Evaluation of Program Options to Meet Unmet Need for Family Planning in Ethiopia

MEASURE *DHS+*

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ORC Macro
Calverton, Maryland USA

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The Ethiopia DHS is part of the MEASURE *DHS*+ project designed to collect, analyze, and disseminate data on fertility, family planning, and maternal and child health. Additional information about the MEASURE *DHS*+ project may be obtained from MEASURE *DHS*+, ORC Macro, 11785 Beltsville Drive, Calverton, MD 20705 (telephone: 301-572-0200; fax: 301-572-0999; email: reports@macroint.com; internet: www.measuredhs.com.

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Chapter 1

Introduction

1.1 Background

Ethiopia currently has a population of around 65 million, half of whom are female. Women of reproductive age (15-49) constitute 44 percent of the total female population. The country is growing at an annual rate of about 3 percent (CSA, 1999). Demographically, the population is very young—more than 40 percent are below the age of 15—which indicates that there is considerable momentum for growth. This, together with the high level of fertility and a low level of contraceptive use, suggests that the population will continue to grow at a fast pace for at least another generation. At the current rate, it will double in size 23 years.

Such a high rate of population growth has an adverse effect on the economic development of the country. The population is predominantly rural, with only 15 percent residing in urban areas. Most Ethiopians rely on agriculture for their livelihood; more than 95 percent of the rural population are involved in agriculture. Food shortages are common because most of the farming depends on the infrequent rains, and the soil fertility is poor because of continuous plowing. The population growth rate often outstrips the gains made in economic development; therefore, population issues have become a major concern. Solving the population problem is now recognized by many as a prerequisite for future development.

Administratively, the country is divided into nine regional states, namely Tigray, Amhara, Oromia, Somali, Benishangul-Gumuz, Southern Nations, Nationalities and Peoples (SNNP), Gambela, and Harari, and two administrations (Addis Ababa and Dire Dawa). The regional states and the administrations are further divided into 66 zones and 523 weredas (districts) (MOH, 2001a). Weredas in both urban and rural areas are made up of localities called kebeles, which are the smallest administrative unit.

The 2000 Ethiopia Demographic and Health Survey (DHS) reported that the total fertility rate in the country stands at 5.9, which is among the highest in sub-Saharan Africa. Of the currently married women, 14 percent have never heard of family planning, while only 17 percent have ever used a method. Current use of family planning is very low and stands at 8 percent among the same group of women. Of the currently married women who are not using family planning, 46 percent intend to use a method. Among the currently married women, only 22 percent want to have another child soon, 32 percent want no more children, and 36 percent want a child but would like to wait two or more years. Similarly, among the currently married men, 25 percent do not want any more children, while 43 percent want to wait two or more years. (CSA and ORC Macro, 2001).

Among women who are not currently using contraception, some indicate that they want to space births, while others indicate that they do not want to have any more children. These groups of women are classified as having an unmet need for family planning. The first group of women has unmet need for spacing, while the second has unmet need for limiting. The sum of the two groups constitutes the total unmet need among the population. The DHS survey indicates that

among currently married women, the unmet need for spacing is 22 percent, while the unmet need for limiting is 14 percent. Thus, the total unmet need is 36 percent.

It is necessary to identify the reasons for such a high unmet need and present program options that meet the need for family planning. It is also important to look into the details of the variations of unmet need to address the need accordingly. Therefore, the in-depth analysis of the DHS data on the evaluation of program options to meet unmet need for family planning will provide critical information that can be used to develop programs and strategies.

1.2 Study Objectives

All institutions involved in the coordination and implementation of population programs, particularly those concerned with reproductive health, need information that assists them in designing effective interventions. The DHS survey has revealed some of the achievements and gaps in family planning programs. This paper has the following objectives:

