NATIONAL GUIDELINE FOR FAMILY PLANNING SERVICES IN ETHIOPIA

Federal Democratic Republic of Ethiopia

Ministry of Health

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Forward

We are only a few years behind the year 2015, the time by which 189 nations, including Ethiopia, pledged to achieve the eight Millennium Development Goals (MDGs). The Federal Government has undertaken several developmental measures towards the achievement of these goals, of which the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) is notable.

To this end, the Federal Ministry of Health has developed and launched the 20-year rolling Health Sector Development Program (HSDP) which has currently reached its fourth stage – HSDP IV- with prime priorities being Maternal Health, Neonatal and Child Health, HIV/AIDS, TB, and Malaria.

With the implementation of the Civil Service Reform Program considerable achievement has been gained in transforming customer-based care throughout the health system. Moreover, review of the implementation of HSDP I, II, and III has indicated that substantial progress has been achieved in the implementation of primary health care through the expansion of the Health Extension Program (HEP), and capacity building in human resource and health care facilities. However, there still is concern on the progress for MDG 5 – improving maternal health – including family planning service coverage.

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

This Guideline is developed with the objective of transforming an enabling environment for the implementation of HSDP IV and the subsequent attainment of MDG 5. I believe this guideline, along with a standardized training manual and the revised RH Strategy, will gear the implementation of HSDP IV towards the fulfillment of the MDG milestone. To this end it is imperative that GO/NGOs, CSOs, the private sector and the social market make concerted effort in availing the necessary commodities and services.

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

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante natal Care
ART	Anti Retroviral Therapy
BCC	Behavioral Change Communication
BCG	Bacillus Calmette-Guerin
BPR	Business Process Reengineering
BTL	Bilateral Tubal Ligation
CAC	Comprehensive Abortion Care
CEDAW	Convention on Elimination of all forms of Discrimination against Women
CPR	Contraceptive Prevalence Rate
CYP	Couple Year Protection
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertusis, Tetanus
EPI	Expanded Program on Immunization
FGAE	Family Guidance Association of Ethiopia
FLE	Family Life Education
FMOH	Federal Ministry of Health
FP	Family Planning
GBV	Gender Based Violence
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Service Development Program
HTP	Harmful Traditional Practices
IBP	Implementing Best Practices
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive devise
LAM	Lactation Amenorrhea Method
MDG	Millennium Development Goal
MDG5	Millennium Development Goal 5

NGO	Non Governmental Organizations
PHCU	Primary Health Care Unit
PLWH	People Living With HIV
RH	Reproductive Health
RHB	Regional Health Bureau
ROC	Reproductive Organ Cancers
SDM	Standard Days Method
STD	Sexually Transmited Disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UN	United Nations
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WoHO	Woreda Health Office

Contents

1. Background

1.1. Health, Population (demographics) and development

1.1.1. Population

The total population of Ethiopia is nearly 79.5 million of which 83.8% live in rural areas and 16.2% is urban. Females and males constitute 49.5% and 50.5% of the total population. Ethiopia's population is young with an average age of 17 years. The population density is 67.9/km^2 (**Census Report 2007**).

Life expectancy at birth for females and males is 55.4 years and 53.4 years, respectively **(Health indicators 2009, MoH)**. Average household size is 4.7 with urban population having a lesser household size at 3.9 compared with 4.9 in the rural population (**DHS 2005**). The dependent population accounts to 52.8% of the total population (**Census Report 2007**).

Women aged 15 – 49 years constitute 23.4% of the total population. Underfive children account to 12.2% of the population, and 42.6% of the total population is under 15 years of age. Adolescents aged 10 – 19 years, young people aged 15 – 24 years and youth 10 – 24 years of age make up 26.0%, 20.6% and 34.7% of the total population, respectively (**Census Report 2007**).

Infant and underfive mortality is showing a decreasing trend. Infant mortality rate is 77/1000 infants and child mortality rate is 50/1000 children giving an under five mortality rate of 123/1000 children. With a crude birth rate of 35.7/1000 and a crude death rate of 13.2/1000 population per year the rate of natural increase is 2.6% every year **(DHS 2000, DHS 2005, Health indicators 2009, MoH)**.

The Per-capita income is **330 USD (World Bank 2010)**. With a decrease in fertility there is a period where the productive segment of the population is expected to increase with proportional economic growth. This phenomenon called 'demographic bonus' is likely to

occur in Ethiopia in the near future through a well organized family planning programs and services.

1.1.2. Health

The potential health service coverage is 90%. Health service utilization is 0.3% (**Health indicators 2009, MoH)**. The health service delivery follows a three tier system. The primary health care unit with one health center and five satellite health posts serve 25,000 people. The district hospital with four referring health centers serves 100,000 people. Zonal hospitals and regional referral hospitals provide health care for 1 million and 5 million people, respectively. The cadres of health care providers range from health extension workers that carry out their duties at the community and health post level to medical specialists.

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

Total fertility rate is 5.4 children/woman. Contraceptive acceptance rate is 56.2%. The contraceptive prevalence rate in married women is 13.9% **(DHS 2005, Health indicators 2009, MoH)**. Antenatal care attendance, institutional delivery rate and postpartum care coverage though improving is still low at 67.7%, 18.4% and 34.3%, respectively. Child pentavalent3 and measles immunization coverage for under one year old children is 81.6% and 76.6% (**Health indicators 2009, MoH**).

Adult HIV prevalence is 2.4% with a higher prevalence in women 2.6 % compared to 1.7% in men. In 2008/9, the number of people that ever accessed ART has reached 152,472 (**Health indicators 2009, MoH)**.

1.2. Historical Background and progress of FP programs in Ethiopia

Modern FP services in Ethiopia is pioneered by The Family Guidance Association of Ethiopia, FGAE, that was established in 1966. FGAE's only family planning **s**ervices were provided from a single-room clinic run by one nurse. FGAE's program activities and services are gradually spread all over the country with a network of 8 branches, 18 clinics, 26 youth centers, 740 community-based reproductive health service outlets, 242 outreach sites, 6 marketplace and 8 workplace sites. The Ministry of Health also provided MCH/FP services in health facilities. Since 1980, The Ministry further expanded its FP services with cyclic country support programs by UNFPA and other stakeholders.

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

In 1996, The Ministry of Health released 'Guidelines for FP services in Ethiopia' to guide stakeholders as well as expand and ensure quality FP services. In this guideline, the ministry designed new outlets for FP services in addition to the pre-existing facility based and outreach FP services. Moreover, integration and linkage of FP services with other RH services has been emphasized in other policy and strategic documents to enhance FP utilization.

