



National Guidelines for Conducting Family Planning Outreaches in Uganda

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ACKNOWLEDGEMENTS

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DEFINITION OF TERMS

Client refers to the patient or beneficiary of reproductive health care.

Contraceptive refers to any safe, legal, effective and scientifically proven modern family planning method, device or health product, whether natural or artificial, that prevents pregnancy but does not primarily destroy a fertilized ovum from being implanted in the mother's womb in doses of its approved indication as determined by the National Drug Authority.

Family Planning (FP) refers to a program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have access to a full range of safe, affordable, effective, non-abortifacient modern natural and artificial methods of planning pregnancy

Informed Choice means effective access to information that allows individuals to freely make their own decision, upon exercise of free choice and not obtained by any special inducements or forms of coercion or misinterpretation, based on accurate and complete information on a broad range of reproductive health services.

Management of complications refers to an initial assessment confirming the presence of complications, medical evaluations, counseling of the patient regarding medical condition and treatment plan, prompt referral and transfer if patient requires treatment beyond the capability of the facility, stabilization of emergency conditions and treatment of any complications (both complications present before treatment and complications that occur during or after the treatment procedure), conduct of appropriate procedures, health education, and counseling on family planning, responsible parenthood, and prevention of future complications, among others.

Marginalized refers to the basic, disadvantaged, or vulnerable persons or groups who are mostly living in poverty and have little or no access to land and other resources, basic and social economic services such as health care, education and water and sanitation, employment and livelihood opportunities, housing, social security, physical infrastructure, and the justice system.

Modern methods of Family Planning (MFP) refer to safe, effective, non-abortifacient and legal methods or health products, whether natural or artificial, that are registered with the National Drug Authority to plan pregnancy. Modern natural methods include Billings Ovulation or Cervical Mucus Method, Basal Body Temperature, Symptothermal Method, Standard Days Method, Lactational Amenorrhea Method, and other method deemed to be safe, effective, and natural by the Ministry of Health. Modern artificial methods and/or health products include oral contraceptive pills, condoms, injectables, intrauterine devices, No Scalpel Vasectomy, Bilateral Tubal Ligation, sub-dermal implants, and any other method deemed to be safe, and effective by the Ministry of Health.

Natural Family Planning (NFP) refers to a variety of modern methods used to plan or prevent pregnancy based on identifying the woman's fertility cycle.

Private Sector refers to the key actors in the realm of the economy where the central social concern and process are mutually beneficial production and distribution of goods and services to meet the physical needs of human beings. The private sector comprises of private corporations, households, and non-profit institutions serving households.

Reproductive Health (RH) refers to the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. This implies that people are able to have a responsible, safe, consensual, and satisfying sex life that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. This further implies that women and men attain equal relationships in matters related to sexual relations and reproductions.

Unmet need for modern family planning refers to the number of women who are fecund and sexually active but are not using any modern method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.

LIST OF ABBREVIATIONS

ANC	Ante Natal Care
CBOs	Community Based Organizations
CPR	Contraceptive prevalence rate
DHO	District Health Officer
FP	Family Planning
HC	Health Centre
HTS	HIV Testing Services
IUD	Intrauterine, contraceptive device
LAM	Lactational amenorrhea method
MCH	Maternal and Child Health
MMR	Maternal mortality ratio
MoH	Ministry of Health
NGOs	Non Governmental Organizations
PHC	Primary Health Care
PNFP	Private Not For Profit
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SMOs	Social Marketing Organizations
SDM	Standard days method
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Population Fund
VHTs	Village Health Teams
WRA	Women of Reproductive Age

SECTION ONE: INTRODUCTION AND BACKGROUND

1.1 Background and Context

Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods (UDHS, 2016). The methods are classified as modern or traditional where the former methods include female sterilization, male sterilization, pill, intrauterine, contraceptive device (IUD), implants, injectables, male condoms, female condoms, emergency contraception, standard days method (SDM), and lactational amenorrhea method (LAM). The latter methods include rhythm, withdrawal, and folk methods are grouped as traditional.

According to the Uganda Demographic and Health Survey (2016), 39% of currently married women are using a method of family planning; 35% of currently married women are using a modern method while 4% of currently married women are using a traditional method (Figure 1). Among currently married women, the most popular methods are injectables (19 percent) and implants (6 percent). The contraceptive prevalence rate (CPR) among married women generally increases with age, peaking at age 40-45 (47%) before declining to 29% among women age 45-49 (Figure 2). Women with no education are less likely (26%) than women who have any education (38-51%) to use a method. Contraceptive use increases with wealth and number of living children. Among sexually active unmarried women, 51% are currently using a contraceptive method; 47% are using a modern method and 4 percent are using a traditional method. The most commonly used methods among sexually active unmarried women are injectables (21%) and male condoms (14%).

