



FP_{WATCH} RESEARCH BRIEF

Ethiopia 2015 contraceptive commodity and service assessment: Findings from public and private sector outlets

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Suggested Citation: Ethiopia 2015 Outlet Survey Findings. (2016) FPwatch Research Brief. Population Services International and FPwatch. Washington DC: USA.

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Background

The FP2020 commitment for Ethiopia is to increase its contraceptive prevalence rate (CPR) to 65% by 2015 and reach an additional 6.2 million women and girls with family planning services by 2020.

FAMILY PLANNING ENVIRONMENT IN ETHIOPIA

Ethiopia's 2014 population was estimated at 97.0 million people, with a projected growth of 2.5 percent per year.¹ Almost a quarter of married women of reproductive age in Ethiopia have an unmet need for contraception.² Important gains have been made in access to modern contraceptive methods in Ethiopia in recent years. The modern contraceptive prevalence rate (mCPR) has more than doubled since 2005, reaching 40% in 2014.³ Despite this progress, the mCPR remains far below the government's goal of 65% by 2015. Unmet need remains high among married women and higher still among rural, low-income and young women.⁵ There is low use of long-acting reversible contraceptive (LARC) methods, with the majority of all users using injectables.³

SECTOR ROLES

Health services provided through the public sector have been augmented by a rapid expansion of the private for-profit and private not-for-profit sectors.⁵ Thirteen percent of modern contraceptive users acquired their method from a private sector source in Ethiopia in 2011 (with private clinics being the main private sector supplier), compared with over 35% of methods acquired from the private sector across Sub-Saharan Africa.^{3,4} However, high-quality evidence on the growing private sector provision of contraceptive methods remains limited.

KEY STRATEGIES TO DATE

The Ethiopian government plays an active leadership role in national efforts to improve family planning (FP) and reproductive health (RH). In 2003, the Federal Ethiopian Ministry of Health (FMOH) launched the Health Extension Program (HEP), training over 30,000 health extension workers (HEWs) to deliver basic health services and promote healthy behaviors in rural areas. FP is a key component of the HEP, with

HEWs delivering contraceptive methods and information to the predominantly rural population.⁶

In 2006, the FMOH released Ethiopia's National Reproductive Health Strategy (2006-2015). The plan focused on six priority areas, including social and cultural determinants of women's reproductive health; fertility and family planning; maternal and newborn health; and reproductive health of youth. As a supplement to this strategy, the FMOH released the National Adolescent and Youth Reproductive Health Strategy to target RH and FP needs of youth; increase awareness; strengthen multi-sectoral partners; and promote evidence-based programs.⁷ **In 2012, Ethiopia committed to the London Summit on Family Planning's FP2020 Initiative goals.**

KEY INTERVENTIONS

In an effort to improve use of LARC methods, the FMOH began scale up of the provision of the implant Implanon® at the community level through HEWs in 2010. HEWs are the first non-professional cadre to insert implants in Africa. The Intrauterine Contraceptive Device (IUD) Initiative started in 2011, focusing on promoting IUD uptake at health centers.⁶ In 2012, the FMOH launched the Health Development Army, a volunteer cadre supporting HEWs, including encouraging FP and contraceptive use in rural communities.⁷

In the private sector, social marketing actors such as PSI and DKT International, as well as franchising initiatives such as the Marie Stopes International (MSI) "BlueStar" Network, are actively distributing contraceptives, including condoms, oral contraceptives and implants in Ethiopia. These players, along with many others such as UNFPA, work together to promote contraception use across the country.⁸

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FPwatch at a glance

WHAT IS FPWATCH?

FPwatch is a multi-country research project implemented by Population Services International (PSI) with funding from the Bill and Melinda Gates Foundation (BMGF) and the Three Millennium Development Goal Fund. Standardized tools and approaches are employed to provide comparable data across countries and over time. FPwatch is a response to the Family Planning 2020 (FP2020) goal to **enable 120 million additional women and girls to have informed choice and access to family planning information and a range of modern contraceptive methods.**⁹ Launched in 2015, FPwatch is designed to provide timely, relevant and high-quality FP market information. Research methods implemented include outlet surveys and interviews with national FP experts.

GOAL

The FPwatch project aims to inform and monitor national and global policy, strategy and funding decisions for improving informed choice and access to FP information and a range of modern contraceptive methods.

RELEVANCE

The Ethiopia 2015 FPwatch survey complements concurrent data collection focused on tracking FP2020 progress, including surveys conducted by the Performance Monitoring and Accountability 2020 (PMA2020) project in Ethiopia. The 2015 Ethiopia FPwatch assessment will supplement and build upon these surveys by conducting a full contraceptive commodity audit and service provider questionnaire providing information on contraceptive commodity and service availability, price, volume and service readiness for all public and private outlets.

FPwatch market monitoring in Ethiopia in 2015 was implemented in the context of national strategies designed to improve access to modern contraceptive methods. These included national efforts to:

- Improve voluntary uptake of LARCs through task shifting to mid-level providers, including distribution of Implanon[®] implants through HEWs and IUDs via Health Centers.
- Establish a minimum contraceptive method mix for each service delivery level
- Make available three or more methods of modern contraception to all Ethiopian households in need
- Improve public-private partnerships to meeting rising demand
- Improve training for FP providers and acceptance of FP
- Explore cost recovery in contraceptive distribution channels

OUTLET SURVEYS

Outlet surveys are the core component of the FPwatch project. The outlet survey in Ethiopia was designed to monitor key FP market indicators at the national level and within four key regions: the largely rural regions of Amhara, Oromia and Southern Nations Nationalities and Peoples' Regions (SNNP); and the urban area of Addis Ababa.

This summary report presents cross sectional data from the 2015 outlet survey.

5

Number of FPwatch outlet surveys implemented internationally from 2015-2016

+25,000

Total number of outlets screened in 2015

+6,500

Number of outlets interviewed in 2015

What questions are answered by the outlet survey?



What types of outlets in the public and private sectors are carrying modern contraceptive methods?



What proportion of public and private sector outlets are stocking selected modern contraceptive commodities, offering contraceptive services and providing a range of methods?



What is the relative market share for each contraceptive method and for each outlet type?

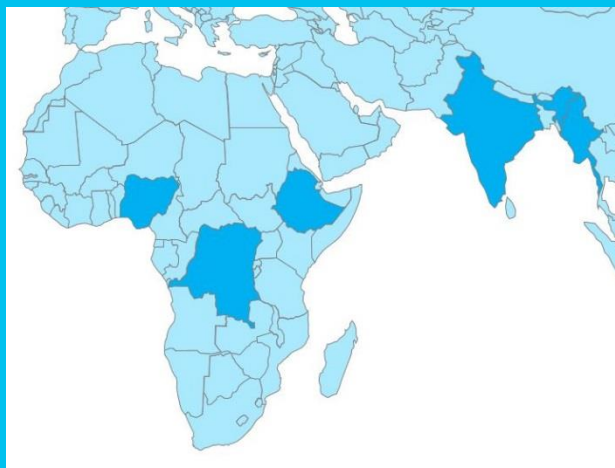


What is the consumer price of modern contraceptive methods among private sector outlets?



What is the readiness of selected outlet types for performing contraceptive services?

The FPwatch Countries, 2015 -16



Methods

FPwatch implements standardized methods and questionnaires that allow for comparisons between countries. Together, a full census of all outlets providing contraceptive methods, a full audit of all available contraceptive commodities and a provider interview on contraceptive services give a complete picture of the FP market.

HOW IS THE SAMPLING CONDUCTED?

A two-stage, probability-proportional-to-size cluster design was used to select clusters within each stratum, with cluster population serving as the measure of size. The primary sampling unit used was the *kebele*, the lowest government administrative level, with 5,000 to 10,000 inhabitants. The next administrative level is the *woreda*, which was the secondary sampling unit. A representative sample of outlets providing contraceptive methods to consumers was selected for each of the four regions in Ethiopia.

WHAT TYPES OF OUTLETS ARE SURVEYED?

The main types of outlets surveyed included public and private not for-profit health facilities, health extension workers (HEWs)/health posts, private for-profit health facilities, registered and unregistered pharmacies, drug shops/rural drug vendors (RDVs) and general retailers. Regulations for provision of contraceptive commodities and services are shown on page 13.

HOW ARE THE OUTLETS IDENTIFIED?

The FPwatch outlet survey included all outlets in selected kebeles with the potential to sell modern contraceptive commodities (except those offering only condoms) or offering contraceptive services. As many of these outlets are unregistered, mobile or recently opened, official listings of these outlets and their locations were not available. A census approach was therefore implemented, supported by local informants including government stakeholders, local maps and lists of registered outlets where available.

WHAT IS AN OUTLET CENSUS?

This involves a team of data collectors moving systematically through a defined area to identify all outlets that have the potential to sell or distribute contraceptive methods.

WHAT HAPPENS AFTER AN OUTLET IS IDENTIFIED?

The outlet is screened for availability of modern contraceptive methods or services. Outlets were included in the survey if they had modern contraceptive commodities including oral contraceptives, emergency contraceptives, injectables, implants or IUDs in stock at the time of survey or in the previous three months, or offer contraceptive services including contraceptive injections, implant or IUD insertions, or male or female sterilizations. Other commodities including



Photo credit: UNICEF Ethiopia/Getachew

CycleBeads®, vaginal foaming tablets, diaphragms, birth control rings and patches were considered but not found in outlets surveyed. Permission to conduct the interview was obtained from the main provider.

HOW IS INFORMATION ON CONTRACEPTIVE COMMODITIES AND SERVICES CAPTURED?

Full contraceptive audits were conducted among outlets with eligible contraceptive commodities in stock. Information was recorded for each unique contraceptive identified in the outlet. Among outlets offering eligible contraceptive services, providers were interviewed to provide information for each type of service.

WHAT INFORMATION IS RECORDED ON THE AUDITS AND PROVIDER INTERVIEWS?

An audit sheet is completed for each unique modern contraceptive commodity in stock. The audit sheet captures product information from the product package including the brand name, manufacturer, country of manufacturer and formulation/strength (if applicable). The audit sheet also captures information from the provider including the amount sold in the last one month, retail price and stock-outs in the previous three months. The provider interview captures the number of services performed, price, provider credentials and the availability of a minimum set of essential equipment.

Comprehensive product information and provider reports on amount distributed and retail price allow for calculating estimates of contraceptive method availability, price and relative market share. Comprehensive service and provider information allows for calculating estimates of readiness for contraceptive services.



Photo credit: Andrew Andrada (PSI)

Sample

Outlet types providing modern contraceptive methods

HOW MANY OUTLETS WERE INCLUDED IN THE SAMPLE AND SCREENED?

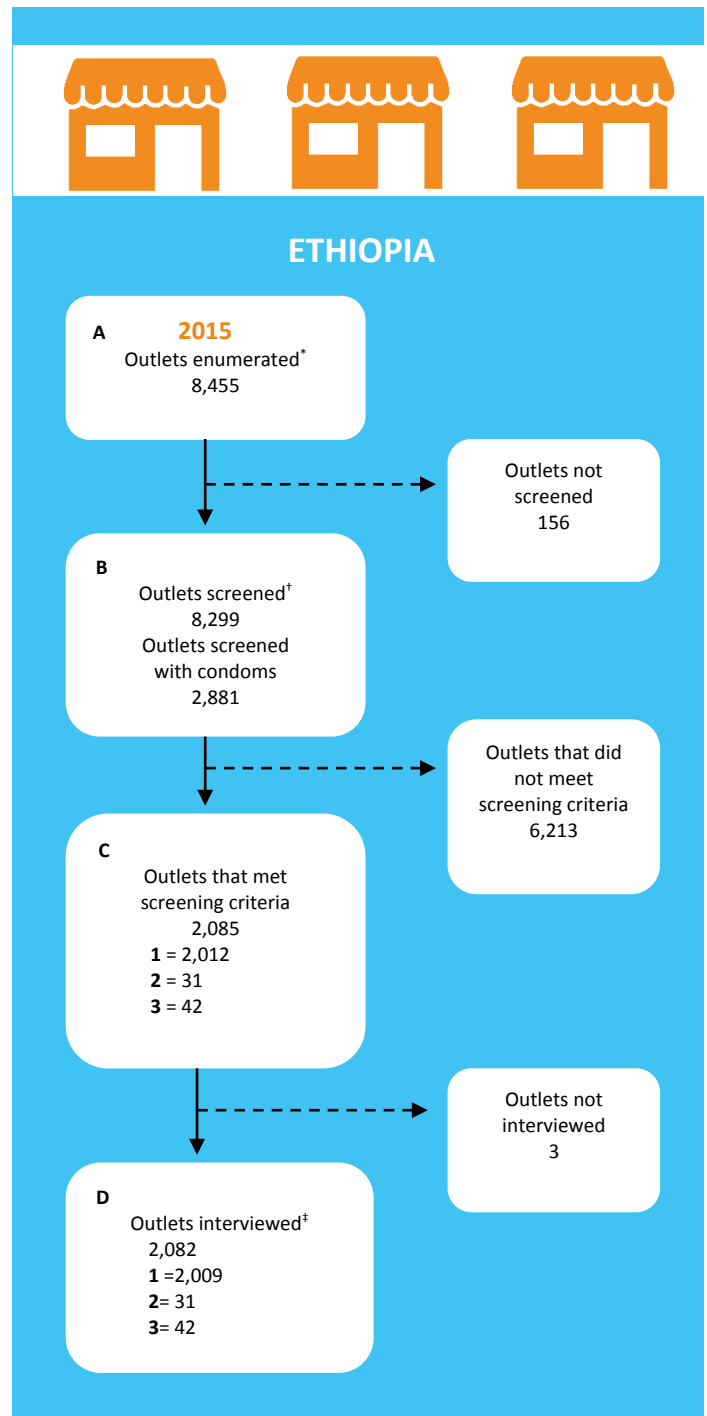
Across the survey rounds, more than 8,400 outlets across greater than 900 *kebeles* were enumerated (i.e. identified as outlets with potential to sell or provide modern contraceptive commodities and services). Among those that were screened, one-third provided information on condoms and 25 percent met at least one of the three eligibility criteria in that they had modern contraceptive commodities other than condoms currently in stock, in stock in the previous three months or provided contraceptive services.