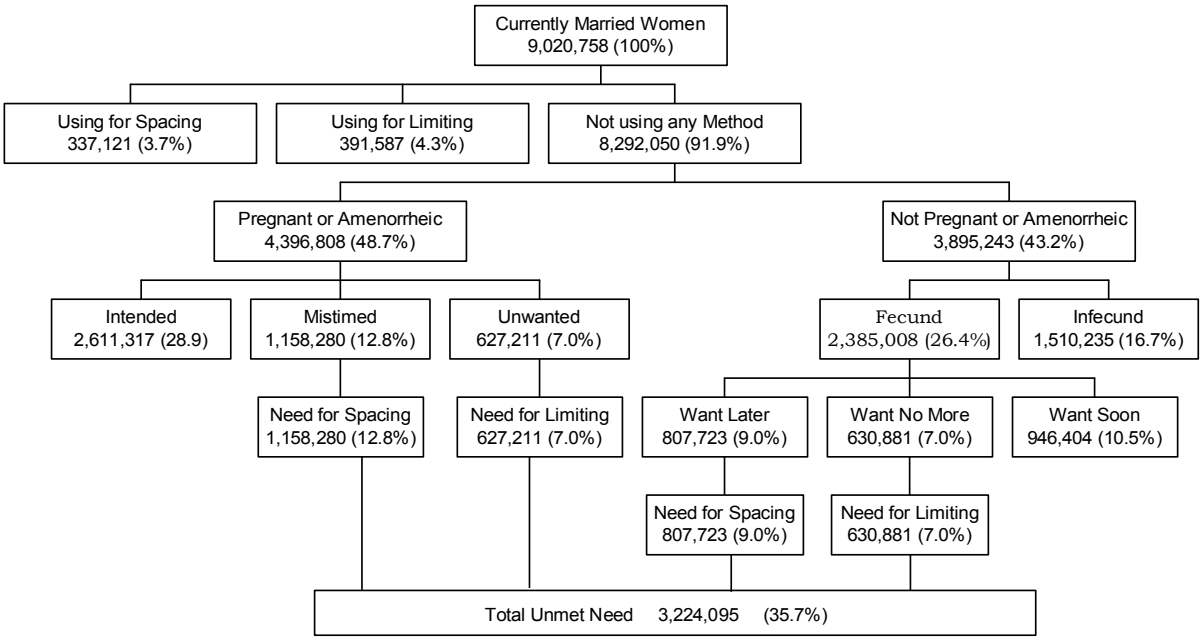
- Investigate the characteristics of women with unmet need
- Investigate the reasons for nonuse of family planning among women who report unmet need
- Investigate the amount and types of family planning services available in the country
- Investigate the availability of family planning facilities for different groups of women
- Determine program options that may help women who are not using family planning begin using a method.

1.3 Concept of Unmet Need

The concept of unmet need dates from the 1960s when KAP surveys were being conducted. At that time, "KAP-gap"—the gap between the reproductive intentions of women and their contraceptive behavior—was being measured. The World Fertility Survey (1972-1984) also studied this condition in detail. The Contraceptive Prevalence Surveys (mid 1970-1984) refined the concept by adding questions about women's interest in postponing or spacing next births, thus making it possible to measure those who want to space their births and those who want to limit them. The Demographic and Health Surveys further refined the concept by using additional information that referred to pregnant women on whether their current pregnancies were intentional, mistimed, or unwanted, and also on whether they were using contraception at the time of conception. This approach made it possible to classify some pregnant women according to whether or not they had an unmet need for family planning (Robey et al., 1996).

The current definition of *unmet need for spacing* (among currently married women) includes pregnant women whose pregnancy was mistimed, amenorrheic women whose last birth was mistimed, and women who are neither pregnant nor amenorrheic, are not using any method of family planning, and say that they want to wait two or more years for their next birth. This group also includes women who are unsure whether they want another child or who want another child but are unsure when to have the birth. *Unmet need for limiting* (among currently married women) refers to pregnant women whose pregnancy was unwanted, amenorrheic women whose last child was unwanted, and women who are neither pregnant nor amenorrheic are not using any method of family planning, and want no more children (CSA and ORC Macro, 2001). The sum of the unmet need for spacing and the unmet need for limiting forms the *total unmet need* (see Figure 1).