Unmet need for FP among married women (Figure 3) is 28% nationally; unmet need is highest in West Nile region (43.2%), Acholi region (39.0%) and Busoga region (36.53%) and lowest in Karamoja region (19.7%). Among sexually active unmarried women, 32% have an unmet need for family planning, and 51% are currently using a contraceptive method. The total demand for family planning among unmarried sexually active women is 83%, and at present 61% of the potential demand for family planning is being met. If all of the unmarried sexually active women who said they want to space or limit their births were to use family planning methods, the CPR would increase from 51% to 83% (UDHS, 2016).

The purpose of this study was to review all the different outreach models used by FP implementing partners in Uganda with the view of assessing the costs involved in conducting FP outreaches used by the different implementing partners and establishing possibilities of sustainability mechanisms of the different FP outreach models. The study further aimed to identify and recommend the most suitable FP outreach models based on their effectiveness to reach wider communities and their sustainability. This would in turn inform identification of areas for capacity support in delivery of recommended FP outreach models as well as development of guidelines for implementing recommended FP outreach models. This report is structured as follows; Section One gives the introduction and background, Section Two delves into the methodology used, Section Three details out the findings while Section Four outlines the conclusions and recommendations. Annexed are the terms of reference and the data collection tools.

1.2 Uganda's Family Planning services delivery system

The Ugandan National Health System comprises the public and private sectors, with the government operating 54 % of all health facilities. The public health delivery system comprises all MoH health facilities, health services of the Ministry of Defense, Education, Internal Affairs (Police and Prisons), and the Ministry of Local Government. The private sector includes private commercial, NGOs including SMOs and Faith Based Organizations as well as traditional and complementary medicine practitioners (MoH, 2015).

Health service delivery is decentralised, with districts and sub-districts responsible for delivery and management of health services at lower levels. The health system is organised through a hierarchical system, with each higher level carrying out more specialized functions and supervising the lower level. This hierarchical system in Uganda is designed around three referral levels consisting of:

- The primary level, which includes the Village Health Teams (VHTs), 47 General Hospitals, 166 HC IVs, 962 HC IIIs and 1,321 HC IIs.
- The secondary level, which includes the regional referral hospitals (14) and other private not for-profit hospitals with large bed capacities (874) and private commercial (1,488).
- The tertiary level, which includes 2 national referral hospitals (Mulago and Butabika) and three other highly specialized hospitals (Uganda Virus Research Institute, Uganda Cancer Institute and Uganda Heart Institute).

1.3 Family Planning outreach services

Several innovative FP service delivery models have been successfully implemented by MoH and NGOs in Uganda. The main outlets are the different levels of public sector health facilities ranging from the National Referral Hospitals, Regional Referral Hospitals, General Hospitals, Health Centre (HC) IV, Health Centre IIIs and Health Centre IIs. Different types of FP methods provided in these health facilities (Table 2), whether short term or long term contraception methods are provided free of charge. For example, permanent methods like tubal ligation are provided in HCIVs and other higher level health facilities where physicians are available. The long term reversible FP methods are mainly administered by nurses and midwives in the lower level health facilities during out-post and outreach services by higher level health facilities as well as in private clinics managed by midwives and clinical officers or medical officers.

Uganda committed itself to universal access to family planning and to reduce unmet need for family planning from 40% to 10% in 2022. It further committed to increase the annual government allocation for family planning supplies from US \$3.3 million to US \$5 million for the next five years and improve accountability for procurement and distribution. These commitments were reflected in the Uganda Family Planning Costed Implementation Plan, 2015–2020. Through this plan, government laid out strategies for integration of family planning into other services, including partnerships with the private sector, by supporting the alternative distribution channel for the private sector and scaling up of innovative approaches such as outreaches in order to increase choice for family planning¹.

