empowerment. The 2018 human development report has released the gender inequality index (GII) which
measures gender inequalities in three important aspects of human development: reproductive health, women empowerment and economic status. Ethiopia has a GII of 0.22 ranking 121st out of 195 countries. It has estimated that only 11.2% of women aged 25 and older have at least secondary education while 21.45 of males have completed secondary level education making the gender parity index to be only 52%, revealing the presence of a huge gender gap.

Women and girls are forced to marry at their early age. In this context, the 2016 EDHS indicated that the median age at first intercourse is 16.6 for women 25 to 49 years of age, while their median age of first marriage is 17.1, all below the legal age of marriage. Still the median age of first childbirth is 19.2 years, in the teen age group. Other forms of violence practices against Ethiopian women include female genital cutting, where more than 65% of women are circumcised, the highest record being in Somali (99%). Forty-nine percent of circumcised women age 15-49 were circumcised before age 5, and 24% were circumcised at age 10 or older. Around 33% of ever-married women report that they have experienced either physical or sexual violence. While another 26% of married women have some form of intimate partner violence. In most cultures across Ethiopia, the man also suppresses women decision-making power and ownership of assets. Men are more likely than women to own a house alone (35%), and are less likely to share ownership (17%)\(^3\). With land, the ownership rate is also higher among men than women are (48% and 40%, respectively), with men less likely than women to own land jointly with someone (15% and 25%, respectively). On the other hand just 15% of women age 15-49 use an account in a bank or other financial institution, compared with 25% of men; and 27% of women and 55% of men owned mobile phones at the time of the survey. A critical aspect of women’s autonomy is control over the decision to marry. More 35% ever-married women age 15-49 reported that they made the decision to marry, while 61% say that their parents made the decision.

### 3.2.5. Population and Development

The 2018 world Population Data has put Ethiopia to be the fifth country with the greatest projected population increase from 2018 to 2050 by adding more than 83.4 million people, next to India, Nigeria, Congo and Pakistan. This makes the total population of Ethiopia rise from its

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\(^3\) DHS 2016
The current value of 107.5 million to 139.6 million (an increase of 33.6%) in 2030 and 190.9 million (an increase of 101.6%) in 2050. However, this estimate works under the assumption of medium fertility decline.

Currently, the ratio of under 15 population, productive age group and elderly population is 14:16:1 in Ethiopia, putting a high pressure on the country’s economy; high unemployment rate, underemployment, heavy burden of social investment, and political unrest. However, this is projected to be 9:17:1 and 4:11:1 in 2030 and 2050 respectively, making the dependency ratio to fall from 93.75 at present to 45.5 in 2030. This provides a window of opportunity for demographic dividend in the country.

Ethiopia has set its own goals for population, which is articulated in the population policy (not updates) and the HSTP, reducing TFR to three and expanding CPR to 55% by 2020. However, 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 4.6 by 2016 (EDHS 2016). 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, women are also spending fewer years in school than men. The inter regional variations in TFR and level of CPR are other concerns that do also require high-level advocacy.

In conclusion, the TFR is still high, implying further rapid population growth in the years ahead. Under the current natural increase of 2.6%, the doubling time for the current population is 27 years. This will make the countries effort to maximize gains from the demographic dividend (DD) very challenging. DD will be gained only when investment in fertility reduction is matched with appropriate fiscal policies for better education, quality of health care, innovations in technology and employment opportunities for the growing labor force. Accordingly, it requires quite concerted activity to increase the country’s CPR and shift the method mix to a greater emphasis on long-acting and permanent FP methods as one of the strategies to address fertility.

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4 EDHS 2016
3.2.6. Policy Environment

The Constitution of Ethiopia:

Recognizing the low status of women, the Government of Ethiopia has established constitutional rights, laws, directives, and strategies to empower women and address gender inequity. The Constitution of Ethiopia, adopted in 1995, assures women of equal rights with men in every sphere (Art 35.1) and emphasizes affirmative action to remedy the past inequalities suffered by women (Art. 35.3). It also affirms the need to enforce the elimination of harmful customs and laws that oppress women (Art. 35.4)

Article: 35.1:

“Women shall, in the enjoyment of rights and protections provided for by this Constitution, have equal right with men”

Article 35.4:

“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.”

It also reiterates the rights of women to own and administer property as well as access to reproductive health services. Additionally, the family law has been revised (in the year 2000) to align it with the constitutional rights of women and the Penal Code (revised 2005) have been made more congruent with international and regional instruments. The country has put in place a Joint Land Certification Program, which has a positive impact on various dimensions of women’s livelihood and gender relations.

International Conventions

Ethiopia as a member of the international community has signed a number of agreements promoting and protecting the rights of women. It is either signatory or party 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. It has also ratified the Convention on the Political Rights of Women (CPRW), the Convention on Elimination of All Forms of Discrimination against Women (CEDAW), the Universal Declaration of Human Rights, the Convention on the
Rights of the Child, and has endorsed and engaged with the Sustainable Development Goals of 2015\(^5\).

*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, most of the targets set in the population policy, thought it need to be revised, directly or indirectly relate to FP, of which reducing TFR to approximately 4.0 by the year 2015 and increase CPR to 65% by the year 2015 are focused to this guideline.

**Health Sector Transformation Plan (HSTP)**

Building on the lessons learned in implementing the health sector development plans, and taking the current socioeconomic landscape in the country; the Federal Ministry of Health has developed the health sector transformation plan (HSTP) which is part of the second Growth and Transformation Plan. This plan has identified four transformation agenda; Transformation in equity and quality of health care, Information revolution, Woreda transformation, and creating a Caring, Respectful and Compassionate health workforce. It has also identified major impact indicators, reduction of maternal mortality ratio to 199/100,000 live births from the current 412/100,000 per\(^6\) being one of them. To achieve most of the impact indicators, a list of strategic interventions were set, among which high impact interventions of RMNCAHY nutrition,

prevention and control of communicable diseases is a focus of interest where family planning interventions are part.

The National Reproductive Health Strategy (2016-2020):
This strategy is a continuation and revised version of the 2000-2015 strategy. 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 to provide 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.

FP 2020 Commitment: The commitment of the FMOH is reflected in both the achievements gained, future strategic plans, and international commitments endorsed. Ethiopia has also updated its commitment to Family planning 2020 commitment at the Family Planning Summit in London, UK on July 11, 2017. The main objectives in the commitment are:

• To reduce adolescent pregnancy rate from 12% to 3%,
• Reduce unmet need for family planning among women aged 15-19 from 20% to 10% and among women ages 20 to 24 years from 18% in to 10%.
• Increase mCPR among women ages 15 to 19 years from 32% in to 40% and ages 20 to 24 years from 38% to 43%
• Improve collection, analysis, and utilization of age- and sex-disaggregated data on adolescents and youth.

To achieve FP2020 commitments the government committed to increase its financing of family planning services by continuing to allocate incrementally funds from its SDG pool fund for its FP budget and using the National Health Account to track expenditures for FP.
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 creating access to quality FP services. However, existing regional disparities and the current sociopolitical environment require further high-level advocacy and enforcement of the application of existing strategies and policy directions.

4. Rationale for Family Planning Services

Ethiopia is signatory to nine of the CEDAW articles since 1980. According to article 10 of the convention, women’s right to education includes “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning”. While, article 16 of the convention entitles women equal rights in deciding “freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights”.

In a similar context, the Constitution of the Federal Democratic Republic of Ethiopia (1995), Article 35.9 states “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.”

Family planning not only has the potential to improve health; investing in expanding access to voluntary family planning contributes to better economic outcomes for households, communities, and nations. Unintended pregnancy has a major impact on numerous social, economic, and cultural aspects of modern life. East Africa is one of the regions with the highest prevalence of unintended pregnancies in 2010-2014; 112 per 1000 reproductive age women while the global average is just 62. This brings more than 55% of unintended pregnancies to end up in abortion in the developing world. Pregnancy and childbirth complications are the leading cause of death among 15 to 19 year-old girls globally, with low and middle-income countries accounting for 99% of global maternal deaths of women ages 15 to 49 years. In another context, an estimated 23 million adolescent girls have an unmet need for modern contraception and are at risk of

unintended pregnancy. Addressing these all challenges will be possible only through creating access to informed and voluntary family planning services.

According to the 2016 EDHS, 12.5% of teenagers have already started child bearing, with high inter regional variation 3% in Addis Ababa and 23.4% in Afar region. Teen mothers are less likely to graduate from high school or attain a graduate education; earn less income and are prone to face economic problems, experience social exclusion and psychological problems too.

In conclusion, family planning saves [the] lives of women and children and improves the quality of life for all, and reduces morbidity and mortality from pregnancy. It also helps to space or limit repeated pregnancies and childbirth and enhances women’s education, employment, and productivity that result in improved status of women in the society. This will intern have impact at individual, family, community and national development.

5. The need for a revised FP policy guide

The Government of the Federal Democratic Republic of Ethiopia has committed itself to the achievement of the sustainable development goals. SDG 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. In this regard, several policies and strategies have been developed with the goal of strengthening the demand and service for and supply of FP services. The health sector transformation plan for the period 2015-2020 recognizes SRH (including FP) as an essential priority in the Ethiopian health sector development.

The first family planning guideline was developed in 1996, and revised in 2011 to reflect the existing national health policy and strategic documents. After the finalization of the health sector development plan, the health sector transformation plan has been in place and the current

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9 http://apps.who.int/iris/bitstream/handle/10665/255862/WHO-RHR-17.10-eng.pdf?sequence=1
guideline need to be aligned and reflect existing policy and strategic documents. Hence, the RMNCAYH directorate decided to review the guideline for the following major reasons:

- 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,
- Recognizing the recent development of the World Health Organization Medical Eligibility Criteria (MEC 2015) for FP use;
- Understanding the importance and relevance of the integration of FP services with other RH services, information, education, and behavior change communication (BCC) activities, FP commodity supply chain management, the District Health Information System (DHIS) , and coordinated partnership in FP programs and services;
- Being aware of the fact that the 2011 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.