1 in 4

Number of outlets that met the screening criteria

Key:

- 1: Modern contraceptive commodities (includes oral contraceptives, emergency contraceptives, injectables, implants or IUDs) in stock on day of visit
- 2: Modern contraceptive commodities reportedly in stock during the previous three months but not on the day of the visit
- 3: Contraceptive services (including contraceptive injections, implant insertions, IUD insertions, male sterilizations or female sterilizations) available but no modern contraceptive commodities in stock (commodities purchased elsewhere and brought for service)
- * Outlets enumerated: Identified as outlets with potential to sell or distribute modern contraceptive commodities (male condoms, female condoms, oral contraceptives, emergency contraceptives, injectables, implants, IUDs) and/or provide contraceptive services (injections, implants, IUDs, male/female sterilizations) during the census
- † Outlets screened: Administered questions to assess current or recent (previous three months) availability of modern contraceptive commodities or services
- ‡ Outlets interviewed: A partial or complete interview was conducted with an outlet representative, which includes the senior-most available outlet staff member



Geographic focus

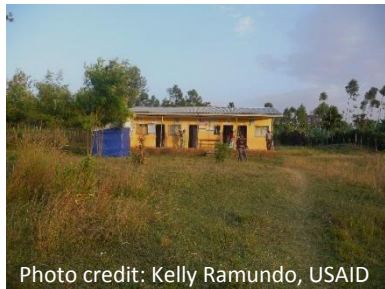


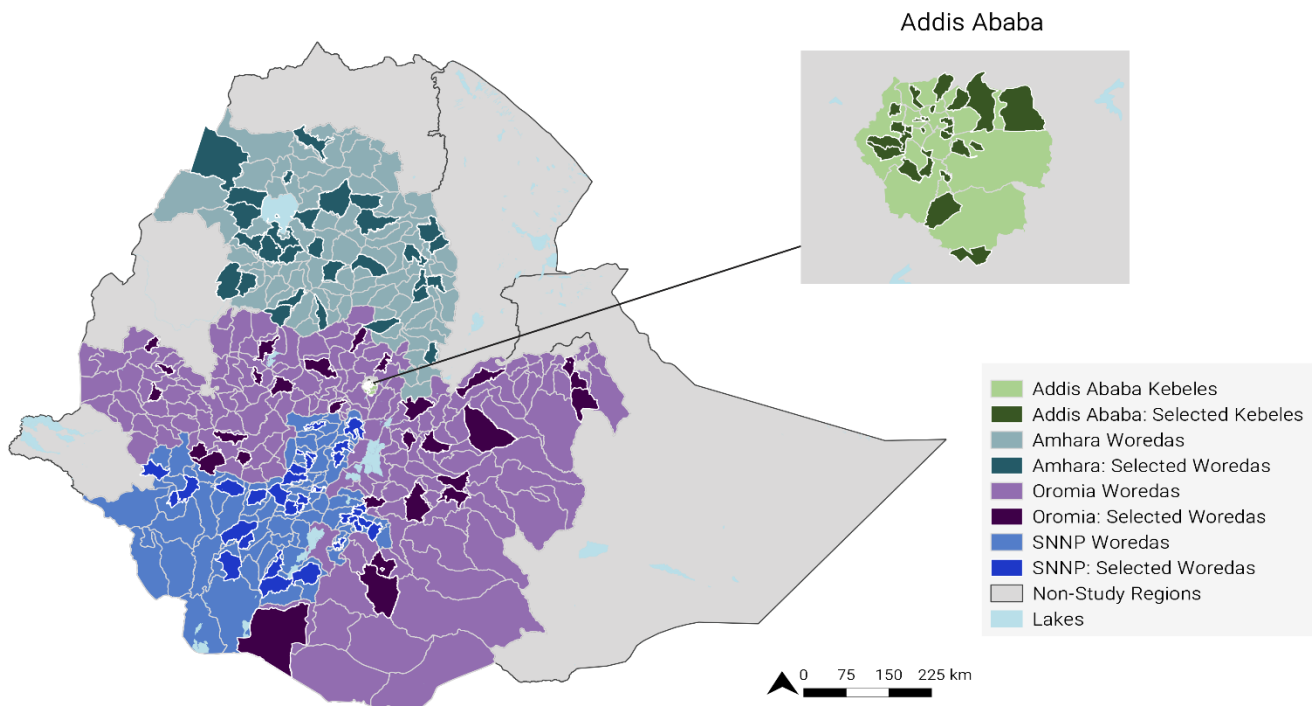
Photo credit: Kelly Ramundo, USAID

>85%

The percentage of Ethiopia's population accounted for by the four study regions

Regions	# Selected Woredas	# Selected Kebeles	# Outlets Enumerated	# Outlets that Met Screening Criteria
Addis Ababa	N/A	27	1,076	378
Amhara	30	300	2,697	569
Oromia	30	291	2,530	634
SNNP	33	319	2,152	504
Total	93	910	8,455	2,085

Ethiopia FPwatch Study Areas



Market composition

WHAT IS CONTRACEPTIVE MARKET COMPOSITION?

Contraceptive market composition illustrates the distribution of all outlets that were found to have at least one modern contraceptive commodity in stock on the day of survey or in the past three months or provide at least one contraceptive service. The pie charts below illustrate the distribution of these outlet types according to the public and private sector and by each outlet category. Outlets with condoms only were excluded. No general retailers had modern contraceptive commodities other than condoms available in interviewed outlets.

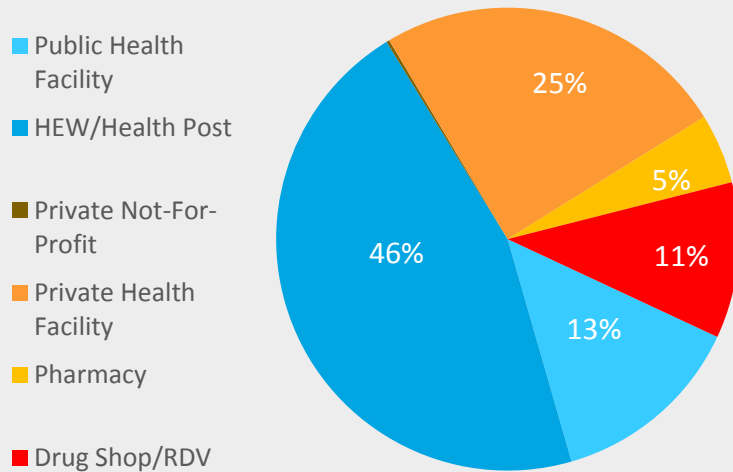
WHAT IS THE 2015 MODERN CONTRACEPTIVE MARKET COMPOSITION?

The private sector accounted for more than 40 percent of contraceptive-stocking outlets or those that offered contraceptive services. Thirteen percent of these were health facilities (primarily clinics) and sixteen percent of these outlets were pharmacies or drug shops (including rural drug vendors (RDVs)). In the public sector, HEWs/health posts comprised 46 percent of all outlets and health facilities (primarily health centers) made up 25 percent of outlets providing contraceptive commodities and services.

41%

The modern FP market composition (excluding outlets with only condoms) accounted for by the private sector in 2015

CONTRACEPTIVE MARKET COMPOSITION FOR 4 REGIONS COMBINED, BY OUTLET TYPE, 2015



N= 2,085

Total number of contraceptive-stocking and/or service-providing outlets by type in 2015: public health facility N=282; HEW/health post N=760; private not-for profit N=10; private health facility N=535; pharmacy N=215; drug shop/RDV N=283.

This chart only includes outlets with modern contraceptive commodities above the level of condoms. No general retailers were found with modern contraceptive commodities excluding condoms.

ETHIOPIA OUTLET GUIDELINES*

Public facilities consist of public hospitals and health centers. According to National FP Guidelines, public facilities can stock all contraceptive commodities. **Public hospitals** can provide all contraceptive services. Health centers can provide all contraceptive services, except male or female sterilizations without trained staff available. **HEWs/health posts** can stock all short-acting commodities as well as Implanon® implants. HEWs/health posts can provide contraceptive injection services and insertion services for Implanon® if trained. **Private health facilities** consist of private hospitals and small, medium and higher clinics. Private hospitals can stock all contraceptive commodities and provide all contraceptive services if trained staff available. All levels of clinics can stock all short-acting methods and provide contraceptive injection and LARC insertion services. Higher clinics can provide male or female sterilizations if trained staff available. **Pharmacies** can stock all short- and long-acting contraceptive commodities. **Drug shops** can stock all short-acting commodities and implants. **RDVs** can stock all short-acting commodities. **Pharmacies, drug shops and RDVs** are not allowed to provide any contraceptive services unless qualified staff are available. **General retailers** typically stock only male condoms.

* See http://phe-ethiopia.org/resadmin/uploads/attachment-158-National_Family_planning%20guideline%20.pdf for full National FP Guidelines.

HOW DOES CONTRACEPTIVE MARKET COMPOSITION DIFFER AMONG REGIONS?

It is important to consider the contraceptive market composition according to geographic differences. For example, the public sector composition was only 10 percent in Addis Ababa but much higher in the largely rural regions, ranging from over half in Amhara to two-thirds in Oromia and three-quarters in SNNP. Within the public sector, HEWs/health posts contributed approximately half of the market composition in Amhara and Oromia and nearly two-thirds in the highly rural region of SNNP, while HEWs/health posts are not found in urban Addis Ababa where the public sector consists predominantly of higher-level facilities.

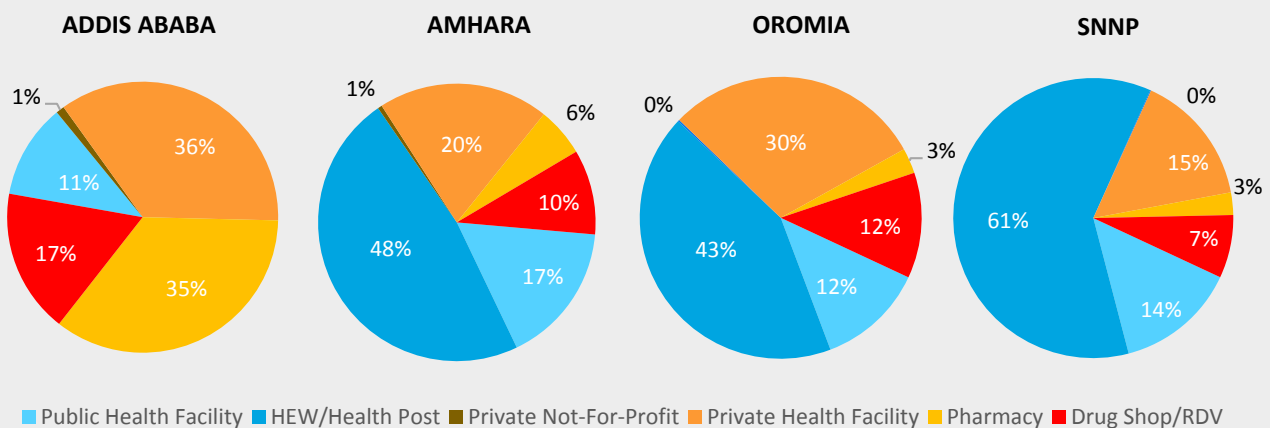
The private sector composed nearly 90 percent of the market in Addis Ababa. It ranged from 45 percent in Amhara to 36 percent in Amhara, and only 25 percent in SNNP. Higher-level private facilities were more common in Addis Ababa and Amhara compared to Oromia and SNNP. Thirty-five percent of outlets with modern contraceptive commodities or services were pharmacies in urban Addis Ababa, versus 6 percent or less in the other three regions surveyed.