Knowledge of FP has increased to 87% in currently married women. However, FP use is still trailing at 14.7% in 2005 though a recent survey with representative samples from the four populous regions demonstrated the CPR to have reached 32% (**Baseline survey, L10K 2009**). This can, in most part, be attributed to The Ministry of Health's new health extension program, HEP, to increase the gateway of preventive and promotive health services that include FP services at the community and household level.

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

1.3. Current RH status of the Ethiopian Population

1.3.1. Status of women in Ethiopia-socio economic, gender perspectives

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

Women's status in the community is low. The family system is patriarchal with dominance of male and the elderly. Gender discrimination starts from birth. Decision making from the household is dominated by males. Women education delays marriage and first birth, increases FP use, improves communication with partner and advance women's status in the community. Although girls' enrollment in school has significantly increased there still is a difference in favor of males. Besides, continuation of schooling is disproportionately limited for girls than boys. Moreover, women employment is lower for females. In addition, exposure to the media though generally low is better in males.

Knowledge of FP and HIV is better in males compared to females. Knowledge of all women about any method of contraceptive is 86.1%, compared to 91% in all men. The average number of contraceptive methods known is 2.7 for females compared to 3.6 methods in men. Burden of FP is more in females. Male dependent/dominated contraceptive methods account only to 1.1% of the 13.9% CPR in married women. This disproportionate burden is despite better knowledge of methods about male dependent methods.

Early marriage is prevalent in Ethiopia. Among women aged 25-29 year at the time of the 2005 survey, 61.7% were married by 18 years of age. In addition, 12.7% of 15-19 year olds were already married by 15 years of age. Of adolescents aged 15-19 years,

20.4% have had a live birth by 18 years of age. Nearly half, 46.1% of women aged 20 – 24 years in 2005 gave birth before they were 20 years old **(DHS 2005)**. However, the legal age of marriage in the country is 18 years.

Because of the low status of women, abduction, rape, and other biological and traditional reasons adult prevalence of HIV is twice higher in women at 1.9% compared to 0.9% in men. Nearly 90% of women compared to 96.6% of men have heard about AIDS. Similarly, knowledge of prevention of HIV transmission is high among men than women **(DHS 2005)**.

HTPs are prevalent in Ethiopia. Nearly three-quarters, 74.3% of women were victims of Female Genital Cutting, FGC. Approval of the continuation of FGC practice declined from 59.7% in 2000 to 31.4% in 2005. This is despite a constitutional right (Art. 16) of protection from bodily harm. Physical violence by intimate partner is reported in 49% of women. Wife beating is justified by 81% of women. Nearly 8% of women were married by abduction **(DHS 2005)**. Furthermore, in some areas sexual violence by intimate partner is reported by 59% of women (**WHO 2005**). One in five ever–widowed women is dispossessed of property **(DHS 2005)**.

There is a need to change women's status in the community. Recognizing the low status of women, The Government has passed constitutional rights, laws, directives and strategies to empower women. However, realizing these rights calls for collective actions from all stakeholders.

1.4. Maternal Mortality and Morbidity

Death of a mother is a tragic loss not only to the family but also to the community and the country at large. Mothers are the productive segment of the population. Chance of child survival and pursuing education is limited if the mother is dead. In Ethiopia, the maternal mortality ratio has drop from 1,068/100,000 live birth in 1990 to 871 and to 673/100,000 live births in 2000 and 2005, respectively. A recent estimate by WHO shows the maternal mortality has dropped to 470/100,000 live births (**DHS 2000, DHS 2005, WHO 2010**). On the other hand, the maternal mortality rate was 1.34/1000 reproductively active women. Maternal deaths accounted to 21% of all deaths to women aged 15-49 years **(DHS 2005)**.

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

1.5. Trends in TFR and CPR Ethiopia

Ethiopia has set its own goals for population articulated in the population policy as a TFR of 4 and CPR of 44% by 2015. The population size has doubled five and half times from 11.5 millions in 1900 to 74 million in 2007. The demographic transitions in Ethiopia is characterized by an initial slow growth at a rate of less than 1.5 % per annum until the 40s which then accelerated between 1955 to 1995 to 3% after which the annual growth rate declined slowly and is currently maintained at 2.6% . The population doubling time currently is estimated to be of 23 years.

The increase in population size is mainly as a result of two very important demographic events the gradual decline in the crude death rate in the last four decade from around 30 /1000 to around 15 deaths / 1000 in 2005; however crude birth rate has been constantly between 40 to 50 /1000 from 1960 to 2000. The total fertility rate for the country has increased from 6 to 7.7 in three decades up to the 90s after which there is a gradual decline in TFR to 5.4 in 2005 based on the EDHS . Although the urban TFR has started declining as early as 1984 and was half of the rural TFR by 2000; the decline in rural TFR has not only been lagging behind but has only dropped by one child in a decade. There is also more reliance on short term methods for contraception rather than long-term and permanent ones.

In conclusion, the TFR is still high, implying further rapid population growth in the years ahead which requires quite a streamlined activity to increase the CPR of the country and also avail a method mix with emphasis on long tem and permanent family planning method.

2. Policy Environment

The Ethiopian Government is a signatory to several International Conventions/Charters and declarations including those arising from the 1987 Safe Motherhood Conference in Nairobi; the 1990 World Summit for Children; the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference for Women. Ethiopia is also one of the signatories of the Convention on Elimination of all forms of Discrimination against Women (CEDAW) and the Millennium Declaration.

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

The constitution of Ethiopia in article 35 clearly states "…Women shall have equal right with men, laws costumes and practices that oppress or cause bodily or mental harm to women are prohibited… To prevent harm arising from pregnancy and child birth and in order to safe guard the health, women have the right of access to family planning information education and capacity."

The National Health Policy: *states its main objective as* "to give a comprehensive and integrated primary health care in a decentralized and equitable fashion". 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 mother and child health deserves due consideration. The National Health Policy emphasizes inter-sectoral collaboration, particularly with regards to family health and population planning.

The National Population Policy: The overall objective of the population policy is to harmonize the rate of population growth with economic development and thereby improve the welfare of the people. Within the context of current development strategies

in Ethiopia, all the eight set targets set in population policy are directly or indirectly focus on family planning, of which two are most applicable to this document: Reducing the current total fertility rate to approximately 4.0 by the year 2015; and increase the prevalence of contraceptive use to 44.0% by the year 2015.

Rolling 20-year Health Sector Development Plan (HSDP): The Ethiopian Health Sector Development Program (HSDP) is a 20-year effort to achieve universal access to essential primary health care services by 2017. Designed to serve as a framework for technical and financial support to the health sector, the program is aimed at providing and extending access to primary health care services, enhancing the quality of such services, and for improving health sector management. It is part of the government's 20 years investment program, and its overall objective is to improve the health status of the population, resulting in; productivity of the population; decreasing of household expenditure on health, increasing opportunities for productive investment of these resources; and contributing to the alleviation of poverty and support socioeconomic development.

