

REPORT

Ethiopia: An Emerging Family Planning Success Story

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From 1990 to 2011, contraceptive use in Ethiopia increased ninefold and the total fertility rate fell from 7.0 to 4.8. These are two dramatic illustrations of a family planning success story that has emerged over the last two decades and is still emerging. What are the main elements of this success? We posit that the four most significant factors are: political will, generous donor support, non-governmental and public-private partnerships, and the government's establishment of a network of health extension workers. In this study, we look at these factors and how their interaction increased the proportion of women having both the desire to use and ability to access contraceptives. Also highlighted are some of the key lessons learned in Ethiopia that are relevant to other African countries interested in emulating the country's success. (STUDIES IN FAMILY PLANNING 2013; 44[4]: 445–459)

An emerging family planning success story is under way in Ethiopia. Over the past two decades, contraceptive use went from a very low starting point to a vastly higher level. From 1990–2000, Ethiopia more than doubled its contraceptive prevalence rate (CPR), and then quadrupled it in the subsequent decade. In 1990, Ethiopia's CPR for modern methods was 2.9 percent (CSA 1991). In 2000, the first Demographic and Health Survey conducted in Ethiopia (EDHS) reported that the CPR for modern methods among married women aged 15–49 was 6.3 percent, which, at that time, was lower than that of any country in Eastern and Southern Africa except Eritrea (CSA and ICF International 2012). The CPR in Ethiopia subsequently increased to 13.9 percent in 2005 and to 27.3 percent in 2011.

Moreover, the 2011 EDHS reported that Ethiopia's total fertility rate (TFR)—the average number of children born to a woman in her lifetime—had declined from 7.0 in 1990 to 4.8 in 2011. This compares with an average TFR in 2011 of 5.1 for Eastern African and sub-Saharan African countries. The Ethiopian government says the drop from 2005 to 2011 was a consequence of declining fertility in rural areas (MOH [Ethiopia] 2011), where TFR decreased from 6.0 in 2005 to 5.5 in 2011 (in contrast to urban areas, where it actually increased slightly from 2.4 to 2.6 during that same time period). Ethiopia is one of the most rural societies in Africa; 83 percent of its population lives in rural areas.

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By 2011, knowledge of modern contraception became almost universal in Ethiopia, increasing from 85 percent of currently married women in 2000 to 97 percent in 2011. Knowledge of modern contraception was slightly higher among men and among single and sexually active individuals, and was 99.9 percent among sexually active unmarried men (MOH [Ethiopia] 2011).

With a population of 87 million in 2012 (PRB 2012), Ethiopia is the second most populous country in Africa and the fourteenth largest in the world. If current trends hold, it will become the world's tenth most populous country by 2050, with a population reaching 167 million. The Ethiopian government is determined, however, for current trends not to hold, and has set an ambitious CPR target of 66 percent by 2015. The rapid rise in the CPR and drop in the TFR during the past two decades show what is possible when government, donors, and civil society work together to achieve a common goal. This report reviews the main elements of this success, and explores how these central elements contributed to increasing the proportion of women having both the desire to practice and the ability to access contraception.

BACKGROUND

The interrelationship between culture, demography, and the environment in Ethiopia during the past three decades created conditions that were conducive to the development of a recognition of the need to promote family planning. The growing population increased demand for resources and accelerated the rate at which resources were consumed. This prompted the adoption of environmentally and economically regressive methods for using land, water, and other resources. Some of the more challenging developments during these decades were as follows:

- The population of Ethiopia more than doubled, from 35 million in 1980 to 87 million in 2010 (UN 2012).
- Agricultural production was hampered by erratic rainfall, population pressures, constant erosion, and a lack of conservation and agricultural policies.
- The historic famine of 1984–85, and less severe famines in 1998, 2006, and 2008, took their toll on human life and the environment.
- Ethiopia was subject to “water stress” over the decades, having a “water scarcity” of less than 1,000 cubic meters per person per year, one of 14 countries in this category in 2002 (PRB 2002).
- The annual rate of deforestation was estimated at 88,000 hectares per year, whereas the rate of afforestation was only 6,000 hectares per year (Office of the Prime Minister [Ethiopia] 1993).
- In every generation, landholdings are reduced because multiple sons share inheritances. This generation's recognition that the amount of inherited land cannot support a family contributed to family planning acceptance.

