MINISTRY OF HEALTH

COSTED IMPLEMENTATION PLAN FOR FAMILY PLANNING IN ETHIOPIA, 2015/16–2020

January 2016

MINISTRY OF HEALTH

Costed Implementation Plan for Family Planning in Ethiopia, 2015/16–2020

January 2016

CONTENTS

LIST OF FIGURES

FOREWORD

The Government of Ethiopia (GOE) has been working diligently over the past two decades to ensure the fertility rights of women and men by informing and making accessible safe, effective, affordable, and acceptable contraception and/or family planning (FP) methods. A considerable proportion of our people of reproductive age have benefited from the services made available at all primary healthcare delivery points and other outlets.

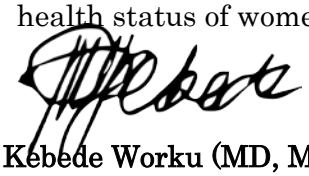
The country has come far from its previous high rates of unacceptable and untimely but avoidable deaths of mothers, newborns, and children. Family planning has been one of the strategies implemented to reduce this high maternal death rate; it has contributed immensely to this outcome by helping to avoid unwanted and unplanned pregnancies. Moreover, it also has been possible to reduce serious pregnancy-related complications and thereby affect the disability-adjusted life years of women.

A large gain has been observed in FP coverage since the early 1990s; the contraceptive prevalence rate has risen from 4 percent to 42 percent in 2014. This success in reducing a considerable percentage of unmet need for spacing of births has contributed to child survival, hence enabling women to limit their desired number of children. The average number of children a woman will have has decreased from nearly seven in the 1990s to 4.1 in 2014. Nonetheless, there are challenges we must overcome to ensure that these gains continue. Some of these challenges include addressing the disparity of success amongst the regions of the nation, dependency on short-term FP methods, identifying additional resources to meet the funding needs for family planning, and the need for contraceptive security and an efficient supply chain management system.

In line with Ethiopia's FP2020 commitments, the Health Sector Transformation Plan is aimed at scaling up informed and voluntary use of contraception to reach an additional 6.2 million women so as to reduce unmet needs and increase the contraceptive prevalence rate (CPR) to 55 percent by 2020. In addition to key strategic plan documents aimed at improving maternal health, the Ministry of Health, in collaboration with partners, has developed the Family Planning Costed Implementation Plan (CIP), 2015–2020 to harness efforts for increased access to FP information and services. The development of the CIP is recognized as a critical process for aligning the government and stakeholders around a common vision, and outlining the activities and timeline for achieving key milestones. This document reflects the strategies, goals, and objectives of the GOE and its many partners and stakeholders, and serves as a common blueprint for Ethiopia to achieve the FP goal set forth in the Health Sector Transformation Plan (2015/16–2019/20).

It is the conviction of the Ministry of Health that the full implementation of this CIP will enable Ethiopia to reach its goals and implement efforts to scale up the use of modern FP methods, as well as reduce regional disparities and inequities. This achievable task requires the concerted efforts of the government at the federal and regional levels, along with the active participation and ownership of communities and commitment from development partners and the private sector.

Finally, I would like to extend my acknowledgment to all who participated in the development of this plan, and assure them of the GOE's continued commitment to maintaining the outstanding past achievements in FP services and thus improve the health status of women and children.



Kebede Worku (MD, MPH)
State Minister, Ministry of Health

PREFACE

The July 2012 London Summit on Family Planning renewed the global community's enthusiasm and commitment to family planning (FP); in taking action, countries have begun developing costed implementation plans (CIPs). In mid-2014, Ethiopia began its Costed Implementation Plan for Family Planning, 2015–2020 under the direction of the Maternal and Child Health Directorate at the Ministry of Health. In September 2014, the Health Policy Project (HPP), funded by USAID, assembled a Technical Support Team to provide additional expertise.

Through May 2015, the Ministry, with the Technical Support Team, worked to (1) conduct a comprehensive situational analysis, including a desk review and consultations; (2) identify strategic priorities; (3) solicit strong stakeholder input (through group consultations and in-person meetings); (4) develop activities; and (5) estimate costs. The team was guided throughout the process by the Costed Implementation Plan Task Force, comprising high-level experts from the Ministry of Health, development partners, implementing partners, and FP advocates. The costs and impacts in this plan were revised in June 2016 to align it with the National Reproductive Health Strategy.

The Technical Support Team conducted more than 30 stakeholder interviews at the national level and more than 20 consultations with ministry officials and their partners in each of the nine regional states and two chartered cities. These stakeholder interviews and consultations solicited input on the following topics:

- Contraceptive security
- Human resources
- Health systems management
- Advocacy (including policy, resources, and enabling environment)
- Social and behaviour change communication
- General FP service delivery
- Youth-friendly FP/reproductive health services
- Integration of FP services into other health services and sectors
- Decentralization and family planning

The Technical Support Team presented the plan and activity matrix in various forms to expert groups, including the task force and Ministry of Health experts across technical areas. The team refined the plan based on this feedback and input. In addition, the team identified and considered global best and high-impact practices,[1] analysed them for applicability in Ethiopia, and included relevant activities in the CIP (including activities for piloting and evaluation before larger scale-up), as appropriate to the country context and according to the expert opinions of various stakeholders.

The team presented key questions to the ministry and stakeholders through ongoing group and one-on-one consultation meetings to ensure that the activities were feasible and the costing details were correct and aligned with local costs for implementation.

Finally, the ministry circulated draft versions of the activity matrix and complete CIP to its partners and stakeholders before the plan was finalised.

ACKNOWLEDGEMENTS

The Ministry of Health would like to express its appreciation to the many partners and groups who supported development of the Costed Implementation Plan for Family Planning, 2015–2020. This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, development partners, implementing partners, professional associations, and for-profit organizations working in aligned areas.

We appreciate the following government agencies with which the ministry works to ensure that FP programmes can be implemented effectively and efficiently:

- Ethiopia Central Statistical Agency
- Ministry of Finance and Economic Development
- Ministry of Women, Children and Youth Affairs
- Ministry of Urban Planning
- National Planning Commission, Population and Development Directorate
- Pharmaceuticals Fund and Supply Agency
- Health administrative at sub-regional and regional level

The following development partners, implementing partners, professional associations, and for-profit organizations also provided valuable input and feedback throughout the process via in-person meetings and online communications.

The Ministry of Health would also like to acknowledge the financial and technical support provided by USAID through the Health Policy Plus project made this publication possible.

Finally, the Ministry would like to acknowledge the efforts and dedication of its staff in coordinating the inputs of all stakeholders and developing this plan.

EXECUTIVE SUMMARY

The Government of Ethiopia's (GOE) vision for the next five years is to improve the health and well-being of all Ethiopians. One of the strategies is scaling up family planning (FP) services using a rights-based approach. In line with this vision, Ethiopia has committed to increasing the modern contraceptive prevalence rate to 55 percent amongst married women by 2020 and reducing the total fertility rate to 3.0. The full implementation of this Costed Implementation Plan (CIP) for Family Planning, 2015–2020 by the Ministry of Health and development partners will enable Ethiopia to reach these ambitious goals.

The strategic priorities in the CIP represent key areas for financial resource allocation and implementation performance. These priorities reflect issues and interventions that must be acted on to reach the country's goals. Based on a desk review and key stakeholder interviews, a Technical Support Team identified **five strategic priorities**. These priorities serve as the foundations of the **thematic areas** for CIP activities:

- **Priority # 1—Demand Creation (DC):** To 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:** To increase the number of skilled providers delivering high-quality contraceptive services and to ensure access for all populations, especially youth and pastoralists, through an effective referral system, outreach and mobile clinics, and adolescent and youth-friendly sexual and reproductive health (SRH) services.
- **Priority # 3—Procurement and Supply Chain:** To improve the distribution of FP commodities and consumables from the central level to service delivery points by increasing the capacity of healthcare workers to manage the logistics system and the Pharmaceuticals Fund and Supply Agency (PFSA) by improving human resource and commodity supply chain logistics to manage the national supply chain.
- **Priority # 4—Monitoring and Coordination:** To improve multisectoral coordination in the planning, implementation, and monitoring of FP programmes at all levels.
- **Priority # 5—Financing:** To increase the budget allocation for family planning both at the federal and regional levels to ensure reproductive health commodity security.

The cost of the total plan is projected to be 6.2 billion Ethiopian Birr (ETB) or US$285 million between 2015 and 2020, which will increase the number of women in Ethiopia currently using modern contraception from approximately 6.2 million users in 2014 to 10 million users in 2020. Between 2015 and 2020, the annual cost of the plan will be about US$47.5 million. The interventions, activities, and accompanying costs in this plan will help the Ministry of Health and partners to mobilise resources and monitor the implementation of the FP programme.

ABBREVIATIONS

BCC	Behaviour change communication
CIP	Costed Implementation Plan
CPR	Contraceptive prevalence rate
CSA	Central Statistical Agency
CSO	Civil society organisation
DC	Demand creation
EDHS	Ethiopia Demographic and Health Survey
EMDHS	Ethiopia Mini-Demographic and Health Survey
ETB	Ethiopian Birr
FMHACA	Food, Medicine and Health Care Administration and Control Authority
MOH	Ministry of Health
FP	Family planning
FP2020	Family Planning 2020 (initiative)
GOE	Government of Ethiopia
HC	Health centre
HEW	Health extension worker
HDA	Health Development Army
HIV	Human Immunodeficiency Virus
HMIS	Health management information system
HP	Health post
HSTP	Health Sector Transformation Plan
ICT	Information and communications technology
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
LARM	Long-acting reversible method
MC	Monitoring and coordination
mCPR	Modern contraceptive prevalence rate
MOE	Ministry of Education

MOFED	Ministry of Finance and Economic Development
NGO	Nongovernmental organisation
PFSA	Pharmaceuticals Fund and Supply Agency
PMA2020	Performance, Monitoring and Accountability 2020
RHB	Regional health bureau
RMNCAHN	Reproductive, maternal, newborn, child, and adolescent health and nutrition
RMNCH	Reproductive, maternal, newborn, and child health
SDA	Service delivery and access
SDG	Sustainable development goal
SMS	Short message service
SRH	Sexual and reproductive health
TFR	Total fertility rate
THE	Total health expenditure
TMA	Total market approach
TOT	Training-of-trainers
TWG	Technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

SECTION 1: INTRODUCTION

During the past two decades, the Government of Ethiopia (GOE) has made significant progress in improving the access to and quality of family planning (FP) throughout the country. As the Ministry of Health (MOH) began to review and update key strategic plans for the health sector, it identified the development of a costed implementation plan (CIP) for family planning as essential for aligning the government and stakeholders around a common vision and outlining the activities and timeline for achieving key milestones. This document reflects the strategies, goals, and objectives of the GOE and its many partners and stakeholders, and serves as a common blueprint for Ethiopia to achieve the FP goal outlined in the Health Sector Transformation Plan HSTP (2016–2020): To scale up FP services through a rights-based approach.[2] This goal will be accomplished in line with the strategies set in the Reproductive Health Strategy (2016–2020).[3]

In addition, this Costed Implementation Plan for Family Planning in Ethiopia, 2015–2020 sets the following objective in support of achieving the national FP goal found in the HSTP: To increase the contraceptive prevalence rate (CPR) amongst married women and women in union from 42 percent in 2014 to 55 percent by 2020.

The activities outlined in this plan represent the building blocks needed to achieve this objective. Ultimately, implementation of the CIP will contribute to the improved health, rights, and well-being of the Ethiopian population.

How to Use the CIP

Ethiopia has one of the highest fertility rates in Africa, with 45 percent of its population under age 15.[4] Although this high youthful population can be a great force for economic and developmental growth, to benefit from a demographic dividend, Ethiopia must first achieve a demographic transition—move from high to low birth and death rates, so there is a larger number of this population in the work force (ages 15–64) caring for a smaller number of dependent children. These shifts in age structure will allow households to save more money and invest more in the well-being of a smaller number of children. In addition, whereas a more balanced age structure is needed to open the window of demographic opportunity, Ethiopia must also make the necessary investments in integrated demographic, economic, and social programmes to improve the health, education, and welfare of the population to realise this demographic dividend.[5, 6]

Ethiopia's strong investments in the health sector have contributed to significant progress over the last 10 years in reducing infant and child mortality, increasing the use of contraception, and reducing fertility rates. However, fertility and population growth rates remain high, at 4.1 and 2.6 percent, respectively.[7, 8] Continuing to lower fertility and shifting the age structure are important first steps towards achieving a demographic dividend and meeting the country's development goals. The activities outlined in this plan will contribute greatly to achieving these objectives.

The CIP is the guide for all FP programming across all sectors and amongst the government in partnership with development and implementing partners. It details the necessary programme activities and the costs associated with achieving national goals by providing clear programme-level information on the resources the country must raise domestically and from partners. The plan gives crucial direction to Ethiopia's FP programme, ensuring that all components of a successful programme are addressed and

targeted in the budgets of government and partner programming, including all of those engaged in FP service provision.

More specifically, the CIP will be used to

- Ensure that one unified country strategy for family planning is followed: The CIP articulates Ethiopia's consensus-driven priorities for family planning—derived through a consultative process—and is thus a social contract for the government, development partners, and implementing partners. The plan will (1) help ensure that all FP activities are aligned with the country's needs, (2) prevent fragmentation of efforts, and (3) guide current and new partners in their FP investments and programmes. All stakeholders must align their FP programming to the strategy detailed in this document. In addition, the MOH will hold development and implementing partners accountable for their planned activities and realign funding to the country's priority needs. Given the cross-sectoral nature of many FP programmes, the MOH will coordinate and collaboratively work with other ministries to implement the CIP.
- Define key activities and an implementation roadmap: The CIP includes all necessary activities, with defined targets appropriately sequenced, to deliver the outcomes needed to reach the country's FP goals by 2020.
- Determine impact: The CIP includes estimates of the demographic, health, and economic impacts of the FP programme, providing clear evidence for advocates to use to mobilise resources.
- Define a national budget: The CIP determines detailed commodity and programme activity costs associated with the entire national FP programme. It provides concrete activity and budget information to inform the MOH budget requests for FP programmes aligned with national goals between 2015 and 2020. It also provides guidance to the ministry and partners to prioritise the funding and implementation of strategic priorities.
- Mobilise resources: The CIP should also be used by the GOE and partners to mobilise needed resources internally, as well as those from development partners. The plan details the activities and budget required for the public sector to implement a comprehensive FP programme, so the MOH and partners can systematically track available resources against those required and conduct advocacy to mobilise funds from development partners to fill any remaining funding gaps.
- Monitor progress: The CIP's performance management mechanisms, including semi-annual reviews, measure the extent of activity implementation and help ensure that the country's FP programme is meeting its objectives; these mechanisms also help to ensure coordination and guide any necessary course corrections.

This CIP document was finalised during an opportune time, when several other key MOH five-year strategies were being developed. The CIP's goals, objectives, and implementation framework are in alignment with the country's Reproductive Health Strategy (2016–2020) and the HSTP (2016–2020). Various technical working groups overseeing these respective strategic plans worked in close coordination to ensure the strategies and plans can be smoothly implemented and efficiently monitored.

The Global Context

Scaling up FP services is one of the most cost-effective interventions to reduce maternal, infant, and child morbidity and mortality globally. FP interventions helped to achieve the Millennium Development Goals (MDGs) and are expected to achieve the newly established Sustainable Development Goals (SDGs). Family planning can prevent unintended pregnancy and thus reduce maternal deaths. It also indirectly contributes to positive health outcomes. For example, FP interventions help to reduce poverty, increase gender equity, prevent the spread of HIV, and lower infant deaths.[9] Currently, more than 200 million women in developing countries desire to space or limit pregnancies, yet they lack access to FP options. Amongst women of reproductive age in developing countries, 57 percent (867 million women) are in need of contraceptive access because they are sexually active but do not want to have a child in the next two years. Of these women, 645 million (74%) are using modern methods of contraception; the remaining 222 million are not, resulting in significant unmet need for modern FP methods.[10]

Figure 1: Ethiopia country commitments to FP2020

Commitment 1: Ethiopia's objectives are to increase the CPR to 55 percent; reduce total fertility rate (TFR) to 3; and reach an additional 6.2 million women and adolescent girls with FP services by 2020.[1]

Commitment 2: Ethiopia commits 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: Ensure commodities security.

Commitment 5: Increase the uptake of long-acting reversible methods (LARMs).

Commitment 6: Expand youth-friendly services, with a focus on adolescent girls.

Commitment 7: Scale up the delivery of services for the hardest-to-reach groups.

Commitment 8: Monitor the availability of contraceptives.

Family Planning 2020 (FP2020)

The UK Department for International Development and the Bill & Melinda Gates Foundation partnered with the United Nations Population Fund (UNFPA) to host a gathering of leaders from national governments, development partners, civil society, the private sector, the research and development community, and other interest groups to renew and revitalise global commitment to ensuring that the world's women and girls, particularly those living in low-resource settings, have access to contraceptive information, services, and supplies.[11] The resulting event, the London Summit on Family Planning, was held on July 11, 2012. At the summit, implementers,

[1] Originally, Commitment 1 was "Ethiopia's objectives are to increase the CPR to 69 percent by 2015 (currently 29%), reduce TFR to 4 by 2015 (currently 4.8), and reach an additional 6.2 million women and adolescent girls with family planning services." The goal has been modified in accordance with the new Health Sector Transformation Plan V (2015–2020).

governments, and FP stakeholders united to determine priorities and set forth commitments.

The summit aimed to "mobilize global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020."[12] Achieving this ambitious target would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 212,000 childbirth-related and maternal deaths, and 3 million infant deaths.[13] The GOE made several significant commitments hand in hand with other governments and stakeholders (see Figure 1).

The London Summit on Family Planning called on all stakeholders to work together on various areas,[14] including the following:

- Increasing the demand and support for family planning
- Improving supply chains, systems, and service delivery models
- Procuring the additional commodities countries will need to reach their goals
- Fostering innovative approaches to FP challenges
- Promoting accountability through improved monitoring and evaluation

Sustainable Development Goals

Building on the commitments of the MDGs, the global SDGs have been newly proposed by the United Nations to address domestic and global inequalities by 2030. Proposed Goal 3 aims to "ensure healthy lives and promote well-being for all at all ages." Further, the sub-activity states the following:

- *3.1:* By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- *3.7:* By 2030, ensure universal access to sexual and reproductive health services, including family planning, information and education, and the integration of reproductive health into national strategies and programs.[15]

Further, Proposed Goal 5, "achieve gender equality and empower all women and girls," includes sub-activity 5.6: To ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. Given the focus placed on family planning and equitable access, if the necessary resources, political will, and in-country priority are provided, the SDGs are set to achieve substantial impact outcomes.[16]

The Ethiopian Context

Overview

Ethiopia's population increased from 22.2 million in 1960 to 90 million in 2015.[17] With an annual growth rate of about 2.6 percent, the population is projected to reach 112 million by 2020.[18] The progressively declining fertility rate (from 5.9 live births per woman in 2000 to 4.1 in 2014) is expected to slow down the rate of population growth.[19, 20] Preferences for larger families, traditions of women marrying at a very young age, the high drop-out rates for girls from school, and unintended pregnancies as a result of low contraceptive use all contribute to high fertility in Ethiopia.[21] With more than half of the total population age 20 and under, a shift in population distribution to a

more balanced age structure may take some time. The increase in FP use and scaling up of girls' education will support this balance.