Figure 1 Unmet Need for Contraception in Ethiopia



Chapter 2

Unmet Need for Family Planning

2.1 Level of Unmet Need

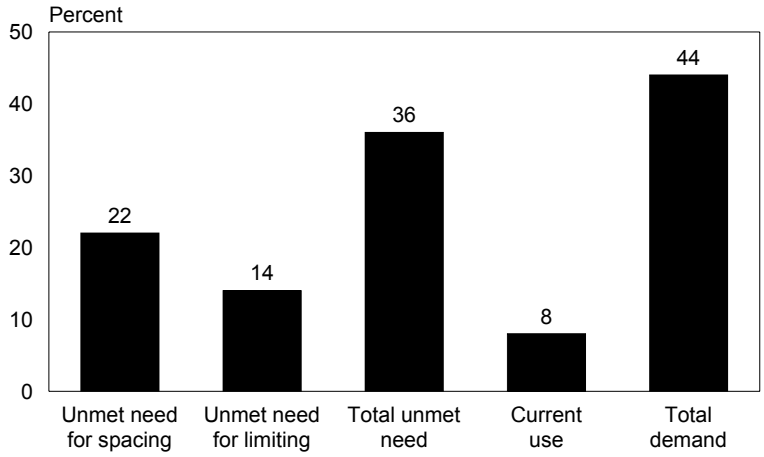
The level of unmet need in a country is not static but constantly changing. Most countries follow a similar pattern as they move through the demographic transition from high to low fertility. In general, the demand for limiting births in a population passes through four stages during which the level of unmet need for limiting first rises and then falls. These stages are: 1) high fertility stage—where there is neither much contraceptive use nor much unmet need because most couples do not want to, or are unaware that they can, limit or space births; 2) change-in-attitude stage—where as more couples want to control their fertility, unmet need rises because attitudes change faster than the use in contraceptives; 3) change-in-behavior stage—where contraceptive use rises rapidly, while unmet need declines; and 4) lower-fertility stage—where use of family planning is high and unmet need becomes very low (Robey et al., 1996). These four stages can also be referred to as the pretransition stage, the early transition stage, the late transition stage, and the final stage (Westoff and Ochoa, 1991).

For some people, unmet need is a stage they pass through when they recognize a need to control their fertility, but have not yet taken action. Others have unmet need because of impediments that prevent them from using family planning. The most commonly recognized reasons for nonuse of family planning are: inconvenient or unsatisfactory services, lack of information, fears about contraceptive side effects, belief that becoming pregnant is unlikely, ambivalence about future childbearing, and opposition from husband's family and community.

Ethiopia is at a high-fertility stage, where the use of contraceptive methods is low and the size of the unmet need group is high. This is because more couples are becoming aware of the possibility to limit or space their births. The demand for family planning in Ethiopia will continue to increase in coming years. The future trend in the level of the unmet need in the country may increase if demand outstrips supply. Several African countries have exhibited different trends in levels of unmet need, although all have shown large increases in the total demand for family planning (Westoff and Ochoa, 1991).

The Ethiopia DHS survey indicates that among currently married women unmet need for spacing is 22 percent, while unmet need for limiting is 14 percent. Thus, the total unmet need is 36 percent. Met need for family planning is 4 percent for spacing and 4 percent for limiting (a total of 8 percent). Thus, the total demand for family planning for the country is 26 percent for spacing and 18 percent for limiting (a total of 44 percent). Only 18 percent of the total demand for family planning is currently being satisfied. If all the women who reported unmet need for family planning were using a method, the contraceptive prevalence rate would increase to 44 percent (Figure 2).

Figure 2 Unmet Need for Family Planning and the Demand for Family Planning



The survey results indicate that there are variations in the level of unmet need among currently married women with different background characteristics (Table 1). The level of unmet need for family planning does not show a strong variation by age of women. However, there is a strong variation when distinction is made between unmet need for spacing and unmet need for limiting. Unmet need for spacing is higher among younger women, while unmet need for limiting is higher among older women. There is also strong variation in the level of unmet need according to the place of residence of the women. Total unmet need is higher in rural areas than in urban areas. This is mainly because of wider use of family planning in urban areas (36 percent of currently married women in urban areas use family planning, compared with 4 percent in the rural areas). The major difference in the level of unmet need between the rural and urban women is due to the differences in the level of unmet need for spacing, where 14 percent of urban and 23 percent of rural women report such a need.