These developments affected the number of children desired, which, in turn, led to an increased demand for contraceptives even before the Ethiopian government supported the effort. When the Ministry of Health (MOH) started supporting family planning more actively

in 2005, a huge latent demand and a shortage of contraceptives existed. That latent demand was revealed in 2005, when 52 percent of currently married women not practicing contraception reported in the EDHS that they intended to practice it in the future, and also from 2004 to 2011, when the couple years of protection delivered by DKT International—the sole contraceptive social marketing organization operating in Ethiopia—more than tripled.

Modern family planning services in Ethiopia were pioneered by the Family Guidance Association of Ethiopia (FGAE), which was established in 1966 and became an affiliate of International Planned Parenthood Federation (IPPF) in 1971. FGAE's services were first provided from a one-room clinic run by a single nurse and were later expanded across the entire country.

In 1981 the first demographic survey was conducted, and in 1984 the first census. Since 1980, the MOH has expanded its family planning services through programs supported by UNFPA and other donors. Demographic surveys have been conducted regularly since 1990. In 1993, the government adopted its first national population policy (Office of the Prime Minister [Ethiopia] 1993). The primary objective of the policy was to harmonize the rate of population growth and socioeconomic development. Objectives of the policy included:

- Reducing the TFR from 7.7 to 4.0 by 2015;
- Increasing the CPR from 4.0 percent to 44.0 percent by 2015 (the target was later increased to 66.0 percent);
- Reducing maternal, infant, and child morbidity and mortality rates;
- Eliminating legal restrictions and discouraging customary practices that prevented women from enjoying full economic and social rights;
- Mounting an effective population information and education program addressing issues of family size and its relationship to human welfare and environmental security.

About two decades ago, the National Office of Population was established to implement this policy, and national and international organizations collaborated with the government to expand family planning services. Other important initiatives included:

- The 1996 Guidelines for Family Planning Services (updated in 2011), which authorized new outlets for family planning services beyond facility-based and outreach services;
- Four versions of the Health Sector Development Program from 1996 to 2010;
- The Plan for Accelerated and Sustained Development to End Poverty of 2005–06, which gave priority to reproductive health and family planning (MOFED 2006);
- The National Reproductive Health Strategy for 2006–15, which sought to increase the CPR to 60 percent by 2010 and couples' approval of family planning to 75 percent by 2015 (MOH [Ethiopia] 2006).

METHODS

The evidence collected for this report was gathered from the following sources: interviews with current and former leaders of NGOs working on family planning in Ethiopia; articles, surveys, and published and unpublished reports; websites of governmental agencies and NGOs; and from our firsthand experiences working in family planning/reproductive health in Ethiopia.

FOUR CENTRAL DETERMINANTS OF SUCCESS

We argue that four factors were primarily responsible for Ethiopia's success in reducing fertility rates: political will, generous donor support, nongovernmental and public-private partnerships, and the Health Extension Program.

Political will: In formulating development policies, the Ethiopian government paid increasing attention to demographic factors, recognizing population growth as one of the main challenges to poverty reduction and implementing mostly supportive policies. The government has set the goals of increasing CPR to 66 percent and reducing TFR to 4.0 children per woman by 2015, and has funded contraceptive commodities.

Generous donor support: Donors—notably the British Department for International Development (DFID), the Embassy of the Kingdom of the Netherlands, Irish Aid, the David & Lucile Packard Foundation, the United Nations Population Fund (UNFPA), and the United States Agency for International Development (USAID)—have provided consistent support for purchasing commodities, strengthening government capacity, and improving policy, research, and training.

Nongovernmental organizations and public-private partnerships: Many national and international nonprofit organizations have supported the government's efforts and used such innovations as social marketing, behavior-change campaigns, mobile clinics, and social franchising as means of providing more individuals with contraceptives and instruction regarding how to use them.

Health Extension Program: The government invested in a network of 38,000 frontline health workers stationed at 17,000 health posts to bring health information, contraceptive methods, and services to rural areas previously lacking health facilities and workers.

Political Will by the Government of Ethiopia

To prevent harm arising from pregnancy and child birth and in order to safeguard their health, women have the right of access to family planning information, education and capacity. — Constitution of the Federal Republic of Ethiopia, 1995

Although women's right to family planning was established in the Constitution in 1995, the Ethiopian government was slow to recognize the latent demand for family planning. Once it did, however, numerous changes came about, such as the launch of the Health Extension Program, improved policies, and donor funding. Government support encouraged donor investments, which led to programmatic success. This success engendered additional investments, which led to more success, in a virtuous circle now in its third decade.

"The original [family planning] plans provided both qualitative and quantitative outcomes that the Ministry of Health was seeking to address," says Tewodros Melese, an Ethiopian who is now director-general of IPPF in London (personal communication, 2013). "Successful performance was then demonstrated in a short time, providing donor confidence in both the commitment and momentum that had been generated. This led to further funding being provided."