1.4 Justification for Family Planning Outreach Guidelines

The Government of Uganda has committed itself to universal access to family planning services in the Second National Development Plan (2015) in order to address the high total fertility rate which currently stands at 5.4, and the high unmet need estimated at 28% (UDHS, 2017). As part of Uganda's commitments to FP2020, scaling up partnerships with civil society organisations and the private sector for FP outreach services was one of the ways to addressing the high unmet needs for family planning (Commitment 6: Uganda FP CIP, 2014). As such developing the FP outreach service delivery guidelines will contribute towards these commitments in order to improve maternal health and bring about development. Consequently,

- **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,

¹ London Summit on Family Planning (2012)

- **Cognizant** of the need to coordinated FP outreaches in the country to ensure standardized, high quality, socio-culturally appropriate and client-centered FP services that recognizes the varied needs of vulnerable and marginalized hard to reach populations,
- **Considering** the ever increasing costs of FP services by rural communities given the limited geographical against the high unmet needs,
- **Recognizing** the ever developing FP approaches including method-mix and the limited access to these methods by rural poor communities which impact on service uptake and continued use of FP,
- **Mindful** of the significance of FP outreaches as contributory to increasing uptake which is directly linked to reduction in TFR within the overall dimension of socio-economic development of the country, The Ministry of Health has developed these FP outreach services guidelines. The guideline is developed with close consideration and reference of the Second National Health Policy (2010), Uganda FP CIP, (2014), the Second National Development Plan (2015), and the Health Sector Development Plan (2015).

1.5 Goal and Objectives of the Family Planning Guidelines

1.5.1 Objectives

These FP outreach guidelines are developed to fulfill the following objectives:

1. Guide FP outreach service providers both public and non-government institutions
2. Be a guide to all cadres of health care providers directly or indirectly involved in the provision of FP outreach services
3. Set standards for FP outreach services
4. Direct integration of FP services with other RH services

1.5.2 Users of the Family Planning Outreach Services Guidelines

The users of this guideline are:

- Health managers
- FP program coordinators and managers at all levels
- All health care cadres providing family planning services in in government, non-government and private sectors
- Donors, other stakeholders and implementers of FP outreach programs in government, non-government and private sectors

1.6 Definition of Family Planning Outreach Services

Outreach service is a strategy for providing a wide range of FP methods to underserved communities. In the context of these guidelines, FP outreach service delivery is defined as FP services provided by a team of trained providers, from a higher-level health facility to a lower-level facility (facility based) and either supported by public facility, PNFP facility or an NGO, in an area with limited or no FP or health services. Outreach services can be provided at lower-level health facilities or health posts, locally available community facilities that are not used for routine clinical services, such as schools (community based), home of a community health worker or other community structures (Out post). The outreach team brings any equipment and supplies that are unavailable at the local area. The team may also upgrade the lower-level facilities and train the local staff or community health worker in FP to sustain these services after it has left the community (Thapa and Friedman, 1998). The choice of a FP outreach will be determined by a need assessment in any given community.

1.7 Steps in planning and conducting FP outreaches

There are seven steps that shall be followed to provide FP outreach services illustrated infra.

Step 1: Mapping the vulnerable and establishing FP needs

Mapping will be conducted to identify the vulnerable populations/ families who usually have little information and knowledge on their health rights, entitlements, and the benefits of preventive health services and are in most cases invisible to the health care delivery system. This process will entail capturing their problems regarding access to FP services, knowledge gaps, FP choices as well as other SRHR related service needs. This will also focus on the socio-economic relationships and issues of access to health care beyond the geo-spatial distribution of populations that is the object of such mapping. In addition, mapping shall also include identifying community based organizations or individuals who can support this population after delivery of FP outreach services to address issues of continued use and management of side effects as well as continued community mobilization. The process will further identify parts of the community where high concentrations of these populations are so that outreaches can be organized at these alternative places. Mapping will further help in determining timing of the outreach in terms of days of the week, opening and closing times, and frequency of conducting them, either monthly, quarterly or biannually (in case of mobile camps).

Step 2: Identification of Community Health Workers (VHTs)

In order to facilitate mapping, mobilization of such groups and providing follow up care, community health workers (Village Health Teams) of diverse backgrounds for diverse roles shall be actively identified and mobilized. These can become peer educators belonging to specific vulnerable groups including but not limited adolescents and key populations. Given the role male play in decisions making with regard to access to health care, specific emphasis shall be made to identify males as part of the VHTs.

Step 3: Comprehensive Referral System from Outreaches

To enable continuity of care and ensure quality of care, mechanisms shall be established to refer these populations to supportive health care facilities during or after conducting FP outreaches.

Step 4: Establish the FP service package

Following the mapping exercise, establish the scope of FP services that will be provided during the outreach. This will determine whether the outreach will be in the form of a mobile camp, health facility or community based outreach or outpost. It will further help determine the cost involved in relation to the human resources expertise required and the relevant partnerships for resource leverage, logistical issues as well as drugs and FP commodities required. The Minimum Standards for Family Planning Service Outreaches are detailed in Table 1 below.

