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Ethiopia

Family Planning Market Analysis: Using Evidence on Demand and Use for Contraception to Plan for a Total Market Approach in Ethiopia

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Abstract

A market analysis was conducted using data from 2005 and 2011 Ethiopian Demographic and Health Surveys to better understand the variation in trends in contraceptive use by income, place of residence, region, education, and age. The findings will help better segment the contraceptive market and provide policymakers with information to develop targeted strategies and policies to increase contraceptive use, improve public-private collaboration, and make equitable resource allocation decisions. Expanding, strengthening, and diversifying the family planning market will be a key strategy for fueling the country's demographic transition and meeting Ethiopia's health and development goals.

Cover photo: A client receives family planning counseling at a health clinic in Bussa, Ethiopia. USAID | DELIVER PROJECT.

Contents

Acronyms

CPR	contraceptive prevalence rate
CS	contraceptive security
DfID	Department for International Development (UK)
DHS	Demographic and Health Survey
EDHS	Ethiopia Demographic and Health Survey
FGAE	Family Guidance Association of Ethiopia
FMOH	Federal Ministry of Health (Ethiopia)
FP	family planning
FPTWG	Family Planning Technical Working Group
GoE	Government of Ethiopia
HEW	health extension worker
HSDV IV	Health Sector Development Program
IPLS	Integrated Pharmaceutical Logistics System
IUD	intrauterine device
LAPM	long-acting permanent methods
MSA	market segmentation analysis
MSI	Marie Stopes International
NGO	nongovernmental organization
PFSA	Pharmaceutical Fund and Supply Agency
PSI	Population Services International
RH	reproductive health
SNNPR	Southern Nations, Nationalities, and Peoples' Region
TFR	total fertility rate
USAID	United State Agency for International Development
WRA	women of reproductive age

Acknowledgments

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Executive Summary

The Federal Ministry of Health (FMOH) in Ethiopia is committed to enhancing the reproductive health (RH) status of women, men, and young people of Ethiopia, particularly by continuing to increase access to quality family planning (FP) services and expand the market for contraceptives across public and private sectors. The USAID | DELIVER PROJECT works with the FMOH and other partners to strengthen the country's family planning program by helping to ensure that contraceptives are available when and where customers need them through support of the country's comprehensive *Reproductive Health Commodity Security Strategy*.

According to the Ethiopian Demographic and Health Survey (EDHS), between 1990 and 2011, total fertility in Ethiopia declined from 6.4 to 4.8 births per woman (CSA 2012a). Furthermore, the use of contraceptive methods among women in union or those who are sexually active has increased nearly sixfold in the last 11 years, from 7 percent in 2000 to 14 percent in 2005 to 28 percent in 2011 (CSA 2001a, 2006a, 2012a).[1] These are significant achievements by any standard, though the current fertility rate and unmet need for family planning still remain high. Further, population growth remains around 2.6 percent annually, making Ethiopia Africa's second-most-populous country with an estimated population of 88 million in 2011 (US Census, 2013).

As a result of these demographic changes, today, more people are part of the economic productive age group (15–64 years) than are in the group of dependents (under 15 years and over 64 years). This is a unique window for Ethiopia to achieve a healthier population, economic growth, prosperity, and security as a middle-income country (World Bank, 2013). By continuing to fuel uptake in family planning use and other health services among this productive segment of the population, men and women will experience fewer maternal and infant mortalities, and, overall, be better equipped to pursue additional training and education, contribute to the workforce, and make a more significant contribution to overall productivity and development. In other words, expanding the family planning market will be a key strategy for fueling the country's "demographic transition or dividend"[2] and meeting Ethiopia's health and development goals.

The FMOH in Ethiopia is committed to strengthening the family planning market to take advantage of this development opportunity. As part of its overall effort to strengthen FP across all sectors (public and private), the FMOH, through its Family Planning Technical Working Group (FPTWG), decided to examine the contraceptive market to identify gaps in access and use—including among socioeconomic groups, age, region, education, and other characteristics.

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[1] These figures are slightly different from the published figures in the EDHS report, as those only include women in union. For the purpose of this report, all results are for women in union **or** those who are sexually active (in the last four weeks).

[2] Policies to spur future job creation and economic growth are shaped by the age structure of a country's population. Declining fertility, accelerated by investments in better health, family planning services, and gender equality, results in a smaller population of young dependent ages and a larger population of adults in the labor force, and then leads to a swelling in the ranks of the elderly. Through concrete policy actions in family planning, health, education, gender equality, and labor market policies, a number of countries have produced large and positive economic returns, referred to as the "Demographic Dividend." Most developing countries have a short window of opportunity to enact policies and promote investments that raise the human capital of young people while positioning them for greater economic productivity when they enter their working years (World Bank 2013).

The results produced from this analysis were disseminated, validated, and used for strategic planning during a two–day, multisectoral workshop, titled "*Expanding Supply and Demand for Family Planning Services: A Key to Achieving Health and Development Goals in Ethiopia,*" held in Addis Ababa, November 8–9, 2012. During this activity, participants engaged in a collaborative process among all FP product and service providers to identify strategies to better satisfy remaining unmet need and demand for family planning and to consider ways to engage new private sector partners in expanding their share of the family planning market. This report provides the data analysis results that were used during this workshop. A complementary guide and a brief that provides background on the event itself can be found on the USAID | DELIVER PROJECT website.

The main findings of the analysis illustrate that injectables have always been popular in Ethiopia, and their use continues to grow. In addition, women are increasingly using implants. The public sector remains the major source of modern contraceptive methods in Ethiopia, serving 84 percent of users, with the government health extension workers increasingly providing contraceptives to those with an unmet need for family planning.

However, there is still remaining unmet need for FP and a contraceptive market that can be diversified further in terms of method mix, service provider, geography, wealth quintile, etc. For example, many wealthier women, who may be able to pay for contraceptives, are obtaining their methods from the public sector for free. To meet the country's family planning goals, the gains of the past will need to be sustained and expanded in the future. At the same time, the government and its partners may need to employ strategies to shift wealthier users to the non-public sector to ensure a more sustainable approach to contraceptive financing and service provision in the long term.

Finally, expanding the family planning market across public and private sectors and population segments is essential to fueling the demographic transition mentioned above and ensuring that an increase in contraceptive prevalence translates into future health and development gains.

A summary of the findings and recommendations from the analysis is provided below.

CPR and Unmet Need

- CPR for all women increased substantially in a short time (7 percent in 2000 to 14 percent in 2005 to 28 percent in 2011).

- There is disparity in contraceptive use between the poorest and the richest quintiles (13.7 percent vs. 51.8 percent), and unmet need is consistently high (26–30 percent) in most wealth quintiles.

- CPR and unmet need are also affected by education level: CPR increases, and unmet need declines, with higher education levels.

- There are still significant differences in use among regions, despite most regions having doubled or nearly doubled their CPR since 2005.

- Nearly 90 percent of all women with unmet need live in either Oromiya, Amhara, or Southern Nations, Nationalities, and Peoples' (SNNP) regions; in Amhara, Afar, and Harari regions, young women (ages 15–19) have 10–15 percent higher unmet than other women in the same regions.

- Since 2005, unmet need has declined at varying degrees throughout most regions, with Tigray, Afar, and Somali experiencing less of a decline.

- Overall national fertility rates have continued to decline, although they have plateaued in urban areas.

Demand for Family Planning

- Demand for FP and satisfying this demand has improved substantially since 2005 in rural areas. However, in urban areas, especially among youth (ages 15–19), demand and demand satisfied have stagnated or decreased.

- Specific socioeconomic segments (e.g., the wealthiest quintile or urban women) have a relatively high total demand for contraceptives, while others (poorest quintile or rural women) lag behind.

- Least wealthy women of all ages continue to have less of their demand satisfied than do the rest of the population.

- While all regions have been able to satisfy more of the demand for FP in 2011 than in previous years, with notable improvements in Amhara and Gambela, the total demand for FP in most regions is still below 66 percent, the national family planning goal.

- Particular areas throughout the country, traversing regional boundaries, display similar patterns of use and demand satisfied. These areas include the central part of the country, covering parts of southeast Amhara, northern Oromiya, and the western edge of Afar; the south, covering parts of southern Oromiya and southeast SNNPR; and the west, covering northern Gambela, west Oromiya, and northwest SNNPR (see maps in figures 40 and 41).

Method Mix

- Short-term methods, specifically injectables, continue to be the most common method used among all socioeconomic and geographical segments, but use of long-acting and permanent FP methods has increased (4 percent of all users in 2005 to 15 percent of all users in 2011).

- Traditional methods are used slightly more among better-educated and richer women than among less-educated and poorer women.

Source of Contraceptives

- The public sector continues to provide most family planning services to the population (84 percent of market), although condoms and pills are also obtained in pharmacies while private facilities provide pills, IUD, and injections.

- The commercial sector market share ("private sector"), which includes pharmacy/shop/friend and private facilities, decreased from 18.3 percent in 2005 to 13.2 percent in 2011.[3]

- Youth (ages 15–19) were more likely to access contraceptives through the private sector than were all other age groups.

- The market share accounted for by government hospitals and government health centers decreased from 61.5 percent in 2005 to 55 percent health facilities in 2011 while government

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[3] While these were considered private facilities during data collection, it should be noted that much of the product sold in pharmacies is actually subsidized through social marketing programs such as DKT.

health post/health extension worker (HEW) market share has increased significantly, from 19.6 percent to 28.8 percent during the same period.

- The composition of the family planning market varies among the regions. In Dire Dawa, Addis Adaba, Harari, Amhara, Afar, and Tigray health centers are the most popular sources for methods. In SNNPR, Ben-Gumz, and Oromiya most women obtain methods from health post/HEW. In Gambela, most women obtain methods at private facilities.

Reasons for Non-Use

- The most common reasons for non-use for women who are not currently using are that they: recently had a baby, are breastfeeding, and/or fear of side effects.

Future Use

- Most women (56 percent) who are currently not using any method intend to use FP in the future.

Summary of Recommendations

Client Demand and Utilization

- Use of family planning in urban areas has stabilized since 2005, although unmet need is still high and may be increasing, particularly among young, urban women.

  – Study use preference and determine factors to better develop messages and services that meet needs of urban population, particularly youth. This can help ensure that productive age groups in all areas of the country continue to help fuel the demographic transition mentioned above.

- Gambela and Tigray display use and need patterns that are different from other regions'; Gambela has experienced a higher increase in contraceptive use since 2005 than other regions, whereas Tigray exhibits a lower rate of increase than to other regions.

  – Consider studying these populations further to better understand the factors that affect women's use in these regions and whether this higher rate of use in Gambela has resulted in improved health and development outcomes.

Service Delivery

- Women with unmet need are concentrated in certain regions: SNNP, Oromiya, and Amhara. In addition, unmet need among adolescent women in Afar, Amhara, and Harari is 10–15 percent points higher than the average for all women in those regions.

  – Consider further studying, through qualitative and quantitative analysis, reasons for non-use in these specific areas to understand barriers to use for large proportions of women with unmet need in these targeted areas, particularly young women in Afar, Amhara, and Harari.

  – Using this analysis, develop tailored strategies to increase access and utilization of quality FP information and services, particularly for young people and those who have reached desired

family sizes, to satisfy the large proportion of women with unmet need residing in these regions.

Private/Public Sector

- Most women across all age groups are primarily using injectables.

  – Continue to support efforts to strengthen the capacity of the public sector to provide long-acting permanent methods (LAPMs) and other short-term methods and counsel women on alternative methods for their point in their childbearing life cycle to ensure that women, particularly those in productive age groups, have a wider choice when accessing contraceptives and can attain their fertility preferences.

- Wealthier women, although they may have an ability to pay for family planning, are obtaining their methods from the public sector, where products and services are free.

  – Consider carrying out ability- and willingness-to-pay studies, along with research about why they are currently using the public rather than the private sector, to see whether these women could be shifted to nongovernmental organization (NGO) or private sector facilities to obtain services.

  – Continue efforts to partner with the private sector to expand and coordinate its services with the public sector and attract wealthier clients to the non-public sector for more sustainable coverage of the total market over time.

Background

With an estimated population of 88 million in 2011, Ethiopia is one of the least urbanized countries in the world; only 16 percent of the population lives in urban areas (CSA 2012a, US Census 2013). In addition, with an average population growth rate of 2.6 percent and a GDP growing at 11 percent per year in the past five years, the average annual per capita income has increased at 8.4 percent.

Further, according to the Ethiopian Demographic and Health Survey (EDHS), between 1990 and 2011, total fertility in Ethiopia declined from 6.4 to 4.8 births per woman, and the use of contraceptive methods among all women has increased nearly sixfold in the last 11 years, from 7 percent in 2000 to 14 percent in 2005 to 28 percent in 2011 (CSA 2001a, 2006a, 2012a).[4] This is a significant achievement by any standard, though the current rate of unmet need for family planning still remains high.

As a result of these demographic changes, today, more people are part of the economic productive age group (15–64 years) than are in the group of dependents (under 15 years and over 64 years). These economic and demographic changes create a unique window for Ethiopia to achieve a healthier population, economic growth, prosperity, and security as a middle-income country (World Bank 2013). By continuing to fuel uptake in family planning use and other health services among this productive segment of the population, men and women will experience fewer maternal and infant mortalities and, overall, be better equipped to pursue additional training and education, contribute to the workforce, and make a more significant contribution to overall productivity and development. Expanding the family planning market will be a key strategy for fueling this "demographic transition or dividend"[5] and meeting Ethiopia's health and development goals.

Reproductive Health Commodity Security in Ethiopia

One key aspect of maintaining increasing access to family planning is adequate financing and commitment to procure and effectively distribute contraceptives to the population where and when they are needed. In recent years, considerable progress has been made toward reproductive health commodity security (RHCS) in Ethiopia, and much of the success can be attributed to a high level of commitment from the federal and regional governments to improve and expand service provision and strengthen the contraceptive supply chain, while, at the same time, set policies, strategies, and programs that improve access to contraceptives and the quality and availability of family planning services.

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[4]These figures are slightly different from the published figures in the EDHS report, as those only include women in union. For the purpose of this report, all results are for women in union **or** those who are sexually active (in the last four weeks).

[5]Policies to spur future job creation and economic growth are shaped by the age structure of a country's population. Declining fertility, accelerated by investments in better health, family planning services, and gender equality, results in a smaller population of young dependent ages and a larger population of adults in the labor force, and then leads to a swelling in the ranks of the elderly. Through concrete policy actions in family planning, health, education, gender equality, and labor market policies, a number of countries have produced large and positive economic returns, referred to as the "Demographic Dividend." Most developing countries have a short window of opportunity to enact policies and promote investments that raise the human capital of young people while positioning them for greater economic productivity when they enter their working years (World Bank 2013).

For example, in 1993, the Transitional Government adopted a national population policy that triggered developments nationally and internationally that have direct bearing on the country's population. The primary objective was to harmonize the rate of population growth with socioeconomic development to achieve a high level of welfare.

In addition, the Federal Ministry of Health (FMOH) has committed, in its Health Sector Development Program (HSDP IV) policy, to reducing the total fertility rate (TFR) and increasing the contraceptive prevalence rate (CPR), specifically:

- Reduce TFR from 4.8 children per woman in 2011 to 4 children per woman in 2015.

- Increase CPR from 29.2 percent in 2011 to 66 percent in 2015.

To meet the Government of Ethiopia's family planning targets and to promote the importance of RHCS, the USAID | DELIVER PROJECT and other reproductive health stakeholders actively support the FMOH to improve the family planning program, strengthen the contraceptive supply chain, and implement a broad *Reproductive Health Commodity Security Strategy*. The RHCS strategy is implemented under the auspices of the Family Planning Technical Working Group (FPTWG), led by the FMOH. Part of this RHCS strategy includes expanding the market for family planning (FP) methods across public and private sectors.

The contraceptive market analysis presented in this report provides evidence that can be used to understand where the country has made the most progress in family planning coverage in recent years and to identify areas where family planning service providers, across all sectors, can do a better job of meeting demand. This analysis should be considered complementary to the work conducted by the United Nations Population Fund (UNFPA) in its 2012 report, *A Decade of Change in Contraceptive Use in Ethiopia: In-Depth Analysis of the EDHS 2000–2011.*

By using an evidenced-based approach, better support can be given to the Government of Ethiopia (GoE) to implement its RHCS strategy, achieve its health and development goals, and, ultimately, improve living conditions for Ethiopian families, mothers, and children of the future.

Methodology

As part of its overall effort to strengthen the family planning market, the FMOH, through its FPTWG, decided to collaborate with the USAID | DELIVER PROJECT and other key partners to examine the contraceptive market and identify gaps in access and use through a participatory market analysis process. The first step in this process included a quantitative market analysis that is presented in this report.

Market analysis refers to the process of using quantitative and qualitative data analysis to divide the FP market into subpopulations whose needs, characteristics, and practices result in distinct service delivery and/or commodity marketing strategies. Typically, analysis of the FP market examines both supply and demand and helps to identify and target groups with an unmet need or demand that has not been satisfied for FP. It also provides important information to government planners interested in improving the effectiveness of national resource allocations and improving equity in access to FP services across public and private sectors.

Once the analysis was complete, the data were disseminated, validated, and used for strategic planning during a two-day multi-sectoral workshop, titled "*Expanding Supply and Demand for Family Planning Services: A Key to Achieving Health and Development Goals in Ethiopia*," held in Addis Ababa, November 8–9, 2012. During this activity, participants engaged in a collaborative process among all FP product and service providers to identify strategies to better satisfy remaining unmet need and demand for FP and to consider ways to engage new private sector partners in expanding their share of the FP market. A complementary guide and a brief that provides background on the event itself can be found on the USAID | DELIVER PROJECT website.

Data Analysis

The findings presented in this report are based on a basic segmentation analysis[6] of the FP market primarily using data from the Ethiopia DHS for 2000, 2005, and 2011 (CSA 2001b, 2006b, and 2012b). The overall population examined in this analysis includes all **women of reproductive age (ages 15–49) in union or those who are sexually active (in the last four weeks**).[7] In other words, it does not restrict the analysis to married women or women in union as is often the case when using DHS analysis to report on family planning use.

The analysis includes data from two levels. First, variables to assess the performance and characteristics of Ethiopia's FP program include—

- modern method contraceptive prevalence rate (CPR);

- traditional method CPR;

- unmet need for FP;

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[6] Group of the entire population examined into subpopulations or homogenous segments for multiple variables.

[7] In the DHS, women (ages 15–49) are independently categorized through their marital status as "currently in union/living with a man" or through their recent sexual activity. This analysis groups them together into one total population.

- reasons for non-use among those with unmet need;

- method-mix among those currently using modern FP methods; and

- source for modern methods.

Then, the sampled population is segmented and analyzed along several different dimensions to understand the influence or relevance of each dimension within the context of FP use. These variables include the distribution of all sampled women by:

- place of residence (rural versus urban);

- wealth quintile[8];

- age group;

- region; and

- education.

In addition to statistical analysis, the EDHS carried out geo-spacial analysis to determine where use, unmet need, and total demand for FP varied by region and across regional boundaries. Maps presented throughout this report illustrate the results of this analysis. Specifically, a cluster analysis[9] was conducted to identify spatial patterns among certain indicators, e.g., whether areas with higher total demand and demand satisfied for FP crossed regional boundaries.

Participatory Market Analysis

When used as a policy tool, market analysis pinpoints opportunities for public and private sector stakeholders to better coordinate their efforts. Given the different objectives and target populations of the public sector, NGOs, and the private sector, an underlying assumption in any market analysis is that it should be possible to identify their complementary roles in providing FP products and services.

Market analysis provides comprehensive evidence of service utilization and strategies for expanding the family planning market by:

- conducting in-depth analysis of the DHS or similar data available to the public;

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[8] The wealth quintiles are defined by a composite index of a household's cumulative living standard. Quintile data are presented in all DHS final reports and survey datasets as a background characteristic for socioeconomic status (Rutstein and Johnson 2004). The index is calculated using data collected on a household's ownership of selected assets, such as radios, fans, telephones, televisions, and bicycles; materials used for housing construction (floor, wall, and roofing material); and types of water access and sanitation facilities. Generated with a statistical procedure known as principal components analysis, the wealth index places individual households on a continuous scale of relative wealth. DHS separates all interviewed households into five equal groups, or quintiles, based on its score. The first quintile represents the poorest household and the fifth quintile represents the richest. It is important to note that the asset index used in this analysis ranks households based on those assets described, not on monetary income, and tends to be slightly skewed toward urban areas.

[9] This analysis was conducted using SaTScan™, a program that allows the user to statistically test the existence of patterns (Kulldorff and Information Management Services, Inc.,2009). It groups data with similar patterns geographically using circles, then using Monte Carlo simulation, checks to see if the points within each circle are higher or lower than would be expected by chance. Where there are no groupings—this indicates that either the DHS clusters are at an average level across the board, or there is too much variety (too many highs and lows) for SaTScan™ to identify a clear pattern. When the analysis detects a group—this indicates that the group exhibits the same similar pattern of the indicator (e.g., using a modern contraceptive method) and is statistically different from the national average. Maps are presented in the latter part of the report illustrating this cluster analysis.

- grouping clients by characteristics, needs, and/or common preferences to understand their FP needs;

- analyzing use, demand, and provision of contraceptives in the total market (public, NGO, and commercial); and

- using these data for decisionmaking through a participatory dissemination and action planning process in-country.

For more details on the participatory process often employed by the USAID | DELIVER PROJECT to strengthen the FP using market analysis data, see *A Participatory Approach: Using Market Analysis to Improve Access to Family Planning Services*.

Population Profile

Characteristics by Wealth Quintile

Table 1 shows the relationship of wealth to other important characteristics examined in this analysis, including residence, region, age, and education.

Nearly 82 percent of women live in rural areas, and there is great wealth disparity from rural areas to urban ones. A staggering 78 percent in the wealthiest quintile live in urban areas, while about 99 percent of women in rural areas are in the bottom three quintiles.

Similarly, the predominantly urban regions of Addis Ababa, Dire Dawa, and Harari have the highest proportions of their population in the highest wealth quintiles. Addis Ababa, in particular, comprises a significantly larger urban and wealthy population than any other region; 99 percent of women living in Addis Ababa are in the wealthiest quintile. Conversely, 43 percent and 55 percent of the women in the largely rural regions of Afar and Somali, respectively, are in the poorest quintile.

The wealth quintiles are fairly evenly distributed across age groups, with a slight variance among the oldest and youngest age groups. In both cases, a slightly larger proportion of women are in the lower three quintiles (poorest – poorer – middle) in contrast to the other age groups.