As noted in a 2012 report by the African Institute for Development Policy (AFIDEP), "While government officials and political leaders appear to appreciate the adverse effects of rapid population growth for the country's development, family planning is largely promoted

as a child and maternal health intervention.” The report says that political will has been the factor most critical to family planning implementation in Eastern and Southern Africa and is common, to a greater or lesser degree, in the five countries in Eastern Africa considered most successful in family planning: Ethiopia, Kenya, Malawi, Rwanda, and Tanzania.

Government support has not been manifested at the highest level in Ethiopia as it is in Rwanda, where President Paul Kagame openly and strongly promotes family planning as a critical tool of development. The Ethiopian heads of state have never been vocal about family planning, although the late Prime Minister Meles Zenawi did coauthor an article in *The Lancet* calling on African governments to make family planning a national development priority (Zenawi 2012). Rather, the political will has mostly been manifested through full empowerment of the Ministry of Health and the unwavering support of Tedros Adhanom Ghebreyesus, who served as Minister of Health from 2005–12.

Many observers note that the upsurge in family planning coincided with the appointment of Tedros as Minister of Health. A globally recognized malaria researcher, Tedros emerged as one of the most accomplished and distinguished African health ministers and a global health leader who worked “to enhance Ethiopia’s active engagement in a number of major international forums,” according to his bio on the Ministry of Health website. Tedros made family planning a priority, and was successful at convincing donors to commit support. In November 2012, Tedros became Ethiopia’s foreign minister.

“Government ownership is critical [for improving reproductive health],” Dan Pellegrom, former president of Pathfinder International, told RH Reality Check in 2012 (Mack 2012). “And Ethiopia’s government took ownership.”

Successes

The Ethiopian government has taken an active role in health and has doubled the health budget in the past five years. Combining these resources with increased funding from the Global Fund to Fight AIDS, TB, and Malaria; the US President’s Emergency Plan for AIDS Relief (PEPFAR); and other donors, the annual per capita expenditure on health has increased from US\$7.10 in 2004–05 to \$16.10 in 2007–08, although this is less than half of the World Health Organization’s (WHO’s) recommended \$34 per capita (MOH 2010b). WHO reports that the Ethiopian government’s expenditures on health as a percentage of total government expenditures have increased from 10 percent in 2005 to 14 percent in 2010. We were unable to obtain data concerning the government’s specific spending on family planning.

Historically, most contraceptives in Ethiopia were provided through donation. In 2007, however, the government earmarked a budget line item for procurement of contraceptives using its own resources (MOH 2011). The government reports that between 2007 and 2009, using its own funds and donor “basket funds” under its control, it increased the amount spent on public sector contraceptives from 59 percent in fiscal year 2007–08 to 68 percent in 2009 (MOH [Ethiopia] 2011). AFIDEP (2012) reports, however, that only 5 percent of these funds come from internally generated revenue.

Ethiopia’s four major regions—Amhara; Oromia; Southern Nations, Nationalities, and Peoples; and Tigray—have also committed some of their own funds to support contraceptive security, and have shown their support in their respective policy documents, according to the Ethiopian government.

What has the government done with these funds? Perhaps its most significant decision—and the one most often credited for the increase in CPR—was the 2003 launch of the Health Extension Plan (HEP), which the government considers its flagship health program. HEP delivers health promotion, prevention, and primary curative care, including family planning, to individuals living in the most neglected areas of the country. These services are provided by HEP's 34,000 female health extension workers (HEWs) assigned to 17,000 rural health posts, which is a tremendous expansion from a mere 76 health posts in 1996. Voluntary community health workers provide support, and an additional 4,000 HEWs practice in urban areas.

Since the mid-1990s, the Ethiopian government has improved the policy environment to support implementation. In addition to the policy changes mentioned above, the government took these more recent steps. In 2007, the government waived import taxes on contraceptives following an intensive advocacy campaign by two Ethiopian ministries, development partners, and nongovernmental organizations (NGOs). This change helped increase the flow of commodities into the country. Starting in 2007, the government allowed HEWs to administer injectables, which helps explain the doubling of injectable use from 10 percent in 2005 to 21 percent in 2011 (see Table 1). In 2009, the government started training HEWs in the insertion of Implanon implants. Use of implants rose from 0.2 percent in 2005 to 3.4 percent in 2011. The government has not allowed HEWs to be trained in the removal of implants, however.