The delivery of FP services is also an important strategy for reducing maternal morbidity and mortality. Multicountry studies have shown that accessing family planning can reduce maternal deaths by as much as 40 percent,[22, 23] infant mortality by 10 percent, and childhood mortality by 21 percent.[24] The main causes of maternal mortality are haemorrhage, hypertension during pregnancy, obstructed labor, infection, and abortion.[25, 26]

The country has made significant progress by reducing the maternal mortality ratio by 69 percent (from about 1,400 in 1990 to 420 per 100,000 live births in 2013). The MDG of Ethiopia related to maternal mortality is to reduce maternal mortality further, to a ratio of 267 per 100,000 live births by 2015.[27] As a complementary intervention, the country must continue its efforts to improve access to and the quality of FP services, so that Ethiopian women of reproductive age can live long, healthy, and productive lives. Beyond achieving these health-related goals, FP programmes can have a multitude of positive effects. In Ethiopia, every dollar invested in family planning results in more than US$2 of savings in other development areas.[28]

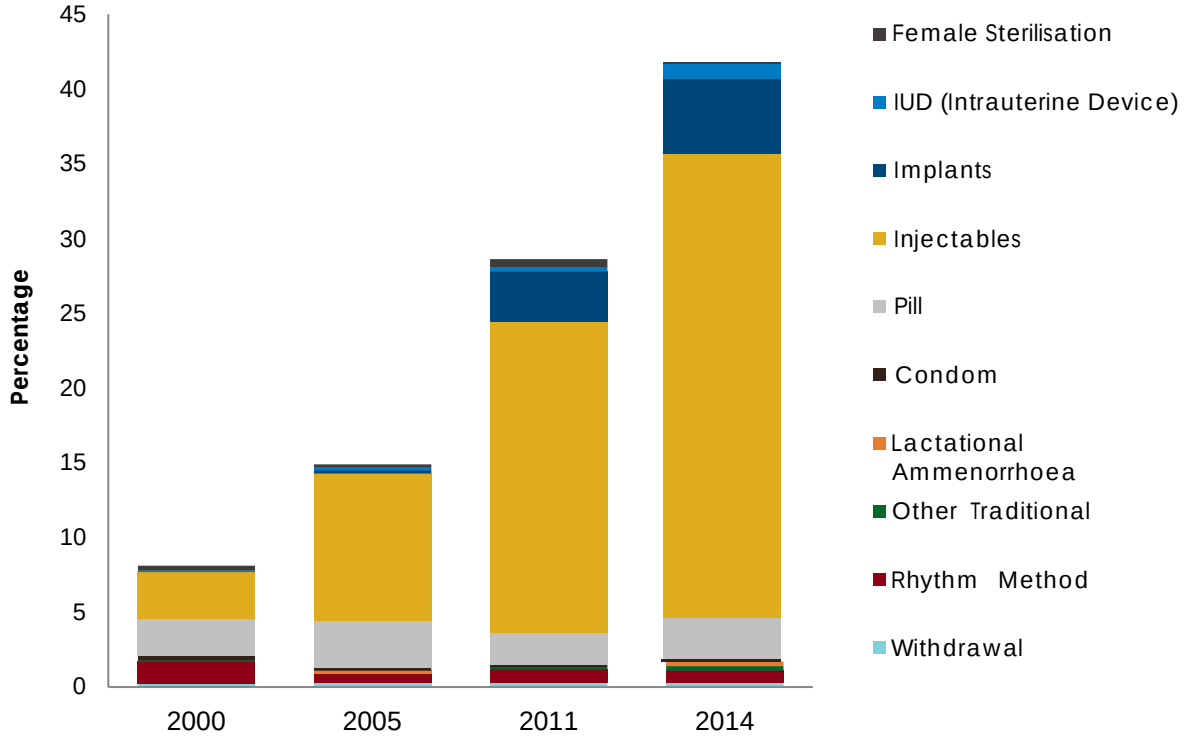
Unintended pregnancies

Unintended pregnancies lead to high levels of unplanned births, unsafe abortions, and maternal injury and death. About a decade ago, Ethiopia had one of the highest maternal mortality ratios in the world, with low availability of contraception resulting in more than 40 percent of pregnancies being unplanned and more than 2 percent of women of reproductive age seeking an abortion every year.[29] Policy changes allowing for abortion in certain instances have dramatically reduced abortion-related mortality;[30] however, the high rate of abortion remains a serious concern and indicates a need to improve the accessibility of contraception to prevent unwanted pregnancies. Although the health extension worker (HEW) programme has substantially increased the availability of contraceptives, a high unmet need for family planning still exists, especially amongst adolescent girls.[31]

Contraceptive use

In 2014, 42 percent of married women of reproductive age (15–49 years) were using FP methods.[32] As Figure 2 shows, Ethiopia has achieved impressive growth in its CPR since 2000. Use of modern FP methods increased considerably, with the availability and use of injectable contraceptives providing the largest increase. Building on this positive trend, the CPR needs to increase substantially over the next six years to reach the goal of 55 percent set in the HSTP (2016–2020).[33]

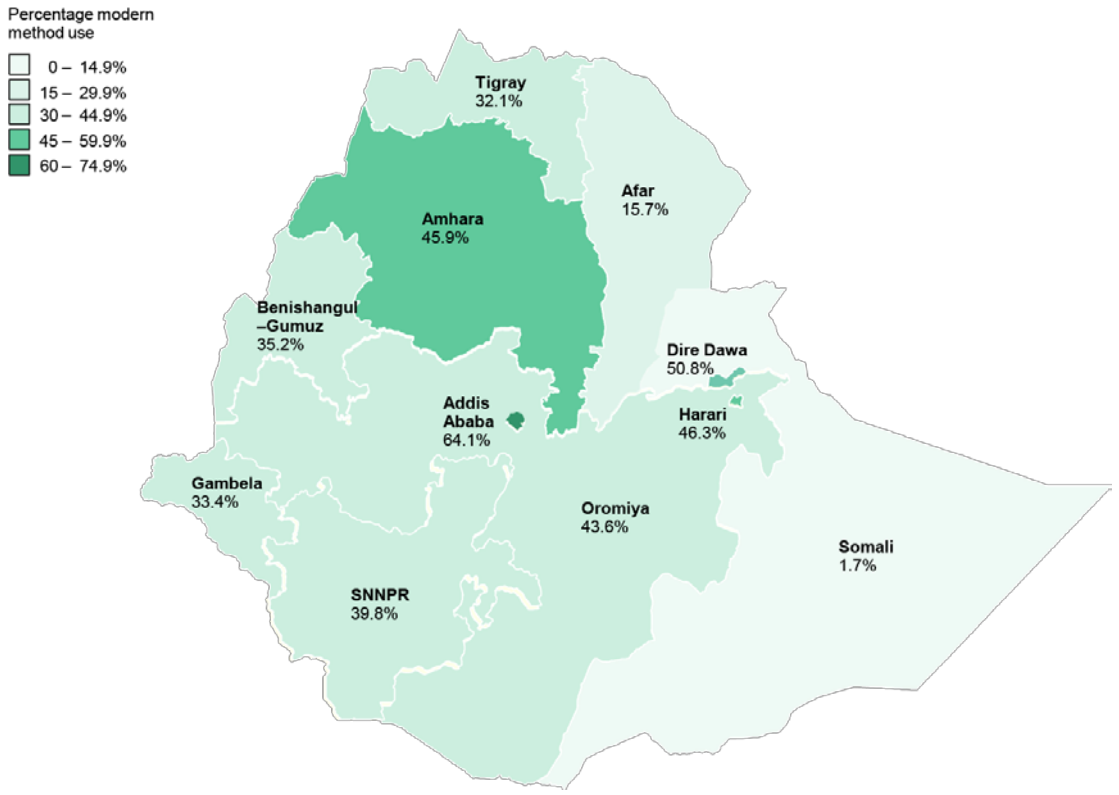
Figure 2: Contraceptive use trends amongst married women of reproductive age, by method, 2000–2014[34, 35]



The successful deployment of the HEW programme coincides with increases in the CPR over the last 15 years. Ethiopia's track record in consistently increasing FP uptake has often been cited as a global success story. Many Ethiopian women have opted for injectables, likely due to their ease in administration, ability to use them privately, and their longer period of action than other short-term methods, such as pills or condoms. As the country continues its efforts to increase FP uptake through a rights-based approach, it will be vital that every woman is aware of the options available to her for delaying, spacing, and preventing pregnancy, and that she has access to whatever method she chooses.

Disparities in contraceptive use exist by age, marital status, education, religion, socioeconomic status, and rural-urban geographic location. Married women ages 25–40 have a substantially higher use of modern contraceptive methods compared with adolescents, whereas demand amongst women between ages 15 and 44 is relatively constant, ranging between 52 to 59 percent. Nearly one in three adolescent girls has an unmet need for contraception,[36] and recent data from the Performance, Monitoring and Accountability 2020 (PMA2020) project suggests that whereas unmet need is decreasing amongst married women, it is continuing to increase amongst unmarried adolescents.[37] Women in the lowest wealth quintile have the lowest levels of use, regardless of marital status, with women in the highest quintile more than twice as likely to use contraception. The CPR amongst women in urban areas is higher compared to women in rural areas, with clear regional differences. As Figure 3 shows, Addis Ababa has the highest CPR, at more than 64 percent for married women, and the Somali region has the lowest, with less than 2 percent of married women using any modern contraceptive method.[38]

Figure 3: Contraceptive use amongst currently married women using any modern contraceptive method, by region, 2014[39]



Fifty-five percent of Ethiopia's population is under age 20, with nearly 34 percent of the population ages 10–24.[40] Adolescents and young adults are particularly at risk for unintended pregnancy, and high rates of adolescent marriage lead to high-risk pregnancies amongst these groups. Fifty-eight percent of girls in Ethiopia are either pregnant or have given birth by the time they turn 20.[41]

Unmet need

Unmet need is the percentage of women who want to space their births or do not want to become pregnant but are not using contraception.[42] Twenty-five percent of married women of reproductive age had an unmet need for family planning in 2011;[43] however, recent data from PMA2020 suggest that improvements in contraceptive availability have reduced unmet need to 24.4 percent.[44] Amongst married women reporting unmet need, nearly two-thirds expressed a desire to space their pregnancies (16%), whereas the remaining one-third (9%) expressed a desire to limit (cease childbearing).[45] Women in rural areas report higher levels of unmet need, at 27 percent, compared with their counterparts in urban areas, at 15 percent.[46] Women in the highest wealth quintile have the lowest level of unmet need, at 14 percent, whereas the remaining four quintiles have unmet need ranging from 26.5 to 30.5 percent.[47]

Key Issues and Challenges

The FP programme faces challenges that must be overcome to meet the country's FP goals of a 55 percent CPR by 2020.

Demand creation (DC)

Knowledge of family planning is an important determinant for increased FP use.[48] The majority of Ethiopians know of at least one method of contraception, with 97 percent of

women being able to name at least one method.[49] However, knowledge about long-acting reversible and permanent methods is significantly lower, with only 39 percent of women knowledgeable about intrauterine devices (IUDs) or sterilisation. Modern contraception uptake is hindered by misconceptions, misinformation, and misinterpreted side effects.[50]

Some traditional cultural and religious beliefs also serve as substantial barriers to increasing the modern CPR (mCPR). In Ethiopia, gender inequalities commonly affect women's ability to make decisions in the household. This power dynamic often limits a woman's ability to choose to use contraceptives, leading to lower FP uptake in households where there are negative sociocultural sentiments about women's decision-making abilities.[51] In Ethiopia, women's empowerment and contraceptive use correlate positively.[52] Religion also can act as a significant barrier to family planning. There is a well-accepted belief in some parts of Ethiopia that religion prohibits the use of modern FP methods. This belief creates an impediment to demand.[53]

Service delivery and access

In Ethiopia, most health facilities have the capacity to provide short-acting FP methods, as well as the basic infrastructure and provider interest to offer long-acting reversible contraceptives (LARCs).

In addition, HEWs, a cadre of providers who deliver primary healthcare, especially in areas of the country where access is limited, are vital in improving FP access by the rural population. However, accessibility varies across regions, with emerging regions[2] especially lacking access to FP services. There are also variations amongst population groups; for example, youth have less access to family planning. Moreover, availability of and access to a range of FP methods is a problem; the majority of FP users still depend on short-acting methods, particularly injectables, and the use of long-acting reversible and permanent methods remains extremely low. Implants are the most popular LARC, with 12 percent of contraceptive users opting for this method.[54]

FP commodities should be accessible to both men and women, including youth. Access to FP counselling is also a critical element of a successful FP programme. Numerous supply-side barriers hinder access to FP services in Ethiopia; for example, clients are often unable to access counselling and receive commodities due to geographical distances and lack of supplies or equipment at facilities. Although the HEW programme has dramatically increased access to FP information and short-acting methods (condoms, pills, and injectables), women seeking long-acting reversible and permanent methods often travel long distances to reach health facilities providing a full method mix. Additionally, sporadic stockouts of FP commodities at facilities and long wait times for service further impede access. Reducing inequities related to poverty, gender, age, and marital status; counselling; and access to and use of family planning are continuing challenges. Unmarried sexually active youth also face a unique set of challenges related to access, due to provider bias and cost of FP services through the private sector.[3, 55]

---

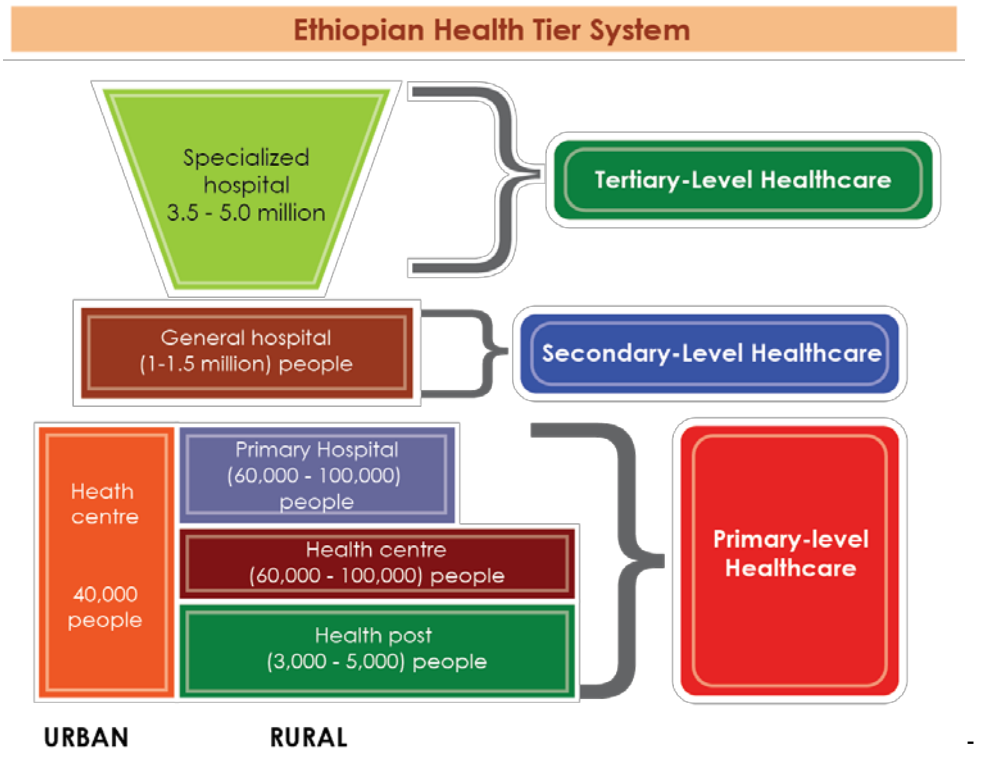
[2] "Emerging regions" include Affar, Somali, Benishangul-Gumuz, and Gambela; these regions are often grouped together as target geographical areas for health service improvement, as they are sparsely populated, have less health infrastructure, and are home to pastoralists, all of which pose unique challenges to ensuring that health services are available and accessible.

[3] Youth are more likely to access FP services through the private sector. Twenty-three percent of modern contraceptive users ages 15–19 accessed family planning most recently through the private sector as compared with 13.4 percent for all age groups.

Health service delivery is decentralised, with regions and woredas responsible for delivery and management of health services at lower levels. The Ethiopian health service has been restructured into a three-tier system.

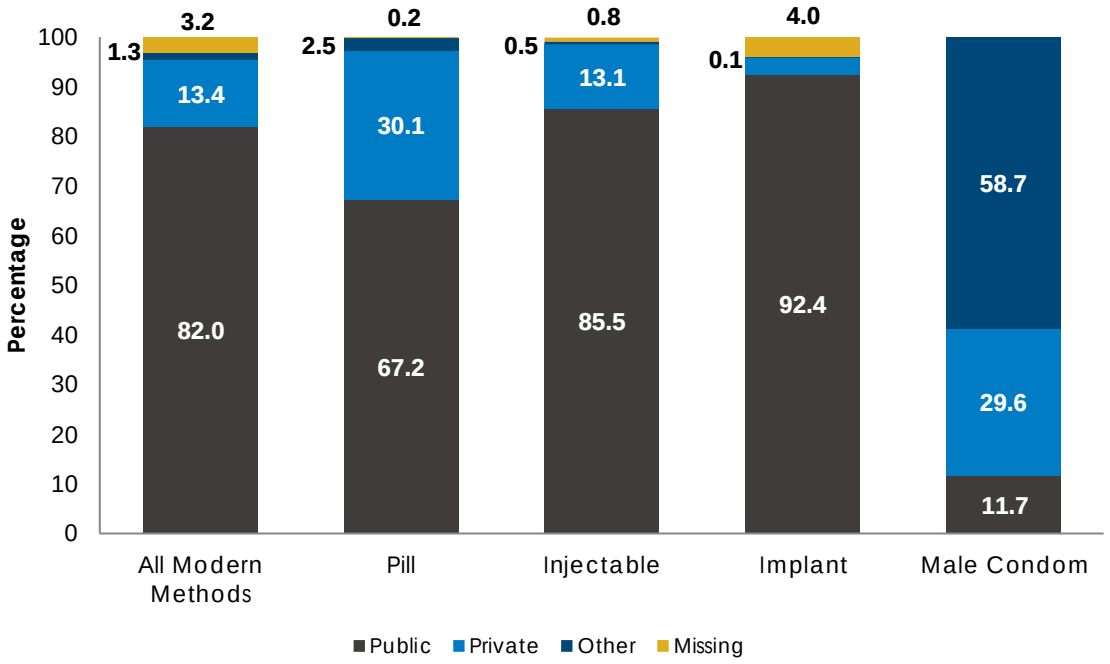
1) *Specialised hospitals*: Provide specialised health services and referrals; cater to a catchment population of 3.5–5 million people.
2) *General hospitals:* Provide inpatient and ambulatory services to an average of 1,000,000 people.
3) *Primary health care unit:* Composed of a primary hospital, a health centre (HC), and five satellite health posts that provide services to a population of 25,000. The primary hospital provides inpatient and ambulatory services to an average population of 100,000. In addition to what an HC can provide, a primary hospital provides emergency surgical services, including caesarean sections, and gives access to blood transfusion services. It also serves as a referral centre for HCs under its catchment areas and a practical training centre for nurses and other paramedical health professionals.

Figure 4: Ethiopian health tier systems



As Figure 5 below shows, nearly all FP demand in Ethiopia is satisfied through the public sector with the exception of male condoms, which are also distributed through private sector pharmacies (27%) and shops (51%).

Figure 5: Source of modern contraceptive methods accessed, by all current modern method users ages 15–49 (2011)[56]



Note: "All modern methods" include "Other" modern methods but exclude the lactational amenorrhoea method and standard days method.

Contraceptive security

At the London Summit on Family Planning, the GOE committed to increasing commodity security, which aims to ensure that the full spectrum of contraceptive commodities and related supplies are adequate and available to meet the needs and choices of FP clients.

Providing a choice of FP methods to meet the changing needs of clients throughout their reproductive lives increases overall levels of use and enables individuals and couples to meet their reproductive goals and safeguard their human rights. The method mix available influences not only successful client use and satisfaction, but also has implications for provider confidence and competence.

In Ethiopia, the MOH, in collaboration with the Pharmaceuticals Fund and Supply Agency (PFSA) and relevant stakeholders, is responsible for forecasting, quantifying, and initiating procurement of contraceptive commodities. The PFSA is responsible for the procurement, storage, and distribution of contraceptives and consumables from the central warehouse all the way to the service delivery points.

The National Growth and Transformation Plan has made the availability of pharmaceuticals a priority, and procurement lead time has gone down from 240 days in 2010 to 140 days in 2012.[57] The PFSA currently operates 10 distribution hubs nationwide, with an additional six warehouses to be added in 2015. From the regional hubs, the commodities and supplies are distributed down to the health centre level.

HEWs travel to health centres to acquire the necessary commodities for their health posts.

The government and stakeholders agree that at the national level, commodities are more reliably available.[58] At service delivery points, stock availability has increased over recent years; however, there are still challenges in getting the commodities from the health centres to the health posts, with the majority of challenges occurring in emerging regions.[59]

Monitoring and coordination

Achieving FP objectives will take multisectoral coordination with many other government ministries, stakeholders, and partners. Additionally, service provision requires ongoing communication between all levels of the government—from the Kebele (community) to the federal level.

Various ministries have undertaken initiatives that can positively affect FP uptake and build on each other. Establishing mechanisms to enable frequent communication and collaboration can ensure that opportunities are not missed. For example, although the GOE has made it a priority to target youth, the MOH; Ministry of Women, Children and Youth Affairs; and Ministry of Education (MOE) are still working on a collaborative approach to developing and implementing FP programmes. The MOH is working with regions to fully understand the ministry's FP objectives; FP plans will be developed at the regional level to effectively operationalise national FP goals and objectives. Consultations with stakeholders have identified a need for increased communication between the federal and regional governments, and raised the issue of further developing the technical capacity of regional health bureau (RHB) staff as a critical requirement for them to improve coordination and implementation of FP programmes.[60]

The private sector can play an important role in increasing the availability of FP services for urban and peri-urban populations in Ethiopia. As noted earlier, 87 percent of current users obtaining male condoms acquired them from a non-public source.[61] Approximately 26 percent of reproductive healthcare costs are spent at private health facilities.[62] Many key health and FP policies and strategies recognize the value that the sector brings to the table; thus, the role of the private sector in providing FP services currently is being strengthened under the HSTP.

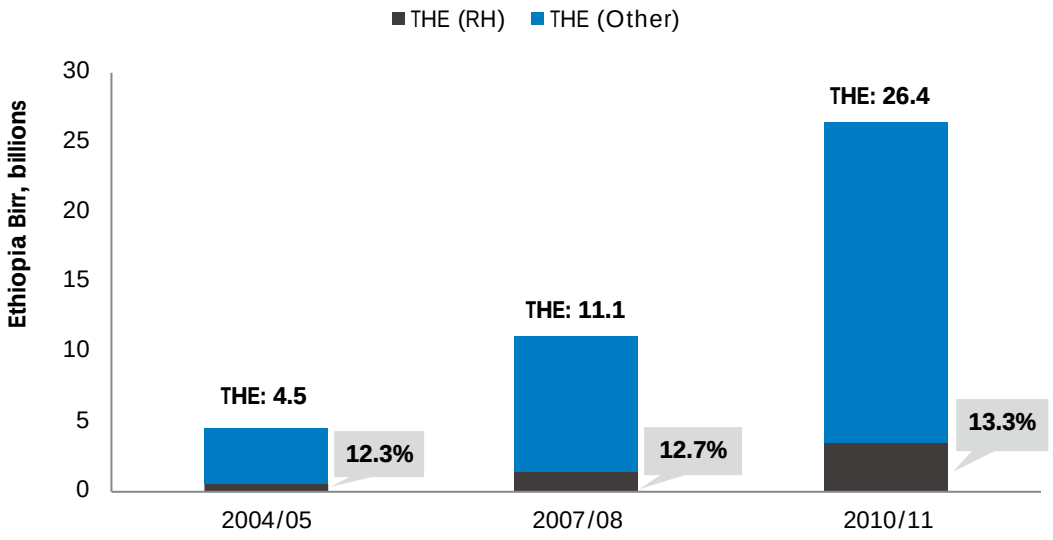
Effective FP programming and implementation requires the availability and use of accurate monitoring data. Ethiopia has an extensive health information management system to gather data from the Kebele level up to the national level.