There is also a positive correlation between education and wealth. About 71 percent of women have no formal education, with the highest concentration of those with no education in the poorer quintiles. Likewise, approximately 22 percent of women completed primary education while seven percent completed secondary education or higher, with the vast majority of women coming from the two wealthiest quintiles. However, that being said, there is a dramatic difference between the second-richest quintile, where 2.2 percent of women completed secondary education or higher, and the richest quintile, where 30.2 percent completed secondary education or higher.

These data also show that there has been an overall increase among women of all quintiles completing secondary education, which is an improvement since 2005, when only the wealthiest quintile completed secondary education. However, women completing more than secondary education continue to come primarily from the wealthiest quintile.

Table 1. Percentage Distribution of Women by Education, Residence, Age, and Region, According to Wealth Quintiles

Characteristics	Poorest	Poorer	Middle	Richer	Richest	Total
Residence						
Urban	1.7	1	1	6.8	78.3	18.4
Rural	98.3	99	99	93.2	21.7	81.6
Region						
Tigray	25.1	21.4	15.8	12.8	24.9	6.2
Afar	55.1	10.2	4.9	6.9	23	1.0
Amhara	20.5	23.4	22.6	17	16.5	26.9
Oromiya	16.2	21.4	22.2	22.5	17.6	38.3
Somali	43.9	8.1	9.5	11.2	27.4	2.2
Ben-Gumz	29.1	17.8	17.2	20.1	15.8	1.2
SNNP	23.9	20.4	20.2	19.7	15.7	19.6
Gambela	28.1	6.3	8.3	30.4	26.9	0.5
Harari	1.8	6.2	10.9	20.5	60.6	0.3
Addis Ababa	0.2	0.2	0.1	0.2	99.2	3.5
Dire Dawa	7.7	10.1	10.7	5.4	66.1	0.4
Age						
15–19	24.1	20.4	22.3	19.3	14	7.6
20–24	18.1	21.1	18.3	17.7	24.8	17.4
25–29	18.5	20.5	18.9	18.8	23.2	24.4
30–34	19.3	18.5	21.1	18.2	23	16.6
35–39	21.3	20	20.2	18.5	20	15.4
40–44	20.4	22.4	18.9	20.2	18	9.9
45–49	23	20.9	24.1	19	13.1	8.7
Education						
No education	87.7	83.4	78.9	68.6	35.7	71.0
Primary	12.1	16.1	20.4	29.2	34.1	22.3
Secondary	0.2	0.4	0.7	1.9	19.7	4.6
Higher	0.0	0.1	0.0	0.3	10.5	2.2

Note: Totals may not add to 100 percent due to rounding.
Source: Central Statistical Agency [Ethiopia] and ICF International 2012b.

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Trends in Fertility

Total Fertility Rate

One of the key objectives of Ethiopia's national policies is to reduce its total fertility rate (TFR) from 4.8 children per woman (2011) to 4 children per woman in 2015. As Figure 1 illustrates, Ethiopia saw notable decreases in TFR between 2000 and 2011, dropping from 5.5 to 4.8.

Figure 1 also shows the relationship of TFR with Ethiopia's impressive gains in modern contraceptive use and decrease in unmet need among all women[10]. There has been a 10 percentage point decrease in unmet need since 2000.

Figure 1. Ethiopia Total Fertility Rate, Current Use, and Unmet Need for All Women, 2000–2011

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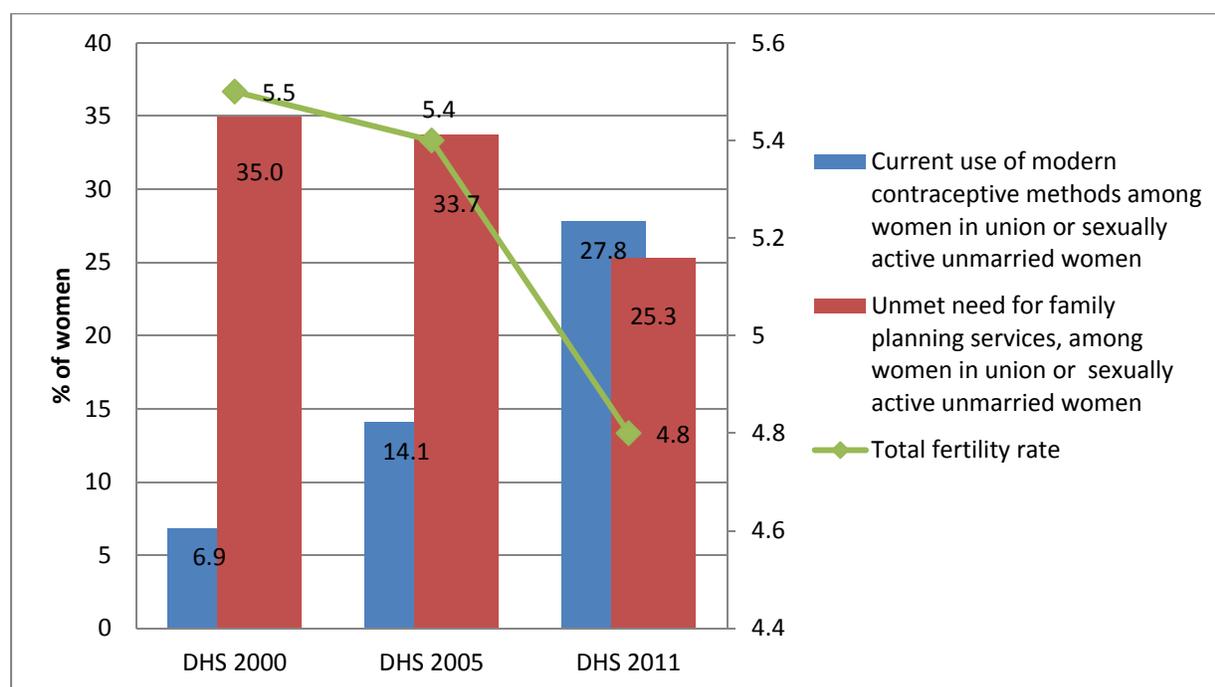
[10]These figures are slightly different from the published figures in the EDHS report as those only include women in union. For the purpose of this report, all results are for women in union **or** those who are sexually active (in the last four weeks).

Residence

As seen in Figure 2, the TFR in urban areas is significantly lower than in rural areas. While urban areas remained fairly constant from 2005 to 2011 (2.4 and 2.6, respectively), 2011 showed a decrease in TFR in the rural areas, from 6 in 2000 and 2005 to 5.5. This decline in rural areas has caused the drop in the national rate.

Figure 2. Total Fertility Rate by Residence for All Women, 2000–2011
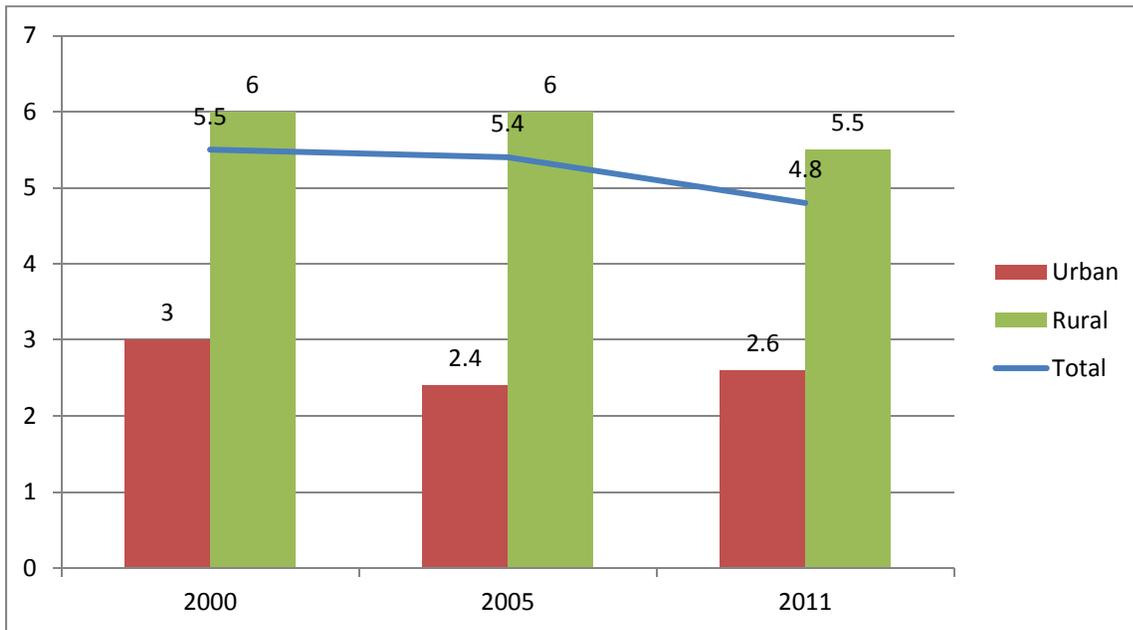
Age

Like TFR, age-specific fertility rates have declined at a faster rate over the previous five years than they did in the five years preceding this period. As shown in Figure 3, the fertility rate among adolescents age 15–19 is 79 births per 1,000 women. For the country as a whole, the age-specific fertility rates rise from 79 births per 1,000 women age 15–19 to 207 births among women age 20–24, reach a peak of 237 births for women age 25-29, and then fall steadily to 28 births among women age 45–49. Fertility peaks at age 25–29 in both rural and urban areas.

Figure 3. Age-Specific Fertility Rates by Year for All Women, 2000–2011
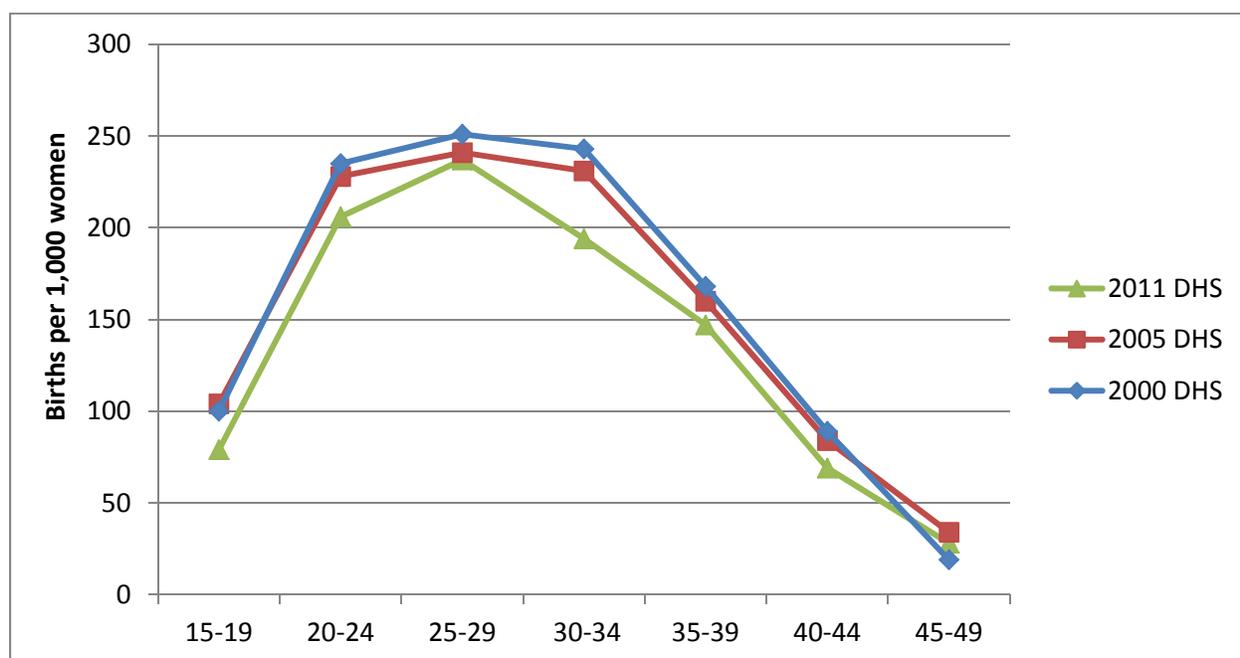
Region

There are substantial differentials in the TFR among the regions, ranging from 1.5 children per woman in Addis Ababa (below the replacement level of fertility) to 7.1 children per woman in Somali (CSA 2012a). Fertility levels are higher than the national average in Somali, Oromiya, Benishangul-Gumuz, Afar, and SNNPR and lower than the national average in the other six regions.

Wealth

Fertility is also strongly associated with wealth quintiles. Women in the lowest wealth quintile have a TFR of 6.0, more than twice as high as women in the highest wealth quintile, at 2.8 (CSA 2012a).

Education

The level of fertility is inversely related to women's educational attainment, decreasing sharply from 5.8 children among women with no education to 1.3 children among women who have more than secondary education (CSA 2012a).

In sum, although fertility has declined, significant progress will need to be made to meet the national fertility goal and continue to fuel a more consistent demographic transition, with even lower fertility rates, particularly among productive age groups, across most of the population. Major disparities still exist nationally across populations (see figures 2 and 3) that, unless addressed more systematically, can limit the demographic transition necessary to promote and attain health and economic development goals.

Trends in Contraceptive Use/ Method Mix

Contraceptive Prevalence Rate

Another key goal of the FMOH in Ethiopia is to increase the CPR from 29.2 percent in 2011 to 66 percent in 2015. From 2000 to 2011, Ethiopia has seen a significant increase in total CPR (including modern and traditional methods), reaching 29.2 percent in 2011, as shown in Figure 4. Similar to TFR goals, significant progress (more than doubling) would need to be made to meet the national goal for CPR in 2015.

Figure 4. Contraceptive Prevalence Rate for All Women, 2000–2011
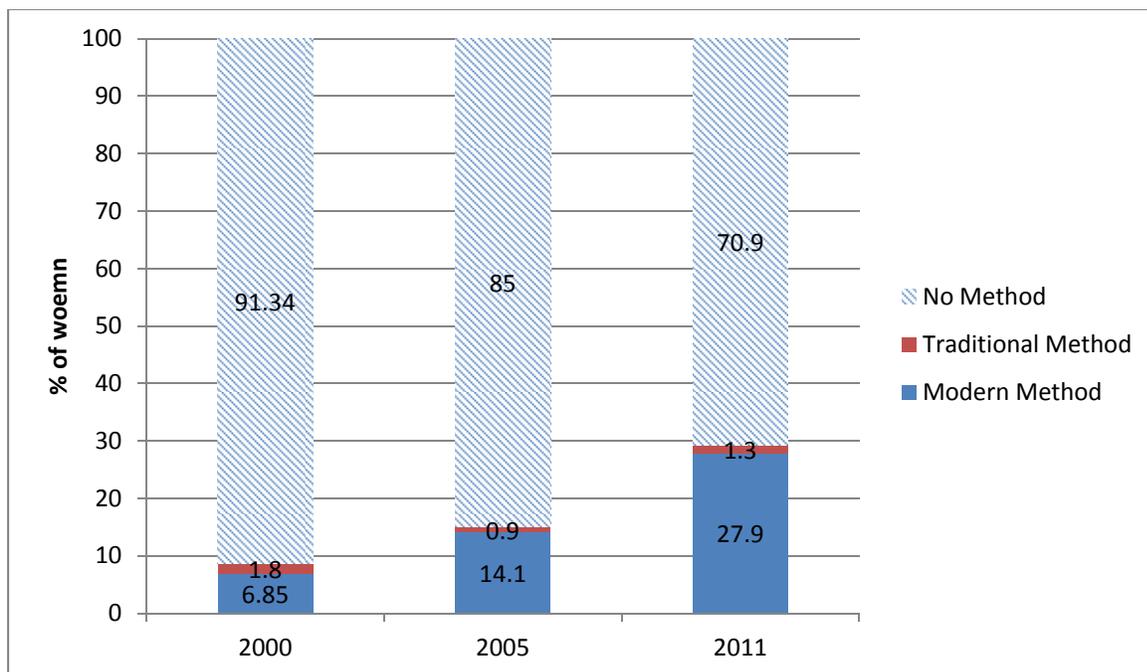
Region

Differences in contraceptive use can be seen by region. Addis Ababa, Gambela, Dire Dawa, and Harari regions have higher than average CPR (see Figure 5). More variation among regions can be observed in 2011 as some reached higher levels of CPR than the country average. In 2005, however, most regions were in the 10–19 percent range. Somali has the lowest contraceptive prevalence of all regions, with only 4.5 percent of women using contraception in 2011.

Figure 5. CPR by Region for All Women, 2005–2011
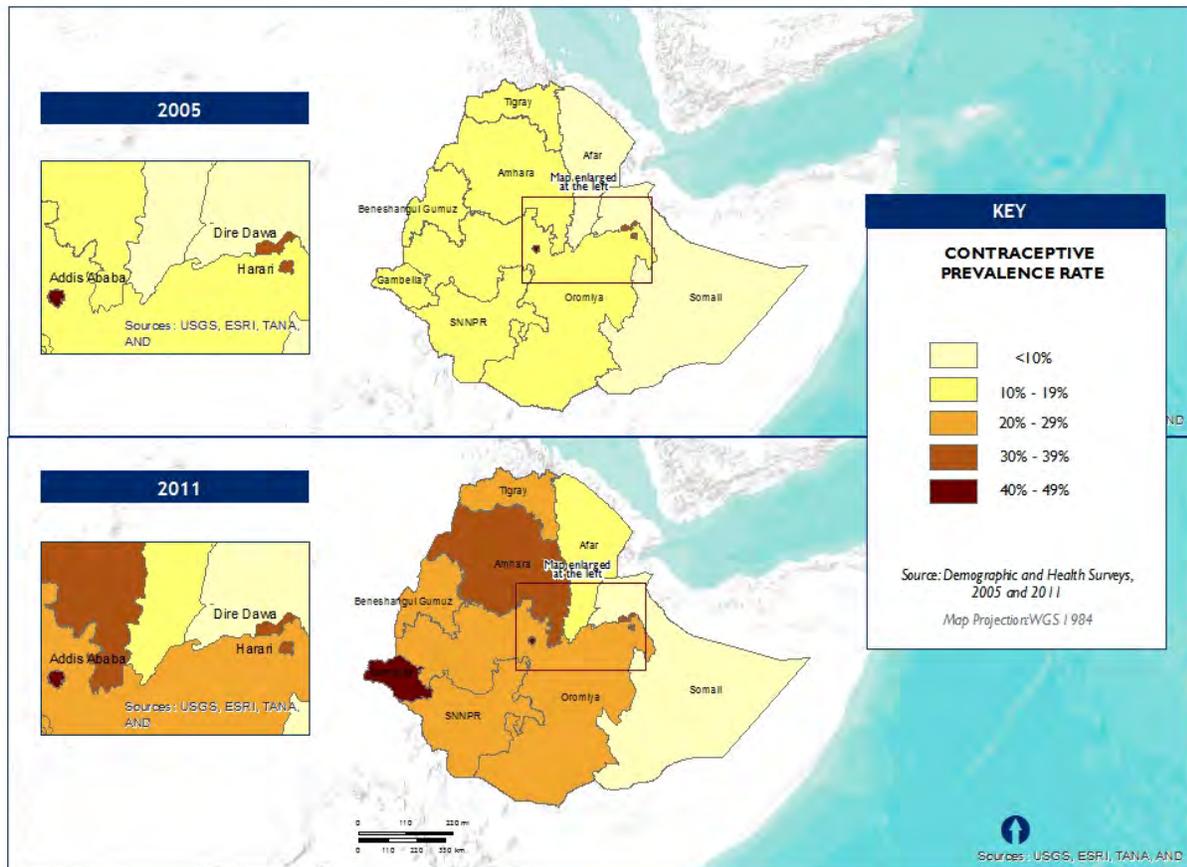
Figure 6 illustrates the rate of change in CPR from 2005 to 2011. The changes in total CPR during this period appear to be driven primarily by use in rural areas. As will be observed later in the source of supply profile, much of the increase in rural areas can be attributed to a significant increase in services provided at the community level through the HEW program and health posts. There is an increase in all regions except Afar, Dire Dawa, Harari, and Somali. Gambela and Benishangul-Gumuz have experienced a much higher rate of increase than other regions.

Figure 6. Rate of Change in CPR for All Women, 2005–2011
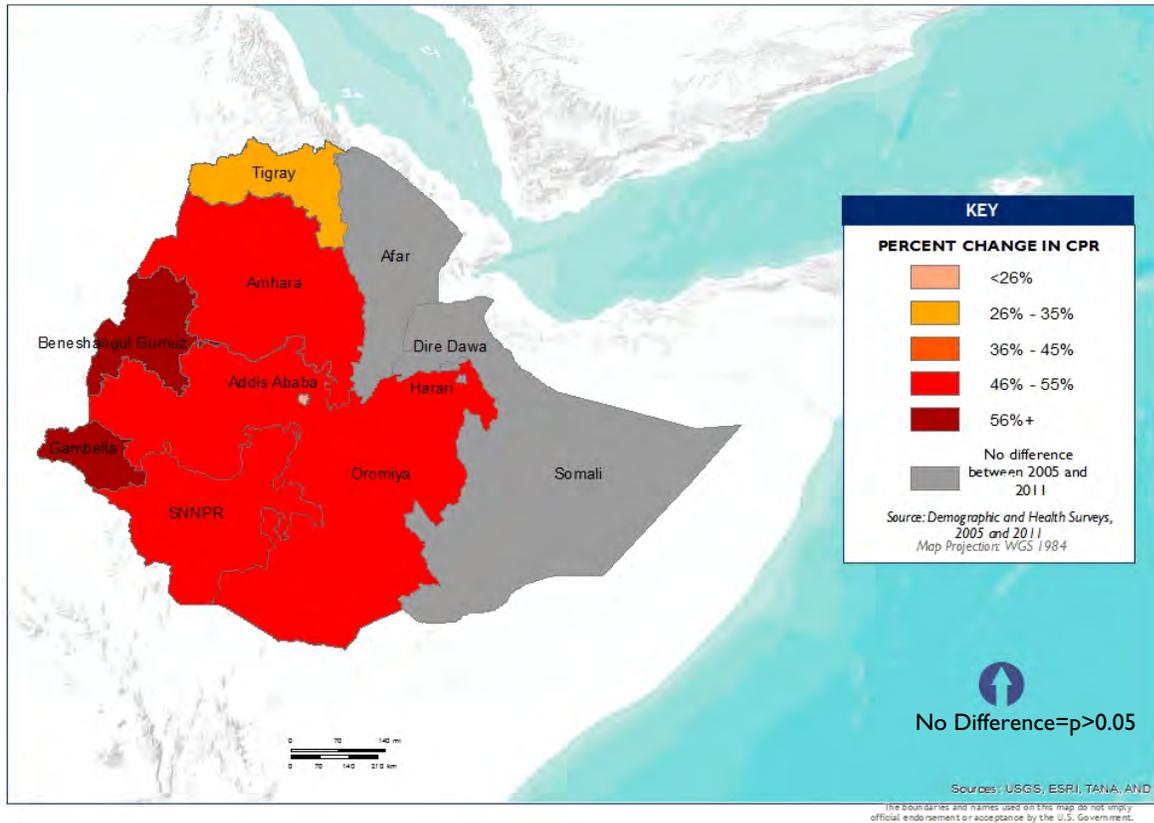
Education and Residence

CPR also varies with attainment of education (Figure 7). Women with some formal education are twice as likely to use contraception as those with no formal education. Contraceptive prevalence for those with primary education or higher is between 34 percent and 55 percent, while those with no formal education is only 22 percent. The most significant difference in CPR is seen in women completing secondary education or higher, jumping from a CPR of 34 percent, for those completing primary school, to 53.5 percent for those completing secondary school. Further, use of traditional methods increases steadily by each education level, from only 0.4 percent in the group with no education to 10.8 percent in the group completing higher education.