Because Ethiopia sociodemographically a very diverse country, it is very difficult to recommend and apply “one size fits all” type of guideline equally to each region. We hope that this guideline provides a better recommendations and guidance to reach region where specific contexts will be identified and focus and efforts will made accordingly to expand access to quality of family planning service based on informed voluntary choice of the client.
6. **Major Changes in the 3rd revised FP guideline**

The formatting of the guideline follows the 2011 guideline to ensure continuity and familiarity to existing users. However, the background section has been intensively revised to show the existing health and socioeconomic status of the country. Major policy and strategic documents were reviewed and the guideline was tried to be aligned with all those documents. Moreover, taking recommendations from the FP technical working group in the RMNCAYH directorate, the following sections were given major emphasis:

- Catchment based clinical mentoring and ensuring quality for FP
- Role of the private sectors
- FP services for people with special needs (Workplace and internally displaced people)
- The need to focus on high level advocacy and communication at the federal and regional leaderships
- Review of the family planning counseling guide based on the revised MEC 2015 manual
- Expansion of FP services in schools
- Preservice training for health professionals

7. **Objectives of the revised Family Planning 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 program design and implementation, service provision and monitoring and evaluation of programs.
- 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.
8. Family Planning Services

8.1. Definition of FP

Family planning refers to a conscious effort by a couple to anticipate and attain, limit or space the desired number of children they have with contraceptive methods and the treatment of involuntary infertility.

Family planning interventions promote 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 and have the capacity 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 it.

8.2. Service eligibility

Any person in the reproductive-age group—male or female, regardless of marital status—is eligible for FP services, including information, education, and counseling. Specific medical eligibility criteria for each contraceptive methods need to follow the world health organization (WHO) revised 5th edition Medical Eligibility Criteria for contraceptive use (MEC 2015). The safety of each contraceptive method is determined by several considerations; primarily whether the contraceptive method creates risk to the clients, worsens an existing medical condition, or whether the medical circumstance makes the contraceptive method less effective. The safety of the method need to be weighed along with the benefits of preventing unintended pregnancy. Annex 71 contains the quick reference from the revised WHOS’s MEC criteria.

8.3. Range of services to be offered in FP

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

- Demand creation and FP Counseling

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10 WHO, Medical Eligibility Criteria for contraceptives, 2015
- Offering pregnancy testing and counseling
- Provision of contraceptive methods to help women and men plan and space births, prevent unintended pregnancies, and reduce the number of abortions;
- Expanding prevention, screening, and management for STIs, including HIV to improve the health of women, men and infants
- Health promotion and prevention of infertility, and ensuring access to basic infertility treatment
- Screening for reproductive organ cancers focusing on breast and cervical cancer
- Follow-up and Referral System
- Record Keeping and timely reporting
- Supervision and clinical mentoring

8.3.1. Demand creation and FP counseling

Demand creation for family planning services at a community level is pivotal in improving health-seeking behavior. Supported with a strong mass media intervention, the health extension workers and health development army’s structure is an exemplary, which plays a significant role in cascading community dialogues and addressing socio cultural barriers on family planning. On the other hand, client counselling at a facility level is an important prerequisite for the initiation and continuation of a FP method. Counselling should be an interactive process between the service provider and client. The health care professional should provide adequate information to help the service user have an informed and voluntary decision making capacity to take the service. There should be no incentives or coercion to adopt FP practices or to use any particular method of contraception. Service providers should have basic counseling techniques to provide a balanced and updated counseling service. Health professionals providing counselling for FP might encounter clients who are coming for FP services, but have other needs as well, in which case the service provider need to be capacitated to integrate the client to other SRH services.

8.3.2. Provision of contraceptive methods

- The contraceptive mix in Ethiopia consists of the following commodities and methods. However, the recent WHO list includes some convenient method mixes, where this guideline recommends review of new family planning methods and incorporating those to the national commodity lists; mainly 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
  - Implants
  - Intrauterine contraceptive device (IUCD)
  - Bilateral tubal ligation (BTL)
  - Vasectomy
  - Others as updated by the national drug authority and control authority (DACA)

For the convenience of clients, a 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 s/he could 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 and voluntary decision-making (IVDM), as well as ensuring method-mix as 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.

**8.3.3. Offering pregnancy testing and Counseling**

**8.3.4. Education about, screening for, and treatment of STIs and HIV/AIDS**

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.

STIs often have no signs or symptoms, particularly in women. Because of the disturbance and unpleasant manifestations of symptomatic STIs, people tend to seek treatment for STIs promptly. However, as most people might not have the symptoms, People should seek care if they think that they or their partners might have been exposed to STI or have an STI. In most patients, STIs are transmitted through unprotected sex, where the need for the need for FP is evident. Specifically, the use of male and female condoms can also be used to prevent SSTIs when used consistently and correctly. 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. Providers should also be aware that people with sexually transmitted infections including HIV could use most family planning methods safely and effectively. However, it is very important to note the need for counseling of couples to be screened and
treated for any STIs before conception. Some special family planning considerations for clients with STIs including HIV/AIDS are summarized as follows\(^{12}\)

<table>
<thead>
<tr>
<th>Method</th>
<th>Has STIs</th>
<th>Has HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrauterine device</strong></td>
<td>Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or PID. A current IUD user can safely continue using an IUD during and after STI treatment.</td>
<td>A woman with HIV clinical disease that is mild or with no symptoms, including a woman on ARV therapy, can have an IUD inserted. Generally, a woman should not have an IUD inserted if she has HIV clinical disease that is severe or advanced (WHO Stages 3 or 4). A woman using an IUD can keep the IUD in place when she starts ARV therapy.</td>
</tr>
<tr>
<td><strong>Female sterilization</strong></td>
<td>If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.</td>
<td>Women with HIV, including women on ART can safely undergo female sterilization. The procedure may need to be delayed if she currently has an HIV-related illness.</td>
</tr>
<tr>
<td><strong>Vasectomy</strong></td>
<td>If client has scrotal skin infection, active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured.</td>
<td>Men who are living with HIV, including men on ARV therapy, can safely undergo vasectomy. The procedure may need to be delayed if he currently has an HIV-related illness.</td>
</tr>
<tr>
<td><strong>Spermicides</strong></td>
<td>Can safely use spermicides.</td>
<td>Should not use spermicides if at high risk of HIV. Generally, should not use spermicides if she has HIV infection.</td>
</tr>
<tr>
<td>(including when Used with diaphragm or cervical cap)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COCs, monthly injectable</strong></td>
<td>Can safely use combined hormonal methods.</td>
<td>Can safely use combined hormonal methods.</td>
</tr>
<tr>
<td><strong>POPs, injectable, and implants</strong></td>
<td>Can safely use progestin-only methods.</td>
<td>Can safely use progestin only methods.</td>
</tr>
</tbody>
</table>

8.3.5. Prevention of infertility, and ensuring access to basic infertility treatment

Management of infertility is expensive, requiring sophisticated services. A large WHO study in the late 1970s found that STIs were a major cause of infertility in developing countries, but it is not known how much STIs contribute to infertility now. However, the evidence is clear that, if left untreated, gonorrhea and chlamydia can infect the fallopian tubes, the uterus, and the ovaries in women. The role of FP is mainly in STI prevention, through promotion of responsible sexual behavior, use of condoms (dual protection), screening and treatment, counseling, referral, and

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seeking of services, when indicated. If a client presents with infertility, information on where to get services should be provided.

On the other hand, health professionals should make clear that contraceptives do not cause infertility. Despite the presence of variations related to age and health status of the woman, with most modern contraceptive methods, there is no significant delay in the time to desired pregnancy after contraception is stopped. On average, pregnancy occurs after 3 to 6 months of unprotected sex. However, the return of fertility after injectable contraceptives are stopped usually takes longer than with most other methods. When counseling couples who stop contraception and want to have a child, aging and other factors affecting the fertility of the woman and the man need to be considered. Among women with current gonorrhea or chlamydia, IUD insertion slightly increases the risk of pelvic inflammatory disease in the first 20 days after insertion.

8.3.6. Screening for reproductive organ cancers (Breast and cervical cancer)

FP offers a unique opportunity to screen and teach the client to do self-examination for some of the reproductive organ cancers (ROCs). Where facilities exist, women should be encouraged to have annual Pap smear or have visual inspection of the cervix using acetoacetic acid (VIA) or Lugols Iodine Solution (VILI) at a health centers level at least every three years according to WHO recommendations (WHO prefers screening with a combination of cytology and HPV testing every 5 years or cytology alone every 3 years). Health care workers should be capacitated on reproductive organ cancer screening and they need to teach all clients to regularly do breast self-examination. Health Extension Workers should also educate women and their families about ROCs and about the benefits of screening.

8.3.7. Record Keeping and timely reporting

All FP providers should maintain proper records on each client and the distribution of contraceptives. As a follow up to the FP2020 commitment, each service should be age and sex disaggregated and show service utilization by adolescent and youth communities. Non-governmental organizations (NGOs), School clinics, workplace clinics, the private sector and all other service delivery outlets should also follow the Ministry of Health’s record-keeping and service provision guidelines.
8.3.8. Catchment based clinical mentoring
Clinical mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Clinical mentors need to be experienced, practicing clinicians in their own right, with strong teaching skills. Mentoring should be seen as part of the continuum of education required to create competent health care providers. It ensures that guidelines are being followed and clients’ needs are being met. It should be encouraged, and the mentor should be seen as a team member who motivates staff and guarantees the rights of providers and clients.

