Federal Democratic Republic of Ethiopia
Ministry of Health

National Guideline for Family Planning Services In Ethiopia

Third Edition

July 2020
Addis Ababa, Ethiopia

Foreword

The Government of Ethiopia is committed to meet the sustainable development goals, and strongly believes that FP is one of the key strategies to improving maternal health and bringing about development. Since the revision of the first guideline in 2011, there have been various local and international updates on the provision of family planning services. The revision of the second national family planning guideline follows the development of the health sector plan, the release of revised WHO medical eligibility criteria, and the need to expand access to quality and equitable family planning services across the country.

Contraceptive prevalence rate has steadily increased from 8% in 2000 to 41.4 as per the mini DHS. Unmet need has declined from 37% in 2000 to 22% in 2016. There is still a huge disparity across regions and among various socio demographic indicators. The CPR is 3.4% in Somali compared to 50% in Addis Ababa. The ministry of health believes that access to family planning service is one of the reproductive rights of a woman and it is one of the tools used to prevent unintended pregnancy and to reduce maternal mortality in Ethiopia.

The purpose of this guideline is to provide guidance to health service providers, health managers and partners working in reproductive health and to set standards for FP program design, implementation, service provision and monitoring and evaluation of programs. In this revised guideline, ensuring quality of family planning services through improving health care providers counseling capacity on access to full, free and informed choice is given a priority. Accordingly, lists of minimum standards of care to ensure quality of service provision are included in this document. Similarly, in ensuring equity to access family planning service, special need populations are identified and major strategies pointed out to reach those communities.

In the past decades, family planning service provision has been mainly promoted through the public health sector with little emphasis given to expand access to quality services in the private sector. Noting this fact, this guideline provides clear roles and responsibilities for the private sectors and non-governmental organizational clinicsin expanding quality family planning services.

The role of the health extension worker was also limited in expanding information and providing referral services to family planning to that of providing only short acting family planning services. This guideline provides guidance to the level four health extension worker (L4HEW) to also provide long acting family planning services which will play a significant role in expanding the service.

Dereje Duguma(MD,MPH)
State Minister
Ministry of Health of Ethiopia

Acknowledgments

The Federal Ministry of Health would like to extend its sincere appreciation and gratitude to all of those who were instrumental in reviewing and finalizing the National Guideline for Family Planning Service. The Maternal, Neonatal, Child Health and Nutrition Directorate (MNCHN) would like to thank the following individuals and partner organizations for their contribution:

1. Dr.Tadele Kebede (MoH);
2. Tenaye Kebede (MoH);
3. Berhane Assefa (Intra Health International);
4. Dr. Assefa Alem (EngenderHealth);
5. Dr. Kidest Lulu (Pathfinder International);
6. Dr. Solomon Kumbi (Addis Ababa University);
7. Dr. Nega Tesfaw (Marie Stopes);
8. Dr. Zewditu Kebede (USAID);
9. Dr. Demeke Desta (Ipas),
10. Dr. Dereje Negussie (USAID/PHSP Abt);
11. Dr. Wegen Shiferaw (WHO),
12. Gemechis Shogo (UNFPA);
13. Yalewayker Yilma (CHAI); and
14. Meaza Girma (PSI).
15. Dr. Gizachew Balew(Consultant)

The MNCHN Directorate would also extend its appreciation to UNFPA and EngenderHealth for their financial support in reviewing and printing the national guideline for family planning service.

Meseret Zelalem (MD, Pediatrician)

Director, Maternal and Child Health Directorate
Ministry of Health of Ethiopia

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List of Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
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
MOH	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
IVDM	Informed and voluntary decision-making
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
PHCU	Primary Health Care Unit
PLWH	People living with HIV
PMTCT	Prevention of mother-to-child transmission (of HIV)
EPSA	Ethiopian Pharmaceutical Supply Agency
PWD	Persons with disability
RH	Reproductive health
ROC	Reproductive organ cancer
SBC	Socio behavior change
SDG	Sustainable development goals
SDM	Standard day's method
STI	Sexually transmitted infection
TFR	Total fertility rate
UNFPA	United Nations Population Fund

VCT	Voluntary counseling and testing
WHO	World Health Organization

1. Introduction

The Government of Ethiopia committed itself to the achievement of Sustainable Development Goals (SDGs), and strongly believed 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 the provision of FP services.

The first family planning guideline was developed in 1996and revised in 2011 to reflect the existing national health policy and strategic documents. This guideline is revised in line with the current health sector transformation plan, current WHO recommendations and new updates and principles of task sharing. The current guideline focuses on the role of the private sector, the rights based approach for FP, LARCs by level IV HEWs, emerging FP initiatives (the School Health Program), and catchment based clinical mentorship, and socio-ecological model for social and behavioral change where life skill based education is emphasized at the individual level. In addition, the revised guideline provides an update on comprehensive service integration, addresses underserved and special segments of the population, the expanding method mix, and ensuring full, free, and informed choice.

The guideline aims to provide guidance to national family planning and reproductive health programs in the delivery of contraceptive services. Potential users of the guideline include policy makers, health managers, FP program coordinators and implementers, all cadres of health care providers, instructors and students at health training institutions, researchers, monitoring and evaluation experts, donors, community educators including media people, individuals and communities.

1.1. Background

1.1.1. Global and regional context

In an effort to achieve a better future for all, SDG 3 targeted to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030. The SDG plans to ensure universal access to sexual and reproductive health-care services including for family planning[1], which will be measured by the proportion of reproductive age women who have their need for FP satisfied with modern methods of contraception.

International Conventions

Ethiopia as a member of the international community has endorsed and signed a number of agreements promoting and protecting the rights of 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[2].Ethiopia has also updated it's commitment to Family Planning 2020 at the London Summit by increasing it's financing of FP services from its SDG pooled fund and using the national health account to track expenditures for FP.

Regional Conventions

In 2006, African ministers of health and delegates agreed on the Maputo Plan of Action. It illustrates the political will within the continent to provide high quality information and services to women, men and young people, targeted to reduce high-risk pregnancies as well as sexually transmitted infections. Improving youth friendly SRH services, reducing the incidence of unsafe abortion and increasing resources to ensure commodity security were the priority actions in the Maputo Plan of Action. Similarly, in 2010, the African Union endorsed the campaign for the accelerated reduction of maternal mortality in Africa (CARMMA). Leaders recognize the large

[1] UN Sustainable development goals; https://www.un.org/sustainabledevelopment/health/

[2] UN Women; preliminary gender profile of Ethiopia, Nov 2014:https://www.usaid.gov/sites/default/files/documents/1860/Preliminary%20Gender%20Profile%20of%20Ethiopia%20Nov%2017%20final.pdf

number of maternal and child mortality that occur from preventable causes in the region and commit to avert them. Family planning interventions are identified as major components to be strengthened to help in the reduction of maternal and child mortality and morbidity.

1.1.2. National Context

1.1.2.1. 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*."

In line with this, the family law was revised in 2000 to align with the national constitutional rights of women, the revised Penal Code (2005), and 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.

The National Health Policy:

The main objective of the National Health Policy is 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 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 inter-sectoral collaboration, particularly with regard to family health.

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). Most of the targets set in the population policy directly or indirectly relate to FP, including reducing the total fertility rate (TFR) and increasing the contraceptive prevalence rate (CPR). This policy is currently under review.

Health Sector Transformation Plan (HSTP):

Ethiopia has been implementing various long-term development plans over the past five decades. Since 1997, the health sector has effectively implemented four phases of health sector development plans followed by the health sector transformation plan (HSTP) that was initiated in 2016. This plan identified four transformation agendas which included equity and quality of health care, information revolution, Woreda transformation, and creating a caring, respectful and compassionate health workforce. It also identified major impact indicators which include the reduction of maternal mortality ratio from 412/100,000 to 199/100,000 live births[3], increase CPR from the 36% to 55%, reduce unmet need for FP from the 22 to 10, and reduce teenage/adolescent pregnancy rate from 12% to 3%.

The National Reproductive Health Strategy:

The revised National RH Strategy (2016-2020) states that the goal of FP is to reduce unintended pregnancies and enable individuals to achieve their desired family size. To achieve this overall objective, the strategy sets the following as action points:

[3] USAID, STAT Compiler: the DHS program: https://www.statcompiler.com/en/

- Delegate services 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 their desired family size.
- Create acceptance of and demand for FP, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth.

The Adolescent and Youth Health Strategy:

The population age structure of Ethiopia shows that adolescents make up more than 33.8% of the total population. Recognizing the growing needs of adolescents, the ministry has been implementing the ***Adolescent and Youth Health Strategy*** (AYH) strategy to create access to quality youth friendly services. The strategy has been targeted to increase CPR and reduce the unmet need for modern contraception among adolescents and youth.

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 quality FP services. However, existing regional disparities and the sociopolitical environment require further enforcement of the application of existing strategies and policy direction.

1.1.2.2. Health Service Delivery System

The public health service delivery in Ethiopia follows a three-tier system; the *Primary Health Care* (PHC- consisting of satellite health posts, a health center and a primary hospital); general *hospital; and* a highest s*pecialized hospital.* The cadres of health care providers range from Health Extension Workers (HEWs), who carry out their duties at the community and health-post levelsto medical specialists. The health infrastructure expansion in the past couple of decades has enabled the health sector to enhance the coverage of primary health care services to almost 100%. However, the provision of quality health care services at all levels is found to be low.

