

TECHNICAL BRIEF

**Expanding Access to Long-Acting Reversible Contraceptives
in Rural Communities of Ethiopia Through Integrated
Backup Support from Health Centers**

Lessons from the USAID Transform: Primary Health Care Activity



SUMMARY

In response to increased demand for long-acting reversible contraceptive (LARC) insertion and removal services after the Federal Ministry of Health (FMOH) of Ethiopia launched its Implanon scale-up program in rural communities in 2009, the USAID: Transform Primary Health Care Activity (2017-2022) continued and expanded the integrated backup LARC service approach that the USAID Integrated Family Health Program (IFHP, 2008-2016) began in September 2011. In this intervention, a team of providers from health centers (HCs) regularly visits and provides a range of contraceptive services for clients at health posts (HPs) in rural communities.

In 2020, the Activity assessed the impact of this support, comparing rural HPs receiving backup support from HCs, with those that did not receive support. The assessment found that integrating backup LARC service support into the existing health system was a relatively easy way to support rural communities with family planning (FP) services. The intervention expanded contraceptive method mix and uptake among rural clients; saved clients time and money; reduced the burden of service provision on HCs; strengthened linkages among HCs, HPs, health extension workers (HEWs), and clients; and strengthened the capacity of frontline health workers. It also made service delivery more efficient, helped ensure equitable access to a continuum of care for rural clients, and strengthened health system capacity and ownership.

CONTEXT

Though modern contraceptive use by currently married Ethiopian women steadily increased from 6% in 2000 to 35% in 2016, unmet need for contraception in the country hovered at 25% in 2011 and 22% in 2016.¹ Contraceptive use in Ethiopia has been highly skewed toward short-acting methods, with use of injectables seeing the greatest increase, from 3% in 2000 to 23% in 2016. Implant use increased from less than 1% in 2000 to 8% in 2016, while use of the intrauterine contraceptive device (IUCD) showed a marginal increase from 0.1% in 2000 to 2% in 2016.²

To reduce unmet need for FP by expanding access to a wide range of contraceptives for rural communities, Ethiopia has implemented a range of programs. In 2004, HPs began offering short-acting contraceptives, including injectables, through trained HEWs.³ In 2009, the government launched an Implanon scale-up program, training HEWs to provide Implanon insertion services, in addition to oral contraceptive pills, condoms, and injectables, at the HP level.⁴ As a key partner to the FMOH, Pathfinder International, through the USAID-funded IFHP, supported implementation of the Implanon scale-up program.⁵ The following year, the country implemented an IUCD scale-up initiative to revitalize IUCD insertion and removal services by mid-level clinicians.⁶ In addition to static FP services provided at public health facilities, mobile outreach programs implemented by private and nongovernmental organizations expanded

access to a broader contraceptive method mix—including LARCs and permanent methods—for rural communities.⁷

As HEWs expanded their services, they were met with demand for a range of contraceptive services, including implant removal, which had not been addressed by the Implanon scale-up program. A Pathfinder-led study on the Implanon scale-up program, along with service monitoring data, showed high demand for all contraceptive methods, including LARCs. The study indicated that, of the clients served, 96.1% (n=5741) chose Implanon. Of those who chose Implanon, 23% were new users of contraception, and nearly all of those who used contraception previously switched to Implanon from short-acting methods.⁸ Similarly, service monitoring data of 7,500 clients served during the Implanon insertion practicum sessions showed that more than 25% of those who received Implanon were new acceptors; about 60% had shifted to an implant from a short-acting method. During training, clients requested a range of services, including Jadelle and Implanon insertion and removal, and IUCD insertion and removal—services not normally provided at the HP level by HEWs. This necessitated referral of some clients to HCs.

IMPLEMENTATION

Pathfinder International led the USAID Transform: Primary Health Care Activity (January 2017-September 2022) in partnership with the Government of Ethiopia to prevent child and maternal deaths by strengthening the country's primary health care system at all levels. The Activity supported the Health Sector Transformational Plan I & II (HSTP I & II) agendas in more than 400 districts of the five major regions of the country: Amhara; Oromia; Southern Nations, Nationalities, and Peoples' Region (SNNPR); Sidama; and Tigray. In response to the increased demand for LARC insertion and removal services after the FMOH of Ethiopia launched its Implanon scale-up program in rural communities, the Activity continued and expanded the integrated backup-LARC-service approach that IFHP began in September 2011. As part of this approach, a team of providers from HCs regularly visited and provided a range of contraceptive services to clients in rural communities.