8.3.9. Commodities supply
Service providers are expected to have a consistent supply of methods available in order to offer a choice to clients. The pharmaceutical fund and supplies agency (PSA) is responsible for the procurement, storage, and distribution of contraceptive commodities through warehouses that are located regional hubs. On the other hand, providers are expected to provide commodity bimonthly report and re-supply requisition through their health facility in order to avoid both under-stocking and over-stocking of commodities. In addition, this information enables PSA to develop an accurate picture of stocks in the country, thereby supporting advance planning and commodity security (Detail information is available on Page 53).

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

9.1. HIV counseling and testing (HCT)
HCT services can be good entry points for FP services, and vice versa. Both HIV and unwanted pregnancy are in most cases the consequences of unprotected sex. 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.

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

A woman seeks abortion or post abortion care largely because of unwanted pregnancy. Abortion and post abortion 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.). Similarly, FP counseling should be part of focused antenatal care (ANC), Delivery and postnatal care services. It is imperative that all women who give birth at health facilities should be counseled on FP and informed about the availability of the services.

9.3. 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.

9.4. School Health program

Recognizing the presence of a great portion of the adolescent and youth population in school, more than 28 million population lives in school, the ministry of health has planned to implement a school health program in collaboration with the ministry of education. This school health program (SHP) aims to help guide service providers and administrators at different levels of education to provide quality, standardized and comprehensive promotive, preventive, curative and rehabilitative health services to school students at the pre-primary, primary, secondary and tertiary levels of education in a healthy environment. Sexual and reproductive health interventions including family planning services are components of the basic service packages. The public
health sector and partners working in the SRH area need to support capacity building, service provision and referral service to ensure access to quality SRH services including family planning.

10. Family planning service strategies

Currently, it is estimated that more than 90% of the Ethiopian population has potential health service coverage. The national health system follows a three-tier system for health service delivery, having PHCU$s consisting of five satellite Health Posts, one Health Centre, and a Primary Hospital at the lower level. All public health institutions in Ethiopia—rural and urban, hospitals, health centers, health posts; school clinics, workplace based clinics, youth center clinics, private clinics and clinics owned by non-governmental organization shall provide FP services. FP services shall be delivered through the following service delivery modalities:

- Facility-based services (private and public)
- Social marketing
- Outreach based community services
- Mobile health team approaches
- School health services
- Workplace services
- Social franchising

10.1. 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, post abortion 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 in the public health structure

<table>
<thead>
<tr>
<th>Level of facility</th>
<th>Type of health personnel available for FP</th>
<th>FP services</th>
</tr>
</thead>
</table>
| Health post       | Health Extension Workers                  | • Counsel on FP and other RH issues  
|                   |                                          | • Counsel on natural FP methods  
|                   |                                          | • Provide injectables  
|                   |                                          | • InsertImplanon  
|                   |                                          | • Refer to health center for other long-acting and permanent methods  
|                   |                                          | • Do planning based on local data  
|                   |                                          | • Keep clients record and share monthly reports to nearby health center |
| Health center     | Health Officers (HOs), Midwives, Clinical Nurses, Public Health Nurses | 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, HIV counseling and treatment.  
|                   |                                          | • Train community-level workers and junior health professionals in FP  
|                   |                                          | • Provide on job training  
|                   |                                          | • Conduct clinical mentoring and facilitative supervision to health posts |
| Primary Hospital  | Non physician clinicians, GMPs, HOs, Midwives, Clinical Nurses, Public Health Nurses | The above activities, plus:  
|                   |                                          | • Investigate and manage infertility  
|                   |                                          | • Provide permanent methods of contraception  
|                   |                                          | • Manage complicated STIs  
|                   |                                          | • Receive referrals  
|                   |                                          | • Manage complications and side effects  
|                   |                                          | • Do work-ups for infertility  
<p>|                   |                                          | • Train health workers on comprehensive contraception |</p>
<table>
<thead>
<tr>
<th>General and Referral hospital</th>
<th>Obstetrician-Gynecologists, GMPs, HOs, Midwives, Clinical Nurses, Public Health Nurses</th>
<th>The above activities, plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Establish training centers</td>
<td>• Manage complications and side effects of contraceptive methods</td>
</tr>
<tr>
<td></td>
<td>• Conduct clinical mentoring and facilitative supervision to catchment health centers</td>
<td>• Manage reproductive organ cancers (ROCs)</td>
</tr>
<tr>
<td></td>
<td>• Conduct clinical mentoring and facilitative supervision to catchment health centers</td>
<td>• Clinical mentoring to catchment based district hospitals</td>
</tr>
<tr>
<td></td>
<td>• Preservice training on comprehensive contraception</td>
<td>• Perform research</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Level of facility</th>
<th>Type of health personnel available (minimum)</th>
<th>FP services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lower clinic</td>
<td>1 Clinical or General Nurse (Diploma) 1 Lab. Technician</td>
<td>• Counsel on FP and RH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Distribute male and female condoms, oral contraceptives, (including ECPs), and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provide injectables</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Record keeping and monthly reports to nearby health center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral service for long acting contraceptives</td>
</tr>
</tbody>
</table>

| 2. Medium clinic  | 1 GMP/HO 1 Clinical Nurse At least 1 Lab. Technician | The above, plus: |
|                   |                                                 | • Long acting contraceptives |
|                   |                                                 | • Tubal ligation and vasectomy* |
|                   |                                                 | • Provide on the job training |
|                   |                                                 | • Removal of IUDs and Implants |

| 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 |
|                       |                                                                | • |

FMOH
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  
   - Generating evidences and lessons learned

5. General and Specialized Hospital (MCH)  
   Variable types and numbers of professionals (including specialists)  
   - All methods of FP  
   - Have training centers and train health professionals

Table 3. Task analysis for provision of FP

<table>
<thead>
<tr>
<th>Task</th>
<th>Provider’s category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Obstetrician-gynecologist</td>
</tr>
<tr>
<td>Client assessment</td>
<td>✓</td>
</tr>
<tr>
<td>• History taking</td>
<td>✓</td>
</tr>
<tr>
<td>• Physical examination</td>
<td>✓</td>
</tr>
<tr>
<td>• Bimanual pelvic exam</td>
<td>✓</td>
</tr>
<tr>
<td>• MEC assessment</td>
<td>✓</td>
</tr>
<tr>
<td>Counseling</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of FP services, by method</td>
<td></td>
</tr>
<tr>
<td>• Natural methods</td>
<td>✓</td>
</tr>
<tr>
<td>• Condoms</td>
<td>✓</td>
</tr>
<tr>
<td>• Pills</td>
<td>✓</td>
</tr>
<tr>
<td>• Emergency contraceptives</td>
<td>✓</td>
</tr>
<tr>
<td>• Injectables</td>
<td>✓</td>
</tr>
<tr>
<td>• Implanton</td>
<td>✓</td>
</tr>
<tr>
<td>• Other implants</td>
<td>✓</td>
</tr>
<tr>
<td>• IUCD</td>
<td>✓</td>
</tr>
<tr>
<td>• BTL</td>
<td>✓</td>
</tr>
<tr>
<td>• Vasectomy</td>
<td>✓</td>
</tr>
<tr>
<td>Other RH services</td>
<td></td>
</tr>
<tr>
<td>• Syndromic management of STIs</td>
<td>✓</td>
</tr>
<tr>
<td>• Management of complicated STIs</td>
<td>✓</td>
</tr>
<tr>
<td>• Cancer screening</td>
<td>✓</td>
</tr>
<tr>
<td>• Treatment of ROCs</td>
<td>✓</td>
</tr>
<tr>
<td>• Management of</td>
<td>✓</td>
</tr>
</tbody>
</table>
infertility

Pain medications

- Nonnarcotic analgesics ✓ ✓ ✓ ✓ ✓ ✓ ✓
- Narcotic analgesics ✓ ✓ ✓ X X X ✓
- Local anesthesia ✓ ✓ ✓ ✓ ✓ ✓ ✓

Management of complications ✓ ✓ ✓ ✓ ✓ ✓ ✓

Follow-up care ✓ ✓ ✓ ✓ ✓ ✓

Universal precautions ✓ ✓ ✓ ✓ ✓ ✓

Integration of FP and other RH services ✓ ✓ ✓ ✓ ✓ ✓

Instrument processing ✓ ✓ ✓ ✓ ✓ ✓

SBCC ✓ ✓ ✓ ✓ ✓ ✓

Recording and reporting ✓ ✓ ✓ ✓ ✓ ✓

Training junior health ✓ ✓ ✓ ✓ ✓ ✓

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

10.2. Outreach

Outreach: FP outreach program is when a health facility team arranges on its own a service provision program at a catchment Kebele or village. The team might be from a health center, which supports a health post or a health extension worker going to a catchment village within a Kebele. Such programs should be regular and happen at fixed intervals (e.g., every month or quarterly).

Mobile Outreach: A mobile outreach program is when a team of FP team provides comprehensive family planning services including long-acting and permanent methods at the health post or to a special pastoral community. 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.

10.3. 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 communication channels. 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.

10.4. Social Franchising

This type of partnership focuses on building the capacity of existing private-sector health facilities and their staff providers to deliver selected health care services that require a clinical procedure. In family planning, experienced organizations in providing family planning service provision can collaborate with a private sector and strengthen their system to expand access to quality informed and voluntary services.

10.5. Workplace-based services

The government of Ethiopia places high focus on industrial park development and expansion in its plan to join the middle-income country through promotion of local production and export under the private sector engagement. This sector is expected to open job opportunities to thousands and millions of Ethiopian youth. Addressing SRH issues of these working age population is very vital. FP services at the workplace have the benefit of accessing an easy-to-reach, known population of workers. Ministries and agencies that have health facilities (e.g., Trade and Industry, Agriculture, Energy and Mines, Transport, and Communications), including factories, are encouraged to run FP services. It potentially saves employees time, minimizes lost productivity, and has the benefit of reaching more male targets. Facilities at workplaces must be
registered by the FMOH and must function based on the staffing and facility standards of the FMOH. The ministry of health and partners should build the capacity of health workers working in those health facilities on SRH especially family planning services.