These findings show diversity in the market landscape composition according to location and especially as they relate to the rural/urban make-up of these regions. The findings are indicative of the types of outlets that may be ready to provide access to modern contraceptive methods in Ethiopia.

The regional market landscapes vary. While public sector composition was low in Addis Ababa, it made up more than 1/2 to 3/4 of the market in rural regions largely due to the high proportion of rural HEWs/health posts.

Private health facilities (primarily clinics) and pharmacies dominated the private sector in Addis Ababa, while clinics and drug shops were most common in the mostly rural regions.

CONTRACEPTIVE MARKET COMPOSITION, BY REGION AND OUTLET TYPE, 2015



N= 2,085; Addis Ababa N=378; Amhara N=569; Oromia N=634; SNNP N=504.

These charts only include outlets with modern contraceptive methods above the level of condoms. No general retailers were found with modern contraceptive commodities excluding condoms.



Contraceptive method availability



Photo credit: © 2013 Sarah V. Harlan /JHU•CCP, Courtesy of Photoshare

WHAT IS THE AVAILABILITY OF SELECTED SHORT-ACTING CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS?

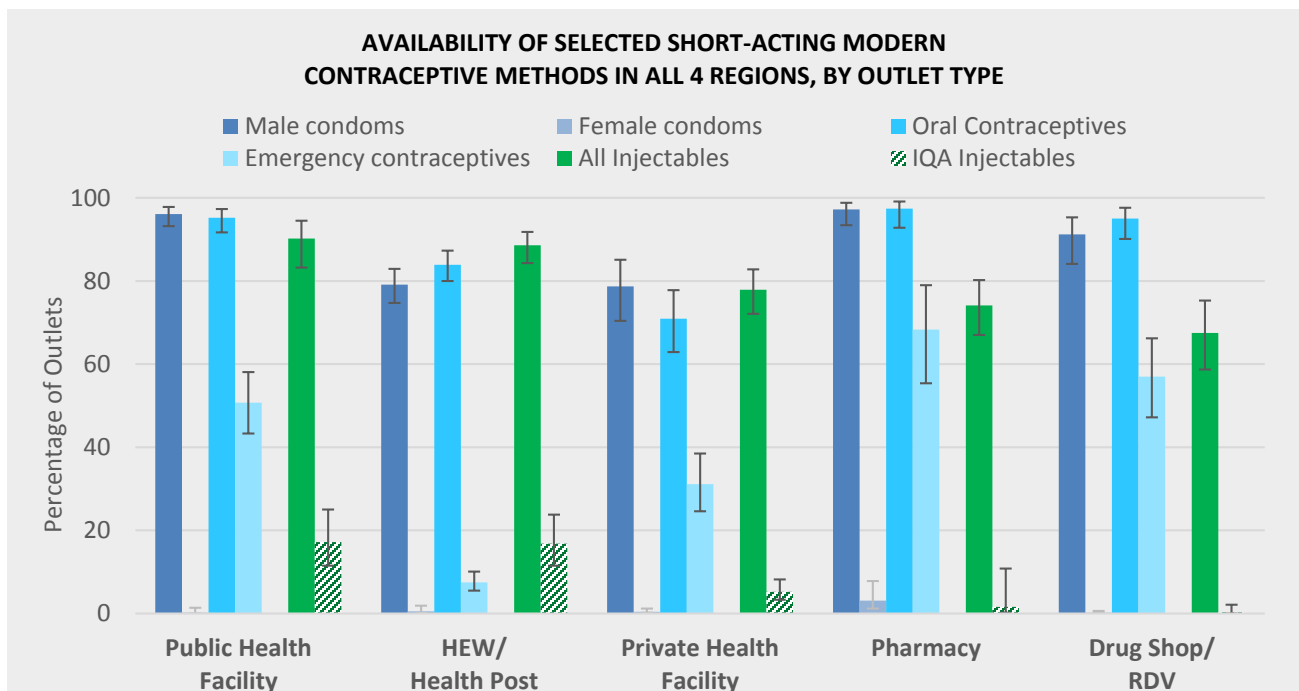
The census approach involved a search for all outlets that had the potential to provide modern contraceptive methods in each selected area. The graphs show the percentage of outlets that were found to have selected short-acting contraceptives and LARCs among outlets with at least one modern contraceptive commodity in stock on the day of the survey or in the past three months, or providing at least one contraceptive service.

For short-acting contraceptives in the public sector, more than 90 percent of health facilities had male condoms, oral contraceptives and injectables. More than 80 percent of HEWs/health posts had these methods available. Availability of emergency contraceptives was lower in the public sector with half of facilities and less than 10 percent of HEWs/health posts reporting their availability. In the private sector, approximately 80 percent of health facilities had male condoms, oral contraceptives and injectables available. Pharmacies and drug shop/RDVs had comparatively high availability of male condoms, oral contraceptives and, especially, emergency contraceptives.

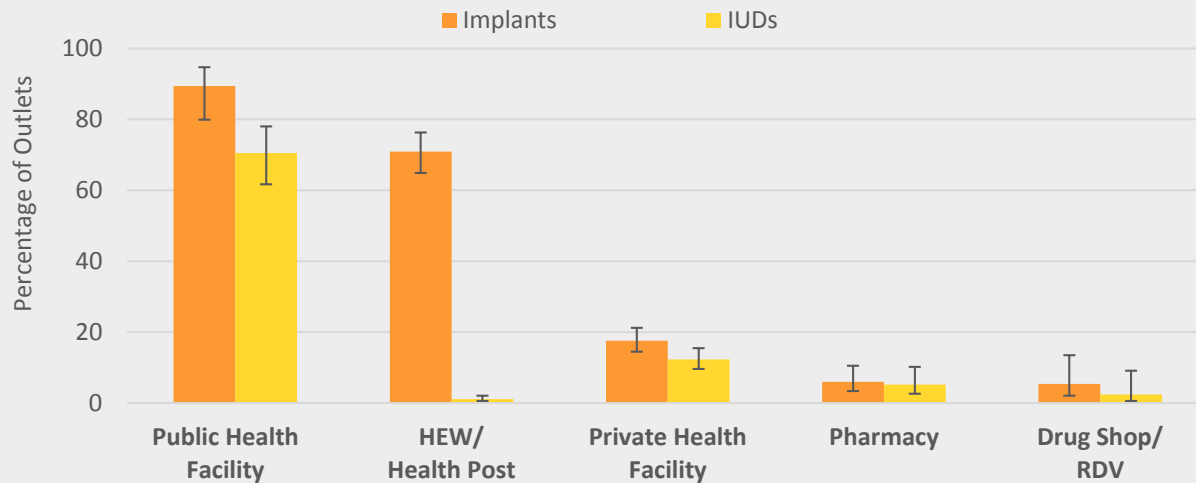
Both public and private outlets had high availability of short-acting contraceptive methods. All outlet types had low availability of international quality-assured injectable brands.

WHAT IS THE AVAILABILITY OF QA (QUALITY-ASSURED) SHORT-ACTING CONTRACEPTIVE BRANDS AMONG ELIGIBLE OUTLETS?

International quality-assured (IQA) contraceptives are defined as those on the WHO Prequalification or a Stringent Regulatory Authority list. All oral contraceptive, implant and IUD brands found during the survey and nearly all emergency contraceptive brands were quality-assured according to this definition. Only one brand of injectable met these quality-assurance standards. Accordingly, less than 20 percent of public facilities and HEWs/health posts had an IQA brand of injectable available and less than 5 percent of private sector outlets had an IQA brand of injectable available.



AVAILABILITY OF SELECTED LONG-ACTING CONTRACEPTIVE METHODS IN ALL 4 REGIONS, BY OUTLET TYPE



WHAT IS THE AVAILABILITY OF SELECTED LONG-ACTING AND PERMANENT METHODS AMONG ELIGIBLE OUTLETS?

For LARCs in the public sector, the majority of health facilities had implants and intrauterine devices (IUDs) available. Implant availability among HEWs/health posts also reached more than 70 percent, predominantly due to the high availability of Implanon®. In the private sector, low availability of both implants and IUDs was reported, ranging from less than 20 percent in health facilities to less than 5 percent in pharmacies and drug shops/RDVs. Despite LARC method availability at pharmacies and drug shops/RDVs, these outlets typically do not have credentialed staff to deliver the LARC services. Availability of male and female sterilizations was very low (<2 percent) among both public and private health facilities and was not reported in other outlet types.

HOW DOES AVAILABILITY OF SELECTED SHORT-ACTING CONTRACEPTIVES AMONG ELIGIBLE OUTLETS DIFFER AMONG REGIONS?

In regional graphs on the following pages, few differences were seen in the availability of male condoms, oral contraceptives and injectables between regions in the private sector. However, emergency contraceptive availability was considerably higher for Addis Ababa, at over 80 percent, compared to the predominantly rural regions at 20 percent or less. Only slight differences were observed in the availability of select short-acting contraceptive methods in private sector facilities.

HOW DOES AVAILABILITY OF SELECTED LARCS AMONG ELIGIBLE OUTLETS DIFFER AMONG REGIONS?

In regional graphs on the following pages, little difference was observed for the availability of implants across regions in public sector outlets. IUD availability in Addis Ababa public outlets was considerably higher (nearly 80 percent) compared to public sector outlets in the other regions (approximately 20 percent). In private sector facilities, IUDs were slightly more available in Addis Ababa and Amhara private outlets. However, private outlets generally had low availability of LARCs across the four regions.

High availability of implants was found in public sector outlets and high availability of IUDs among public health facilities.

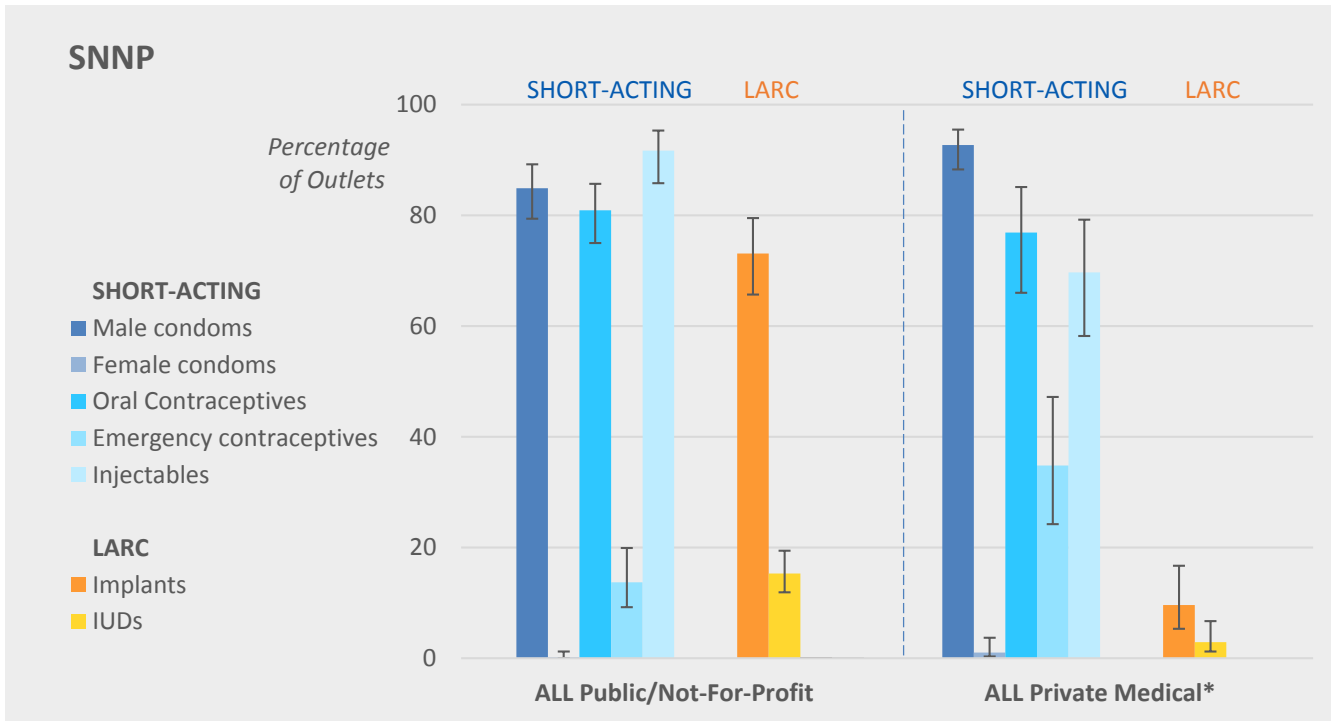
Availability of LARCs in the private sector was generally very low.