The mainly nomadic regions of Affar and Somali have the lowest proportion of women with unmet need. On the other hand, Addis Ababa has a low proportion of unmet need because of the very high proportion of users of family planning (45 percent of the currently married women in Addis Ababa are users of family planning). The Amhara Region has the highest proportion of women with unmet need. Total unmet need shows little variation by educational level of women (35 percent of women with no education, 42 percent of women with primary education, and 29 percent with secondary education and higher have unmet need). The use of family planning increases sharply with the increase in the level of education (only 5 percent of those with no education use family planning compared with 45 percent of those with secondary education or higher). Thus, the total demand for family planning increases as women's level of education increases. The total demand for family planning is 40 percent among those who have no education, 58 percent among those who have primary education, and 74 percent among those with secondary or higher education.

Table 1 Percentage of currently married women with unmet need for family planning, and percentage of demand satisfied, by background characteristics

Background characteristics	Unmet need			Percentage of demand satisfied
	For spacing	For limiting	Total	
Age group				
15-19	35.8	4.6	40.4	8.8
20-24	31.7	6.2	37.8	16.5
25-29	28.4	8.7	37.2	20.6
30-34	21.1	17.7	38.8	18.8
35-39	13.9	21.9	35.8	23.3
40-44	9.8	27.3	37.2	17.6
45-49	3.4	14.7	18.1	18.6
Residence				
Urban	13.8	11.2	25.0	58.8
Rural	22.9	14.3	37.3	10.3
Region				
Tigray	18.8	9.1	28.0	26.7
Affar	7.7	4.6	12.3	38.6
Amhara	21.2	19.7	40.9	15.5
Oromiya	23.1	13.3	36.4	15.4
Somali	10.9	3.4	14.3	15.3
Benishangul Gumuz	19.5	12.4	31.9	21.5
SNNPR	24.3	11.2	35.5	15.2
Gambella	23.0	11.4	34.4	28.2
Harari	14.6	15.6	30.1	42.2
Addis Ababa	8.1	11.1	19.2	70.2
Dire Dawa	15.4	9.1	24.5	53.7
Education				
No education	21.0	14.3	35.3	11.5
Primary	28.0	13.6	41.6	28.3
Secondary or higher	20.2	8.9	29.0	60.6
Religion				
Orthodox	21.0	17.7	38.7	20.6
Protestant	25.1	10.8	35.9	14.8
Muslim	21.1	10.3	31.4	16.9
Other	23.9	8.5	32.4	12.6
Ethnic group				
Amara	20.0	19.7	39.7	23.2
Oromo	23.4	12.7	36.1	14.4
Tigraway	19.0	9.3	28.3	28.7
Other	22.6	10.0	32.7	14.0
Number of living children				
0	19.5	4.0	23.5	15.7
1	27.6	4.5	32.1	16.9
2	29.0	7.3	36.3	18.5
3	26.3	10.8	37.1	21.9
4+	15.9	23.8	39.7	18.1
Total	21.8	13.9	35.8	18.4
Number	2,136	1,365	3,501	3,501

Orthodox Christians have the highest unmet need, 39 percent. Protestant Christians have an unmet need of 36 percent, and unmet need among Muslims is 31 percent. Among the different ethnic groups, the Amharas have the highest unmet need for family planning (40 percent). The Oromos have an unmet need of 36 percent, while the Tigraways have an unmet need of only 28 percent.

As expected, unmet need for limiting increases sharply with the number of children. About one-fourth of women who have four or more children have an unmet need for limiting. The proportion of women who have an unmet need for spacing is highest among those who have one to three living children.

2.2 Characteristics of Women with Unmet Need

Statistical weights were used to obtain estimates of the population of women with unmet need by various background characteristics (Table 2). The weights were calculated to provide the actual size of the unmet need group in the areas covered by the survey (a total of 14 million women age 15-49 in the country). The survey covered the entire country, except for some nomadic areas of Affar and Somali. In the Affar Region, only the sedentary parts of three of the five zones were covered, while in the Somali Region only the sedentary parts of three of the nine zones were covered.

