AN EFFECTIVE MODEL FOR THE INTEGRATION OF MODERN FAMILY PLANNING SERVICES INTO COMMUNITY-LEVEL HIV PROGRAMMING FOR FEMALE SEX WORKERS IN ETHIOPIA
EXECUTIVE SUMMARY

Despite significant improvements in access to and voluntary uptake of modern family planning (FP) methods in Ethiopia, certain marginalized groups, including female sex workers (FSWs), remain underserved. Integrating voluntary, modern FP services into ongoing HIV prevention programs that reach FSWs can be an appropriate and cost-effective means to address this important coverage gap.

In 2014, the United States Agency for International Development (USAID) launched a pilot intervention in Ethiopia to integrate a range of modern FP services (hormonal implants, pills, injectables and emergency contraception) into an ongoing HIV prevention project, that was using portable tents to deliver community-level outreach clinical services among FSWs. Prior to the FP service delivery pilot, the ongoing HIV prevention project offered a comprehensive service package for FSWs that included information tailored to FSWs on HIV, sexually transmitted infections (STI) and FP, HIV testing and counseling (HTC) and STI services, along with referrals for short- and long-acting reversible contraception (LARC) FP services. The provision of direct, modern FP counseling and services was carefully incorporated into the HIV prevention project’s outreach clinical services model via a revised client-flow algorithm and standardized referral protocol.

Using mapping data collected by PSI/Ethiopia in 2014, locations in twenty-three towns were carefully selected for the FP services pilot by identifying FSW population hot spot areas with limited access to nearby facility-based FP service outlets. During implementation of the modern FP services pilot, PSI/Ethiopia worked closely with regional and district-level health offices to plan multi-day outreach clinical service events in each intervention town. All outreach activities were conducted with healthcare providers from nearby public or private clinics who were identified by the project as being proficient in all four of the modern FP methods offered through the pilot intervention. In consultation with local health officials, PSI/Ethiopia recruited and retrained these health care providers to offer outreach clinical services tailored to meet the unique needs of FSWs. Peer educators, managed by local community-based organizations, conducted voluntary informational sessions with FSWs in order to generate informed demand for a wide range of modern FP methods, using standardized educational materials and approaches.

During the 18-month implementation period, 11,383 beneficiaries voluntarily accessed modern FP services, after being referred by project-supported FSW peer educators. Approximately 20% of all beneficiaries served by the project reported not using any other modern FP method at the time of service provision. No complications or adverse events were reported. The total program cost per beneficiary served with modern FP services was approximately $13.01, excluding FP commodity costs.
BACKGROUND

The challenge: Address unmet need for modern FP services among FSWs in Ethiopia

Despite a three-fold increase in the modern contraceptive prevalence rate (mCPR) among married women during the past decade in Ethiopia, from 14% in 2005 to 41% in 2015, less than 60% of the demand for modern FP in Ethiopia is currently being met. Only 46% of sexually active young women age 15 to 24 in Ethiopia report ever having used a modern FP method. The modern FP usage gap is especially inequitable among unmarried sexually active women, where the mCPR is only 8.8% within the poorest wealth quintile, compared with 58.2% in the wealthiest quintile. Efforts to reduce disparities in the mCPR among youth in Ethiopia to date have focused primarily on married adolescents and those living in rural areas. As a result, a growing population of poor young women living in urban areas has been largely overlooked by national modern FP initiatives.

FSWs make up an important subset of this underserved population of young, poor, unmarried and sexually active women and girls residing in urban areas in Ethiopia. A recent FSW population size estimation and venue mapping conducted by PSI/Ethiopia identified more than 85,000 women and girls working in the sex industry at 31,562 distinct venues in 89 cities and towns throughout the country. The average age of the FSWs mapped was 21, with over 1,000 found to be under the age of 18.

During the next 35 years, the number of people living in urban centers in Ethiopia is expected to increase from 18 million to over 70 million due to internal migration and rapid population growth. Accelerated urbanization brings hundreds of thousands of poor, rural young women in search of work into larger towns and cities clustered along the country’s main transport corridors. Facing extreme economic hardship, many ultimately turn to the sex industry after exhausting all other available livelihood options.

Qualitative research conducted by PSI Ethiopia in 2014 revealed that male “brokers” regularly recruit young women and girls into the sex industry at bus stations in larger cities and towns.