Opportunities

Table 1 shows the proportions of currently married women of reproductive age reporting use of various modern contraceptive methods in the last three Ethiopian Demographic and Health Surveys. The table shows that the increase in modern contraceptive use in Ethiopia from 2000–11 was driven by the increase in use of injectables. The table also shows that use of implants, though still low in percentage terms, has increased considerably in recent years. The government has not permitted HEWs to insert IUDs, and the proportion of women using IUDs has hardly budged from 2000 (0.1 percent) to 2011 (0.3 percent).

The government should continue to push for greater use of injectables but should also promote other methods, especially long-acting reversible methods. A recent analysis of evidence from 1982–2009 by Ross and Stover (2013: 1) found that “use of contraception may be increased by extending the availability of current methods.” The goal should be to reach, to

TABLE 1 Percentage of currently married women aged 15–49, by modern contraceptive method used, Ethiopia, 2000–11

Variable	2000	2005	2011
Injectable	3.1	9.9	20.8
Implant	0.0	0.2	3.4
Pill	2.5	3.1	2.1
Female sterilization	0.3	0.2	0.5
IUD	0.1	0.2	0.3
Condom	0.3	0.2	0.2
LAM	na	0.2	na
Total	6.3	13.9	27.3

na = Not available. LAM = Lactational amenorrhea method.

SOURCE: Ethiopian Demographic and Health Surveys, 2000, 2005, 2011.

the greatest extent possible, the 26 percent of married women who have an unmet need for contraception suited to them.

USAID (2012a: 11) in its "USAID/Ethiopia Country Development Cooperation Strategy 2011–2015," although citing "continual progress" in health because of the government's commitment, also sounds a note of caution. "The ambitious [health] targets are threatened by the lack of evidence-based planning, high turnover of health professionals, weak control by government institutions over budget support (with poor management of funds leading to suspicions of fraud), lack of sustainability (for example, uncertainty of donor funding for ARVs for HIV-positive people for life), and tight control over civil society participation."

In making the Ethiopian government's commitment at the 2012 London Family Planning Summit, then-Minister of Health Tedros said that Ethiopia has built a woman-centered health system with family planning at its core. "We now have in place a strong primary health care service," Tedros said. "Health extension workers in every village are reaching women with vital reproductive health and family planning information. As a result, we have seen an unprecedented upsurge of real, voluntary demand for contraceptive use" (Tedros 2012).

Former Minister of Health Tedros said his government was focusing on three issues to close the family planning gap: (a) recognizing that early childbearing is a major contributor to maternal mortality, (b) doing more to ensure commodity security by strengthening the supply chain and expanding contraceptive methods, and (c) closing the 50 percent funding gap for commodities that exists despite the fact that government has increased its family planning allocation every year.

The government of Ethiopia pledged to continue increasing its funding of family planning through a strong network of health providers. In particular, as stated on the Family Planning 2020 website, the government declared at the London Family Planning Summit that "the needs of adolescent girls will be met through partnerships with nongovernment and private providers, as well as expanding youth-friendly services." The government also pledged to improve access for isolated pastoralist communities.

Generous Donor Support

From 2000 to 2010, Ethiopia was the fifth largest recipient of family planning assistance from all donors (only Bangladesh, Egypt, India, and the Philippines received more), and the largest in sub-Saharan Africa, having received US\$173 million during this period (UNFPA and NIDI 2013). Table 2 shows the amounts received by Ethiopia and its East African neighbors, plus Nigeria. The shaded countries are those identified in the AFIDEP (2012) study as having developed the political will to expand family planning. Table 2 shows remarkable CPR increases in many countries, which were abetted by the generosity of donors and political will.

Our interviews with NGO officials working in Ethiopia revealed that they believe that the other reasons why donors have offered generous family planning assistance include the country's large population, its per capita gross national income purchasing power parity (one of the lowest), recurrent drought, the deleterious effects of the population on the environment, and high maternal and child mortality rates. "Ethiopia is the second largest country in Africa, with a dreadful record in family planning until recently," said Sahlu Haile, an Ethiopian who works on family planning for an international donor. "It was therefore normal that, once the government was committed to this cause, donors responded favorably."