Table 1: Minimum Standards for FP Outreach Services

FP Outreach Service	Minimum Set of FP Services	Required Minimum Staffing with Training	Basic Resource Requirements
Community based outreaches	<p>FP promotion/ education</p> <ul style="list-style-type: none"> FP counseling Provision of FP methods: pills, condoms, injectables, long term reversible methods, SDM, interval/post-partum 	<p>Clinical Officer, Midwife and/or nurse with the following trainings:</p> <ul style="list-style-type: none"> Basic FP course on all NFP methods, including SDM Fertility awareness orientation 	<p>Basic clinic equipment/instruments/supplies:</p> <ul style="list-style-type: none"> Stethoscope BP apparatus Weighing scale Examination table Gooseneck lamp Instrument tray Adequate supplies of

FP Outreach Service	Minimum Set of FP Services	Required Minimum Staffing with Training	Basic Resource Requirements
	IUD insertion, insertion and removal of Subdermal implants, No-scalpel Vasectomy <ul style="list-style-type: none"> • Infection prevention and control • Risk assessment by history • Management of minor side effects • Routine check-up/follow-up of clients • Follow-up of dropouts/defaulters • Referral for major complications of contraceptives 	<ul style="list-style-type: none"> • Interval IUD Skills training • Postpartum IUD training • Implant insertion and removal training • Orientation on Informed choice and voluntarism (ICV) 	contraceptives (condoms, pills, and injectables, IUD kit, Subdermal implant kits) <ul style="list-style-type: none"> • Auto disable syringes or disposable syringes with needles • Thermometer • NFP charts • Cycle beads • Clinic service records, referral slips, IEC materials and consent forms for IUD insertions
FP Outreach camps	All services in community based outreaches plus; <ul style="list-style-type: none"> • No-Scalpel Vasectomy (NSV) • BTL provision • Management of major complications related to contraceptives 	A team composed of surgeon, nurse and/or midwife trained on the above courses PLUS -surgeon and nurse or midwife trained on Implant, NSV, and BTL	Basic clinic equipment/instruments/supplies: <ul style="list-style-type: none"> • Stethoscope • BP apparatus • Adequate supplies of contraceptives including requirements for NFP • Forms including client consent forms (e.g. IUD, BTL, NSV) • BTL kits, Subdermal implants kits, IUD kits, NSV kits • OR equipment/ instruments for BTL- Minilaparotomy under Local Anesthesia (MLLA) • Medical supplies
Facility based outreach at HCIII and HCII	All services offered primary care facility plus: <ul style="list-style-type: none"> • Risk assessment by physical exam • IUD insertion (interval/postpartum) • Subdermal implant insertion and removal • NSV • BTL-MLLA • Management/referral of complications • Diagnosis and management of STIs, • Cancer screening (Acetic acid wash/ Pap 	Nurse and/or midwife trained on the above training courses plus; <ul style="list-style-type: none"> • Comprehensive FP Training including Postpartum Intrauterine Device Insertion (PPIUD) and Implant • NSV training for physicians • BTL-MLLA training for physicians • Subdermal implant insertion and removal for 	All resources available above plus; <ul style="list-style-type: none"> • IUD insertion and removal kit (ovum forceps, scissors, speculum, tenaculum forceps, uterine sound alligator forceps) • Sterilizer or stove with covered pan • Sterile gloves, microscope laboratory facilities for RTI diagnosis • Acetic acid wash kit, pap smear kit, NSV kits vas dissecting forceps, vas fixating clamp, and BTL kits and surgical record forms

FP Service	Outreach	Minimum Set of FP Services	Required Minimum Staffing with Training	Basic Resource Requirements
		smear) • Counseling on infertility • Management/ referral of complications	physicians	• Subdermal implant kit • Consent forms
HCIV facility with the capacity to provide the above services and management of major complications		All services offered above plus; • Infertility workup and referral management of other STIs and gynecological diseases • Management of major complications	A team composed of a physician/surgeon, nurse, and/or midwife trained on the above courses plus; • Physician and nurse trained for laboratory facilities • Laboratory technologist • Medical specialists • Obstetrician–Gynecologist • Anesthesiologist • General surgeon, • Urologist	All resources available above plus; • VSC drugs and supplies • Operating room, minilap kit, NSV kits, Lap kit • Other related equipment (Basic Laboratory) • General hospital requirements

