Ethiopia Ministry of Health

July 2016

Costed Implementation Plan for Family Planning in Ethiopia, 2015 – 2020

Background

In the past two decades, the government of Ethiopia has worked diligently to support the fertility rights of women and men by informing and improving the accessibility of safe, effective, affordable, and acceptable contraception methods. Ethiopians of reproductive age have benefited from the availability of these services in all primary healthcare delivery points and other outlets. The country has also significantly reduced the high rate of unacceptable and untimely, but avoidable, deaths of mothers, newborns, and children. Preventing unwanted and unplanned pregnancies by increasing the use of family planning (FP) is one strategy implemented to reduce the high maternal mortality rate.

Ethiopia has seen a substantial increase in FP coverage since the early 1990s. Then, the contraceptive prevalence rate (CPR) stood at just 4 percent, but rose to 42 percent in 2014. The success in meeting unmet need (women who are sexually active and do not currently want to become pregnant, but are not using any method of contraception) has contributed to increased child survival rates. At the same time, the total fertility rate (TFR)—or the average number of children a woman will have in her lifetime—decreased from nearly 7 in the 1990s to 4.1 in 2014.

In line with Ethiopia's FP2020 commitments, the Health Sector Transformation Plan (HSTP) is aimed at scaling up informed and voluntary use of contraception to reach an additional 6.2 million women, thereby further reducing unmet need and increasing CPR to 55 percent by 2020.

Costed Implementation Plan

In addition to producing key strategic planning documents to improve maternal health, the Ministry of Health (MOH) has collaborated with partners to develop a Family Planning Costed Implementation Plan (CIP) (2015/16–2019/20) to harness efforts for increased access to FP information and services. The CIP specifies the interventions and activities to be implemented, and itemizes the financial and human resources needed to meet comprehensive national FP goals.

Country Vision

- Scale up FP services through a rights-based approach.

Operational Goals

- Increase the CPR among married women from 42 percent in 2014 to 55 percent by 2020
- Reduce the TFR from 4.1 in 2014 to 3.0 in 2020
- Reach 6.2 million additional women and adolescent girls with FP services by 2020, as compared to 2011

The CIP serves as a common blueprint for Ethiopia to achieve the FP goal outlined in the HSTP. The plan estimates the cost to achieve the country vision, goal, strategic priorities, interventions, and inputs. It also details the priorities that will help the government and its partners meet national targets for increasing the CPR, increasing the number of women reached with rights-based FP services, and reducing the TFR by 2020.

The CIP identifies the following strategic priorities for the next five years:

Priority 1 — Demand creation:
Strengthen demand for and increase acceptability of FP services, especially long-term methods, by providing targeted, easily accessible, and accurate information to the population on the full method mix.

Priority 2 — Service delivery and access:
Increase the number of skilled providers delivering high-quality contraceptive services and ensure access for all populations, especially youth and pastoralists, through an effective referral system, outreach and mobile clinic, and the provision of adolescent- and youth-friendly services.

Priority 3 — Procurement and supply chain:
Improve the distribution of FP commodities (including consumables) from the central level to service delivery points by increasing the capacity of healthcare workers to manage the logistics system and the national supply chain.

Priority 4—Monitoring and coordination:
Improve multisectoral coordination in the planning, implementation, and monitoring of FP programs at all levels.

Priority 5—Financing:
Increase the budget allocation for family planning, both at the federal and regional levels, to ensure reproductive health commodity security.

(All activities under the five thematic areas listed above align with the FP2020 commitments to address the goals.)