REGIONAL AVAILABILITY OF SELECTED MODERN CONTRACEPTIVE METHODS, BY OUTLET TYPE



* ALL Private Medical includes private health facilities, pharmacies, drug shop/rural drug vendors. Does not include general retailers.

REGIONAL AVAILABILITY OF SELECTED MODERN CONTRACEPTIVE METHODS, BY OUTLET TYPE



*ALL Private Medical includes private health facilities, pharmacies, drug shop/rural drug vendors. Does not include general retailers.

Available range of contraceptive methods

WHAT IS THE AVAILABILITY OF SELECTED RANGES OF CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS?

Choice of contraceptive method is an integral component of FP2020 and Ethiopia’s national commitment and availability of a range of methods is a critical component of choice. Ranges examined include the availability of three or more methods, three or more methods with at least one long-acting reversible contraceptive or permanent method (LARC/PM) available and five or more methods.

In the public sector, nearly all health facilities had 3+ methods and more than 80 percent of HEWs/health posts had 3+ methods. Including a LARC/PM, availability of 3+ methods was still high in both health facilities and HEWs/health posts (approx. 90 and 65 percent, respectively). However, fewer public health facilities had 5+ methods (about two-thirds) and very few HEWs/health posts had 5+ methods available (five percent) due to lack of credentials for delivery of all LARC/PM methods.

In the private sector, both pharmacies and drug shops had high availability of 3+ methods at 80 percent or more. However, the availability of 3+ methods with at least 1 LARC/PM and of 5+ methods was low for all private sector outlets (<20 percent).

ARE THERE REGIONAL DIFFERENCES IN AVAILABILITY OF SELECTED RANGES OF METHODS?

The regional graphs on the following page demonstrate some important variation in method range. First, HEWs/health posts are not posted in Addis Ababa, an urban area. For HEWs/health posts in the predominantly rural regions, slightly higher proportions have the selected ranges in Amhara compared to Oromia and SNNP.

In the private sector, the percentage of pharmacies and drug shops/RDVs having 3+ methods was at or above 80 percent in all regions except for drug shops/RDVs in SNNP (approximately 70 percent). Availability of 3+ methods was higher for private health facilities in Amhara (80 percent) compared to 45-60 percent for the other regions. Availability of 3+ methods with at least 1 LARC/PM and of 5+ methods was generally low for all private sector outlet types in the regions. There was a slightly higher percentage of private facilities in Addis Ababa with these ranges and a slightly higher percentage of pharmacies in Oromia with these ranges compared to other regions.

Percent of outlets with 3+ modern FP methods

86% vs. **71%**

of public sector outlets vs. of private sector outlets

Percent of medical outlets with 3+ modern FP methods available and at least 1 LARC/PM

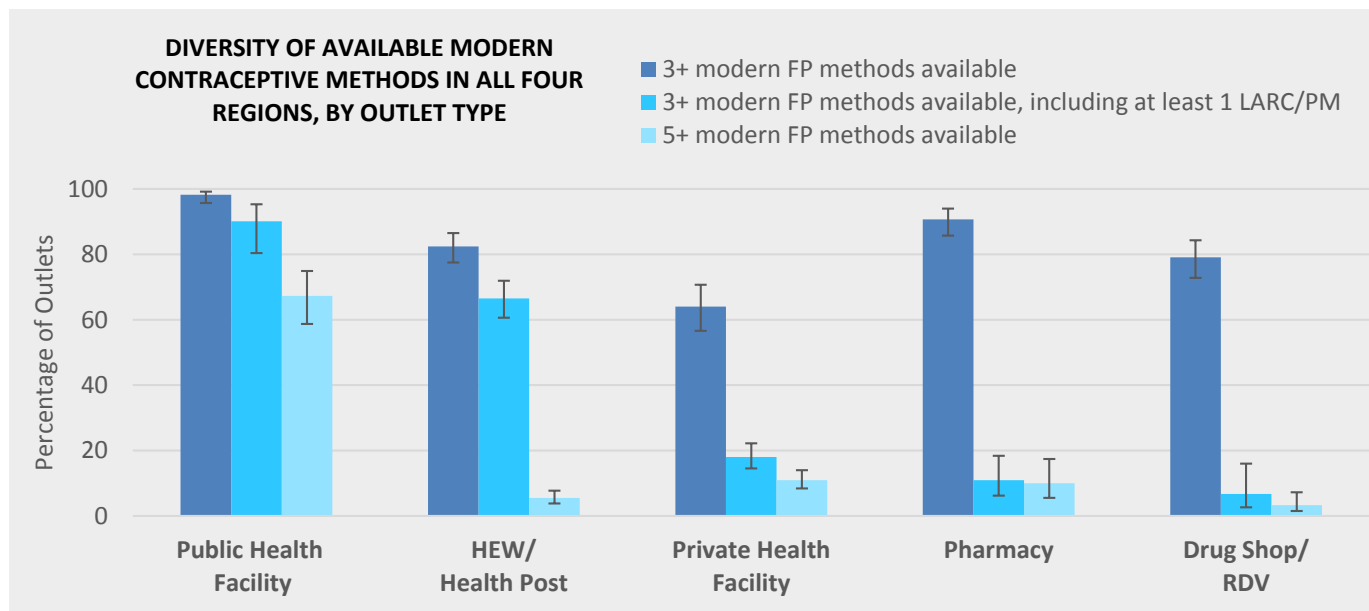
72% vs. **14%**

of public sector outlets vs. of private sector outlets

Percent of outlets with 5+ modern FP methods

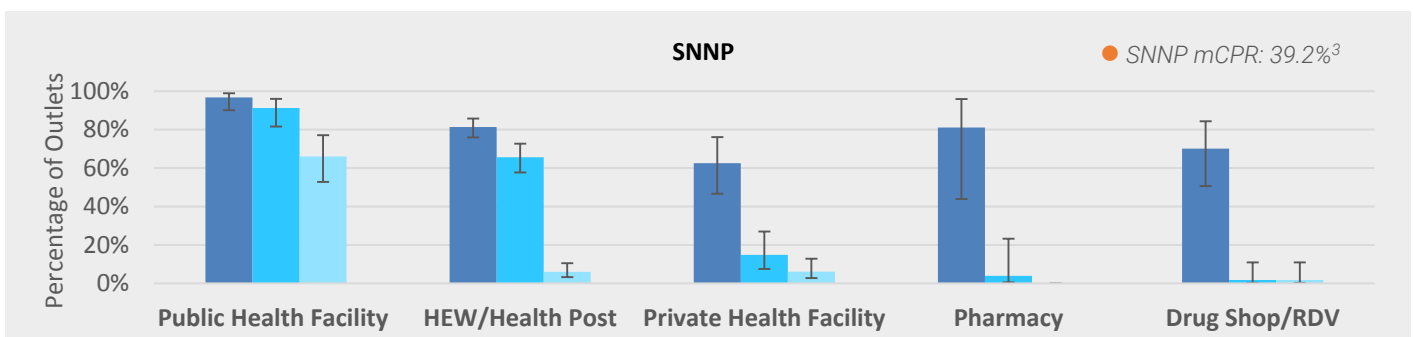
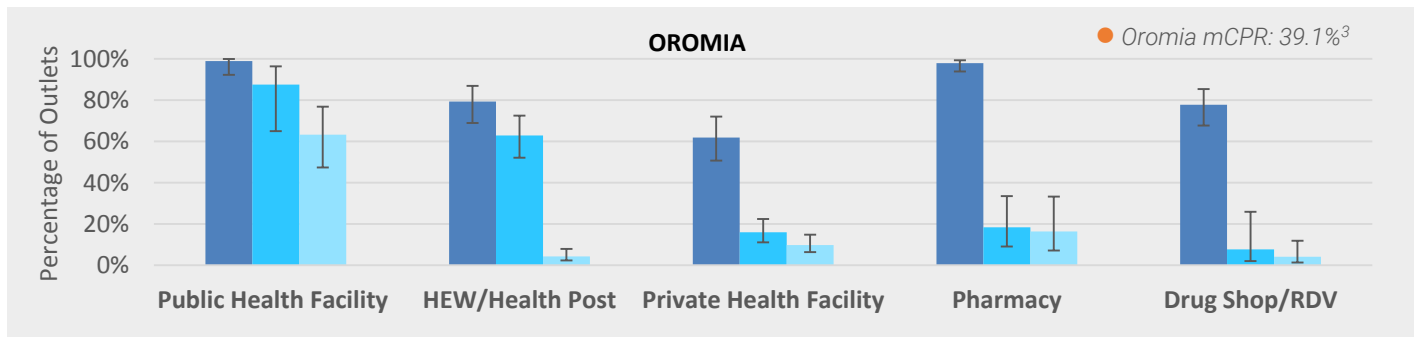
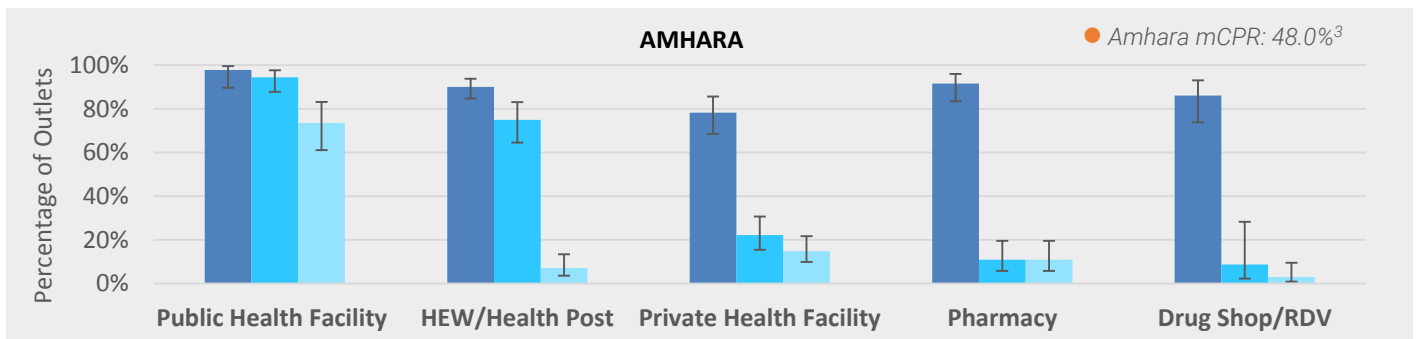
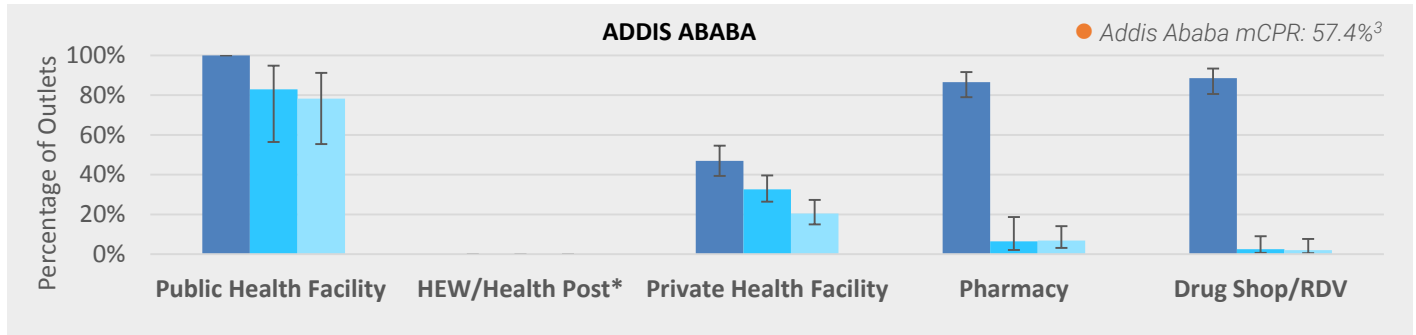
20% vs. **9%**

of public sector outlets vs. of private sector outlets



REGIONAL DIVERSITY OF AVAILABLE MODERN CONTRACEPTIVE METHODS, BY OUTLET TYPE

- 3+ modern FP methods available
- 3+ modern FP methods available, including at least 1 LARC/PM
- 5+ modern FP methods available



* HEWs are not deployed in urban Addis Ababa.

³ Central Statistical Agency [Ethiopia]. 2014. Ethiopia Mini Demographic and Health Survey 2014. Addis Ababa, Ethiopia.