However, data are often not effectively analysed and used for decision making at the subnational level. Timely entry of accurate data at the sites and full analysis and use of data will be critical in ensuring that sites have the necessary trained staff and commodities to provide counselling and the full spectrum of FP services.

Financing

Although Ethiopia's total health expenditure (THE) doubled between 2007—2008 and 2011—2012, 34 percent of this funding comes from households. Heavy reliance on out-of-pocket payments is undesirable, as it can make healthcare inaccessible to vulnerable households. To expand and ensure access to healthcare services for all and to protect households from catastrophic expenditures, the GOE is working to identify alternative and sustainable domestic sources for financing healthcare.

Figure 6: Ethiopia total health expenditure trend, 2004–2011



The proportion of funding available for reproductive health has increased over the past decade, from 12 to 13 percent (see Figure 5).[63.64]

In recent years, regional ownership for financing health has grown. More than half of the government's financial contribution to health is from regional and local governments. Two regions (Amhara and SNNPR) and Addis Ababa recently earmarked 3.3 million Birr for FP programmes and commodity procurement for 2015.

SECTION 2: COSTED IMPLEMENTATION PLAN

The MOH developed the CIP based on the government's FP2020 pledges made in 2012 and in line with other health sector strategies, particularly the HSTP (2016–2020)[65] and the Reproductive Health Strategy (2016–2020). Through extensive consultation with stakeholders, the CIP's priorities and activities have been refined. The plan clearly defines the country vision, goal, strategic priorities, interventions, and inputs, and presents the estimated cost to achieve them. The CIP details the strategic priorities that will help the government and nongovernment sectors meet the national targets for increasing the CPR and number of women reached with rights-based FP services and for reducing the TFR by 2020.

The CIP specifies the interventions and activities to be implemented, and itemises the financial and human resources needed to meet the comprehensive national FP goals.

Operational Goals

- Increase the CPR amongst married women from 42 percent in 2014 to 55 percent by 2020[66]
- Reduce the TFR from 4.1 in 2014 to 3.0 in 2020[67]
- Reach 6.2 million additional women and adolescent girls with FP services by 2020 as compared to 2011[68]

Strategic Priorities

The strategic priorities in the CIP represent key areas for financial resource allocation and implementation performance. Strategic priorities reflect the issues and interventions that must be acted upon to reach the country's goals. Based on a desk review and key stakeholder interviews, a Technical Support Team from the Health Policy Project (HPP), funded by USAID, identified **five strategic priorities**. These priorities serve as the foundations of the **thematic areas** for CIP activities:

- **Priority # 1—Demand Creation:** To 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:** To 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 clinics, and adolescent and youth-friendly sexual and reproductive health (SRH) services.
- **Priority # 3—Procurement and Supply Chain:** To improve the distribution of FP commodities and consumables from the central level to service delivery points by increasing the capacity of healthcare workers to manage the logistics system and the PFSA by improving human resource and commodity supply chain logistics to manage the national supply chain.
- **Priority # 4—Monitoring and Coordination:** To improve multisectoral coordination in the planning, implementation, and monitoring of FP programmes at all levels.
- **Priority # 5—Financing:** To increase the budget allocation for family planning both at the federal and regional levels to ensure reproductive health commodity security.

Intervention and activity mapping to FP2020 commitments

The GOE is determined to meet its FP2020 commitments, which prioritise outreach to specific population groups and an increase in uptake of LARCs—interventions that cut across core components of an FP programme. When resources are limited, they should be directed to areas that have the greatest potential to meet those commitments and reduce the unmet need for family planning. In the case of a funding gap between resources required and those available, FP2020 activities should be given precedence to ensure the greatest impact and progress towards the objectives laid out. These activities will enable the MOH to focus resource and time investments on coordination and leadership for CIP execution. However, all of the components necessary for a comprehensive FP programme (all of the activities that support, complement, and complete the FP programme) have been detailed by activities and costed; the strategic priorities of the plan will be used to guide national priorities for additional and new funding and programme development.

All activities under the five thematic areas will address the eight FP2020 goals. Notably, while the CPR, TFR, and uptake goals presented in Commitment 1 are cross-cutting in nature, Thematic Area 5 will speak more to Commitments 2 and 3 (increase financing for family planning). Thematic Area 3 will contribute to Commitment 4 (commodity security). Thematic Areas 1 and 2 will especially align with Commitments 5, 6, and 7 (increase uptake of LARCs and expand service delivery for youth and hardest-to-reach groups). Thematic Area 4 will contribute to Commitment 8 (monitor contraceptive availability).

Thematic Areas

Across the five thematic areas, there are 23 strategic outcomes for implementing a full FP programme in Ethiopia. Each thematic area is further detailed with expected results, activities, sub-activities, inputs, outputs, and timeline information. Refer to Annex A: Implementation Framework with Full Activity Detail.

Demand creation (DC)

Strategy

The wide gap between knowledge about contraceptives and their use indicates the need for a focused communications strategy to ensure FP programme coordination and increase demand. A behaviour change communication (BCC) strategy will be developed to streamline communication efforts with consistent messages targeting priority groups. The BCC strategy will be informed by formative and assessment research. Campaigns should be adaptable for different cultural audiences and populations.[69] For example, campaigns that speak to the needs of the population will often need to be specific to regions or even districts. Thus, regional input and stakeholder engagement in the strategy development process will be critical. The formative research will outline the knowledge, attitudes, and perceptions of the audience so the campaign addresses the actual needs of the target population.[70] Successful campaigns can result in increased demand, increased acceptance of family planning amongst family members, increased knowledge and access to FP services, and informal peer-to-peer advocacy for FP methods amongst users.[71]

Once an evidence-based strategy is developed, a series of demand creation activities will be implemented at the national, subnational, community, and interpersonal levels. Multiple media outlets—including mass media; information, education, and communication materials; interpersonal communications; advocacy campaigns; and champions—will increase demand and uptake of services.[72] By increasing knowledge

and awareness of family planning at all of these levels, the demand creation strategy will increase the desire to access FP services and lower the barrier to access.

In addition, specific demand creation efforts will be targeted at youth (ages 15–19), community and religious leaders, and men as husbands and fathers. Youth have a tendency not to access FP services, as they do not feel they need to "plan a family"; thus, the BCC strategy will utilise appropriate terminology to help overcome this barrier. Meanwhile, there is a rising trend amongst urban youth to access emergency contraceptives on an ad hoc basis rather than using contraceptives more consistently and appropriately to their health needs and reproductive desires. Demand creation activities that make the full spectrum of contraceptives better understood and more relevant to youth can significantly improve the welfare of the population through the prevention of unintended pregnancies.

Community and religious leaders strongly influence women's decision to access family planning. Historically, traditional, community, and religious leaders have perceived FP use negatively. However, with concerted outreach efforts that listen to and address their concerns, these leaders can become some of the strongest supporters for family planning in their communities. Successful partnership efforts by the Benishangul-Gumuz RHB with local sharia leaders to support family planning within their communities are good examples of how government and religious leaders can work together to support FP use to improve the health of community members.[73] MOH and RHBs will identify and work more with national- and community-level leaders to improve the acceptability of family planning.

Although men share responsibility for reproductive health decisions, lack of a specific focus on them can lead to the belief that family planning is not men's concern. However, male involvement is crucial to a successful demand creation campaign. Barriers for uptake include power and gender dynamics that inhibit women from making open decisions about FP use in their households. Providing information to men about how family planning can improve health outcomes for women and children, as well as dispelling myths and misconceptions, is important in ensuring their support.[74]

Ultimately, women must feel empowered and knowledgeable about family planning to make the decision to access it. Embracing family planning as a community, such as by providing an opportunity for satisfied FP users to share their stories through the Health Development Army (HDA), will increase community and women's awareness that FP decisions not only can be made by women, but that this kind of decision making about their health and reproductive outcome is a core right of all women. Combined with the demand creation campaign focusing on influencers such as community leaders and husbands, mass media campaigns on women's rights to FP decision making will increase acceptance.

Strategic outcomes

DC1. Increase awareness of available FP methods and how to access them by developing and executing a comprehensive BCC strategy tailored to specific target groups and cross-cutting issues: To increase FP acceptability, a comprehensive BCC strategy will be developed. The MOH will spearhead this strategy development process, in consultation with RHBs and other key stakeholders for FP programme implementation. The FP Technical Working Group (TWG) will identify key target groups and priority cross-cutting issues to address through demand creation activities. Potential target groups include young married women, youth ages 15–19, men, pastoralists, community leaders, and service providers. Cross-cutting issues to be tackled by BCC include addressing myths and misconceptions

about family planning, especially around LARCs; the intersection of religion and FP use; women's empowerment and access to family planning; and regional and cultural backgrounds as they relate to FP acceptability and use.

DC2. Increase awareness of and demand for family planning, especially LARCs: Using the key messages developed by the new communications strategy, targeted BCC campaigns will be developed to increase FP awareness and knowledge. Mass media will be leveraged to reach the population nationally, and existing outreach models, such as the HDAs and use of the HEWs, will be leveraged to reach target communities at a more personal level. Innovative mobile platforms will be used to provide access to information about family planning on demand, such as the Mobile 4 Reproductive Health systems in operation in Kenya and Tanzania.[75] This outreach mechanism is believed to be most optimal for youth ages 15–24.

DC3. Increase awareness of and demand for FP services amongst both in- and out-of-school youth: To improve the knowledge of sexual and reproductive health and family planning as they relate to married and unmarried youth, demand creation activities will focus on improving the quality and depth of information available to youth. Peer educators, both male and female, will be trained to provide accurate FP and reproductive health information and promote health-seeking behaviour amongst both male and female youth. Communication materials specifically targeting youth will be distributed through youth centres and schools. Furthermore, support systems for youth—parents, caregivers, and teachers—will be given the tools to advise them effectively on why family planning is relevant to them, how it can impact their health, and how FP use can benefit their welfare by preventing unintended pregnancies.

DC4. Establish and sustain engagement with national- and community-level advocates of family planning, including traditional and religious leaders: To increase the engagement of community and religious leaders who have the ability to promote family planning within the community, the MOH and RHBs will take a step-by-step approach. First, they will engage the leaders and address their concerns. Through these discussions, the MOH and RHBs then will identify FP champions. Leaders already working in health will be cultivated, leveraging their ongoing work by integrating family planning into it, and tools will be developed to support FP advocacy.

DC5. Increase male engagement in FP issues: Special Men's Day events will be held at the regional level to raise awareness of family planning amongst men. In addition, male role models will be selected and cultivated to provide community leadership and guide group education, including discussion sessions and participatory methods for learning. Additionally, these male role models will conduct community outreach and mobilisation. While increasing men's support of women's FP-related rights, male engagement activities will focus on countering the concept of family planning as only a women's issue. In addition, other activities will include men as a target group for specific programming and messaging, including strategies DC1 and DC3.

DC6. Build capacity of women to ensure they are knowledgeable of their rights for making FP decisions and empowered to act on them: To increase women's empowerment within the community, especially in rural areas and emerging regions, existing programmes will be leveraged to include family planning within women's empowerment activities. Also, HDA activities will feature women who are satisfied with family planning to build other women's confidence in their knowledge of and ability to make an informed choice about family planning while feeling that the community is supportive of their decisions. These activities will complement the demand creation activities amongst community leaders

and men (outlined in strategies DC3, DC4, and DC5), as well as a mass media campaign (outlined in DC2) to raise awareness of the rights of women to make FP decisions and address community norms that act as barriers to contraceptive access.

Service delivery and access (SDA) Strategy

Ethiopia's strategy focuses on making a wide range of high-quality methods available and accessible while ensuring rights and equity amongst regions and population groups. Primary focus will be placed on increasing the number of FP service providers who can appropriately counsel and deliver a full range of methods by implementing a series of trainings throughout the country, especially in the pastoralist and emerging regions. Some of the activities that will support access to service delivery include an expansion of established networks of providers, development of mobile outreach services for family planning, and increased training for HEWs in these hardest-to-reach regions.

Uptake of long-acting methods is disproportionately low, partly due to the lack of appropriate skills amongst service providers at all levels. Thus, emphasis will be placed on increasing the clinical capacity of providers to administer long-acting reversible and permanent methods, and reduce provider bias towards shorter-term methods. In combination, the health system will be strengthened to improve the availability, accessibility, and quality of FP services to promote full access, choice, and rights. Referral systems will be streamlined so that women can more easily access FP services at higher-level facilities. New guidelines will be developed to integrate other reproductive, maternal, newborn, and child health (RMNCH) services with family planning. Facilities will be upgraded to improve privacy—a right for women accessing services and a factor critical to ensuring quality of service delivery.

Young people ages 15–19 in Ethiopia have high unmet need for family planning. They experience stigma, providers often refuse to offer FP services to them due to their age or marital status, and services fail to provide them with privacy and confidentiality. Accordingly, this strategy prioritises building additional FP access points for youth by instituting youth corners in health facilities, training service providers in youth-friendly services, increasing the capacity of youth centre staff to provide FP information and education, and strengthening the capacity of college and university clinics to provide high-quality FP information and services.

Strategic outcomes

SDA1. Increase the number of trained health providers at all levels to provide the full spectrum of FP services: Currently, three out of four women rely on injectables for contraception. To address this reliance on a single method and promote access to a full spectrum of FP methods and services, all service providers will be trained to provide the entire range of FP services available at their level, with a rights-based focus. A pool of trainers will be created at the regional level. These trainers will train nurses and midwives on the full spectrum of FP methods, with emphasis on counselling and LARCs. Moreover, physicians and health officers will be trained on both LARCs and permanent FP methods to ensure that the full method mix is available to the population. The expansion of available services at all service delivery levels will likely result in a shift in method mix to a more balanced distribution.

SDA2. Strengthen the referral system to streamline and simplify the process for women to access higher-level health facilities for FP services: When some FP methods are not available at a facility, clients will be referred to a higher-level facility so they can access their method of choice. Thus, the referral system and feedback mechanism need to be institutionalised and strengthened. A handout on the use of referral and feedback forms

will be developed and then distributed to the regions, woredas, and facilities. Service providers will also be oriented as to the importance of referral and feedback forms for increasing their awareness.

SDA3. Increase availability and accessibility of high-quality FP services in emerging regions: Some emerging regions lack access to a range of FP methods due to the significant distance from the community to the health facility. Accordingly, regional trainer pools will be developed and used to train health professionals on inserting and removing implants and IUDs, so that LARCs are available at the community level. Moreover, mobile outreach services will be piloted in emerging regions to increase access to LARCs and address geographic barriers to services provided at higher-level health facilities.

SDA4. Increase quality of FP services, especially in the area of counselling, privacy, and informed choice: Rights-based FP programmes can be measured by the quality of counselling, which is vital to realise informed choice and maintain privacy and confidentiality. Characteristics of high-quality FP service delivery include the provision of appropriate and complete information to clients, freedom for the client to choose, client-provider interaction that is professional and confidential and respects informed choice, and technically competent staff with the appropriate tools and supplies to provide adequate service. Combined with the medical skills capacity-building training covered under SDA1, FP services providers will be trained in counselling techniques that acknowledge privacy and informed choice. The culture of quality improvement will be institutionalised by establishing quality assurance teams within health facilities. Furthermore, the MOH and RHBs will work together to assess and identify facilities that need renovation to ensure clients' right to privacy during FP counselling. Based on the assessment findings, selected health facilities will be renovated.

SDA5. Increase FP uptake by increasing opportunities for women to access FP services through RMNCH service integration: Integrating family planning into other RMNCH services, such as antenatal care, delivery, and child immunisation services, will play a paramount role in improving FP uptake and reducing unmet need. The MOH will develop a service integration manual and train nurses, midwives, and health officers on integrated services provision, including postpartum family planning. To increase awareness of integrated FP and MNCH service provision, and maintain coordination amongst the RMNCH programmes, FP and MNCH focal persons at all levels will hold periodic coordination meetings.

SDA6. Increase the number of FP service access points for youth: To improve access to FP services for youth and adolescents, FP and SRH trainings will be organised for youth centre staff across the country so they can effectively engage youth in conversation about family planning, impart knowledge regarding the full spectrum of FP options available to them, and refer them to youth-friendly service providers should they choose to receive an FP service. In conjunction, additional health facilities will be made more youth friendly by establishing youth corners and training service providers on youth-friendly services. To address the FP needs of university students, advocacy meetings will be organised to ensure high-quality FP service delivery by university and college clinics.

SDA7. Increase the number of private sector providers who can provide a full spectrum of high-quality FP services: The private sector plays an important role in providing health services in Ethiopia. Capacity building and quality improvement will also encompass the private sector, so all women have access to a full spectrum of FP choices wherever they may choose to access health services. To ensure that capacity-building trainings cover those key FP service components especially lacking in the private sector, an

assessment will be conducted first. Based on the assessment findings, the FP training programme will be adapted.

Procurement and supply chain (PSC)

Strategy

Because the central-level supply of FP commodities is generally adequate, forecasting, quantification, and procurement will continue as in recent years. However, improved data are necessary to provide more accurate forecasting. Specific activities will help strengthen the capacity of facility staff to (1) report on contraceptive commodity distribution and place orders in an accurate and timely manner; and (2) ensure that contraceptives are delivered to hospitals, health centres, and health posts to achieve commodity security in both urban and rural areas.

At the national level, the MOH, in collaboration with the PFSA and relevant stakeholders, is responsible for forecasting, quantifying, and procuring contraceptive commodities and consumables. The PFSA is responsible for procurement, storage, and distribution of contraceptives and consumables from the central warehouse all the way to the service delivery point. Support will be provided to ensure that the FP commodity supply remains secure and consistently available. Specific activities will build the capacity of the MOH, PFSA, Food, Medicine and Health Care Administration and Control Authority (FMHACA), and RHBs. Activities also will ensure that data are used to improve commodity availability; contraceptives in stock are used; and the procured contraceptives are safe, effective, and of high quality.

Strategic outcomes

PSC1. Conduct annual quantification of contraceptive commodities and supplies. The MOH will conduct forecasting for annual contraceptives and related commodities, as well as quantifications and the supply plan, by collaborating with relevant stakeholders and partners. Forecast accuracy will also be done on an annual basis to check and confirm that they are aligned with actual demand and FP programme performance. Stock availability and stockout rates will also be monitored annually.

PSC2. Conduct quality assurance testing of contraceptives. Support will be provided to the FMHACA to improve capacity in registration and conduct post-market surveillance on contraceptives, including quality assurance testing.

PSC3. Improve the PFSA's capacity to use data generated at the facilities to ensure the timely distribution of commodities. Trainings will be provided at the federal and regional levels for PFSA staff on data aggregation and analysis to increase their capacity to gather and utilise facility-generated data monthly to inform commodity distribution plans.

PSC4. Ensure that capacity is sufficient at all levels for streamlined distribution of commodities from the national level to health posts. Support will be provided for the decentralisation of the PFSA distribution system. Trainings on stock management and monitoring and evaluation (M&E) will be provided to health facility staff to improve the quality of recording and reporting of contraceptives consumption.

To advance monitoring mechanisms for stockouts, appropriate information and communications technology (ICT) will be identified and piloted in selected regions. For example, the automated short message service (SMS) stock-tracking tool used by social franchises presents a potential opportunity to scale up into the public health system. To facilitate the distribution of commodities, the PFSA and MOH will build and equip regional warehouses.

Monitoring and coordination (MC)

Strategy

Specific activities will aim to improve coordination amongst various government sectors and ensure that FP objectives and activities are aligned across all regions. The MOH will strengthen its coordination with other line ministries, including the Ministry of Finance and Economic Development (MOFED); MOE; Ministry of Agriculture; and Ministry of Women, Children and Youth Affairs, amongst others.

To improve coordination between the public and private sectors while ensuring oversight from the MOH, specific activities will aim to facilitate dialogue between the two sectors, clarify the roles of each, and explore opportunities to increase the number of public-private partnerships. Leveraging the resources already available in the private sector can effectively and efficiently increase access to high-quality FP services and products.

Monitoring the progress of FP activities is also critical for successful implementation of this CIP. The planned activities will and should change over time based on findings from regular monitoring. Data must be recorded, and successes and lessons learned should be documented so that programme improvements can be made and best practices scaled up. To ensure that FP-related data are readily available and accurate, responsible staff at the facility level will receive follow-up training on data entry. Throughout the health system level, health officers will engage in data aggregation and review exercises to help data analysis and use become routine. Finally, technical assistance will be provided at the regional and federal levels to ensure that technical staff and policymakers are comfortable in using data to inform decision making.