1.1.2.3. Socioeconomic and gender perspectives

Gender inequality in Ethiopia remains a major barrier to the country's development. Women and girls are forced to marry at an early age. The 2016 EDHS indicated that the median age at first marriage is 17.1, which is below the legal age of marriage. More than 63% of women have experienced Female Genital Cutting (FGC) with the highest record being in the Somali region (99%). Forty-nine percent (49%) of women with FGC aged 15-49 had their genitalia cut before the age of 5 years, while another 24% have experienced it at age 10 or older. Approximately 33% of ever-married women report that they have experienced either physical or sexual violence while another 26% of ever married women have experienced some form of intimate partner violence.

In most cultures across Ethiopia, the man interferes in most women's decision-making power and ownership of assets. Men are more likely than women to own land (48% men and 40% women), use an account in any financial institution (25% men and 15% women), and own mobile phones (55% men, 27%women)[4]. Moreover, 35% of ever-married women age 15-49 reported that they made the decision to marry, while 61% say that their parents made the decision. These all make violence against women in Ethiopia a concern from human rights, economic and health perspectives and poses challenges in achieving gender equality and women's empowerment.

Women and girls are discriminated against in their access in health, including family planning. This requires a holistic approach to narrow the gender gap and ensure the freedom of choice to access family planning as a human right in Ethiopia.

1.1.2.4. Population and Fertility Pattern of Ethiopia

The current natural population increase is 2.6%. It will take 27 years for the population to double in size, which will make Ethiopia to be the fifth country with the greatest projected population increase by adding more than 83.4 million people from 2018 to 2050 (World Population Data, 2018. This makes the total population of Ethiopia 139.6 million in 2030 and 190.9 million in 2050. With the current age structure, 45% of the population will be under 15 years of age which

[4] Central Statistical Agency/CSA/Ethiopia and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa

will put great pressure on the country's economy. As the population that is more youthful is growing, investment in family planning will provide an opportunity for a demographic dividend (DD) in the country. Accordingly, it requires concerted activity to increase the country's CPR and improve the method mix.

1.1.2.5. History of modern FP in Ethiopia

Modern family planning services in Ethiopia was started by the Family Guidance Association of Ethiopia (FGAE) in 1966. Since 1980, the Ministry of Health (MOH) has 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 MOH released the first *Guideline for FP Services in Ethiopia* to guide stakeholders and expand quality FP services. In this guideline, the MOH 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. The first *Guideline for FP Services in Ethiopia* was revised in 2011.

1.1.2.6. Current status of Family Planning in Ethiopian

Ethiopia has shown remarkable progress in reaching women and men with voluntary FP services. The TFR has declined from According to Ethiopian Demographic Survey, The maternal mortality ratio has declined by 53% from 871/100,000 in 2000 to 412/100,000 in 2016 per 100,000 live births. Similarly, infant mortality decreased by 50% from (97/1,000 in 2000 to 48/1,000). The CPR has increased by 37% (8% in 2000 to 41.1% in 2019. live births, indicating a 50% reduction. Whereas, TFR has declined from 5.5 children per woman in 2000, to 4.6 children per woman in 2016.

Despite the significant progress in CPR, there is a huge variation among urban and rural communities, different regions and across socio demographic status. For example, urban women are much more likely than their rural counterparts to use any modern method of contraception (50 percent versus 38 percent); only 3.4 percent use FP in Somali compared to 50 percent in Addis Ababa (2019 mini DHS). Similarly, the unmet need for family planning is gradually declining from 37% in 2000 to 22% in 2016 (EDHS). Ethiopian demographic survey also indicates that in the year 2016, 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 are attributed to the expansion of public and private facilities, the health workforce and health system at the community level. 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 ministry of health and the financial and technical support from partners and the donor agencies have also contributed to the improved achievements in the reproductive, maternal and child health services.

2. Rationale for Family Planning Services

Human Rights Perspective:

The human rights dimension of family planning programs was recognized 50 years ago. The 1968 International Conference on Human Rights brought the Teheran Proclamation, which affirmed family planning to be a human right; "…parents have a basic human right to determine freely and responsibly the number and spacing of their children". This right has been reaffirmed and embellished by various bodies in numerous declarations and conventions over the years, notably the 1979 Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the 1994 International Conference on Population and Development (ICPD), and the 1995 fourth world conference on Women. Since 1980, Ethiopia has been a signatory to nine of

the CEDAW articles[5]. 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 information, education and means to enable them to exercise these rights", similarly, the Committee on Economic, Social and Cultural Rights, UN Economic and Social Council has articulated the right to Sexual and Reproductive Health, as articulated in General Comment No. 22 (2016). This includes "the right to decide whether or when to have children" and "the right to Health Care and Health Protection" including family planning. Governments are also obligated to ensure that all healthcare information, services and commodities are available, accessible, acceptable and of the highest possible quality.

In a similar context, the Constitution of the 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.*" Overall, accessing voluntary family planning services is recognized to be a human right; and governments are obliged to ensure the accessibility of the service. The FDRE constitution also reaffirms it and individuals have the right to claim for information and access to quality family planning services.

Woman's Health Benefits

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[6]. Evidence suggests that FP interventions contributed to more than a 25% reduction in the maternal mortality ratio[7]. In another context, an estimated 23 million adolescent girls have an unmet need for modern contraception and are at risk of

[5] United Nations Treaty Collections: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en

[6] Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: an analysis of 172 countries. The Lancet. 2012 Jul 14;380(9837):111-25.

[7] Ahmed S, Li Q, Liu L, Tsui A. Maternal Deaths Averted by Contraceptive Use: Results from a Global Analysis of 172 countries.

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

Ensuring access to voluntary family planning methods for women and couples has various health benefits to the health of a woman. It helps women preserve their health and contributes to the improvement of the overall quality of their lives. Family planning helps to space and delay pregnancies for a woman who is at risk of pregnancy related problems. Mothers who have chronic cardiac, renal and respiratory problems, multiparous women who are at risk of post-partum bleeding, and adolescents and youth who want to delay pregnancy will benefit from using a family planning method. Unplanned adolescent pregnancies may end in unsafe abortion and death. In conclusion, family planning saves the lives of women and children, improves the quality of life for all and reduces morbidity and mortality from pregnancy.

Child Health Benefits

Having too many children places children's health at risk. In some countries, evidence shows that achieving birth spacing of more than two years between pregnancies could reduce child death by up to a third. In a similar context, evidence shows that an infant born to a teenage mother is more likely to be born too early and weigh too little at birth and is 24 percent more likely to die in the first month of life than an infant born to a mother aged 25-34 years. Families with fewer, healthier children can devote more resources to providing their children with adequate food, clothing, housing, and educational opportunities. By avoiding too closely spaced pregnancies, families will have a greater opportunity to support children, invest in their children's education and bring about better child health. If women had universal access to voluntary family-planning information and services, infant deaths can be reduced by as much as a fifth[8]. Accordingly, FP service is a very cost-effective investment compared with investments in most other health and social interventions to bring quality of health to a woman and her child.

[8] World Economic Forum: the economic benefits of family planning, 26, july 2018: https://www.weforum.org/agenda/2018/07/the-economic-benefits-of-family-planning

Education Benefits

Adolescents and youth who have the freedom to choose and have access to family planning services tend to avoid unintended pregnancies, and educational dropouts. Additionally, having smaller families allows parents to invest more in each child. According to the WHO, children with fewer siblings tend to stay in school longer than those with more siblings. When girls leave school early for marriage and childbearing, it perpetuates the cycle of high fertility, low women's status and high rates of poverty.

Economic Benefits

The ability to decide when or whether to have children is not only a basic human right; it is also the key to economic empowerment. Investing in expanding access to voluntary family planning contributes to better economic outcomes for households, communities, and nations. FP will ensure that women have the freedom to decide when to have children, to be more engaged in various household activities, personal development activities and community participation. On the other hand, investment in family planning service saves various expenses that result from social, economic and cultural impacts of unplanned pregnancy and childbirth. According to the world economic forum 2018, for every dollar invested in reproductive health services, $2.20 is saved in pregnancy-related health-care costs.

Family planning also contributes to the reduction of the national total fertility rate. When developing countries make investments that empower young people to start a family only when they are ready, birth rates fall and the share of the working-age population increases relative to the dependent population. When there is a simultaneous decline in mortality from communicable and non-communicable diseases, life expectancy in a community increases. This implies that more youth will join the labor force market. If this is matched with an appropriate fiscal policy for better education, quality of health care, innovations in technology and employment opportunities, the growing adolescent and youth population will contribute to the national economy through saving and investment.

Environmental Benefits

The global community is working in creating sustainable development which implies a responsible utilization of existing resources to meet human development needs while at the same time sustaining the natural systems to provide the natural resources and ecosystem services for the future generation upon which the economy and society depends. Humans are depleting natural resources, degrading soil and water, and creating waste at an alarming rate in an effort to meet their needs. This is exacerbated as the fertility rate and the overall global population increase. As family planning programs reduce fertility, they can help to relieve the pressures that rapidly growing populations place on environmental resources (land, food and water), reduce strain on community resources (health care, education and agriculture), and lessens pressure on the socio political system.