National Reproductive health strategy: The national reproductive health strategy endorsed by federal ministry of health had given due emphasis to family planning. **Under this section, the document** states the goal of family planning as to reduce unwanted pregnancies and enable individuals to achieve their desired family size. To **achieve** this overall objective, the strategy sets the following as action points

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

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

The five year growth and transformation plan of FDRE not only aims to attain a fast economic growth of 14.9% per annum but also ensure the expansion of quality health service and education to attain the millennium development goal and also ensure the benefit of the youth and women through capacity building and good governance

In summary, the constitution, health related policies and strategies in Ethiopia covers all the major grounds and offers all the necessary provisions creating enabling situation for the management of population dynamics in the interest of sustainable development, and family planning program is given due consideration. The BPR and other quality improvement process initiatives being undertaken by government further facilitate the activities to meet the unmet need of family planning.

3. Rationale for Family Planning Services

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

3.1. Health benefits

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

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

Pregnancy and childbirth poses special risk for some groups of women – adolescents, women older than 35 years of age, women with more than four previous births and women with underlying medical diseases. It is estimated that if all these high risk pregnancies are avoided through the use of family planning 25% of maternal deaths can be prevented (**Royston 1989**). Moreover, unwanted pregnancy leads to unsafe abortion with its resultant short term and long term complications that include death. These suffering and deaths from complications of unsafe abortion can be prevented with use of family planning.

Apart from limiting and spacing birth family planning methods have other non contraceptive benefits. If properly and consistently used condom provides protection from sexually transmitted infections including HIV. The Lactational Amenorrhea Method, LAM, provides special nutritional benefits to the infant and protects the infant from infections. In addition, LAM establishes mother-child bonding early in life that continues through later life. It also reduces the risk of breast cancer in the mother.

3.2. Social and economic benefits

Individual: Pregnancy and childbirth poses a risk to the life of the woman. Repeated pregnancies and childbirth restrict women from education, employment and productivity resulting in poor status of women in the community with the resultant poor living standard. Family planning helps women to pursue their education for a better employment opportunities and payment.

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

Community: Increase in population size leads to increased man/land ratio reduced production and income with consequent urban migration. Furthermore, increase in population size results in poor social services, poor education, compromised women empowerment, increased non-productive segment of the population, deforestation, and over consumption of resources that aggravates poverty.

Global: Uncontrolled population growth intensifies famine, war and migration which are collectively termed ‘demographic entrapment’. Moreover, deforestation, erosion and resource depletion and global warming are consequences of population explosion.

All these individual, family, community and global effects of uncontrolled population growth can be minimized through strong FP programs and services that respect the rights and informed decisions of women and men. FP is one of the most powerful health interventions to achieve MDGs.

3.3 Meeting individual/couples fertility benefits

Meeting individual fertility needs promotes women's right to whether to be pregnant, when to be pregnant. Furthermore, meeting individual fertility needs is essential to attain sexual and reproductive health and rights of women. Besides, meeting fertility needs is one of the tools to empower women and attain the MDGs.

4. Goals and Objectives of the Family Planning Guideline

4.1. The Need for a Family Planning Policy Guide

The Government of The Federal Democratic Republic of Ethiopia has committed itself to the achievement of the eight Millennium Development Goals, MDGs, agreed by 189 United Nations' member countries at the Millennium Summit in 2000. MDG-5 addresses improvement in maternal health. The targets of MDG-5 are reducing maternal mortality by 75% and universal access to reproductive health services by the year 2015. Beyond the MDG, the government strongly believes that family planning is one of the strategies to improve maternal health and bring about development. Hence,

Cognizant of the need to coordinated FP Programs and services in the country to ensure standardized, high quality, client-centered all reaching FP services that recognizes the various level of care from the primary health care unit to the central referral hospitals,

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

Recognizing the ever developing FP program approaches including health extension program, method-mix and development of the medical eligibility criteria for FP use,

Understanding the importance and relevance of integration of FP services with other RH services, IEC/BCC activities, FP commodity supply chain management,

Health management information system, coordinated partnership in FP programs and services,

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

Mindful of the significance of FP programs and services in the overall socio-economic development of the country,

The Federal Ministry of Health of Ethiopia has developed this Family Planning Guideline. The guideline is developed with close consideration and reference of The Constitution, relevant policies, strategies, guidelines, legal documents, scientific evidences as well as international treaties, declarations, conventions and covenants.

4.2. Commitment of FMoH:

The commitment of the Ministry of Health is reflected both in the achievements obtained so far and the strategic plan of the future. There is a gradual increase in CPR, utilization of antenatal care, skilled birth attendant and postpartum care. Moreover, there is a decrease in the number of maternal deaths. The first of the four major areas in strategic objective I of HSDP IV is to improve the health of mothers, neonates, children, adolescent and youth. In this relation, reducing maternal mortality ratio to 267/100,000 and increasing skilled birth attendant to 60% and the CPR to 65% by 2015 are bold targets set by HSDP IV,

One strategy to achieve MDG5 and the objectives of HSDP IV is expanding quality FP services. Collective activities by the government and other stakeholders contributed to the increase in CPR from about 3% in 1970s to 13.9% in 2005 and to 32% in 2009. The Ministry affirms that this leadership and collaboration will be strengthened more to achieve the HSDP IV targets that are in line with the MDGs.

4.3. Objectives of the Family Planning Guideline

This FP guideline is developed to fulfill the following objectives:

- Guide FP programmers and implementers at government, non-government, bilateral and multilateral organizations, private sector as well as charity and civic institutions
- Be a guide to all cadres of health care providers directly or indirectly involved in the provision of FP services including pre-service and in-service training
- Set standards for FP programs and services
- Standardize various components of FP services at all levels
- Expand and improve quality of FP services to be offered
- Direct integration of FP services with other RH services, and
- Be used as a general directive and management tool.

4.4. Users of the Family Planning Guideline

The users of this guideline are:

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

5. FAMILY PLANNING SERVICES

5.1 Definition of FP

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

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

5.2 Service Eligibility

Any reproductive age person, male or female regardless marital status is eligible for Family Planning services including information, education and counseling .