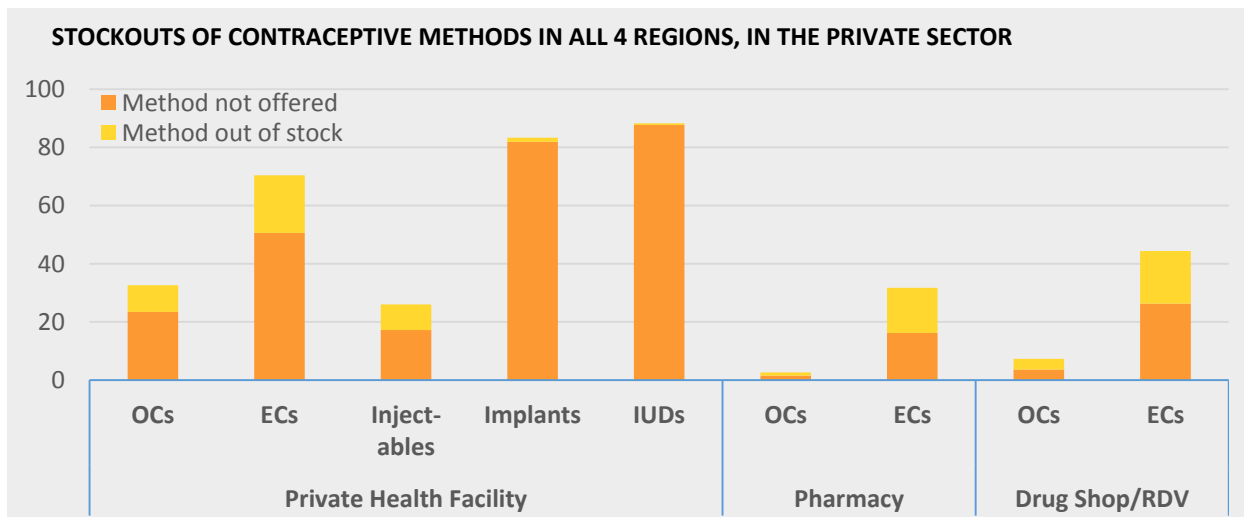
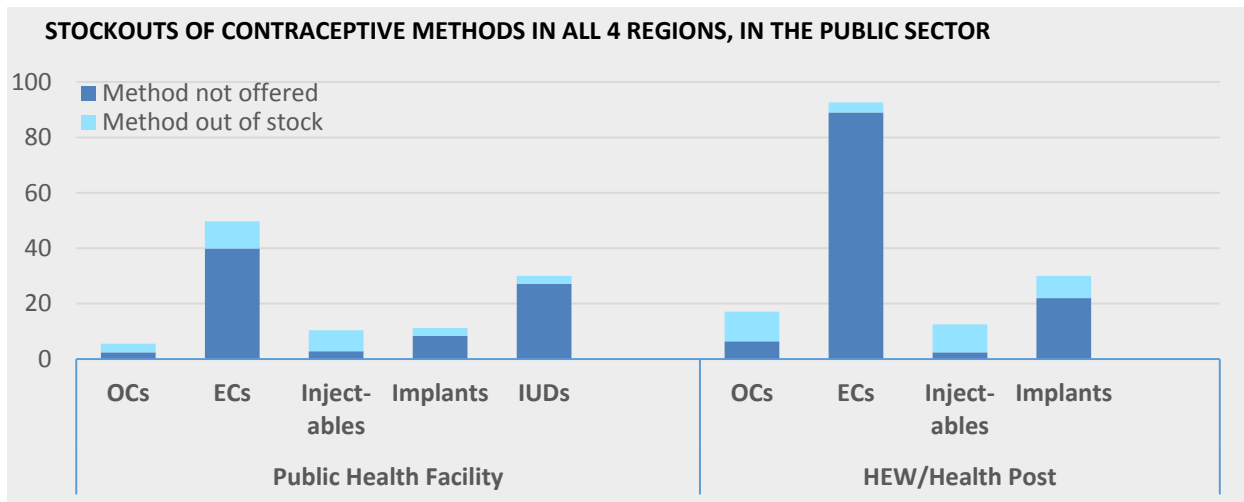
Stock-outs

WHAT ARE STOCK-OUTS

The graphs below present data for point-in-time stock-outs or the percentage of facilities stocked out on the day of the survey, by contraceptive method offered. This means that among outlets reporting that the method is typically stocked, all brands/generics of a contraceptive method were unavailable at the outlet on the day of the survey. Data are presented for outlets not offering the method and for outlets that had at least one brand or generic of a method in stock in the previous three months, but were stocked out at the time of the survey.

WHAT CONTRACEPTIVE METHODS ARE OUT OF STOCK AMONG SCREENED OUTLETS?

About 8 percent of public facilities and 10 percent of HEWs/health posts were stocked out of injectables on the day of the assessment, despite generally high availability in the previous three months. About 20 percent of HEWs/health posts did not offer implants and 8 percent were currently stocked out. In the private sector, 20 percent of private health facilities, 16 percent of pharmacies and 18 percent of drug shops/RDVs which had stocked emergency contraceptives in the past three months were currently stocked out. A smaller proportion of private health facilities (9 percent) that had injectables previously available were currently out of stock.





Contraceptive market share

Role of the public and the private sectors

WHAT IS CONTRACEPTIVE MARKET SHARE?

Market share of modern contraceptive methods, or the relative public and private sector distribution for all modern contraceptive commodities, is estimated using information about reported distribution of each commodity sold and, for sterilizations, the number performed during the one-month period preceding the survey. Market share is reported in couple years of protection (CYP). **CYP is the estimated protection provided by contraceptive methods during a one-year period.** Volume distributed for each method type is converted to CYP by a conversion factor specific to each method.⁹ The graphs on pages 24-25 show contraceptive market share as a proportion of the total CYPs by outlet and method types for all 4 regions, followed by individual regions. The graphs on page 26 present market share as a proportion of the total CYPs within outlet types by method for all four regions followed by individual regions.

The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor.

For example, 1 Sterilization equals:
 139.5 Oral contraceptives
 37.2 Injectables
 ~3.7 Implanon implants
 ~2.0 IUDs

UNPACKING THE PUBLIC SECTOR CONTRACEPTIVE MARKET SHARE

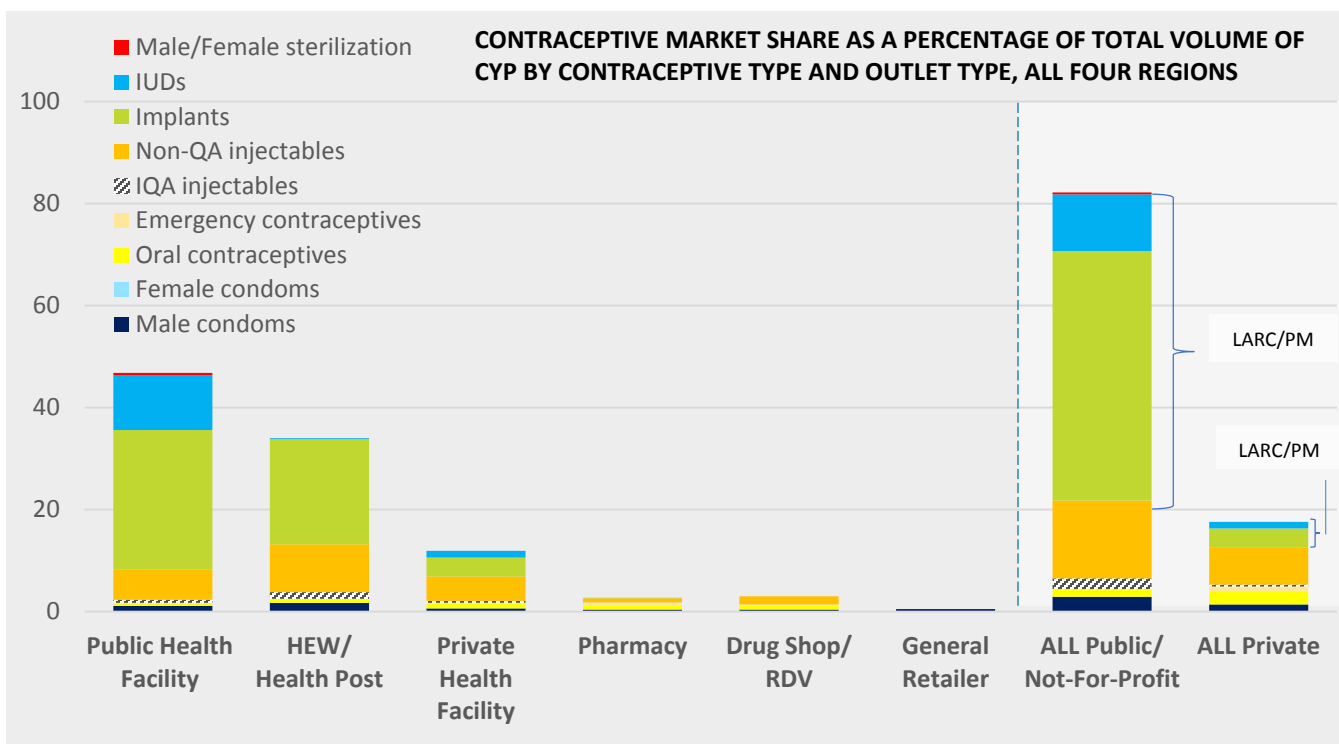
As a proportion of the total volume of CYP, the public sector accounts for about 80 percent of total volume of CYPs distributed, with almost half coming from health facilities and one-third from HEWs/health posts. Implants (49 percent), particularly Implanon® (41 percent), followed by injectables (17 percent) and IUDs (11%) distributed in the public sector, are the main contributors of total CYPs. Within outlet types (graph on page 26), LARCS (implants, 60 percent; and IUDs, 14 percent) account for nearly three-quarters of public sector outlet CYPs with 50 percent coming solely from Implanon®. Among HEWs/health posts, implants account for over 60 percent of CYPs.

18%*

Private sector contribution to total contraceptive market share in CYP

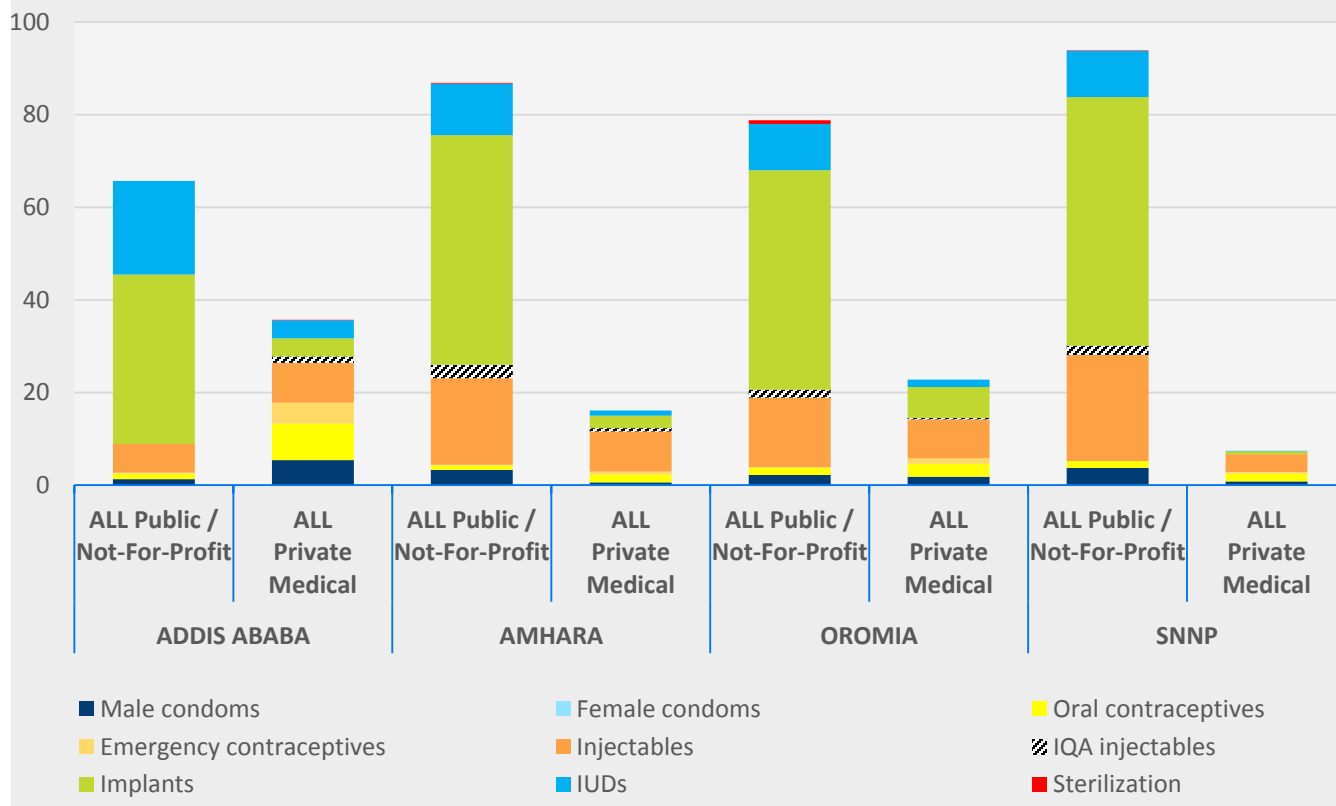
65%

Percent of CYPs, across outlets, accounted for by LARCS



*This does not necessarily reflect the volume of CYPs distributed by the private sector to the public sector. A significant proportion of commodities are known to be distributed through public sector facilities, but to be procured by the private sector

CONTRACEPTIVE MARKET SHARE AS A PERCENTAGE OF TOTAL VOLUME OF CYP BY CONTRACEPTIVE TYPE, SECTOR AND REGION



ARE THERE REGIONAL DIFFERENCES IN THE PUBLIC SECTOR CONTRACEPTIVE MARKET SHARE?