A total of 3.2 million Ethiopian women are estimated to have an unmet need for family planning. Of these, 2 million have an unmet need for spacing, while 1.3 million have an unmet need for limiting. The number of Ethiopian women with unmet need is very large. Greater numbers of women with unmet need have been observed in only a few other countries. Using the results from selected DHS surveys, it was observed that India had 31 million women with unmet need in 1992, Pakistan had 5.7 million in 1990-91, Indonesia had 4.4 million in 1991, Bangladesh had 4.4 million in 1994, and Nigeria had 3.9 million in 1990 (Robey et al., 1996).

When considering the age distribution of the Ethiopian women who have an unmet need for spacing, it is observed that two out of three are below 30 years of age. When considering only those who have an unmet need for limiting, three out of four women are 30 years of age and over. Most of the women who report unmet need (92 percent) are found in the rural areas. Thirty-nine percent of women in the Oromiya Region have an unmet need, while 30 percent of women in the Amhara Region and 22 percent of women in the SNNP Region have an unmet need. However, the Amhara Region has the largest number of women who have an unmet need to limit. Regarding education, 82 percent of women with an unmet need are illiterate, 14 percent have primary education, and only 4 percent have secondary education or higher. More than one-half of the women with an unmet need are Orthodox Christians (54 percent), around one-fourth (26 percent) are Muslims, and 16 percent are Protestants. The number of women who report unmet need among the Oromoes and Amharas is equal (35 percent each). More than one-half of the women (59 percent) who have an unmet need for spacing have one to three children, while 72 percent of those who report an unmet need for limiting have four or more children.

Table 2 Percentage of Ethiopian women with unmet need for family planning and percentage of married women who are using family planning, by background characteristics

Background characteristic	Unmet need for spacing		Unmet need for limiting		Total unmet need		Percentage of married women who are using family planning
	Percent	Number	Percent	Number	Percent	Number	
Age group							
15-19	14.4	284,114	2.9	36,576	9.9	320,690	3.9
20-24	26.8	526,946	8.2	102,706	19.5	629,652	7.5
25-29	27.3	537,414	13.1	165,313	21.8	702,727	9.6
30-34	15.5	305,938	20.3	255,782	17.4	561,720	9.0
35-39	9.4	184,098	23.1	291,129	14.7	475,226	10.9
40-44	5.0	99,118	22.0	276,246	11.6	375,364	7.9
45-49	(1.5)	30,289	10.4	130,339	5.0	160,628	4.1
Residence							
Urban	7.7	151,327	9.8	123,009	8.5	274,335	35.6
Rural	92.3	1,816,589	90.2	1,135,083	91.5	2,951,672	4.3
Region							
Tigray	5.5	108,822	4.2	52,684	5.0	161,506	10.2
Affar	0.4	8,793	0.4	5,292	0.4	14,085	7.7
Amhara	25.7	505,623	37.3	468,734	30.2	974,357	7.5
Oromiya	40.8	803,398	36.7	461,460	39.2	1,264,858	6.6
Somali	0.6	11,308	*	3,490	0.5	14,798	2.6
Ben-Gumz	1.0	19,978	1.0	12,670	1.0	32,649	8.7
SNNP	24.3	477,800	17.5	220,271	21.6	698,071	6.4
Gambela	0.3	6,285	0.2	3,131	0.3	9,416	13.5
Harari	0.1	2,924	0.2	3,118	0.2	6,042	22.0
Addis Ababa	0.9	17,558	1.9	24,053	1.3	41,611	45.2
Dire Dawa	0.3	5,426	0.3	3,189	0.3	8,615	28.4
Education							
No education	80.0	1,573,830	85.1	1,071,091	82.0	2,644,921	4.6
Primary	15.2	299,745	11.6	145,530	13.8	445,275	16.4
Secondary or higher	4.8	94,341	3.3	41,470	4.2	135,811	44.8
Religion							
Orthodox	47.8	940,885	62.9	791,196	53.7	1,732,081	10.0
Protestant	18.4	362,516	12.4	155,869	16.1	518,385	6.2
Muslim	28.8	566,950	22.0	276,433	26.1	843,383	6.4
Other	5.0	97,565	2.7	34,593	4.1	132,158	4.7
Ethnic group							
Amara	28.7	564,733	44.3	557,623	34.8	1,122,356	12.0
Oromo	37.2	731,832	31.6	397,056	35.0	1,128,888	6.1
Tigraway	5.8	113,774	4.4	55,738	5.3	169,512	11.4
Other	28.3	557,577	19.7	247,674	25.0	805,252	5.3

Continued….