TABLE 2 Family planning funding from all donors, population size, and (in year 1 and 2) modern contraceptive prevalence and total fertility, by selected East African countries and Nigeria, 1998–2011

Country	Family planning funding from 2000–10 in US\$ (millions)	Population in 2012 (millions)	Modern CPR		TFR	
			Year 1	Year 2	Year 1	Year 2
Ethiopia	172.8	87.0	6.3 (2000)	27.3 (2011)	5.5 (2000)	4.8 (2011)
Nigeria	135.1	170.1	8.6 (1999)	9.7 (2008)	5.2 (1999)	5.7 (2008)
Kenya	91.9	43.0	31.5 (2003)	39.4 (2009)	4.9 (2003)	4.6 (2009)
Tanzania	73.3	47.7	16.9 (1999)	27.4 (2010)	5.6 (1999)	5.4 (2010)
Uganda	65.2	35.6	18.2 (2001)	26.0 (2011)	6.9 (2001)	6.2 (2011)
Ghana	52.9	25.5	13.3 (1998)	16.6 (2008)	4.4 (1998)	4.0 (2008)
Malawi	44.5	15.9	26.1 (2000)	42.2 (2010)	6.3 (2000)	5.7 (2010)
Zambia	31.9	13.7	25.3 (2002)	32.7 (2007)	5.9 (2002)	6.2 (2007)
Rwanda	28.0	10.8	5.7 (2000)	45.1 (2010)	5.8 (2000)	4.6 (2010)
DRC	26.4	69.1	na	5.8 (2007)	na	6.3 (2007)
Burundi	4.7	10.6	1.2 (1987)	17.7 (2010)	6.6 (1987)	6.4 (2010)
Eritrea	3.6	5.6	7.3 (2002)	na	4.8 (2002)	na

na = Not available. DRC = Democratic Republic of Congo.

NOTES: Population data are drawn from the 2012 World Population Data Sheet (PRB 2012); family planning assistance data are drawn from the Resource Flow Project (UNFPA and NIDI 2013); CPR and TFR figures are drawn from DHS reports. For Burundi, figures for modern CPR and for TFR are given for 1987, the only earlier year for which data were available.

Successes

Key family planning donors to Ethiopia include United States Agency for International Development (USAID), Department for International Development (DFID), Embassy of the Kingdom of the Netherlands, Irish Aid, and UNFPA. The role of each is summarized below.

The United States dispenses development assistance in Ethiopia primarily through USAID, which calls itself (on its website) “the leading donor agency working on family planning in Ethiopia” and considers increased use of contraceptives in Ethiopia as one of its “historical development accomplishments.” In fiscal year 2012, the Obama Administration requested \$37 million for family planning/reproductive health (FP/RH) in Ethiopia (more than any country in the world except Afghanistan). In 2011, USAID began implementing the Global Health Initiative (GHI) in Ethiopia, which improves and increases health services and health systems. Ethiopia is one of eight GHI+ countries, where GHI programs receive additional technical and management resources.

Health is a major focus for DFID Ethiopia, and one of the organization’s key goals is to provide 2 million couples with access to family planning by 2015. DFID (2013) reported allocating 26.3 million British pounds (US\$44.2 million) in 2012–13 to spend on reproductive, maternal, and newborn health in Ethiopia, which is 10 percent of its total budget of £261 million (\$419 million), and to likewise spend 6.2 percent of its budget over the period of 2010–15. Based on the “strategic priorities” that DFID lists in its budget, reproductive, maternal, and newborn health comes fourth in amount of spending in Ethiopia in 2010–15, after education, “other health,” and humanitarian causes.

Ethiopia is one of 15 countries receiving foreign assistance from the Netherlands. In 2010, the Dutch government announced that its new priorities in Ethiopia would be food security, security and the rule of law, and sexual and reproductive health and rights (SRHR), and that it would reduce its overall aid for development. According to its Ethiopia Multi-Annual Strategic

Plan 2012–2015, the total budget for 2012–15 would be €234.7 million (US\$322.7), of which 56 percent would go to food security and 29 percent to SRHR.

Ethiopia is one of nine countries where Irish Aid focuses its development assistance, supporting implementation of the Ethiopian government's new development plan, especially in health, hunger, and governance. Irish Aid anticipates that its next five-year plan, to be developed in 2013, will be approximately €26 million (US\$35 million) per year. In 2012, Irish Aid provided €26 million (US\$34 million), of which 14 percent went to health and HIV/AIDS. Irish Aid supported SRHR, including contraceptive social marketing, through 2012.

According to its website, UNFPA's proposed assistance to Ethiopia during 2007–11 (the most recent period for which information is available) was \$96 million (an average of \$19 million per year), out of which nearly 55 percent was designated for reproductive health activities such as increased services and behavior-change communications, and strengthened institutional capacity for managing programs, "with attention to ensuring reproductive health commodity security."

Ethiopia is a "focus country" for the David & Lucile Packard Foundation, which has been making grants there since 1999. In that year, the Foundation allocated \$30 million to the Ethiopia program over five years. The program has concentrated its grant-making in reproductive health and adolescent reproductive health and advocacy, with support activities in capacity building and leadership development. The original \$30 million investment grew to \$80 million between 1999 and 2012, an average of a little more than \$6 million per year.