Across regions, the public sector accounts for a range from 66 percent of total regional CYP in Addis Ababa to 92 percent of the total in SNNP. Of this, the contribution of LARCs distributed in the public sector account for a range of 57 percent of LARCs in Addis Ababa and Oromia to 64 percent in SNNP of total regional CYP. Within public sector outlets (graph on following page), the share of LARCs of total regional public sector CYP ranges from 69 percent in SNNP to 87 percent in Addis Ababa.

UNPACKING THE PRIVATE SECTOR CONTRACEPTIVE MARKET SHARE

As a proportion of the total volume of CYP, the private sector accounts for about 20 percent of total CYP distributed, with 12 percent coming from private health facilities and 6 percent from pharmacies, drug shops and RDVs. Injectables (8 percent) distributed in the public sector are the main contributors of total CYP. Within outlet types (graph on following page), injectables account for over 40 percent of private sector outlet CYP, with other short-acting methods and LARCs accounting for almost 30 percent each.

While injectables are the main private sector contributors to the total CYP among all outlets, LARCs account for nearly 1/3 of the CYP within private sector outlets.

ARE THERE REGIONAL DIFFERENCES IN PRIVATE SECTOR CONTRACEPTIVE MARKET SHARE?

Across regions, the private sector accounts for a range from 8 percent of total regional CYP in SNNP to one-third in Addis Ababa. Most of this contribution of private outlets to total CYP comes from injectables in all regions. Looking at CYP within private sector outlets (graph on following page), there is more variance. In private sector outlets in Addis Ababa, approximately one-quarter of CYP within private sector outlets comes each from injectables, oral contraceptives and LARCs, and a relatively high proportion comes from emergency contraceptives (13 percent). In Amhara, nearly 60 percent come from injectables and one-quarter from LARCs. In Oromia, about one-third comes each from injectables, LARCs and other short-acting methods. In SNNP, nearly 60 percent comes from injectables and relatively little (10 percent) from LARCs.

Injectables account for about **20%** of the market share of public outlets and **40%** of the market share of private outlets.

Implants account for about **60%** of the market share of public outlets and **20%** of the market share of private outlets.

IUDs account for **15%** of the market share of public outlets and **7%** of the market share of private outlets.

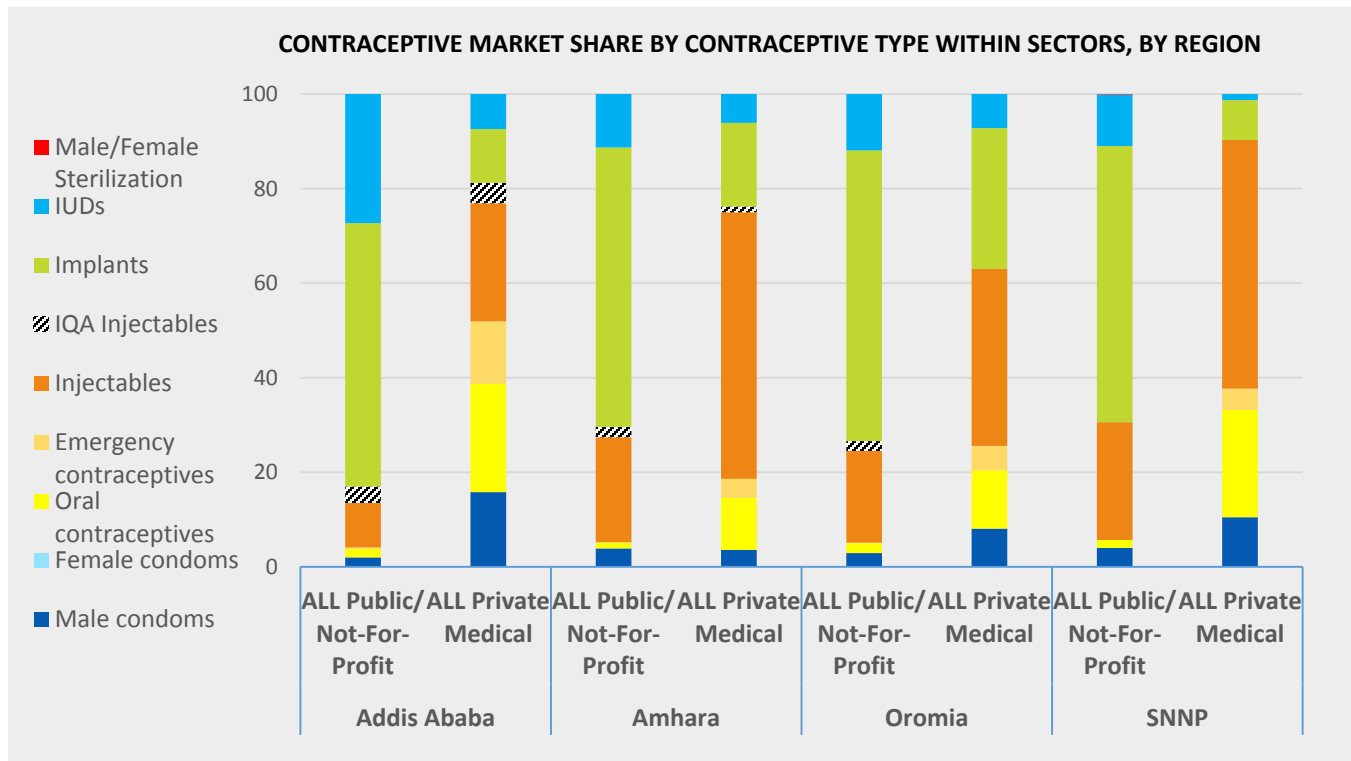
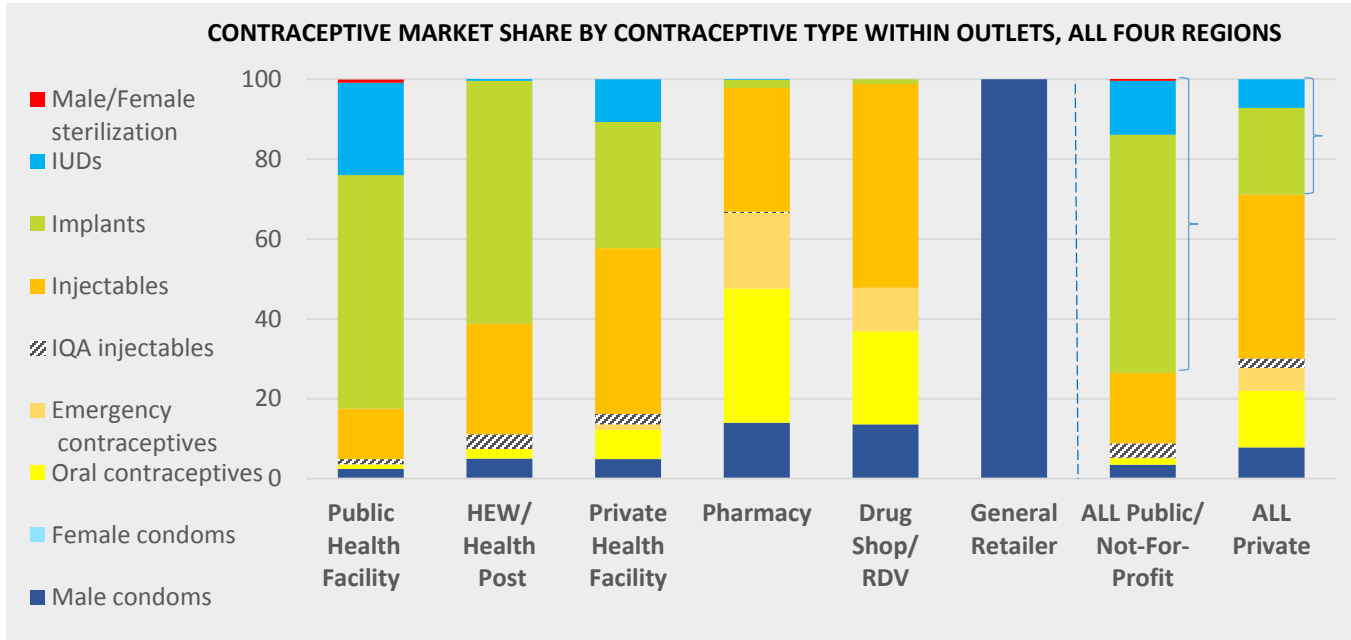




Photo credit: PSI

Readiness to provide contraceptive services

This section addresses the public and private sector readiness to offer provider-dependent contraceptive services (or procedures) according to Ethiopia's National FP Guidelines. It addresses availability and service readiness to provide contraceptive services.

Outlets that offer contraceptive services

WHERE ARE PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES OFFERED?

This graph shows the percentage of outlets that had selected contraceptive services available among all screened outlets of the outlet type. Contraceptive services are typically not performed in pharmacies, drug shops and RDVs due to staff lacking necessary credentials to perform the service.

In the public sector, over 90 percent of facilities offered an injection or implant insertion service, while fewer (70 percent) offered IUD insertion services. Nearly all HEWs/health posts offered injection services and more than three-quarters offered implant insertion services (primarily Implanon®).

Male and female sterilization services were only offered in higher-level facilities, and in very few outlets.

In the private sector, while nearly all private health facilities offered injection services, only 20 percent offered implant insertions and 15 percent offered IUD insertions.

About 1 in 5 private health facilities offer contraceptive implant insertions and about 1 in 6 offer IUD insertions.

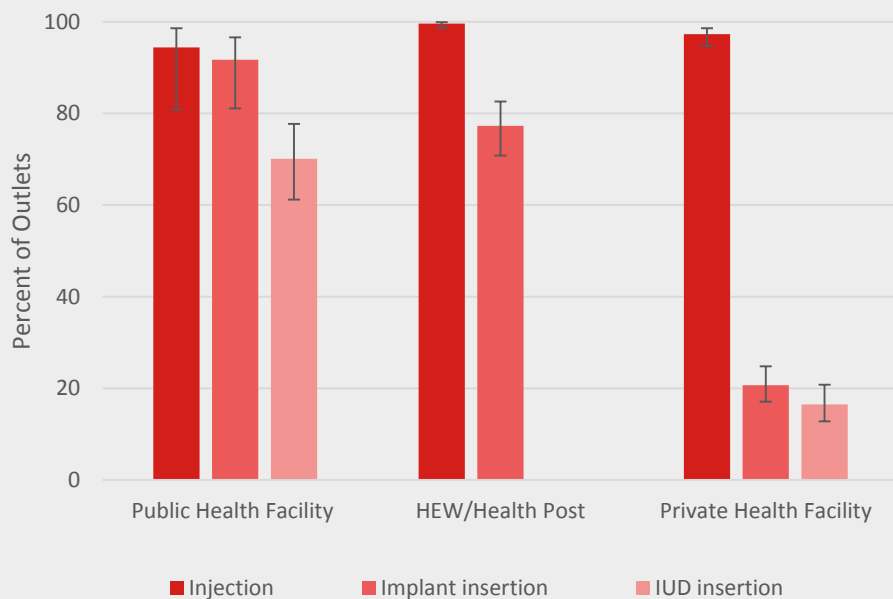
AVAILABILITY OF CONTRACEPTIVE SERVICES ACROSS 4 REGIONS, BY OUTLET TYPE

>75%

HEWs/health posts that offered (Implanon®) implant insertion services

70%

Public sector facilities that offered IUD insertion services



ARE OUTLETS MEETING QUALITY STANDARDS TO DELIVER PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES?

Two graphs are displayed on the following page. The first presents service readiness among all screened outlets that were likely to offer contraceptive services. Lower-level outlets rarely offered contraceptive services and were not included. In the second graph, service readiness is assessed for all outlets that reported offering the particular contraceptive service.

For injection services, large majorities (>80 percent) of screened (>80 percent) and providing (>90 percent) health facilities and HEWs/health posts are service-ready. Service readiness to provide injection services in private health facilities is slightly lower for screened (70 percent) and facilities offering services (80 percent).