3. Objectives of the Family Planning Guideline

This FP guideline has been revised with the following general and specific objectives

3.1. General Objective

- To support reduction of preventable maternal and child death as well as solve infertility problems through provision of standardized family planning services at all levels

3.2. Specific objectives:

- Set standards for FP program design and implementation, service provision and monitoring and evaluation of programs
- Guide FP programmers and implementers at government, nongovernment, and bilateral and multilateral organizations, and at private sector as well as charity and civic institutions implement standardized FP services
- 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 trainingExpand and improve the quality of FP services to be offered
- Guide integration of FP services with other RH and non-RH services
- Be used as a general directive and management tool

4. Guiding Principles

This guideline considers the following guiding principles in designing FP programs and expanding access to quality family planning services:

- ***Availability****:* Health care facilities, trained providers and contraceptive methods are available to ensure that individuals can exercise full choice from a range of contraceptive methods, including follow-up and removal services for implants and IUDs.
- ***Accessibility***: Health care facilities, trained providers and contraceptive methods are accessible—without physical, economic, socio-cultural or informational barriers.
- ***Acceptability***: Health care facilities, trained providers and contraceptive methods are respectful of medical ethics and individual preferences, are sensitive to gender and life cycle requirements and respect confidentiality.
- ***Quality****:* Individuals have access to full range of quality contraceptive methods which are scientifically and medically appropriate, have access to clear and medically accurate information, and should get the service from technically competent provider at a well-equipped health facility that ensures client-provider interactions.
- ***Empowerment*****:** Individuals are empowered as principal actors and agents to make decisions about their reproductive lives, and can execute these decisions through access to contraceptive information, services and supplies.

- ***Equity and non-discrimination*:** Individuals have the ability to access comprehensive contraceptive services free from discrimination, coercion and violence. FP services should not vary by non-medically indicated characteristics, such as age, geography, language, ethnicity, disability, HIV status, income, and marital or other status.
- ***Informed choice***: Individuals have the ability to access accurate, clear and readily understood information about a variety of contraceptive methods and their use.
- ***Voice and participation***: Individual beneficiaries have the ability to participate meaningfully in the design, provision, implementation, and evaluation of contraceptive services, programs and policies.

5. Family Planning Services

5.1. Definition of FP

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

5.2. Service eligibility

Any person, male or female, who is sexually active and married is eligible for FP services, including information, education, and counseling.

5.3. Range of services and activities to be offered in FP

The following services and activities offered at different levels of the national health care delivery system, in accordance with Tables 1 and 2:

- FP Counseling
- Provision of contraceptive methods
- Prevention, screening, and management for STIs, including HIV
- Prevention and management of infertility
- Counseling and linkage to other SRH services including for sexual dysfunction
- Prevention, screening and treatment for reproductive organ cancers focusing on breast and cervical cancer
- Follow-up and referral
- Supporting supervision and clinical mentorship
- Record Keeping and reporting

5.3.1. FP counseling

Counselling should be an interactive process between the service provider and client using the REDI counseling framework. The health care professional should provide adequate information to help the service user has informed and voluntary decision-making capacity to take the service.[9] There should be no incentive 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. Family planning providers may encounter clients with additional needs, in which case the service providers need to be capacitated to link the client to other SRH and health services. Similarly, service providers working in different units across a health facility should be able to counsel clients for family planning service to avoid any missed opportunities.

5.3.2. Provision of contraceptive methods

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

- Fertility awareness–based methods, such as the standard day's method (SDM), rhythm (calendar) method, two-day method/or cervical mucus method, and sympto-thermal method
- Lactational amenorrhea method (LAM)

[9]Counselling for Maternal and Newborn Health Care: A Handbook for Building Skills. WHO 2009.

- Male and female condom
- Emergency contraceptives
- Progestin-only pill
- Combined oral contraceptive pills
- Injectable contraceptives
- Implants
- Intrauterine contraceptive device (IUCDs)
- Bilateral tubal ligation (BTL)
- Vasectomy
- Others as approved by the Ethiopian Food and Drug Authority (EFDA)

Specific medical eligibility criteria for each contraceptive methods needs to follow the world health organization (WHO) fifth 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 needs to be weighed along with the benefits of preventing unintended pregnancy.

While respecting clients' rights and supporting full, free and informed choice, ensuring method-mix is central to quality FP services.

5.3.3. Prevention, screening and management of STIs and HIV/AIDS

All clients should get 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, offer STI/HIV screening or refer to 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. Health care providers should strongly recommend dual protection to all clients suspected of STIs and HIV/AIDS.

5.3.4. Prevention and management of infertility

The role of FP in the prevention of infertility is through the promotion of responsible sexual behavior, use of condoms (dual protection), STI counseling, screening and treatment when indicated. 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, most modern contraceptive methods do not cause a significant delay in the return to fertility. However, if a client presents with infertility, appropriate counseling and information on where to get services should be provided.

5.3.5. Counseling and linkage to other SRH services including sexual dysfunction

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Health facilities mainly focus on providing access to reproductive health service. The focus towards creating access to sexual health including counseling for sexual dysfunctions, gender based violence, and the prevention of sexually transmitted infections is usually overlooked. This guideline recommends that health facilities integrate sexual health into family planning services. Health care providers also need to identify and manage sexual problems and/or ensure referral where needed.

5.3.6. Prevention and screening for reproductive organ cancers

FP offers a unique opportunity to screen for cervical cancer and teach the client to do self-examination for breast cancer. Where facilities exist, women should be encouraged to have an annual Pap smear or visual inspection of the cervix using acetoacetic acid (VIA) or Lugols Iodine Solution (VILI). Health workers should educate women and their families about reproductive organ cancers (ROCs) and the benefits of screening. Women found to have ROC should receive their treatment either in the same facility or be referred as urgently as possible.

5.3.7. Follow-up and Referral

Ensuring follow up, referral and continuity of care is an important component of family planning services.

5.3.8. Clinical mentorship and supportive supervision

Clinical mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable and high-quality clinical care outcomes. Clinical mentors need to be experienced, practicing clinicians in their own site, with strong teaching skills. Mentorship 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.

Supportive supervision is a facilitative approach that promotes mentorship and joint problem solving between supervisors and supervisees. Supportive supervision should be conducted periodically from a supervisor to supervisees to ensure the generation of quality data for evidence based decisions and improved service quality across all levels.

5.3.9. Record Keeping and reporting

All FP providers should maintain proper records on each client and on the distribution of contraceptives. Each service should be age and sex disaggregated and show service utilization by adolescent and youth communities. All service delivery outlets including public health facilities, non-governmental organizations (NGOs), higher institution and school clinics, workplace clinics, and the private sector should document and report FP service provision to the nearest Ministry of Health structure. Pharmacies and drug venders on the other hand should record and report dispensed commodities.

6. Integration of FP and other Health services

Service integration is an approach in which health care providers use opportunities to engage the client in addressing broader health and social needs beyond those promoting the initial health care encounter. In the case of family planning, it might be either using an internal referral mechanism (especially for long acting contraceptives) or direct provision of FP services depending on the context. Integration of FP with other RH and non-SRH service delivery units is cost-efficient and enables maximum utilization of health care services in one visit.

6.1. HIV Testing and Counseling (HTC)

HTC services can be good entry points for FP services, and vice versa. Both HIV and unintended pregnancy are, in most cases, the consequences of unprotected sex. Integrating HTC 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 should have basic knowledge and counseling skills to provide FP services. Facilities should also create the enabling environment to strengthen the integration of FP services. Women at high risk of acquiring HIV infection can generally use all methods of contraceptives. With minimum input, both types of providers can deliver services to clients seeking HTC and FP services in one stop.

6.2. Comprehensive abortion care

A woman seeks safe abortion or post abortion care largely because of unintended pregnancy. Abortion and post abortion care may be the first encounter of a woman within the health system, so providers should utilize this opportunity to counsel and provide FP services to the woman or couple. The *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* recommends that a woman should be provided with the choice of contraception immediately after abortion (MOH, 2014). Global evidence indicates that post abortion women accept family planning methods at a higher rate when the method is offered at the same time and location as abortion or post abortion care treatment prior to discharge from the facility. Therefore this guidance recommends that post abortion family planning counseling and services be provided to women seeking abortion or post abortion care services prior to being discharged from the treating facility.

6.3. Antenatal care, delivery care, and postpartum care

Evidences suggest that there is high-unmet need for post-partum family planning in Ethiopia (Reference). Despite a high proportion of women being exposed to health providers when utilizing maternal health services, only a small proportion receive FP information during these interactions. Accordingly, this guideline advises integrating postpartum family planning (PPFP) into maternal, newborn, and child health services to increase the likelihood that every new mother will leave the clinic having made an informed choice about family planning.

During antenatal care visits, providers should discuss the benefits of spacing between births, counsel on family size, post-partum family planning and exclusive breastfeeding along with having a skilled birth attendant. Similarly, during delivery and post-partum period, providers should support breast-feeding; introduce lactational amenorrhea method (LAM) and other immediate post-partum contraceptive options; injectable, implants, post-partum IUCD and others as per the MEC criteria 2015.

6.4. Child health, immunization, and other RH services

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

6.5. Integration with other health services (inpatient and outpatients)

It is true that the large majority of health facility users visit a facility for an outpatient clinical service. In 2017 in Ethiopia, more than 36 million clients visited outpatient departments out of which, more than 18 million were women visits. With a minimum input to health care providers in an outpatient department, integration of family planning services will provide an opportunity to expand access to quality FP service provision. Integration of services at OPD might be either using an internal referral mechanism (especially for long acting contraceptives) or direct provision of FP services at OPD level (especially for short acting FP services) depending on the context.

6.6. School Health program

Recognizing the more than 28 million adolescent and youth population that attend school, the ministry of health has started implementing a school health program in collaboration with the ministry of education. This school health program (SHP) aims to guide service providers and administrators at different levels of school to provide quality, standardized promotive, preventive, and curative health services to school students at the pre-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 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].

7. Family planning service delivery modalities

Currently, estimations show that close to 100% of the Ethiopian population has potential health service coverage. 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 through pharmacies, drug stores and rural drug venders
- Outreach based community services
- Mobile health team approaches
- School health services
- Workplace services
- Social franchising

7.1. Family planning services by level of Health facility

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 competency in 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.