10.6. School-based health services

The school health program (SHP) which was launched in 2017 guides service providers and administrators at different levels of education to provide quality, standardized and comprehensive health promotive, preventive, curative and rehabilitative health services to school students at the pre-primary, primary, secondary and tertiary levels of education. 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. This will help for further reduction of unwanted pregnancy, avoid unsafe abortions, and help reduction of educational wastage.

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 as per the national school health strategies. A comprehensive life skill education approach should be the main strategy for demand creation and behavioral change in the area of SRH.

10.7. Role of NGO and professional associations

Under the strategic leadership played by the government of Ethiopia, NGOs and public–private partnerships have been major contributors to Ethiopia’s family planning success. Most of the
large international NGOs that specialize in FP/RH have programs in Ethiopia. NGOs need to partner with FMOH and shall continue to take part in FP programs, through capacity building, quality assurance, strengthening commodity supply and service provision as depicted in the harmonization manual of the HSDP. The NGO sector need to work in strengthening alignment of interventions with the health sector and other national policies for effort maximization and better system building.

**10.8. Role of the private sector**

Both the public and private sectors have critical roles to play, but the private sector, and in particular the for-profit private sector, is often forgotten when family planning programs are discussed. The private health facilities make more than 1/3rd of the health care service provision in Ethiopia. Recent data show that in sub-Saharan Africa and Asia, close to 40 percent of women rely on the private sector as their source for family planning. In this context, it is critical to make sure that when women go to private providers, they are able to access correct information, have a wide range of methods to choose from, and the best quality of care possible that helps them to voluntarily decide the method for them.

One way to ensure this is by making sure that private providers have training opportunities similar to those that their public sector colleagues receive. They also need to have access to family planning products, and support to demand creation interventions.

**11. Services for clients with special needs**

FP service providers have a duty to ensure equitable access to services for all, including groups with special needs. These guidelines focus on the following categories of clients that are considered to have special needs:

**11.1. Adolescents and youth**

According to the national adolescent and youth health strategy, “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.”
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.
- SBCC 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.

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

11.2. 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 and the right of all women to decide their number and timing of children, regardless of HIV status need to be respected. 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.

11.3. 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.

11.4. Persons with disability, including mental disability

Women and men with disabilities can and want to be productive members of society. Based on the World Report on Disability jointly issued by the World Bank and World Health Organization, there are an estimated 15 million children, adults and elderly persons with disabilities in Ethiopia, representing 17.6 per cent of the population. PwDs encounter

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discriminatory practices and stigma within the society, as well as within health facilities. All discrimination constitutes a denial of human rights. FP service providers must ensure that women and men living with disabilities have access to counselling on sexual and reproductive health services and access to informed and voluntary FP services. Health professionals also need to be updated on the need to address the needs of people with disability. The following are lists of recommendations to be taken to address the needs of people with disability:

1. Special consideration should be given to individuals who are mentally challenged or those with psychiatric disorders who might require specialized counselling or referral for treatment.

2. Where the nature of the condition does not allow for informed choice (e.g., severe mental challenge), an FP method should be provided only after full discussion with all parties, including 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.

3. 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.

4. 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.

5. Health care professionals need to be trained and updated on counseling and FP service provision for people with disabilities.

6. The health care system need to be more accessible and friendly to PWDs (providing wheelchair ramps, adjustable examination couches, and/or staff who are trained in sign language).

7. The reproductive rights of the individual must be considered in any such decisions.

### 11.5. Daily laborers

In an expanding labor-intensive small-scale industrialization, more people from the rural community migrate to the semi urban areas. An experience from a flower plantation work in Adama showed that more than 88% of the daily laborers are women of reproductive age. Most of
them have very little knowledge of sexual and reproductive health services, as well as a low level of literacy and income. Unintended pregnancy is more common which affects their future work life balance and income in the work place. This requires providing access to family planning a priority. The recommended approaches for service expansion in the workplace include:

- Expanding outreach family planning services to workplaces
- Partnering and strengthening the existing clinics to incorporate family planning interventions
- Support and enforcement of workplaces to establish quality clinics that can provide access to reproductive health services including family planning
- Enforcing workplace clinics to keep record and regularly report to nearby health facilities.
- Strong clinical mentoring and supportive supervision

11.6. People in emergency situations (internally displaced communities)

Latest figures from the Internal Displacement Monitoring Centre (IDMC) reveal globally, there are 5.2 million new internal displacements associated with conflict and violence in the first half of 2018, based on the analysis of data from the 10 worst affected countries. More than 32 million women’s and girls’ of reproductive age worldwide require humanitarian assistance inclusive of reproductive health and contraception. In Ethiopia, more than 1.4 million people are internally displaced.

The sexual and reproductive health needs of women and girls do not stop when emergencies strike. Demand for contraceptive is often found to be high during emergencies, at times when women and girls need it most. The onset of crisis brings an increased risk of unintended pregnancy, childbirth or disability during pregnancy, childbirth, and unsafe abortion. As such, evidences suggest that nearly 40% of women experiencing displacement across diverse settings want to avoid becoming pregnant in the next two years. This makes contraception as an essential part of any emergency health responses. In this context, the government and partners should work:

- Include minimum FP and SRH service packages for emergency situations
- Work with emergency partners to training emergency taskforces to create access to informed and voluntary FP services
12. **Social and Behavioral Change Communication, Advocacy for Family Planning**

Behavioral change communication 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 SBCC is the process of learning that empowers people to make decisions, modify behaviors, and change social conditions. Communication interventions require to be developed based upon needs assessments, sound educational principles, and periodic evaluation, using a clear set of goals and objectives. According to measure evaluation, health communication strategies globally have evolved from a “clinic era” where the public invests on infrastructure and assume that people will come to the facility only based on clinic based information and education system to a “field era” where community mobilization interventions have been strong in reaching more people. Currently, which they called the “strategic era”, is characterized by multi-channel integration and increased use of multimedia channel and increased use of electronic media consistent with the expansion of radio and television receivers in most parts of the developing world.

The federal ministry of health has applied the socio ecological model to analyze the existing gaps and come up with recommendations for a social and behavioral communication strategy, 2015-2020. According to the analysis, the major gaps in the existing interventions were:

- Weak interactions among Primary Health Care Unit and communities that empower communities for ownership and sustainability
- Weak capacity of HEWs in interpersonal communication and community empowerment skills
- Lack of harmonized messages and community-focused guidelines
- Weak in identifying, documenting, and sharing societal values and best practices for health
- Gaps in promoting and enforcement of healthy workplace and environment

• Increase support to availability and access of essential SRH commodity supplies in emergency situations
• Limited mass media involvement and use of technologies to reach different segments of the society
• Weak in identification, sensitization and advocacy for implementation of existing public health laws and legal frameworks
• Inadequate multi-sectoral involvement for health promotion to address social determinants of health and factors that discourage demand for health services

These limitations also apply to most public health interventions in the country, including family planning. Based on these findings, the ministry has recommended individual, community, organizational and socio economic level strategies. This guideline has also applied a similar socio ecologic model; and recommends an audience centered design, development and intervention of social and behavioral change communication approaches to family planning.

12.1. Individual level interventions

A mix of traditional and innovative approaches should be applied to reach individuals and families to address their knowledge, attitude and behavior towards a healthy behavior. This requires developing and/or standardizing health education and promotion messages based on audience analysis at all levels. The Eastern Central and Southern Africa countries (ECASA) agreement implement comprehensive sexuality education at school level gives a greater opportunity to expand individual knowledge, attitude and behavior to sexual and reproductive health, including family planning. While some African countries have made it to incorporate CSE in to their education curriculum, Ethiopia is still behind. The federal ministry of health therefore need to work with the ministry of health and ensure that CSE is incorporated at school level. At the same time, various co-curricular interventions being implemented by partners in addressing comprehensive sexuality educations including family planning need to be standardized to reach individuals in the community with a standard approach. Other communication interventions to build the capacity of individuals towards family planning interventions include:

• Standardized eclectic counseling (both directive and non-directive counseling) on family planning through home visits
• Supporting peer dialogue sessions
• Strengthening extracurricular training sessions based on a standard curriculum (life skill training, comprehensive sexuality education, financial skill building)

• Male involvement and ensuring gender equity

12.1.1. Male involvement and ensuring gender equity

Fertility and family planning research programs have ignored men's roles in the past, focusing on women's behavior (Vouking, Evina, & Tadenfok, 2014) for maternal and child health. Men are also recognized to be responsible for the large proportion of ill reproductive health suffered by their female partners. Studies have shown that couples who discuss the number of children they desire or the use of family planning are more likely to use a contraceptive and achieve their reproductive goals than those who do not (Vouking et al., 2014). Some of the studies conducted in different parts of Ethiopia also show that husband’s involvement and husband-wife communication on FP were strongly associated with couple’s contraception use. (Mesfin, 2002; Tolossa, 2004; Haile, 2005; Tuloro, 2006; Mohamamed, 2007). All in all there are numerous and plausible reasons to involve men in FP activities and services:

• The family system is patriarchal in most parts of the country.

• Due to traditional socio-cultural norms, economic and property ownership status, men dominate the decision-making on family planning issue and the number of children to have.

• 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.

• A negative male attitude towards FP and reproductive health still exists and is viewed as a significant barrier to the effective implementation of family planning, making the burden of FP is on women.