Successful monitoring of FP activities must include identifying successful strategies and ongoing bottlenecks. The activities included in the monitoring and coordination of this plan will help to identify successful approaches to reaching youth and under-served populations with FP services, document how the results were achieved, and disseminate evidence through coordinated mechanisms to ensure that the most effective approaches and best practices can be replicated countrywide.

Strategic Outcomes

MC1. Improve FP service delivery by clarifying roles and responsibilities, and streamlining national-level programme coordination: Using the CIP as a foundation, a detailed, annual FP programme implementation plan (workplan) will be developed to define each ministry's role in supporting family planning and clarify each partner's responsibilities. Workplan implementation will be reviewed semi-annually, and an overarching CIP mid-plan assessment will be conducted in 2018.

MC2. Improve coordination with the private sector to better leverage its resources in FP service provision: The MOH will take the stewardship role and reach out to private sector organisations providing FP services, including social franchises. A market segmentation analysis will be conducted, with results disseminated through regional workshops. At the same time, existing guidelines for private sector provision of FP services will be reviewed and revised as necessary to ensure coordination with public sector FP service delivery, and supportive supervision of social franchises will be conducted to improve quality, coordination, and oversight.

MC3. Ensure that regional objectives and perspectives are integrated into the national-level plan, so family planning becomes a priority on the development agenda for the regions: An FP coordinator will be designated in each region to improve coordination amongst partners and stakeholders; this coordinator, along with other regional representatives,

will be included in the annual process to develop the national FP workplan. Other health and non-health private sector and civil society representatives will be involved in the workplan development process to ensure that it includes coordination efforts and is responsive to the needs of the community. The FP TWG or similar groups at the regional level will be instrumental in contributing to the development of annual national and regional FP workplans.

MC4. Increase the evidence base for FP programming and improve data use for FP programmes: Case studies on effective interventions for reaching target populations will be conducted as part of programme evaluations and disseminated to partners and stakeholders as evidence for further action through a biannual FP meeting. This meeting will also be a platform to engage policymakers in family planning.

MC5. Ensure the availability of service delivery data through leveraging the Health Management Information System (HMIS): Additional trainings will be conducted to ensure that health facility staff can enter HMIS data accurately and on time, and refresher trainings will be conducted based on an updated HMIS training database. At the federal level, the FP TWG will review quarterly HMIS data to identify bottlenecks and regions where data analysis needs additional support.

Financing (F)

Strategy

To address the limited financial commitment to family planning from domestic sources commensurate with need, the MOH will advocate increased funding within national and regional budgets. The ministry will cultivate FP advocates within the MOFED and Parliament by developing an advocacy strategy. This approach will ensure that the national budget includes a growing line item for FP programming that meets the increasing demand for FP services as BCC and FP access activities expand over the next five years.

Similar advocacy efforts will be conducted at the regional level to establish line items for family planning in regional government budgets. Regions that already have a line item for FP commodities will strive to increase their budgets while also advocating additional budget lines for FP programming and the purchase of supplies and consumables needed for high-quality FP service delivery. Inter-regional knowledge sharing will be encouraged so that advocacy approaches effective in one region can be replicated in others, and regional staff can build a support system for resolving similar challenges in their regions. The activities outlined here will help to achieve the sustainability of FP programmes in Ethiopia.

Strategic outcomes

F1. Advocate increased funding for family planning from the federal government: The MOH will develop an advocacy strategy to gain buy-in from parliamentarians to support increases in the ministry's FP line items. Evidence-based advocacy briefs will be drafted to show how increased funding from the government can improve the livelihood of Ethiopia's citizens and how investments in family planning can yield both economic and health benefits. The MOH will hold advocacy meetings with the MOFED and parliamentarians, and proactively track the national government's progress towards meeting its FP2020 commitment to increase the budget for family planning.

Parallel efforts will be made at the regional level to secure or increase FP line items. Inter-regional knowledge-sharing meetings will be held throughout the five-year period

to share successes and challenges amongst the regions, and replicate effective approaches and best practices.

SECTION 3: COSTING

The CIP costing tool[76] was used to determine the cost of implementing the plan's 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 so cost per year could be estimated. The subsections below summarise the costs of CIP activities, broken down by thematic areas.

Costing Assumptions

Unit costs were gathered from various sources and include standards provided by the MOH, the PFSA, and implementing partners. If specific costs for items were not available (e.g., if an activity has yet to be implemented in Ethiopia), the costing data were drawn from an African regional or international source and noted as such in the costing tool. All cost elements, unit costs, quantities, and frequencies are editable in the costing tool based on changes in the plan.

Contraceptive costs were calculated from 2015 to 2020 using the 2014 Ethiopia Mini-Demographic and Health Survey (EMDHS) results for CPR amongst married women as a baseline for the 2014 method mix. Using the 2020 objective CPR of 55 percent amongst married women, the CPR for each intermediate year between 2014 and 2020 was interpolated. To achieve the 2020 objective, Ethiopia will need to increase the CPR by 2.2 percent annually. The estimated CPR inputs can be updated when the PMA2020 data are released each year to reflect a realistic commodity requirement; the objectives should also be updated if these CPR inputs are changed. The projected method mix for 2020 was calculated in line with the objectives set in the Reproductive Health Strategy (2016–2020) and corresponds with the priority activities within this plan.

Unless otherwise noted, 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. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in U.S. dollars (US$) and converted to local currency. Figure 7 shows the annual cost of contraceptive commodities for each method.

Figure 7: Contraceptive costs per couple-years of protection

Contraceptive Method	Unit Cost (includes .05% for wastage)	Couple-Years of Protection Provided/ (units per year)	Couple-Years of Protection Cost
Pills	$0.30	(5)	$1.50
IUDs IUD consumables	$0.39 $0.47	4.6	$0.19
Injections	$1.25	(4)	$5.00
Male condoms	$0.03	(120)	$4.03
Female condoms	$0.57	(120)	$68.29

Contraceptive Method	Unit Cost (includes .05% for wastage)	Couple-Years of Protection Provided/ (units per year)	Couple-Years of Protection Cost
Female sterilisation consumables	$0.00 $10.45	13	$0.80
Male sterilisation consumables	$0.00 $2.94	13	$0.23
Implants Implant consumables	$8.93 $1.85	2.5	$4.31
Lactation amenorrhoea	n/a	n/a	$0.00
Emergency contraceptive pills	$0.21	(20)	$4.20
Traditional methods	n/a	n/a	$0.00

Costing Summary

The estimated total costs of the plan from 2015–2020 are US$285 million (6.2 billion Ethiopian Birr) (see Figures 8–10).

Overall, US$215 million, or 75 percent of the overall costs, are in commodities, including contraceptives and consumables. Another 4 percent are in DC, 12 percent in service delivery and access, 7 percent in programming for contraceptive security and supply chain management, <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 activity cost per woman of reproductive age is US$0.47 per year, which is significantly lower than the costs in other countries—generally in the US$2–5 range. The lower activity costs in Ethiopia are due largely to the economies of scale generated in conducting national programmes for such a large population, and the government's policies that aim to lower activity costs (e.g., conducting many meetings and training in house and keeping government per diem at US$14 per day). Whereas the activity cost of the Ethiopia CIP is lower than in many other countries, the cost per user for FP commodities is US$4.69—above the range of US$4–4.20 seen in other countries.[77] This disparity is likely due to Ethiopia's method mix, which is heavily skewed towards injectables and costs $4.76 per woman per year for the commodities alone. As Ethiopia moves towards a more balanced method mix with increased uptake of LARCs, the commodity cost per woman of reproductive age will likely increase in the near future due to the higher one-time costs of providing long-term methods but decline over time as those methods provide multiple years of protection.

Figure 8: Summary costs, by thematic areas and total, in millions US$

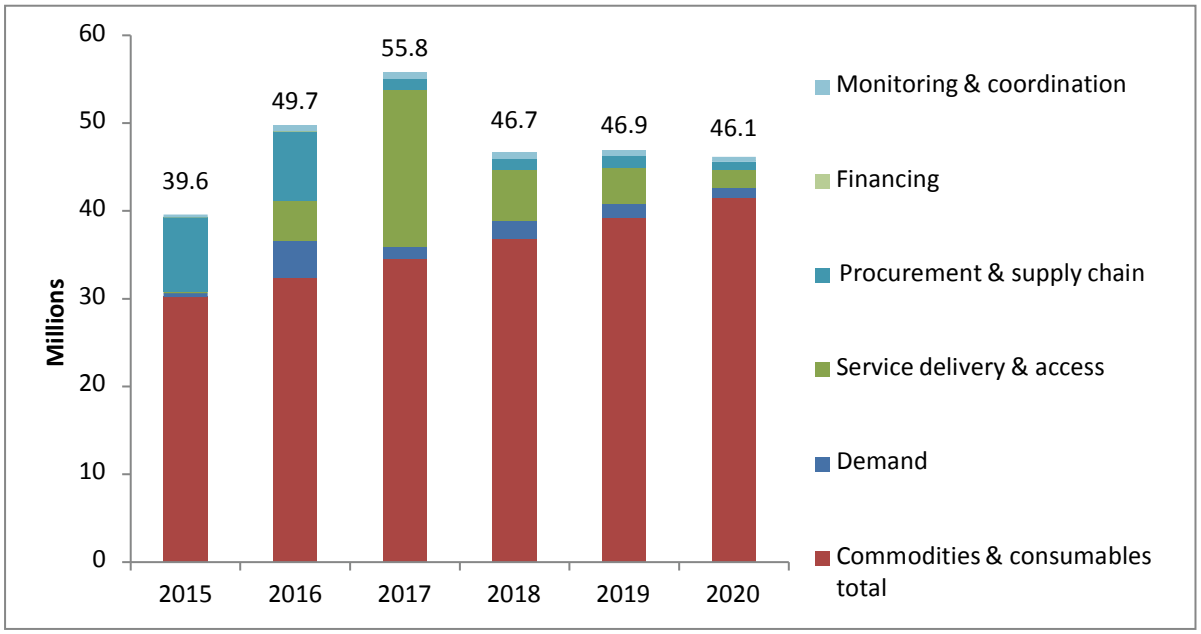
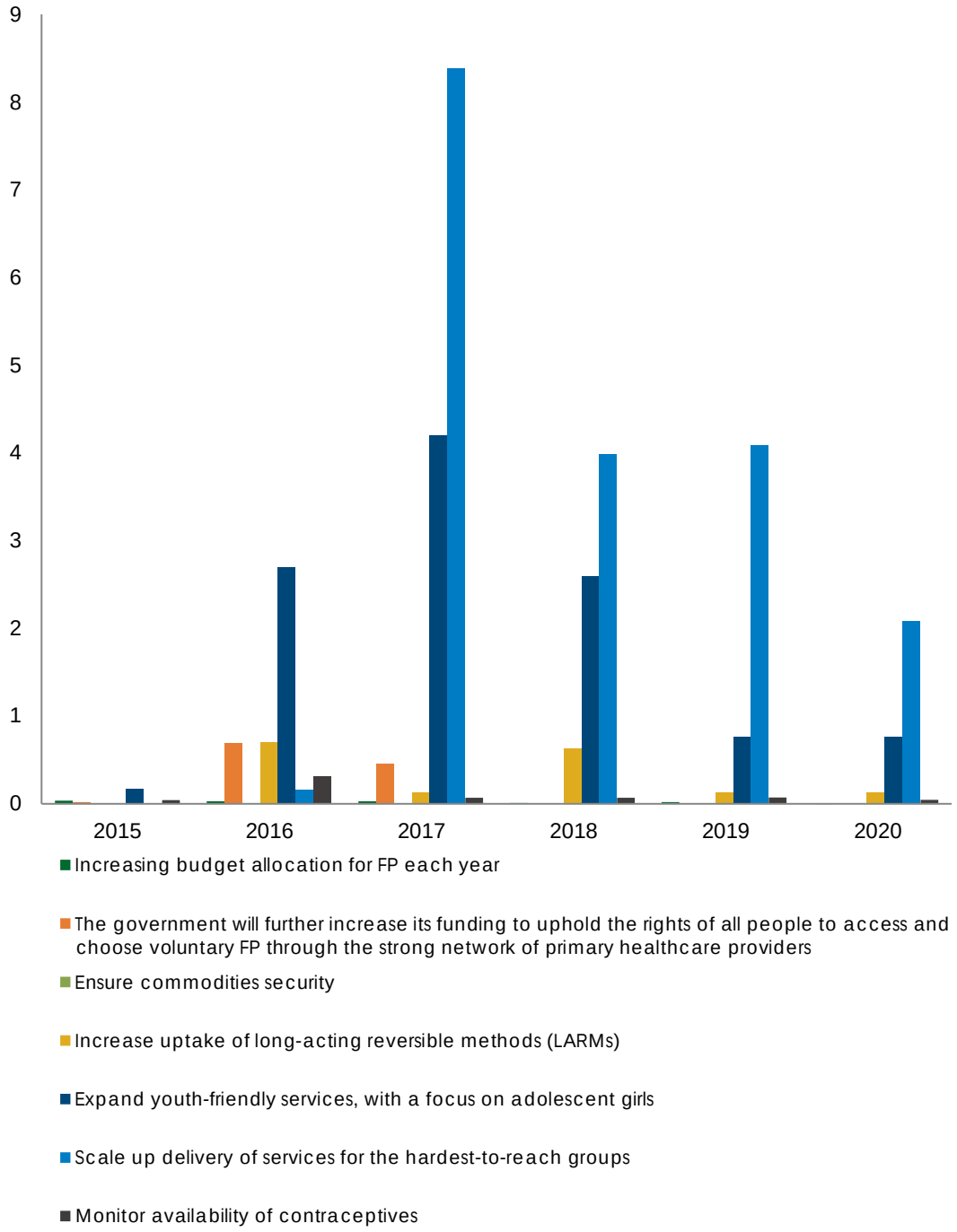


Figure 9: Costs, by category, in millions US$*

	2015	2016	2017	2018	2019	2020	Total
Demand creation	0.4	4.3	1.4	2.0	1.7	1.0	10.9
Service delivery and access	0.1	4.5	17.9	5.8	4.1	2.2	34.7
Contraceptive security (programmes)	8.5	7.9	1.2	1.3	1.3	0.8	21.1
Contraceptive security (commodities and consumables)	30.2	32.3	34.4	36.8	39.2	41.6	214.6
Financing	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Monitoring and coordination	0.2	0.6	0.7	0.7	0.6	0.6	3.4
Total	39.6	49.7	55.8	46.7	46.9	46.1	284.7

*Column totals are not always equal to the sum of the column figures due to rounding.

Figure 10: Costs, by FP2020 commitment, by year, in millions US$



SECTION 4: PROJECTED METHOD MIX AND CONTRACEPTIVE NEEDS

Assumptions

The CIP activities will lead to the attainment of a CPR of 55 percent for all married women in 2020, an mCPR of 54.4 percent amongst married women, and an mCPR of 83.2 percent amongst unmarried sexually active women.[78] This translates to a CPR of 35.2 amongst all women of reproductive age, which will lead to a total of 10 million women users of contraception in 2020.

The method mix for 2020 was projected for the CIP based on baseline data from the 2014 EMDHS and PMA2020, and considers various factors, including availability of infrastructure, provider capacity, activities planned for scale-up, and historical trends. The method mix projections are based on the following assumptions, which were guided by best practices and recommendations made by members of the stakeholder expert groups:

1. The CIP will be fully implemented by the MOH and its partners; it will emphasise reaching under-served populations (e.g., youth, hard-to-reach populations) and creating demand and improving access for LARCs.
2. The method mix changes will consider recommendations of the MOH and stakeholder groups to maintain the widest possible range of method choices.
3. Use of LARCs will increase once they are available at more service delivery points and demand-creation activities for them have begun, with a scale-up of training probable in project activities as indicated in the Reproductive Health Strategy.[79] The greatest rise in LARCs will be for implants, accompanied by an increased demand for IUDs. Moderate increases in female and male sterilisation are projected to occur as these services become more accessible.
4. The method mix quantification for the CIP differs from the projections in the annual national quantification for FP commodities because it is based on variably adjusting CPR method mixes for married and unmarried women. In addition, for the CIP, only male and female condoms were included in the method mix and costed for the amount required for FP usage alone—condoms are not included in this FP costing if women used them, along with another method, to prevent HIV and other sexually transmitted infections.
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—a contraceptive method for use when other primary methods either are not used or fail.

Figure 11 shows the 2014 baseline method mix and the 2020 objective method mix assumptions for married women.[4]

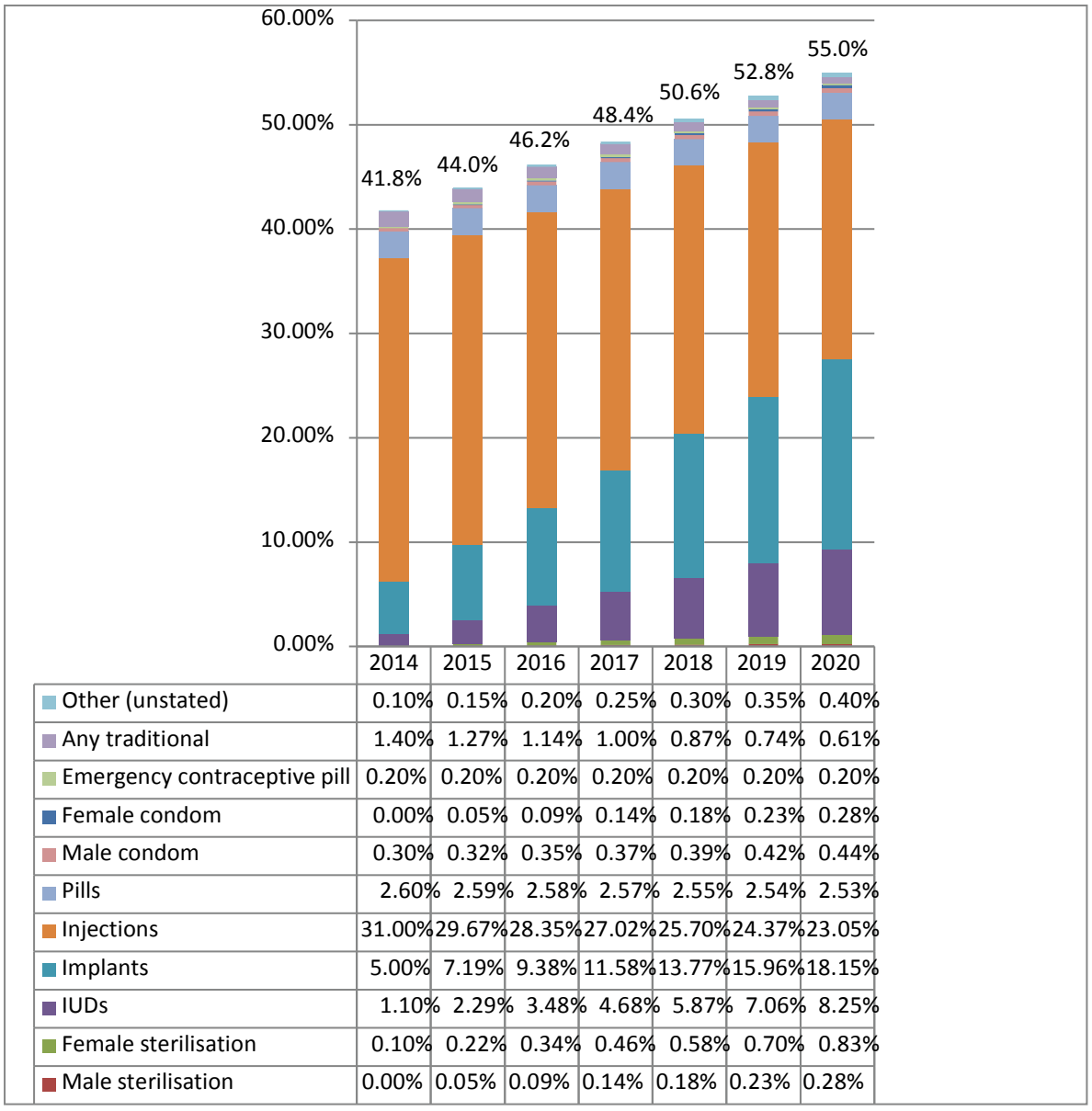
Figure 11: Baseline method mix 2014 and projected method mix 2020, married women

Contraceptive Method	Method Mix	
	2014 Baseline Method Mix[80]	2020 Projections
Pills	6.2%	4.6%
IUDs	2.6%	15.0%
Injections	74.2%	41.9%
Male condoms	0.7%	0.8%
Female condoms	0.0%	0.5%
Female sterilisation	0.2%	1.5%
Male sterilisation	0.0%	0.5%
Implants	12.0%	33.0%
Other modern methods	0.7%	1.1%
Any traditional methods	3.3%	1.1%
CPR, married women	**41.8%**	**55.0%**

Details of the annual method mix, services/commodities, contraceptive prevalence by methods, and demographic and health impacts are shown in the figures below. Standard couple-years of protection conversion factors and standard units needed for one year of use were used for these calculations.[81]