Source: Adopted from the Philippine Clinical Standards Manual for Family Planning 2014

Step 5: Conduct social mobilization for family planning

One of the important aspects of outreach services is the emphasis on both supply and demand. Outreach services will only be successful if they are advertised in order to create demand through social behaviour change communication (SBCC). This 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. Mobilization shall adopt culturally appropriate information, education and communication (IEC) combined with strategies, approaches and methods that enable individuals, families, groups, organizations and communities to play active roles in FP service uptake. Embodied in IEC will be the process of learning that empowers communities to make decisions, modify behaviors and change social conditions. Activities will be developed based upon needs assessments and sound educational principles. The key communication objective will be to make the community, especially women from vulnerable sections and other stakeholders in the community, aware of service availability on fixed days.

Contents of IEC/SBCC messages and activities

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

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

The following media and methods for IEC shall be used without limiting other innovative approaches:

- Wall writings in the local language
- Hoardings at one or two prominent places in the locality
- Handbills and pamphlets
- Community radios
- Places of worship, schools and market places as well as other gatherings
- House to house mobilization by VHTs
- Leaflets, Brochures, Posters
- Banners, Billboards
- Young people and adolescent clubs
- Visiting of work places
- Community dialogues

Step 6: Outreach service delivery

On the day of service delivery, the outreach team shall arrive earlier than the time communicated to the communities and set up the work station. The following issues should be emphasized:

- a) The team leader shall provide briefing on the processes and client flow during the exercise.
- b) The designated service delivery time should be adhered to with a level of flexibility depending on the community needs i.e. can be extended late in the evening depending on circumstances.
- c) During the process providing FP services, the team will build capacity of VHTs on site on issues of demand creation, helping to understand community needs, generating interest, providing information to clients, and assisting with referral and follow-up.
- d) After the outreach, communities through the VHTs should be informed about the due date of the next outreach.

Step 7: Follow up FP outreach services

Following a FP outreach, the service provider shall ensure that there are follow-up mechanisms for:

- a) Management of minor side effects by community health workers and lower level health facilities
- b) Management of complications and severe side effects by setting up referral mechanism to higher level health facilities
- c) Systems for follow-up and continuity of care by VHTs
- d) Provide for regularity of outreaches for returning clients to handle implant removal

1.8 Services for clients with special needs

All FP outreach service provider shall take cognizant of special needs sub groups including adolescents and young people, people living with HIV, (PLWHAs), survivors of sexual violence and persons with disability including mental disability.

1.8.1 Adolescents and young people

The high rate of unwanted pregnancy among young people and adolescents is contributed to by 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 (Uganda FP CIP, 2014). Uganda Demographic Health Survey (2016) indicated that 25% of adolescents age 15-19 have begun childbearing: 19% of women age 15-19 have given birth, and another 5% were pregnant with their first child with 19% of these being in rural areas. The unmet needs among adolescents 15-19 years and young people 20-24 years are high standing at 30.4% and 29.3% respectively. This

situation precipitates the need for special attention to this population sub group. In this respect, FP outreach services should provide for adolescent and young people friendly services as follows:

1. Friendly procedures to facilitate easy and confidential registration, short waiting time, swift referral, consultation with or without appointment
2. Providers should be competent, with good communication skills, motivated and supportive, informative and responding to questions and concerns
3. Offer privacy and maintain confidentiality, conveniently located with convenient working hours
4. Involve adolescents in planning and service delivery
5. Have comprehensive service package and ways of increasing access with outreach and peer-to-peer services
6. Adolescents prefer RH services under one roof; hence all efforts shall be made to provide FP and other RH services in youth centers.
7. IEC messages shall be gender and age-oriented and recognize the special needs of adolescents.
8. Good counseling and support is particularly essential. Ensuring privacy and confidentiality is particularly important in addressing the FP needs of adolescents and young people
9. Married adolescents require FP services to delay and space childbirth.
10. 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.
11. Young people that are not sexually active should get information and education on FP.
12. As casual and forced sex is more prevalent in young people than older ones, provision of Emergency Contraceptive Pills (ECPs) and condoms to young people in advance is recommended.
13. 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.

1.8.2 People living with HIV

Dual protection is critical in reducing transmission of STIs and HIV among PLWHA helps to prevent transmission of the virus to uninfected partner. In addition, dual use helps the PLWHA 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. Cognizant of the fact that PLWHA have equal rights to found a family and bear and rear children, the following shall be considered when conducting FP outreach services:

1. Health care workers shall provide information on various family planning methods.
2. Dual use of family planning shall be part of family planning counseling.
3. HIV positive women shall be informed about the implications of pregnancy, and prevention of pregnancy shall be encouraged.
4. 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.
5. Health care providers working in ART clinics shall inform and educate PLWHA about prevention of unwanted pregnancy and use of FP.