Since the 1994 ICPD and the 1995 UN World Conference on Women, interest in men's involvement in reproductive health has increased. Male involvement is crucial both from the programmatic point of view and as a process for bringing about a gender balance in men and women’s reproductive rights and responsibilities. It helps not only in accepting a contraceptive
method but also in its effective use and continuation. Accordingly, men should be addressed in FP programs and services as users, promoters, and decision makers. Therefore, the following should be considered to ensure male engagement in family planning:

- Identify and strengthen community structures to engage men in reproductive health specifically on family planning.
- Focus on a gender equity approach to expand family planning services and ensure male involvement
- Design a greater degree of monitoring and more rigorous evaluation of programs targeting men engagement and gender equity.
- Improve couples’ communication regarding fertility and FP, so that decisions reflect the needs and desires of both men and women, mainly through structured mass media interventions.
- Strengthen more advocacy programs for involving men in reproductive health and family planning services at the local, regional and national levels
- 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. The need to promote the concept of dual protection among men and the importance of men’s cooperation 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.

12.2. Community Level interventions

The community should be made aware of the overall benefits and availability of FP services. FP programs and services, including SBCC 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. However, the major concern is what works for the local community in disseminating information and bringing behavioral change.
The 2015-2020 social and behavioral change strategy identified the presence of weak linkage between the PHCU and community. Moreover, the existing interventions to enhance community empowerment and ownership are very limited. 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. However, HEWs were also found to have limited capacity in interpersonal communication and community empowerment. At the same time, the level of effort is very diverse and inconsistent across different societies. It requires strong monitoring and evaluation as well as commitment at all levels.

In expanding social and behavioral change communication to family planning interventions in the community, the following are the priority recommendations in this guideline:

▪ Identify existing community structures and strengthening community participation through standardized trainings and participatory dialogues
▪ Focus on gender transformative approaches and social inclusiveness to ensure gender equity and SRH rights for all.
▪ Support PHCU and communities interaction and strengthen catchment based mentoring and evaluation.
▪ Ensure different community representatives such as women, the youth and community figures are members of PHCU board
▪ Enhance communication and facilitation skills and knowledge of HEWs, HDAs and other community level structures according to the context

12.3. Organization level Interventions

The health sector is one of the major sources of health and health related information for the community. In this regard, enhancing the capacity of the health care providers on interpersonal communications and counseling skills is very important. The major approaches for expanding facility-based access to health information include:
1. Standardize waiting areas at each level of the health care delivery system (PHCU, Hospitals and the like)
2. Strengthen the production and distribution of standard audio video communication materials to be used in the waiting areas.
3. Support health service providers with appropriate and standardized communication materials, job aids and print materials.
4. Enhance client provider counseling

Beyond the health sector, women and girls, adolescent and youth are found in different sectors across the community. The education sector, the industrial sector and workplaces, and youth centers are some of the institutions that require focus to address SRH issues. As recommended above, comprehensive sexuality education is one of the tools to be strengthened at school level. Other standardized life skill education and CSE co-curricular interventions can also be applied at workplace, and youth centers to expand access to FP information. These places need also to be supported to have access to standard print materials, audio and video materials, and other indoor and outdoor communication supports like; community dialogues, peer support, family support and health bazars.

The mass media structure in Ethiopia is also expanding very fast in the past two years. However, their focus in expanding healthy behavior to the general community and ensuring social responsibility seems very immature. Accordingly, every actor in the SRH area need to advocate for a wider involvement of the mass media and include different communication technologies to enhance access to FP services. The public sector also need to have a regular update of media people on some of the misconceptions, which affect the community health seeking behavior including FP interventions.

12.4. Socio-cultural, Economic and Environment Level Strategies

Family planning programs vary significantly across regions. The current socioeconomic and political situation in the country is also posing a significant challenge on the future implementations in family planning. While some part of the country perceives that FP intervention is not important taking their sparse regional population, some others which have a better progress in the last couple of years are claiming that family planning interventions have played a significant role in reduction of their population. These values disregard the importance of
family planning in reducing child mortality, maternal mortality and reduction of unintended pregnancies and its consequences; unsafe abortion. The FMOH recognized the importance of population and investment in its people to bring a healthy and productive population in line with the country’s economic and development capacity. However, family planning interventions seems highly politicized and its effect in population, its role in national budget distribution, and its contribution for a political seat in the parliaments being overemphasized. Accordingly, the current strategy recommends a high-level advocacy both at federal and regional level focusing on:

- The role of investment on adolescent youth
- Fertility interventions and its role for Demographic dividend
- The importance of establishing a strong national and regional population study centers on population and development
- The role of family planning for a countries economy
- Family planning and the human rights perspective

12.5. Communication channels

For effective SBCC, a mixed indoor and outdoor communication channels approach should be used. SBCC messages should be standardized, 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 and girls, men, adolescents and youth, communities, media personnel, and partner organizations.

12.6. Contents of SBCC messages and activities

The contents of SBCC 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 of Family planning to the mother, to the child, to the family, to the community, the nation and to the world
- Gender transformation and equity to access SRH services
- Where services are available
- Characteristics of FP methods
• Sensitization on existing national laws, strategies and guidelines
• Clients’ rights: to information, access to quality services, choice, safety, privacy, confidentiality, dignity, comfort, continuity of services, and opinion
• Related RH issues and the need for integration—STIs/HIV, pregnancy, parenthood, ROCs, infertility
• Dispelling of rumors and misconceptions
• Highveld regional and national advocacy for politicians, religious and community leaders.

12.7. Media and opportunities for SBCC

All available channels and outlets should be used to ensure that coordinated SBCC messages and activities reach the target populations. The channel of choice for SBCC activities should be based on the target audience and the local availability and acceptability of the channel. Actors in the public health area also need to advocate for a wider involvement of the mass media in to the SRH area and include different communication technologies to enhance access to FP services. The public sector also need update media people regularly on some of the misconceptions, which affect the community health seeking behavior including FP interventions.

The use of standardized and comprehensive media message through a multi-channel approach is recommended, that involve both indoor and outdoor approaches to promote behavioral changes.

1. Indoor Approaches

Indoor communication channels involve mass media interventions like; serial radio drama, radio spots, music, TV drama, TV spots, social media and individual based trainings.

2. Outdoor Approach

The outdoor communication channels include leaflets or brochures, posters, news and magazines, market place, school based sensitizations, home visits, community sensitization events, roadshows and billboards.

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

Commodity security is essential for effective delivery of quality health services. Contraceptive security exists when people are able to choose, obtain and use contraceptive products whenever they need them.\(^{14}\) In order to ensure that clients are always getting their choice of contraceptives, the six “Rights” of supply chain must be fulfilled in contraceptive supplies management. This means that when the **Right** goods, in the **Right** quantities, and in the **Right** condition are delivered to the **Right** place at the **Right** time for the **Right** Cost. Thus, a well-functioning supply chain that ensures the fulfillment of the six “Rights” are important components of family planning service provision.

Ethiopia is currently using an integrated pharmaceuticals logistics system (IPLS) for managing contraceptive supplies together with other program commodities. The IPLS is a single pharmaceutical reporting and distribution system operated based on the overall mandate and scope of the PSA.

**13.1. Logistics management information system**

A strong supply chain requires good data, based on routinely and accurately updated records and timely reporting to inform decisions. In the IPLS, valuable information used to make re-supply decisions is recorded on the Bin Card and Stock Record Card. Data from these records are used in reporting, calculating, ordering quantities and in monitoring stock levels. Logistics information is collected and reported monthly by health posts, every other month by health centers and hospitals and as per interlay established schedule by dispensary units on logistics management information system (LMIS) forms. The following are the major forms to be used for LMIS at various levels:

- **Internal Facility Report and Resupply Form (IFRR):** This form is used for resupplying of needed pharmaceuticals, including contraceptives to the dispensary units within a health center and hospital as per the schedule established for internal reporting and resupplying purpose. The person in charge of the family planning unit required to report essential logistics data on the IFRR. The store manager then uses the information from the report.

section to determine re-supply quantities and issue the determined quantities of contraceptives.

- **Health Post Monthly Report and Re-supply Form (HPMRR):** This form is used for resupplying pharmaceuticals, including contraceptives to the health Posts. A Health Extension worker in a health post report essential logistics data to health centers monthly using the HPMRR and collect pharmaceuticals from those health centers. The health centers use the data in the HPMRR to calculate consumption and resupply quantities of a health post.

- **Report and Requisition Form (RRF):** This form is completed by the Health Centres and Hospitals and sent to the PSA for order processing every other month for direct delivery facilities. For non-direct delivery facilities, a combined report and requisition form is completed by health centres and sent to PSA branches through WoHOs. The Health Centre’s order should include the contraceptive requirements of its Health Posts.

For management and supervision purposes, a copy of the health center report and order and a copy of each health post report are sent to the Woreda Health Office. A copy of the hospital report and order is sent to the RHB/ZHD. 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.
13.2. Forecasting

Forecasting is used to estimate the quantities of each product that a family planning program will dispense to clients for a specified period. FMOH will use Forecasting data for resource generation in ensuring adequate funding for sustainable availability of contraceptives and other RH commodities in the country.

Forecasting shall be done at the central level, where procurement usually takes place, and is often done by a national Family planning commodity quantification team in which relevant stakeholders are represented. The quantification exercise shall be done annually for a period of three years and should be reviewed every six months. The quantification process shall start in April and ends in June to align with the national budget year plan. Whenever there is a change of the forecasting assumptions about client preferences or policy, the quantification team 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 shall use the following family planning related data:

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

### 13.3. Contraceptive Supply plan

Once the forecasting exercise completed, supply plan shall be done. The total funds required to cover the annual net requirement of contraceptives shall be presented to potential donors organizing donors’ meetings in order to confirm available funds. The supply plan shall be developed by product quantities to be purchased by each donor according to its promised contribution, with required delivery period in order to guarantee adequate stock levels. The FMOH shall communicate the validated supply plans to each donor to ensure timely funding allocation and action as they promised on the donors meeting.