5.3 Range of Services to be offered In Family Planning Services

The following services shall be offered at each level of the health system

- Counseling
- Provision of contraceptives
- At levels above a health post Screening for reproductive organ cancers
- Prevention, screening and management for sexually transmitted infections including HIV
- Prevention and management of infertility

5.3.1 **Counseling**

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

5.3.2 Provision of Contraceptives

The contraceptive mix in Ethiopia will consist of the following commodities and methods:
Natural Family Planning Methods,

- Abstinence
- Fertility awareness based methods: Standard Days Method (SDM),Rhythm(Calendar) Method, two-days method, Cervical mucus (Billings ovulation) method, Sympto-thermal method
- Lactation amenorrhea method (LAM),
- Withdrawal method

Modern Family Planning Methods

- Male and Female Condoms/Diaphragms and other barrier methods
- Vaginal Contraceptive Foam Tablet and jellies
- Emergency Contraceptives
- Progestin-Only Pills
- Combined Oral Contraceptives
- Injectables contraceptives
- Implants
- Intra-Uterine Contraceptive Devices
- Bilateral tubal ligation

- Vasectomy

To avoid inconvenience of clients, a family planning practicing health worker could prescribe 13 cycles of pills at a visit as the case may be. Similarly 48 pieces of condoms to be used for 3 months could be prescribed for a client at one visits, and the client should be informed that he/she can come for more if these run out before appointment day.

While respecting clients rights and supporting informed decision making as well as ensuring method-mix is central to quality FP service, the FP program should focus on highly effective contraceptive methods with particular emphasis on long-term methods. Dual use should be strongly recommended to all clients..

5.3.3 Screening for Reproductive Organ Cancers (ROC)

Family Planning offers a unique opportunity to screen and teach the client to do self-examination for some of the ROC cancers. Health workers should teach all clients to regularly do self-breast examination. Where facilities exist, women should be encouraged to have annual Pap smear or have visual inspection of the cervix using acetoacetic acid or lugol's solutions (VIA/VILI) at health centers level. Community heath worker shall educate women and their families about ROCs and the benefits of screening

5.3.4 Education On, Screening and Treatment of Sexually Transmitted Diseases

All clients should be given information on sexually transmitted infections including HIV. The diseases should be described clearly using local terms where they exist. Clients should be informed about the symptoms, methods of prevention, treatability and in the event of suspected diseases, where clients can obtain examination and treatment.
If a client is found to have an STI, it should be managed according to the national guideline for the management of STI using the syndromic approach.

5.3.5 Prevention and Management of Infertility

Management of infertility is expensive, requires sophisticated services. More than 80% of female infertility is due to infections. The role of Family Planning is mainly in STI prevention, by promotion of responsible sex behavior, use of condoms, screening and treatment, counseling, referral and services where indicated.

5.3.6 Integration of FP and other RH services

Integration should be considered at all levels of health care delivery system. Integration of FP with other RH service delivery is cost effective and enables maximum utilization of health care services in one visit.

5.3.6.1. HIV Counseling and Testing (HCT)

HCT services can be good entry points to FP services and vice versa. Both HIV and unwanted pregnancy are consequences of unprotected sex. Hence, clients attending HCT clinics and clients seeking FP services are sexually active people. Integrating HCT and FP service delivery is cost effective and enables maximum utilization of health care in one visit. Knowledge and skill of counseling prevails in health care workers that provide services for PLWHA and FP clients. With minimum input both types of providers can provide service to clients seeking HCT and FP services at one stop.

The HIV/AIDS Policy and Guidelines for Voluntary Counseling and Testing for HIV, PMTCT, and antiretroviral and opportunistic infections treatment in Ethiopia recommend that basic FP information and services should be incorporated into the services for all clients regardless of their HIV serostatus. The feasibility and success of integration of FP services with HIV/AIDS care and support has been demonstrated in the country.

5.3.6.2 Education, screening and treatment of STI

Because of the disturbance and unpleasant manifestations of STIs, people tend to seek treatment for STIs promptly. In such patients as unprotected sex is the culprit of the STIs the need for FP is evident. Health care providers that use the syndromic approach in the management of STIs should educate and counsel clients about high risk behavior

and promote condom use and dual use of FP. Partner notification and treatment in syndromic management of STIs creates an opportunity for male involvement in FP.

5.3.6.3. CAC, ANC, delivery care, postpartum care

A woman seeks abortion or postabortion care largely because of unwanted pregnancy. One of the elements of comprehensive abortion and postabortion care is provision of FP counseling and services based on free and informed choice. Abortion and post abortion care can be the first encounter of a woman with the health system. So, this opportunity shall be utilized to counsel and provide FP services. The Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia recommends a woman should be provided with the choice of contraception immediately after abortion. If a woman comes for a repeat abortion, then, the health system has failed in preventing unwanted pregnancy.

FP counseling should be part of focused ANC services. Though institutional delivery and postpartum care is less than 10% of all deliveries, it is imperative that all women who give birth at health facilities should be counseled on FP and informed about the availability of FP services.

5.3.6.4. Child health, immunization and other RH services

Child health and immunization services create a good opportunity for provision of FP information and counseling. Furthermore, programs that address HTPs, GBV, prevention and management of infertility, screening for gynecological malignancies, family life education, FLE, and other RH services create opportunity for family planning services. Hence, these services shall be utilized to address issues related to FP.

5.3.6.5 Family life education

family life education helps prepare young people for the transition to adulthood. In-school programs can result in positive behavior changes.

6. Family Planning Service Strategies

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

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

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

6.1 Family planning services by level of care

The provision of family planning 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, Family Planning counseling and service should be made available to post-partum, postabortion women, individuals with special needs.

All health workers providing Family Planning services should have Contraceptive Clinical and Counseling skills.

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

Table 1 organization of services by level of care

Level of Facility	Type of health personnel available	Family planning services
Health posts	Health Extension Workers	• The above activities plus • Counseling on FP and other SRH issues • Counsel on natural family planning methods • Provide injectables • Implanon insertion and removal • Refer to health center for other long acting and permanent methods of contraception • Planning based on local data
Health Centers	General Medical Practitioners (GMPs) and/or , Health Officers (HOs) Midwives, Clinical Nurses, Public Health Nurses, Laboratory Technicians	The above activities plus, • General physical and pelvic examination including VIA/VILI • Provide implant insertion and removal • Provide IUCD insertion and removal • Where a trained GP/HO is available provide Tubal ligation and Vasectomy • Manage complications and side effects • Provide syndromic management of STIs • Provide HIV testing and counseling including care • Training of Community level workers and junior health professionals in Family planning • Monitoring and facilitative supervision
District/Zonal Hospitals	Obstetrician and Gynecologist and/or General Medical Practitioners (GMPs), Health Officers (HOs) Midwives, Clinical Nurses, Public Health Nurses, Laboratory Technicians	The above activities plus: • Provide permanent method of contraception • Receive referral • Manage complications and side effects • Work-up for infertility
Referral hospitals	Obstetrician and Gynecologist , General Medical Practitioners (GMPs), Health Officers (HOs) Midwives, Clinical Nurses, Public Health Nurses, Laboratory Technicians	The above activities plus: • Management of infertility • Management of complicated STIs • Manage complications and side effects of contraceptive methods • Management of reproductive organ cancers • Research