1.8.3 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. The NDPII (2015) recognizes sexual violence under

Gender Based Violence (GBV) as a critical human right, public health and economic issues with 56% of women citing having experienced physical violence by the age of 15 years while 28% of women aged 15-49 citing having ever experienced sexual violence. In providing outreach services to this sub group, the following measures shall be adhered to:

1. Emergency contraception shall be provided for all victims of completed rape who are at risk of pregnancy that present within five days of the assault
2. 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.
3. 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.

1.8.4 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:

1. Counseling and informed decision shall 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.
2. Some drugs that are used for treatment of mental disorders affect bioavailability and efficacy of hormonal contraceptives. Hence, alternative methods of contraception shall be considered.
3. 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.

1.9 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 shall be considered to ensure male involvement:

1. Counselling for improved communication between couples regarding fertility and FP that would reflect the needs and desires of both men and women
2. FP services shall address the specific needs of men and shall be made men-friendly based on the mapping findings.
3. Males shall be provided with information that enable them to responsibly participate in FP use and decision making.
4. Males shall be encouraged to accompany their partners in FP visits.
5. 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.
6. 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.
7. 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.

1.10 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 through outreaches:

1. Advocacy for community participation
2. Community mobilization /involvement
3. Promoting family life education
4. Strengthening the use of RH data base
5. Involving religious, cultural and community leaders

1.11 Health Management Information System

Family planning outreach services records and reports are important tools for strategic planning, supervision and monitoring. Individual client records shall be kept confidential and shall not be accessible to unauthorized personnel. All data analysis has to be done without identifying individual clients. Three main FP outreach services records are described below.

Client Card

All clients seeking family planning outreach services shall 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, they help to track defaulters.

Family Planning Outreach Services Register

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

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

Referral form

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

1.12 Roles and responsibilities of stakeholders

The Ministry of Health recognizes the important contribution and roles of the FP stakeholders representing public, social marketing organizations and NGO sectors as outlined in Table 2.

Table 2: Roles of FP outreach stakeholders

FP Stakeholders	Roles
MoH	<ul style="list-style-type: none">• Coordinating all FP outreach services implementing and funding partners• Funding implementation of the guidelines• Monitoring & Evaluating implementation of the guidelines• Documentation & dissemination of best FP outreach practices• Review and approval of FP outreach services materials developed by partners• Operational research
NGO/SMOs	<ul style="list-style-type: none">• Resourcing and conducting FP outreaches• Development of SBCC materials for FP outreaches and dissemination• Documentation of best practices and lessons learnt• Community mobilization• Operational research
Development partners	<ul style="list-style-type: none">• Capacity development• Provide funding/ Resource mobilization• Monitoring and evaluating implementation
Local governments	<ul style="list-style-type: none">• Mainstreaming of FP outreaches into existing work plans• Lead and monitor implementation of FP outreaches• Harmonize and coordinate implementation of FP outreaches• Mobilization of communities
Media	<ul style="list-style-type: none">• Advocacy and engagement of target populations• Guide development of tailored messages• Dissemination of SBCC materials and messages for FP outreaches
CBOs and VHTs	<ul style="list-style-type: none">• Dissemination of SBCC materials for FP outreaches• Referrals and follow up of clients• Community mobilization

References

- Ministry of Health (2010). The Second National Health Policy
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Second National Development Plan (NDPII) 2015/16 – 2019/20
- Ministry of Health (2010). The Family Planning Costed Implementation Plan
- Thapa, S., and M. Friedman. (1998). Female sterilization in Nepal: A comparison of two types of service delivery. *International Family Planning Perspectives*, 24(2).
- Uganda Bureau of Statistics (2016). Uganda Demographic and Health Survey, 2016

Appendix 1: Family Planning Outreach Referral form

Ministry of Health Family Planning Outreach Services Referral Form

Date _____

Medical record number _____

Referred to _____

Referring Institution _____

Name _____ Age _____ Sex _____

Address: District _____ HSD _____ Sub County _____ Outreach site _____

Brief History:

Brief physical examination

Reason for referral _____

Name of the FP outreach services provider _____

Signature of the provider _____

Please use the following section for feedback

Referred to _____ Referring Institution _____

Feed back

Signature: _____