Table 2—*Continued*

Background characteristic	Unmet need for spacing		Unmet need for limiting		Total unmet need		Percentage of married women who are using family planning
	Percent	Number	Percent	Number	Percent	Number	
Number of living children							
0	10.0	196,595	3.2	39,792	7.3	236,387	4.4
1	20.3	399,909	5.2	65,443	14.4	465,352	6.5
2	21.7	426,095	8.5	106,623	16.5	532,718	8.3
3	17.4	342,060	11.2	141,156	15.0	483,216	10.4
4+	30.7	603,258	71.9	905,077	46.8	1,508,334	8.8
Months since last birth							
0-11	30.5	599,845	21.2	266,430	26.9	866,275	3.4
12-23	29.2	574,057	24.8	311,496	27.5	885,553	8.5
24-47	27.7	545,684	36.8	463,566	31.3	1,009,250	12.2
48	3.9	76,587	15.2	191,395	8.3	267,982	9.5
Never gave birth	8.7	171,744	2.0	25,205	6.1	196,949	4.1
Total	100.0	1,967,916	100.0	1,258,091	100.0	3,226,008	8.1

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that the figure is based on fewer than 25 unweighted cases and has been suppressed.

The demand for family planning is high soon after the birth of a child. It was observed that one out of the three women who report unmet need for spacing had their last birth within the previous 12 months. Unmet need to limit births within this group of women is also high. One out of five women who have unmet need for limiting had their last birth within the previous 12 months. Therefore, the fact that many women had a recent birth cannot be taken as an indicator of low demand for family planning.

Knowledge of contraceptive methods among women who have unmet need is limited. One out of ten women with unmet need has never heard of family planning, and more than half of the women with unmet need do not know a source for any family planning methods (Table 3). Only 13 percent of women with unmet need have heard about family planning on the radio during the last few months. One of the reasons for the lack of media exposure to family planning messages is the scarcity of radio sets in the country. Only 19 percent of women with unmet need have a radio in the house. Some of the women who have unmet need have used a method of family planning in the past. Eighteen percent of those who have an unmet need for limiting and 11 percent of those who have an unmet need for spacing have ever used a method of contraception.

Table 3 Percentage of Ethiopian women with unmet need for family planning and percentage of married women who are using family planning, by knowledge of and attitudes toward family planning

Background characteristic	Unmet need for spacing		Unmet need for limiting		Total unmet need		Percentage of married women who use family planning
	Percent	Number	Percent	Number	Percent	Number	
Knowledge of any method							
Knows no method	12.7	250,541	7.6	95,760	10.7	346,301	0.0
Knows any method	87.3	1,717,375	92.4	1,162,331	89.3	2,879,706	9.4
Knowledge of source for any method							
Knows source	40.0	787,640	44.8	564,004	41.9	1,351,644	16.0
Does not know source	60.0	1,180,276	55.2	694,088	58.1	1,874,364	2.9
Has radio							
No	76.2	1,499,242	79.2	996,627	77.4	2,495,869	4.6
Yes	19.9	391,778	17.1	214,628	18.8	606,406	20.7
Not dejure resident	3.9	76,200	(3.7)	46,837	3.8	123,037	7.6
Heard FP on radio last month							
No	86.8	1,708,028	87.4	1,096,367	87.0	2,804,395	5.3
Yes	13.2	259,888	12.6	158,127	13.0	418,015	24.1
Ever use of any FP method							
Never used	89.0	1,751,417	82.3	1,035,985	86.4	2,787,402	NA
Ever used	11.0	216,500	17.7	222,106	13.6	438,606	48.6
Husband approves of FP							
Disapproves	29.8	586,052	22.0	276,844	26.8	862,897	3.0
Approves	35.6	700,763	45.5	571,758	39.5	1,272,521	18.9
Don't know	34.6	681,101	32.4	407,506	33.8	1,088,607	2.2
Discussed FP with partner							
Never	67.3	1,325,201	60.1	755,135	64.5	2,080,336	2.5
Once or twice	19.3	380,131	20.4	256,503	19.7	636,634	16.1
More often	13.3	262,584	19.5	244,471	15.7	507,055	27.5
Respondent approves of FP							
Disapproves	19.5	383,466	13.7	172,441	17.2	555,907	0.8
Approves	69.8	1,373,774	78.9	990,669	73.3	2,364,443	12.4
Don't know	10.7	210,677	7.4	92,998	9.4	303,674	1.1