In Ethiopia, a primary health care unit (PHCU) is the lowest functional health service delivery unit, consisting of one HC and an average of five HPs that serve rural communities. The HC is responsible for all technical and administrative issues of the HPs in the PHCU. As part of the routine health care delivery system, HCs make regular visits to HPs to support antenatal care, prevention of mother-to-child transmission of HIV, HIV testing for pregnant women, monitoring, and supervision.⁹ Because Pathfinder leveraged this established system to implement the integrated backup LARC support intervention, no additional health workforce was needed to reach rural communities with FP services not normally provided at the HP level (Table 1). This model of FP service expansion, adapted from mobile provision of FP services (Figure 1), is a unique example of



Photo credit: Pathfinder International. A family planning client receives an Implanon insertion.

local health systems strengthening and ownership, because planning, implementation, follow-up, and reporting are all performed within the PHCU.¹¹ Backup-LARC-service support is designed at a woreda health office (WorHO) level for all PHCUs in the woreda. The WorHO provides administrative support for HCs to integrate the intervention into their existing family planning and reproductive health (FP/RH) service delivery system by allocating resources and conducting supervision within the woreda health service performance improvement system. Providers from HCs conduct the backup visits to HPs both regularly and on demand, depending on the needs of the HP or direction from the WorHO. In this approach, different levels of the PHCU health system collaborate for demand creation, service registration, post-service care and follow-up, complication management, referrals, monitoring, reporting, and supportive supervision.

1 "Ethiopia Demographic and Health Survey 2011" (Addis Ababa, Ethiopia: Central Statistical Agency [Ethiopia] and ICF, 2012), <https://dhsprogram.com/publications/publication-fr255-dhs-final-reports.cfm>.

"Ethiopia Demographic and Health Survey 2016" (Addis Ababa, Ethiopia, and Rockville, MD, USA: Central Statistical Agency/CSA/Ethiopia and ICF, 2016), <https://dhsprogram.com/publications/publication-FR328-DHS-Final-Reports.cfm>.

2 Ibid.

"Ethiopia Demographic and Health Survey 2000" (Addis Ababa, Ethiopia: Central Statistical Authority/Ethiopia and ORC Macro, 2001), <https://dhsprogram.com/publications/publication-fr118-dhs-final-reports.cfm>.

3 "Health Extension Program (HEP) Implementation Guide" (Addis Ababa, Ethiopia: Ministry of Health of Ethiopia, 2004).

4 "Training Strategy: Scaling Up Availability and Access to Implanon Service Through Service Provision by Health Extension Level" (Addis Ababa, Ethiopia: Ministry of Health of Ethiopia, 2009).

5 Yewondwossen Tilahun et al., "Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Program in Ethiopia," *Global Health: Science and Practice* 5, no. 4 (December 28, 2017): 592-602, <https://doi.org/10.9745/GHSP-D-17-00215>.

6 "Ethiopia IUD Scale-up Initiative (2011-2013) Project Proposal" (Addis Ababa, Ethiopia: Ministry of Health of Ethiopia, 2010).

7 TD Ngo et al., "Expanding Long-Acting and Permanent Contraceptive Use in Sub-Saharan Africa to Meet FP2020 Goals" (London, UK: Marie Stopes International, 2013), <https://www.msichoice.org/media/2197/expanding-long-acting-and-permanent-contraceptive-use-in-sub-saharan-africa-to-meet-fp2020-goals.pdf>

8 Mengistu Asnake et al., "Addressing Unmet Need for Long-Acting Family Planning in Ethiopia: Uptake of Single-Rod Progestogen Contraceptive Implants (Implanon) and Characteristics of Users," *International Journal of Gynecology & Obstetrics* 123 (November 2013): e29-32, <https://doi.org/10.1016/j.ijgo.2013.07.003>.

9 "Health Extension Program (HEP) Implementation Guide."

10 "Mobile Outreach Services: Expanding Access to a Full Range of Modern Contraceptives."