[10] MOH, National School Health Strategy:2015-2020

Table 1: Organization of services by level of care in the public health structure

Level of facility	**Type of health personnel available for FP**	**FP services**
Health post	Health Extension Workers	● Counsel on FP and other RH issues ● Counsel on fertility awareness FP methods such as LAM, two day method and standard day's method. ● Provide injectable, and implant insertion ● Provide Implant Removal where there is a competent provider ● Provide IUCD insertion and removal where there is a competent provider ● Referral based on client's complaint for STI to HCs for further treatment ● Refer to health center for 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 (Where there is a competent provider) ● Manage complications and side effects ● Provide syndromic management of STIs, HIV counseling and treatment. ● Conduct screening for ROCs ● Train community level workers and junior health professional ● Provide on job training ● Conduct clinical mentorship and supportive supervision to health posts
Primary Hospital	Integrated Emergency Surgical Officers (IESOs), GMPs, HOs, Midwives, Clinical Nurses, Public Health Nurses	The above activities, plus: ● Do work-ups for infertility ● Provide permanent methods of contraception ● Manage complicated STIs ● Receive referrals ● Manage complications and side effects

		• Train health workers on comprehensive contraception • Establish training centers • Conduct screening for ROCs • Conduct clinical mentoring to catchment health centers
General and Referral hospital	Obstetrician-Gynecologists, GMPs, HOs, Midwives, Clinical Nurses, Public Health Nurses	The above activities, plus: • Manage complications and side effects of contraceptive methods • Manage reproductive organ cancers (ROCs) • Clinical mentorship to catchment based district hospitals • Preservice training on comprehensive contraception • Management of Infertility • Perform research

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

Level of facility	**Type of health personnel available (minimum)**	**FP services**
1. Primary clinic	1 Clinical or General Nurse (Diploma) 1 Lab. Technician	• Counsel on FP and RH • Counsel on use of fertility awareness methods • Distribute male and female condoms, oral contraceptives, (including ECPs), and • Provide injectables • Provide insertion and removal of Implants • Provide insertion and removal of IUCD • Record keeping and monthly reports to nearby health center • Referral service for permanent contraceptive and other SRH services
2. Medium clinic	1 GMP/HO 1 Clinical Nurse At least 1 Lab. Technician	The above, plus: • Tubal ligation and vasectomy (where there is a competent provider and facility readiness) Provide on the job trainings
3. Higher-level clinic	1 Specialist/GMP (Head) 1 Specialist/GMP	• The above, plus: • Do work-ups for infertility

	1 Nurse At least 1 X-ray technician	• Provide permanent methods of contraception • Manage complicated STIs • Receive referrals • Manage complications and side effects • Train health workers on comprehensive contraception • Conduct clinical mentoring and supportive supervision to health posts • Conduct screening for ROCs • Conduct clinical mentoring to catchment health centers
4. Specialized clinic (ob-gyn)	At least 1 Ob-gyn specialist 1 X-ray technician 1 Lab. technician 1 Midwife/Nurse	• The above, plus: • All methods of FP including fertility awareness methods • Generating evidences and lessons learned • Manage complications and side effects of contraceptive methods • Manage reproductive organ cancers (ROCs) • Establish training centers
5. General and Specialized Hospital, MCH Specialty Center (MCH)	Variable types and numbers of professionals (including specialists)	• The above, plus: • Have training centers and train health professionals • Manage complications and side effects of contraceptive methods • Manage reproductive organ cancers (ROCs) • Manage complications and side effects of contraceptive methods • Manage reproductive organ cancers (ROCs) • Perform research

Table 3: Task Analysis for Provision of Family Planning services

Task	***Provider category***					
	Obs/Gyne specialist	*GMP /ISO*	*BSc(HO, Nurse, Midwife)*	*Diploma (Midwife, Nurse)*	*HEW-L4*	*HEW-L3*
Client assessment						
• History taking	✓	✓	✓	✓	✓	✓
• Physical examination	✓	✓	✓	✓	✓	✓
• Bimanual pelvic exam	✓	✓	✓	✓	✓	X

• MEC assessment	✓	✓	✓	✓	✓	✓
• Counseling	✓	✓	✓	✓	✓	✓
Provision of FP services, by method						
• Natural methods	✓	✓	✓	✓	✓	✓
• Condoms	✓	✓	✓	✓	✓	✓
• Pills	✓	✓	✓	✓	✓	✓
• Emergency contraceptives	✓	✓	✓	✓	✓	✓
• Injectables	✓	✓	✓	✓	✓	✓
• Implanon insertion	✓	✓	✓	✓	✓	✓*
• Other implants insertion	✓	✓	✓	✓	✓	X
• Implants removal	✓	✓	✓	✓	✓	X
• IUCD insertion and removal	✓	✓	✓	✓	✓	X
• BTL	✓	✓*	✓*	X	X	X
• Vasectomy	✓	✓*	✓*	X	X	X
Other RH services						
• Syndromic management of STIs	✓	✓	✓	✓	X	X
• Management of complicated STIs	✓	✓	✓	X	X	X
• Cancer screening	✓	✓	✓	✓	X	X
• Treatment of ROCs	✓	X	X	X	X	X
• Management of infertility	✓	X	X	X	X	X
Pain medications						
• Nonnarcotic analgesics	✓	✓	✓	✓	✓	✓
• Narcotic analgesics	✓	✓	✓	X	X	X
• Local anesthesia	✓	✓	✓	✓	✓*	✓*
Management of complications and side effects	✓	✓	✓	✓	✓^	✓^
Follow-up care	✓	✓	✓	✓	✓	✓
Universal precautions	✓	✓	✓	✓	✓	✓
Integration of FP and other RH services	✓	✓	✓	✓	✓	✓
Instrument processing	✓	✓	✓	✓	✓	✓

SBCC	✓	✓	✓	✓	✓	✓
Recording and reporting	✓	✓	✓	✓	✓	✓
Training junior health professionals and community health workers	✓	✓	✓	✓	✓	✓

Key;

✓ = Roles expected to be performed by the category

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

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

X = Roles not expected of the category

7.2. Outreach/Mobile

Outreach health program is when a health facility team arranges for service provision at a catchment area. Mobile FP service delivery is a service provided by a team of competent providers who travel from a center to a community that has limited or no FP services. Such programs should be regular and occur at fixed intervals. In pastoralist settings where the community might have seasonal movement in search of grazing land or water, the mobile health team might be the best option. Homeless people can also be served with outreach health programs.

7.3. Social marketing

Social marketing is a strategy that promotes, distributes, and sells contraceptives at an affordable price through existing commercial channels. Social marketing is used for the promotion and sales of condoms, pills, ECPs and injectables through pharmacies, drug stores, and rural drug vendors to complement facility based services.

7.4. 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. Organizations experienced in providing family planning services can collaborate with the private sector and strengthen their system in expanding access to quality informed and voluntary FP services.

7.5. Workplace-based services

Factories, enterprises, large farms, and industrial parks employ large numbers of young people, predominantly women, with limited access to SRH/FP services. Hence, ministries and agencies (e.g., Trade and Industry, Agriculture, Energy and Mines, Transport, and Communications) should ensure the availability of SRH services. Availing FP services at the workplace have the benefit of accessing an easy-to-reach, known population of workers. It potentially saves employees' time, minimizes lost productivity, and has the benefit of reaching more potential users. Facilities at workplaces must be registered and function based on the staffing and facility standards of the MOH. The ministry of health at each level should closely work with stakeholders to support workplace based FP service.

7.6. School-based health services

The provision of sexual and reproductive health services, including FP services in school settings and in higher learning institutions, have the benefit of accessing an easy-to-reach and known population of youth. Student clinics in 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 unintended pregnancy, avoid unsafe abortion, and help reduce school dropout.

School based interventions should include building the capacity of health providers working in student clinics, and equipping the school based clinics with necessary materials, equipment and supplies. In addition, it should involve establishing and /or strengthening referral arrangements between student clinics and health facilities (Hospitals and health centers) for FP services that are

not offered in the student clinics. Prevention of unintended 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 skills education approach should be the main strategy for demand creation and behavioral change in the area of SRH.

8. The role of NGOs, Private sector &Professional Associations in the delivery of FP services

8.1. NGOs and Professional Associations

Under the strategic leadership played by the government of Ethiopia, NGOs have been the major contributors to Ethiopia's family planning success. NGOs shall continue to take part in FP programs through capacity building focusing on quality counseling and service provision, quality assurance, strengthening commodity supply and service provision in alignment with national policies and programs.

8.2. The private sector

Private health facilities make up more than one third of the health care service provision in Ethiopia. Despite the critical roles expected from the private health service, their contribution in expanding access to family planning has been limited. Cognizant of this gap, the MOH has launched a public private mix (PPM) implementation guideline for RMNCH, which is expected to pave the way for better provision of FP and other RH services in the private facilities.

9. 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:

9.1. 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 unintended pregnancy.*" Evidence suggests that fewer than 10% of married girls aged 15–19 years use any modern FP method. Almost one-third (31.1%) of adolescents have experienced unintended or mistimed live birth[11], indicating limited access to FP services or access to 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. In light of these facts, FP services need to be adolescent and youth-friendly and be accessible irrespective of their age and marital status. This implies services to be unbiased, non-discriminatory, affordable, confidential, convenient, and comprehensive.