Continued…

Table 3—*Continued*

Background characteristic	Unmet need for spacing		Unmet need for limiting		Total unmet need		Percentage of married women who use family planning
	Percent	Number	Percent	Number	Percent	Number	
Problem if became pregnant							
Big problem	76.4	1,115,688	87.8	932,269	81.2	2,047,957	12.2
Small problem	7.8	113,833	4.5	48,306	6.4	162,139	14.8
No problem	14.3	208,881	5.6	59,793	10.7	268,673	12.8
Says she can't get pregnant/ not having sex	*	21,179	(2.0)	21,509	(1.7)	42,688	8.6
Husband's desire for children							
Both want same	35.9	706,476	35.0	439,116	35.5	1,145,592	12.3
Husband wants more	26.4	519,064	29.8	374,676	27.7	893,740	7.7
Husband wants fewer	4.4	86,617	6.6	82,875	5.3	169,492	13.9
Don't know	33.3	655,759	28.6	359,441	31.5	1,015,200	3.2
Total	100.0	1,967,916	100.0	1,258,091	100.0	3,226,008	8.1

Note: Information on "problem if became pregnant" was collected by excluding women who are pregnant. Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that the figure is based on fewer than 25 unweighted cases and has been suppressed.

Communication between husband and wife is low. One out of three women with unmet need does not know whether her husband approves of family planning, while 40 percent believe that their husband approves and 27 percent believe that their husband disapproves. Sixty-five percent of women have never discussed family planning with their husband during the last year, while 20 percent discussed family planning once or twice, and only 16 percent discussed family planning more often. Approval of family planning among married women with unmet need is high. More than seven out of ten women approve of family planning, while only 17 percent disapprove. Eighty-one percent of women with unmet need report they would find it a big problem if they became pregnant within a few weeks. Thirty-two percent do not know how many children their husband wants, while 28 percent believe that their husband wants more children than they do. Only 5 percent believe that their husband wants fewer children than they do.

Users of contraception differ from nonusers in various ways. The proportion of all women (those who have unmet need and those who do not have unmet need) who are using contraception is indicated in the last columns of Tables 2 and 3. As can be observed in these tables, urban women, highly educated women, Orthodox Christian women, and those who have three or more children are more likely to be users of family planning. Similarly, those who have knowledge of sources of family planning methods and those who have radio sets in the house are also more likely to be users of family planning. Approval of family planning by the husband and approval of family planning by the woman herself are predictors of contraceptive use.

Table 4 Distribution of Ethiopian women with unmet need for family planning by intention to use a family planning method, main reason for not using a method, and preferred future method of family planning