Table 2 Service organization of private, NGO, Higher learning institutions and work based facilities by level of care

Level of facility	***Type of health personnel available (minimum)***	***Family Planning services***
1. Small clinic	-Clinical or General Nurse(Diploma)= 1 -Clinical nurse= 1 -Lab. Technician= 1**+**	**-**Counsel on FP and SRH **-**Distribute male and female condoms and oral contraceptive methods, including ECP, Injectables **-**Provide implant and IUCD insertion and removal*
2. Medium clinic	-Health Officer/GP= 1 -Clinical Nurse= 1 -Lab. Tech.= 1**+**	The above plus tubal ligation and vasectomy*
3. Higher clinic	-Specialist/GP (Head)= 1 -Specialist/GP= 1 -Nurse= 1 -X-ray tech.= 1**+**	-The above plus management of complications and side effects
4. Gyn/Obs Specialized clinic	-Gyn/Obs specialist= 1**+** -X-ray tech= 1 -Lab.tech= 1 Midwife/Nurse= 1	- All methods of FP services.
5. General and Specialized Hospital (MCH)	Variable type and number of professionals (including specialists)	-All methods of FP services

Table 3 Task analysis for provision of Family Planning

Task	Provider's category				
	Obstetrician and Gynecologist	GMPs	BSC(Health Officers, Nurse, Midwives)	Midwives clinical Nurse at diploma level	Health extension worker
Client assessment					
• History taking	✓	✓	✓	✓	✓
• Physical examination	✓	✓	✓	✓	X
• Bimanual pelvic exam	✓	✓	✓	✓	X
• MEC	✓	✓	✓	✓	✓
Counseling	+	+	✓	✓	✓
Provision of Family planning services by method					
• Natural methods	✓	✓	✓	✓	✓
• Condoms	✓	✓	✓	✓	✓
• Pills	✓	✓	✓	✓	✓
• Emergency Contraceptives	✓	✓	✓	✓	✓
• Injectables	✓	✓	✓	✓	✓
• Implanon	✓	✓	✓	✓	✓
• Other Implants	✓	✓	✓	✓	X
• IUCD	✓	✓	✓	✓	X
• BTL	✓	✓*	✓*	X	X
• Vasectomy	✓	✓*	✓*	X	X
Other RH services					
• Syndromic management of STI	✓	✓	✓	✓	X
• Management of complicated STI	✓	✓	✓	X	X
• Cancer screening	✓	✓	✓	✓	X
• Treatment of ROC	✓	X	X	X	X
• Management of infertility	✓	X	X	X	X
Pain Medications					
• Non-narcotic Analgesics	✓	✓	✓	✓	✓
• Narcotic analgesics	✓	✓	✓	X	X
• Local anesthesia	✓	✓	✓	✓	✓
Management of complications and side effects	✓	✓	✓	✓	✓^
Follow up care	✓	✓	✓	✓	✓
Universal precautions	✓	✓	✓	✓	✓
Integration of FP and other RH services	✓	✓	✓	✓	✓
Instrument processing	✓	✓	✓	✓	✓
IEC/BCC	✓	✓	✓	✓	✓
Recording and reporting	✓	✓	✓	✓	✓
Training junior health professionals and community health workers	✓	✓	✓	✓	✓

Key;

- ✓ = Roles expected to be performed by the category
- ✓ *= Roles expected to be performed by the category after additional in service training
- ✓^ = Reassurance and analgesics for mild side effects and refer
- X = Roles not expected of the category
- + = May initiate and/or partly perform the task

6.2 Outreach

Out-reach: When a health center staff arranges on its own a service provision program at the health posts or kebele under its catchment. The program is regular and happens at fixed date, e.g., every month or quarterly.

Mobile Out-Reach: When the health center staff are accompanied by staff from hospitals to provide long acting and permanent method at health post or health center level. The program is not regular and need based.

One of the reasons for low utilization of long acting and permanent family planning methods is difficult geographic access, or unavailability of the service at the near by health service outlet. Hence, the out reach or mobile out reach program is meant to cover those households where the distance from nearest health center is a limiting factor. Outreach services should include Family Planning IEC, counseling and services integrated with other Maternal/Child Health activities including EPI.

6.3 Social Marketing

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

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

6.4 Work place based

Family planning services at work place has the benefit of accessing an easy to reach, known population of workers. It potentially saves time of employee, minimizes lost productivity and has a benefit for reaching more male target.

Ministries, which have health facilities e.g. trade and Industry, Agriculture, Energy and mines, Transport and Communications including factories are encouraged to run Family Planning services. Facilities at work places are registered by FMOH and function based on the staffing and facility type.

6.5 School based

Family planning services in school settings and institution of higher learning has the benefit of accessing an easy to reach, known population of the young and adolescents . the centers not only provides objective information on sexuality and responsible sexual behaviors but also can offer opportunities for HIV testing , STI prevention and early management and family planning services .

6.6 Role of NGO/Private Sector in FP Programme

The Federal Ministry of Health recognizes the important role and contribution of NGO and the private sector to Health. HSDP III recognizes the proactive involvement of NGOs and the private sector "... significantly complement the public's sector capacity to tackling public health problem". Non Governmental Organizations will partner with FMOH and shall continue to take part in FP programmes as depicted on the harmonization manual of the HSDP.

7. Services for clients with special needs

7.1 Adolescents and youth

'*Limited knowledge of sexual physiology, early marriage, limited use of contraceptives, limited access to reproductive health information, and girl's limited agency over her sex lives all contribute to the high rate of unwanted pregnancy.*' National Adolescent and Youth Reproductive Health Strategy.

Less than 10% of married girls aged 15 – 19 years use any modern method of family planning. Almost a third, 31.1%, of adolescents experienced unwanted or mistimed live birth indicating limited access to or less friendly FP services (**DHS 2005**).

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

- FP services need to be youth-friendly, i.e.,.
    - Friendly procedures to facilitate easy and confidential registration, short waiting time, swift referral, consultation with or without appointment
    - Providers should be competent, with good communication skills, motivated and supportive, informative and responding to questions and concerns
    - Offer privacy and maintain confidentiality, conveniently located with convenient working hours
    - Involve adolescents in planning and service delivery
    - Have comprehensive service package and ways of increasing access with outreach and peer-to-peer services
    - Have evidence-based guideline and services with a MIS
    - The minimum service standard for AYRH should be observed

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

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

7.2 PLWH

Dual protection is critical in reducing transmission of STIs and HIV. For PLWH dual use helps to prevent transmission of the virus to uninfected partner. In addition, dual use helps the PLWH to prevent acquisition of other strains of HIV that could be drug resistant. For the HIV negative client, it prevents the sexual transmission of HIV and other STIs from an infected partner.