Service readiness for implant insertion services was relatively high for public health facilities, with approximately 70 percent of both screened outlets and those providing services meeting conditions. Service readiness was lower for HEWs/health posts, with only 40 percent of all HEWs/health posts classified as service-ready and slightly over half of those that provide implant insertions were service-ready. For private health facilities, provision was low for all screened facilities at about 10 percent, but over half of those that reported providing the service were service-ready.

Looking at IUD insertion services, only half of all public health facilities met conditions for service readiness, three-quarters of those providing the service met requirements. Less than 10 percent of all private health facilities were service-ready, but over half of those that reportedly provided the service met the conditions.

Male and female sterilizations were rarely reported and only available in higher-level public and private health facilities. However, for those reporting availability, more than 60 percent of public facilities were service-ready, while only 40-50 percent of private health facilities were service-ready.

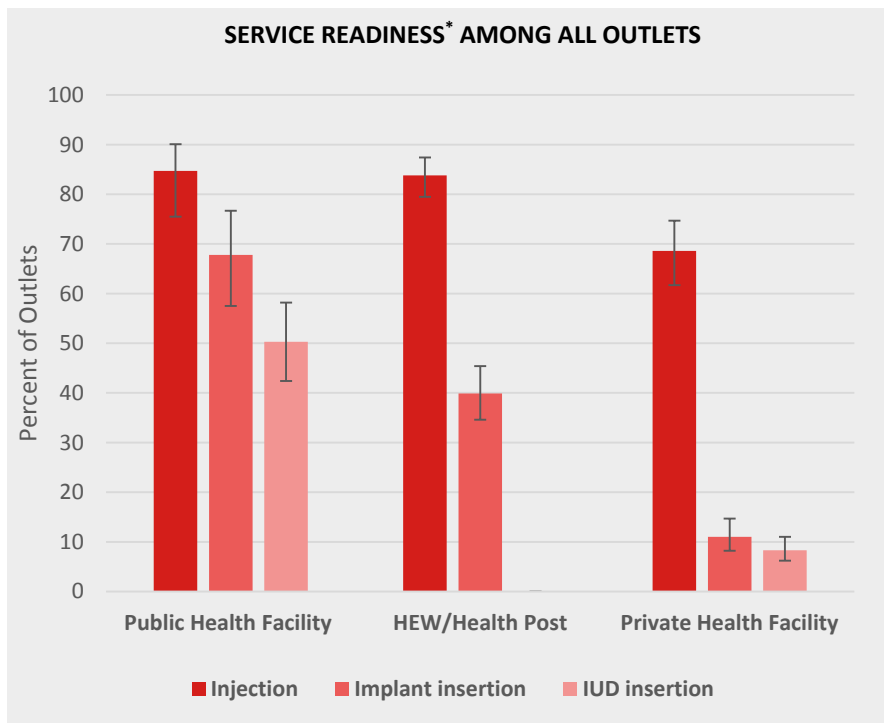
Readiness to provide contraceptive services is a composite indicator combining:

- 1. Availability of contraceptive on-site (not applicable to sterilizations);*
- 2. Trained/credentialed providers; and*
- 3. A minimum set of equipment needed for the service.*

If an outlet meets all 3 conditions, it is classified as service-ready.

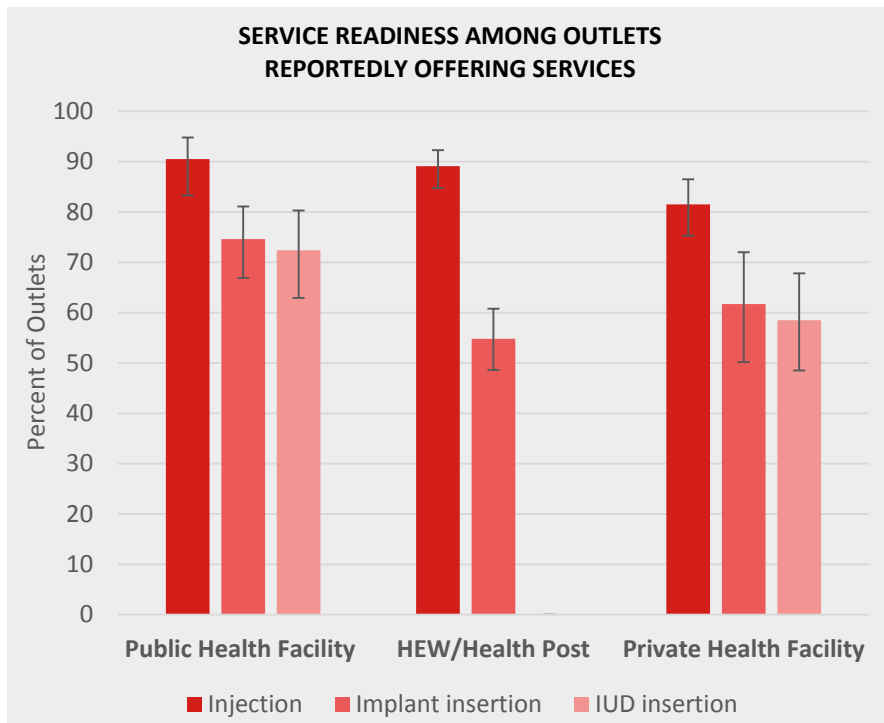


Photo credit: Danielle Garfinkel (PSI)



40%

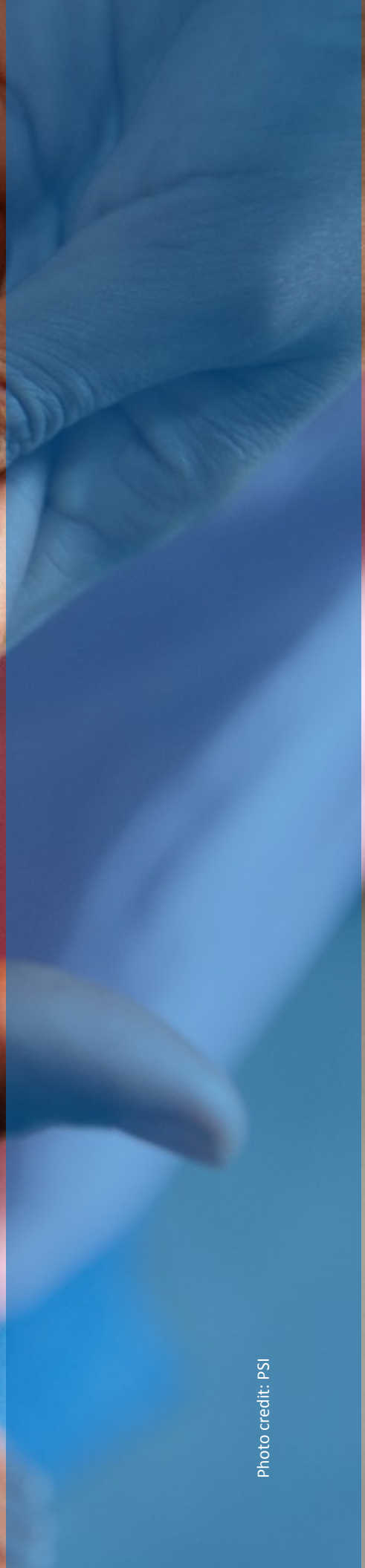
Percent of all HEWs/health posts screened meeting service readiness standards to provide implant insertion services



3 of 5

Number of private health facilities offering LARC insertion services that were service ready

* Full service readiness is defined as having available: 1. The commodity (not applicable for male/female sterilization); 2. A provider with credentials meeting the Ethiopia National Family Planning Guidelines (http://phe-ethiopia.org/resadmin/uploads/attachment-158-National_Family_planning%20guideline%20.pdf) to perform the service; and 3. A minimum set of sentinel equipment (http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/long-acting-permanent-methods/percent-of-facilities-with-appropriate) for providing the service.



Modern contraceptive market prices

WHAT IS THE COST PER CYP IN USD, FOR CONTRACEPTIVE METHODS IN THE PRIVATE SECTOR?

Prices for contraceptive methods were standardized across methods by converting into price per CYP. The following graph reports median USD price and price per CYP for both short-acting contraceptives and LARCs in the private sector. In the public sector, nearly all contraceptive commodities are distributed for free. The prices listed are those incurred by the end-user and do not necessarily reflect any subsidy that may be provided.

Comparing private outlet types, few significant differences were seen in price per CYP for short-acting methods. The median price for oral contraceptives tended to be higher in pharmacies, but other short-acting contraceptive prices were relatively uniform across outlet types. While few pharmacies and drug shops/RDVs provided LARCs, the median price tended to be lower compared to private health facilities.

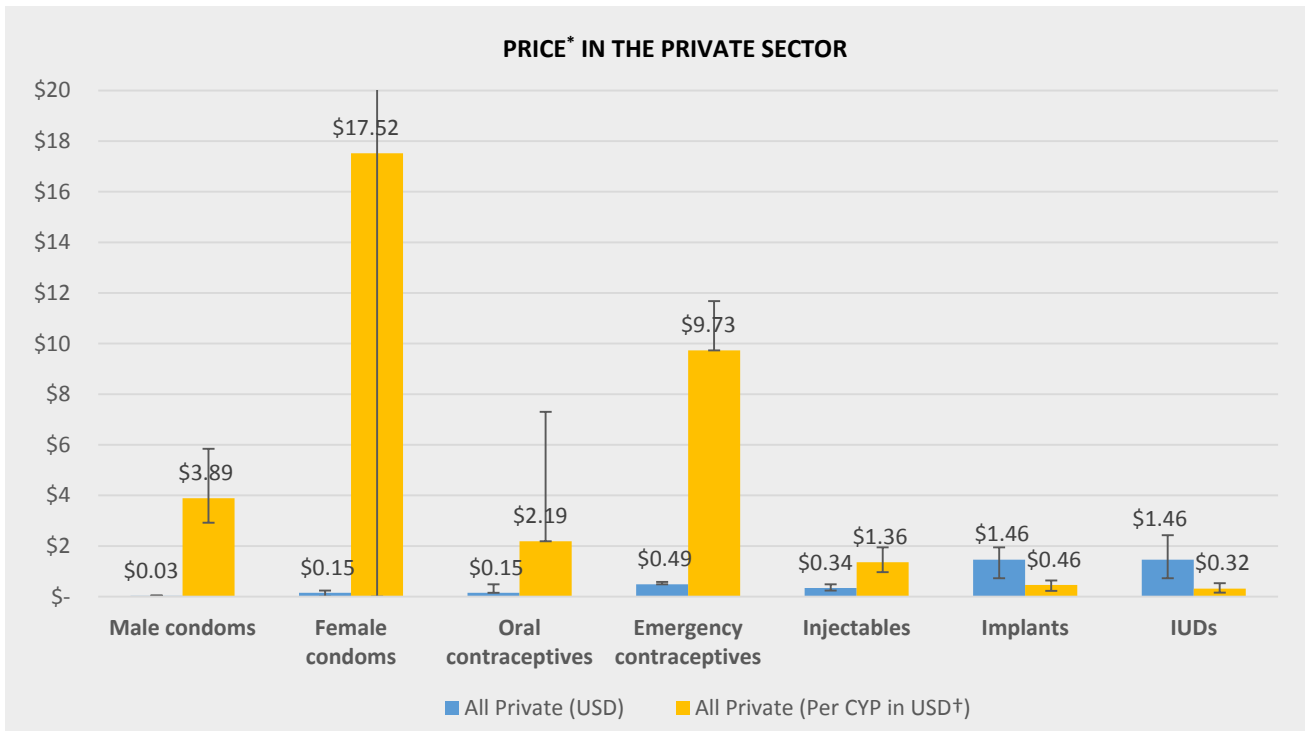
Comparing methods, the median price tended to be highest for emergency contraceptives at \$9.73 per CYP (20 doses) across private outlets, followed by oral contraceptives (15 doses), male condoms (120 condoms) and injectables (4 doses) at \$1.36 per CYP in all private outlets. LARCs were significantly less costly with the median cost of implants at \$0.46 (for 2.5, 3.2 or 3.8 CYPs) and the median cost of IUDs at \$0.32 (for 4.6 CYPs). **There were no significant differences in price by outlet type or region.**

3X

The increase in price of one CYP for an injectable vs. an implant in the private sector

4X

The increase in price of one CYP for an injectable vs. an IUD in the private sector



* For those outlets selling both the commodity and providing the service, prices were often not distinguished into separate prices for both the commodity and service and, instead the combination was reported. In these cases, the combined price was used.

† Price conversion was done from birr to USD based on the average conversion rates during the period of data collection, July 6 – August 15, 2015 of 20.56 Birr per 1 USD.



Photo credit: Andrew Andrada (PSI)

Summary

While Ethiopia has not yet reached its ambitious FP2020 goals for CPR and national goals for unmet need among the population, FPwatch findings on the family planning market suggest that national strategies are setting the foundation for reaching those goals.