Finally, CPR in urban areas is twice as high as it is in rural areas.

Figure 7. CPR and Unmet Need by Education and Residence for All Women, 2011

Age
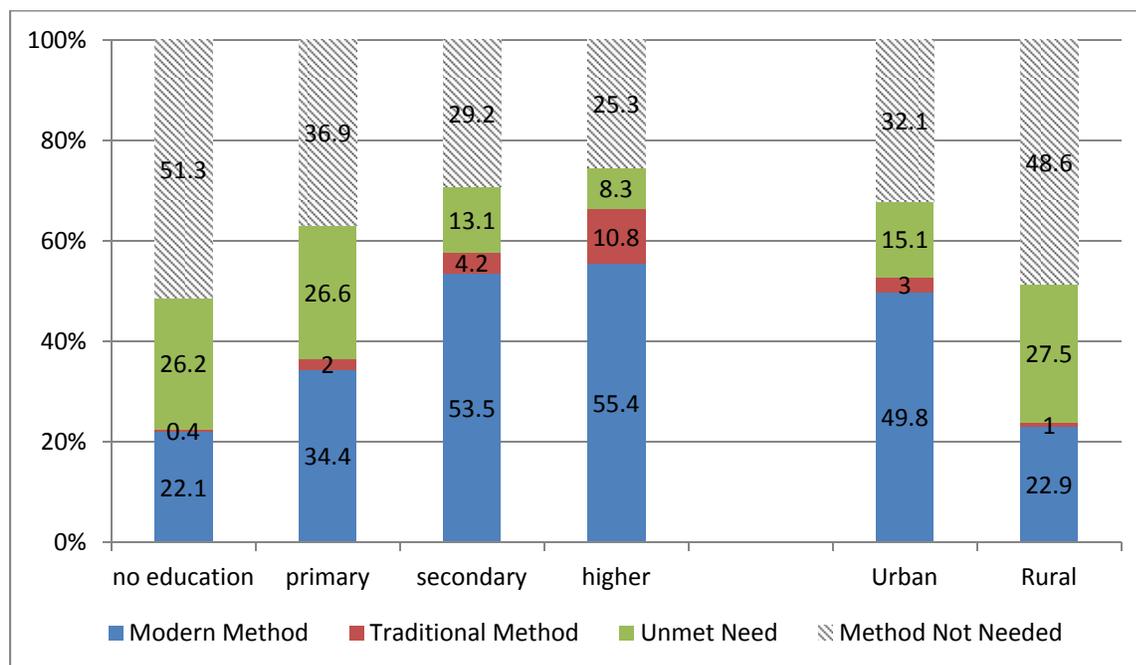
As shown in Figure 8, there is not a strong correlation between age and CPR, especially among women ages 15–34. It is interesting to note, and will be discussed in another section, CPR for age groups 15–19 and 40–49 is less than or equal to CPR for women who have an unmet need for family planning.

Figure 8. CPR and Unmet Need by Age for All Women, 2011
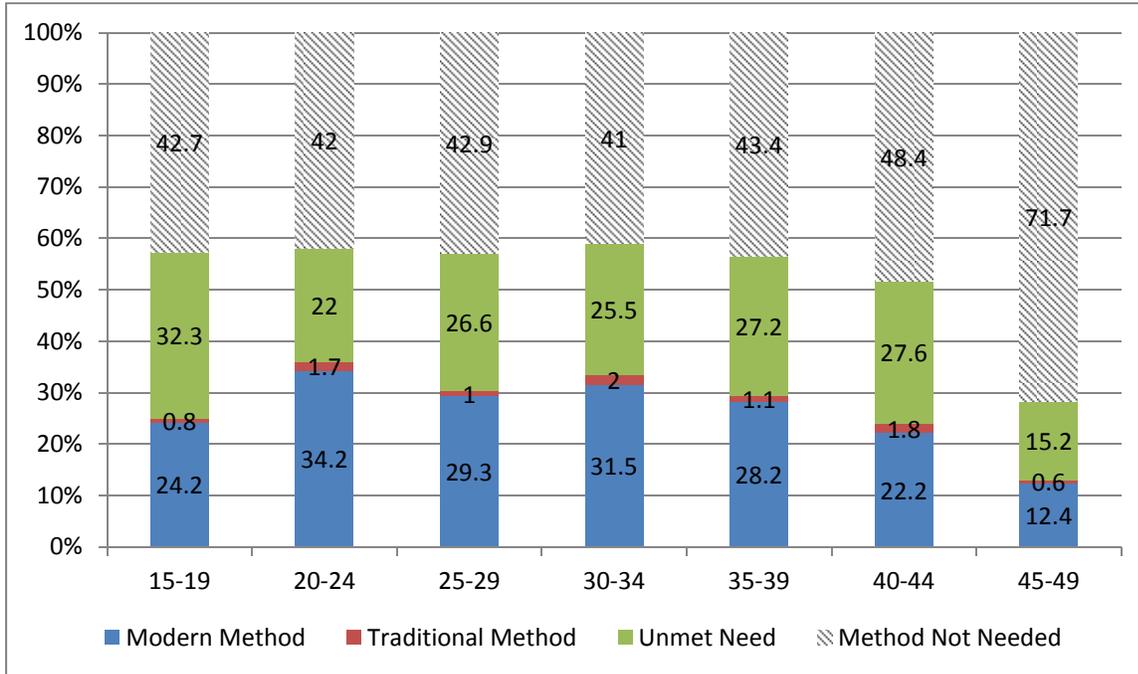
Wealth

Examining contraceptive use across wealth quintiles reveals an extreme disparity in use between the poorest and the richest women, although unmet need is consistently high in most quintiles. As Figure 9 illustrates, use of both modern and traditional methods increases with wealth. While the country's overall contraceptive prevalence is still below government targets, CPR in the wealthiest quintile is quadruple that of the poorest quintile (52 percent versus13 percent).

Figure 9. CPR and Unmet Need by Wealth Quintile for All Women, 2011
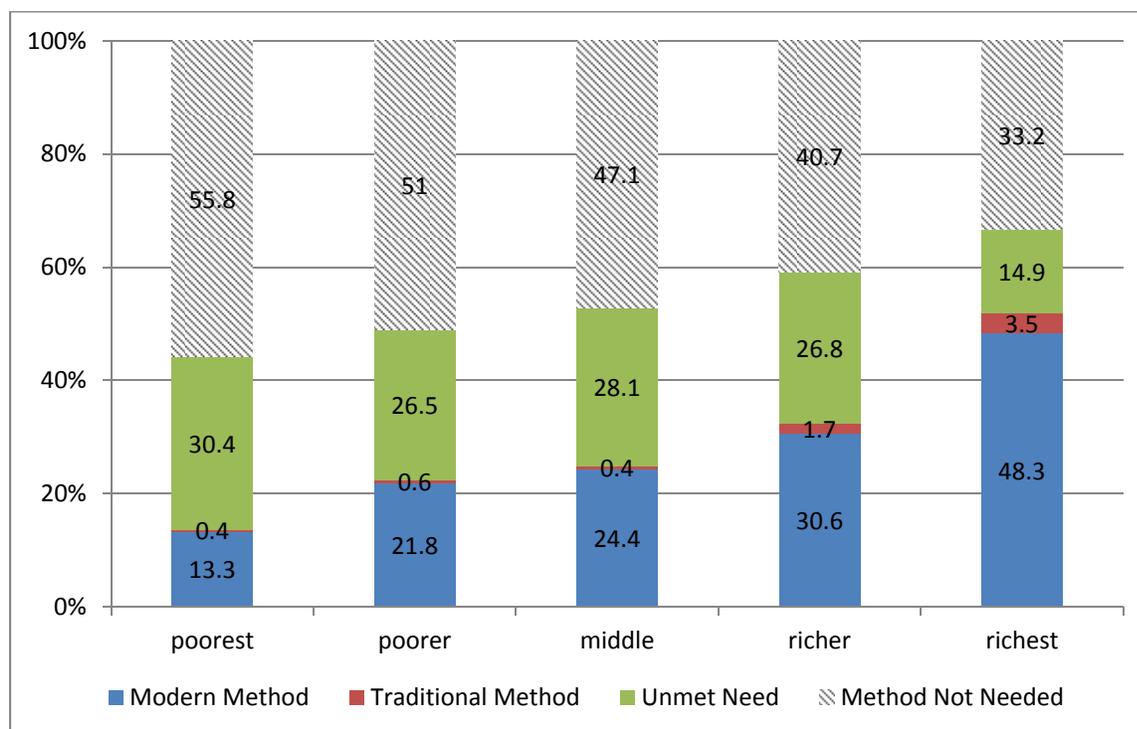
Method Mix

Figure 10 shows the contraceptive method mix for 2011. Currently available contraceptive methods in Ethiopia can be categorized into traditional methods and modern methods, which include injectables, pills, condoms, implants, female sterilization, intrauterine devices (IUDs), and other modern methods (lactational amenorrhea, female condom, and the standard days method).[11]

Of the modern methods in use, injections (72 percent), implants (12 percent), and pills (7 percent) are the three most popular. These three methods combined represent 91 percent of current contraceptive method mix. Traditional methods account for 5 percent in 2011. Overall, injectables and implant use has increased since 2005, while use of pills has declined the most markedly, from 21 percent in 2005 to 7 percent in 2011 (see Figure 11).

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[11] Both female condom and standard days method have limited availability in the Ethiopian health system (both public and private)

Figure 10. Contraceptive Method Mix for All Women, 2011
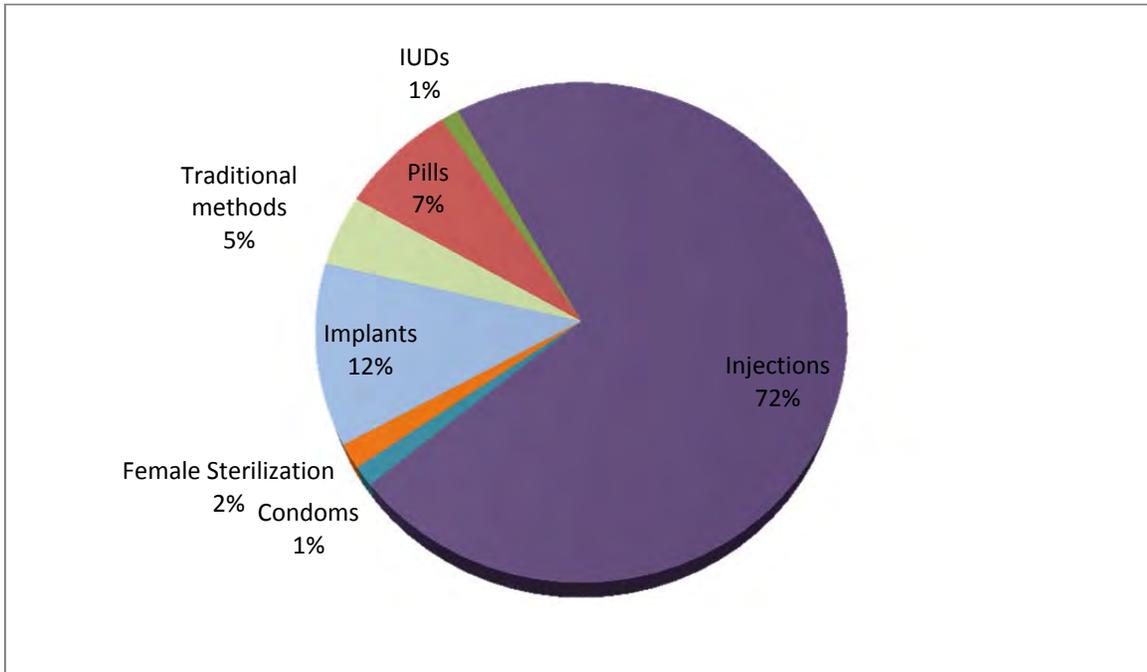
Figure 11. Contraceptive Method Mix for All Women, 2005
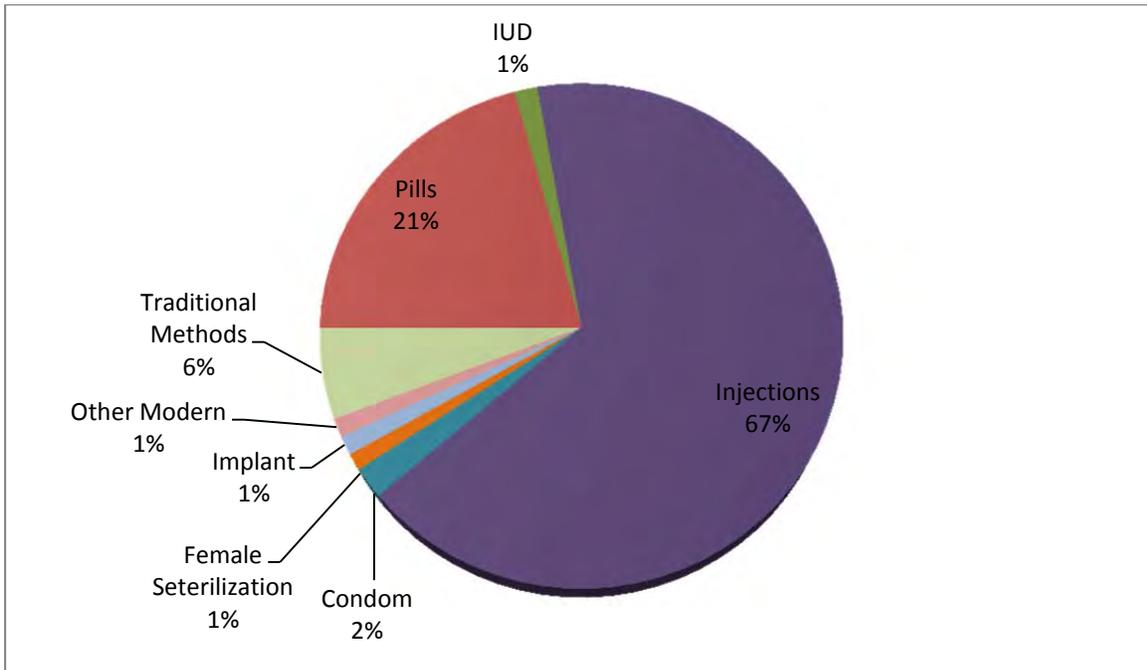
Residence

When looking at the method mix by location, injectables and pills make up the largest proportion of method mix in urban areas (see Figure 12). In rural areas, implants are the second-most-common method, with injectables also the most commonly used. Use of pills in the rural area is minimal, with just under 5 percent of rural women using the method, while condom use is observed primarily in urban areas.

Figure 12. Method Mix by Location for All Women, 2011
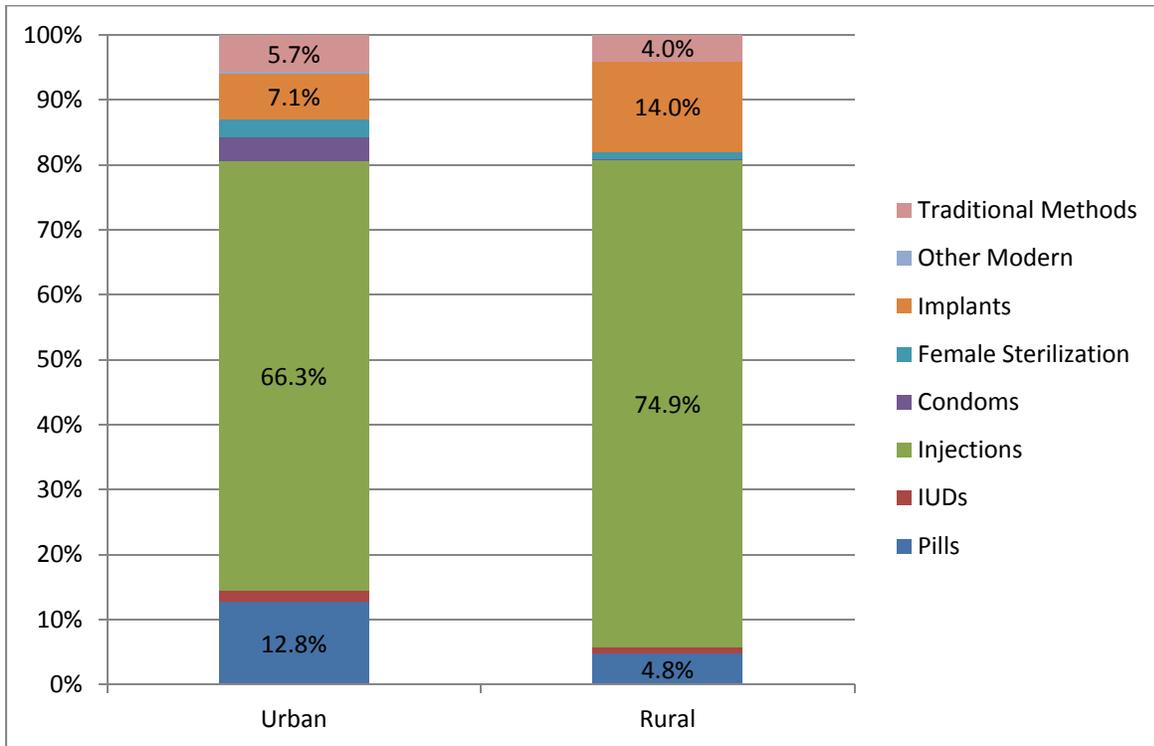
Education

The proportion of injectable users decreases with education while, conversely, the use of pills increases with education level. Approximately 76 percent of those with no education use injectables, while only 4 percent use pills. On the other hand, only 48 percent of users with higher education use injections, while 19.3 percent use pills. The share of women using implants also decreases with education (14.9 percent, no education; 8.9 percent, primary; 8.5 percent, secondary; 6.1 percent, higher). Implants are the second-highest method for users with no education, similar to those living in the rural area.

Figure 13. Method Mix by Education Level for All Women, 2011
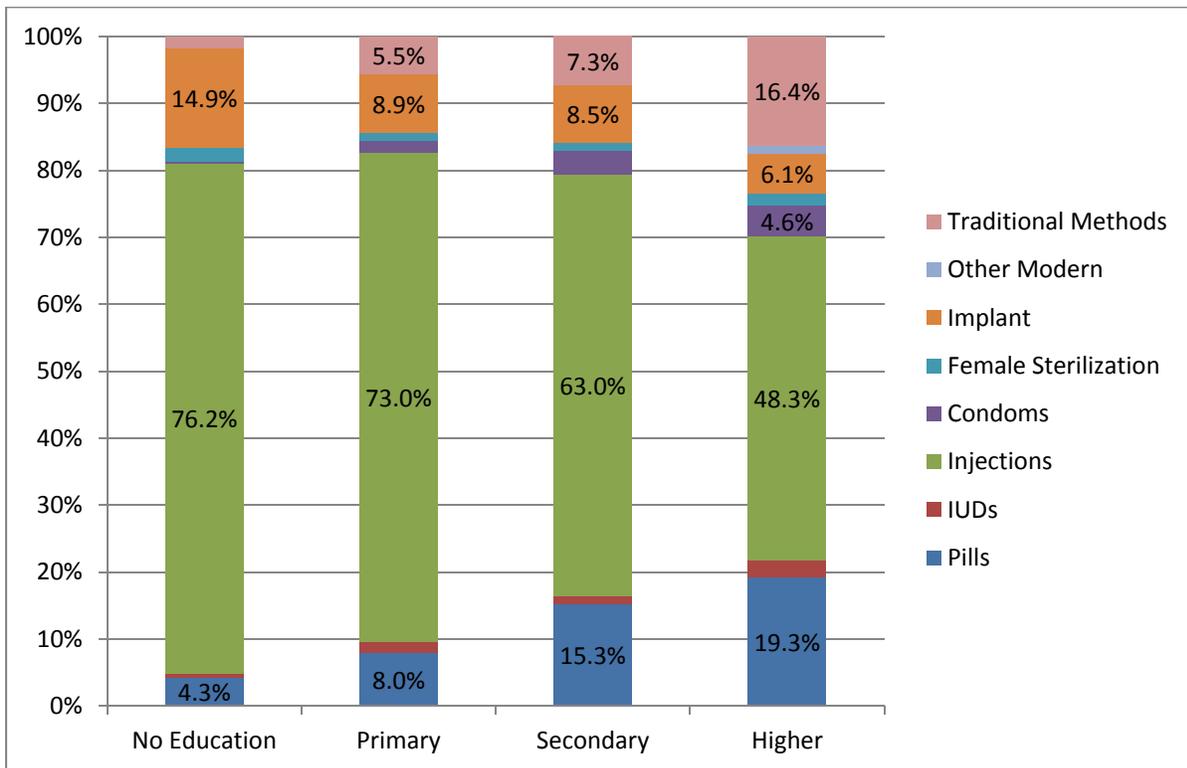
Wealth

For short-term methods, injections have the highest prevalence across income groups (see Figure 14). In addition, use of traditional methods increases considerably when moving from the poorest to the richest group. Condom use for family planning is close to nil in almost all quintiles, increasing very slightly in the wealthiest group to 2 percent of users. This is consistent with the trend seen when comparing urban and rural settings: condom use is higher in urban areas, which tend to be wealthier than rural areas. The use of pills also increases with wealth, with pills being the second-most-common method used by those in the wealthiest quintile. Use of long-acting methods also varies among quintiles. Implants are the most common long-acting method used in all quintiles and are used more frequently among poorest, poorer, and middle quintiles than among the richer and richest. The use of IUDs is slightly more prevalent in the wealthiest quintile, but is still very low in all quintiles.