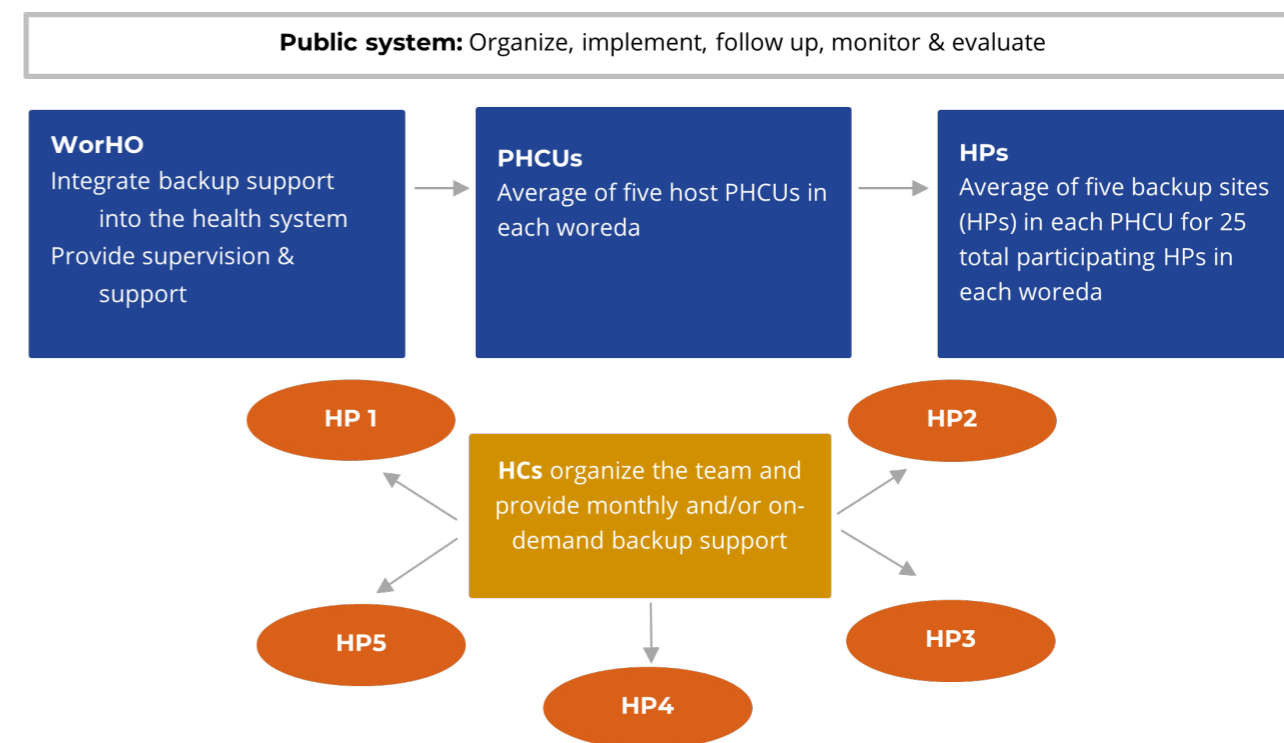
11 "Mobile Outreach Services: Expanding Access to a Full Range of Modern Contraceptives," *High-Impact Practices in Family Planning (HIPs)* (Washington, DC, USA: USAID, 2014), <http://www.fphighimpactpractices.org/briefs/mobile-outreach-services/>.

"Using Mobile Outreach Services to Expand Access to Contraception in Ethiopia."

Table 1. Model for Integrated Backup-LARC-Service Support from HC to Rural Communities¹⁰

Activity level	Key stakeholders	Main activities	Remarks
Organization of integrated backup LARC-service support	<ul style="list-style-type: none"> Head of PHCU FP service providers in FP/RH units of HCs Partner(s) (e.g., to support initial cost of kits and consumables) 	<ul style="list-style-type: none"> Talk with HEWs to prepare for the visit and set client appointments Meet with the FP team at the HC Prepare FP kits and commodities Prepare visit schedule 	HCs are responsible for the technical and administrative issues of HPs under the PHCU.
Integrated backup LARC visits to rural communities	<ul style="list-style-type: none"> Rural communities (HPs) FP service providers from HCs and HEWs from HPs under the PHCU 	<ul style="list-style-type: none"> IUCD and implant insertions and removals Provision of short-acting methods to address short-term method shortages in HPs 	The backup FP services are integrated with existing HC provision of technical assistance, monitoring, and ANC, PMTCT, and HIV testing services at HP level.
Post-implementation follow-up	<ul style="list-style-type: none"> HEWs Clients PHCU management 	<ul style="list-style-type: none"> HEWs who provided information and counseling, follow up with those clients as part of routine care, providing follow-up care, management of complications, and referrals if required. PHCU management support and ensure continuity of services at the community level through the integrated back-up approach. 	<ul style="list-style-type: none"> Promotes trust between HEWs and clients through the continuum of care, as they interact during demand creation, service provision, follow-up care, and referrals. Improves linkage between the HPs (HEWs) and the HCs (administrative and technical staff).