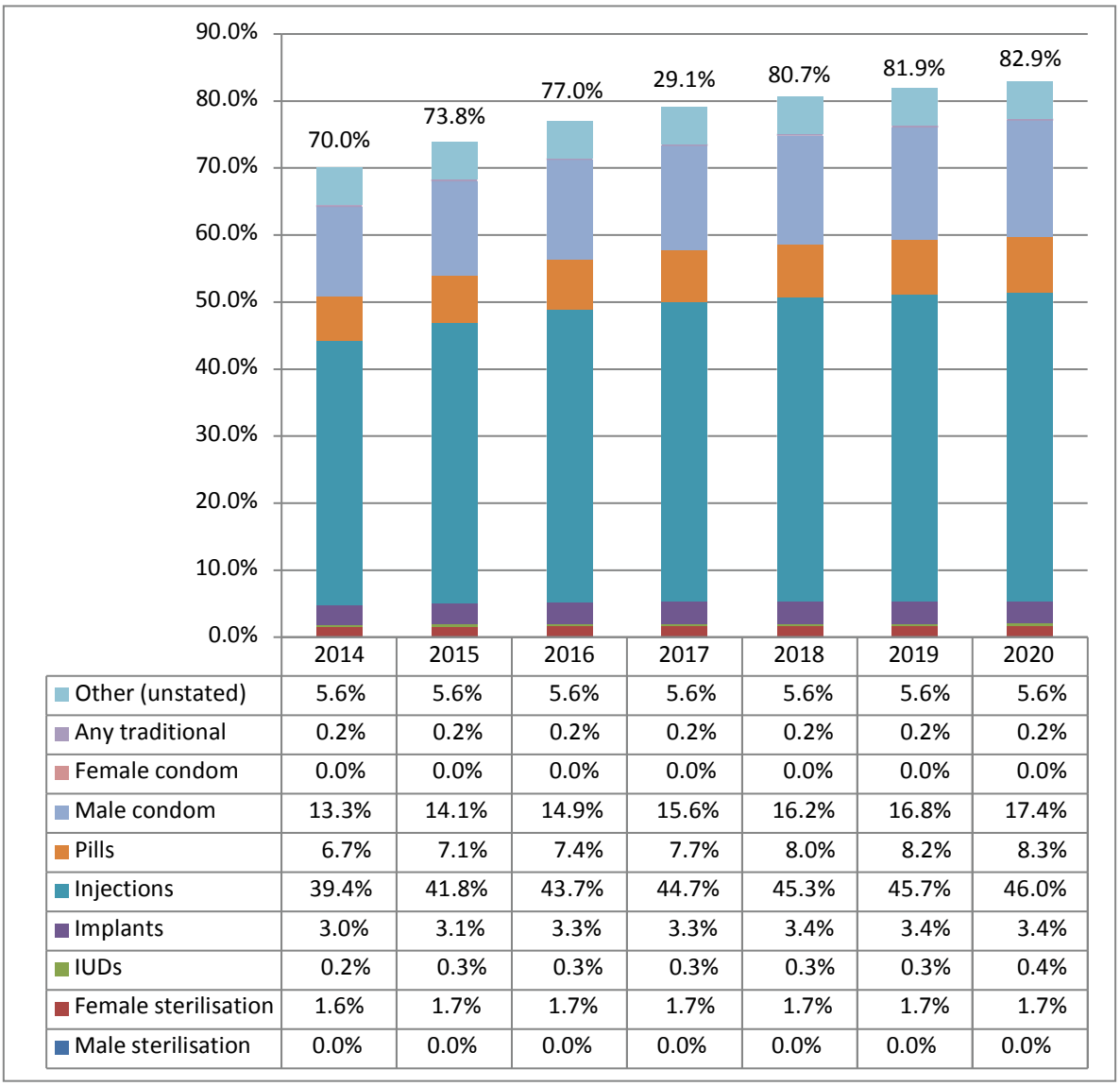
[4] Impacts are calculated based on the CPR objective for married women. The actual impacts of fully implementing the CIP will be slightly higher than what is reported here, due to the resulting increase in contraception use amongst unmarried women in addition to married women.

Figure 12: Contraceptive prevalence by method, married and women in union, 2014 baseline, projected 2015–2020



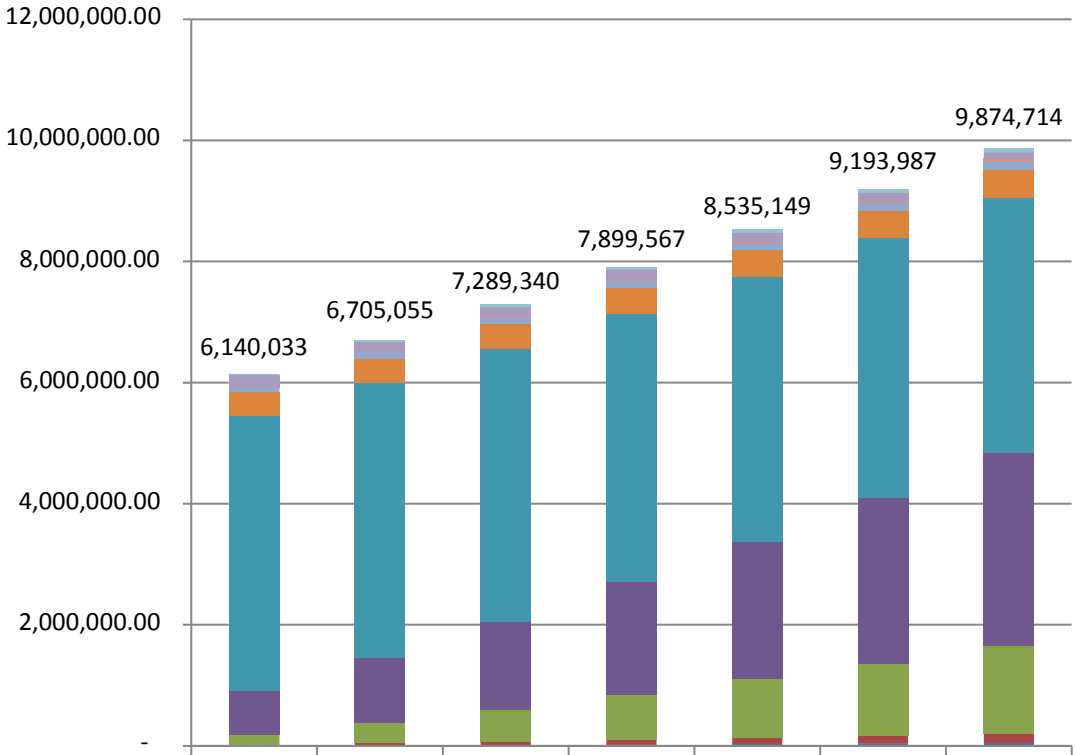
	2014	2015	2016	2017	2018	2019	2020
Other (unstated)	0.10%	0.15%	0.20%	0.25%	0.30%	0.35%	0.40%
Any traditional	1.40%	1.27%	1.14%	1.00%	0.87%	0.74%	0.61%
Emergency contraceptive pill	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%
Female condom	0.00%	0.05%	0.09%	0.14%	0.18%	0.23%	0.28%
Male condom	0.30%	0.32%	0.35%	0.37%	0.39%	0.42%	0.44%
Pills	2.60%	2.59%	2.58%	2.57%	2.55%	2.54%	2.53%
Injections	31.00%	29.67%	28.35%	27.02%	25.70%	24.37%	23.05%
Implants	5.00%	7.19%	9.38%	11.58%	13.77%	15.96%	18.15%
IUDs	1.10%	2.29%	3.48%	4.68%	5.87%	7.06%	8.25%
Female sterilisation	0.10%	0.22%	0.34%	0.46%	0.58%	0.70%	0.83%
Male sterilisation	0.00%	0.05%	0.09%	0.14%	0.18%	0.23%	0.28%

Figure 13: Contraceptive prevalence by method, unmarried sexually active women, 2014 baseline, projected 2015–2020



	2014	2015	2016	2017	2018	2019	2020
Other (unstated)	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
Any traditional	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Female condom	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Male condom	13.3%	14.1%	14.9%	15.6%	16.2%	16.8%	17.4%
Pills	6.7%	7.1%	7.4%	7.7%	8.0%	8.2%	8.3%
Injections	39.4%	41.8%	43.7%	44.7%	45.3%	45.7%	46.0%
Implants	3.0%	3.1%	3.3%	3.3%	3.4%	3.4%	3.4%
IUDs	0.2%	0.3%	0.3%	0.3%	0.3%	0.3%	0.4%
Female sterilisation	1.6%	1.7%	1.7%	1.7%	1.7%	1.7%	1.7%
Male sterilisation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Figure 14: Total FP users, married and unmarried, 2014 baseline, projected 2015–2020



	2014	2015	2016	2017	2018	2019	2020
Other (unstated)	14,332.33	22,293.91	30,773.80	39,805.81	49,391.26	59,519.34	70,178.39
Any traditional	201,332.4	189,088.5	175,371.2	160,376.5	144,015.6	126,222.4	106,977.0
Female condom	-	6,812.03	14,104.66	21,893.19	30,183.55	38,970.99	48,247.64
Male condom	79,709.31	88,414.64	97,344.77	106,592.3	116,117.9	125,870.6	135,811.5
Pills	390,996.7	404,873.1	418,396.8	432,017.6	445,579.5	458,912.7	471,919.8
Injections	4,551,799	4,530,020	4,491,444	4,439,694	4,374,283	4,294,072	4,198,594
Implants	724,774.8	1,077,829	1,453,451	1,853,221	2,277,148	2,724,787	3,195,681
IUDs	158,335.5	341,363.5	536,825.3	745,307.7	966,907.9	1,201,440	1,448,666
Female sterilisation	18,751.41	37,547.17	57,523.43	78,764.56	101,336.6	125,219.6	150,388.8
Male sterilisation	-	6,812.03	14,104.66	21,893.19	30,183.55	38,970.99	48,247.64

Figure 15: Number of FP users per year, projected 2015–2020[82]

	2015	2016	2017	2018	2019	2020
Pills	404,873	418,397	432,018	445,580	458,913	471,920
IUDs	341,364	536,825	745,308	966,908	1,201,441	1,448,667
Injections	4,530,021	4,491,444	4,439,695	4,374,284	4,294072	4,198,595
Male condoms	88,415	97,345	106,592	116,118	125,871	135,812
Female condoms	6,812	14,105	21,893	30,184	38,971	48,248
Female sterilisation	37,547	57,523	78,765	101,337	125,220	150,389
Male sterilisation	6,812	14,105	21,893	30,184	38,971	48,248
Implants	1,077,830	1,453,451	1,853,221	2,277,149	2,724,787	3,195,682
Other modern methods	22,294	30,774	39,806	49,391	59,519	70,178
Any traditional methods	189,089	175,371	160,377	144,016	126,222	106,977
Total	6,705,055	7,289,340	7,899,567	8,535,149	9,193,987	9,874,714

SECTION 5: IMPACT

The ImpactNow model[83] was used to calculate the impacts of increasing the CPR to 55 percent by 2020. These demographic, health, and economic impacts include the following:

- Unintended pregnancies averted
- Abortions averted
- Maternal deaths averted
- Child deaths averted (due to improved birth spacing)
- Healthcare costs saved (in US$)

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 between 2015 and 2020. Additionally, the interventions will lead to saving US$417 million in maternal and infant healthcare costs alone during the six-year plan period.[84]

These 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.[85]

Figure 16 shows the impacts of increases in FP demand, use, and priorities for 2015–2020 in Ethiopia. The numbers are drawn from EMDHS 2014 data and projected outward based on full CIP implementation; they show how the scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health in Ethiopia, and how the improved outcomes will lead to significant cost savings for the health system.

Demographic impacts: "Unintended pregnancies averted" refers to the number of births that will not occur due to the increased use of contraception. Outcomes of these pregnancies include live births, abortions, miscarriages, and stillbirths. The number of pregnancies, including abortions, averted also affects maternal mortality, given that women sometimes die from abortion complications. As the number of abortions declines due to increased FP use and fewer unintended pregnancies, maternal deaths also will decline.[86]

Health impacts: As a result of full CIP implementation, significant numbers of maternal and child deaths will be averted, as well as unsafe abortions, thus contributing to a healthier population.[87]

Economic impacts: "Economic impacts" refers 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.

Figure16: Annual impacts of the CIP

	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	14,855,458
Births averted[5]	1,431,678	1,571,504	1,717,982	1,872,618	2,035,011	2,205,011	10,834,092
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	30,065
Child deaths averted	51,759	56,814	62,110	67,700	73,571	79,728	391,683
Economic impacts							
Maternal and infant healthcare costs saved (US$, millions)	$55.2	$60.5	$66.2	$72.1	$78.4	$85.0	$417.4

[5] Births averted are calculated as a subsection of unintended pregnancies, for which the number of births averted is equal to the number of unintended pregnancies averted, multiplied by the expected number of live births per unintended pregnancy.

SECTION 6: INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

Performance Monitoring and Accountability

Measuring performance against set targets in the CIP is crucial to generating essential information to guide strategic investments and operational planning. Monitoring and evaluation of the CIP will rely on various systems and data sources (routine and periodic), supported and maintained by numerous stakeholders. Soon after the launch of the CIP, the MOH will develop a comprehensive performance monitoring plan and associated monitoring tools.

Service utilisation data will be collected through the HMIS and from the Track20 and PMA2020 initiatives. The MOH and working groups will routinely use the information generated to track progress in mobilising resources and achieving results against set programme targets. This mechanism will help ensure that implementation efforts conform to the plan and the results achieved align with performance targets. Also, process monitoring will allow for corrective and preventive action along the way, including fine tuning of strategies and planning and coordination.

Data will be collected for several categories and levels of indicators. A comprehensive list of output-based indicators is included in the activity matrix in **Figure 17**.

Key performance indicators will hinge on strategic priorities to assess implementation progress and be presented in a dashboard format to provide a snapshot view of the programme's status.

Biannually, the MOH will convene a joint progress review meeting to assess the progress of CIP implementation against targets and agree on priorities for the upcoming period. The RHBs also will attend these meetings to share and discuss progress in their districts. The meetings thus will serve to assess CIP outputs/outcomes as key accountability mechanisms in assessing implementation. The meetings also will involve reviewing the planning and programming process in time to make recommendations for the next annual work planning cycle or long-term strategic planning.

A formal appraisal of CIP implementation will be conducted midway through the plan period to assess progress and areas of preventive or corrective action.

Figure 17: Illustrative list of indicators

Categories	Illustrative Indicators		Data Sources
Demographic indicators	• CPR • mCPR • Percentage distribution of users by modern method • Number of additional FP users • Percentage of women with an unmet need for modern contraception • Percentage of women whose demand is satisfied with a modern method • Couple-years of protection • Unmet need • Teenage pregnancy rate		• Track20, PMA2020, and Ethiopia Demographic and Health Survey (EDHS)
Service statistics	• Number of women receiving counselling or services in family planning—new acceptors and continuing clients • Number of women receiving FP services, by method • Number of products dispensed, by method • Number of youth receiving counselling or services in family planning—new acceptors and continuing clients		• HMIS
Process indicators	Demand creation	• Percentage of non-users that intend to adopt a certain practice in the future • Number of radio and television spots aired • Percentage of audience that recalls hearing or seeing a specific message • Availability of accessible, relevant, and accurate information about SRH, tailored to young men	• Project reports • Programme surveys • EDHS • CIP progress monitoring database
Process indicators	Service delivery and access	• Number of providers trained on family planning, by district • Number of mobile clinic events organised and number of people reached, by district • Number of youth-friendly service clinics established • Availability of accessible, relevant, and accurate information about SRH tailored to young men	• Project reports • Programme surveys • EDHS • CIP progress monitoring database
Process indicators	Procurement and supply chain	• Contraceptive stockouts (national, facility level) • Actual annual expenditure of government funds on contraceptive procurement for the public sector	• Project reports • Programme surveys • EDHS

Categories		Illustrative Indicators	Data Sources
		• Percentage of facilities that experienced a stockout at any point during a given time period • Occurrence of stockouts for any contraceptive or other identified reproductive health commodity at the central-level warehouse during a specified time period • Number of facility staff reporting on contraceptive commodity distribution	• CIP progress monitoring database
Process indicators	Monitoring and coordination	• Evidence of FP programmes incorporated into national strategic and development plans • Evidence of documented improvement in the enabling environment for family planning, using a validated instrument (e.g., the Family Planning Programme Effort Index and Contraceptive Security Index) • Evidence of targeted public and private sector officials, faith-based organisations, or community leaders publicly demonstrating a new or increased commitment to family planning • Documentation of instances in which an operational directive or plan is issued to accompany a national or subnational FP policy • Evidence of multisectoral structures established or strengthened to promote FP policy • Evidence of data or information used to support repositioning of FP efforts • Evidence of government departments or other entities established or strengthened to support the FP agenda	• Project reports • Programme surveys • EDHS • CIP progress monitoring database
Process indicators	Financing	• Annual expenditure on family planning from government domestic budget • Evidence of new financing mechanisms for family planning identified and tested • Evidence of private for-profit sector participation in family planning • Share of contraceptive procurement for the public sector financed by the government	• Project reports • Programme surveys • EDHS • CIP progress monitoring database

ANNEX A: IMPLEMENTATION FRAMEWORK WITH FULL ACTIVITY DETAIL

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
Clear BCC strategy based on data is lacking	DC1. Increase awareness of different FP methods and how to access them by developing and executing a comprehensive BCC strategy tailored to specific target groups and addressing cross-cutting issues	DC1.1 Compile and review existing research on communication messages to different target groups	DC1.1.1 Define (MOH) the target groups and cross-cutting areas to focus the strategy, in consultation with FP TWG	• 1 half-day FP TWG meeting to define the strategy scope o @ MOH o 15 people each o Printing: 5 pages per person	• BCC strategy scope defined	2015
			DC1.1.2 Obtain input from RHBs on messaging that works in their regions	• MOH to conduct 1-hour meetings with FP focal points in each region on messaging that will be accepted by local communities	• MOH meetings with regional FP focal points held (target: 11)	2015
			DC1.1.3 Review existing documentation	• MOH to identify individual or partner to conduct literature review and RHB interviews, and summarise results • 1 federal FP TWG meeting to report back o @ MOH o 15 people each o Printing: 5 pages per person	• Summary report on existing research on BCC	2015
		DC1.2 Develop key messages for a tailored communications strategy	DC1.2.1 Develop key communication messages	• MOH to identify individual or partner • 10 pilot tests of communication messages (2 per target group; 5 target groups) o @ location convenient to participants	• Key messages developed (target: 10)	2015

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
				o 8 people per pilot o Tea breaks o Transport refund • 1 two-hour stakeholder validation workshop o @ MOH o 15 people o Transport refund o Printing: 5 pages per person		
			DC1.2.2 Develop a communications strategy for selected target groups based on the developed messages	• MOH to delegate individual or partner organisation • 1 two-hour validation workshop o @ MOH o 15 people o Transport refund o Printing: 5 pages per person	• Communications strategy developed	2015
			DC1.2.3 Print and disseminate strategy	• Printing: 40-page communications strategy • 1 two-hour dissemination meeting o @ hotel in Addis o 100 people o Transport refund o Printing: 5 pages per person	• Communications strategy printed (target: 500) • Dissemination meeting held	2015
Although awareness of family planning	DC2. Increase awareness and demand for the	DC2.1 Develop and implement an FP mass media	DC2.1.1 Develop FP radio spots	• MOH to delegate individual or partner organisation	• Radio spots developed (target: 5)	2015 2018

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
in general is high, knowledge of the various FP options—specifically long-term methods—is low	use of family planning, especially LARCs	campaign based on the new communications strategy and its updated message guide		• Develop five 30-second radio ads (1 per target group) • 1 two-hour validation workshop: o @ hotel in Addis o 15 people o Printing: 5 pages per person		
			DC2.1.2 Develop a 117-episode FP radio soap opera (4.5-year broadcast, with episodes produced annually over 2 months)	• Hire a production firm for 2 months annually • 3 one-day advisory committee meetings to guide the soap opera's development o @ hotel in Addis o 20 people each o Lunch and tea breaks o Transport refund o Printing: 50 pages per person	• Radio soap opera developed (target: 26 episodes per year)	2015 2016 2017 2018 2019
			DC2.1.3 Develop 5 FP videos targeting youth	• Hire a production firm for 3 months to develop the video • 2 one-day advisory committee meetings to identify 5 priority messages to be highlighted in the video o @ hotel in Addis o 20 people each o Lunch and tea breaks o Transport refund o Printing: 10 pages per person	• FP videos developed (target: 5)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			DC2.1.4 Buy media space for FP messages	• Buy space for each radio ad o National and 3 major regional radio stations o Each ad plays 3 times a week o Quarterly purchase • Buy 117 one-hour radio spots to run the radio soap opera o National and 3 major regional radio stations o Each hour plays once every 2 weeks • Buy time to host quarterly discussions on television and radio, including call-in discussions with satisfied users	• Radio airtime purchased (target: 4 stations for 5 radio spots; 26 one-hour spots per year)	2016 2017 2018 2019 2020
			DC2.1.5 Promote the radio soap opera	• Run radio ads for the soap opera • Purchase marketing materials for each region, such as hats, shirts, and banners • Distribute marketing materials in conjunction with other health events	• Radio airtime purchased (target: 100 30-second spots) • Marketing materials purchased (target: 300 hats, 300 shirts, and 10 banners)	2016 2017 2018 2019
			DC2.1.6 Orient national and regional radio and television presenters, and health	• 1 one-day orientation workshop o @ hotel in Addis o 50 people o Lunch and tea breaks	• Workshops held (target: 2)	2015 2018