9.2. HIV Positive People

For HIV positive People, dual method use helps to prevent transmission of HIV to an uninfected partner. The fertility intentions of HIV positive People 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 unintended pregnancy in HIV-positive women using FP is one of the four prongs of PMTCT. Regardless of their use of ART, HIV positive People can start and continue to use most contraceptive methods safely. Health care providers working in ART clinics should inform and educate HIV positive People about the prevention of unintended pregnancy and the use of FP. 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 unintended pregnancy. However, assessing eligibility using MEC is recommended for each family planning method.

[11] (Central Statistical Agency [Ethiopia] and ORC Macro, 2006)

9.3. 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. Unintended pregnancy is one of the consequences of sexual violence. Hence, emergency contraception should be availed for all victims of rape who are at risk of pregnancy. ECPs and the IUCD are the available types of emergency contraception. Whenever prepackaged ECPs are not available, combined oral contraceptive or progesterone only pills (COC & POP) can be substituted. There are no known medical conditions for which ECP use is contraindicated. Providers should refer the national management guideline for victims of sexual assault.

9.4. FGC (Infibulation)

Female genital cutting (FGC) is a practice that involves altering the female genitalia for non-medical reasons, and is internationally recognized as a human rights violation. Family planning service providers might have difficulty in providing IUCDs in women with infibulation. Therefore, such clients need to be counseled on other choices of contraceptive methods.

9.5. Persons with disability, including mental disability

Women and men with disabilities can and want to be productive members of society. Health service providers must ensure that – people with disabilities have access to counselling on sexual and reproductive health services and access to informed and voluntary FP services. The following are lists of recommendations to be taken to address the needs of people with disability:

- Special consideration should be given to individuals who are mentally challenged or those with psychiatric disorders who might require specialized counselling,
- Where the nature of the disabilities does not allow for informed choice (e.g., severe mental challenge), a FP method should be provided only after full discussion with all parties, including parents, or next of kin, legal appointed representatives or guardians, depending on the degree of the mental disability. In the absence of these caretakers, the provider may decide on a method choice in the best interests of the client with serious mental disability,

- Some drugs that are used to treat mental disorders may affect the bioavailability and efficacy of hormonal contraceptives in which case alternatives should be considered.
- As much as possible, FP methods that do not seriously demand user compliance (e.g. Injectable, IUCD, and implants) should be encouraged to ensure efficacy and compliance.
- The health care system need to be more accessible and friendly to PWDs such as providing wheelchair ramps, adjustable examination couches, and/or staff who are trained in sign language.
- The reproductive rights of the individual must be considered in any of such decisions.

9.6. Daily laborers including the homeless community

In an expanding rural urban migration and fast urbanization, more people earn their life through the informal sector and are becoming homeless. 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 through innovative approaches.

9.7. People in emergency situations (IDPs and Refugees)

Violence against girls and women in humanitarian setting increases the risk of unintended pregnancy and its consequences. Demand for contraception is often found to be high during emergencies. 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 an essential part of any emergency health response. In this context, the government and partners need to:

- Include minimum FP and SRH service packages for emergency situations
- Work with emergency partners in training emergency taskforces to create access to informed and voluntary FP services
- Increase support to availability and access of essential SRH commodities in emergency situations

10. Quality of care in family planning

The HSTP has identified quality as one of the transformation agendas pillars. To help in cascading quality interventions at all levels, the ministry has developed Ethiopian National Health Care Quality Strategy 2016-2020. This strategy defines quality as "Comprehensive care that is measurably safe, effective, patient centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently[12]. It 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. 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 following components need to be considered to ensure quality of care in FP service provision.

10.1. Technical Competencies (Capacity building Training, Clinical Mentorship)

Ensuring family planning service providers' competency in counseling and performing procedures is a pre-requisite for quality of service. Accordingly, facilities and health managers need to ensure:

- The presence of centers of excellence and well equipped facilities for family planning service provision
- The availability of adequate number of competent staff at each service delivery unit for FP service
- Ongoing competency-based training and mentorship of health-care personnel on the delivery of counseling and services as per the national guidelines
- Availability and use of guidelines, protocols, job aids, checklists and standards
- The facility follows good infection-prevention practices routinely and
- Both clients and provider perspectives are used in improving the quality of service

10.2. Counselling

[12] Ethiopian National Health Care Quality Strategy

FP counseling services that ensure full, free and informed choice without breaching privacy and confidentiality are pre requites to ensure quality of FP services. REDI framework is the counseling tool currently in use Annex 2. The BCS strategy can also be taken as an alternative counseling tool. Annex 3 describes the details of BCS strategy for the counseling approaches.

10.3. Method Mix

Every health facility has the responsibility of ensuring the availability of a wide range of contraceptive methods to choose from. Clients also have the right to access the broadest range of contraceptives to choose and change when they need or encounter any side effects from an earlier method. Health professionals should provide an unbiased counseling service to ensure full, free and informed choice to ensure method mix.

10.4. Availability, Affordability and accessibility

The right to access health facilities, goods and services is central to realizing the right to quality of care. It includes ensuring that information and services are accessible and affordable. Health facilities and health professionals should take measures to ensure that clients can easily find health providers and FP units in a convenient way; ensuring badges to service providers, legible labels of the FP unit and sign boards to show the service delivery unit.

10.5. Compassionate and Respectful Care

The HSTPII has identified creating compassionate, respectful and caring health workforce as a priority across all health services; and the MOH has developed and is implementing national CRC guideline and training manual. In this context, health service providers should provide client-centered care with empathy through effective communication and need to consider the complex psychological, social and economic needs of clients. Therefore, health facility and managers should ensure that family planning services comply with the CRC guideline.

10.6. Client Centered care

Client centered care is one of the rights of a family planning client. One approach of ensuring this is assessing quality of care, including client satisfaction. This requires an improved involvement

of the client through routine client's feedback collection, satisfaction surveys etc. Health managers should ensure the presence of feedback collection mechanism, analyze data, and take corrective measures.

10.7. Continuity of Care

Family planning service is not a one-time intervention. It involves counseling and provision of each specific contraceptive method as per the standard and ensure the follow up and continuity of service. Some of the methods might have side effects and complications, which need to be followed and managed by a health care provider. Ensuring the availability of services and management of such side effects is an important component in quality of FP services. Clients information should be appropriately recorded, they should have referrals when needed, they should be informed about their date of return for routine follow up, they should be appointed for removals in case of implants and IUCD and they should have the removal service when they need.

10.8. Minimum Standards of Care

The MOH has set the minimum standards of care to be met by any service organization or individual providing family planning services as duty bearers (Annex 4.) At the same time, the clients have the right to claim the availability and accessibility of these services to meet their needs.

10.9. FP Client's rights

The rights based approach, which was developed at the ICPD 1994 is 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:

- Gender equity
- The right to attain the highest standard of sexual and reproductive health services
- The right to safety and dignity
- The right to decide whether and when to have children and how many

- Rights to information about and access to a range of SRH services
- The right to make decision and to exercise control over one's sexuality and reproduction free from discrimination, coercion and violence
- The right to protect one's health and prevent disease
- The right to choose among available options
- The right to privacy and confidentiality
- 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. 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. In this context, it should be clear that adolescents get service without mandatory parental and guardian authorization/notification. Similarly, "*for a woman to get FP services no third-party authorization is required including spousal approval"* and providers should affirm that individual decision is respected.

In order for these rights to be met, 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 full, free and informed choice.

10.10. Full, free and informed choice

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 has 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. Due emphasis in respecting clients rights and follows whether informed decision making is violated while trying to expand service mix. Informed choice is understood as a voluntary, well-considered decision that an individual makes based on options, information and understanding, specifically to family planning services. Program planners, monitoring and evaluation experts and clinical mentors need to ensure that IVDM is respected and not violated. For most methods, provision of FP services requires only having a verbal consent from the individual client to get the service. However, permanent contraceptive methods need to have the following written consent form signed before getting the service:

10.11. The needs of health care staff

Supportive 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 need 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. The ministry of health is working in expanding continuous professional development (CPD). Family planning service provision and quality of service should be incorporated as one of the skills in a professional development course and the quality of preservice family planning training should be strengthened.

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.

Recognitions/Motivation:

Ethiopia has major human resource for health challenges including shortage, urban/rural and regional disparities, and poor motivation, retention and performance. Health managers and

institutions need to create a system of recognition and motivation to ensure continuity and coverage of services. However, with regard to family planning caution has to be taken to avoid informed and voluntary decision-making.

11. Social and Behavioral Change (SBC) for FP

Social and Behavioral change 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. The 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. Accordingly, the following individual, community, organizational and socio economic level strategies are recommended to increase awareness and demand for family planning services.

11.1. 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. The MOH will strengthen life skill education at school level.

Male involvement in FP

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 supporters. 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

- Improve couples' communication regarding fertility and FP, so that decisions reflect the needs and desires of both men and women.
- Provide men with information that enables them to responsibly participate in FP use and decision-making.
- Provide space in all levels of health facilities for couples' counseling in FP.
- Make information on FP, STIs/HIV, and other RH issues available to men, 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 unintended pregnancy and STIs.
- 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.

11.2. Community Level interventions

The community should be aware of the overall benefits and availability of FP services. FP programs and services, including SBC 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. In expanding social and behavioral change interventions in the community, the following are the priorities of 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.
- Ensure different community representatives such as women, the youth and community figures are involved
- Enhance communication and facilitation skills and knowledge of various community level structures according to the context
- Ensure that messages are tailored to address the different segments of the community including those with disability, illiterate, homeless and other special groups

11.3. 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, men, 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. Life skills education is one of the tools to be strengthened at school level. Other standardized life skills education 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 across time. However, their focus in expanding healthy behavior to the general community and ensuring social responsibility is limited. The MOH and partners need to target to build the capacity of journalists and the media in general about sexual and reproductive health and family planning message production and broadcasting messages in a responsible manner. Media people need to be regularly updated on FP program and interventions.