This 2015 Ethiopia study, conducted among 2,085 public and private outlets with modern contraceptives and/or services as well as information from 2,881 outlets on condoms within fully censused kebeles, provides contraceptive market data relevant for monitoring and informing Ethiopia's FP2020 commitments. The survey was designed to provide high-quality and timely information on five research questions for assessing the accessibility and equity, quality and choice among modern contraceptive commodities and services in markets in Addis Ababa, Amhara, Oromia and SNNP.

What types of outlets in the public and private sectors are carrying modern contraceptive methods?

Of the 2,085 outlets, private sector outlets in the contraceptive market comprise 41 percent of all outlets with at least one modern method available among: oral contraceptives, emergency contraceptives, injectables, implants, IUDs and/or male/female sterilizations. Private health facilities (predominantly private clinics) comprise one-quarter of all facilities with at least one modern method available, followed by 11 percent for drug shops/RDVs and 5 percent for pharmacies. Male condoms were the only method found to be available in general retailer outlets such as kiosks. Nearly half of all outlets in the public and private sectors were HEWs/health posts and a further 13 percent were higher-level public health facilities (primarily health centers).

There are significant differences in contraceptive market composition by region. In the urban region of Addis Ababa, 87 percent of outlets censused were private sector outlets and only 12 percent were public sector outlets; with higher



representation for private health facilities and pharmacies. In the highly rural regions, HEWs (which are not deployed in Addis Ababa), make up a larger share of outlets providing at least one modern contraceptive method; ranging from 43 percent in Oromia to 61 percent in SNNP. In Oromia, there was a slightly higher proportion of private outlets (45 percent) compared to 36 percent in Amhara and only 25 percent in SNNP.

What proportion of public and private sector outlets are stocking selected modern contraceptive commodities, offering contraceptive services and providing a range of methods?

Among short-acting methods, over two-thirds of all outlet types had oral contraceptives and injectables in stock. Private sector facilities were twice as likely to have emergency contraceptives available (>40 percent) compared to public facilities and HEWs/health posts (<20 percent). Despite higher availability, about 20 percent of private health facilities, pharmacies and drug shops/RDVs had emergency contraceptives in

stock in the previous three months, but were currently out of stock. Injectables were found to be out of stock on the day of the survey in about 10 percent of private and public health facilities and HEWs reporting injectables in stock in the previous three months but unavailable on the day of the survey. For services associated with short-acting methods, nearly all private and public health facilities and HEWs provided contraceptive injection services. The majority of pharmacies and drug shops/RDVs are not staffed by clinicians that are credentialed to provide contraceptive services. A small number of pharmacies and drug shops/RDVs did report provision of contraceptive injection services, but this was not common.

Private outlets, particularly pharmacies and drug shops/RDVs, typically have only short-acting contraceptive methods available due to national restrictions on credentials required for distributing and providing services for LA/PMS. Less than 20 percent of private health facilities (hospitals and clinics) had implant or IUD commodities and/or services available, while less than 10 percent of pharmacies and drug shops/RDVs had LARC commodities (but no services) available. There were few differences seen between regions in availability of selected contraceptive methods and services.

Public outlets, on the other hand, were considerably more likely to distribute implants, with 90 percent of facilities and two-thirds of HEWs having implant commodities and/or services available. For IUDs, while two-thirds of facilities (predominantly health centers) had IUD commodities and services available, HEWs are not sanctioned to provide IUDs. IUDs were also not available at health posts. There were few differences seen between regions in availability of selected contraceptive methods.



Photo credit: PSI

Nearly all brands of modern contraceptives found in the Ethiopia survey were on the World Health Organization (WHO) Prequalification of Medicines Program or a stringent regulatory authority list. However, only one brand of injectable, the most commonly used method by women in Ethiopia, found in the survey met this standard of international quality assurance. International quality-assured injectables were available at less than 20 percent of public sector outlets less than 5 percent of private sector outlets. Despite the high proportion of non-IQA injectables available, few quality or effectiveness issues for these injectables have been identified in practice.

Ethiopia's National Reproductive Health Strategy 2006–2015 aims to make at least three contraceptive methods available to all households by 2015, improving contraceptive choice for Ethiopian women. According to our findings, 86 percent of public health facilities and HEWs/health posts and 71 percent of private health facilities, pharmacies and drug shops/RDVs have three or more methods available. Availability of three or more methods did not vary considerably from region to region.



Photo credit: PSI

Despite high proportions of both public and private sector facilities with three or more methods available, the proportions of those with at least one LARC/PM decreased for public outlets and reduced considerably for private outlets. Only 14 percent of private outlets (excluding general retailers) had three or more methods with at least one LARC/PM available. Ten percent or less of HEWs/health posts and private sector outlets met the higher criteria of offering five or more methods.

What is the relative market share for each contraceptive method and for each outlet type?

Despite accounting for 41 percent of all outlets censused with at least one modern contraceptive method available, private sector outlets directly distributed only 18 percent of the total volume of CYPs in all four regions to individual consumers. This is due to the higher volume of short-acting methods distributed in private outlets relative to long-acting methods. Also, this does not fully reflect the significant proportion of commodities distributed through public sector facilities that are procured by the private sector. Of the 18 percent of total volume of CYPs accounted for by private sector outlets, private facilities contribute the majority of CYP volume, mostly from implants and injectables. Pharmacies, drug shops/RDVs and general retailers account for only about 5 percent of the total CYP volume in all regions, primarily from oral contraceptives and injectables. Private

sector distribution in the contraceptive market was considerably higher in urban Addis Ababa, at 90 percent of outlets with modern contraceptives and one-third of the contraceptive market share in CYP compared to rural regions.

While public health facilities accounted for only 10 percent of the market composition in all four regions, they distributed nearly half of the total CYP volume from the study. Public health facilities generally distribute high volumes of contraceptives and in particular, higher-CYP LARCs. IUDs distributed at public health facilities accounted for 11 percent of the total CYP distributed in all four regions and nearly one-quarter of the total CYP from public health facilities. There was some regional variation with IUD distribution at public health facilities accounting for over 20 percent of total CYP in Addis Ababa, Amhara and Oromia but only accounting for 10 percent in SNNP. About one-third of the total CYP volume was distributed by HEWs. Just over 20 percent of total CYPs in all four regions came from HEWs/health posts delivering implants, and implants accounted for about 60 percent of total CYPs from HEWs/health posts.

What is the consumer price of modern contraceptive methods among private sector outlets?

For the most commonly used method in Ethiopia, injectables, the median price for an injectable (three months protection against pregnancy) in private outlets was \$0.34 USD. Implants (three to five years protection depending on type) and IUDs (ten years protection) had a median cost of \$1.46 USD in private sector outlets which typically did not include the service or associated cost. There was little variability between private outlet types and regions in cost of common methods. Looking at price per CYP demonstrates the value added comparing LARCs to injectables. Injectables were three times the cost per CYP compared to implants and four times the cost of IUDs per CYP in private sector outlets. Prices for contraceptive commodities and services were typically free to women in public sector outlets.

What is the readiness of selected outlet types for performing contraceptive services?

Service readiness includes availability of the commodity (except for sterilizations), credentialed and trained staff and a minimum set of equipment. Looking at service readiness among facilities, regardless of whether they actually provide the service, only half of all public health facilities met the requirements to provide IUD insertions and only 40 percent of all HEWs met the requirements to provide implant insertions. Those that were not service ready in the public sector typically had appropriate training and equipment, but did not have the commodity available. Among all private health facilities, 10 percent or less were service ready to provide implant or IUD insertions. Again, this was often because the outlet did not carry the commodity on the day of the survey.



Photo credit: PSI

Among those private health facilities that did report providing services, service readiness standards were high for injectables (80 percent) and LARCs (about 60 percent) and were generally comparable to that of the public sector. Across all four regions, of those public health facilities providing IUD insertions, nearly three-quarters of public facilities were service ready to provide IUD insertions for women requesting the service. Similarly, among HEWs reporting provision of implant insertions, 55 percent were service ready to provide implant insertions for women. In public outlets, the criteria most often not met for service readiness was the lack of the physical commodity available for the service.

Assessing recent contraceptive market initiatives

The contraceptive market findings in Ethiopia demonstrate the effect recent task-shifting initiatives such as the scale up of Implanon® distribution through HEWs/health posts begun in 2011 and the IUD Initiative focusing on health center distribution since 2011. Three-quarters of HEWs/health posts had implants (predominantly Implanon®) in stock and provided implant insertion services. HEWs/health posts accounted for one-third of the total contraceptive market composition and, while not present in urban Addis Ababa, accounted for 43-61 percent of the total composition of the more rural Amhara, Oromia and SNNP regions. The inclusion of Implanon® was also largely responsible for two-thirds of HEWs/health posts providing three or more methods with at least one of those methods being a LARC. Just over 20 percent of total CYPs in all four regions came from HEWs/health posts delivering implants, and implants accounted for about 60 percent of total CYPs from HEWs/health posts. Over half of HEWs/health posts were service ready to provide implant insertions, with the majority of those who were not service ready not meeting the standard due to the lack of a private area to perform implant insertion services. Implants at public health facilities (largely health centers) also accounted for a large share (one-quarter) of the total CYPs from all four regions.

The apparent success of the HEW Implanon® Initiative through extension of LARC delivery via HEWs/health posts, as reflected in the data, offers an intriguing case study of task-shifting of LARC methods at the community level. However, there is room for improvement given findings that 1 in 5 HEWs/health posts do not currently offer implants and about 1 in 10 HEWs/health posts offered the service in the previous three months, but were currently stocked out of implant commodities. Nearly three-quarters of higher-level public health facilities, mostly health centers, had copper-T IUDs and IUD insertion services available. The availability of IUDs also contributed to over 90 percent of public health facilities having three or more and three or more with at least one LARC method available in all four regions. In addition, nearly two-thirds of public health facilities met the highest method mix standard of five or more methods available.



Photo credit: PSI

Comparison to PMA2020 Ethiopia surveys

FPwatch findings support findings from the third round of PMA2020 surveys¹⁰ on contraceptive method availability in public and private outlets and method ranges in public outlets (method ranges not available for private outlets in PMA2020). Comparing PMA2020 with FPwatch, 98 percent of public health facilities offered 3 or more methods (98 percent in PMA2020), while 67 percent offered 5 or more methods (vs. 85 percent). Looking at HEWs/health posts, 82 percent had 3 or more methods (vs. 87 percent) but only 6 percent with 5 or more methods (vs. 17 percent). While there is general concurrence on similar indicators, some differences may be due to differing methodology and regions of focus.

Findings on current availability of methods, method mixes, private sector participation in the family planning market and service readiness are promising. In addition to providing context for the family planning environment in Ethiopia, the findings also present a baseline to measure the scaling up and acceptance of existing and future private sector engagement and innovation, task shifting, method mix guidelines, product and service quality improvement and pricing activities and strategies. This findings brief will be followed by additional documents on programmatic and policy implications of the data, generated in collaboration with the Ethiopia FMOH and other contraceptive market stakeholders.


Acknowledgements

We would like to acknowledge Berhane Assefa and Dr. Ephrem Lemango from the Ethiopian Ministry of Health and Woldemariam Girma, Donato Gulino, Girma Tadesse, Habtamu Tamene, Endale Workalemahu, Richard Semakula, Risha Hess, Metsehate Ayenekulu and Elias Legesse from PSI-Ethiopia. Thank you to the data collection management team from Alliance for Better Health, PLC: Fekadu Dubi, Dr. Marcos Feleke, Eyob Kifle and Dr. Mengistu Tafesse.

We would also like to thank the members of the ACT/FPwatch team who contributed to this work: Andrew Andrada, Erick Auko, Dr. Katie Bates, Dr. Nirali Chakraborty, Danielle Garfinkel, Tarryn Haslam, Dr. Megan Littrell, Jen Pope, Mac Schoen, Dr. Bryan Shaw and Kate Thanel.

We would like to thank our Technical Advisory Group members: Dr. Jane Bertrand, Veronique Dupont, Janine Hum, Amy Lin, Dr. Scott Radloff and Dr. Prashant Yadav.

Lastly, we would like to thank the members of the quality control team, the supervisors, members of the questionnaire traffic control team, the enumerators and all of the providers who participated in these surveys. Your contributions are invaluable.

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Photo credit: Kate Thanel (PSI)

FPwatch is a multi-country research project designed to provide timely, relevant and high quality contraceptive market evidence. Launched in 2015 with funding from the Bill and Melinda Gates Foundation, it is currently implemented in 5 countries with additional funding from the Three Millennium Development Goal Fund in Myanmar. Standardized tools and approaches are employed to provide comparable data across countries and over time.

The project will inform FP market strategies and priorities for national Ministries of Health and their partners. Additional resources are available on the website (www.fpwatch.info).

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