Opportunities

Analysis conducted by Population Action International (PAI 2012) of the US government's GHI strategies praised Ethiopia's policy as being strong on integration. The Ethiopia GHI team has used PEPFAR resources to build up the overall health system and to provide FP/RH, and has plans to integrate FP/RH with HIV/AIDS services in other ways. But PAI (2012) criticized the strategy for being "weak on championing civil society" and warned that "FP/RH and HIV targets will be harder to achieve without [civil society] engagement and not prove sustainable over the long run."

The July 2012 London Family Planning Summit—co-organized by DFID, the Bill & Melinda Gates Foundation, and UNFPA—succeeded in securing \$2.6 billion in new commitments for family planning. Ethiopia's Minister of Health, Kesetebirhan Admasu, noted that these pledges will help an additional 10 million women in Ethiopia benefit from family planning services in the coming eight years.

Nongovernmental Organizations and Public–Private Partnerships

Most of the large international NGOs that specialize in FP/RH have programs in Ethiopia. Listed in the order in which they opened offices in Ethiopia (some were working in Ethiopia before they had offices there), these NGOs are: Family Guidance Association of Ethiopia (1966, an affiliate of IPPF), EngenderHealth (1987), DKT International (1990), Marie Stopes International (1991), JSI (1994), Pathfinder International (1995), FHI 360 (1996), Management Sciences for Health (2005), and the Population Council (2007).

The contribution of NGOs to family planning in Ethiopia evolved considerably over the past two decades. In the early 1990s, as Ethiopia was emerging from several years of war, the government's focus was on reconstruction, and interest in family planning was limited. (Import duties on donated contraceptives were only dropped in 2007.) By the late 1990s, the Ethiopian government had become interested in family planning but lacked the capacity to perform basic functions. NGOs played an instrumental role in building service delivery (EngenderHealth, FGAE, and Marie Stopes), behavior-change communication via mass media (DKT), and building the capacity of government (EngenderHealth and Pathfinder).

In 2003 the Ethiopian government launched HEP, which expanded greatly in the second half of the decade when receiving extensive support from civil society, particularly USAID-supported NGOs such as EngenderHealth, JSI, and Pathfinder. In addition to using social marketing to sell contraceptives, DKT played a leading role in procuring commodities for the government and NGOs and continues to procure contraceptives for its own program. Marie Stopes has expanded its presence to 207 fixed clinics and 10 mobile clinics and, in 2009, established a social franchising network.

The Ministry of Health allocated project areas for NGOs that worked closely with the public sector to ensure optimum allocation of resources, and monitored the organizations' work through national, regional, and local structures. The MOH did not apply this control to all NGOs. For example, DKT's social marketing program was national in scope and therefore not limited to certain geographic areas.

Successes

NGOs and public-private partnerships have been major contributors to Ethiopia's family planning success. The government and NGOs worked closely together. The government played a strategic leadership role in developing the family planning program, and the NGOs communicated issues through NGO platforms.

A major focus of NGO work has been the procurement, management, and distribution of family planning commodities. When the MOH broadly embraced family planning in 2005, it was unprepared for the large demand that already existed, and donors asked several NGOs for help. From 2002–10, four parties imported virtually all contraceptives: the MOH (47 percent), DKT (32 percent), Pathfinder (18 percent), and FGAE (3 percent) (MOH 2010c).

DKT continues to procure contraceptives for its own large social marketing program, which distributes three brands of condoms (and eight variants), three brands of oral contraceptives, two brands of IUDs, two brands of injectables, one brand of emergency contraception (EC), and several other health products. DKT regularly supplies 32 percent of Ethiopia's couple years of protection (CYPs) and more than quadrupled its annual CYPs from nearly 600,000 in 2000 to more than 2.5 million in 2012.

Based on DKT's 2011 contraceptive sales in Ethiopia, we believe the CPR may be higher than the EDHS suggests. For example, the EDHS reports that oral contraceptives are used by 2.1 percent of currently married women of reproductive age. This translates to slightly less than 3 million pills per year. Yet DKT Ethiopia alone sold more than 3.2 million pills in 2011. DKT sales data show that the same is true of condoms. The phenomenon of underreporting has been raised in the population literature at least since 1984, when Ahmed and colleagues

(1984) suggested that the CPR for condoms in Bangladesh, which had been estimated at 1.6 percent in 1981, might actually be as high as 5 percent.