“... After that I go around the bus station. There you can find women who come from the rural areas, who are fired, who got divorced and with a lot of problems. So using that opportunity I do my job to attract them to work in hotels.” — FSW broker, Bahir Dar

Women and girls engaged in sex work in Ethiopia commonly experience gender-based violence (GBV), and are at a higher risk for contracting HIV and other STIs. A disproportionate number of FSWs in Ethiopia were victims of sexual abuse prior to joining the sex work; nearly half report experiencing a non-consensual first sex. The estimated national HIV prevalence of FSWs in Ethiopia is 24%, more than 10 times higher than the general female population. Although the extent of FSW’s unmet need for modern FP in Ethiopia remains unclear, unplanned pregnancies and abortions among FSWs are common, and studies from other countries in the region indicate that unmet need for FP is likely to be significant in this group. While the vast majority of FSWs report consistent use of condoms with their paying clients, reported condom use is still low among FSWs and their regular, non-paying male partners. A survey conducted in 2013 revealed that approximately half of FSWs who had sex with one or more non-paying male partners in the past three months also reported not using condoms consistently with all non-paying partners during that time.

Several contextual factors may hinder uptake of modern FP among FSWs in Ethiopia, including a lack of informed demand, as well as perceptions of limited accessibility and affordability. While modern FP services are generally offered for free or at highly subsidized prices in most public healthcare facilities in Ethiopia, many FSWs report feeling uncomfortable accessing public sector services for fear of mistreatment or stigmatization. The ambiguous legal status of FSWs in Ethiopia may also contribute to FSWs’ reluctance to access mainstream government reproductive health services. For low-income FSWs earning 20 to 50 Ethiopian birr (USD $1 to 3) per sex act, the cost of purchasing modern FP methods from private urban clinics is also a barrier to consistent use.

The Government of Ethiopia recognizes that FSWs require comprehensive interventions tailored to meet their unique needs, and has been supportive of more inclusive facility-based and community-based HIV prevention programs, linked to comprehensive peer education. As recently as 2008, less than 30% of FSWs in Ethiopia reported ever having undergone an HIV test. Today, that figure is closer to 90%, thanks largely to service delivery approaches that offer confidential, non-discriminatory, voluntary HIV testing and STI screening services, at times and locations known to be convenient for low-income FSWs. Thus, reaching marginalized FSWs with effective, modern FP interventions requires dynamic supply and demand-side approaches based on data-driven insights into FSWs’ behavior and service preferences.

The opportunity: Leverage existing HIV combination prevention projects to reach FSWs

In March of 2012, USAID launched an HIV combination prevention project in Ethiopia focused primarily on reaching FSWs. The project developed a comprehensive service package of mutually-reinforcing behavioral, biomedical and structural interventions, based on in-depth quantitative and qualitative research into FSW behaviors and service preferences. The project used teams of trained peer educators to reach FSWs from 169 towns and cities, and invited them to voluntarily participate in 12 weekly small-group learning sessions, discretely organized in private homes, public meeting spaces or locally-owned bars or restaurants. During these sessions, FSW participants received standardized, in-depth information on HIV and STIs, as well as information on a wide range of modern FP methods. The project supported trained health providers at nearby public and private clinics to offer inclusive, non-discriminatory HTC and STI treatment services, tailored to meet the needs of FSWs. The project also provided FSW small-group participants with referral coupons, which they could redeem for free HIV and STI clinical services. In addition, FSWs could access modern FP services (including LARC services when available) at these same referral sites, however, subsidies...
modern FP services among vulnerable and hard-to-reach FSWs, while avoiding duplication with existing facility-based services for FSWs. To accomplish this, the FP services pilot leveraged the HIV combination prevention project’s tent-based clinical outreach model to deliver a range of modern FP services at the same site where FSWs were accessing HIV and STI services. Intracuterine devices (IUDs) were not selected as an FP method for the pilot due to challenges presented by the tent-based outreach model. Nonetheless, linkages were established with nearby public and/or private referral sites prior to each outreach activity to attend to referrals for IUD insertions and removals, implant removals, permanent method services, and any resulting complications. Figure 1 below illustrates how the modern FP services pilot leveraged the HIV combination prevention project’s outreach clinical services model to directly provide a full range of modern FP services.

To prepare for the introduction of modern FP service provision, the PSI/Ethiopia team first revised the HIV combination prevention project’s peer education curriculum to further underscore the importance of informed consent and client choice, as part of the modern FP information and referrals already being provided. The PSI/Ethiopia team then revised the HIV combination prevention project’s outreach clinical services client flow algorithm to include direct FP service provision through clinical outreach events.