The use of emerging communication channels like the social media (Facebook, telegram, twitter and the like) need to be explored and supported to reach the growing youth population. In addition, use of role models, actual clients/cases, and influential leaders of the community should be encouraged according to the context.

11.4. Socio-cultural, Economic Communication channels

For effective SBC, a mixed indoor and outdoor communication channels approach should be used. SBC 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. Management of Contraceptives Supplies

Contraceptive security exists when people are able to choose, obtain and use contraceptive products whenever they need them.[13] Ethiopia is currently using an integrated pharmaceuticals logistics system (IPLS) for managing contraceptives 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 Ethiopian Pharmaceutical Supplies Agency (EPSA).

A strong supply chain requires routine and accurate updates of records, timely reporting, and generating information for decision-making. In the IPLS decision to resupply commodities, bin card and stock card must be completed. Data from these records are used in monitoring stock levels and ordering refill quantities. Logistics information should be collected and reported monthly by health posts, every other month by health centers and hospitals using logistics management information system (LMIS) forms. Contraceptives should be always in full supply to maintain appropriate level of stock at all-time using the necessary inventory control tools. The following table summarizes the minimum and maximum stock and emergency order points at different health facilities:

Table 4: minimum-maximum level of FP commodities for health facilities

Description	Level of Health Facility	
	Health Centers and Hospitals	Health Posts

[13] SPARHCS: Strategic Pathway to reproductive health commodities security: a tool for assessment, planning and implementation. Available at; http://www.who.int/rhem/policy/sparhcs/en/index.html

Review Period	Every other month	Monthly
Maximum Months of Stock	4 months	2 months
Minimum Months of stock	2 months	1 months
Emergency Order point	0.5 months (=2 weeks)	0.25 months (=1 week)

The following are the major forms used for LMIS at various levels:

- Internal Facility Report and Resupply Form **(IFRR):** This form is completed by different units within a health facility; exemplified by various dispensary units report to a central store within a health center or hospital.
- Health Post Monthly Report and Re-supply Form **(HPMRR):** This form is used for resupplying pharmaceuticals, including contraceptives from health posts to health centers.
- Report and Requisition Form **(RRF):** This form is completed by the Health Centers and Hospitals and sent to the regional PSA for order processing every other month for direct delivery facilities. For management and supervision purposes, a copy of the health center report and request 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.

Management of contraceptive supplies involves various other functions too; forecasting, planning contraceptive supply, financing contraceptives, procurement, warehousing and storage, transport and distribution and inventory control procedures. Forecasting and procurement have been practiced only at central level. A national Family planning commodity quantification team under the FP logistics TWG in which relevant stakeholders are represented under the leadership of by FMOH and EPSA does forecasting. Contraceptive supply plan follows the forecasting exercise where total funds to cover annual requirements are presented to potential partners and the FMOH. Donor governments have been the major sources of finance for contraceptive commodities. However, to meet the growing needs for high quality contraceptives and ensure sustainability, Ethiopia has demonstrated its commitment to allocate fund from the sustainable development (SDG) pool fund and the government budget allocation in line with the existing donor support, which might include including FP products in to the community based insurance system.

Once procurement is done, commodities are stored in both national and regional EPSA warehouse system, which is already networked and managed using an electronic system. These stores transport and distribute commodities to respective facilities/districts, which is based on geographic proximity.

13. Health Management Information System (HMIS)

Ethiopia has been implementing the health management information system since 2008 to capture and provide core indicators to improve the provision of health services. The system is a major source of information for monitoring and adjusting policy implementation and resource use. Recently, the health information system, which uses HMIS, has been replaced by the district health information system (DHIS2), which provides aggregates of health information at a facility level.

The family planning service provision is one of the services, which need to be captured through the DHIS system. In this guideline, the major data that need to be captured in the DHIS and the tools used to collect clients information are described to help health care workers and health managers to follow FP services are well recorded and used for decision making. The major records are categorized as individual client's records, aggregate registers, and tally sheets.

13.1. Individual FP recording tools at Health Facilities

13.1.1. Integrated individual Folder

Any client who came to health facilities to receive FP service should visit medical record room and issued integrated individual folder that captures the basic demographic information of the client. The inside part of the folder contains a summary sheet to summarize summary of service provided for client at each visit and should be filled by service providers immediately after the service is provided.

13.1.2. Women's Card

All clients seeking FP services need to have a Women card. The card records their socio-demographic and health history including screening for family planning, past and current FP

methods, 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.

13.1.3. Appointment Card

It is a small card, which is used to remind clients who have next appointment. The card contains the client demographic information, appointment date and reason for appointment.

13.1.4. Referral form

Referral form is used to transfer basic information from referring health facilities to accepting health facilities. The referral form is attached in which is based on the community-based health information system (CHIS) from HP to HC.

13.1.5. Family health Card [at health post level]

Any clients that visit health post should be issued a family health card. The card helps the HEW to capture all demographic information, FP provision and long-term FP removal. The HEW should keep all family health cards with appointments in a tickler box. Otherwise it should be put on the back on family folder.

13.1.6. Registers

A. Family Planning Register

Family Planning Register is a longitudinal register that is used to capture HMIS data related to family planning services. The information required to complete the FP register is obtained from woman's card. The register should be kept in the Family Planning service room. The service provider will obtain complete information on individual clients from a woman's card and copy all the required information to the family planning register. This will help to compile and generate monthly family planning service statistics reports.

B. Long Acting Removal Register

The Long Acting Removal Register is used to record data for clients who have had long acting family planning methods and who have returned for removal. The family planning methods that are included for removal are implants (different types) and IUCD. Data is abstracted from women card and entered to the LAFP removal register by service providers.

13.7. Tally Sheets

A. Family Planning service tally sheet

It is used to summarize FP users by age and method to ease the reporting monthly. It is kept at FP service provision room and tallied immediately after transcribing the information on FP register.

B. Family Planning dispensed count tally

It is used to collect the total amount of contraceptives distributed by type of method. It is kept at FP service delivery point and tallied immediately after providing the FP method for clients. The information is aggregated and reported annually.

At a health post level, the FP service and dispensed method count tally sheets are captured in a single format and used to summarize reportable data elements.

13.8. Reporting and Data Use

The ministry of health designed and is implementing HMIS that captures information from all government, private and other non-governmental agency health institutions to monitor health sector performance. Data need to be aggregated and reported from health facilities to the next level at monthly, quarterly and annual base. District Health information system (DHIS2) is a web-based platform used to aggregate statistical data collection, validation, analysis, management, and presentation. Currently all health facilities and administrative health units use DHIS2 for reporting, data analysis, performance tracking and feedback provision. Similarly, family planning data are reported and analyzed using this DHIS2 in monthly, quarterly and annual base. The following table summarizes the major reportable data elements and indicators captured from routine health information system.

Table 5: Major reportable data elements and indicators for FP services

SN	*FP Data elements*	*FP indicators*
1	*Family Planning New and repeat acceptors by method and age*	*Contraceptive acceptance rate (Part of national Indicator)*
2	*Immediate Postpartum acceptors by age and method*	
3	*Total number of premature removals of LAFP within 6-month insertion*	*Long term family planning coverage (Program Indicator)*
4	*Total LAFP removal*	*Immediate post-partum coverage*

		(Program Indicator)
5	Family planning method dispensed	Premature removal rate of LTFP (Program Indicator)
6	HIV testing with result	

14. Monitoring and evaluation of FP interventions

Monitoring and Evaluation is one of the key components that helps policy makers, program managers, and health workers to track performance, to know areas of improvement and help for an overall strategic decision making at all level. As part of the overall health sector transformation plan, routine health management information system (HMIS), and population and facility-based surveys (EDHS, PMA 2020) were some of the information source for measuring FP program. Monitoring of family planning interventions helps to know the FP performance, tells which activities are more efficient and effective to meet the program objectives, informs to make data-driven decisions, and identify challenges, opportunities and strengths during program implementation.

In this regard, this guideline recommends the use of interventions like review meeting, clinical mentoring and supportive supervisions, in addition to the major indicators captured through the routine health information system and surveys for an immediate program support.

Review meeting

Programs are reviewed at different levels of intervention to check how they are being implemented and to identify major challenges and successes. Review meetings with health care workers, partners, and health managers are held at district, zonal, regional and national levels and conducted at various frequencies each year. The MOH holds a biannual review meeting with implementers, partners and donor agencies where FP service performance is one of the priorities reviewed. This guideline recommends that FP program review should be continued at national and subnational level as one of the priority programs reviewed.

Mentorship and supportive supervision

The ministry of health has launched a national mentorship guideline for maternal and reproductive health services, mainly for BEmONC and family planning services. This is a team based technical support and program review from a nearby health facility which is identified to have a better performance on FP services; coverage as well as quality. This guideline recommends that clinical mentors and supervisors use the data they have for the improvement of FP service provision.

15. Annexes

Annex A: 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.