### 13.4. Financing of contraceptives products

The success of family planning programmers can only be achieved when adequate finances are available for ensuring accessibility, availability of high quality contraceptive to meet the growing demand for contraceptives. Ethiopia has demonstrated its commitment to family planning through arranging various mechanism for meeting the required funding in FP2020. The following are the major recommendations to ensure availability of contraceptive demand at a national level:

- **In-kind donation:** Funding is secured for those products through in-kind donations of products by some donor agencies associated with the supply of specific products.
- **Allocation from the sustainable development goal (SDG) pool fund:** the MOH allocates funds from the SDG to procure contraceptive products. MOH has already committed to increase contraceptive fund from SDG pool fund in FP2020
- **Government budget allocation:** These federal government budgetary allocations for contraceptive supplies, which is still playing significant role by covering 4% of the national contraceptive demand annually. However, as the country is moving to join the middle-income country, increasing local funding both at the local and central level should be given attention.
• Health Insurance System: Ethiopia is also trying to expand community-based insurance. System development and early planning has to be initiated to accommodate FP products in the health insurance packages.

13.5. 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. 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. The FMOH issues letter granting for covering the finances for procurement of quantities planned to be procured through the SDG funds. The agency should also work closely with donors to ensure that the requested quantities are procured and delivered in a timely manner to satisfy national contraceptive needs.

13.6. Warehousing and storage

Warehouses should operate according to the standard storage guideline, and there must be ways to ensure the practice of good storage principles at all levels. Physical inventory should also be taken at least every year at all levels.

13.7. Transport and distribution

PSA use its vehicle for transport and distribution of contraceptive supplies together with the other pharmaceuticals. PSA has scheduled delivery routes to health facilities based on their geographic locations and use this route for distributing contraceptives and other supplies to Health facilities. For efficient transport and distribution, the health facilities should submit their completed RRF timely, and each facility will be scheduled to receive delivery of FP commodities every two months.

13.8. Inventory control procedures

The inventory control system for the IPLS is a Forced Ordering Maximum/Minimum inventory control system. This means that all facilities are required to report on a fixed schedule (monthly at health posts, every other month at health centers and hospitals) for all products. In addition,
products will be resupplied as soon as possible after report is sent to the respective PSA hub. To maintain appropriate inventory levels, contraceptives should be always 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). The following table summarizes the minimum and maximum stock and emergency order points at different health facilities:

Table: min-max level for health facilities

<table>
<thead>
<tr>
<th>Level</th>
<th>Review Period</th>
<th>Maximum Months of Stock</th>
<th>Minimum Months of stock</th>
<th>Emergency Order point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centers and Hospitals</td>
<td>Every other Month</td>
<td>4 months</td>
<td>2 months</td>
<td>0.5 months (= 2 weeks)</td>
</tr>
<tr>
<td>Health Posts</td>
<td>Monthly</td>
<td>2 months</td>
<td>1 months</td>
<td>0.25 months (= 1 week)</td>
</tr>
</tbody>
</table>

In order to maintain an appropriate inventory for contraceptive supplies, every facility should use the necessary inventory control tools, such as Bin Cards and Stock Record Cards, and these tools should always be updated.

13.9. Ordering and reporting

- Health centers and hospitals are required to report and order every two months.
- Health centers and hospitals calculate their own order quantities, ordering sufficient quantities of all pharmaceuticals to bring stock levels up to the maximum level.
- Health posts report data monthly to their affiliated Health Centre. The Health center calculates the re-supply quantities that are needed to bring health post stocks up to the maximum level.
- If the stock on hand for any product at a facility falls below a set emergency order point before the end of the reporting period, an emergency order should be placed.

14. Quality of care in family planning

The health sector transformation plan has identified quality as one of the challenges facing the Ethiopian health sector, which need to be transformed. To help in cascading quality interventions at all levels, the ministry has developed Ethiopian national health care quality strategy 2016-2020.
This strategy provides a roadmap for addressing key quality challenges and for accelerating the improvement of health care quality nationwide. Quality is sometimes viewed as a best demand creation strategy. 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.

15. The rights of clients

The rights based approach, which was developed at the ICPD 1994 a consensus on the relationship between population policy and sexual and reproductive rights. The approach assumes that empowering women and meeting the sexual and reproductive health needs of people will help in population stabilization by choice and opportunity. In this context, SRH is considered as a
basic human right, the basic elements of which include gender equity and equality, sexual and reproductive rights, client centered sexual and reproductive health care. Reproductive rights refer to an individual’s right to exercise control over his or her own body, sexuality and reproduction and include:

1. Gender equity
2. The right to attain the highest standard of sexual and reproductive health services
3. The right to safety and dignity
4. The right to decide whether and when to have children and how many
5. Rights to information about and access to a range of SRH services
6. The right to make decision and to exercise control over one’s sexuality and reproduction free from discrimination, coercion and violence
7. The right to protect one’s health and prevent disease
8. The right to choose among available options
9. The right to privacy and confidentiality
10. The right to continuity of care

The essence of a rights based approach to service delivery is helping individuals exercise the right to make and act on their own decisions about their health and reproduction. The challenge for service providers is to help clients access whatever information and services they need and to help them make the decisions necessary to achieve SRH and their desired family size. Most governments and donors have formally committed to upholding these rights; however, the rhetoric has not become a reality for many complex reasons. Individual’s status (economic, gender, age, marital and education) with in their family and their culture influences their awareness of and ability to exercise their sexual and reproductive rights. Members of the marginalized population groups notably women and adolescents are less able to assert their rights than more privileged and powerful members of the community. Cultural constraints on individual’s ability to enjoy their sexual and reproductive rights will not be overcome unless and until social norms change.

In order for these rights to be met, they need to be contextualized in a culturally appropriate and meaningful manner and need to be recognized and protected by law. Individuals need to know
their rights and providers need to understand sexual and reproductive rights, their role in supporting clients and the power imbalances inherent in the society and in the client provider interaction, which can impede client’s ability to assert to their rights. One of the recommended ways to support rights based approach is to support informed and voluntary decision-making.

15.1. Informed and voluntary decision making

The international community has clearly stated and widely endorsed the rights of individuals to access SRH services to make their own decision about SRH care and to have the information necessary to make those decisions. However this have become a challenge despite efforts to building strong policy, to train service providers in counseling skills and to require informed consent for specific methods and procedures. Ethiopia gives due emphasis in respecting clients rights and meticulously follows whether informed decision making is violated while trying to expand service mix at a community level. Informed choice is understood as a voluntary, well-considered decision that an individual makes on the bases of options, information and understanding, specifically to family planning services. The concept of informed and voluntary decision-making applies to broadly to any health care decision and assumes that individuals have both the right and the ability to make their own health care decisions. Accordingly, any family planning service is expected to be based on informed and voluntary decision-making procedure. Programme planners, monitoring and evaluation experts and clinical mentors need to ensure that IVDM is respected and not violated.

15.2. 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.

16. 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 was a primary source of data for monitoring, since it being replaced by District Health Information system (DHIS2) in January 2018. Currently the ministry of health shifted the information system into District Health Information System (DHIS2) and operationalized it since 2018. which analyze the data,

DHIS2 is used to aggregate statistical data collection, validation, analysis, management, and presentation. This data analytics and management platform is completely web-based and boasts great visualization features and the ability to create analysis from live data in seconds. In addition, DHIS2 can be used to monitor patient health, improve disease surveillance, map disease outbreaks, and speed up health data access for health facilities and government organizations.

Two commonly used FP records are described in this chapter.

16.1. 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.
16.2. 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 registers include Family planning register, long acting FP removal register and postnatal care and delivery registers which include immediate postpartum FP. (Annex….)

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
- Provide information on method mix

16.3. Referral form

Records of clients referred are obtained from the referral records. The referral record is attached in page 63, which is based on the community based health information system (CHIS) from HP to HC.

16.4. Supplies records

Records of contraceptive supplies are described in the section on contraceptive logistics (page 58).

16.5. 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 district health office. A district 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.

16.6. **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.

17. **Annexes**

17.1. **Annex 1: 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.

<table>
<thead>
<tr>
<th>Method</th>
<th>Unit</th>
<th>CYP Per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptives</td>
<td>cycles</td>
<td>0.077</td>
</tr>
<tr>
<td>Condoms</td>
<td>Unit</td>
<td>0.008</td>
</tr>
<tr>
<td>Female condoms</td>
<td>Unit</td>
<td>0.008</td>
</tr>
<tr>
<td>Vaginal foaming tablets</td>
<td>Unit</td>
<td>0.008</td>
</tr>
<tr>
<td>Depo-Provera injectable</td>
<td>dose(ml)</td>
<td>0.250</td>
</tr>
<tr>
<td>Noristerat injectable</td>
<td>Dose</td>
<td>0.167</td>
</tr>
<tr>
<td>Cyclofem monthly injectable</td>
<td>Dose</td>
<td>0.077</td>
</tr>
<tr>
<td>Copper-T 380-A IUCD</td>
<td>IUD</td>
<td>5.500</td>
</tr>
<tr>
<td>Implannon implant</td>
<td>Implant</td>
<td>2.000</td>
</tr>
</tbody>
</table>
17.2. Annex 2: The balanced Counseling Strategy

The GATHER and REDI approaches are largely known counseling approaches in family planning by health care providers. These approaches are largely dependent on the memory of the health provider to be able to remember key steps. Evidences suggest that providers fail to discuss client’s wishes; rather they tend to mainly ask medical questions (such as date of client’s last menstruation). At the same time, clients are overloaded with excessive information on most of the methods available in the health facility—whether or not the methods are suitable for the clients’ needs. Information provided on the chosen method is usually sparse and most of the counseling time is spent describing numerous method options.

Cognizant of all these challenges, a Balanced Counselling Strategy (BCS) Plus which is a client centered counseling strategy is developed and tested in Kenya and South Africa. This strategy assures privacy and confidentiality, emphasizes the client’s right to make informed and voluntary decisions, and it is designed to provide the information and tools needed to improve the effectiveness and efficiency of consultations. Its use is also found to simplify decision making and responds to the client’s needs and reproductive intentions in family planning counseling sessions. The third edition of the BCS+ includes content updated according to the latest WHO Medical Eligibility Criteria (2015). It incorporates the most up to date evidence on clinical indications for the provision of family planning methods, including new methods. The “plus job aids” in the BCS plus is more reliable than memory and designed to minimize trial and error and to reduce the amount of recall necessary to perform a task. The toolkit has three main job aids; the algorithm, counseling cards and brochures.