Fertility intentions of PLWH are varied. The Guidelines for Prevention of Mother-to-Child Transmission in Ethiopia recommends respect to the right of all women to decide the number and timing of children regardless of HIV status. Avoiding

unwanted pregnancy in HIV positive women using FP is one of the four prongs of preventing mother-to-child transmission of HIV.

Antiretroviral treatment service is widely available in the country. The service provides opportunity to discuss FP and other RH matters. PLWH regardless of use of ART can start and continue to use most contraceptive methods safely. Considering these realities:

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

7.3 Survivors of Sexual Violence

Sexual violence is a public health problem and a violation of human rights. Sexual violence is associated with numerous physical, psychological and emotional consequences. Unwanted pregnancy is one of the complications of sexual violence. Hence, emergency contraception shall be provided for all victims of completed rape who are at risk of pregnancy.

Emergency contraceptive pills and IUCD are the two recommended types of emergency contraception. Whenever pre-packaged emergency contraceptive pills are not available oral contraceptives can be substituted. There are no known medical conditions for which emergency contraceptive pills use is contraindicated. Considering these facts:

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

7.4 Persons with disability including Mental disability

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

- Counseling and informed decision should involve parents, or next of kin, or guardian depending on the degree of the mental disability. In the absence of these care takers the provider, in the best interest of the client with serious mental disability, decides on method choice.
- Some drugs that are used for treatment of mental disorders affect bioavailability and efficacy of hormonal contraceptives. Hence, alternative methods of contraception should be considered.
- As much as possible methods that do not seriously demand user compliance (e.g., injectables, IUCD, Implants, Surgical methods) shall be encouraged to ensure efficacy.

8. Advocacy , communication and social mobilization for family planning

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

Behavioral change communication is the process of educating, persuading and disseminating information to people to positively influence their behavioral pattern and enable them to take actions that will enhance their reproductive health status.

The aims of the IEC /BCC in family planning are

- To increase awareness and use of family planning /child spacing methods and other relevant reproductive health services
- Promote client-provider interaction

8.1. Communication channels

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

The target group shall include:

- Policy makers
- Health care providers
- Opinion leaders, religious bodies
- Women
- Men
- Adolescents and youth
- Communities
- Media personnel, partner organizations

8.2. Contents of IEC/BCC Messages and Activities

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

- Benefits to the mother, to the child, to the family, to the community and to the world, Where services are available,
- Characteristics of methods
- Client's rights: information, access to quality service, choice, safety, privacy, confidentiality, dignity, comfort, continuity, opinion
- Related SRH issues – STDs/HIV, pregnancy, parenthood, reproductive organ cancers, infertility
- Dispelling rumors and misconceptions

8.3. Media and opportunities for IEC/BCC

All available channels and outlets shall be used to ensure coordinated IEC/BCC messages and activities reach the population. The channel of choice for IEC/BCC activities should be based on the target audience and the local availability and acceptability of the channel.

- Newspapers, Magazines
- Radio, Television ,sonic screens
- Leaflets, Brochures, Posters
- Banners, Billboards
- Schools
- Market places
- Home visits
- Youth and anti HIV/AIDS clubs
- Work places
- Kebele, Community meetings
- Cultural festivals
- Panel discussions, debates
- Demonstrations, Drama, Songs
- Cinemas, theatre
- Internet

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

8.4. Male involvement

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

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

- Improve communication between couples regarding fertility and FP that would reflect the needs and desires of both men and women
- FP services should address the specific needs of men and shall be made men-friendly.
- Males shall be provided with information that enable them to responsibly participate in FP use and decision making.
- Males shall be encouraged to accompany their partners in FP visits.
- Men shall be encouraged and helped to develop responsible adulthood and parenthood and play an important role in preventing unwanted pregnancy and STIs. Condom, the most effective method of protection against STIs next to abstinence is a male dependent method. Men's cooperation is essential to stop the spread of STIs including HIV.
- Information on FP, STI/HIV and other RH issues shall be made available to men through various formal and informal channels including places of work and recreation.
- Men shall be involved in the design and implementation of FP and RH services and allowed to express ways in which they can be encouraged to take more responsibility.

8.5. Community involvement

The community shall be made aware of the overall benefits and availability of services for FP. FP programs and services including IEC/BCC activities shall respect the customs and traditions of the community. Community involvement is key to dispel rumors and misconceptions, develop ownership of FP programs by the community for successful and sustainable outcome. The following strategies shall be used for the promotion of FP and reproductive health in the community:

- Advocacy
- Community mobilization /involvement
- Promoting family life education
- Strengthening the use of RH data base
- involving religious leader