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 6: CYP conversion factors updated on the 2011 measure evaluation indicators[14]

Method	Unit	CYP Per Unit	Remark
Copper-T 380-A IUD	IUD	4.60	
Copper-T 380-A IUD (5 year IUD)	IUD	3.30	
3 year implant (e.g. Implanon)	Implant	2.50	
4 year implant (e.g. Sino-Implant)	Implant	3.20	
5 year implant (e.g. Jadelle)	Implant	3.80	
Emergency Contraception	Dose	0.05	20
Fertility Awareness Methods	trained adopter	1.50	
Standard Days Method	trained adopter	1.50	

[14] Measure Evaluation; family planning and reproductive health indicators database; https://www.measureevaluation.org/prh/rh_indicators/family-planning/fp/cyp

LAM	User	0.25	4 users per CYP
Sterilization*	User	10.00	
Sterilization Global	User	13.00	
Oral Contraceptives	Cycle	.07	14 cycles per CYP
Condoms (Male and Female)	Unit	0.01	100 units per CYP
Vaginal Foaming Tablets	Unit	0.01	100 units per CYP
Depo Provera (DMPA) Injectable	Dose	0.25	4 doses per CYP
Noristerat (NET-En) Injectable	Dose	0.17	6 doses per CYP
Cyclofem Monthly Injectable	Dose	0.08	13 doses per CYP
Monthly Vaginal Ring/Patch	Unit	0.07	14 units per CYP

Annex B: REDI – Family planning counseling guide

REDI stands for rapport building, exploration, decision making, and implementing framework. It encourages open communication and less rigid counseling. REDI has different counseling approaches and techniques to counseling clients from different categories; new, repeat and satisfied and non-satisfied clients. Unlike other counseling frameworks, it also addresses whether and how the client will be able to carry out the decision he or she has made.

NEW CLIENT

R - Rapport-building	
Greet client with respect	● Welcome client; offer a seat;, introduce yourself; ask client's name
Assure confidentiality and privacy	● Affirm to the client that the subject would not be disclosed to any other person unless she/he want to. Ensure that there is nobody else listening to the talk and looking at the procedure
Explain the need to talk about sensitive issues	● Explain need to ask personal and sometimes sensitive questions about her sexual and reproductive health, which is helpful for making her visit successful.
E – Exploration	
Ask the reason for visit	● Previous FP method use, whether she has already decided on a method
Explore client's knowledge	● Ask what she/he knows about the types of contraception and

about FP method/s/ and fill the knowledge gaps	Provide information based on the gap about how to use, effectiveness, advantages, disadvantage and complications, protection against STI/HIV
Ask reproductive history and fertility plan	● Pregnancy history and outcomes, number and age of children, whether s/he wants more children, the nature of contraceptive protection desired (Duration, hormone/ non-hormone, etc.)
Explore client's circumstances and relationships	● Partner/spouse/family involvement and support for contraceptive use with particular emphasis on method(s) of interest; ability to communicate with the partner about FP decisions; other factors (socio-economic) that may influence contraceptive use
Explore issues related to sexual life	● Questions/concerns/problems client has about sexual relations/practices; nature of sexual relationships (frequency, regularity) that may affect contraceptive choice and use whenever important
Ask about STI/HIV knowledge/ history and help to perceive risk	● Ask about knowledge, history of STI , any sign and symptoms on the client/partner, perceived risk of STI/HIV and explain the advantage of Dual protection to reduce the Risk,
Rule out pregnancy	● Ask about date of last birth, Breast Feeding practice, last menstrual period and menstrual pattern , history of unprotected sex, recent abortion/miscarriage etc.
Screen client for possible medical condition	● Ask whether client has any known or suspected health problems: Cardiovascular(including high blood pressure), liver, reproductive cancer, bleeding/spotting between periods/after sex, severe anemia etc.
D - Decision making	
Help clients consider or remind the following before making decision:	● Eligibility for the method, if she can tolerate the side effects, STI/HIV risk protection and potential barriers
Encourage to make her/his own decision	● Reconfirm it is her/his choice, confirm that the decision is voluntary
I – Implementation	
Explain the method	● When to start, how to use and where to obtain the method, S/E and their Mx, Warning signs. Explain the procedure if there is one.
Identify barriers to implement decision & develop strategies to overcome barriers	● 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)
Make a follow-up plan	● Timing of medical follow-up or resupply, ensure that client understood all information, remind the client to return or call whenever s/he has questions, concerns or problems

RETURNING CLIENT (WITH PROBLEM)

REDI counseling steps

R- Rapport-building	
Greet client with respect	Welcome client; offer a seat
E – Exploration	
Ask the purpose for visit Confirm correct method use	• Returning client with no problem or with problem Ask the client to describe how she is using the method 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 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;
D- 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
I – Implementation	
Help the client in implementing the decision: - Continue current method - Switch to another method	• Help deal with the side effects • Provide the information and skills (especially for condoms) needed for correct use of the • Method • Help to get services they need or refer (pre-conception or antenatal care) • For clients wanted removal of Implant or IUD, explain removal

	procedure and respond to question.
- Discontinue the method	●
	● 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
Make a follow-up plan	

Returning client (SATISFIED)
REDI Counseling Guide

R - Rapport-building	
Greet client with respect	Welcome client; offer a seat
E – Exploration	
Ask the purpose for visit	● Ask what she/he feels about using the method
Ask about satisfaction with current method	● Check if client has any questions /concerns /problems, especially regarding side effects
Confirm correct method use	● Ask the client to describe how she is using the method(if it is administered by the client herself/himself)
Ask if there are changes in circumstances and sexual life; if she develops any medical problem	● Ask if she has any problems regarding her health condition, if she has changed partner, concerns that she might be exposed to STI / HIV(ask about dual method use) since last visit;
D - Decision making	
Help client identify what services she needs during this return visit	● Re supply ● Regular well women visit ● Follow up visit etc.
I – Implementation	
Make a follow-up plan if, applicable	● 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

Annex C: The balanced Counseling Strategy

Balanced Counselling Strategy (BCS) and is a client centered counseling strategy is developed and tested in Kenya and South Africa[15]. 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. It's 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+

[15] Population Counsel; The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings (Third Edition), 2015: https://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service

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.

ALGORITHM FOR USING THE BALANCED COUNSELING STRATEGY PLUS
THIRD EDITION, 2015

	PRE-CHOICE STAGE
1	Establish and maintain a warm, cordial relationship.
2	Inform client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation.
3	Ask client about current family size and current contraceptive practices. Counsel client on Healthy Timing and Spacing of Pregnancy using counseling card.
A	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.
B	If partner is present, use the male services and support card.
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.
5	Display all of the method cards. Ask client if she/he wants a particular method.
6	Ask all of the following questions. Set aside method cards based on the client's responses.
C	Do you wish to have children in the future? *If "Yes," set aside vasectomy and tubal ligation cards. Explain Why. If "No," keep all cards and continue.*
D	Have you given birth in the last 48 hours? *If "Yes," set-aside combined oral contraceptives (the Pill) and combined injectables. Explain why. If "No," continue with the next question.*
E	Are you breastfeeding an infant less than 6 months old? *If "Yes," set aside the combined oral contraceptives (the Pill) and combined injectable cards. Explain why.* *If "No," or she has begun her monthly bleeding again, set aside the lactational amenorrhea (LAM) card. Explain why.*
F	Does your partner support you in family planning? *If "Yes," continue with the next question* *If "No," set aside the following cards: female condom, male condom, Standard Days Method©, Two Days Method©, and withdrawal. Explain why.*
G	Do you have any medical conditions? Are you taking any medications?

	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.
	If "No," keep all the cards and continue.
H	h) Are there any methods that you do not want to use or have not tolerated in the past?
	If "Yes," set aside the cards the client does not want. If "No," keep the rest of the cards.
	METHOD CHOICE STAGE
7	Briefly review the methods that have not been set aside and indicate their effectiveness.
A	Arrange the remaining cards in order of effectiveness (see back of each card).
B	In order of effectiveness (highly effective to not effective), briefly review the attributes on each method card.
8	Ask the client to choose the method that is most convenient for her/him.
C	If client is adolescent use the counseling card to inform her that she can get any method
9	Using the method-specific brochure, check whether the client has any condition for which the method is not advised.
A	Review "Method not advised if you..." section in the brochure
B	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.

Annex D: Minimum standards of Quality Family Planning Services

Sn	*Quality Criteria*	*Description*
1	*Functional health system*	• There should be a physical infrastructure having clean and comfortable room for privacy • The facility should have adequate utilities, medicines, supplies and equipment for service provision and management of complications • There should be integrated FP service provision across different units in the health facility • Facilities should have an accurate and standard medical record keeping for every woman. • The facility should have a regular monitoring and performance system that accepts and provides feedbacks. • The facility has the infrastructure and practice to follow a good infection-prevention practice
2	*Technically competent health workers*	• Adequate number of knowledgeable and trained staff should be available to provide FP service • There should be an ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptives • Guidelines, protocols and checklists should be available, and staffs use them regularly • The providers should be aware and practice standard infection prevention procedures for FP. • Provider perspectives are used in improving the quality of service

3	Privacy and Confidentiality	• There should be respectful provider-user relationships, safeguarding user's privacy and confidentiality • privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information • Services should be provided based on client centered approach where the user has voluntary, informed and autonomous decision-making • Women's should receive compassionate and timely care in a respectful and caring setting • service is delivered in a culturally competent manner to meet the needs of all clients, including adolescents, and those with disabilities
4	Quality and Evidence based Counseling	• Client's should be counseled on evidence-based information on the effectiveness, risks and benefits of different methods • contraceptive methods are provided to a women after considering recommendations for medical eligibility criteria • Counselling is based on accurate information to meet individuals' specific needs, should be well structured, and should not involve provider bias or coercion. • The clinic routinely provides IEC materials and information: for the procedure; for follow-up care; and for contraception;
5	Choice of Contraceptives	• Service provision should ensure sharing accurate and unbiased information • Providers should ensure non-judgmental and respectful counseling and interaction with users • Ensuring informed voluntary decision marking is central to family planning method choice • Facilities should ensure the availability of a range of contraceptive methods, zero tolerance for commodity stock out.
6	Service accessibility and acceptability	• Health facilities need to expand availability of contraception information and services • services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice) • Contraceptives are accessible in terms of cost and distance • FP services should be integrated along with other health services in the facility.
7	Users Involvement in improving service	• Facilities and service providers should focus on involvement of users in improving services • User satisfaction be regularly monitored and analyzed for quality improvement. • Accountability that allows and enables participation, redress and remedies should be in place
8	Continuity of care	• Clients should have access for continuity of care and follow-up and ensuring their own efficacy • Follow-up services for management of contraceptive side-effects and

		removal of methods when needed be prioritized as an essential component of all contraceptive service delivery • Appropriate referrals for methods not available on site be offered and available.