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			topic journalists on selected FP themes	o Transport refund o Printing: 5 pages per person		
			DC2.1.7 Review uptake of FP message in year 3 and refine radio soap operas accordingly	• MOH to delegate individual or partner organisation • 1 two-hour validation workshop o @ hotel in Addis o 15 people o Transport refund o Printing: 5 pages per person	• Revised FP message	2018
		DC2.2 Visually advertise the advantages of LARCs	DC2.2.1 Develop community posters and billboards	• MOH to delegate individual or partner organisation • Work with RHBs to develop 1 poster and 1 billboard per region	• Community posters and billboards developed (target: 22)	2016 2018
			DC2.2.2 Install posters and billboards in the community	• Install 10 billboards per region • Hang 250 posters per region • Hire 3 community workers to hang signs	• Billboards set up (target: 220) • Posters printed (target: 5,500)	2016 2018

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
		DC2.3 Utilise mobile platforms for FP outreach and information distribution	DC2.3.1 Adapt available SMS platform that provides FP information, addresses myths and misconceptions through tips and stories, and shows where FP services can be accessed in Ethiopia	• Reconfigure available SMS platform database to Ethiopian context • Secure an SMS code for Ethiopia and a platform manager • Set up a free hotline service for clients' questions/concerns related to contraceptives • Hire call centre staff for the hotline	• SMS platform set up (target: 1) • FP hotline developed (target: 1) • FP hotline staff hired (target: 5)	2016 2017 2018 2019 2020
			DC2.3.2 Advertise the SMS platform, with a special focus on youth	• Print 200 posters per region • Hang posters, especially in facilities and universities	• Posters printed and distributed (target: 2,200)	2016
			DC2.3.3 Train peer educators and HEWs on SMS platform use	• Hold 1meeting per district o @ location convenient to participants o 20 people per meeting o Refreshments o Transport refund	• Peer educators and HEWs trained on SMS platform (target: 16,340)	2016
		DC2.4 Use health facility as a key information source	DC2.4.1 Ensure that health facilities have the leaflets and posters on family planning	• Print FP information leaflets and posters for health facilities • Use supportive supervision visits to replenish leaflets at health facilities	• Leaflets and posters distributed (target: 6,000 posters and 12,000 leaflets)	2016 2018 2020
		DC2.5 Leverage existing outreach	DC2.5.1 Develop tools for HDAs and HEWs to	• MOH to assign staff or partner to develop tool	• Potential FP client	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
		models—HDAs, HEWs, and peer educators—and special events to educate the community about the benefits of LARCs	identify potential FP clients	• 1 half-day tool vetting meeting o @ MOH o 20 people o Lunch and tea breaks o Printing: 10 pages per person	assessment tool developed	
			DC2.5.2 Orient HEW supervisors on communications strategies for LARCs	• 1 half-day orientation per region o @ RHB o 20 people o Lunch and tea breaks o Transport refund o Printing: 10 pages per person	• Regional meetings held (target: 11)	2016
			DC2.5.3 Provide support to HEWs and HDAs to conduct monthly meetings and community outreach efforts	• Print information, education, and communication leaflets, and distribute through HEW/HDA system	• Information, education, and communication leaflets printed and distributed (target: 16,340)	2016
			DC2.5.4 Provide sensitisation to peer educators about long-acting methods and referral services	• LARC sensitisation will be conducted as part of larger outreach to peer educators	• Peer educators educated on LARCs (target: 2,000)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			DC2.5.5 Conduct annual FP community outreach events	• 1-day community outreach event in each district o @ central location in district o 10–15 people per outreach event o Refreshments o Mobilisation fee for outreach staff o Transport refund for outreach staff o Airtime for outreach staff	• Community outreach events (target: 4,085)	2016 2017 2018 2019 2020
Youth (ages 15–19) have limited knowledge of family planning and sexual and reproductive health	DC3. Increase the awareness of and demand for FP services amongst both in- and out-of-school youth	DC3.1 Engage peers, with emphasis on college students, to educate young people about rights-based family planning	DC3.1.1 Work with local nongovernmental organisations (NGOs)and their peer educators to train them on family planning so they can become advocates	• 1 five-day camp per region o @ youth centres in regions o 50 people per region o Transport for young people o Printing: 10 pages per person	• Peer educators trained (target: 550)	2015
			DC3.1.2 Support peer educators	• Monthly stipends o 11 regions o 50 stipends per region	• Peer educators supported (target: 550)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
		DC3.2 Create communication materials and outreach opportunities targeting youth	DC3.2.1 Publish (MOH) annual youth magazine that describes youth FP activities that have or are going to occur throughout the year	• Hire 1 writer and 1 designer for 10 days each to write and design the magazine • Print the 20-page magazine • Distribute to youth centres, peer educators	• Youth magazine printed and distributed (target: 25,000)	2016 2017 2018 2019 2020
			DC3.2.2 Produce (MOH) youth FP pull-outs to be put in newspapers	• Hire 1 writer and 1 designer for 10 days to write and design the pull-out • Purchase newspaper space once a week for 4 weeks per year	• Pull-out placed into newspaper (target: 20)	2016 2017 2018 2019 2020
			DC3.2.3 Use (MOH) flyers and posters targeting university students on the importance of avoiding, delaying, and spacing pregnancy, and on FP methods	• Hire marketing firm for 30 days to develop flyers and posters • Print flyers and posters, and post and distribute in universities	• Flyers and posters distributed at universities (target: 11,000)	2016 2017 2018 2019 2020
			DC3.2.4 Host "edutainment" community events at youth centres—such as dances, music concerts, sport competitions—to provide opportunity for knowledge	• 4 events per year per region o @ youth centres in region o 2 staff per region o Per diem o Transport refund o Tent rental	• Community events held (target: 4,620)	2015 2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			exchange amongst young people	o Facilitating entertainment group/person o Showing of FP videos targeting young people (developed under activity DC2.1.3)		
		DC3.3 Collaborate (MOH and MOE) to build the capacity of parents, caregivers, and teachers to help their children avoid teen pregnancy, including improving parent-child communication on sexual issues	DC3.3.1 Develop parent and teacher training materials in collaboration with the MOE	• MOH and MOE to identify individual or partner to develop training materials • 1 one-day validation meeting o @ MOH o 20 people o Tea and lunch o Printing: 20 pages per person	• Parent and teacher training materials developed	2016
			DC3.3.2 Print parent and teacher training materials	• Print the 50-page training materials for regional workshops	• Training materials printed (target: 2,200)	2016
			DC3.3.3 Conduct workshops with teachers and parents to orient them on how best to talk to youth about family planning	• 5 half-day workshops per region o @ schools in region o 50 people in each region o Refreshments o Travel refund o Facilitator per diem o Printing: 10 pages per person	• Teachers and parents trained (target: 550)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			DC3.3.4 Hold community dialogues about how parents can best communicate with their children about sexual education	• 5 two-hour meetings per region per year o @ schools in region o 30 parents at each workshop o Refreshments o Transport refund o Facilitator per diem o Printing: 10 pages per parent	• Parents engaged (target: 8,250)	2016 2017 2018 2019 2020
			DC3.3.5 Hold discussion forums on TV and radio about how parents can best communicate with their children about sexual education	• Purchase 5-minute airtime on TV and radio o One national TV station o One national and 3 regional radio stations o Quarterly • Develop an issue brief for TV and radio hosts	• Television and radio ads distributed (target: 80 radio and 20 television spots)	2016 2017 2018 2019 2020
			DC3.3.6 Work with Schools for Husbands initiative to teach husbands how best to communicate with their children about sexual education	• 4 two-hour workshops per region per quarter o 15 husbands at each meeting o Refreshments o Transport refund o Facilitator per diem o Printing: 2 pages per person	• Husbands engaged (target: 13,200)	2016 2017 2018 2019 2020
Currently, low engagement with community	DC4. Establish and sustain engagement with	DC4.1 Identify national- and community-level	DC4.1.1 Hold awareness-raising	• 2 half-day regional meetings bringing together local community leaders	• Community leaders engaged in	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
and religious leaders who have the ability to promote family planning within the community	national- and community-level advocates of family planning, including traditional and religious leaders	advocates on family planning	events with community leaders	o @ RHBs o 50 community leaders o Lunch and tea breaks o Transport refund o Printing: 2 pages per person	family planning (target: 550)	
			DC4.1.2 Identify FP champions in the community through continued engagement	• 2 half-day regional meetings to address myths and misconceptions, link family planning to religious beliefs, and build a common understanding of family planning	• Champions identified (target: 330)	2016
		DC4.2 Develop a package to guide recruitment, orientation, and monitoring of FP champions	DC4.2.1 Develop an FP champion package	• MOH to identify individual or consultant to lead development of champions • 2 half-day stakeholder meetings o @ offices in Addis o 10 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• FP champion package developed	2016
			DC4.2.2 Disseminate package	• Print the 20-page package • Disseminate regionally o @ RHBs o 30 people o Transport refund o Printing: 5 pages per person	• FP champion package printed and disseminated (target: 550)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			DC4.2.3 Provide support and recognize efforts of regional champions	• Purchase t-shirts and provide certificates for 30 champions per region • Hold annual regional knowledge-sharing meetings o @ RHBs o 30 people o Transport refund o Printing: 5 pages per person	• FP champion jackets distributed (target: 330) • FP champion meetings held (target: 55)	2016 2017 2018 2019 2020
		DC4.3 Engage cultural, religious, and community leaders already working in health to integrate family planning into their work	DC4.3.1 Orient/sensitise community leaders working on HIV, gender-based violence (GBV), and maternal health to include family planning in their current health work	• Hold 1-day workshops regionally o @ RHBs o 50 people o Lunch and tea breaks o Transport refund o Printing: 20 pages per person	• Community leaders working in health oriented on family planning (target: 550)	2016 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
FP acceptance by the household and community is low due to lack of engagement of husbands and fathers (male heads of household)	DC5. Increase male engagement in FP issues	DC5.1 Conduct community outreach events to engage men in family planning	DC5.1.1 Conduct Special Men's Day programmes in each region	• Hold Special Men's Day per region • Purchase 30-second ad radio airtime on 1 national and 3 regional radio stations to air 3 times a day for 2 weeks before the event • Hire a marketing firm for 10 days to develop and print advertising posters • Purchase promotional materials (e.g., pens, bags) • Print 1-page info flyers	• Radio ads aired (target: 840) • Posters printed and distributed (target: 11,000) • Promotional materials distributed (11,000 pens and bags) • Info flyers printed and distributed (target: 55,000)	2016 2017 2018 2019 2020
		DC5.2 Select and train male role models to act as community leaders to guide group education sessions for men, including discussion sessions on participatory methods, community outreach, and mobilisation	DC5.2.1 Develop selection criteria, training curricula, and group leader guidance for male role model programme	• MOH to identify staff or consultant • Hold 2 one-day meetings to develop selection criteria for male role models and approve training curricula and group leader guidance documents for male role model programme: o @ hotel in Addis o 20 people o Transport refund o Printing: 5 pages per person • Printing: 1,100 copies of 100-page finalised training curricula and group leader guidance documents	• Training curricula and group leader guidance documents developed • Training curricula and group leader guidance documents printed (target: 1,100)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
			DC5.2.2 Select male role models and train them to lead group education sessions for men at the community level	• RHBs, with *Woreda* and *Kebele* staff and HEWs, select 100 male role models per region to lead group education sessions at the community level • Hold 4 sets of 1-week training sessions per region to train male role models o @ convenient location for participants o 25 participants per session o Transport refund o Per diem o Printing: 5 pages per person • Hold 4 sets of 2-day refresher training sessions per region every 3 years o @ convenient location for participants o 25 participants per session o Transport refund o Per diem o Printing: 5 pages per person	• Number of male role models trained (target: 1,100) • Number of active men's groups at the community level (target: 550)	2016 2019
Women, especially in rural areas and emerging regions, are not empowered within the	DC6. Build capacity of women to ensure they are knowledgeable of their rights for making FP	DC6.1 Advocate with implementing partners to integrate family planning into other women's empowerment	DC6.1.1 Hold a series of meetings with implementing partners	• Hold semi-annual half-day meetings o @ MOH o 40 people o Lunch and tea breaks o Printing: 5 pages per person	• Meetings with implementing partners held (target: 10)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 1: Demand Creation (DC)						
community and do not feel they have enough knowledge to make an informed and accepted choice about family planning	decisions and empowered to act on them	areas, including microfinance				
		DC6.2 Engage women at the community level through the "Satisfied Health Development Army"	DC6.2.1Engage HDAs on the topic of women's empowerment and family planning regionally	• This activity will be integrated with DC2.5.1	• HDAs engaged on women's empowerment and family planning (target: 16,340)	2015
		DC6.3 Conduct a mass media campaign about the rights women have to make decisions about family planning	DC6.3.1 Develop radio commercials on women's FP rights	• Hire a marketing firm to develop four 30-second radio spots • 2 half-day stakeholder meetings o @ MOH o 40 people o Printing: 5 pages per person	• Radio spots developed (target: 4)	2015
			DC6.3.2 Purchase airtime for radio ads on women's FP rights	• Purchase 30-second radio ad space o Nationally and 3 major regional stations o 4 times a week o Purchased quarterly	• Radio spots aired (target: 6,656)	2016 2017

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
Limited access to a full spectrum of method mix, especially long-term methods, due to causes such as lack of adequately trained staff and access to appropriate level of health service	SDA1. Increase the number of trained health providers at all levels to provide the full spectrum of rights-based FP services	SDA1.1 Scale up training for service providers (nurses, midwives, doctors, and health officers) on FP methods, with a focus on next-generation implants	SDA1.1.1 Conduct training-of-trainers (TOT) on a rights-based approach to the full spectrum of FP methods, with emphasis on counselling and long-acting and permanent methods	• 1 two-day TOT per region o @ hotel in region o 10 trainers per region o Lunch and tea breaks o Transport refund o Per diem o Printing: 50 pages per person o Master trainer allowance and travel	• Trainers trained (target: 110)	2015
			SDA1.1.2 Conduct training of nurses and midwives on a rights-based approach to the full spectrum of FP methods, with emphasis on counselling and long-acting methods	• 4 one-day monthly trainings per region o @ location convenient for participants o 25 participants per training o Lunch and tea breaks o Transport refund for participants o Transport refund for trainers	• Nurses and midwives trained (target: 26,400)	2016 2017
			SDA1.1.3 Conduct training of physicians and health officers on a rights-based approach to the full spectrum of FP methods, with emphasis on counselling and long-acting methods	• 1 two-day monthly training per region (or as many as necessary to retrain the service providers every 5 years) o @ location convenient for participants o 25 participants per training o Lunch and tea breaks o Transport refund for participants o Transport refund for trainers	• Doctors and health officers trained (target: 3,300)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
	SDA2. Strengthen the referral system to streamline and simplify the process for women to access higher-level health facilities for FP services	SDA2.1 Institutionalise use of FP referral and feedback forms for providers who receive referred patients to update the referring facilities	SDA2.2.1 Increase awareness of the appropriate use of referral and feedback forms	• MOH to assign individual or partner to develop handout/guide on the appropriate use of referral and feedback forms • Print one for each facility • RHB- and *Woreda*-level health officers use periodic visits as an opportunity to distribute handouts and train staff on appropriate use of referral and feedback forms	• Referral and feedback form guide printed and distributed (target: 20,000)	2015
Lack of services available/lack of project resources targeted towards emerging regions	SDA3. Increase availability of high-quality, rights-based FP services in emerging regions	SDA3.1 Operationalise policies to increase the number of health workers providing LARCs, with a focus on emerging regions	SDA3.1.1 Conduct TOT for community health workers on implants	• Combined with activity SDA1.1.1	• Trainers trained (target: 110)	2015
			SDA3.1.2 Train HEWs	• 1 one-day monthly training per emerging region o @ location convenient for HEWs o 25 HEWs per training o Lunch and tea breaks o Transport refund for participants o Transport refund for trainers	• HEWs trained (target: 600)	2016
		SDA3.2 Scale up integrated service mobile clinics, a low-cost service delivery model to reach communities in emerging regions	SDA3.2.1 Review effectiveness of mobile clinics	• 2 all-day national review meetings (mid-point and final review): o @ hotel in Addis o 50 people o Lunch and tea breaks o Transport refund o Printing: 10 pages per person	• Review meetings held (target: 2)	2015
			SDA3.2.2 Publicise mobile clinics	• Produce one 30-second radio spot	• Radio ads for mobile	2016 2017

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
				o Hire a marketing firm for 60 days • Purchase radio airtime o 3 times per day, 2 weeks per month before and during the week the team is going into the community	clinics aired (target: 504)	2018 2019 2020
			SDA3.2.3 Scale up mobile clinics to all applicable regions	• Weekly outreach at 45 "routes" (5 routes for each of the 9 regions) o 2 service providers per 5 locations o 1 vehicle o 1 driver per vehicle o 2 equipment bags o 2 tents o 2 collapsible tables per region	• Communities reached through mobile clinics (target: 450)	2016 2017 2018 2019 2020
Low quality of service in areas such as counselling (limits informed choice) and privacy	SDA4. Increase quality of rights-based FP services, especially in the areas of counselling, privacy, and informed choice	SDA4.1 Retrain service providers on appropriate counselling techniques that appreciate privacy and informed choice	SDA4.1.1 Include counselling as part of the FP training (SDA1.1) to ensure a rights-based approach to FP service provision and counselling	• Combined with activity SDA1.1	• Healthcare providers trained (target: 3,631 doctors and health officers; 16,753 nurses and midwives; 600 HEWs)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
		SDA4.2 Ensure that high-quality services can be sustained by institutionalising quality assurance teams and tools	SDA4.2.1 Develop tools and guides for quality assurance	• MOH to assign staff or partner to develop tools and guidelines • 1 all-day review meeting o @ MOH o 25 people o Lunch and tea breaks o Printing: 10 pages per person	• Quality assurance tools, guidelines, posters, etc. developed	2016
			SDA4.2.2 Distribute and train staff on tools and guides	• Combined with activity SDA1.1	• Healthcare providers trained (target: 3,631 doctors and health officers; 16,753 nurses and midwives; 600 HEWs)	2016
		SDA4.3 Make capital investments to improve privacy for FP service provision	SDA4.3.1 Refurbish or reorganise FP service provision sites so there are at least two private rooms for FP services (one for counselling, another for conducting FP procedures)	• MOH to work with RHBs to assess which facilities need to be renovated • Prioritise renovation based on regions and *Woredas* that lack sites meeting national standards • Renovate facilities over the course of 2 years	• Health facilities renovated (target: 800)	2016 2017

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
Lack of integration with RMNCH services, such as antenatal care, postpartum and post-abortion contraception, as well as integration of family planning with prevention of mother-to-child transmission of HIV and immunisation	SDA5. Increase FP uptake by increasing opportunities for women to access FP services through RMNCH service integration	SDA5.1 Orient nurses and midwives on the integration of family planning with other services, such as antenatal care and delivery services	SDA5.1.1 Develop a service delivery integration guideline	• MOH to assign an individual or partner to develop the integration guideline • 2 one-day guideline development meetings (development and review) o @ hotel in Addis o 20 stakeholders o Lunch and tea breaks o Transport refund o Printing: 20 pages per person	• Service delivery integration guideline developed	2016
			SDA5.1.2 Train nurses and midwives on protocols and FP service delivery, including postpartum contraception	• Combine with activity SDA1.1.2	• Nurses and midwives trained (target: 16,753)	2016 2017
			SDA5.1.3 Increase awareness of RMNCH focal points on FP integration	• MOH to facilitate and support communication between the FP focal point and other RMNCH focal points at the regional level to follow up on the integration of FP services into other health services	• Connection between FP and RMNCH focal points strengthened	2016 2017 2018 2019 2020
Need more youth-friendly facilities and services; missed opportunities for integration with life-skills building	SDA6. Increase the number of FP service access points for youth	SDA6.1 Ensure that youth centre staff are informed about how to talk about family planning and are able to refer youth to the full	SDA6.1.1 Educate youth centre staff on SRH for youth, available FP options, and referral mechanisms	• 1 two-day training per region o @ hotel in region o 20 youth centre staff o Lunch and tea breaks o Transport refund o Printing: 100 pages per person	• Youth centre staff trained (target: 220)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
projects, youth centres, and universities		spectrum of FP services	SDA6.1.2 Facilitate relationship building between youth centre staff and referral health facility staff	• Have health centre staff make quarterly visits to youth centres	• Youth centres visited by health workers (target: 110)	2016 2017 2018 2019 2020
		SDA6.2 Establish youth-friendly corners in every hospital, health centre, and health post	SDA6.2.1 Build youth-friendly physical space in health facility	• MOH to work with RHBs to assess which facilities need to be renovated • Renovate space in health centres • For each youth corner: o Desk o Television and DVD player o 15 chairs	• Youth-friendly corners constructed (target: 800)	2016 2017 2018
			SDA6.2.2 Train trainers on youth-friendly services	• 1 two-day TOT per region every 2 years o @ hotel in region o 10 trainers per region o Lunch and tea breaks o Transport refund o Per diem o Printing: 10 pages per person	• Trainers trained (target: 330)	2016 2018 2020
			SDA6.2.3 Train health workers on youth-friendly services	• 4 one-day trainings per region every 2 years o @ hospital in region o 2 healthcare workers from each facility; 40 people per training o Lunch and tea breaks	• Health workers trained (target: 4,800)	2016 2018 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
				o Transport refund o Printing: 10 pages per person		
		SDA6.3 Ensure that campus health centres have trained staff and materials to offer a full spectrum of FP services	SDA6.3.1 Advocate to the private colleges and MOE to include the full spectrum of FP methods in university health clinics	• 3 small group meetings o @ ministry or college o 5 people o Printing: 5 pages per person • 1 half-day advocacy meeting targeting decisionmakers o @ hotel in Addis o 50 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Advocacy meetings held (target: 4)	2016
Private sector's potential to deliver FP services is hampered by lack of skill to provide the full spectrum of high-quality services	SDA7. Increase the number of private sector providers who can provide the full spectrum of high-quality FP services	SDA7.1 Train private providers on FP services, based on skills they lack and focus on geographical areas where private sector potential is yet to be maximised	SDA7.1 Conduct a national private sector service provision assessment	• MOH to assign staff or partner to conduct assessment • Conduct assessment, including key informant interviews with regional and local staff and private sector provider focus groups • 2 half-day meetings (vetting and dissemination) o @ hotel in Addis o 50 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Private sector landscape assessed	2015