Contraceptive distribution and service delivery are the family planning activities most commonly performed by international NGOs; at least nine of them do one or both. At least four NGOs deliver products and services via mobile clinics, one employs social marketing, and another employs social franchising. NGOs played an important role in implementing the community-based distribution program that was the precursor of HEP, which many believe was a critical contributor to the increase in CPR. Since 2003, the Ethiopian government has managed HEP with technical and financial assistance from NGOs.

Three NGOs have implemented major behavior-change communication campaigns in Ethiopia. The 2011 EDHS shows that 44 percent of women and 63 percent of men have heard or seen the message “Birth spacing makes for a loving, caring and healthy family” and 32 percent of women and 50 percent of men have heard or seen the messages “Your family’s happiness is in your hands” and “It’s wise to have a balanced family life.” (These campaigns were developed by DKT International and adopted by the MOH.) The 2012 study by AFIDEP suggests that educational campaigns were one of five key drivers of contraceptive use in Eastern and Southern Africa, including Ethiopia.

Other important NGO activities include social mobilization, training, collecting evidence, quality improvement, research, policy reform, and reaching marginalized groups such as young people in general and adolescent girls in particular. Some of these activities emphasize building the capacity of community health workers and faith-based groups to promote and deliver family planning products and services.

The Population Council manages a program called *Biruh Tesfa* (“Bright Future”) to assist out-of-school girls aged 7–24 in slum areas. This program has been recognized by PEPFAR as a best practice and has created a “Developmental Bible” with the goal of incorporating information concerning reproductive health and gender equity into the teachings of the Ethiopian Orthodox Church (Mekbib, Ferede, and Tameru 2009).

Opportunities

In 2009, the Ethiopian government’s Charities and Societies Agency (CSA) announced a regulation known as the “70/30 Directive,” which was established to improve efficiency in the use of resources. The rule stipulates that no more than 30 percent of NGO project budgets can be comprised of “administrative costs.” Many of the programmatic and technical interventions of NGOs implementing family planning programs are classified as administrative costs, including clinical mentoring, supervision, monitoring and evaluation, training expenses, technical consultancies, and program-related travel. Some NGOs report that this regulation is creating obstacles to their efforts to build the capacity of government, national NGOs, and community-based organizations. A group of NGOs has been working on this issue with CSA. Resolving this situation will ensure that these critical capacity-building exercises go forward.

New legislation to regulate media and civil society has given some the impression that the government is trying to suppress advocacy, and has left NGOs confused about what is and is not permissible. For example, one NGO was told that its communication to CSA should not mention “gender” or “harmful traditional practices.” But another NGO said no such prohibition exists and attributes the confusion to “desk officers at the CSA interpreting the guideline

in various ways.” Clarifying the guidelines and their implementation would greatly help NGOs carry out their work.

Health Extension Program

In 2003, the Ethiopian government launched its flagship health service delivery system, HEP, to increase access to and use of preventive and curative services, including family planning. Service delivery is provided by health centers, which each serve 25,000 individuals and oversee five health posts. Each health post has two HEWs and serves 5,000 individuals. From the beginning, HEP was designed as a national system, not a pilot project, and proved critical to the success of family planning.

In Africa, two broad types of community health workers (CHWs) are found: full-time, salaried, health extension workers who have a year or more of professional training; and part-time, volunteer CHWs who have little training (although many hybrid examples also exist). Ethiopia's HEP falls into the former category, making it somewhat of an exception. The only other CHW programs in Africa that we know of that have full-time, salaried CHWs who have at least one year of training are in Ghana, Nigeria, and Rwanda.

Recent evaluations of HEP by the Center for National Health Development in Ethiopia and Columbia University (2011a, 2011b, 2011c) found that more than 60 percent of the 10,000-plus community members questioned rated all components of HEP services as satisfactory or very satisfactory, and family planning got the highest score (77 percent). More than a third of respondents (37 percent) stated they or a household member had visited the HEWs, and family planning was the leading reason (36 percent). The evaluation recommended strengthening “the achievement gained on use of any modern contraceptive methods through more reliable supply chain management and social behavior change communication.” Also recommended was the provision of alternative contraceptive methods, and long-acting contraceptive methods in particular.