Table 1: Costs by Category, in US$ Millions

	2015	2016	2017	2018	2019	2020
Demand	446,214	4,275,637	1,441,018	2,008,785	1,696,203	1,007,897
Service delivery and access	116,757	4,526,443	17,896,472	5,830,261	4,083,856	2,165,797
Procurement and supply chain	8,530,286	7,934,137	1,221,011	1,251,536	1,282,824	833,476
Financing	33,732	28,383	28,278	7,119	18,777	6,230
Monitoring and coordination	233,811	599,359	670,642	733,010	629,846	552,428
Commodities and consumables total	30,198,994	32,326,476	34,536,990	36,821,820	39,170,259	41,577,038
Total	39,559,794	49,690,435	55,794,409	46,652,530	46,881,766	46,142,866

Figure 1: Summary Costs by Thematic Areas and Total, in US$ Millions

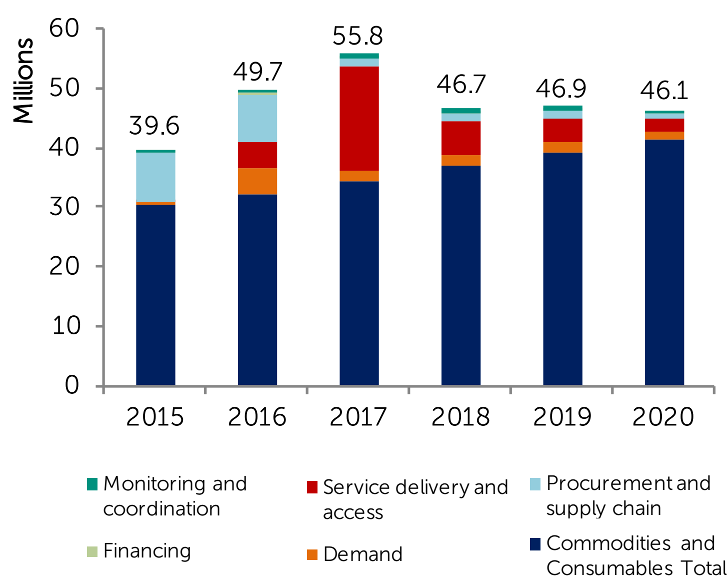

Table 2: Baseline Method Mix 2014 and Projected Method Mix 2020, Married Women

Contraceptive Method	Method Mix	
	2014 Baseline: (mDHS)	2020 Projection:
Pills	6.2%	4.6%
IUD	2.6%	15.0%
Injections	74.2%	41.9%
Male condoms	0.7%	0.8%
Female condoms	0.0%	0.5%
Female sterlization	0.2%	1.5%
Male sterilization	0.0%	0.5%
Implants	12.0%	33.0%
Other modern methods	0.7%	1.1%
Any traditional methods	3.3%	1.1%
Total CPR	**41.8%**	**55.0%**

Costing

A CIP costing tool was used to determine the cost of implementing the activities. Each activity was broken down into individual cost elements (cost items), unit costs assigned, and number of units calculated based on the activity target. The frequency and recurrence of activities over the CIP period (2015–2020) were also assigned to allow the estimation of cost per year. Costing assumptions for unit costs were gathered from various sources and include standards provided by the MOH, implementing partners, and international sources.

Contraceptive costs were calculated from 2015–2020, using the 2014 Ethiopia Mini-Demographic and Health Survey (EMDHS) as a baseline for CPR among married women and the 2014 method mix. Using the 2020 objective CPR of 55 percent among married women, a CPR was interpolated for each intermediate year between 2014 and 2020. The projected method mix for 2020 was calculated in line with the objectives set in the Reproductive Health Strategy and corresponds with the priority activities within this plan.

All recurrent costs (e.g., salaries, per diem rates, fuel costs, venue hire, etc.) are based on current costs as of April 2015, and have been automatically adjusted for a base rate of inflation of 2.5 percent over time. All costs have been calculated in U.S. dollars and converted to local currency.

Using the above assumptions, total costs of the plan from 2015–2020 are US$285 million (6.2 billion ETB). Overall, US$215 million (or 75 percent of overall costs) are in commodities, including contraceptives and consumables. Another 4 percent are in demand creation; 12 percent in service delivery and access; 7 percent in programming for contraceptive security and supply chain management; less than 1 percent in financing; and 1 percent in monitoring and coordination.