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 2: Service Delivery and Access (SDA)						
			SDA7.2 Using the FP training materials and trainers from SDA1.1, train private providers	• Conduct one-day quarterly trainings per region every year o @ location convenient for participants o 25 participants per training o Lunch and tea breaks o Transport refund for participants o Transport refund for trainers • Conduct semi-annual refresher trainings from year 3 o @ location convenient for participants o 25 participants per training o Lunch and tea breaks o Transport refund for participants o Transport refund for trainers	• Private providers trained (target: 4,950)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
Commodity logistics management capacity at the national and local levels is low, causing stockouts at service delivery points	PSC1.Conduct annual quantification of contraceptive commodities and supplies	PSC1.1 Quantify, forecast, and procure FP commodities and consumables (for IUDs, implants, tubal ligations, etc.) annually	PSC1.1.1 Prepare data for annual forecast	• Hire a consultant for 30 days to review current stocks; collect service and purchase estimates from all partners, including NGOs and private facilities sourced through the PFSA; and review planned activities that may impact FP uptake, e.g., training or outreach campaigns	• Commodity and consumable data generated	2015 2016 2017 2018 2019
			PSC1.1.2 Forecast annual FP needs, including service provision by the private sector, in consultation with PFSA and FMHACA	• 1 two-day annual meeting to review annual contraceptive and consumable needs o @ hotel in Addis o 40 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Commodity and consumable needs identified	2015 2016 2017 2018 2019
			PSC1.1.3 Ensure budget availability to meet forecasted FP needs	• 1 one-day annual meeting to confirm budget line with MOH and budget supplement from partners o @ MOH o 25 people o Lunch and tea breaks • Prepare proposals for alternative funding sources and contributions	• MOH and supplement budget clarified • Alternative funding proposals developed	2015 2016 2017 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
			PSC1.1.4 Review current contraceptives and consumables stock status and predicted needs; identify any commodities that may be low in stock and are urgently needed to arrive; remind partners responsible for them	• 3 one-day stock status meetings per year o @ hotel in Addis o 40 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person • Further follow-up with partners, as needed, to ensure orders or additional financing	• Stock status assessed (target: 15)	2015 2016 2017 2018 2019 2020
			PSC1.1.5 Procure FP commodities and consumables	• Procure commodities and consumables based on the finalised annual commodity procurement plan • Ensure that all partners procure agreed-upon commodities and consumables, including budget line provided by MOFED	• Commodities and consumables procured	2015 2016 2017 2018 2019
	PSC2. Conduct quality assurance testing of contraceptive commodities	PSC2.1 Support the PFSA to ensure quality of contraceptives	PSC2.1.1 Conduct post-market surveillance on contraceptives	• Conduct quality assurance testing on incoming contraceptives • Tests should be conducted randomly on condoms, in coordination with internal standards and testing laboratories • All other contraceptives should be procured from qualified vendors, with external testing before shipping	• Quality of contraceptives ensured	2015 2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
	PSC3. Improve capacity of the PFSA to use data generated at the facilities to ensure the timely distribution of commodities	PSC3.1 Support the PFSA to gather and use facility-generated data monthly to inform commodity distribution plans	PSC3.1.1 Conduct data aggregation and analysis training for PFSA staff	• MOH to assign individual or partner to review the data aggregation and analysis skills at the federal level and regional warehouses • 1 one-day refresher course per federal or regional level o @ MOH or warehouse o 5 people per training o Lunch and tea breaks	• PFSA staff trained on data aggregation and analysis (target: 60)	2016
	PSC4. Ensure that capacity is sufficient at all levels for the streamlined distribution of commodities from the national to health post levels	PSC4.1 Improve the logistics capacity of staff at the facility level	PSC4.1.1 Conduct annual TOTs to maintain an adequate training pool	• 2 two-week TOTs on logistics per year o @ hotel in Addis o 22 trainers; 2 per region o Lunch and tea breaks o Transport refund o Per diem o Printing: 50 pages per person	• Trainers trained (target: 120)	2016 2017 2018 2019 2020
			PSC4.1.2 Conduct regional trainings of healthcare workers responsible for reporting and ordering of commodities and supplies at the hospital and health centre levels	• 2 five-day logistics trainings per region per year o @ hotel in region o 25 participants per training (participants identified by regional health officers based on need identified during supervisory visits) o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person	• Health facility staff trained (target: 2,750)	2015 2016 2017 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
			PSC4.1.3 Conduct (MOH/RHBs and PFSA) joint supportive supervision exclusively on quantification	• Semi-annual visit to each trained facility o 2 officers per region o Transport refund o Per diem	• Health facilities visited (target: 2,640—one facility may be counted multiple times if visited over multiple years)	2015 2016 2017 2018 2019 2020
		PSC4.2. Bolster the monitoring system by setting up a procurement system to prevent stockouts ahead of time	PSC4.2.1 Identify new technologies (e.g., SMS) with the potential to improve real-time stock monitoring and resupply planning	• Hire a consultant to conduct a desk review for 30 days • 1 half-day stakeholder meeting o @ hotel in Addis o 25 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• New technologies for stock monitoring management identified	2016
			PSC4.2.2 Pilot real-time stock monitoring system	• Identify 15 *Woredas* to pilot system • Procure mobile phones for all health centres II and III in pilot *Woredas* • Procure computers and software for higher-level health facilities in pilot *Woredas* • Hire technical assistance for 1 person to communicate data to the DHIS 2 electronic health systems management programme	• Pilot *Woredas* identified (target: 15)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
			PSC4.2.3 Train staff on use of ICT equipment	• 5 three-day training sessions o @ hotel in region o 5 participants per higher-level facility o 1 participant per primary healthcare unit o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person	• Facilities trained on ICT equipment (target: 165) • Stock monitoring system piloted (target: 15 *Woredas*)	2016
			PSC4.2.4 Review pilot progress	• 1 half-day stakeholder meeting 6 months after pilot launch to review progress and challenges, and assess scale-up options o @ hotel in Addis o 25 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Pilot progress reviewed	2016
		PSC4.3 Improve regional- and district-level staff capacity to support facilities to quantify and distribute contraceptives	PSC4.3.1 Develop job aid to assist district-level staff to forecast their commodity needs	• Hire consultant: 30 days • 3 stakeholder meetings o @ hotel in Addis o 20 people o Transport refund o Printing: 5 pages per person o Printing: finalised job aid: 2,000 copies, 30 pages	• Job aid developed	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
			PSC4.3.2 Provide on-the-job training, follow-up supervision, and monitoring	• 2 supportive supervision visits by central staff per region per quarter o Transport refund o Per diem o Printing: 5 pages per visit	• Facilities visited (target: 3,000)	2015 2016 2017 2018 2019 2020
		PSC4.4 Improve distribution of FP commodities from health centres to health posts	PSC4.4.1 Review and strengthen (MOH) logistics/commodity management in the Integrated Refresher Training curricula for HEWs with other key logistics stakeholders (e.g., the DELIVER Project, Supply Chain Management System [SCMS], PFSA, UNFPA, USAID)	• MOH to assign staff or partner to lead the revision process • 2 one-day workshops (initiation and validation): o @ hotel in Addis o 25 people o Lunch and tea breaks o Transport refund o Printing: 25 pages per person	• Revised curricula developed	2016
			PSC4.4.2 Disseminate the revised curriculum	• Print the 50-page curriculum • 1 half-day dissemination workshop per region o @ hotel in region o 50 people per region o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Revised curricula printed and disseminated (target: 2,200)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
			PSC4.4.3 Improve capacity of HEWs to review data on stock availability at health posts	• Healthcare workers review stock management with HEWs during monthly supportive supervision visits	• HEWs receive supportive supervision visits (target: 8,000)	2015 2016 2017 2018 2019
			PSC4.4.4 Provide bicycles for remote health posts	• Procure and distribute bicycles • Provide maintenance and procure replacements annually	• Bicycles procured and distributed (target: 8,000 during first year; 800 subsequently)	2016 2017 2018 2019 2020
		PSC4.5 Set up regional warehouses with capacity to deliver supplies more frequently	PSC4.5.1 Invest in warehouse infrastructure that will benefit FP programme and the health system overall	• Build 6 warehouses total in Benishangul-Gumuz, Afar, Somali, SNNPR, and Gambela regions; hire 5 staff and purchase 2 trucks and 5 computers per warehouse	• Warehouses set up (target: 6)	2016 2017
			PSC4.5.2 Train new staff on warehouse and logistics management	• 1 one-week training per warehouse o @ warehouse o 5 staff per warehouse (i.e., all staff) o Lunch and tea breaks o Transport refund o Printing: 50 pages per person	• Warehouse staff trained (target: 30)	2017
			PSC4.5.3 Facilitate meetings and collaboration between the new	• 1 half-day meeting per warehouse o @ warehouse o 25 people per warehouse o Lunch and tea breaks	• Relationship between RHB and warehouse strengthened	2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 3: Procurement and Supply Chain (PSC)						
			warehouse and the RHB serviced by the warehouse	o Transport refund		
			PSC4.5.4 Provide ongoing supportive supervision at all warehouses	• PFSA semi-annual supervisory visits to all 16 warehouses o Transport refund o Per diem	• Warehouses visited for supervisory visits (target: 160; one warehouse may be counted multiple times if visited over multiple years)	2015 2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
Multisectoral coordination between government ministries, as well as with development and implementing partners, is inadequate, causing gaps in service delivery	MC1. Improve FP service delivery by clarifying roles and responsibilities, and streamlining national-level programme coordination and performance management	MC 1.1 Set national priority activities and define programme and geographical assignments for implementation by the government and various partners	MC1.1.1 Create a national research agenda for family planning and ensure that research better informs policymaking and programmes, and that programmes are evidence based	• 1 two-hour TWG meeting annually to determine research priorities • National meeting with partners, researchers, and funders to disseminate research agenda o @ hotel in Addis o 50 people o Lunch and tea breaks o Transport refund o Per diem o Printing: 50 pages per person • Hire a national FP research coordinator for the MOH to ensure coordination, align research questions with funded research projects, and create better connections between policymakers and programme managers and researchers	• Research priorities determined	2015 2016 2017 2018 2019
			MC1.1.2 Develop an annual detailed FP programme implementation plan that details the GOE's and each partner's responsibilities, using the CIP as the foundation	• MOH to assign staff or partner to lead the annual detailed FP programme • 1 two-day TWG retreat annually, with representatives from the private sector, civil society, and other ministries o @ hotel near Addis o 40 people o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person	• Annual FP plan developed	2015 2016 2017 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			MC1.1.3 Distribute the plan to officials at the national and regional levels, as well as NGOs, civil society organisations (CSOs), and development partners	• Print 50-page annual plan • 1 half-day dissemination workshop per region o @ hotel in region o 50 people per region o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Annual FP plan printed and disseminated (target: 2,000)	2015 2016 2017 2018 2019
		MC1.2 Ensure that national annual and 5-year plans are progressing accordingly	MC1.2.1 Review programme progress semi-annually and institute performance management corrections	• 1-day TWG meeting annually o @ hotel in Addis o 60 people, including MOH, development and implementing partners, stakeholders, and representatives from each of the 11 RHBs o Printing: 5 pages per person	• Progress reviewed semi-annually	2015 2016 2017 2018 2019
			MC1.2.2 Conduct mid-term review of the 5-year CIP	• MOH to identify outside organisation to manage the review and modification process o Using 2016 EDHS data, assess progress of the plan against the objective of 60% CPR by 2020 o Interview key stakeholders, community leaders, and key populations to review areas of barriers to FP access, such as female empowerment and male involvement	• Mid-term evaluation report developed	2018

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
				o Interview adolescents, youth, teachers, parents, and other influential figures from schools and colleges to reassess issues of perception and use of family planning amongst adolescents and youth o Interview key government, NGO, and CSO staff to assess progress in the area of supply chain and logistics, policy, monitoring, and coordination		
			MC1.2.3 Modify 5-year plan as necessary at the mid-term stage	• Print the 40-page mid-term evaluation report • 1 one-day review meeting to discuss modifications needed to the plan's objectives and activities o @ MOH o 25 people o Lunch and tea breaks o Printing: 5 pages per person	• Mid-term evaluation printed and disseminated (target: 100)	2018
		MC1.3 Coordinate FP activities with other ministries for a multisectoral approach to rights-based FP programming, particularly for integration with youth activities	MC1.3.1 Prepare technical briefs to advocate for budget framework papers to include family planning as a strategy to improve maternal and newborn health	• MOH to identify a staff or partner to write technical briefs • 1 two-hour vetting stakeholder meeting o @ MOH o 20 people o Printing: 5 pages per person • Print technical briefs	• Technical brief developed, printed, and distributed (target: 200)	2015

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			MC1.3.2 Introduce family planning into workplans for MOE, Ministry of Youth and Sport, and Ministry of Women's Affairs	• MOH to coordinate 3 one-day workshops: one per ministry annually o @ MOH (or other ministry office) o 20 people per workshop o Lunch and tea breaks o 20 copies of CIP per workshop o Printing: 20 pages per person	• Annual meetings with other ministries held (target: 15)	2015 2016 2017 2018 2019
			MC1.3.3 Have FP TWG representative sit on other ministries' TWGs to facilitate continued collaboration and activity alignment	• Transport refund for representative	• FP TWG represented in other ministries' relevant TWGs	2015 2016 2017 2018 2019
			MC1.3.4 Advocate to programmes with interpersonal communication agents, such as peer service provider programmes working in the non-health sector, to integrate FP social and behaviour change communication into their programmes	• 3 half-day advocacy meetings to advocate to non-health sectors, including agriculture, youth and sport, education, women's affairs, etc. for integration of FP social and behaviour change communication into their programmes o @ MOH (or other ministry office) o 20 people per meeting o Lunch and tea breaks o Printing: 20 pages per person	• Advocacy meetings held (target: 15)	2015 2016 2017 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
		MC1.4 Advocate with the MOE to assess the capacity of schools to integrate SRH and family planning into the curriculum, including sexual education in the school health programme	MC1.4.1 Review the school health curriculum for high schools and universities and teacher training materials with the MOE and relevant partners	• 1 full-day national coordination meeting with the MOH and stakeholders o @ MOH or MOE o 50 people o Lunch and tea breaks o Transport refund o Printing: 20 pages per person	• School health curriculum reviewed	2015
			MC1.4.2 Review the availability of information on family planning at university campuses with the MOE and relevant partners	• 1 full-day national coordination meeting with the MOH and stakeholders o @ MOH or MOE o 50 people o Lunch and tea breaks o Transport refund o Printing: 20 pages per person	• Information availability assessed	2015
		MC1.5 Based on progress made over 2015–2020, develop a new, 5-year FP Costed Implementation Plan for 2020–2025	MC1.5.1 Review progress made through the FP CIP 2015–2020	• MOH to assign staff or partner to manage the review and get input on goals, challenges, and priorities • Conduct a desk review, secondary analysis of available data, and key informant interviews	• FP2015–2020 progress reviewed and stakeholder input on upcoming goals and priorities assessed	2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			MC1.5.2 Disseminate progress findings and set priorities for the next 5 years	• 1 two-day meeting involving the national TWG and regional, CSO, and private sector representatives o @ hotel in Addis o 50 people o Lunch and tea breaks o Per diem o Transport refund o Printing: 20 pages per person	• FP CIP 2020–2025 priorities set	2020
			MC1.5.3 Conduct follow-up meetings with stakeholders to vet the new FP CIP 2020–2025	• 4 two-hour TWG meetings o @ MOH o 20 people o Refreshments o Printing: 5 pages per person • One meeting with each region o @ RHBs o Transport refund o Per diem	• FP CIP 2020–2025 finalised	2020
			MC1.5.4 Disseminate the finalised FP CIP 2020–2025	• Printing: 220 copies of 80-page FP CIP 2020–2025 • 2-hour dissemination meeting o @ hotel in Addis o 50 people o Refreshments o Transport refund o Printing: 5 pages per person	• FP CIP 2020–2025 disseminated (target: 220 copies)	2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
Private sector role is undefined and not well integrated into FP programme implementation strategies	MC2. Improve coordination with the private sector to better leverage its resources in FP service provision	MC2.1 Take the total market approach (TMA) to family planning and clarify the roles of the public, nonprofit, and for-profit sectors through a thorough market segmentation analysis	MC2.1.1 Segment the market by analysing secondary data (e.g., EDHS) and primary data collected through assessments	• MOH to identify partner to lead the market segmentation process • Conduct a secondary data analysis of available data • Develop a profile of the market segments through assessments such as qualitative market assessments and willingness-to-pay studies by hiring a market research firm	• Assessments conducted (target: 2)	2015 2016
			MC2.1.2 Develop TMA strategy	• Partner leading market segmentation process works for 2 months to develop TMA strategy • Hold 3 one-day workshops to vet the data and agree on the best approach to reach each segmented group o @ MOH o 25 people o Lunch and tea breaks o Transport refund	• FP TMA strategy developed	2016
			MC2.1.3 Disseminate TMA strategy	• Disseminate the strategy o @ hotel in Addis o 50 people o Tea break o Transport refund o Printing: 50 pages per person	• FP TMA strategy printed and disseminated (target: 200)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
		MC2.2 Clarify the service provision protocol for the private sector by level and cadre	MC2.2.1 Review and identify inconsistencies and areas of improvement within the FP guidelines for the private sector	• MOH to identify individual or partner to review current guidelines from the MOH and FMHACA for the private sector; and identify private sector strengths that may complement the public sector's offerings through desk reviews and key informant interviews	• Private sector strengths identified	2015
			MC2.2.2 Revise or develop new guidelines for the private sector in FP provision	• MOH to delegate individual for 10 days to facilitate the revision process • 1 one-day consultative meeting with the MOH and private sector technical representatives o @ MOH o 15 people o Lunch and tea breaks o Printing: 10 pages per person	• Private sector FP provision guidelines revised	2016
			MC2.2.3 Produce and disseminate new private sector rights-based FP service provision guidelines at the national level	• Printing of revised 50-page guidelines • 1 two-hour dissemination meeting with the MOH, development and implementing partners, and private sector stakeholders o @ hotel in Addis o 50 people o Tea break o Transport refund o Printing: 5 pages per person	• Revised guidelines printed and disseminated (target: 500)	2016
			MC2.2.4 Disseminate to raise	• Printing: 5 copies per region	• Meetings held to disseminate	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			awareness of the new guidelines at the local and regional levels	• 1 meeting per region with RHB staff responsible for private sector engagement to orient them on the new guidelines and encourage them to hold similar meetings with private providers o @ RHBs o 50 people o Tea break o Transport refund	revised guidelines (target: 11)	
		MC2.3 Improve the oversight of private sector distribution of FP services and quantify private sector contribution to FP service provision	MC2.3.1 Strengthen partnership between RHBs and social franchises providing FP services	• 1 half-day consultative meeting annually with the MOH, RHBs, and social franchise operators o @ hotel in Addis o 50 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Partnership between government and social franchise operators strengthened	2016 2017 2018 2019 2020
			MC2.3.2 Distribute service provision report stationery to private facilities	• Annual printing of stationery • Distributed through franchise operators	• Service provision reports printed and distributed (target: 25,000)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			MC2.3.3 Train private sector facilities on how to fill out service provision reports	• 4 half-day trainings per region annually with private facility staff responsible for records o @ hotel in region o 25 people per training o Lunch and tea breaks o Transport refund o Printing: 10 pages per person • 2 half-day refresher trainings per region every 2 years with private facility staff responsible for records o @ hotel in region o 50 people per training o Lunch and tea breaks o Transport refund o Printing: 10 pages per person	• Private sector providers trained (target: 4,400)	2016 2017 2018 2019 2020
			MC2.3.4 Conduct annual supportive supervision with franchise operators	• 1 supportive supervision round per region for each franchise facility o Transport refund o Printing: 5 pages per visit	• Private facilities visited (target: 2,500—one facility may be counted multiple times if visited over multiple years)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			MC2.3.5 Maintain coordination with franchise operators	• 2 half-day coordination meetings per year per region o @ RHBs o 25 people per region o Printing: 10 pages per person	• Consultative meetings held (target: 110)	2016 2017 2018 2019 2020
		MC2.4 Foster an enabling environment for the private sector in FP service provision and explore opportunities for additional public-private partnerships	MC2.4.1 Assess the private sector market and sensitise the local and regional public sector on the private sector contribution to family planning	• MOH to identify staff or partner to conduct an assessment and develop a private sector brief • 1 half-day workshop per region with health and non-health regional staff on the private sector's contribution to the health sector and how FP initiatives contribute to the welfare of the region o @ hotel in region o 50 people per region o Lunch and tea breaks o Printing: 10 pages per person	• Local and regional public sector targets sensitised (target: 11)	2016 2018
			MC2.4.2 Hold annual national forums for public and private sector dialogue to discuss options and issues related to public-private partnerships	• 1 one-day forum o @ hotel in Addis o 50 participants o Lunch and tea breaks o Transport refund o Printing: 10 pages per person	• National public-private forum held (target: 5)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			MC2.4.3 Hold regional meetings with private stakeholders to identify opportunities to expand access	• 1 half-day workshop per region annually to sensitise private organisations on the importance of promoting and using FP services o @ hotel in region o 15 people per region o Lunch and tea break o Transport refund o Printing: 5 pages per person	• Regional public-private forum held (target: 11)	2016 2017 2018 2019 2020
Federal government has clear FP objectives; however, not all regions have the same goals and objectives	MC3 Ensure that regional objectives and perspectives are integrated into the national-level plan so that family planning becomes a	MC3.1 Coordinate with regions to ensure that national-level goals and plans reflect regional objectives, and vice versa	MC3.1.1 Include regional representatives in the national plan development process	• Annual 2-day national planning meeting involving regional representatives o @ hotel in Addis o 50 people per meeting o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person	• Regional input gathered for national annual FP plan (target: 5)	2015 2016 2017 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
	priority development agenda for the regions		MC3.1.2 Present a commitment statement after the national plan development meeting for each regional representative to declare the region's commitment to family planning	• 1 commitment ceremony nationally and per region o @ MOH and regional office	• Regional representatives committed to national plan (target: 55)	2015 2016 2017 2018 2019
		MC3.2 Set up staffing and TWG system to support regional programme implementation in alignment with national priorities	MC3.2.1 Identify FP coordinator position at the regional level	• MOH to send directive to each RHB to assign one staff person to be the FP coordinator, who will liaise with counterparts at the federal level	• FP coordinator hired per region (target: 11)	2015
			MC3.2.2 Establish an FP TWG at the regional level that includes implementing partners and civil society and private sector representatives	• MOH to send directive to each RHB to establish a regional FP TWG • RHB TWG to meet quarterly and share meeting minutes with the MOH to flag any issues that arise	• FP TWG established per region (target: 11) • FP TWG meetings held (target: 220)	2015 2016 2017 2018 2019 2020
			MC3.2.3 Orient FP coordinators on their roles and train them on necessary skills (e.g., FP messaging,	• 1 two-day orientation meeting o @ MOH o 11 participants; 1 non-clinical worker from each region who is responsible for maternal and child	• FP coordinators trained (target: 11)	2015