Figure 14. Method Mix by Wealth Quintile for All Women, 2011
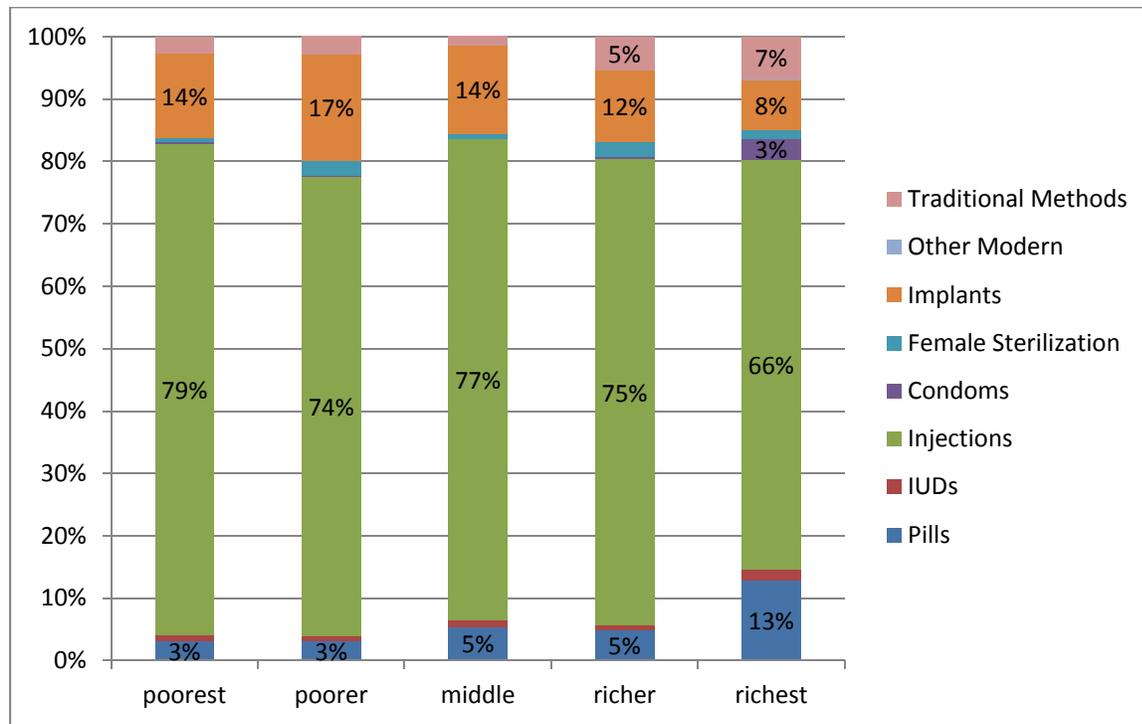
Region

Throughout all regions, injectables are the most commonly used method; however, some regional differences do exist. The use of condoms and pills is proportionally higher among users in the more urban and wealthier regions of Addis Ababa, Dire Dawa, and Harari, as well as Gambela, than in other regions (see Figure 15). Pill use is lowest in Tigray, Amhara, and SNNP regions.

Long-acting methods are also more prevalent in some regions than others. Female sterilization is highest in Addis Ababa; however, implants and IUDs are also used. Implants are used more widely than IUDs, with a much higher proportion of users in Dire Dawa and Tigray regions than in others.

Figure 15. CPR and Method Mix by Region for All Women, 2011
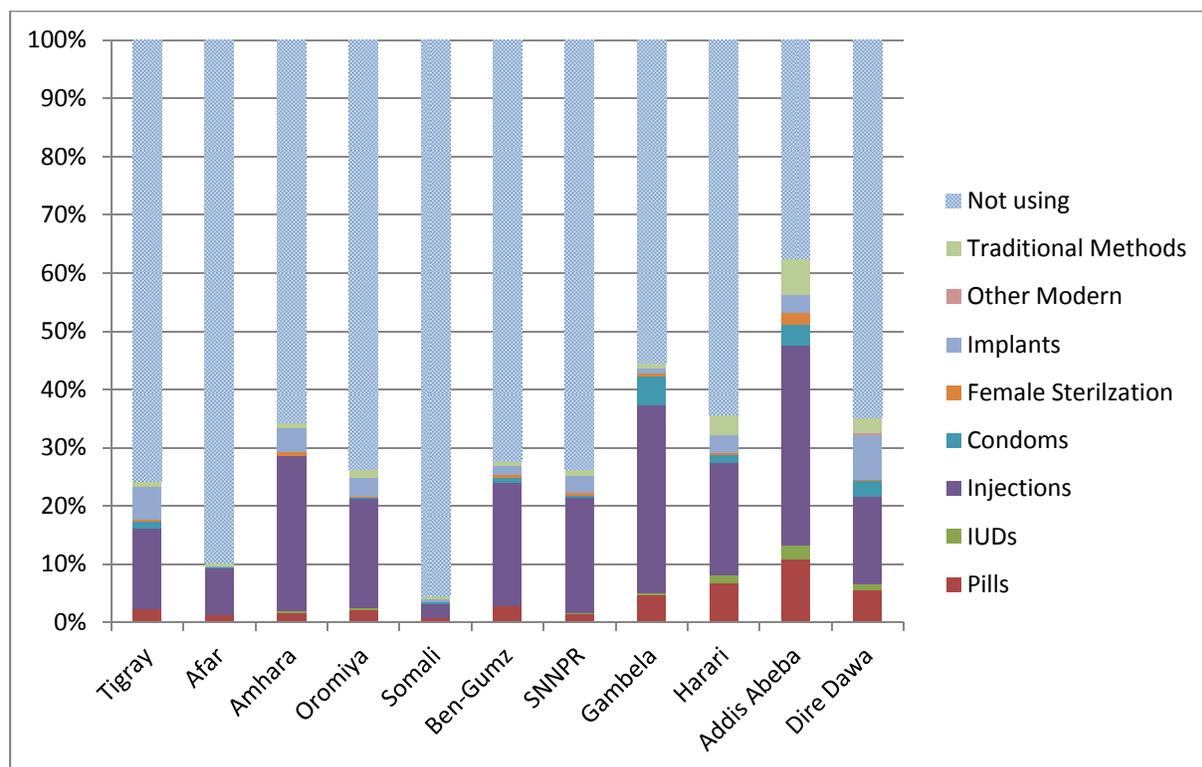
Age

As expected, the preferred method across all age groups is injections (see Figure 16). The pill and implant follow, but use varies by age group between the two methods. Women ages 15–19 years use pills slightly more frequently than implants, but users ages 20–49 years consistently use implants more frequently than pills.

Preference for other long-term methods (IUDs and female sterilization) remains consistently low, increasing only slightly for women 35 years and older. Female sterilization is close to nil in women 15–34.

Figure 16. Method Mix by Age Group for All Women, 2011
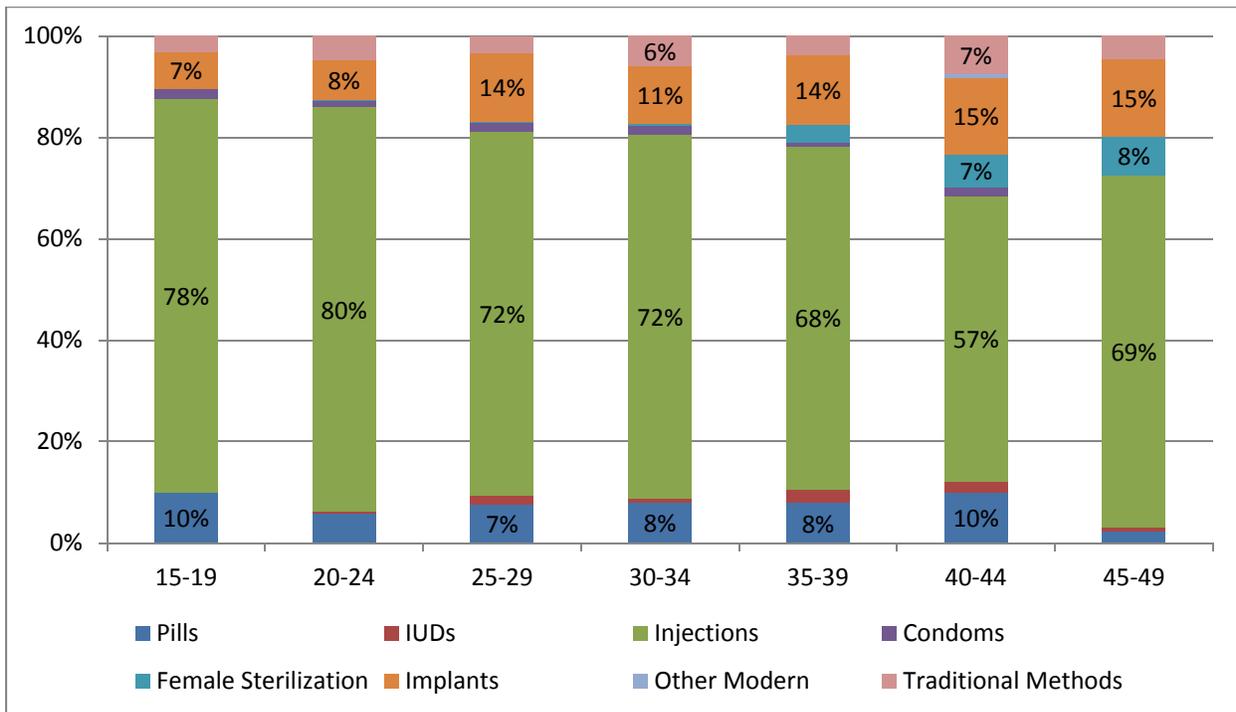
Provider Profile and Sources of Supply

Provider Characteristics

The main source of supply for contraceptives in Ethiopia is FMOH public health facilities, followed by pharmacies (including chemists and drugstores), private clinic facilities, and NGOs such as Family Guidance Association of Ethiopia (FGAE) and Marie Stopes International (MSI). Two social marketing programs, run by DKT International and Population Services International (PSI), also operate within the country. Much of the social marketing contraceptive product distributed in-country is sold in pharmacies and shops.

Table 2 provides information on the range, type, and brand of contraceptives provided by the various in-country service providers. PSI also provides Blue Denim and Protector P condoms free of charge for HIV targeted interventions.

Table 2. Contraceptive Methods Provided According to Source Program, 2012

Method	MOH (public)	DKT (social marketing)	FGAE (private, NGO sector)	MSI (private, NGO sector)	Other Private Sector (commercial clinics & pharmacies)
Orals	Microgynon Lynestrenol (Exluton) Microlut	Choice I Plan Hyan Style (Trigestrel) Post pill	Microgynon Lynestrenol (Exluton) Microlut	Microgynon Lynestrenol (Exluton) Microlut Choice I Plan Style (Trigestrel) Post pill	Choice I Plan Post Pill Style (Trigestrel) Microgynon
Injectables	Depo Provera Petogen Megestrone Depogestine	Confidence (Depogestin)	Depoprovera Petogen Depogestine	Depoprovera Petogen	Confidence (Depogestin)
Condoms	Standard (not branded) Blue Gold Hiwot trust	Hiwot trust Sensation Members only	Standard Blue gold Hiwot trust	Standard Hiwot trust	Hiwot trust Sensation Members only
Implants	Jadelle Implanon Long Act (Sino Implant)	Trust Implant	Jadelle Implanon	Jadelle Implanon Trust Implant	Trust Implant

Method	MOH (public)	DKT (social marketing)	FGAE (private, NGO sector)	MSI (private, NGO sector)	Other Private Sector (commercial clinics & pharmacies)
Intrauterine devices (IUDs)	Copper T 380 A	Long Act U-Kare CU 375	Copper T 380A	Copper T 380A	Long Act U-Kare CU 375

Public Sector

Government hospitals, health centers, health posts, and HEWs provide a wide range of contraceptives on the market (Table 2). Government hospitals and health centers are equipped to provide all methods, including clinical ones (IUDs, implants, male and female sterilization). Health posts and HEWs are trained and equipped to provide condoms, injectables, oral contraceptives, and the one rod implant (Implanon).

Social Marketing

DKT International and PSI are the two main social marketing providers in Ethiopia. DKT markets condoms, oral pills, injectables, IUDs, and implants, while PSI markets condoms.

Private Sector Clinics and Pharmacies

Although a range of family products are available in the private sector (see Table 1), this sector serves only a small share of the current market or contraceptive users (see Figure 17). Many of the condoms sold by pharmacies are placed there by the major in-country social marketing programs. In addition, several of the commercial clinics in-country that provide family planning services, do so through special programs funded and supported by international donors, such as USAID, DfID, and others. In sum, much of the product and many of the FP services provided in the commercial sector are subsidized.

Source of Supply

Figure 17 illustrates the source of supply for contraceptives and how the market has changed slightly since 2005, with government sources still accounting for the largest share (79.5 percent in 2005 to 84 percent in 2011.)

In 2011, over one-quarter of users were obtaining products from government health posts/HEWs, compared with one-fifth in 2005, while the share for government hospitals and government health centers decreased from 61.5 percent to 55 percent. Additionally, the use of the private sector, which includes pharmacy/shop/friend and private facilities, decreased from 18.3 percent in 2005 to 13.2 percent in 2011.

Figure 17. Source of Supply of Modern Contraceptive Methods for All Women, 2005 and 2011
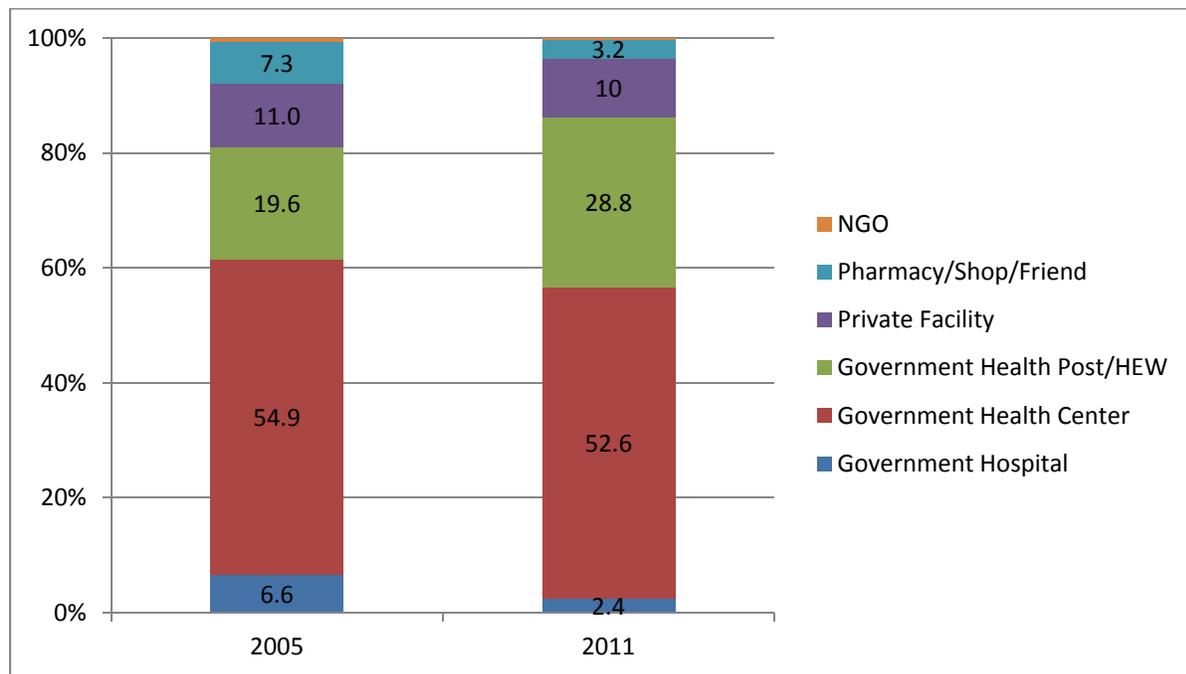
Methods

As mentioned earlier, the most frequently used forms of contraception are injections, followed by implants and pills. For those methods, the public sector (government hospitals, health centers, and health posts/HEWs) comprises the largest share of the contraceptive market (87 percent of injectable users, 98 percent of implant users, and 72 percent of pill users).

Private facilities provide IUDs and other long-acting and permanent methods (like implants) requiring clinical care during their insertion as well as pill and condoms; however, they provide a much smaller proportion of these products than the public sector. Approximately 30 percent of pill users obtain their method in the private sector (11 percent from private clinics and 17 percent from pharmacies, shops, and friends).

Condoms are the only product that is not obtained primarily in the public sector. Only 14 percent of condom users are served through public facilities, with the private sector (primarily pharmacies) serving as the main source (84 percent).

Figure 18. Source of Supply by Modern Contraceptive Method for All Women, 2011
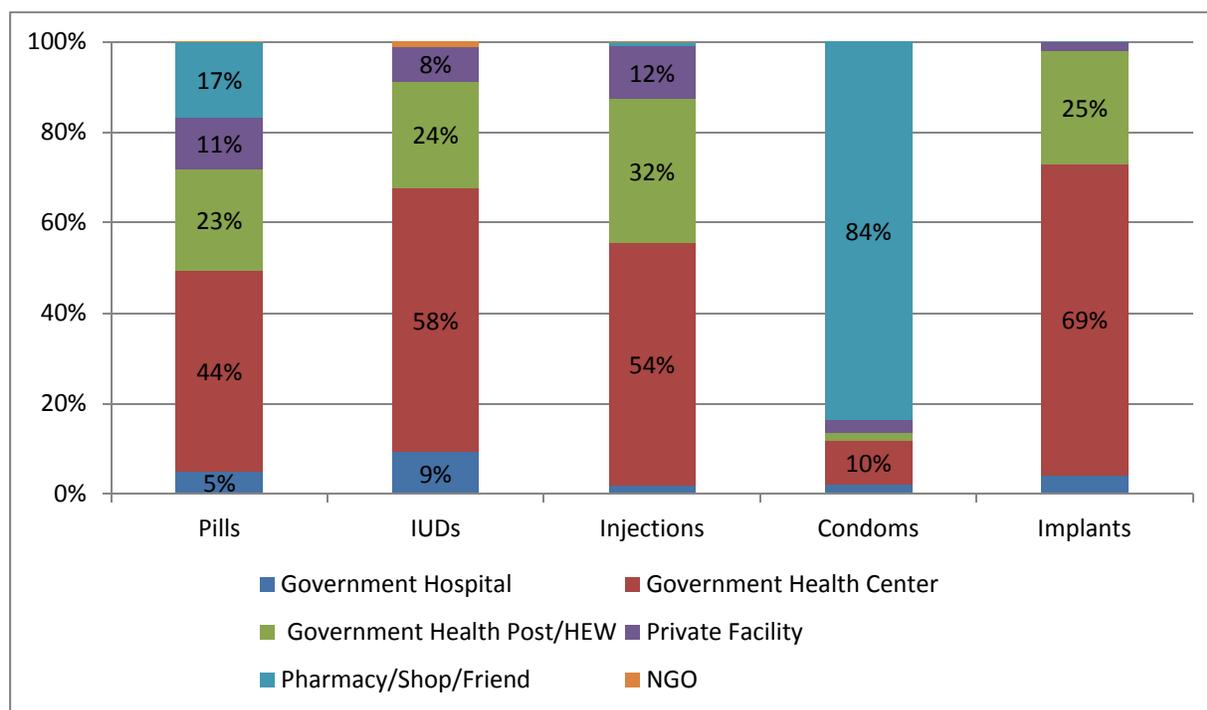
Wealth

Similar to residence, Figure 19 shows that the majority of modern method users, regardless of wealth, receive their contraception from government sources. However, 17 percent of the wealthiest quintile obtains services from private facilities in contrast to 4.6 percent of the poorest quintile.

Although public sector use by wealthier quintiles is lower than that of poorer quintiles, the public sector is still the primary source of contraceptives for the wealthier groups, with the wealthiest group relying on the public sector for 72.5 percent of their contraceptive supply. The wealthiest obtain family planning from government hospitals much more (5.7 percent) than all other quintiles (below 1 percent).

Figure 19. Source of Supply by Wealth for All Women, 2011
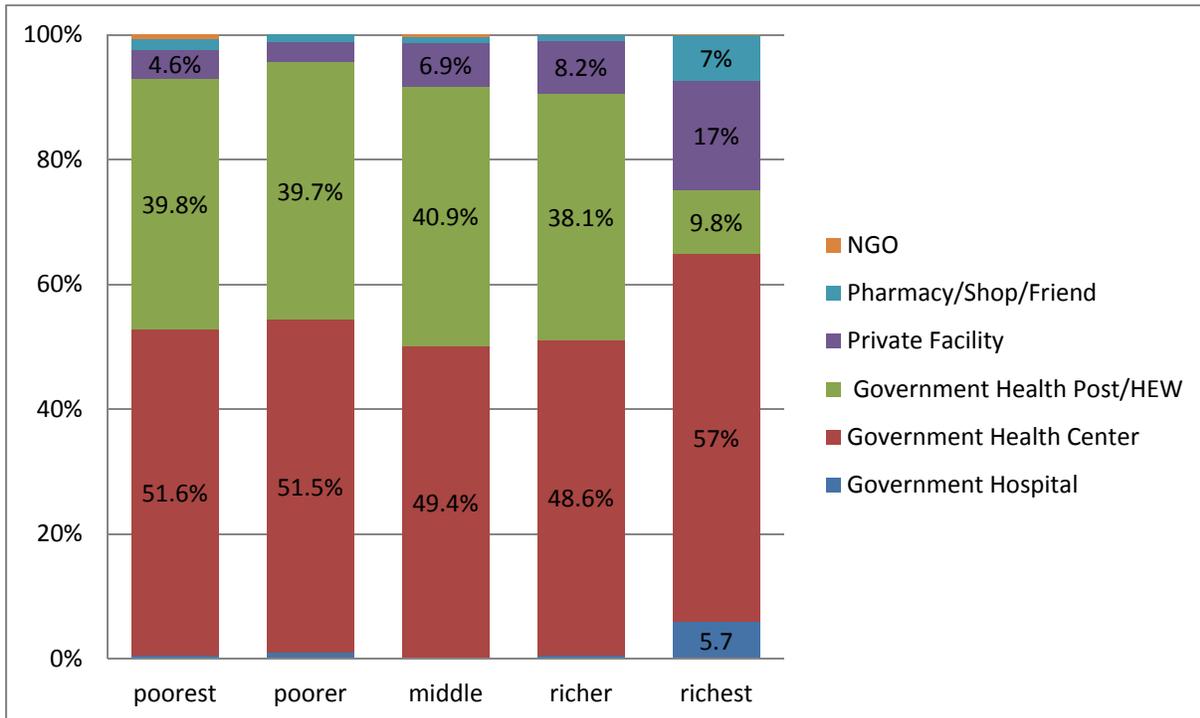
Residence

Source of supply by area of residence follows a similar pattern to use by wealth quintile. Sources of modern contraception for those living in rural areas are similar to sources for the poorer quintiles, and sources for those living in urban areas are similar to sources for those in the wealthier quintiles. As illustrated in Figure 20, over 90 percent of contraceptive users in rural areas rely on public facilities as their source, compared to only 71 percent in urban areas. Also, rural users obtain their methods from HEWs and health posts (39.5 percent) more often than urban users (6.8 percent). Urban users rely predominantly on health centers to obtain their contraceptives.