Annex E: Family planning register

Ministry of Health, Ethiopia
Family Planning Register

Identification Personal Information					Registration			Counseling and Testing					Target Population Category (write Code)	TT status Checked	Contra Indication for IUCD	Clinical Exam & FP Service Provided				Appointment Date
S. N	MRN	Name of Client	Age	Sex (M/F)	Reg. Date (DD/MM/YY)	New Acceptor	Repeat Acceptor	HIV Test Offered	HIV test performed	HIV Test Result (P/N)	HIV Specific FP Counseling offered	HIV Pos. and Linked to ART				Visit N0	Visit Date (DD/MM/YY)	Contraceptive	Appointment Date	*Remark/Name*
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
																1				
																2				
																2				
																4				
																5				
																1				
																2				
																2				
																4				
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																2				
																2				
																4				
																5				
																1				
																2				
																2				
																4				
																5				

Abbreviations

New	Rep

MaC=Male Condom, FeC=Female Condom, OC=Oral contraceptive, Inj=injectable, Ec=Emergency Contraceptive, IUCD=Intrauterine devise, Imp=Implant. Diaph=Diaphragm, TL=Tubal Ligation, Vas=Vasectomy, Oth=Others

Targeted Population Category

A	Female Sex worker
B	Long distance drivers Mobile workers/daily labourers
C	Prisoners
D	OVC
E	Children of PLHIV
F	Partner of PLHIV

MOH VI 2009

G	Other MARPS
H	General Population

NB: ANC, L&D, PAC, & PNC register

Annex F: Long acting Family Planning Removal Register

Ministry of Health, Ethiopia
Long acting Family Planning Removal Register

Identification				Long Acting Family planning Removal Services														Remark/Name
Personal Information				Registration				Date of Removal Service provided (DD/MM/YY)	LAFM Method duration used in month	Reason for Removal (Wire Code)	Counseling and Testing						Post Removal Contraceptive Provided	
S.N	MRN	Name of Client	Age	Reg. Date (DD/MM/YY)	Insertion Date (DD/MM/YY)	Type of LAFP used	Place of LAFP received (Wire Code)				HIV Test Offered	HIV test performed	HIV Test Result (P/N)	HIV Specific Counseling offered	HIV Pos. and Linked to ART	Target Population Category (write Code)		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19

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	within Facility
Out of Facility	
1	Hospital
2	Health Center
3	Health Post

0-6mth	*>6mth*
Implanon	_____
Sinoplant	_____
Jadell	_____
Total Removal	_____

Target Population Category	
a	Female sex worker
b	long distance driver
c	Mobile workers/Daily labourer
d	Prisoner
e	OVC

MOH 2009

4	Private Clinic	f	children of PLHIV
5	Workplace	g	Parent of PLHIV
6	Other	h	Other MARPS
		i	General Population

Annex G: Consent form for voluntary surgical contraception

<u>በፍላጎት የተመሰረተ የቀዶ ህክምና የቤተሰብ እቅድ ተጠቃሚ ደንበኞች መተማመኛ ቅጽ</u>

እኔ ፊርማዬ ከዚህ በታች የሚገኝ ግለሰብ በቀዶ ህክምና የእርግዝና መከላከያ መጠቀም ስለምፈልግ ከዚህ በታች የተዘረዘሩትን ነጥቦች ተብራርተው ተነግረውኝ እና ተረድቼ ተቀብያለሁ፡፡

ይህዉም፡

1ኛ. በቀዶ ህክምና ከሚደረገዉ የእርግዝና መከላከያ ውጭ ሌላ ጊዜያዊም ሆነ ቋሚ የእርግዝና መከላከያ ዘዴወችን በመጠቀም ቤተሰቤን ማቀድ እንደምችል መረጃ ተሰጥቶኛል፤ እኔም በሚገባ አዉቃለሁ፡፡

2ኛ. ይህ በቀዶ ህክምና የሚፈጸም የቤተሰብ እቅድ ዘዴ ነው፡፡ እንደማንኛውም የቀዶ ህክምና ስርአት ደንብ ሰለሚደረግ አነዳንድ መጠነኛ የነነዮሽ ችግሮች ሊከሰቱ እነድሚችሉ ተገልፆልኛል

3ኛ. ይህ የእርግዝና መከላከያ ዘዴ የዘለቄታ መሆኑ ሊታወቅ ይገባል፡፡ ሆኖም ግን ማንኛውም የቀዶ ህክምና መቶ በመቶ እርግዝናን የመከላከል ብቃትን ሊያስገኝ አይችልም፡፤ ለጥቂት ደንበኞችም ላይሰራ እንደሚችልና የቀዶ ህክምናው ውጤት ካልሰመረ ተጨማሪ ልጆች ሊኖረኝ እንደሚችል በሚገባ ተረድቻለው፡፡ (የወንዶች የዘር ፍሬ ማመላለሻን ማሰቋጠር በተለይ ለመጀመሪያ ሶስት ወራት ሙሉ በሙሉ ላይሰራ እነደሚችል ተገለጾልኝ ተረድቻለሁ፡፡)

4ኛ.እኔዉ በራሴ ፍላጎት ያለምንም ተጽእኖና ግፊት የተቀበለኩ ስለሆነ ቀዶ ህክምናዉ ከመስራቱ በፊት በፈለግሁ ጊዚ ሃሳቤን በመለወጥ ድርጊቱን ላለመቀበል እንደምችል ተነግሮኛል፡ ሃሳቤንም በመለወጤ ምክያት የህክምና፤ የጤና እና ሌሎች አገልግሎቶችንና ጥቅሞች ከማግኘት እንደማይከለክለኝ ተነግሮኝ፡ መብቴም እነደሚጠበቅልኝ ተገንዝቤአለሁ፡፡

5ኛ. ይህ የእርግዝና መከላከያ ዘዴ በግብረ ስጋ ግንኙነት ጊዜ የሚተላለፉ በሽታወችን (ኤ.ች.አይ.ቪን ጨምሮ) እንደማይከላከል ተረድቻለሁ፡፡

የደንበኛው ስም፡---------- የሁኪሙ ስም፡----------

የደንበኛው ፊርማ፡---------- የሁኪሙ ፊርማ፡----------

ቀን---------- ቀን----------

Annex H: Referral form

Ministry of Health; Ethiopia
Referral form
Date _____

Client Full Name _____ age _____
sex_____ Medical record number_____

Address:
Region _____Woreda _____Kebele _____ Village_____ House number _____

Reason for Referral: ……..……..…

……..

Referred to _____ Referring Institution _____
Referred By: _____ Occupation_____
Signature_____ Date_____

…….

Referral Feedback

Date _____

Client Full Name _____ age _____
Sex_____ Medical record number_____

Address:
Region _____Woreda _____Kebele _____
Village_____ House number _____

Name of Facility: _____ Feedback to (Institution) _____
Type of Service provided _____
_____

Feedback_____
_____
Follow up Plan_____
_____

Appointment date:_____ _____
Service Provider:_____ Occupation_____

Signature_____ Date_____

Annex I: FP Quick Reference Chart:

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

Cancers	Cervical (awaiting treatment)				I	C
	Endometrial				I	C
	Ovarian				I	C
Breast disease	Undiagnosed mass	**	**	**		
	Current cancer					
	Past w/ no evidence of current disease for 5 yrs					
Uterine distortion due to fibroids or anatomical abnormalities						
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I	C
	Vaginitis					
	Current pelvic inflammatory disease (PID)				I	C
	Other STIs (excluding HIV/hepatitis)					
	Increased risk of STIs					
	Very high individual risk of exposure to STIs				I	C
Pelvic tuberculosis					I	C
Diabetes	Nephropathy/retinopathy/neuropathy					
	Diabetes 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)				I	C
	Improved to Stage 1 or 2 on ARV therapy					
	Not improved on ARV therapy	See iii.		See iii.	I	C
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.

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.

Annex J: Sexual and reproductive Health Rights

In 2016, the Committee on Economic, Social and Cultural Rights, UN Economic and Social Council has articulated the right to Sexual and Reproductive Health, as articulated in General Comment No. 22. These rights include:

1. The Right to Life; Liberty and Security of the Person;
2. The Right to Equality, and to be Free from all Forms of Discrimination;
3. The Right to Privacy;
4. The Right to Freedom of Thought;
5. The Right to Information and Education;
6. The Right to Choose Whether or Not to Marry and to Found and Plan a Family;
7. The Right to Decide Whether or When to Have Children;
8. The Right to Health Care and Health Protection;
9. The Right to the Benefits of Scientific Progress;
10. The Right to Freedom of Assembly and Political Participation; and
11. The Right to be Free from Torture and Ill Treatment.

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