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			integration with other services, access points, referrals)	health issues, including family planning o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person		
			MC3.2.4 Conduct supervisory visit for FP coordinators	• Hold half-day meetings semi-annually o Transport refund o Per diem	• FP coordinators visited (target: 110)	2015 2016 2017 2018 2019 2020
		MC3.4 Define regional priority activities from the CIP and align regional FP programmes with national goals and annual plans	MC3.4.1 Develop annual regional FP plans that detail regional health office and local partner responsibilities	• 1 two-day regional FP TWG retreat annually o @ hotel near region capital o 20 people o Lunch and tea breaks o Printing: 20 pages per person	• Regional annual plans developed (target: 55)	2015 2016 2017 2018 2019
			MC3.4.2 Distribute the regional plans to officials at national and regional levels, as well as NGOs, CSOs, and development partners	• Print the 20-page regional plans • 1 half-day dissemination workshop nationally and in regions o @ hotel in Addis and regions o 50 people per workshop o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Regional plans printed and disseminated (target: 11,000)	2015 2016 2017 2018 2019

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
		MC3.5 Ensure that regional plans are progressing accordingly and lessons are being shared and learned	MC3.5.1Review regional plan progress semi-annually	• 1 two-hour regional meeting annually o @ regional health office o 20 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Regional progress assessed (target: 55)	2016 2017 2018 2019 2020
			MC3.5.2 Ensure that best practices and lessons learned are shared at the regional level	• 1 inter-regional experience-sharing meeting, bringing together all of the regional FP coordinators o @ hotel in Addis o 30 people o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person	• Experience-sharing meeting conducted (target: 5)	2016 2017 2018 2019 2020
There is a lack of data around target populations and success factors for FP programmes	MC4. Increase availability and use of evidence for FP programming	MC4.1 Document successes and develop an evidence base for best practices	MC4.1.1 Conduct programme evaluations	• 1 two-hour TWG meeting annually to identify programmes to evaluate o @ MOH o 20 people o Printing: 5 pages per person • Contract with evaluation firm annually to conduct selected programme evaluations	• Programmes evaluated (target: 5)	2016 2017 2018 2019 2020
			MC4.1.2 Develop case studies, success stories, and lessons learned	• MOH to hire consultant for 20 days semi-annually to interview programme staff and write up case studies	• Case studies developed (target: 25)	2016 2017 2018

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			briefs, using results from FP programme implementations and evaluations	• Printing: 110 copies of 8-page case studies		2019 2020
			MC4.1.3 Disseminate data generated by FP programmes widely	• Hold a half-day FP conference annually to share data generated, success stories, best practices, and lessons learned o @ MOH o 100 people o Printing: 5 pages per person	• Information shared (target: 5)	2016 2017 2018 2019 2020
			MC4.1.4 Advocate to development and implementing partners to fund and conduct similar data-generation activities	• 1 two-hour TWG meeting annually to discuss opportunities for evidence-base generation o @ MOH o 20 people o Printing: 5 pages per person	• Data-generation opportunities identified (target: 5)	2016 2017 2018 2019 2020
HMIS is set up nationally but data from the facilities are not accurately recorded or appropriately and swiftly aggregated at	MC5. Ensure availability of health service delivery data by leveraging the HMIS	MC5.1 Increase the capacity of health facility staff to input accurate data into the HMIS in a timely manner	MC5.1.1 Conduct regional trainings on the HMIS	• 1 two-day training per region for new records staff o @ hotel in region o 20 people per region o Lunch and tea breaks o Transport refund o Per diem o Printing: 20 pages per person	• Facility staff trained (target: 220)	2016

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
the regional and national levels				• Include newly trained staff in a national database of trained facility-based HMIS staff		
			MC5.1.2 Ensure that trained staff maintain their knowledge and keep up with the standards and protocols	• MOH to maintain a national database of trained facility-based HMIS staff, including their assigned facility, when they were trained, when they attended refresher training, and when they have been visited for supportive supervision • 1 one-day refresher training quarterly per region so that records staff get refresher training once every 2 years o @ hotel in region o 20 people per region o Lunch and tea breaks o Transport refund o Printing: 10 pages per person • Supportive supervision visits; each facility should be visited at least twice a year o Transport refund for supervisor o Per diem for supervisor o Printing: 10 pages per site	• Facility staff retrained (target: 3,520) • Facilities visited (target: 3,000)	2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
		MC5.2 Increase the capacity of RHB staff to collect, aggregate, and analyse the HMIS data	MC5.2.1 Review data collected at the regional level to ensure timely and accurate reporting	• MOH to assign staff or partner to develop a dashboard that aggregates key performance indicators at the facility and regional levels • 1 one-day training to train regional HMIS coordinators on dashboard o @ MOH o 22 people (2 per region) o Lunch and tea breaks o Transport refund o Printing: 10 pages per person • Regional HMIS coordinator compiles the monthly dashboard report, shares it with the regional FP TWG, and uses it as tool for supportive supervision	• Monthly regional dashboards developed (target: 660)	2015 2016 2017 2018 2019 2020
		MC5.3 Improve accuracy and timeliness of HMIS data aggregated at the national level	MC5.3.1 Ensure that regional-level HMIS data are reported centrally in a timely manner	• Central-level HMIS team tracks regional HMIS reports • MOH to assign staff or partner to conduct a quarterly root-cause analysis to identify bottlenecks in the HMIS aggregation in regions having difficulty providing HMIS reports on time • Support regions to overcome those bottlenecks through technical assistance and by advocating for the MOFED to add a line item in the budget, as necessary	• Root-cause analysis conducted (target: 20)	2016 2017 2018 2019 2020
			MC5.3.2 Quarterly review of FP key indicators from	• Develop a list of indicators to be tracked, with input from the FP TWG	• Indicators developed	2016 2017

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 4: Monitoring and Coordination (MC)						
			HMIS by the National FP TWG	• Run a quarterly report on key indicators and share it during FP TWG meetings	• Indicator reports produced (target: 20)	2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 5: Financing (F)						
Commodity purchase is heavily donor dependent, hindering long-term sustainability; commodity security strategy is unclear	F1. Advocate for increased funding for family planning from the federal government	F1.1 Advocate for increase in FP line items in the MOH budgets	F.1.1.1 Develop an FP commodity security advocacy strategy	• MOH to identify individual or partner to develop a strategy based on CIP and key informant interviews • 2 one-day FP TWG meetings to vet the advocacy strategy o @ MOH o 20 people o Lunch and tea breaks o Printing: 10 pages per person	• National commodity security advocacy strategy developed (target: 1)	2015
			F1.1.2 Develop a policy brief advocating increase in FP line items to distribute to the parliamentary committee on health	• MOH to assign staff or partner to develop a brief based on above stakeholder meetings • Update strategy every 2 years • Printing: 50 copies of 8 pages	• Advocacy brief developed (target: 1)	2015 2017 2019
			F1.1.3 Advocate for an FP budget line item amongst members of Parliament	• 2 half-day stakeholder meetings annually in advance of the budgeting period o @ hotel in Addis o 20 people o Lunch and tea breaks o Transport refund o Printing: 5 pages per person	• Advocacy meeting held (target: 10)	2016 2017 2018 2019 2020

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 5: Financing (F)						
			F1.1.4 Report (MOH) on progress towards FP2020 financial commitment to increase the budget for family planning	• No additional costs necessary; will be conducted at the same time as the semi-annual review process (activity MC1.2.1)	• MOH financial commitment reported	2016 2017 2018 2019 2020
		F1.2 Advocate for increase or adoption of FP line item in the regional health budgets	F1.2.1 Identify best practices from other regions	• MOH to hold meetings with Addis Ababa, SNNPR, and Amhara RHBs to understand how they achieved including family planning as line item in their regional budgets o @ RHBs o 5 people o Transport refund for MOH staff travelling to regions o Per diem for MOH staff travelling to regions	• Regional meetings held (target: 3)	2015
			F1.2.2 Develop an FP financing guide for regions	• MOH to identify individual or partner to develop a guide for use by regions on how to advocate for establishment of an earmarked budget for family planning • Pilot the guide in 2 regions over a year and revise the tool for finalisation • Print and disseminate the guide in all regions o 20 copies o Transport refund for MOH staff travelling to regions	• Regional FP financing guide developed, printed, and disseminated (target: 20)	2016 2017

Issue Addressed	Priority Objective	Main Activity	Sub-activity	Additional Detail (Inputs Required)	Output Indicators	Timeline
Priority Area 5: Financing (F)						
				o Per diem for MOH staff travelling to regions		
			F1.2.3 Hold inter-regional meeting to assess progress and collaboratively problem solve for adoption of FP line item at the regional level	• 1 all-day meeting, bringing together regional FP coordinators for information sharing o @ hotel in Addis Ababa o 20 people o Lunch and tea breaks o Transport refund for FP coordinators o Per diem for FP coordinators o Printing: 5 pages per person	• Knowledge-sharing meeting held (target: 5)	2016 2017 2018 2019 2020

REFERENCES

[1] Family Planning High Impact Practices. "High-Impact Practices in Family Planning." 2014. Available at: https://www.fphighimpactpractices.org/.

[2] Ethiopia Ministry of Health (MOH). 2015. Health Sector Transformation Plan, 2015/16 – 2019/20, February 2015 Draft.

[3] Ethiopia MOH. 2006. National Reproductive Health Strategy, 2006–2015. Addis Ababa: MOH.

[4] Central Statistical Agency (CSA). 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[5] Bloom, David, E., David Canning, and Jaypee Sevilla. 2003. The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change. Santa Monica, CA: RAND; and Population Reference Bureau. 2013. Harnessing the Demographic Dividend. Available at: http://www.prb.org/Multimedia/Video/2013/demographic-dividend-engage.aspx.

[6] Population Reference Bureau. 2013. Harnessing the Demographic Dividend. Available at: http://www.prb.org/Multimedia/Video/2013/demographic-dividend-engage.aspx.

[7] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[8] United Nations Department of Economic and Social Affairs. n.d. "World Population Prospects: The 2012 Revision, Volume II: Demographic Profiles." Available at: http://esa.un.org/wpp/Demographic-Profiles/pdfs/231.pdf.

[9] Singh, Susheela, Jacqueline E. Darroch, and Lori Ashford. 2013. Adding It Up: The Need for and Cost of Maternal and Newborn Care—Estimates for 2012. New York: Guttmacher Institute. Available at: http://www.guttmacher.org/pubs/AIU-MNH-2012-estimates.pdf.

[10] Singh, Susheela, Jacqueline E. Darroch, and Lori Ashford. 2013. Adding It Up: The Need for and Cost of Maternal and Newborn Care—Estimates for 2012. New York: Guttmacher Institute.

[11] Family Planning 2020. "About Us." n.d. Available at: http://www.familyplanning2020.org/microsite/about-us.

[12] "London Summit on Family Planning—July 11, 2012." Available at: http://www.who.int/workforcealliance/media/events/2012/LondonSummitonFamilyPlanningOverview.pdf.

[13] Family Planning Summit Metrics Group. 2012. Technical Note: Data Sources and Methodology for Calculating the 2012 Baseline, 2020 Objectives, Impacts and Costings. Family Planning Summit, 2012.

[14] "About Us." n.d. The 2012 London Summit on Family Planning. Available at: http://www.familyplanning2020.org/about-us/the-2012-london-summit-on-family-planning.

[15] United Nations Department of Economic and Social Affairs, Division for Sustainable Development Goals. n.d. "Open Working Group proposal for Sustainable Development Goals." Outcome document. Available at: https. http://sustainabledevelopment.un.org/focussdgs.html.

[16] Ibid.

[17] CSA. "Population Projection of Ethiopia for All Regions at Woreda Level from 2014–2017." Available at: http://www.csa.gov.et/.

[18] United Nations Department of Economic and Social Affairs/Population Division. n.d. "World Population Prospects: The 2012 Revision, Volume II: Demographic Profiles." Available at: http://esa.un.org/wpp/Demographic-Profiles/pdfs/231.pdf.

[19] CSA. 2001. Ethiopia Demographic and Health Survey, 2000. Addis Ababa: CSA.

[20] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[21] Futures Group. Health Policy Project. Stakeholder consultations for Family Planning Costed Implementation Plan, 2015–2020.

[22] Ahmed S., Q. Li, L. Liu, and A. Tsui. 2012. "Maternal Deaths Averted by Contraception Use: An Analysis of 172 Countries." Lancet 380: 111–25.

[23] Cleland, John, Agustin Conde-Agudelo, Herbert Peterson, John Ross, and Amy Tsui. 2012. "Contraception and Health." Lancet 380: 149–56.

[24] Ibid.

[25] The Last Ten Kilometers Project. n.d. "Overview of Maternal, Newborn and Child Health in Ethiopia." Available at: http://l10k.jsi.com/Health/index.htm.

[26] Sanders, Rachel, Tewodros Bekele, and Senait Tibebu. 2015. "Impact of the Ethiopia Health Sector Transformation Plan (HSTP) 2015–2019 on Key Health Indicators." Washington, DC. Futures Group, Health Policy Project.

[27] United Nations Development Program/Ethiopia. n.d. "Improve maternal health—Where we are." Available at: http://www.et.undp.org/content/ethiopia/en/home/mdgoverview/overview/mdg5/.

[28] USAID | Health Policy Initiative, Task Order 1. 2009. "Achieving the MDGs: The Contribution of Family Planning, Ethiopia." Washington, DC: USAID | Health Policy Initiative, Futures Group; and Worku, A., G. Tessema, and A. Zeleke. 2014. Trends and Determinants of Contraceptive Use amongst Young Married Women (Age 15–24). Based on the 2000, 2005, and 2011 Ethiopian Demographic and Health Surveys: A Multivariate Decomposition Analysis.

[29] Guttmacher Institute. 2010. "In Brief: Facts on Unintended Pregnancy and Abortion in Ethiopia." New York: Guttmacher Institute.

[30] Berhan, Yifru, and Asres Behran. 2014. "Causes of Maternal Mortality in Ethiopia: A Significant Decline in Abortion Related Death." Ethiopian Journal of Health Science 24: 15–28.

[31] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[32] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[33] Ethiopia MOH. 2015. Health Sector Transformation Plan, 2015/16–2019/20, February 2015 Draft.

[34] United Nations Population Fund (UNFPA). Trends in Maternal Health in Ethiopia: Challenges in Achieving the MDG for Maternal Mortality—In-depth Analysis of EDHS 2000–2011. Addis Ababa: UNFPA.

[35] Ibid; and CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[36] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[37] PMA2020. 2015. "PMA2014/Ethiopia-R2." Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, PMA2020.

[38] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[39] Ibid.

[40] Ibid.

[41] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[42] The DHS Programme. 2014. "Unmet Need for Family Planning." Available at: http://dhsprogram.com/topics/Unmet-Need.cfm.

[43] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[44] PMA2020. 2015. "PMA2014/Ethiopia-R2." Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, PMA2020.

[45] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[46] Ibid.

[47] Ibid.

[48] Bongaarts, John, John C. Cleland, John Townsend, Jane T. Bertrand, and Monica Das Gupta. 2012. Family Planning Programs for the 21st Century: Rationale and Design. New York: Population Council.

[49] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[50] Futures Group. Health Policy Project. Stakeholder consultations for Family Planning Costed Implementation Plan, 2015–2020.

[51] Ibid.

[52] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[53] Futures Group. Health Policy Project. Stakeholder consultations for Family Planning Costed Implementation Plan, 2015–2020.

[54] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[55] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[56] Ibid.

[57] Ministry of Finance and Economic Development. 2010. Growth and Transformation Plan, 2010/11–2014/15. Addis Ababa: Ministry of Finance and Economic Development.

[58] Futures Group. Health Policy Project. Stakeholder consultations for Family Planning Costed Implementation Plan, 2015–2020.

[59] Stakeholder consultations, September 2014.

[60] Ibid.

[61] CSA and ICF International. 2012. Ethiopia Demographic and Health Survey, 2011. Addis Ababa: CSA.

[62] Ethiopia MOH. 2014. Ethiopia's Fifth National Health Accounts 2010/2011. Addis Ababa: MOH.

[63] Ethiopia MOH. 2010. Ethiopia's Fifth National Health Accounts 2007/2008. Addis Ababa: MOH

[64] Ethiopia MOH. 2014. Ethiopia's Fifth National Health Accounts 2010/2011. Addis Ababa: MOH.

[65] Ethiopia MOH. 2015. Health Sector Transformation Plan, 2015/16–2019/20, February 2015 Draft.

[66] Ibid.

[67] Ibid.

[68] FP2020 London Summit. Available at: http://www.familyplanning2020.org/commitments.

[69] Bongaarts, John, John C. Cleland, John Townsend, Jane T. Bertrand, and Monica Das Gupta. 2012. Family Planning Programs for the 21st Century: Rationale and Design. New York: Population Council.

[70] Ibid.

[71] EngenderHealth. 2003. Realizing Rights in Sexual and Reproductive Health Services—Choices in Family Planning: Informed and Voluntary Decision Making. New York: EngenderHealth.

[72] Ibid.

[73] Health Policy Project.Stakeholder consultations for Family Planning Costed Implementation Plan, 2015–2020.

[74] AdemolaAdelekan, Philomena Omoregie, and Elizabeth Edoni. 2014. "Male Involvement in Family Planning: Challenges and Way Forward." International Journal of Population Research vol. 2014, Article ID 416457, 9 pages, doi:10.1155/2014/416457.

[75] FHI360. 2011. Program Research for Strengthening Services Project, Mobile 4 Reproductive Health Booklet. Durham, NC: FHI360.

[76] Health Policy Project. 2015. "Family Planning CIP Costing Tool." Retrieved May 12, 2015, from http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=806 .

[77] Zambia Ministry of Community Development, Mother and Child Health. 2013. Family Planning Services: Integrated Family Planning Scale-up Plan 2013–2020. Retrieved October 2, 2014, from http://www.healthpolicyproject.com/ns/docs/CIP_Zambia.pdf.

[78] 2014 calculations by Technical Support Team using ImpactNow.

[79] Ethiopia MOH. 2015. Reproductive Health Strategy, Zero Draft. Received April 28, 2015.

[80] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[81] The RESPOND Project. 2011. New Developments in the Calculation and Use of Couple-Years of Protection (CYP) and Their Implications for the Evaluation of Family Planning Programs—Meeting Highlights. New York: The RESPOND Project/EngenderHealth.

[82] This is the estimated number of services by method that would need to be provided to reach the FP goal. These have been calculated based on the total users needed to reach the goal, continued use of long-acting and permanent methods from baseline use (from historic services or CPR), and method-specific discontinuation. The results are dependent on the method mix of services set for each year.

[83] Health Policy Project and Marie Stopes International. 2014. "ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use." Washington, DC: Futures Group, Health Policy Project.

[84] Ibid.

[85] CSA. 2014. Ethiopia Mini Demographic and Health Survey, 2014. Addis Ababa: CSA.

[86] Health Policy Project and Marie Stopes International. 2014. "ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use." Washington, DC: Futures Group, Health Policy Project.

[87] Ibid.