Figure 20. Modern Contraceptive Source by Residence for All Women, 2011
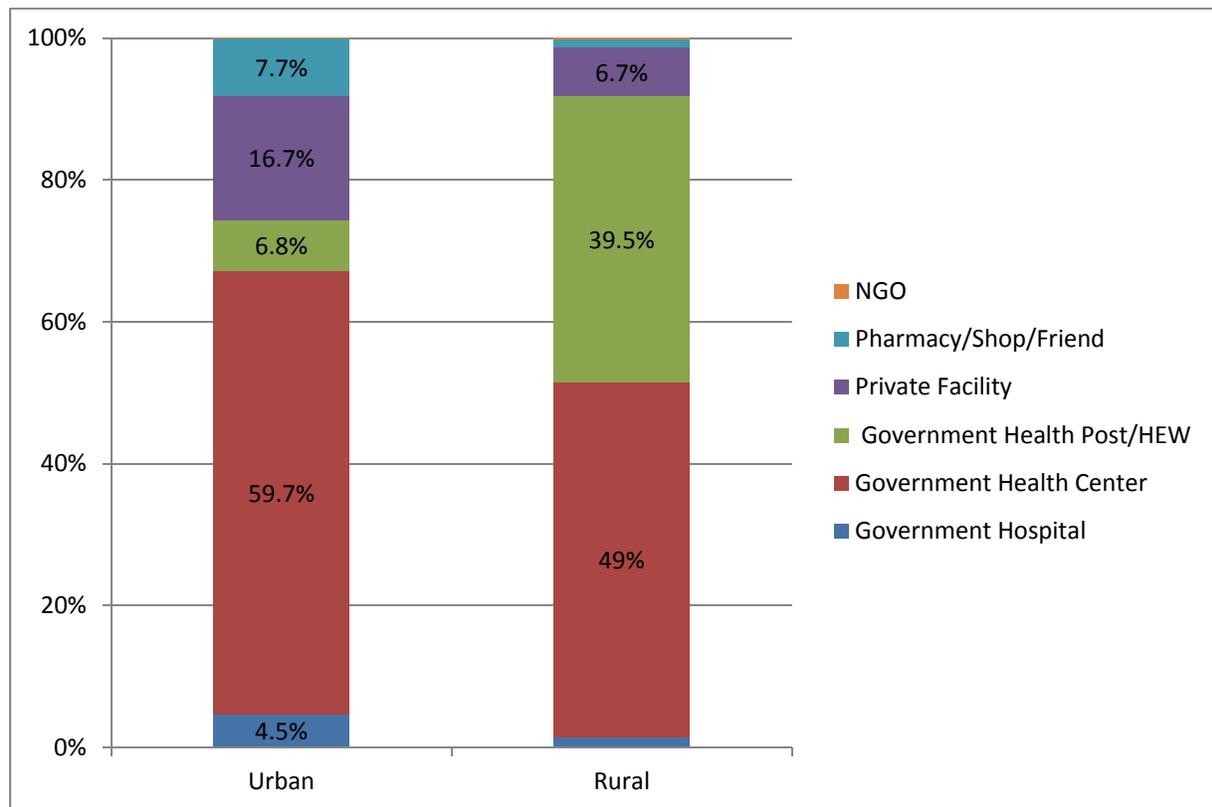
Age

Source of supply does not vary significantly by age. Access to contraceptives through the public sector increases steadily for age groups 15–30 years, but then plateaus for age groups 30–49, at 90 percent. It is interesting, however, that the highest percentage of users of private facilities is the youngest age groups, 15–19 (23 percent) and 20–24 (14.6 percent).

Figure 21. Modern Contraceptive Source by Age Group for All Women, 2011

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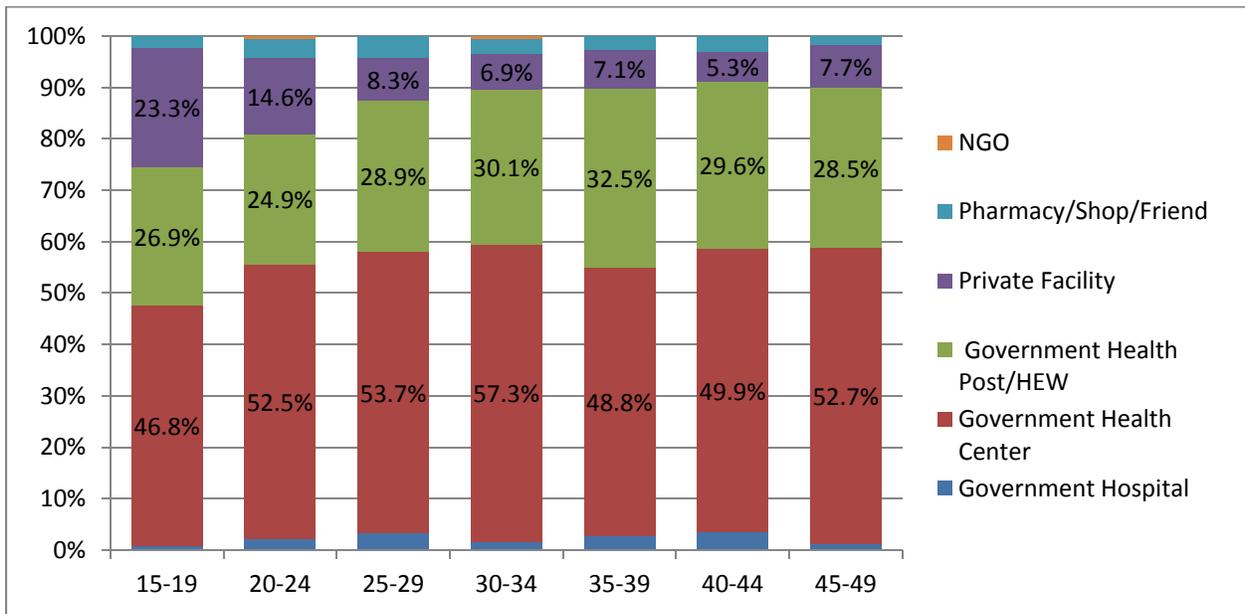
Region

The public sector is also the main provider throughout the regions, with use of health posts and HEWs varying significantly across regions. As shown in Figure 22, in Oromiya, Benishangul-Gumuz, and SNNP regions, over one-third of users in each region access contraceptives through government health post/HEWs, compared with less than 10 percent in regions such as Afar, Gambela, and Addis Ababa. Somali and Harari report the highest proportion sourced from government hospitals (37 percent and 29 percent, respectively). Figure 21 also shows that users in Gambela access contraceptives predominantly from the private sector unlike any other region (60 percent, including both private facilities (50 percent), and pharmacy/shop/friend, (10 percent)).

Figure 22. Source of Supply by Region for All Women, 2011
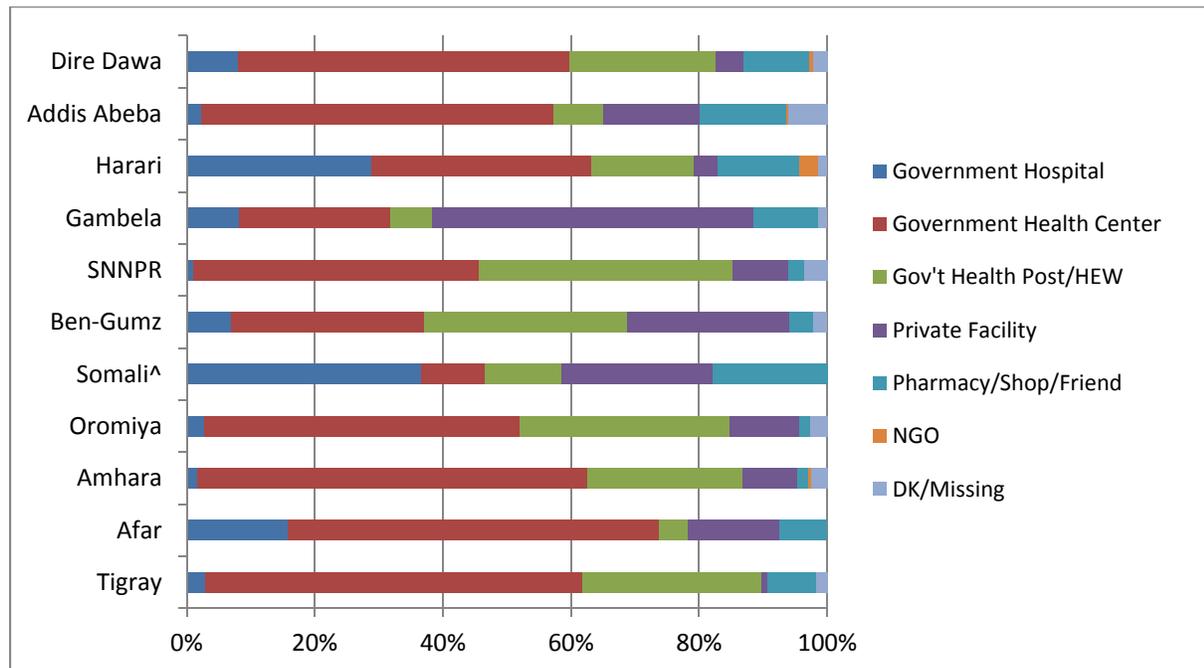
Education

Similar to trends seen in regional and wealth analysis, Figure 23 shows the inverse relationship between education and public sector source of supply. As education increases, users are less likely to access contraceptives from government facilities. There is a significant difference between users with no education and those with secondary and higher education; only about 8 percent of users with no education rely on the private sector, whereas more than 25 percent of users with secondary or higher education receive their contraceptives from private sector facilities.

Nonetheless, a large proportion of users with higher levels of education are obtaining their services from the public sector, mainly health centers.

Figure 23. Source of Supply by Education Level for All Women, 2011
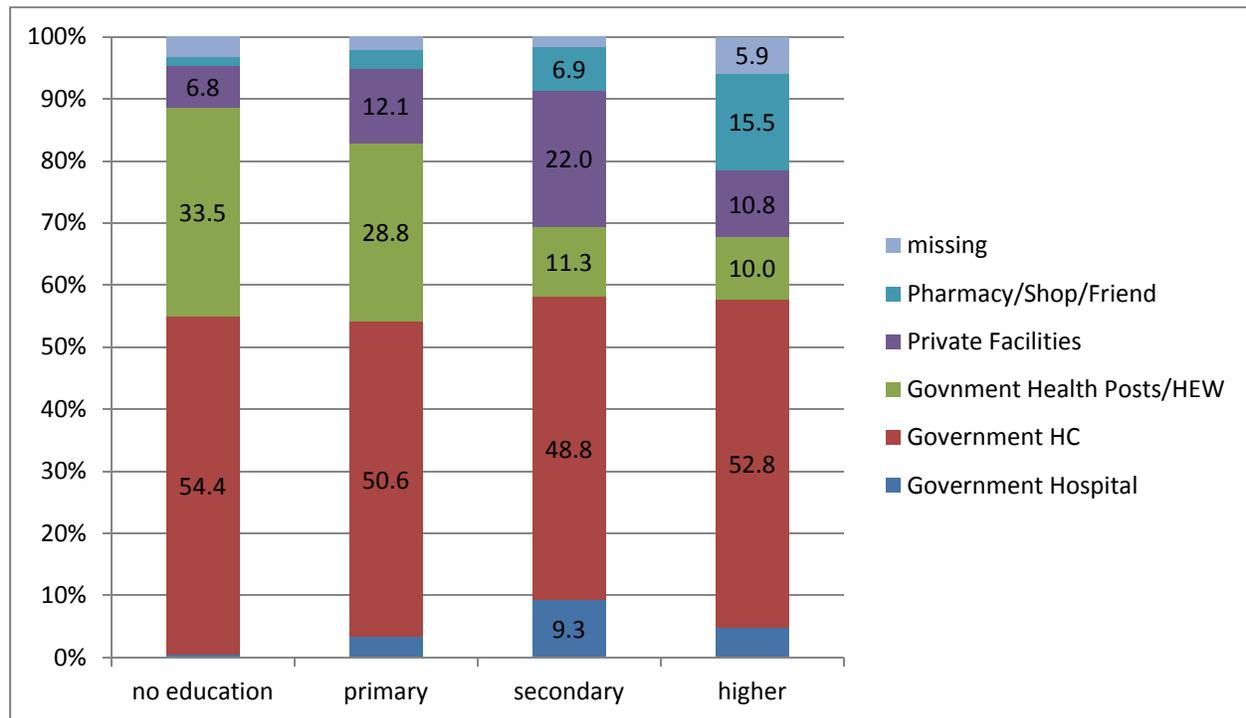
Trends in Unmet Need and Total Demand

Total demand gives us a sense of how well the country is doing in reaching its FP goal by totaling the number of women who are using contraceptives with those who currently have an unmet need for FP. Women with unmet need are identified as those who are sexually active, fertile, and report that they do not want any more children or want to delay the birth of their next child by at least two years. This section presents trends in unmet need and total demand.

Region

As shown earlier (see Figure 1), 25.3 percent of married or sexually active women in Ethiopia have an unmet need for family planning. With a population of close to 13.4 million women of reproductive age (15–49 years) of whom 63 percent are estimated to be married or sexually active, this equates to an estimated 3.3 million women who have an unmet need for FP. Most of these women reside in Oromiya, Amhara, and SNNP. Figure 24 shows the estimated number of women of reproductive age with unmet need by region in 2011. Of these 3.3 million women with unmet need, an estimated 300,000 are adolescents (15–19 years). Unmet need among adolescent women in Afar, Amhara, and Harari is 10–15 percent points higher than the average for all women in those regions (see Figure 25).

Figure 24. Estimated Number and Percent of All Women with Unmet Need by Region, 2011
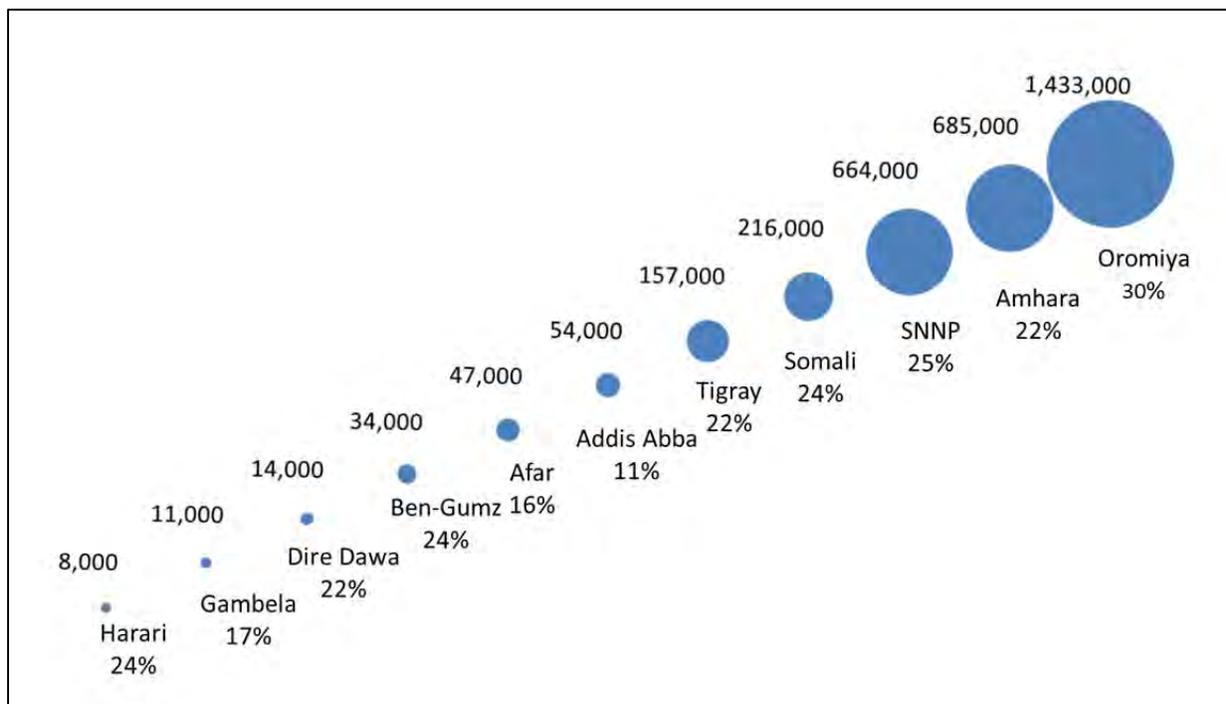
Figure 25. Estimated Number and Percent of Adolescent Women (15–19) with Unmet Need by Region, 2011
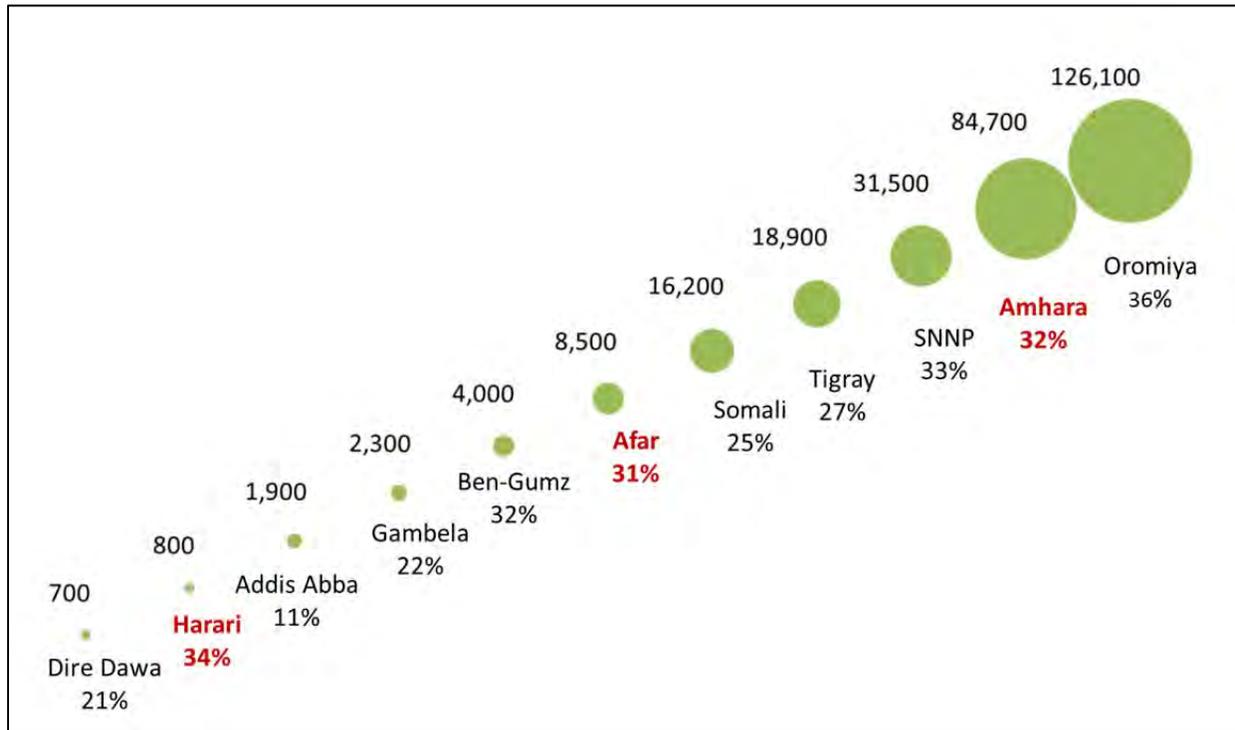
Since 2005, unmet need has declined in most regions, as shown on the map in Figure 26. Further, the rate of decline in unmet need (from 2005 to 2011) is similar in most regions, although Tigray, Afar, and Somali lag behind (see Figure 27).