Figure 1. Integrated Backup-LARC-Service Support Model¹²



PERFORMANCE

The Activity assessed the integrated backup LARC service support to rural communities, comparing HPs receiving backup support with HPs who did not receive the support, to understand whether this support could increase community-level contraceptive method mix and use and save clients time and money. Specifically, the Activity sought to do the following:

1. Understand the differences in contraceptive method mix and utilization between HPs supported by the backup intervention and HPs not supported by the backup intervention;
2. Understand time and money spent by clients who received their method of choice at their HP through the backup intervention compared to those who traveled to an HC to receive the same method of choice because services were not available at their HP.

The Activity assessed the contribution of integrated backup LARC service support to improving LARC access and use in rural communities in two of the four USAID Transform: Primary Health Care Activity intervention regions—Oromia and SNNP—over the implementation period from 2017 to 2021. The team collected data using a mixed-method study design. During the time of data collection, Sidama and Southwest regions were part of SNNP; in this paper, is used to refer to these two regions.

Twenty PHCUs (10 in each region) were randomly selected from a total of 155 PHCUs in the two regions. The PHCUs included received backup support, either regularly or on demand, with a minimum of two to three visits. These PHCUs recorded services provided through backup visits and routine FP services provided at the HP level. With a convenient sampling method, 45 HPs that received backup support and 40 HPs that did not receive backup support were included in this study. Quantitative data was collected from the service use registration books of HPs that received backup support and those that did not. The team conducted 20 qualitative key informant interviews in January and February 2021 using an interview guide to gather specific information from clients who were provided integrated LARC backup services about aspects of the visit and its impact on LARC use, the time and money spent to access these services, and the interaction between HC and HP service providers. Two WorHO experts, two PCHU facility heads responsible for the backup intervention in the HCs, two service providers who conducted backup visits, two HEWs (one from an HP that received backup and one from an HP that did not), and two clients who received FP services during the backup visit were interviewed using the same sampling techniques used for quantitative data collection.

¹² Adapted from "Using Mobile Outreach Services to Expand Access to Contraception in Ethiopia."

FINDINGS

Quantitative findings: Differences in contraceptive method mix and utilization

In HPs receiving backup-LARC-service support from HCs, use of both short-acting methods and LARC services increased, and the contraceptive method mix expanded compared to unsupported HPs. HPs supported with backup visits served more clients with contraceptive methods than HPs with no backup FP services. HPs supported with backup served significantly more clients with LARC services (10,459) than HPs with no backup services (5,892), showing a shift from short-acting methods to LARCs during the assessment period. Supported HPs offered an average of seven contraceptive methods; unsupported HPs offered an average of three methods (p=0.001). The contraceptive service mix in unsupported HPs was limited to short-acting methods and Implanon insertions. In supported HPs, the full contraceptive service mix was available, including Implant removal. Key informant interviews confirmed this finding, with many reporting that clients got their method and service of choice at their HP.



I heard about the IUCD from HEWs during a household visit, and I asked them to provide me one, but they told me that the service was not provided at the HP level, and they referred me to the HC.

- FP Client

There was a significant decrease in the average number of clients receiving implant removal services at HCs once backup services started, compared to the previous year. Clients receiving implant removal services at HCs decreased from an average of 48 served in the year before backup support was initiated at the HCs to 27 during the first intervention year. Similarly, the average number of clients served with Jadelle, IUCD, and Implanon insertions in HCs the year before backup services were initiated decreased from 192 to 124. The results suggest that after HCs started providing integrated backup LARC services at HPs, more FP services, including implant and IUCD insertions and removals, were provided at the community level, easing the strain on HC-level services.

Qualitative findings: Client experiences of cost and quality at HPs with backup support compared to those who had to travel to an HC



Clients get their FP method of choice at the HP/community level. This minimizes travel cost and time. They get the service in shorter time and return to their home. It also increases community trust and satisfaction, because they can get comprehensive FP services at the HP level.

- HC provider

Backup support services saved clients time and money.