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15 https://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service
## ALGORITHM FOR USING THE BALANCED COUNSELING STRATEGY PLUS
### THIRD EDITION, 2015

<table>
<thead>
<tr>
<th>PRE-CHOICE STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish and maintain a warm, cordial relationship.</td>
</tr>
<tr>
<td>2. Inform client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation.</td>
</tr>
<tr>
<td><strong>a.</strong> If client is currently using a family planning method or delaying pregnancy, ask about her/his satisfaction with it and interest in continuing or changing the method.</td>
</tr>
<tr>
<td><strong>b.</strong> If partner is present, use the male services and support card.</td>
</tr>
<tr>
<td>4. Rule out pregnancy using the Checklist to Make Reasonably Sure a Woman is not Pregnant card to be reasonably sure the woman is not pregnant.</td>
</tr>
<tr>
<td>5. Display all of the method cards. Ask client if she/he wants a particular method.</td>
</tr>
<tr>
<td>6. Ask all of the following questions. Set aside method cards based on the client’s responses.</td>
</tr>
<tr>
<td><strong>c.</strong> Do you wish to have children in the future?</td>
</tr>
<tr>
<td>If “Yes,” set aside vasectomy and tubal ligation cards. Explain Why. If “No,” keep all cards and continue.</td>
</tr>
<tr>
<td><strong>d.</strong> Have you given birth in the last 48 hours?</td>
</tr>
<tr>
<td>If “Yes,” set aside combined oral contraceptives (the Pill) and combined injectables. Explain why. If “No,” continue with the next question.</td>
</tr>
<tr>
<td><strong>e.</strong> Are you breastfeeding an infant less than 6 months old?</td>
</tr>
<tr>
<td>If “Yes,” set aside the combined oral contraceptives (the Pill) and combined injectable cards. Explain why.</td>
</tr>
<tr>
<td>If “No,” or she has begun her monthly bleeding again, set aside the lactational amenorrhea (LAM) card. Explain why.</td>
</tr>
<tr>
<td><strong>f.</strong> Does your partner support you in family planning?</td>
</tr>
<tr>
<td>If “Yes,” continue with the next question</td>
</tr>
<tr>
<td>If “No,” set aside the following cards: female condom, male condom, Standard Days Method©, Two Days Method©, and withdrawal. Explain why.</td>
</tr>
<tr>
<td><strong>g.</strong> Do you have any medical conditions? Are you taking any medications?</td>
</tr>
<tr>
<td>If “Yes,” ask further about which conditions or medications. Refer to WHO Medical Eligibility Criteria Wheel or current national guidelines and set aside all contraindicated method cards. Explain why.</td>
</tr>
<tr>
<td>If “No,” keep all the cards and continue.</td>
</tr>
<tr>
<td><strong>h.</strong> Are there any methods that you do not want to use or have not tolerated in the past?</td>
</tr>
<tr>
<td>If “Yes,” set aside the cards the client does not want. If “No,” keep the rest of the cards.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>METHOD CHOICE STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Briefly review the methods that have not been set aside and indicate their effectiveness.</td>
</tr>
<tr>
<td>8. Ask the client to choose the method that is most convenient for her/him.</td>
</tr>
<tr>
<td><strong>c.</strong> If client is adolescent use the counseling card to inform her that she can get any method</td>
</tr>
<tr>
<td>9. Using the method-specific brochure, check whether the client has any condition for which the method is not advised.</td>
</tr>
</tbody>
</table>
Review “Method not advised if you...” section in the brochure
If the method is not advisable, ask the client to select another method from the cards that remain. Repeat the process from Step 8.

**POST-CHOICE STAGE**

10 Discuss the method chosen with the client, using the method-specific brochure as a counseling tool. Determine the client’s comprehension and reinforce Key information.

11 Make sure the client has made a definite decision. Give her/him the method chosen, a referral, and a back-up method depending on the method selected.

12 Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.

**SYSTEMATIC SCREENING FOR OTHER SERVICES STAGE**

13 Using information collected previously; determine client’s need for postpartum, newborn, infant care, well-child services or post abortion care.
   a If client reported giving birth recently, review the Promoting Healthy Postpartum Period and Promoting Newborn and Infant Health card with client. Provide or refer for services, if needed.
   b For clients with children less than 5 years of age, ask if children have been taken to well-child services. Provide or refer for immunizations and growth monitoring services, if needed.
   c If client reported a recent abortion, review the Post Abortion Care card with the client. Provide or refer post abortion care services, if needed.

14 Ask client when she had her last screening for cervical cancer (VIA/VILI or pap smear) or breast cancer.
   a If her last Cervical Cancer screening was more than 3 years ago (*6-12 months if she is HIV positive) or she does not know, ask if she would like to have a screening today. Review the Screening for Cervical Cancer card. Provide or refer for services.
   b If her last Cervical Cancer screening was, less than 3 years ago continue with next question.
   c Review Breast Cancer Information and Awareness counseling card with client.

15 Discuss STI/HIV Transmission & Prevention and dual protection with client using counseling cards. Offer condoms and instructions on correct and consistent use.

16 Conduct STI and HIV risk assessment using the counseling card. If symptoms are identified, treat her/him syndromically.

17 Ask client whether s/he knows her/his HIV status.
   a If client knows s/he is living with HIV,
      • Review Positive Health, Dignity, & Prevention counseling card with client.
      • Refer client to center for wellness care and treatment.
   b If client knows s/he is HIV negative,
      • Discuss a period for repeat testing.
   c If client does not know her/his status,
      • Discuss HIV Counseling and Testing (HCT) with client, using counseling card.
      • Offer or initiate testing with client, according to national protocols.
      • Counsel client on test results. If client is living with HIV, review Positive Health, Dignity, & Prevention counseling card and refer client to center for wellness care and treatment.
   d Counsel client using Women’s Support & Safety Card.
      • If client shows any major Intimate Partner Violence (IPV) triggers, refer her for specialized services.

18 Give follow-up instructions, a condom brochure, and the brochure for the method chosen. Set a date for next visit.

19 Thank her/him for the visit. Complete the counseling session.
17.3. Annex 3: Family planning register

Federal Democratic Republic of Ethiopia
Ministry of Health

Family Planning Register

| S.N | MRN | Name of Client | Age | Sex (M/F) | Reg. Date (DD/MM/YY) | New Accept | Repeat Accept | HIV Test Offered | HIV Test Result (P/N) | HIV Specific FP | Counseling offered | HIV Pos. and Linked to ART | Target Population Category (write code) | Clinical Exam & FP Service Provided | Appointment | Visit NO | Visit Date (DD/MM/YY) | Contra Indication for IUCD | Remark/Name/Sign |
|-----|-----|----------------|-----|-----------|----------------------|------------|--------------|-------------------|---------------------|----------------|-----------------|-----------------------------|----------------------------------|----------------|------------|--------------------------|------------------------|-----------------|
| 1   | 2   | 3              | 4   | 5         | 6                    | 7          | 8            | 9                 | 10                  | 11            | 12              | 13                          | 14                  | 15            | 16                      | 17                      | 18              | 19                      | 20                      | 21              |
|     |     |                |     |           |                      |            |              |                   |                     |               |                 |                             |                     |              |                         |                         |                 |                         |                         |              |
|     |     |                |     |           |                      |            |              |                   |                     |               |                 |                             |                     |              |                         |                         |                 |                         |                         |              |
|     |     |                |     |           |                      |            |              |                   |                     |               |                 |                             |                     |              |                         |                         |                 |                         |                         |              |
|     |     |                |     |           |                      |            |              |                   |                     |               |                 |                             |                     |              |                         |                         |                 |                         |                         |              |

Abbreviations:
- MaC=Male Condom, FeC=Female Condom, OC=Oral contraceptive, Inj=Injectable, Ec=Emergency Contraceptive, IUCD=Intrauterine device, Imp=Implant, Diaph=Diaphragm, TL=Tubal Ligation, Vas=Vasectomy, Oth=Others

Targeted Population Category
- A Female Sex worker
- B Long distance drivers
- C Mobile workers/daily labourers
- D Prisoners
- E OVC
- F Children of PLHIV
- G Partner of PLHIV
- H Other MARPS
- I General Population
### Annex 4: Long acting Family Planning Removal Register

**Long acting Family Planning Removal Register**

<table>
<thead>
<tr>
<th>S.N</th>
<th>MRN</th>
<th>Name of Client</th>
<th>Age</th>
<th>Reg. Date (DD/MM/YY)</th>
<th>Insertion Date (DD/MM/YY)</th>
<th>Type of LAFP used</th>
<th>Place of LAFP received (Wire Code)</th>
<th>Service provided</th>
<th>Type of LAFP used</th>
<th>Place of LAFP removed (Wire Code)</th>
<th>Reason for Removal (Col 11)</th>
<th>Target Population Category</th>
<th>FMOH 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
</tbody>
</table>

**Reason for Removal (Col 11)**

- **a** On recommended time
- **b** Side effect
- **c** Want to get pregnant
- **d** Misconception
- **e** Others

**Place of LAFP Received Col.8**

- **WI** with in Facility
- **HC** Health Center
- **P** Private Clinic
- **W** Workplace
- **O** Other

**Target Population Category**

- **a** Female sex worker
- **b** Long distance driver
- **c** Mobile workers/Daily labourer
- **d** Prisoner
- **e** OVC
- **f** Children of PLHIV
- **g** Parent of PLHIV
- **h** Other MARPS
- **i** General Population
17.5. Annex 5: Consent form for voluntary surgical contraception