Figure 26. Unmet Need for Contraception by Region for All Women, 2005 and 2011
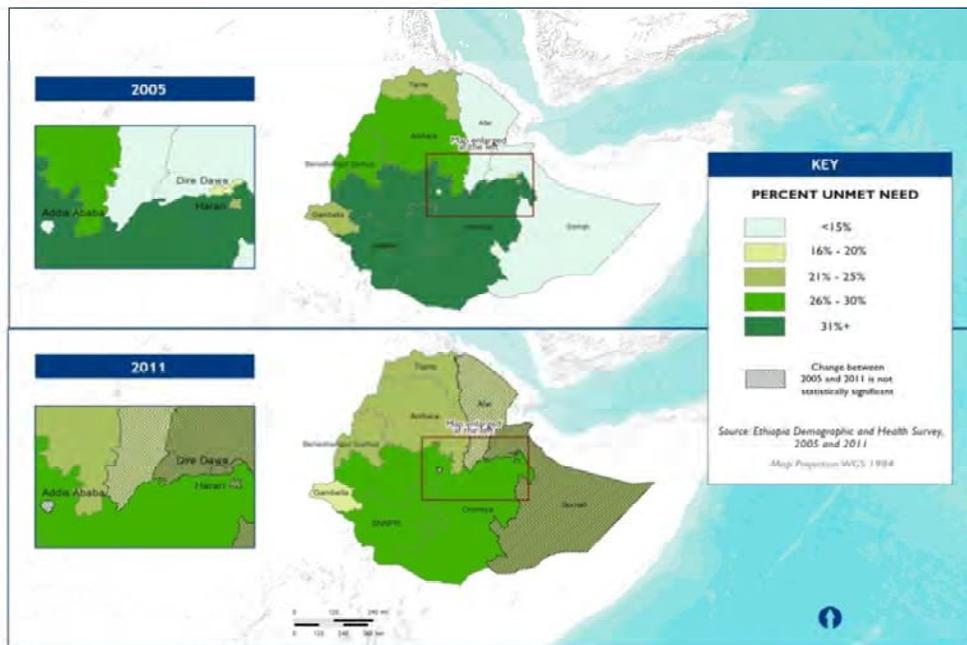
Figure 27. Rate of Decline in Unmet Need by Region for All Women, 2005 and 2011
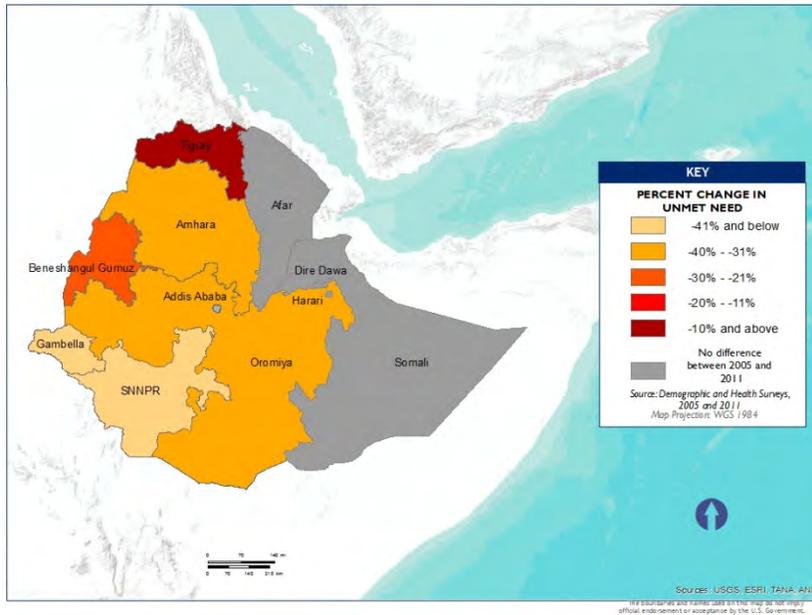
Demand for family planning is important to reach the GoE family planning targets for 2015 and to help fuel the health and development goals of the demographic transition. Overall demand is much higher than current rates of contraceptive use, so there is much potential to continue to increase FP use, thereby lowering fertility rates.

In addition, much progress has been made since 2005. In most regions, demand for contraception was less than 50 percent in 2005 (see Figure 28). In 2011, total demand grew in all regions, particularly in Gambela, which increased by 35 percent to 61 percent (see Figure 29). In 2011, total demand for FP in Afar and Somali remained below 30 percent, while in Addis Ababa it was above 74 percent.

Figure 28. Total Demand for FP by Region for All Women, 2005
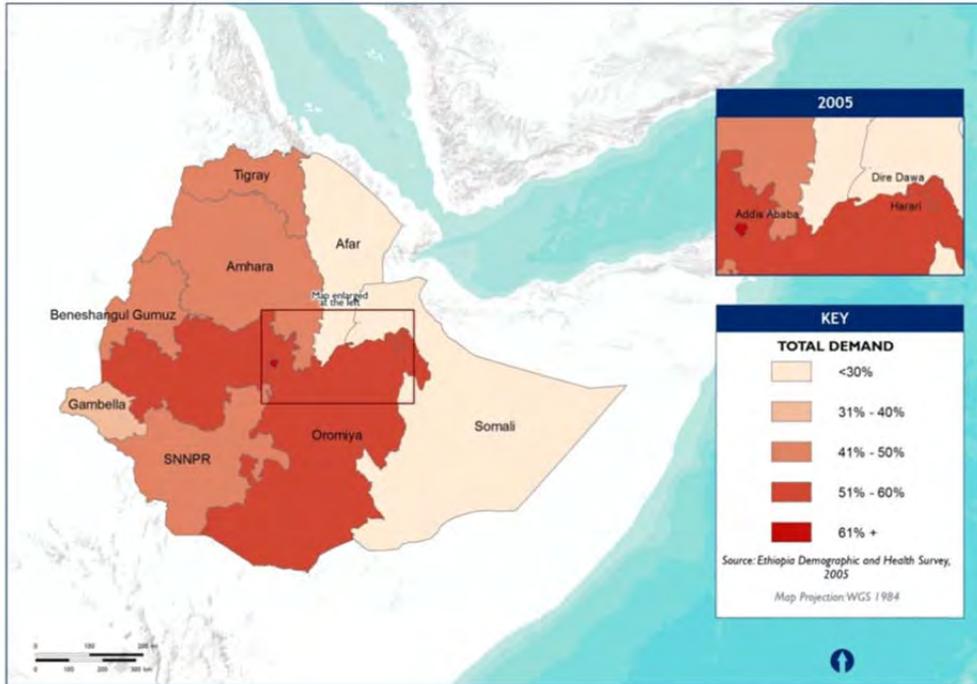
Figure 29. Total Demand for FP by Region for All Women, 2011
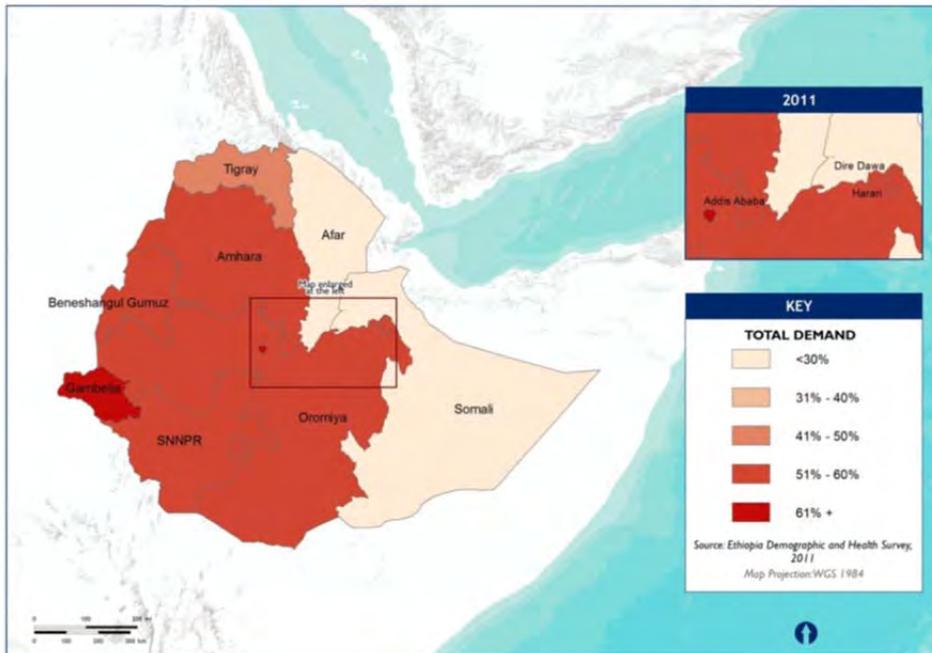
As one might expect, demand for FP was lower in 2005, and much of this demand was not satisfied: only Addis Ababa, Harari, and Dire Dawa had over 60 percent demand satisfied, while all other regions were below 45 percent. However, as shown in figures 30 and 31, some of the demand has been satisfied in 2011. Most significant, in Gambela, satisfied demand for FP increased from 40.3 percent in 2005 to 72.8 percent in 2011. Amhara also saw major improvement from 35.5 percent in 2005 to 60.9 percent in 2011.

Figure 30. Demand for FP Satisfied by Region for All Women, 2005
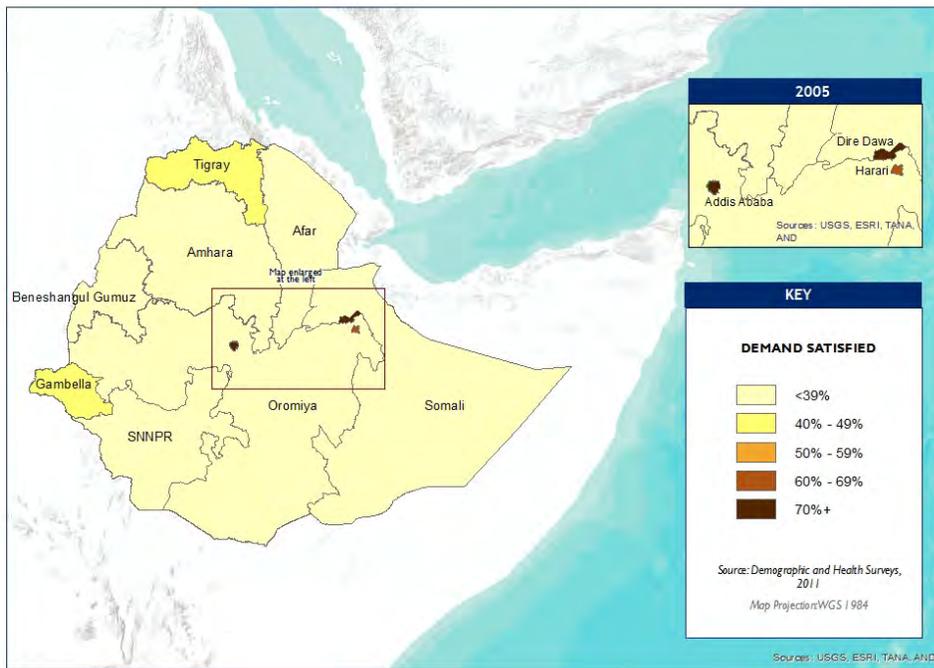
Figure 31. Demand for FP Satisfied by Region for All Women, 2011
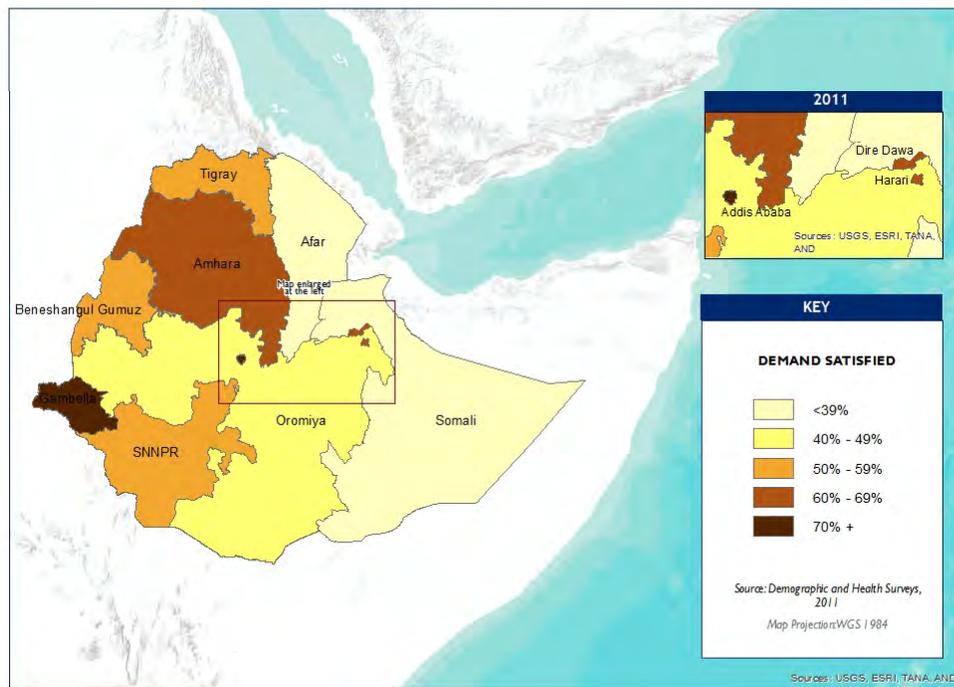
Residence

In the urban areas, although total demand is still greater than in rural areas, little change has occurred since 2005. In the rural areas, as mentioned earlier, there has been a significant increase in women using a method since 2005 (11 percent in 2005 to 24 percent in 2011). However, as Figure 32 illustrates, total demand in the rural area has increased since 2005, and unmet need continues to remain high despite a decline of 8 percentage points. Nevertheless, as shown in Figure 33, there has been significant improvement in the rural areas in satisfying the demand for FP since 2005.

Overall rates of total demand suggest that much progress can be made in the future to increase FP use and attain corresponding health and development goals. If services continue to become increasingly available, and barriers to unmet need are eliminated as they have in the past, much total demand could be satisfied. However, generating demand for FP, particularly in rural areas, is needed to reach national FP goals and fuel demographic transition.

Figure 32. Total Demand by Residence for All Women, 2005 and 2011
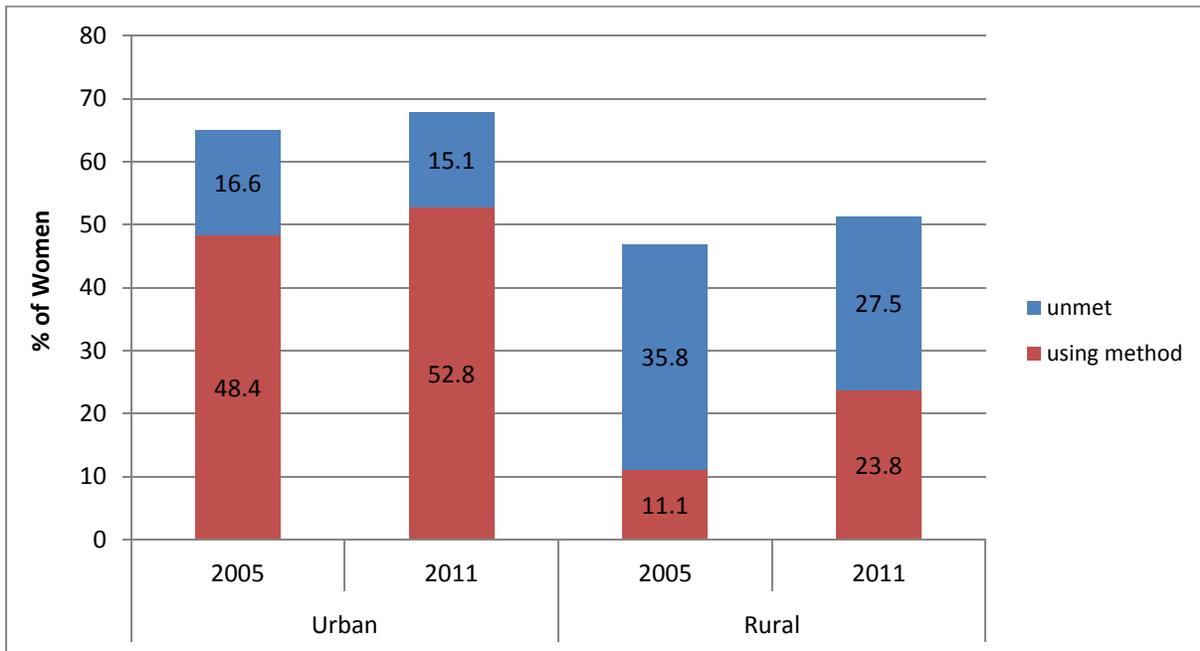
Figure 33. Percentage with Demand for FP Satisfied by Residence for All Women, 2005 and 2011
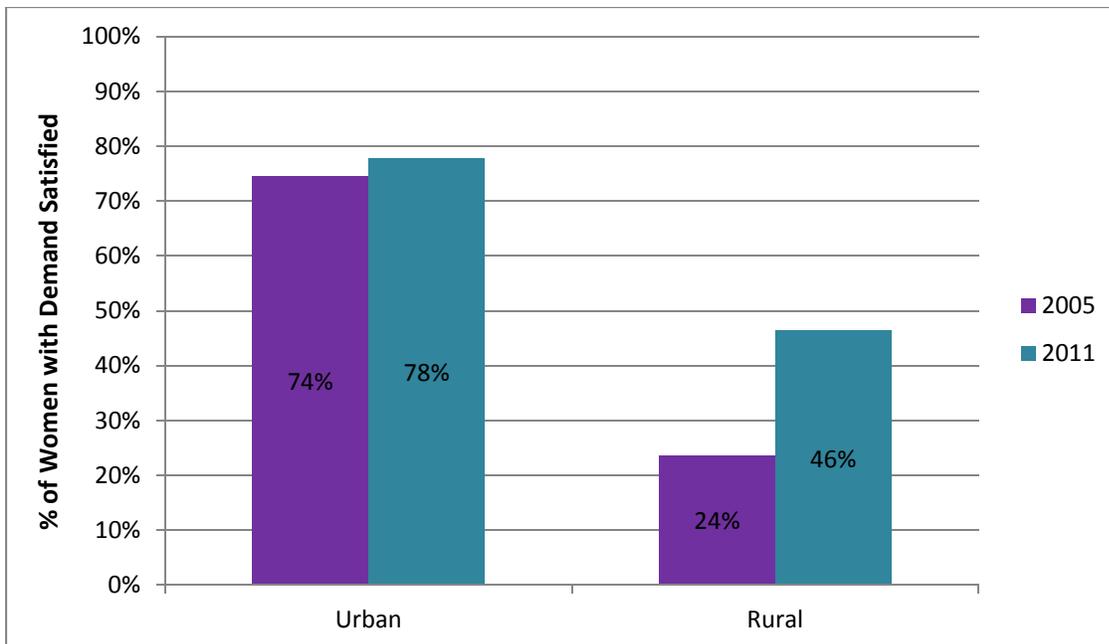
Wealth

While total demand is higher and is most satisfied in wealthier quintiles, all quintiles have seen increases since 2005. Figure 34 compares the total demand by quintile from 2005 to 2011. As expected, in 2005 and 2011, total demand increased with wealth, due to increases in CPR among wealthier women. Additionally, although demand continues to be better satisfied among wealthier women using methods, there has been significant improvement in meeting demand between 2005 and 2011 across all wealth quintiles. Figure 35 shows the total demand satisfied in 2005 and 2011.

Figure 34. Total Demand by Quintile for All Women, 2005 and 2011
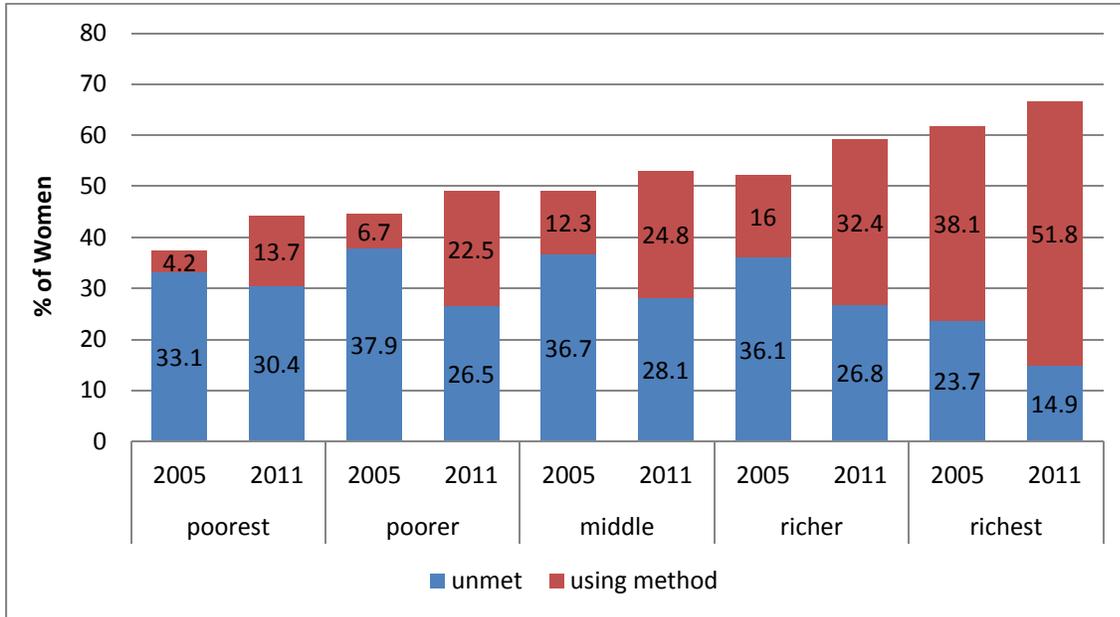
Figure 35. Percentage of Demand Satisfied by Quintile for All Women, 2005 and 2011

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Age
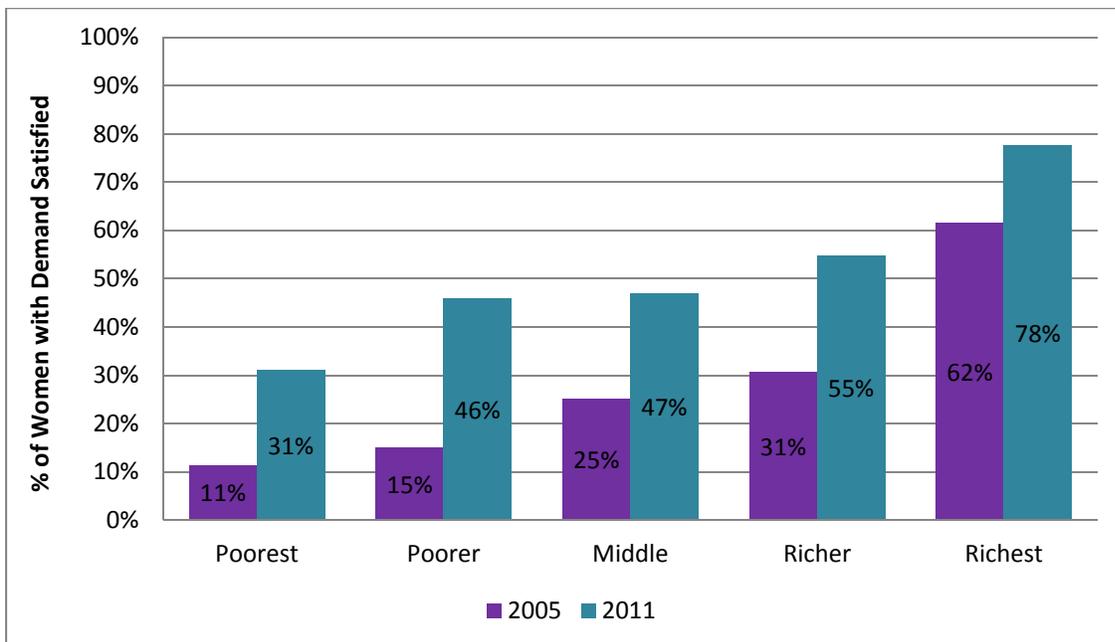
As shown in Figure 8, there is no clear correlation among method use, unmet need, and age. However, as Figure 36 illustrates, all age groups saw a decrease in unmet need and a corresponding increase in percentage of women using contraception between 2005 and 2011. The 15–19 and 20–24 age groups had a fairly large increase in CPR, increasing 60 percent and 52 percent, respectively, between the two periods. Furthermore, all age groups, aside from the oldest, now have a total demand for FP of more than 50 percent.