Clients in integrated backup supported communities walked an average of 32 minutes to reach a HP and receive their method of choice in a familiar environment with HEWs they know. Clients whose HP did not have backup services had to travel by vehicle for an average of 87 minutes to reach an HC—where they were less familiar with the environment and health service providers.

Most clients who received a method of their choice from backup-supported HPs spent no money on travel and other expenses and took less time away from family care, house, and field work than clients who needed travel to HCs to seek similar FP services. One client reported, “My FP method was inserted into my uterus without traveling far to the HC. This saved my time, and I also received my follow-up here in the HP.”

When key informant interview participants were asked if the PHCUs had the capacity to manage the backup LARC-service support, almost all respondents agreed that **existing PHCU human and financial resources were adequate to handle organization, implementation, and follow-up of the activities; it was relatively easy to integrate this intervention into the existing health system.** It was also beneficial; the respondents reported that the integrated backup outreach visits from HCs helped strengthen linkages between the HCs and HPs and ensure sustainable, equitable, and quality FP services at the community level. One PHCU head said, “We have integrated the backup into the system.

We used the available resources for backup, follow-up, and monitoring, and we support the intervention to continue.”

Respondents agreed that the backup LARC service support is an important way to support communities with FP services.

A WorHO head explained, “FP service provision was continuously maintained at HPs with no interruption. Shortage of supplies and commodities were minimized by gap-filling during backup visits. FP service coverage improved at the HP level, and linkages between HPs and HCs were strengthened. Unwanted pregnancy and abortion will be reduced, and the documentation and reporting systems of HPs have improved.” A HEW said, “I have received skill transfer on FP and other health services. Our motivation and commitment have improved because of the improved FP service utilization and coverage at the HP level as a result of the backup visits.”

LESSONS AND RECOMMENDATIONS

Integration into the existing system improves efficiency.

Traditional mobile outreach programs require coordination with local government; careful selection of outreach sites in collaboration with community leaders; recruitment and support of dedicated staff; sustained awareness-raising and communication activities; efforts to link outreach programs with CHWs and local clinics for FP counseling, referrals, and follow-up; and community mobilization.¹³ Provision of backup LARC service support to HPs can accomplish the same goals working through the health system and capitalizing on existing infrastructure, human, administrative, technical, and financial resources.¹⁴

Integrated backup LARC support ensures the continuum of care and access to equitable and quality FP services in rural communities.

Integrated backup LARC support from HCs to communities can ensure continuity of care; the routine support services HCs provide to HPs include regular backup visits and resupply of FP methods and supplies.¹⁵

The HCs conducting the backup service support did so using their available human and financial resources, without the support of a development partner.

The Activity provided FP kits and technical assistance to initiate services, after which the public sector adapted and implemented this approach independently, without partner support, an example of the approach’s sustainability.

Therefore, we recommend inclusion of this approach as a routine component in the health service delivery systems of all PHCUs in Ethiopia. To do so successfully, the following elements are essential:

- The approach, unlike conventional mobile outreach, is completely organized, conducted, and followed up by the public sector, sustainably strengthening local capacity and removing any need to rely on partners.
- Integration of the approach into the existing system using the available human and financial resources ensured continuity of services.
- Providers in HCs and HPs work together to ensure a continuum of care, from demand generation to service provision to referrals for complications to follow-up. This collaboration strengthens access to consistent quality care and generally improves linkages between the HC and HPs.
- Use of one health information system minimizes duplication of service registration and reporting efforts.

¹³ “Mobile Outreach Services: Expanding Access to a Full Range of Modern Contraceptives.”

¹⁴ “Health Sector Transformation Plan II (HSTP II)” (Addis Ababa, Ethiopia: Ministry of Health of Ethiopia, 2021).

¹⁵ “Expanding Contraceptive Choice to the Underserved Through Delivery of Mobile Outreach Services: A Handbook for Program Planners” (Washington, DC, USA: USAID, 2010).

Project overview:

Benefiting nearly 53 million people, the USAID Transform: Primary Health Care Activity (2017-2022) strengthens the management and performance of Ethiopia's national health system by improving quality of service delivery across the continuum of primary health care, improving household and community health practices and health-seeking behaviors, and strengthening program learning to impact policy and activities related to the prevention of child and maternal deaths.

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Suggested citation:

"Expanding Access to Long-Acting Reversible Contraceptives in Rural Communities of Ethiopia Through Integrated Backup Support from Health Centers." Watertown, MA, USA: Pathfinder International, 2022.

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Cover photo credit:

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