The PSI/Ethiopia team also strengthened the assessment protocols to ensure informed choice and consent procedures were consistent with USAID policy and PSI global guidelines for voluntarism and informed choice in FP service delivery. Stringent quality assurance and management protocols were implemented, including the provision of (coupons), commodities and special training for providers on modern FP service provision.

In larger towns and cities, in areas known as hot spots due to the large numbers of FSWs working and living in close proximity, the HIV combination prevention project conducted quarterly clinical outreach activities, during which, up to five portable tents were set up for a period of three to five days; each tent stationed with one trained health provider. The size of the clinical outreach teams and the duration of the activities were determined based on available FSW population size estimation data. In collaboration with local public health officials and private clinic owners, the project engaged trained, health care workers from nearby project-supported public and private clinics to offer HTC, symptomatic screening and syndromic management of STIs, GBV screening, tuberculosis (TB) symptomatic screening, condom provision and promotion of dual protection, risk reduction counseling, as well as referrals and linkages to nearby facility-based services such as anti-retroviral therapy (ART).

TECHNICAL APPROACH

Step 1: Integrate direct, modern FP service delivery into existing comprehensive service package

In April of 2014, USAID piloted the integration of FP counseling and services (hormonal implants, pills, injectables, condoms and emergency contraception) into the HIV combination prevention program described above, as part of a global effort to explore innovative models for scaling up modern FP. The pilot, also implemented by PSI/Ethiopia, aimed to improve coverage of modern FP services among vulnerable and hard-to-reach FSWs, while avoiding duplication with existing facility-based services for FSWs. To accomplish this, the FP services pilot leveraged the HIV combination prevention project’s tent-based clinical outreach model to deliver a range of modern FP services at the same site where FSWs were accessing HIV and STI services. Intracuterine devices (IUDs) were not selected as an FP method for the pilot due to challenges presented by the tent-based outreach model. Nonetheless, linkages were established with nearby public and/or private referral sites prior to each outreach activity to attend to referrals for IUD insertions and removals, implant removals, permanent method services, and any resulting complications. Figure 1 below illustrates how the modern FP services pilot leveraged the HIV combination prevention project’s outreach clinical services model to directly provide a full range of modern FP services.

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Figure 1 Comprehensive services package, with modern FP pilot integrated into outreach clinical services.
Step 2: Prioritize intervention locations in underserved FSW hot spots with modern FP coverage gaps.

In preparation for the FP services pilot implementation, PSI/Ethiopia carefully selected the locations and times for the outreach clinical service events in order to reach underserved FSWs, while avoiding duplication with ongoing facility-based services for FSWs operated by PSI/Ethiopia and/or other implementing partners. Out of a total 169 towns where the HIV combination prevention project was operating, outreach clinical events were already planned in 81 towns containing the largest numbers of FSWs.[39] Of these eligible towns, 23 towns were prioritized for the modern FP services pilot, based on an analysis of the modern FP service coverage gaps in each town.

This was done using FSW population size estimation and health service mapping data collected by PSI/Ethiopia in 2014, as illustrated in the FSW population density map (Figure 3).[40] The PSI/Ethiopia team aggregated FSW location data using Arc GISTM software, and then superimposed it as a color-coded layer over the map of each eligible town, as seen in Figure 3. This analysis allowed the PSI/Ethiopia team to quickly identify the major hot spot areas within each eligible town with the highest concentrations of FSWs.

Step 3: Leverage local capacity to increase efficiency during implementation

For the implementation of the FP services pilot, PSI/Ethiopia worked through existing sub-awards with locally-operated non-governmental organizations (NGOs) assigned to project towns as part of the HIV combination prevention project. The scope of work for these local partners was expanded to include FP service delivery; all quality assurance, health care provider training, and medical equipment and supplies were managed directly by PSI/Ethiopia.

In all FP services pilot intervention towns, PSI/Ethiopia modified the recruitment criteria for public and private health care providers who joined the outreach clinical service events. PSI/Ethiopia worked closely with regional health officials and local NGO partners to identify health care providers who already had training and expertise in all four modern FP methods to be used during the pilot. This allowed PSI/Ethiopia to focus project resources on more streamlined training for the participating public and private health care workers, centered on FSW-specific service provision. These two and a half-day trainings included topics such as: non-discriminatory and inclusive service provision for FSWs; ensuring informed choice for modern FP services; effective integration of modern FP with the project’s other services; making effective referrals for follow-on services or desired services not offered through the project; and use of the project’s program recording tools and adverse event reporting system.