Figure 36. Total Demand by Age Group for All Women, 2005 and 2011
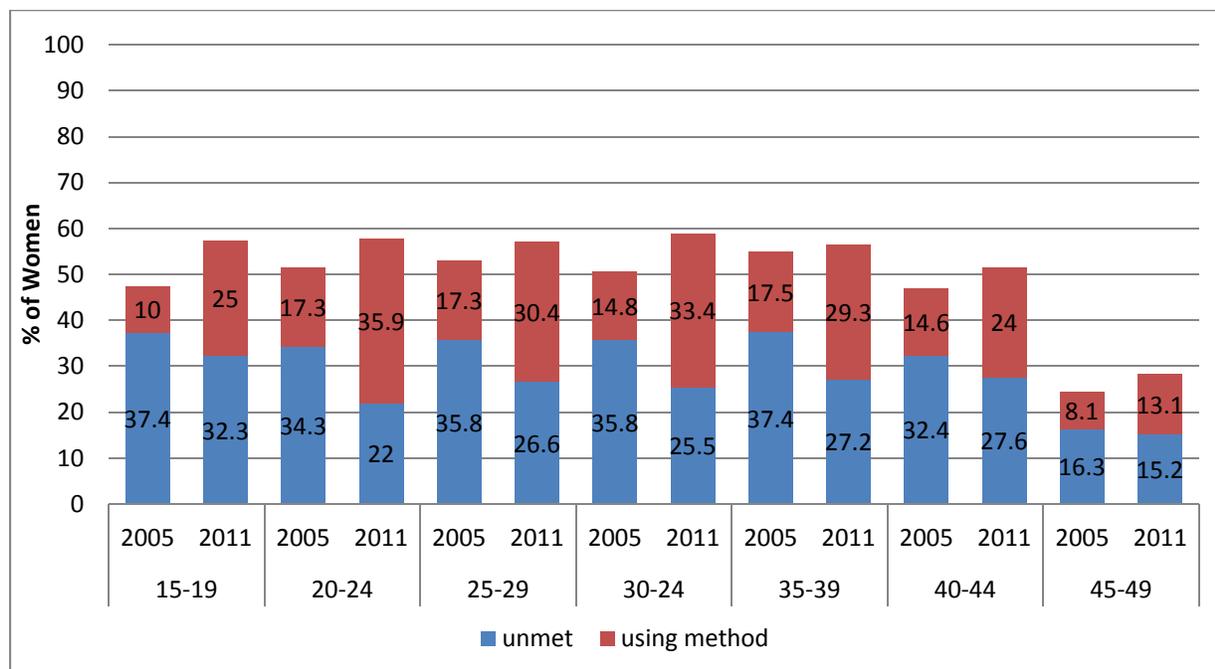
A closer look at just the adolescent population (ages 15–19) reveals that total demand is higher in urban areas than in rural ones. However, results suggest a decline in demand satisfied since 2005 for urban adolescents. In contrast, adolescents in the rural areas have made significant improvement since 2005 (figures 37 and 38).

Figure 37. Total Demand for FP by Residence for All Adolescent Women (ages 15-19), 2005 and 2011
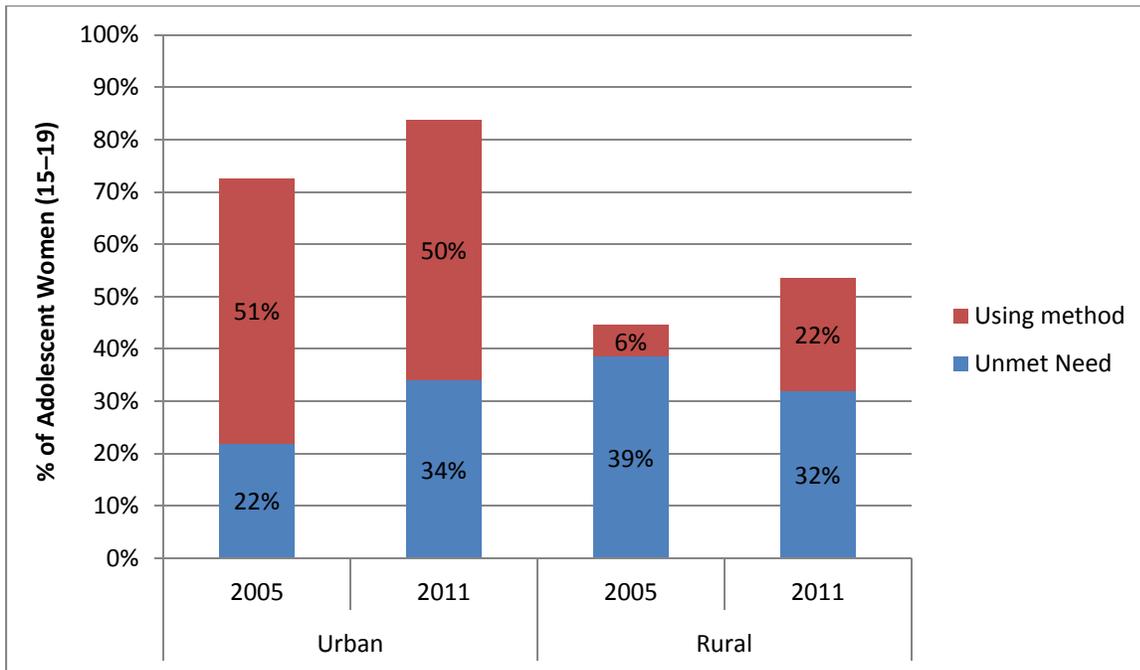
Figure 38. Percentage of All Adolescent Women (ages 15-19) with Demand for FP Satisfied, 2005 and 2011
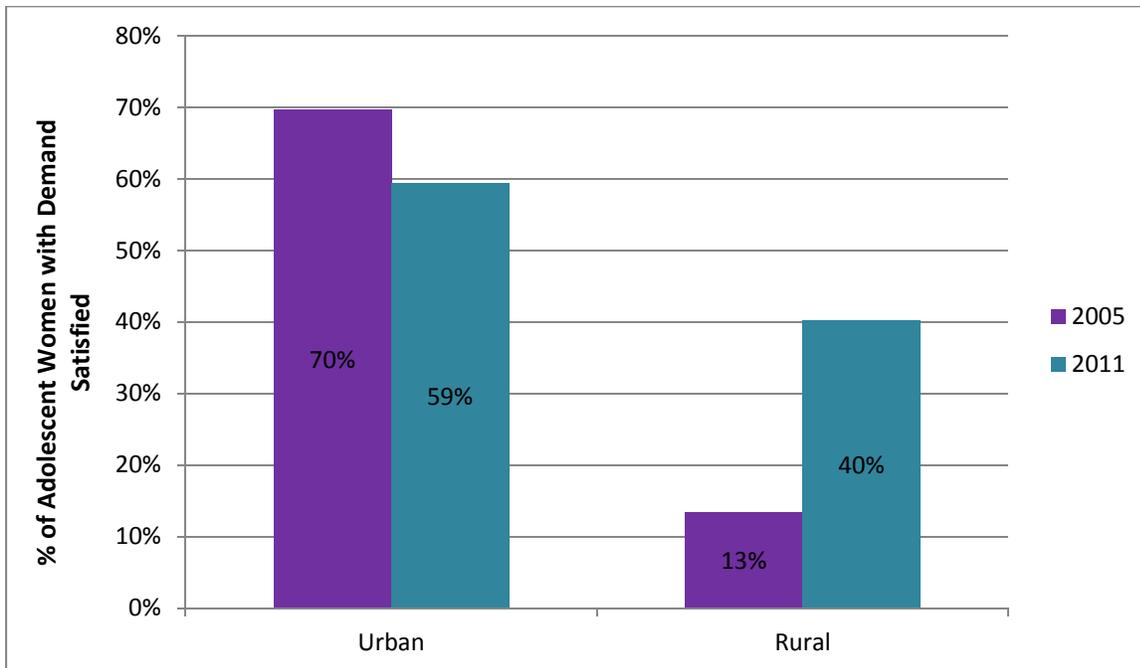
Education

Unmet need decreases significantly as education increases. Further, there is a positive correlation between level of education and total demand. As Figure 39 shows, total demand among women with no education is about 47 percent, whereas women with secondary or higher education have a total demand above 70 percent.

Figure 39. Total Demand and Unmet Need by Level of Education Attained, 2011
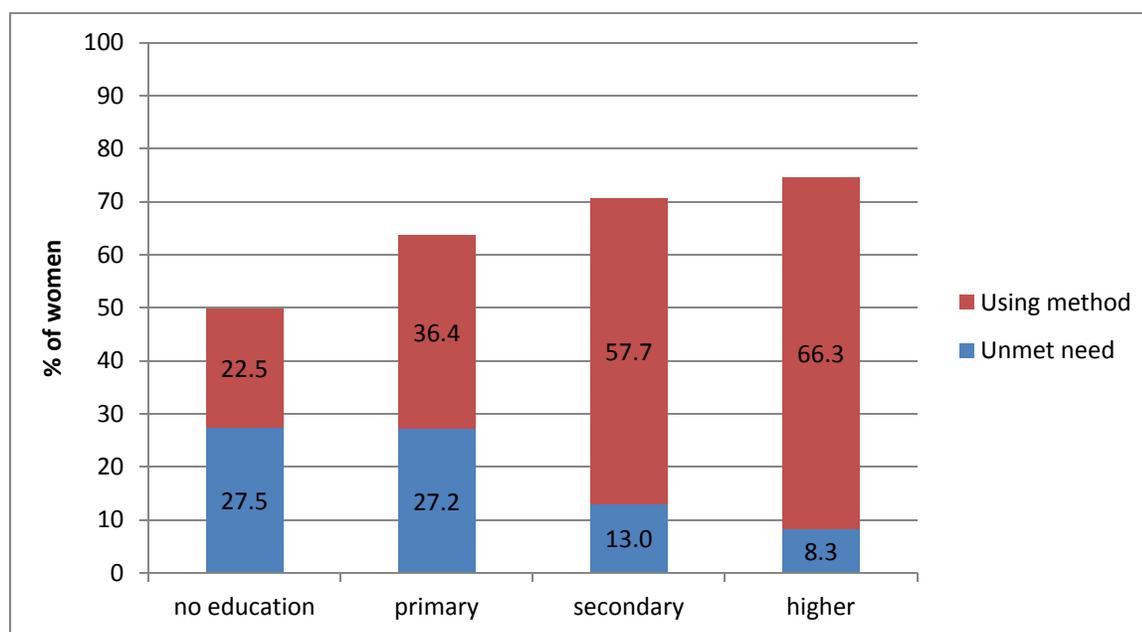
Rural Cluster Analysis

As mentioned earlier, additional geographic analysis was carried out to determine how use, unmet need, and total demand for FP varied by region and across regional boundaries.

Rural areas typically recorded lower demand and demand satisfied for contraceptives, even though unmet need has declined since 2005. The cluster analysis identified five specific areas throughout the country where the rural population uses modern methods at similar rates.

In the first map, in Figure 40, five areas exhibit a similar pattern in modern CPR (mCPR). The areas with higher than national average are northern Gambela, west Oromiya, and northwest SNNP (mCPR=43.9%) and southeast Amhara, northern Oromiya, and the western edge of Afar (mCPR= 37.5%). There are two areas with between half and the national average: central SNNP (mCPR=12.3%) and northern SNNP (mCPR=25.2%). Finally there is one cluster with less than half of the national average covering southern Oromiya and SNNP (mCPR=6%).

In the second map, in Figure 41, five areas transcending regional boundaries exhibit a similar pattern with demand for FP satisfied but slightly different from the previous map. Further, an additional cluster, with rates below the national average, can be observed between Somali and Oromiya.

Figure 40. Cluster Analysis—Modern Methods CPR, 2011
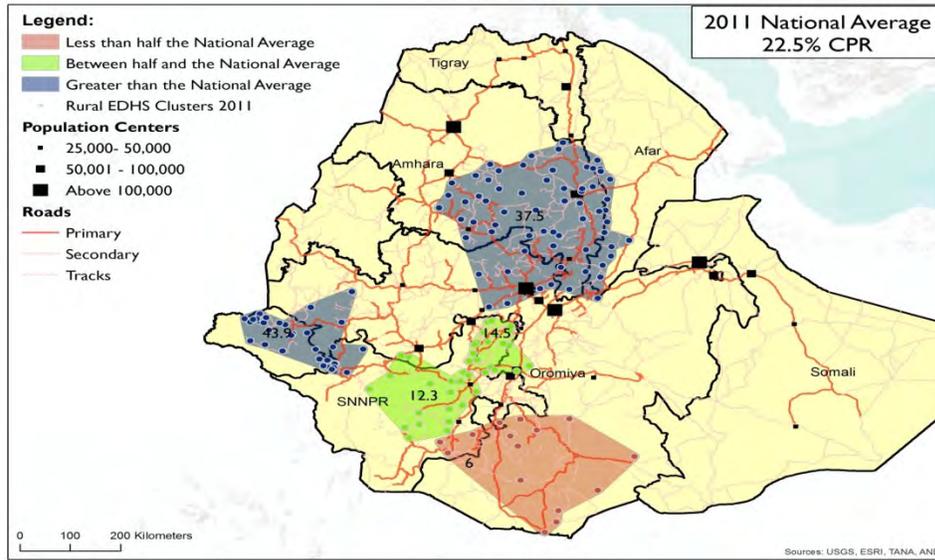
Figure 41. Cluster Analysis—Demand Satisfied, 2011
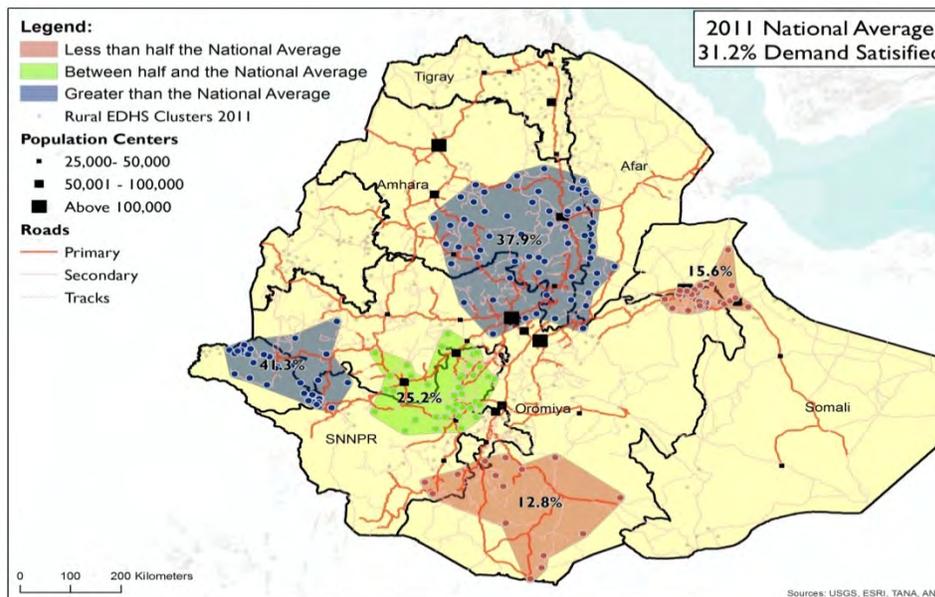
Future Use/Intention to Use Contraception and Reasons for Non-Use

According to the 2011 EDHS, illustrated in Figure 42, about 56 percent of women who do not currently use any form of contraception intend to do so in the future, while the remaining women stated that they did not intend to do so (41 percent) or did not know (3 percent).Of the methods identified, most women intend to use injectables (72 percent), while 19 percent intend to use pills. Other methods included IUDs (2 percent) and other traditional methods (4 percent). Three percent of the women did not know which method they would use in the future (see Figure 43).

Figure 42. Contraception Future Use, 2011
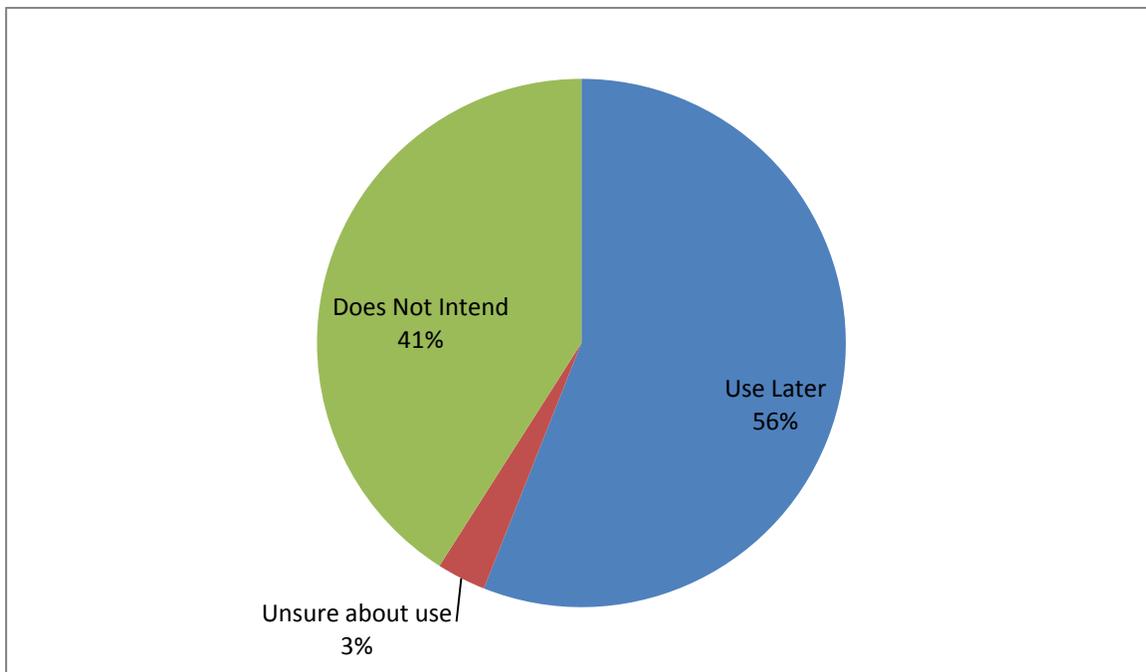
Figure 43. Preferred Future Method
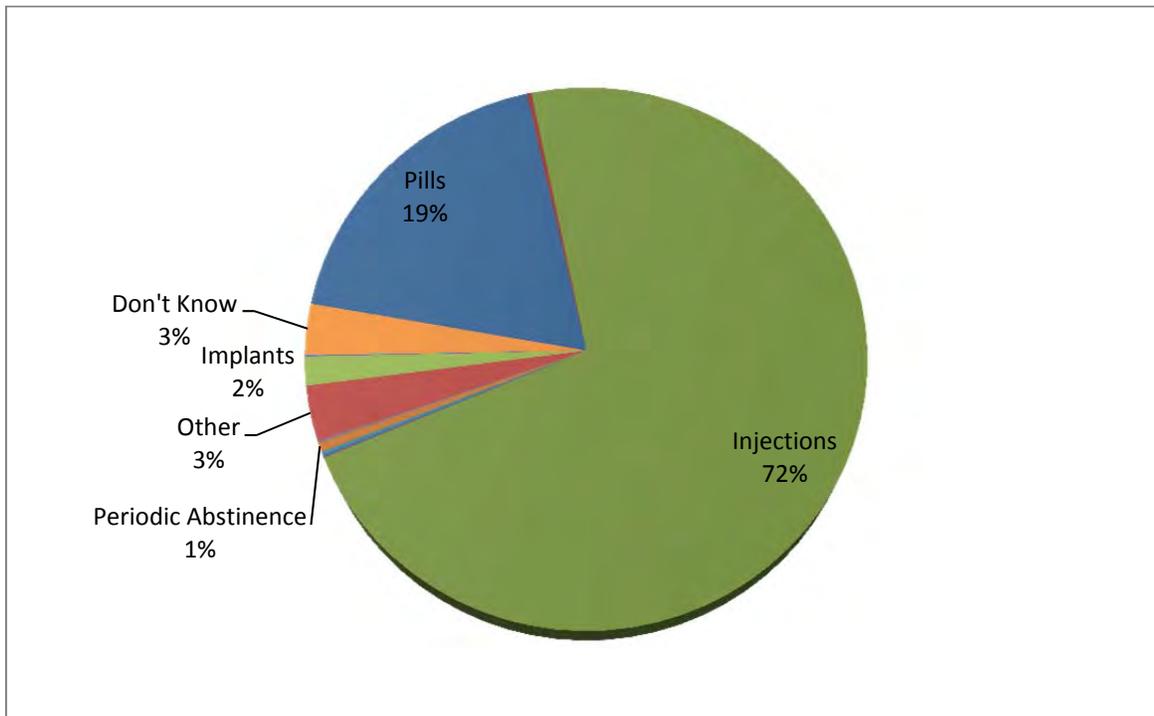
Analyses presented earlier in this document have shown that location, wealth, and education are some of the characteristics with considerable impact on CPR. Assuming that the preferences of future users are similar to those of current ones, comparing future use preferences to current use may highlight where there is a gap in supply and demand and may indicate which methods those with current unmet need will prefer.

The proportion of current injectable users is similar to that of future users, approximately 72 percent. For pills, however, there is a considerable difference between the proportion currently using and that expected to use in the future. Although pill use declined from 21 percent in 2005 to 7 percent in 2011, there appears to be a much larger percentage of women who would like to use this method in the future (19 percent). Conversely, future users prefer the use of two long-acting methods (implants and female sterilization) over current users. Some of this may be due to the higher concentration of older women in the current users group who often have a higher preference for long-term methods than younger women. Last, the percentage of women who rely on traditional methods is higher among current users than it is among future users. This may indicate that many women are relying on traditional methods in the absence of modern methods for FP.

Finally, as shown in Table 3, most women who are not using FP believe they are not at risk because they have recently had a baby (25 percent) and/or they do not use because they fear side effects (18 percent). Breastfeeding and fatalistic reasons are also common (13 percent and 12 percent, respectively). Women very rarely said that high cost was a factor in not using (0.2 percent).