Costs are spread over the duration of the plan, with commodity costs increasing over time as more women are reached. In addition to commodities, the biggest cost drivers are service delivery and access and contraceptive security and supply chain activities, at US$35 million and US$21 million, respectively.

The cost per woman of reproductive age for activity costs is US$0.47 per year—significantly lower than comparable costs in other countries, which generally range from US$2–5. The lower activity costs in Ethiopia are largely due to the economies of scale generated in conducting national programs for such a large population, as well as the government policies that aim to lower activity costs.

Projected Method Mix and Contraceptive Needs

The method mix projections are based on the following five assumptions guided by best practices and by recommendations from stakeholders and expert groups:

1. The FP program will be fully implemented by the MOH and its partners, and will emphasize reaching underserved populations (e.g., youth and hard-to-reach populations) and creating demand for and improving access to long-acting reversible contraceptives (LARCs).
2. The method mix will maintain the widest possible range of method choices.
3. Use of LARCs will increase once they become available at more service delivery points, and demand-creation activities for LARCs will scale up. The greatest rise in LARCs will be for implants, accompanied by an increased demand for IUCDs and female sterilization.
4. The method mix quantification is based on variably adjusting CPR method mixes for married and unmarried women. In addition, male and female condoms are only included in the method mix and costed for the amount required for FP usage.
5. Emergency contraception is not included as a percentage of the method mix, as it is not promoted as a regular or consistent method of family planning. It will be procured for public and private sector use as a lifesaving commodity—as a contraceptive method to be used when other primary methods are not used or fail.

The activities outlined in the plan will lead to a CPR of 55 percent for all married women in 2020, a modern prevalence rate (mCPR) of 54 percent among married women, and mCPR of 83 percent among unmarried sexually active women. This translates to a CPR of 35 percent among all women of reproductive age, and will lead to a total of 10 million women using contraception in 2020.

Impact

The ImpactNow model was used to calculate the impact of increasing CPR to 55 percent by 2020.

Table 4 shows the impact of increased FP demand, use, and priorities for 2015–2020 in Ethiopia. The numbers are drawn from EMDHS 2014 data and projected outward based on full FP program implementation. They show that scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health in Ethiopia, and that improved outcomes will lead to significant cost savings for the health system.

Demographic impacts

Unintended pregnancies averted is a calculation of the total number of pregnancies that will be prevented using contraception. Outcomes of these pregnancies include live births, abortions, miscarriages, and stillbirths. Births averted refers to the number of unintended pregnancies that would have led to live births. The number of pregnancies (including abortions) averted also affects maternal mortality, given that women sometimes die from abortion complications. As the number of abortions decline due to increased FP use and fewer unintended pregnancies, maternal deaths will also decline.

Health impacts

As a result of full FP program implementation, a significant number of maternal and child deaths and unsafe abortions will be averted, contributing to a healthier population.

Economic impacts

Economic impacts refer to maternal and newborn health costs averted through increased provision of family planning. Given the priority on achieving the demographic dividend in Ethiopia, these data hold particular significance.

These calculations estimate that FP interventions in Ethiopia will avert nearly 15 million unintended pregnancies and more than 1 million abortions, resulting in more than 30,000 maternal deaths and 391,000 child deaths averted from

Table 3: Number of FP Users per Year, Projected 2015–2020

Total Users (Married and Unmarried)	2015	2016	2017	2018	2019	2020
Male sterilization	6,812	14,105	21,893	30,184	38,971	48,248
Female sterilization	37,547	57,523	78,765	101,337	125,220	150,389
IUDs	341,364	536,825	745,308	966,908	1,201,441	1,448,667
Implants	1,077,830	1,453,451	1,853,221	2,277,149	2,724,787	3,195,682
Injections	4,530,021	4,491,444	4,439,695	4,374,284	4,294,072	4,198,595
Pills	404,873	418,397	432,018	445,580	458,913	471,920
Male condom	88,415	97,345	106,592	116,118	125,871	135,812
Female condom	6,812	14,105	21,893	30,184	38,971	48,248
Any traditional	189,089	175,371	160,377	144,016	126,222	106,977
Other (unstated)	22,294	30,774	39,806	49,391	59,519	70,178
Total Users	6,705,055	7,289,340	7,899,567	8,535,149	9,193,987	9,874,714