Close collaboration with regional health officials was necessary to ensure that public health care providers were able to participate in the FP services pilot without disrupting ongoing operations.
public services. Sensitization meetings were held in each project town ahead of actual implementation to secure buy-in from local health officials for the FP services pilot. Regional health offices demonstrated a high level of support for the project, participating in multiple internal quality assurance visits organized by PSI/Ethiopia during implementation; and providing several in-kind contributions of medical consumables, such as examination gloves, sharps boxes, etc., which contributed to the overall cost-efficiency of the pilot.

Stringent quality assurance and management systems were put in place ahead of all FP service delivery activities. Each outreach clinical service event organized by the local NGO partners during the pilot was visited by PSI/Ethiopia Clinical Supervisors, and an external quality assurance team from PSI’s headquarters office in Washington conducted a full quality assurance audit of the program in 2015, as per PSI global guidelines.

RESULTS

During 18 months of pilot field implementation, 169 clinical outreach activities were conducted, resulting in a total of 11,383 beneficiaries accessing voluntary, modern FP counseling and services of their choice. Ninety service providers were trained by the project to support these activities, and during implementation, no complications or adverse events were reported.

Data analysis was conducted using 5,000 client intake forms. Among these, 5,000 modern FP users, 47.2% chose injectables, 26.3% opted for oral contraceptives, 23% chose implants and 3.5% received emergency contraception. All clients received free condoms and counseling on dual protection. Additionally, 79.8% self-identified as FSWs during client registration.

As an example, among these, 45% reported having one or more children, 64% reported being pregnant at least once in their lives, and 11% reported having had at least one abortion. When compared to nationally representative survey data among FSWs in Ethiopia from 2014, the FSWs reached by the FP pilot were less likely than the average FSW to be using a modern FP method (20% of FSWs reached by the pilot were not using a method at the time of counseling versus 15% of FSWs reporting via national surveys).

LESSONS LEARNED

As a result of the implementation of the FP services pilot, the PSI/Ethiopia team identified several key lessons, which could inform future FP service delivery projects aimed at reaching vulnerable populations, such as FSWs:

Leverage existing comprehensive HIV prevention programs that offer community-level clinical services. The comprehensive design of the HIV combination prevention project included modern FP messages as part of its community-level peer education activities, and offered modern FP counseling and referrals as part of its clinical services client-flow algorithm. These design elements allowed direct, modern FP services to be easily incorporated into the project offerings at the community-level as part of the pilot, without the need for major program changes. This allowed for FSWs to access comprehensive FP services at the same location as HIV and STI services, without having to use a referral site.

Use available mapping data to direct outreach activities towards modern FP coverage gaps. The use of Global Positioning System (GPS) data to pinpoint FP service delivery coverage gaps was helpful at the planning and prioritization stage. The aggregated FSW population density maps were also a strong advocacy tool when securing buy-in and understanding from local NGO partners and government stakeholders. The result was a geographically targeted approach that avoided duplication and managed to reach FSWs with a high unmet need for FP services.

Integrate health services at all levels of management and service delivery. Instead of creating a vertical management structure for the modern FP pilot, PSI/Ethiopia built an integrated management team at the head office responsible for all clinical service delivery. Regional clinical teams were likewise tasked with integrating modern FP services into ongoing HIV and STI clinical outreach activities. Local NGO partners were given additional responsibilities for FP service delivery within existing clinical services teams and approaches. Through a series of joint planning meetings, the PSI/Ethiopia central technical management team, based in Addis Ababa, together with regional managers and local NGO partners, developed integrated work...
plans to reach myriad health service goals that included modern FP. All aspects of program operations, from human resources to supply chain logistics, were integrated into ongoing activities, which facilitated program efficiency and effectiveness.

Secure the buy-in of key regional and local stakeholders. From the onset, PSI/Ethiopia embraced the modern FP pilot as an opportunity to engage with key governmental and community-level stakeholders. PSI/Ethiopia continually solicited local input and suggestions, and adjusted program tactics to address the reality of the local context. For example, local health officials helped to coordinate the timing of outreach activities with local considerations, such as harvest seasons, which can modify the size of migratory worker and FSW populations. This collaboration also allowed the project to effectively leverage local resources; with the support of regional and district-level health offices, the PSI team successfully engaged health care providers already trained in FP service provision, and secured medical supplies and other forms of support, from local public health clinics in all 23 modern FP pilot towns.