Successes

Since launching HEP, the Ethiopian government has invested heavily in building its network of HEWs, who bring family planning products, services, and information to neglected areas of the country. In partnership with NGOs, these HEWs are trained to administer some contraceptive products and services (including condoms, pills, injectables, and some implants) and provide family planning counseling. HEP has trained and deployed 38,000 HEWs, working in 17,000 health posts, to bring basic health care to Ethiopian communities. HEWs are further supported by voluntary CHWs who identify and train “model families” and “model communities” in good health practices, including the use of family planning.¹

Opportunities

The Ethiopian government is now hoping to mobilize 3 million women from these model families into a “Health Development Army,” an initiative to scale up the best practices of HEP,

1 Early adopters of the health services promoted by HEWs, once they have successfully implemented 75 percent of the program package, are certified as “model families.” When enough “model families” have been certified in a given community, then it is certified as a “model community.”

with particular emphasis on improving reproductive, maternal, newborn, and child health. Minister of Health Admasu, who has been leading the implementation of HEP, says that the initiative will need political commitment and multisectoral collaboration.

CONCLUSION AND LESSONS LEARNED

Undeniably, Ethiopia has made considerable progress in family planning during the past two decades. The government of Ethiopia, donors, and national and international NGOs all deserve credit for increasing the CPR ninefold between 1990 and 2011. With 26 percent of married women still expressing an unmet need for family planning, however, the work must continue.

The government rightly sees the main challenges to sustaining and improving family planning services in Ethiopia as: addressing remaining unmet need; maintaining sufficient supply of commodities; high turnover of health workers; shortage of staff at all levels; uneven distribution of mid- and high-level professionals in urban versus rural and public versus private sectors; training of HEWs in the provision of Implanon implants; and constraints associated with the monitoring and evaluation system (MOH 2010a).

Some lessons learned in Ethiopia that we believe are relevant to other African countries interested in emulating the Ethiopian success are as follows.

- Political commitment to family planning at every level is one of the most important ingredients of success. Although not necessarily indispensable, success is much harder to achieve when political will is weak or absent. Money, community mobilization, NGOs, and public–private partnerships all flow more easily when political will is strong.
- Positioning population and family planning, as Ethiopia did, at the center of the development agenda is critical. Doing so helps promote integrated development.
- The presence of a large and active social marketing program contributes substantially to increasing CPR. From 2002–10, DKT imported a third of all contraceptives and currently contributes 32 percent of all CYPs in Ethiopia.
- Although much of Ethiopia's success was fueled by international donor funding, the government is now increasing the proportion of funds it invests in health, including family planning. This must continue, and Ethiopia must meet the commitment that it made 12 years ago in the Abuja Declaration to allocate at least 15 percent of its budget to health by 2015. Other African governments must make similar commitments and ensure that they are fulfilled.
- Ethiopia has made some progress in integrating its response to HIV/AIDS with family planning, but this integration needs to be strengthened—in Ethiopia and elsewhere—so that delivery of family planning services can be improved even when donor funding dwindles.
- The Ethiopian government has sometimes been overly wary of civil society, including national and international NGOs, the private sector, universities, research institutions, churches, and faith-based organizations. Its government and other African governments must overcome their distrust of these critical partners and create an environment that is conducive for NGOs and others to contribute to family planning success.

- More effort must be made to diversify the modern contraceptive method mix—particularly condoms, implants, IUDs, pills, and sterilization—to satisfy the high unmet need.
- The role of the private sector should be better exploited. For example, the Ethiopian government (and other governments) could license more private pharmacies, drug stores, and clinics; permit the sale of all reproductive health drugs through the pharmaceutical network; and further liberalize advertising of contraceptives.

At the 2012 London Family Planning Summit, the Ethiopian government pledged to uphold the rights of all Ethiopians to access voluntary family planning through a strong network of primary health care providers, with particular attention to serving pastoralist communities and adolescent girls and to providing youth-friendly services. The MOH is targeting regions that have high unmet need, and the effectiveness of these efforts in the most challenging regions, which are overwhelmingly rural, will help determine future contraceptive rates. Civil society and the private sector will be key partners in this undertaking. The next five years will reveal the extent to which the government and its partners can maintain the impressive momentum that has been built up over the past two decades. Simultaneously, we hope that other African countries are able to emulate Ethiopia's successes and adapt some of its approaches to their own unique national contexts.

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ACKNOWLEDGMENTS

The authors would like to thank the many people consulted for this article, particularly Yetnayit Demissie Asfaw of EngenderHealth, Menguistu Asnake and Tariku Nigatu Bogale of Pathfinder, Marianne Eelens of UNFPA/NIDI Resource Flows Project, Nils Gade of Marie Stopes International, Sahlu Haile of the David & Lucile Packard Foundation, Philip D. Harvey of DKT International, Tewodros Melesse of the International Planned Parenthood Federation, Henry B. Perry of the Johns Hopkins University Bloomberg School of Public Health, and Christopher Purdy of DKT International.