Table 4: Annual Impact of the Plan

	2015	2016	2017	2018	2019	2020	Total
Demographic impacts							
Unintended pregnancies averted	1,963,084	2,154,811	2,355,658	2,567,691	2,790,360	3,023,853	14,855,457
Births averted	1,431,678	1,571,504	1,717,982	1,872,618	2,035,011	2,205,298	10,834,091
Health impacts							
Abortions averted	186,118	204,296	223,338	243,440	264,551	286,689	1,408,432
Unsafe abortions averted	107,376	117,863	128,849	140,446	152,626	165,397	812,557
Maternal deaths averted	5,469	5,406	5,257	5,019	4,681	4,234	30,066
Child deaths averted	51,759	56,814	62,110	67,700	73,571	79,728	391,682
Economic impacts							
Maternal and infant healthcare costs saved (US$, millions)	$55.2	$60.5	$66.1	$72.1	$78.4	$85.0	$417.3

2015–2020. Additionally, the interventions will lead to savings of US$417 million during the six-year plan period—just in maternal and infant healthcare costs.

Impacts were calculated by estimating the current CPR for all women of reproductive age and inputting method mix assumptions for the baseline year 2014, based on 2014 EMDHS data.

Institutional Arrangements for Implementation

Progress monitoring will allow for timely corrective and preventive action, including fine-tuning of strategies, planning, and coordination. Monitoring and evaluating FP implementation will rely on various systems and data sources (routine and periodic), supported and maintained by numerous stakeholders. For the current implementation period, the MOH will develop a comprehensive performance monitoring plan and associated monitoring tools. Service utilization data vwill be collected through the Health Management Information System and from the Track20 and PMA2020 initiatives.

The MOH and its partners will routinely use the information generated to track progress in mobilizing resources and achieving results against set program targets. This mechanism will ensure that implementation efforts conform to the plan and that results achieved align with performance targets. Data will be collected for several categories and levels of indicators. Key performance indicators will hinge on strategic priorities to assess implementation progress, and will be communicated regularly.

The MOH will convene a biannual joint progress review meeting to assess the progress of FP implementation against targets and agree on priorities for the upcoming period. The Regional Health Bureaus will also attend these biannual meetings to share and discuss progress at lower levels. The meetings will therefore assess FP outputs/outcomes as key accountability mechanisms to evaluate implementation. They will also review the planning and programming process in time to make recommendations for the following annual work planning cycle or for long-term strategic planning. A formal appraisal of FP implementation will be conducted mid-way through the implementation period to measure progress and areas of preventive or corrective action.

Ethiopia Country Commitments to FP2020

Commitment 1: Ethiopia will increase its CPR to 55 percent; reduce TFR to 3; and reach an additional 6.2 million women and adolescent girls with FP services by 2020.

Commitment 2: Ethiopia will commit to increasing the budget allocation for family planning each year. The current funding gap is 50 percent.

Commitment 3: Contraceptive use has doubled in Ethiopia since 2005. The government will further increase its funding to uphold the rights of all people to access and choose voluntary family planning through a strong network of primary healthcare providers.

Commitment 4: Ethiopia will ensure commodities security.

Commitment 5: Ethiopia will increase the uptake of long-acting reversible methods.

Commitment 6: Ethiopia will expand youth-friendly services, with a focus on adolescent girls.

Commitment 7: Ethiopia will scale up delivery of services to the hardest-to-reach groups.

Commitment 8: Ethiopia will monitor the availability of contraceptives.

Ministry of Health. Forthcoming. *Costed Implementation Plan for Family Planning in Ethiopia, 2015 – 2020.* Addis Ababa: Federal Democratic Republic of Ethiopia.

The Ministry of Health would like to acknowledge the financial support provided by the United States Agency for International Development through the Health Policy Plus project.