Table 3. Most Common Reasons for Non-Use

Reasons for non-use	Percentage
Postpartum Amenorrheic	25
Fear of Side Effects	18
Breastfeeding	13
Fatalistic	12
Religious Prohibition	7
Husband/Partner Opposed	5
Not Having Sex	5
Interferes with Body's Processes	4
Infrequent Sex	4
Knows No Source	4
Knows No Method	4
Inconvenient to Use	3

*Multiple responses permitted. Therefore sum of table is greater than 100 percent

Summary of Findings and Conclusions

This market analysis reconfirms that tremendous success has been achieved in Ethiopia. The use of contraceptive methods among women in union or those who are sexually active has quadrupled in the last 11 years, from 7 percent in 2000 to 14 percent in 2005 to 28 percent in 2011 (CSA 2001b, 2006b, 2012b).

With careful planning, these achievements will translate into health and development gains into the future, particularly if demand for FP continues to be satisfied at similar rates as in the past. As discussed previously, there is much potential for continued gains in the future to fuel the demographic transition and ensure that members of productive age groups can attain fertility, health, and education goals and contribute even more actively to the workforce and economic advances the country is already experiencing. These gains can continue to accelerate into the future if productive segments of the population are given access to the health and FP services they need and demand.

Furthermore, the analysis in this report and subsequent strategic planning and implementation activities can support the building of a stronger and more diversified FP market in Ethiopia that can be sustained across public and private sectors in the future.

Key results of this analysis illustrate that women, across all sectors, continue to mainly use injectable contraceptives, and that use of other methods is still very low. Nevertheless, more and more women are also using implants. In addition, the public sector remains the major source of modern contraceptive methods in Ethiopia, serving 84 percent of users, with HEWs increasingly providing contraceptives to those with an unmet need for FP. The HEW program has been instrumental in satisfying demand for FP since 2005, since the major gains observed in rural areas are primarily served by this program.

However, the current market lacks diversity, and the rates of coverage currently maintained by the public sector will be difficult to sustain with restricted government health budgets if demand continues to increase at such a rapid rate. Most women, even the wealthiest, are turning to the public sector to obtain FP services. Furthermore, there is still significant unmet need, particularly in the poorest and least-educated segments of the population.

Finally, total demand for FP in many geographic areas does not amount to the 66 percent goal the government wants to achieve by 2015. To meet the country's ambitious FP goals, the gains of the past will need to be sustained and expanded in the future, and more demand generation will be needed in many geographic areas, including urban and hard-to-reach areas.

A summary of more specific findings and recommendations from the analysis are provided below.

CPR and Unmet Need

- CPR for all women increased substantially in a short period: 7 percent in 2000 to 14 percent in 2005 to 29 percent in 2011.

- There is disparity in contraceptive use between the poorest and richest quintiles (13.7 percent versus 51.8 percent), and unmet need is consistently high (26–30 percent) in most wealth quintiles.

- CPR and unmet need are also affected by education level: CPR increases, and unmet need declines, with higher education levels.

- There are still significant differences in use among regions, despite most regions doubling or nearly doubling their CPR since 2005.

- Nearly 90 percent of all women with unmet need live in either Oromiya, Amhara or SNNP regions; in Amhara, Afar, and Harari regions, young women (ages 15–19) have 10–15 percent higher unmet need than other women in the same regions.

- Since 2005, unmet need has declined at varying degrees throughout most regions, with Tigray, Afar, and Somali experiencing less of a decline.

- Overall, national fertility rates have continued to decline, although they have plateaued in urban areas.

Demand for Family Planning

- Demand for FP, and satisfying this demand, has improved substantially since 2005 in rural areas. However, in urban areas, especially among youth (ages 15–19), demand and demand satisfied have stagnated or decreased.

- Specific socioeconomic segments (e.g., the wealthiest quintile, or urban women) have a relatively high total demand for contraceptives, while others (poorest quintile, or rural women) lag behind.

- Least-wealthy women of all ages continue to have less of their demand satisfied than the rest of the population.

- While all regions have been able to satisfy more of the demand for FP in 2011 than in previous years, with notable improvements in Amhara and Gambela, the total demand for FP in most regions is still below 66 percent, the national FP goal.

- Particular areas throughout the country, traversing regional boundaries, display similar patterns of use and demand satisfied. These include the central part of the country, covering parts of southeast Amhara , northern Oromiya, and the western edge of Afar; the south, covering parts of southern Oromiya and southeast SNNPR; and the west, covering northern Gambela, west Oromiya, and northwest SNNPR (see maps in figures 39 and 40).

Method Mix

- Short-term methods, specifically injectables, continue to be the most common method among all socioeconomic and geographical segments, but use of long-acting and permanent FP methods has increased (4 percent of all users in 2005 to 15 percent of all users in 2011).

- Traditional methods are used slightly more among more highly educated and richer women than among less-educated and poorer women.

Source of Contraceptives

- The public sector continues to provide most FP services to the population (84 percent of market), although condoms and pills are also obtained in pharmacies, while private facilities are providing pills, IUDs, and injections.

- The commercial sector market share ("private sector"), which includes pharmacy/shop/friend and private facilities, decreased from 18.3 percent in 2005 to 13.2 percent in 2011.[12]

- Youth (ages 15–19) were more likely to access contraceptives through the private sector than were all other age groups.

- The market share accounted for by government hospitals and government health centers decreased from 61.5 percent in 2005 to 55 percent health facilities in 2011, while government health post/HEW market share increased significantly, from 19.6 percent to 28.8 percent, during the same period.

- The composition of the FP market varies among regions. In Dire Dawa, Addis Ababa, Harari, Amhara, Afar, and Tigray, health centers are the most popular source for methods. In SNNPR, Ben-Gumz, and Oromiya, most women obtain methods from health post/HEWs. In Gambela, most women obtain methods at private facilities.

Reasons for Non-Use

- The most common reasons for non-use among women who are not current using are that they recently had a baby, are breastfeeding, and/or fear side effects.

Future Use

- Most women (56 percent) who are currently not using any method do intend to use FP in the future.

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[12] While considered a private facility during data collection, it should be noted that much of the product sold in pharmacies is actually subsidized through social marketing programs such as DKT.

Recommendations for Improving Equity and Contraceptive Security

Client Demand and Utilization

- Use of FP in urban areas has stabilized since 2005, although unmet need is still high and may be increasing, particularly among young, urban women.

  – Study use preference and determine factors to develop better messages and services that meet needs of urban population, particularly youth. This can help to ensure that productive age groups in all areas of the country continue to help fuel the demographic transition mentioned above.

- Gambela and Tigray display use and need patterns that are different from those of other regions; Gambela has experienced a higher increase in contraceptive use since 2005 compared to other regions, whereas Tigray exhibits a lower rate of increase than in other regions.

  – Consider studying these populations further to better understand the factors that affect women's FP use in these regions and whether this higher rate of use in Gambela has resulted in improved health and development outcomes.

Service Delivery

- Women with unmet need are concentrated in certain regions: SNNP, Oromiya, and Amhara. In addition, unmet need among adolescent women in Afar, Amhara, and Harari is 10–15 percentage points higher than the average for all women in those regions.

  – Consider studying further, through qualitative and quantitative analysis, reasons for non-use in these specific areas to understand barriers to use for large proportions of women with unmet need in these targeted areas, particularly young women in Afar, Amhara, and Harari.

  – Using this analysis, develop tailored strategies to increase access to and utilization of quality FP information and services, particularly for young people and those who have reached desired family sizes, to satisfy the large proportion of women in these regions with unmet need.

Private/Public Sector

- Most women across all age groups are using primarily injectables.

- Continue to support efforts to strengthen the capacity of the public sector to provide LAPMs and other short-term methods and counsel women on alternative methods for their point in their childbearing life cycle to ensure that women, particularly those in productive age groups, have a wider choice when accessing contraceptives and can attain their fertility preferences.

- Although they may have an ability to pay for family planning, wealthier women are obtaining their methods from the public sector, where products and services are free.

  - Consider carrying out ability-and-willingness-to-pay studies, along with research about why they are currently using the public rather than the private sector, to see whether these women could be shifted to NGO or private sector facilities to obtain services.

  - Continue efforts to partner with the private sector to expand and coordinate services with the public sector and attract wealthier clients to the non-public sector for more sustainable coverage of the total market over time.

In summary, the rapidly increasing CPR is evidence of improved levels of service provision, an increase in the availability of contraceptives, and, overall, a more robust supply chain. These services leave families less vulnerable to unintended pregnancies and births and reduce abortion rates, maternal and infant deaths, and sexually transmitted infections, including HIV. Yet, more work needs to be done to meet Ethiopia's FP and development goals. Accelerating these gains can make a powerful contribution to the country's economic growth, poverty reduction, and helping Ethiopia achieve its Millennium Development Goals and to benefiting from the dividend accrued by the demographic transition[13].

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[13]Policies to spur future job creation and economic growth are shaped by the age structure of a country's population. Declining fertility, accelerated by investments in better health, FP services, and gender equality, results in a smaller population of young, dependent ages and a larger population of adults in the labor force, and then leads to a swelling in the ranks of the elderly. Through concrete policy actions in FP, health, education, gender equality, and labor market policies, a number of countries have produced large and positive economic returns, referred to as the "Demographic Dividend." Most developing countries have a short window of opportunity to enact policies and promote investments that raise the human capital of young people while positioning them for greater economic productivity when they enter their working years (World Bank 2013).

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Appendix A

Data Tables

Table 4. Ethiopia Total Fertility Rate, Current Use, and Unmet Need for All Women, 2000–2011

	DHS 2000	DHS 2005	DHS 2011
Current use of modern contraceptive methods among women in union or sexually active unmarried women	6.9%	14.1%	27.8%
Unmet need for family planning services, among women in union or sexually active unmarried women	35.0%	33.7%	25.3%
Total fertility rate	5.5	5.4	4.8

Table 5. Total Fertility Rate by Residence, 2000–2011

	Total	Urban	Rural
2000	5.5	3	6
2005	5.4	2.4	6
2011	4.8	2.6	5.5

Table 6. Age-Specific Fertility Rates (per 1,000 women) by Year 2000–2011

	2000 DHS	2005 DHS	2011 DHS
15–19	100	104	79
20–24	235	228	206
25–29	251	241	237
30–34	243	231	194
35–39	168	160	147
40–44	89	84	69
45–49	19	34	28
Total fertility rate ages 15–49	5.5	5.4	4.8

Table 7. CPR for All Women, 2000–2011

	2000 (%)	2005 (%)	2011 (%)
Modern Method	6.9	14.1	27.9
Traditional Method	1.8	0.9	1.3
No Method	91.3	85.0	70.9

Table 8. CPR and Unmet Need by Education and Residence for All Women, 2011

	No Education (%)	Primary (%)	Secondary (%)	Higher (%)	Urban (%)	Rural (%)
Modern Method	22.1	34.4	53.5	55.4	49.8	22.9
Traditional Method	0.4	2	4.2	10.8	3	1
Unmet Need	26.2	26.6	13.1	8.3	15.1	27.5
Method Not Needed	51.3	36.9	29.2	25.3	32.1	48.6

Table 9. CPR and Unmet Need by Age for All Women, 2011

	15–19 (%)	20–24 (%)	25–29 (%)	30–34 (%)	35–39 (%)	40–44 (%)	45–49 (%)
Modern Method	24.2	34.2	29.3	31.5	28.2	22.2	12.4
Traditional Method	0.8	1.7	1	2	1.1	1.8	0.6
Unmet Need	32.3	22	26.6	25.5	27.2	27.6	15.2
Method Not Needed	42.7	42	42.9	41	43.4	48.4	71.7

Table 10. CPR and Unmet Need by Wealth Quintile for All Women, 2011

	Poorest (%)	Poorer (%)	Middle (%)	Richer (%)	Richest (%)
Modern Method	13.3	21.8	24.4	30.6	48.3
Traditional Method	0.4	0.6	0.4	1.7	3.5
Unmet Need	30.4	26.5	28.1	26.8	14.9
Method Not Needed	55.8	51	47.1	40.7	33.2

Table 11. Contraceptive Method Mix for All Women, 2011

Method	Percentage
Pills	7
IUDs	1
Injections	72
Condoms	1
Female Sterilization	2
Implants	12
Other Modern	0
Traditional Methods	5

Table 12. Contraceptive Method Mix for All Women, 2005

Method	Percentage
Traditional Method	6
Pills	21
IUDs	1
Injections	67
Condoms	2
Female Sterilization	1
Implants	1
Other Modern	1

Table 13. Method Mix by Location for All Women, 2011

Method	Urban (%)	Rural (%)
Pills	12.8	4.8
IUDs	1.6	1.0
Injections	66.3	74.9
Condoms	3.6	0.2
Female Sterilization	2.7	1.1
Implant	7.1	14.0
Other Modern	0.3	0.0
Traditional Methods	5.7	4.0

Table 14. Method Mix by Education Level for All Women, 2011

	No Education (%)	Primary (%)	Secondary (%)	Higher (%)
Pills	4.3%	8.0%	15.3%	19.3%
IUDs	0.6%	1.7%	1.1%	2.6%
Injections	76.2%	73.0%	63.0%	48.3%
Condoms	0.2%	1.7%	3.5%	4.6%
Female Sterilization	2.0%	1.1%	1.3%	1.8%
Implants	14.9%	8.9%	8.5%	6.1%
Other Modern	0.0%	0.0%	0.0%	1.1%
Traditional Methods	1.8%	5.5%	7.3%	16.4%

Table 15. Method Mix by Wealth Quintile for All Women, 2011

	Poorest (%)	Poorer (%)	Middle (%)	Richer (%)	Richest (%)
Pills	3%	3%	5%	5%	13%
IUDs	1%	1%	1%	1%	2%
Injections	79%	74%	77%	75%	66%
Condoms	0%	0%	0%	0%	3%
Female Sterilization	1%	3%	1%	2%	2%
Implants	14%	17%	14%	12%	8%
Other Modern	0%	0%	0%	0%	0%
Traditional Methods	3%	3%	1%	5%	7%

Table 16. CPR and Method Mix by Region for All Women, 2011

Method	Tigray (%)	Afar (%)	Amhara (%)	Oromiya (%)	Somali (%)	Ben-Gumz (%)	SNNPR (%)	Gambela (%)	Harari (%)	Addis Ababa (%)	Dire Dawa (%)
Not using	75.8	89.8	65.7	73.6	95.4	72.3	73.7	55.6	64.3	37.5	64.9
Pills	2.2	1.2	1.6	2.1	0.8	2.7	1.4	4.6	6.8	10.8	5.5
IUDs	0	0	0.3	0.3	0	0	0.3	0.5	1.2	2.5	1.1
Injections	14	8.1	26.7	18.9	2.3	21.3	19.7	32.2	19.3	34.4	15.1
Condoms	1.2	0.2	0	0.1	0.4	0.8	0.4	5.1	1.5	3.5	2.6
Female Sterilization	0.3	0	0.7	0.2	0	0.6	0.5	0.4	0.3	2.1	0.2
Implants	5.5	0.2	4	3.3	0.5	1.5	2.8	0.9	3	3	7.7
Other Modern	0	0	0.1	0	0	0	0	0	0.1	0.1	0.4
Traditional Methods	1	0.4	0.9	1.4	0.5	0.8	1.1	0.8	3.5	6.2	2.5

Table 17. Method Mix by Age Group for All Women, 2011

Method	15–19 (%)	20–24 (%)	25–29 (%)	30–34 (%)	35–39 (%)	40–44 (%)	45–49 (%)
Pills	10	6	8	8	8	10	2
IUDs	0		2	1	3	2	1
Injections	78	79	72	72	68	57	69
Condoms	2		2	2	1	2	0
Female Sterilization	0 0		0	0	4	7	8
Implant	7	8	13	11	14	15	15
Other Modern	0 1		0	0	0	1	0
Traditional Methods	3 0		3	6	4	8	5

0

5

Table 18. Source of Supply of Current Modern Contraceptive Methods for All Women, 2005 and 2011

	2005 (%)	2011 (%)
Government Hospital	6.6	2.4
Government Health Center	54.9	52.6
Government Health Post/HEW	19.6	28.8
Private Facility	11.0	10
Pharmacy/Shop/Friend	7.3	3.2
NGO	0.7	0.2

Table 19. Source of Supply of Modern Contraceptive Method for All Women, 2011

	Pills (%)	IUDs (%)	Injections (%)	Condoms (%)	Implants (%)	Other Modern (%)
Government Hospital	4.9	9.3	1.9	2.2	4.1	1.5
Government Health Center	44.5	58.4	53.7	9.8	68.8	0.0
Government Health Post/HEW	22.5	23.5	31.7	1.7	25.1	0.0
Private Facility	11.4	7.7	11.6	2.8	2.0	0.0
Pharmacy/Shop/Friend	16.6	0.0	0.9	83.7	0.1	98.5
NGO	0.0	1.2	0.2	0.0	0.0	0.0

Table 20. Source of Supply by Wealth for All Women, 2011

	Poorest (%)	Poorer (%)	Middle (%)	Richer (%)	Richest (%)
Government Hospital	0.6	0.9	0	0.6	5.7
Government Health Center	51.6	51.5	49.4	48.6	57
Government Health Post/HEW	39.8	39.7	40.9	38.1	9.8
Private Facility	4.6	3	6.9	8.2	17
Pharmacy/Shop/Friend	1.6	1.2	0.9	0.9	7
NGO	0.7	0	0.4	0	0.1

Table 21. Modern Contraceptive Source by Residence for All Women, 2011

Source	Urban (%)	Rural (%)
Government Hospital	4.5	1.4
Government Health Center	59.7	49
Government Health Post/HEW	6.8	39.5
Private facility	16.7	6.7
Pharmacy/Shop/Friend	7.7	1.1
NGO	0.1	0.2

Table 22. Modern Contraceptive Source by Age Group for All Women, 2011

Source	15–19 (%)	20–24 (%)	25–29 (%)	30–34 (%)	35–39 (%)	40–44 (%)	45–49 (%)	Total (%)
Government Hospital	0.8	2.2	3.3	1.7	2.6	3.2	1.1	63.2
Government Health Center	46.8	52.5	53.7	57.3	48.8	49.9	52.7	1,384.40
Government Health Post/HEW	26.9	24.9	28.9	30.1	32.5	29.6	28.5	757.4
Private Facility	23.3	14.6	8.3	6.9	7.1	5.3	7.7	262.3
Pharmacy/Shop/Friend	2.2	3.8	4.1	3	2.4	2.7	1.5	85
NGO	0	0.4	0	0.4	0	0	0	4.1
Missing	0	1.5	1.7	0.6	6.5	9.2	8.6	77.6

Table 23. Source of Supply by Region for All Women, 2011

	Gov't Hospital (%)	Gov't Health Center (%)	Gov't Health Post/HEW (%)	Private Facility (%)	Pharmacy/ Shop/ Friend (%)	NGO (%)	DK/Missing (%)
Tigray	2.94	58.85	28.05	0.8	7.63	0	1.73
Afar	15.75	58.04	4.47	14.34	7.4	0	0
Amhara	1.62	60.97	24.24	8.5	1.78	0.41	2.49
Oromiya	2.69	49.24	32.87	10.89	1.63	0	2.69
Somali	36.58	9.9	12.1	23.5	17.93	0	0
Ben-Gumz	6.93	30.19	31.68	25.25	3.81	0	2.14
SNNPR	1.08	44.56	39.62	8.7	2.42	0	3.63
Gambela	8.18	23.7	6.43	50.15	10.21	0	1.34
Harari	28.82	34.41	16.04	3.61	12.73	3	1.38
Addis Ababa	2.31	54.92	7.85	14.99	13.63	0.18	6.12

Table 24. Source of Supply by Education Level for All Women, 2011

	No Education (%)	Primary (%)	Secondary (%)	Higher (%)
Government Hospital	0.46	3.39	9.28	4.88
Government HC	54.35	50.63	48.81	52.84
Government Health Posts/HEW	33.51	28.82	11.29	9.98
Private Facilities	6.75	12.06	21.95	10.82
Pharmacy/Shop/Friend	1.38	2.9	6.93	15.54
NGO	0.26	0.06	0.04	0
Missing	3.29	2.14	1.7	5.93

Table 25. Total Demand by Residence for All Women, 2005 and 2011

	Urban		Rural	
	2005 (%)	2011 (%)	2005 (%)	2011 (%)
Unmet	16.6	15.1	35.8	27.5
Using Method	48.4	52.8	11.1	23.8

Table 26. Percentage with Demand for FP Satisfied by Residence for All Women, 2005 and 2011

	2005 (%)	2011 (%)
Urban	74	78
Rural	24	46

Table 27. Total Demand by Quintile for All Women, 2005 and 2011

	Poorest		Poorer		Middle		Richer		Richest	
	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)
Unmet	33.1	30.4	37.9	26.5	36.7	28.1	36.1	26.8	23.7	14.9
Using Method	4.2	13.7	6.7	22.5	12.3	24.8	16	32.4	38.1	51.8

Table 28. Percentage of Demand Satisfied by Quintile for All Women, 2005 and 2011,

	2005 (%)	2011 (%)
Poorest	11	31
Poorer	15	46
Middle	25	47
Richer	31	55
Richest	62	78

Table 29. Total Demand by Age Group for All Women, 2005 and 2011

Age	15–19		20–24		25–29		30–24		35–39		40–44		45–49	
Year	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)	2005 (%)	2011 (%)
Unmet Need	37.4	32.3	34.3	22	35.8	26.6	35.8	25.5	37.4	27.2	32.4	27.6	16.3	15.2
Using Method	10	25	17.3	35.9	17.3	30.4	14.8	33.4	17.5	29.3	14.6	24	8.1	13.1

Table 30. Total Demand for FP by Residence for All Adolescent Women (ages 15–19), 2005 and 2011

	Urban		Rural	
	2005 (%)	2011 (%)	2005 (%)	2011 (%)
Unmet Need	22%	34%	39%	32%
Using Method	51%	50%	6%	22%

Table 31. Percentage of Adolescent Women (ages 15–19) with Demand for FP Satisfied, 2005 and 2011

	2005 (%)	2011 (%)
Urban	70%	59%
Rural	13%	40%

Table 32. Total Demand and Unmet Need by Level of Education Attained, 2011

	Unmet need (%)	Using method (%)
No Education	27.48	22.48
Primary	27.23	36.4
Secondary	13.04	57.71
Higher	8.34	66.25

Table 33. Contraception Future Use, 2011

Method	Percent
Use Later	55.9
Unsure about Use	3.0
Does Not Intend to Use	40.9
Missing, N/A	0.3

Table 34. Preferred Future Method

Preferred Future Method	Percent
Pill	19
IUDs	0
Injections	72
Condom	0
Female Sterilization	0
Periodic Abstinence	1
Withdrawal	0
Other	3
Implants	2
Lactational Amenorrhea	0
Diaphragm, Foam, Jelly	0
Don't Know	3

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