DISCUSSION

Experiences from the pilot in Ethiopia point to the feasibility of reaching FSWs with unmet need for modern FP by integrating modern FP services into HIV combination prevention programs that offer community-level outreach clinical services. USAID encourages HIV combination prevention approaches that use mutually-reinforcing behavioral, biomedical and structural interventions to generate informed demand for essential HIV prevention or treatment services, provide those services in conducive settings, and then support sustained uptake of these services by ameliorating the context of vulnerability of the intended population.45 HIV combination prevention programs therefore offer a unique opportunity to reach vulnerable population groups, such as FSWs, with FP service delivery approaches that are tailored to meet their specific needs. Most HIV combination prevention programs are required to conduct FSW population size estimation studies,46 and these data can be useful for informing the selection of modern FP service locations.

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ENDNOTES

1. The MULU/MARPs HIV Prevention Project ("MULU" means "comprehensive" in Amharic, and MARPs stands for most-at-risk populations) is a 5-year cooperative agreement funded by USAID and implemented by PSI that supports the Government of Ethiopia’s objective of reducing new HIV infections by 50% by focusing primarily on groups at elevated risk for HIV, such as FSWs and women engaged in transactional sex.

2. See page 4 for a complete list of services included in the existing comprehensive service package.


4. See page 4 for definition of how FSW "hotspot" areas were defined during the pilot.

5. See page 6 for more details on the FSW population size estimation and service mapping exercise that was used to identify these gaps.

6. The total amount spent by the program, including all indirect and above-country support costs, was $148,118. This did not include the costs of FP commodities, which were donated to the project by USAID, or the costs of certain medical consumable items such as examination gloves, which were donated by the Government of Ethiopia via the Regional Health Bureaus as part of their in-kind support for the project.


15. A total of 30 in-depth interviews were conducted including 24 gatekeepers (brokers/pimps, police officers, hotel owners/managers, police officers and guards) in Addis Ababa, Bahir Dar and Logia in October and November of 2014 (see citation below).


18. According to the 2011 Ethiopian Demographic Health Survey, the HIV prevalence among women age 15-49 is 1.9%.


Transmitted Infections for Sex Workers in Low- and Middle-income Countries: Recommendations for a public health approach. December 2012.

32 HIV combination prevention is an approach aimed at generating informed demand for essential HIV prevention and related reproductive health services; providing those services in conducive settings; and then supporting the sustained uptake of those services by ameliorating the context of vulnerability of the intended beneficiary population.

33 The HIV combination prevention project’s comprehensive service package included: peer education and informed demand generation for relevant services (including for modern FP), market-based business skills training and savings group formation, HIV testing and counseling (HTC), symptomatic screening and syndromic management of STIs, tuberculosis symptomatic screening, condom provision and promotion of dual protection, gender-based-violence screening, and referrals & linkages to HIV treatment and other appropriate services.

34 The HIV combination prevention project provided participating public and private health facilities with HIV test kits, STI treatment commodities, as well as standardized training on FSW-inclusive HIV testing and counseling and STI screening and treatment.

35 The HIV combination prevention project reimbursed participating private clinics for the service of providing HIV testing and counseling and/or STI treatment services to FSW customers bearing referral coupons provided by the project’s FSW peer educators.

36 Public and private referral clinics were selected based on their proximity to clusters of FSW working/living areas, identified during the FSW population size estimation and venue mapping investigation as having 100 or more FSWs per square kilometer (Girma, et al, 2014.)


38 The Strengthening International Family Planning Organizations (SIFPO) project is a five-year centrally-funded cooperative agreement funded by the United States Agency for International Development (USAID) and implemented by Population Services International.

39 As part of the HIV combination prevention project, only towns with a minimum of 250 FSWs were selected for outreach clinical services.


41 All data in the Results section is based on the 5,000 client intake forms that were analyzed.

42 Nearly all the women served during the modern FP pilot were referred to outreach clinical services by project-supported FSW peer educators. Nonetheless, it is assumed that some women preferred not to self-disclose their status as FSWs during client registration.


44 As part of the project implementation, PSI was permitted to stock FP commodities needed for project implementation from an existing FP project currently underway in Ethiopia and implemented by another international NGO. The unit costs above include minor warehousing and commodity transport costs associated with the FP pilot implementation.