17.6. Annex 6: 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

________________________________________________________________________

Feedback

Signature:
17.7. Annex 7: FP Quick Reference Chart:

2015 Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Sub-condition</th>
<th>COC</th>
<th>DMPA</th>
<th>Implants</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Less than 6 weeks postpartum</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 weeks to &lt; 6 months postpartum</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 months postpartum or more</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Postpartum and not breastfeeding</td>
<td>&lt; 21 days</td>
<td>See i.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VTE = venous thromboembolism</td>
<td>&lt; 21 days with other risk factors for VTE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥ 21 to 42 days with other risk factors for VTE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 42 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum and breastfeeding or not breastfeeding</td>
<td>&lt; 48 hours or more than 4 weeks</td>
<td>See ii.</td>
<td>See ii.</td>
<td>See ii.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥ 48 hours to less than 4 weeks</td>
<td>See ii.</td>
<td>See ii.</td>
<td>See ii.</td>
<td></td>
</tr>
<tr>
<td>Postabortion</td>
<td>Immediate post-septic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Age ≥ 35 years, &lt; 15 cigarettes/day</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age ≥ 35 years, ≥ 15 cigarettes/day</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple risk factors for cardiovascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>History of (where BP cannot be evaluated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP = blood pressure</td>
<td>BP is controlled and can be evaluated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elevated BP (systolic 140 - 159 or diastolic 90 - 99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elevated BP (systolic ≥ 160 or diastolic ≥ 100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep venous thrombosis (DVT) and pulmonary embolism (PE)</td>
<td>History of DVT/PE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute DVT/PE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DVT/PE, established on anticoagulant therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major surgery with prolonged immobilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known thrombogenic mutations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic heart disease (current or history of) or stroke (history of)</td>
<td></td>
<td></td>
<td>I</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Known hyperlipidemias</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complicated valvular heart disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systemic lupus erythematosus</td>
<td>Positive or unknown antiphospholipid antibodies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe thrombocytopenia</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Immunosuppressive treatment</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Headaches</td>
<td>Non-migrainous (mild or severe)</td>
<td>I</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Migraine without aura (age &lt; 35 years)</td>
<td>I</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Migraine without aura (age ≥ 35 years)</td>
<td>I</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Migraines with aura (at any age)</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Unexplained vaginal bleeding (prior to evaluation)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Gestational trophoblastic disease</td>
<td>Regressing or undetectable β-hCG levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Persistently elevated β-hCG levels or malignant disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancers</td>
<td>Cervical (awaiting treatment)</td>
<td>I</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endometrial</td>
<td>I</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ovarian</td>
<td>I</td>
<td>C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast disease</th>
<th>Undiagnosed mass</th>
<th>**</th>
<th>**</th>
<th>**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past w/o no evidence of current disease for 5 yrs</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Uterine distortion due to fibroids or anatomical abnormalities</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>STIs/PID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current purulent cervicitis, chlamydia, gonorrhea</td>
<td></td>
<td>I</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Vaginitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current pelvic inflammatory disease (PID)</td>
<td></td>
<td>I</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Other STIs (excluding HIV/hepatitis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased risk of STIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very high individual risk of exposure to STIs</td>
<td></td>
<td>I</td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>

| Pelvic tuberculosis                                               |                  |    |    |    |
| Diabetes                                                          |                  |    |    |    |
| Nephropathy/retinopathy/neuropathy                                |                  |    |    |    |
| Diabetics for > 20 years                                          |                  |    |    |    |

| Symptomatic gall bladder disease (current or medically treated)   |                  |    |    |    |
| Cholestasis (history of)                                         |                  |    |    |    |
| Related to pregnancy                                             |                  |    |    |    |
| Related to oral contraceptives                                   |                  |    |    |    |

| Hepatitis                                                         |                  |    |    |    |
| Acute or flare                                                    |                  | I  | C  |    |
| Chronic or client is a carrier                                    |                  |    |    |    |

| Cirrhosis                                                         |                  |    |    |    |
| Mild                                                              |                  |    |    |    |
| Severe                                                            |                  |    |    |    |

| Liver tumors (hepatocellular adenoma and malignant hepatoma)      |                  |    |    |    |
| High risk of HIV or HIV-infected (Stage 1 or 2)                   |                  |    |    |    |
| AIDS (HIV-infected Stage 3 or 4)                                  |                  |    |    |    |
| No antiretroviral therapy (ARV)                                   |                  |    |    |    |
| Improved to Stage 1 or 2 on ARV therapy                           |                  |    |    |    |
| Not improved on ARV therapy                                       |                  |    |    |    |

| Drug interactions                                                 |                  |    |    |    |
| Rifampicin or rifabutin                                           |                  |    |    |    |
| Anticonvulsant therapy***                                          |                  |    |    |    |

**Category 1** There are no restrictions for use.

**Category 2** Generally use; some follow-up may be needed.

**Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

**Category 4** The method should not be used.

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. It is used to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, and copper intrauterine device (Cu-IUD).

I/C Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method.

Where I/C is not marked, the category is the same for initiation and continuation.

NA Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.

i. See condition ‘Postpartum and breastfeeding or not breastfeeding’ instead.

ii. See condition ‘Breastfeeding’ or condition ‘Postpartum and not breastfeeding’ instead.

iii. Women who use methods other than IUDs can use them regardless of HIV stage or use of ART.

* Other risk factors for VTE include previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m2, postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.

** Evaluation of an undiagnosed mass should be pursued as soon as possible.

*** Anticonvulsants include phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.
### 17.8. Annex 8: REDI – Family planning counseling guide

#### NEW CLIENT

<table>
<thead>
<tr>
<th>R - Rapport-building</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Greet client with respect</strong></td>
<td>Welcome client; offer a seat, introduce yourself; ask client’s name</td>
</tr>
<tr>
<td><strong>Assure confidentiality and privacy</strong></td>
<td>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 listening to the talk and looking at the procedure</td>
</tr>
<tr>
<td><strong>Explain the need to talk about sensitive issues</strong></td>
<td>Explain need to ask personal and sometimes sensitive questions about her sexual and reproductive health, which is helpful for making her visit successful.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E – Exploration</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask the reason for visit</strong></td>
<td>Previous FP method use, whether she has already decided on a method</td>
</tr>
<tr>
<td><strong>Explore client’s knowledge about FP method/s/ and fill the knowledge gaps</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Ask reproductive history and fertility plan</strong></td>
<td>Pregnancy history and outcomes, number and age of children, whether s/he wants more children, the nature of contraceptive protection desired (Duration, hormone/non-hormone, etc.)</td>
</tr>
<tr>
<td><strong>Explore client’s circumstances and relationships</strong></td>
<td>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; other factors (socio-economic) that may influence contraceptive use</td>
</tr>
<tr>
<td><strong>Explore issues related to sexual life</strong></td>
<td>Questions/concerns/problems client has about sexual relations/practices; nature of sexual relationships (frequency, regularity) that may affect contraceptive choice and use whenever important</td>
</tr>
<tr>
<td><strong>Ask about STI/HIV knowledge/history and help to perceive risk</strong></td>
<td>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,</td>
</tr>
<tr>
<td><strong>Rule out pregnancy</strong></td>
<td>Ask about date of last birth, Breast Feeding practice, last menstrual period and menstrual pattern, history of unprotected sex, recent abortion/miscarriage etc.</td>
</tr>
<tr>
<td><strong>Screen client for possible medical condition</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D – Decision making</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Help clients consider or remind the following before making decision:</strong></td>
<td>Eligibility for the method, if she can tolerate the side effects, STI/HIV risk protection and potential barriers</td>
</tr>
</tbody>
</table>
## Encourage to make her/his own decision
- Reconfirm it is her/his choice, confirm that the decision is voluntary

### I – Implementation

<table>
<thead>
<tr>
<th>Explain the method</th>
<th>• 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify barriers to implement decision &amp; develop strategies to overcome barriers</td>
<td>• Consider barriers like side effect, Partner relationship, cost and availability of method and deal with them like what to do with side effect, role of emergency contraceptive, options to switch, negotiation with partners, etc. and provide written information (if any)</td>
</tr>
<tr>
<td>Make a follow-up plan</td>
<td>• 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</td>
</tr>
</tbody>
</table>

## RETURNING CLIENT (WITH PROBLEM)

### RDI 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 the client to describe how she is using the method
- Confirm correct method use: Check if client has any questions/concerns/problems, especially regarding side effects
  - 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/test 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)
- Ask about satisfaction with Current method: 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: 

#### 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;
### Decision Making

| Identify what decisions the client needs to confirm or make | Continuing with current method, switching to another method, discontinuing FP method, STI/HIV risk reduction/dual protection, complying with treatment etc. |
| Encourage to make own decision | Reconfirm her/his choice, confirm that the decision is voluntary |

### Implementation

<table>
<thead>
<tr>
<th>Help the client in implementing the decision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Help deal with the side effects</td>
</tr>
<tr>
<td>• Provide the information and skills (especially for condoms) needed for correct use of the method</td>
</tr>
<tr>
<td>• Help to get services they need or refer (pre-conception or antenatal care)</td>
</tr>
<tr>
<td>• For clients wanted removal of Implant or IUD, explain removal procedure and respond to question.</td>
</tr>
<tr>
<td>• 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</td>
</tr>
</tbody>
</table>

### Returning client (SATISFIED)

#### REDI Counseling Guide

##### Rapport-building

| Greet client with respect | Welcome client; offer a seat |

##### 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; |

##### Decision Making

| Help client identify what services she needs during this return visit | • Re supply |
| Regular well women visit |
| Follow up visit etc. |

##### Implementation

| Make a follow-up plan 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 |
18. References


Integration of FP and HIV: Pathfinder, Miz-Hasab, JHU study.


WHO Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Info Project. 2007. Family planning: A global handbook for providers. Baltimore and Geneva.