9. Contraceptive Supplies and Management

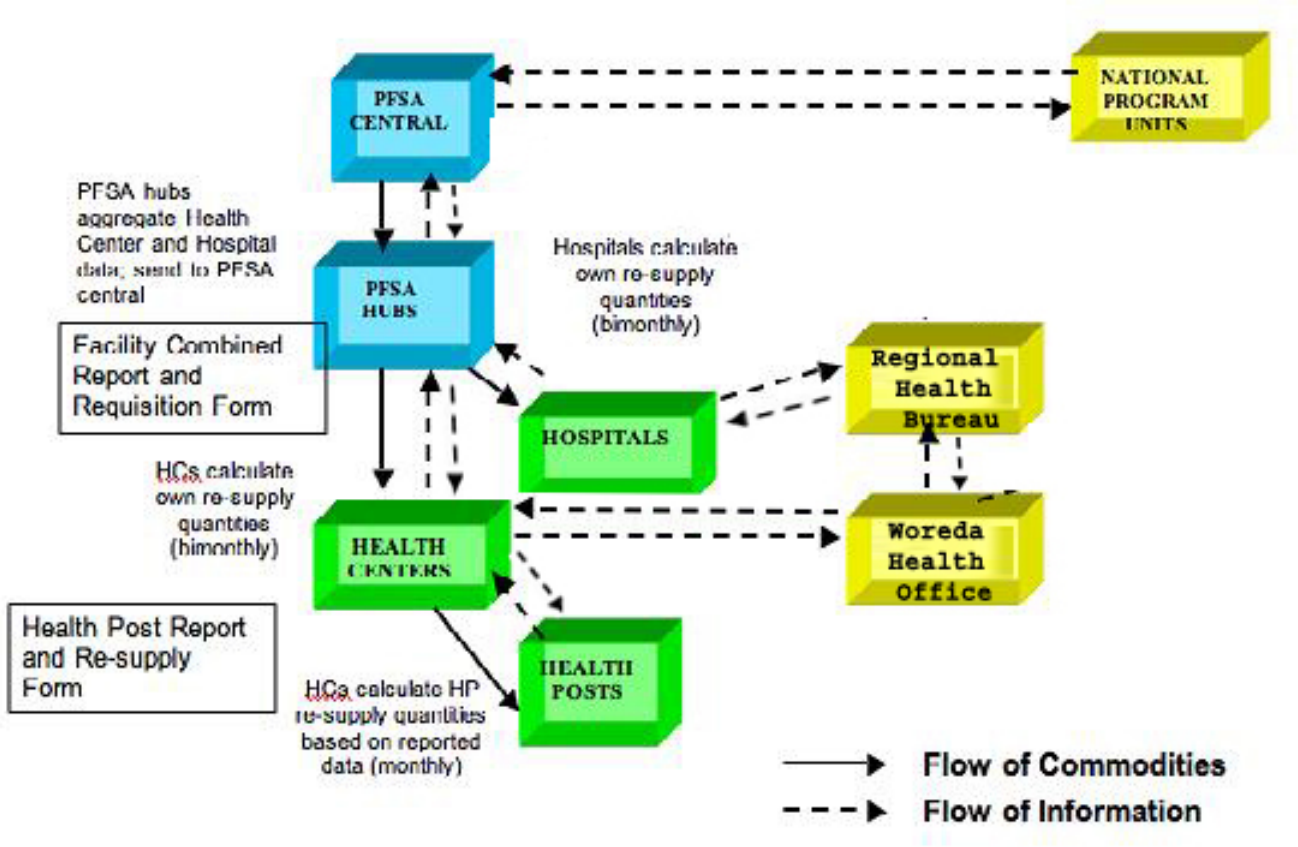
Logistics Management Information System

The new logistics pipeline, which is expected to be functional at the end of 2011, is designed in such a way that logistics information is collected and reported monthly by Health Posts and every other month by Health Centres and Hospitals using LMIS forms to the next higher level. Each month, Health Centres should issue enough stock to bring the Health Posts stock level up to its Maximum of 2 months of contraceptives.

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

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

Figure: Flow of Commodities and Information (Flow of Information not yet finalized)



The Existing Logistics Pipeline

The current pipeline has 5 levels and products flow from the central PFSA down to regions; and from regions to Zones, where they exist, and then to Woredas and finally to SDPs. Information flow follows the same line, but down up.

The facilities send monthly LMIS reports to the woredas. At the woreda level, these reports are compiled and sent to the zones (regions); from the regions, the reports go to the central-level quarterly.

Forecasting

Forecasting is used to estimate the quantities of each product that a program will dispense to users for a specified period of time. It is the only way to ensure that programs order the right amount of each type of contraceptive that clients are likely to use. Forecasting is done at central level where procurement usually takes place and it is often done by logistic and program managers. Having a reliable supply of contraceptives and essential RH commodities available requires accurate forecasting. Thus far, contraceptive forecasts have been prepared by outside consultants by the request of the FMOH. As a result, in-country capacity and experience in contraceptive forecasting is limited.

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

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

Consumption Method (Logistics Forecasting)

Demographic Method (Population-Based forecasting)

Service Statistics Method (Service Data Forecasting)

Procurement

Contraceptive procurement should be done in accordance with the quality, timing and, quantity specifications in the procurement plan. Efficient procurement means that contraceptives are available at the best possible cost to both programs and customers. The government's procurement system must be sufficiently robust and flexible to respond to evolving commodity needs.

PSFA is accountable for procurement of contraceptives and other essential drugs. Thus, besides building its capacity on procurement the agency is working closely with the donors to ensure that the requested quantities are procured and delivered in a timely manner and that the procurement complements the government's and other funding agencies' procurements.

Warehousing and Storage

Storage is a basic part of warehousing. Warehousing and storage, however, are more than just shelving products. It is important to avail storage guidelines and/or posters for proper storage procedures. First-to-expire, first-out (FEFO) and cold chain maintenance for products that require these conditions should be followed. Warehouses should operate according to the standard storage guideline. Physical inventory should be practiced at least every year.

Transport and Distribution

A system of regular deliveries to health facilities is proposed by PFSA. Health Facilities will be grouped on efficient delivery routes. Each route will be scheduled to commence at the same time in each delivery period so that the health facilities will submit their re-supply request for the delivery of their commodities.

Inventory Control Procedures

A combination of inventory control systems (push and pull) is in place for reproductive health commodities at the central and regional levels, with a set maximum and minimum inventory control system. Established guidelines for maximum and minimum stock levels are available at all levels for family planning. Contraceptives should be full supply i.e. there should be enough stock at the various levels of the logistics pipeline, and when people order they can expect to get what they order every time or at least almost every time.

Bin Cards and *Stock Record Cards* are used to account for products held in health facilities, including their receipt and issue. Every facility should use the necessary inventory control tools and these tools should always be updated.

Ordering and Reporting

The Logistics Reporting form is used for both requesting products and reporting. At woreda level, the logistics data should be collected, aggregated and sent to Zones and Zones, in turn, should aggregate the received data from all woredas and send to the Regions every two months. The regions are also expected to aggregate logistics data from all zones and report to central level quarterly.

10. Quality of Care in Family planning

Reproductive health programs face increasing pressure to provide quality, customer-oriented services. Both the ongoing health sector reform process in countries worldwide and the comprehensive reproductive health agenda from the 1994 International Conference on Population and Development (ICPD) are pushing many family planning programs to move away from demographic targets and towards an emphasis on the quality of the services they provide to meet their clients' holistic reproductive and other primary health care needs.

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

Quality in health care is often defined as providing client-centered services and meeting clients' needs (Berwick et al., 1990). The Quality Improvement (QI) process is an effort to continuously do things better until they are done right the first time every time. Quality services are those that meet the needs of your clients (or customers) and are provided in a manner consistent with accepted standards and guidelines. The concepts that clients have rights and that staff have needs are internationally accepted as the basis for quality health care.

The Rights of Clients

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

Access to services: Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Clients have the right to access family planning services free of charge at the level of health care where the services has been made available

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

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

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

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

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

The Needs of Health Care Staff

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

Information, training, and development: Health care staff 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.

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

11. HEALTH MANAGEMENT INFORMATION SYSTEM

Family planning records and reports are important tools for strategic planning, supervision and monitoring. The Health Management Information System (HMIS) is put in place as of **2009**. Two commonly used FP records are described in this chapter. The other records as relevant should be added once the HMIS is fully developed.

11.1. Client Card

All clients seeking family planning services need to have client card. The client card records the socio-demographic and health history, physical examination findings and current method of use. The follow up section of the card records the history and physical examination findings at the time of the visit (client card insert copy of client card).

The client card provides information on past and current use of a FP method and method switch (if any).
It is an important tool for monitoring the quality of services as it provides information on whether the client has been screened for eligibility to use the method. It is useful for follow up of clients. When the client cards are organized in a systematic way, it helps to track defaulters.

11.2. Family Planning Register

This register records relevant information of all the clients who got service from a health facility. The family planning register is kept in the family planning room of the facility. Family planning register should be completed by the provider at the time of service provision.
The register includes information on the medical record number, sex, date of visit, counseling services , contraindication for methods, method provided and number of visit , FP method used and the date of last visit (in case of condoms, combined oral contraceptives and injectables). The register:

- Provides information on the contraceptive use in a specified geographical area
- Useful tool for tracking clients, especially defaulters
- Provides information on supplies of contraceptives.

11.3. Referral form

Records of clients referred are obtained from the referral records. The referral record is annexed

11.4. Supplies records

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

11.5. Reports

Family planning reports provide information on the progress of the various indicators that have been identified by the Federal Ministry of Health. The reports shall include complications with use of methods and are important tools for monitoring. The health facility shall compile a monthly report and forward to the woreda health office. A woreda health office shall compile all reports from all facilities in its catchment area monthly and shall submit a report to the zonal health office which in turn will summarize the report every 3 months to Regional Health Bureau. The regional health bureau will compile the total contraceptive acceptor and the LMIS report to FMOH biannually.

11.6. Confidentiality of Records and data use

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

Health Center / Hospital Family Planning Register

Region	Sub-city / Woreda	Health Facility Name	Begin Date	End Date

Family Planning Register

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

Abbreviate type (Column 17) as follows:
__MaC__ - Male Condom; __FeC__ - Female Condom; __OC__ - Oral Contraceptive
__Inj__ - Injectable; __EC__ - Emergency Contraception __Diaph__ - Diaphragm;
__IUCD__ - Intrauterine Contraceptive device __Imp__ - Implant

INSTRUCTIONS FOR FAMILY PLANNING REGISTRATION AT HEALTH CENTER / HOSPITAL

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

Location information to be completed at front of register:

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

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

INSTRUCTIONS FOR FAMILY PLANNING REGISTRATION AT HEALTH CENTER / HOSPITAL

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

Monthly counts for service delivery:

At end of month, add

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

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

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

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

12. Annexes

a. Consent form for voluntary surgical contraception

በፍላጉት የተደ ሕክምና ቤተሰብ ምጣኔ ደንበኞች የሚሞላ መተግመኛ ቅጽ

እኔ ፈርማዙ ከዚህ በታች የሚገኝ ግለሰብ በተደ ሕክምና የእርግዝና መከላከያ ማለት _____ ለማስደረግ ስለፈለግሁ ከዚህ በታች የተዘረዘሩትን ነጥቦች ተረድቼ ተቀብያለሁ::

ይኸውም፣

1ኛ) በቀዶ ሕክምና ከሚደረገው የእርግዝና መከላከያ ሌላ ጊዜያዊ የሆኑ የእርግዝና መከላከያ ዘዴዎችን በመጠቀም የቤተሰቤን ምጣኔ ለማድረግ እንደምችል አውቃለሁ::

2ኛ) ይህ በቀዶ ሕክምና የሚፈጸም የቤተሰብ ምጣኔ ዘዴ ነው:: እንደማንኛውም የቀዶ ሕክምና ስርዐተ ደንብ ስለሚደረግ አንዳንድ መጠነኛ ችግሮች ሊከሰቱ መቻሉን ሀኪሜ ገልጿው ልኖል:: በወሲብ ግንኙነት የሚከተል ችግር የለም:: በወር አበባዙ ላይ ለውጥ አይፈጥርም::

3ኛ) ዘዴው የዘለቂታ መሆኑ ሊታወቅ ይገባል:: ሆኖም ማንኛውም የቀዶሕክምና መቶ በ መቶ ዋስትና ሊያስገኝ አይችልም:: ለጥቂት ደንበኞችም ላይሰራ ይችላል:: የቀዶ ሕክምናው ውጤት ከሰመረ ተጨማሪ ልጆች ሊኖሩኝ አይቻልም::

4ኛ) እኔው በአራሴ ፍላጉት ያለምንም ተጽእኖና ግፊት የተቀበልኩ ስለሆነ በፈለግሁ ጊዜ ሀኪሜን በመለወጥ ድርጊቱን ላለመቀበል እችላለሁ:: ሀኪሜንም በመለወጤ ምክንያት የሕክምና፣ የጤና፣ ሌሎች አገልግሎቶችና ጥቅሞች ላይነኩብኝ መብቴ የተጠበቀ ነው::

_____
የደንበኛው ስምና ተራ ቁጥር

_____ _____
ቀን የደንበኛው ፈርማ/አሻራ

_____
የባል (ሚስት) ስምና መለያ ቁጥር

_____ _____
ቀን የባል ወይም የሚስት አሻራ ወይም ፈርማ ካስፈለገ (ባል ወይም ሚስት ካልሆነ ይገለጽ)

_____ _____
ቀን የሐኪም ወይም ስምንቱ በደንበኛው ተግልጋይ ፈቃደኝነት መፈጸሙን ለማረጋገጥ የተወከለ ባለሙያ

_____
*ለሴት ደንበኞች ብቻ

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b. Referral form

Federal Ministry of health

Referral form

Date _____

Medical record number_____

Referred to _____

Referring Institution _____

Name _____ age _____

sex_____

Address: region _____Woreda _____kebele _____ house number _____

Brief History:

Brief physical examination

Reason for referral _____

Name of the provider _____

Signature of the provider _____

……

Please use the following section for feedback

Referred to _____Referring Institution

_____

Feed back

Signature:

COUPLE YEAR PROTECTION

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

How is CYP calculated?

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

Method	CYP Per Unit
Sterilization (male and female)*	
- Asia	10 CYP
- Latin America	10 CYP
- Africa	8 CYP
- Near East/North Africa	8 CYP
Oral Contraceptives	15 cycles per CYP
Condoms	120 units per CYP
Female Condoms	120 units per CYP
Vaginal Foaming Tablets	120 units per CYP
Depo Provera Injectable	4 doses (ml) per CYP
Noristerat Injectable	6 doses per CYP
Cyclofem Monthly Injectable	13 doses per CYP
Copper-T 380-A IUD	3.5 CYP per IUD inserted
Norplant Implant	3.5 CYP per Implant
Implanon Implant	2.0 CYP per Implant
Jadelle Implant	3.5 CYP per Implant
Emergency Contraceptive Pills	20 doses per CYP
Natural Family Planning (SDM)	2 CYP per trained, confirmed adopter
Lactational Amenorrhea Method (LAM)	4 active users per CYP (or .25 CYP per user)

c. **Counseling guide**

NEW CLIENT: REDI- Family planning Counseling Steps

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

Returning client (WITH PROBLEM)

REDI - Counseling Steps

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

Returning client (SATISFIED)

REDI - Counseling Steps

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

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