	Unmet need for spacing		Unmet need for limiting		Total unmet need	
	Percent	Number	Percent	Number	Percent	Number
Intention to use FP method						
Use later	64.7	1,274,191	71.7	900,954	67.5	2,175,145
Unsure about use	(1.9)	36,871	*	12,545	(1.5)	49,416
Does not intend to use	33.4	656,854	27.3	342,609	31.0	999,463
Total	100.0	1,967,916	100.0	1,258,091	100.0	3,226,008
Main reason for not using a FP method						
Fertility-related reasons						
Infrequent sex	*	9,046	*	23,539	(3.1)	32,585
Menopausal, hysterectomy			*	3,904	*	3,904
Sub fecund, infecund			(5.9)	20,916	(2.0)	20,916
Wants more children	36.4	252,744	*	3,286	24.4	256,031
Opposition to use						
Respondent opposed	8.2	57,157	(8.3)	29,406	8.3	86,563
Husband opposed	(6.9)	48,154	*	17,858	6.3	66,013
Others opposed	*	152	*	10	*	162
Religious prohibition	10.8	74,858	14.0	49,786	11.9	124,644
Lack of knowledge						
Knows no method	11.7	80,936	14.6	52,021	12.7	132,957
Knows no source	*	27,168	*	5,937	(3.2)	33,106
Method-related reasons						
Health concerns	10.6	73,220	24.9	88,419	15.4	161,639
Fear of side effects	*	31,618	*	26,289	(5.5)	57,907
Lack of access	*	1,883	*	1,335	*	3,218
Costs too much			*	2,733	*	2,733
Inconvenient to use	*	2,795	*	1,681	*	4,476
Interfere with body	*	7,217	*	5,828	*	13,045
Other	*	16,938	*	8,999	(2.5)	25,937
Don't know	*	9,837	*	13,207	*	23,045
Total	100.0	693,725	100.0	355,154	100.0	1,048,880
Preferred future method of FP						
Pill	37.3	475,049	30.3	272,647	34.4	747,697
Injectables	48.0	610,859	53.5	481,149	50.3	1,092,008
Norplant	(4.8)	60,956	(6.7)	59,845	5.6	12,801
Other methods	3.8	48,681	*	*	3.2	69,571
Don't know	5.8	73,889	7.5	67,090	6.5	140,979
Total	100.0	1,272,072	100.0	898,983	100.0	2,171,055

Note: Information on "main reason not to use a method" was collected by excluding women who intend to use family planning. Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that the figure is based on fewer than 25 unweighted cases and has been suppressed.

Sixty-seven percent of women with unmet need for family planning say they intend to use a method of contraception in the future (Table 4). Intention to use family planning is higher among women with an unmet need to limit than among those with an unmet need to space. Information on the reasons why they do not intend to use family planning was collected from women with unmet need who do not intend to use. "Health concerns" and "fear of side effects" together are cited by 21 percent of these women. Lack of knowledge about family planning methods or lack of knowledge about sources of the methods is reported by 16 percent. Opposition to the use of family planning by the respondents and/or their spouses is reported by 15 percent. Twelve percent of respondents who do not intend to use family planning believe that their religion opposes the use of family planning. One in four women with unmet need reported that they do not intend to use family planning because they want more children. The latter response was obtained even though the question referred to their intention to use family planning after they had attained the number of children they desire. One of the reasons for this may be that some of these women believe that contraception is a means of limiting births but not of spacing them (Govindasamy and Boadi, 2000).

Several in-depth studies were conducted in the 1990s that involved primary data collection using qualitative and quantitative approaches. These data were compiled along with several DHS survey analyses that examined the causes of unmet need (Casterline and Sinding, 2000). From these in-depth studies, the major causes of unmet need are identified to be the following: access to services, lack of necessary knowledge about contraception methods, social opposition to their use, and health concerns about possible side effects. In the 2000 Ethiopia DHS, women who were not using family planning were asked the reason why they were not using any method. Table 5 presents the responses of women who were currently not using a method but who intended to use one in the future. The women were allowed to mention more than one reason for not using family planning. Therefore, the percentages presented in the table refer to the percentage of the women who cited each particular reason out of the total women. Lack of knowledge about family planning sources was cited by 21 percent of respondents, while 11 percent reported that they lacked knowledge about family planning methods. Health concerns were cited by 10 percent, while 7 percent said that they are afraid of side effects. Ten percent of the women stated that their husbands are opposed to the use of family planning.

Table 5 Percentage of Ethiopian women with unmet need for family planning who intend to use a family planning method in the future by reason for not using a method

	Unmet need for spacing		Unmet need for limiting		Total unmet need	
	Percent	Number	Percent	Number	Percent	Number
Fertility-related reasons						
Not having sex	(4.2)	40,043	3.9	28,861	4.1	68,904
Infrequent sex	(1.8)	17,325	3.9	28,271	2.7	45,596
Postpartum amenorrheic	27.6	261,431	18.0	131,727	23.4	393,158
Breastfeeding	24.9	236,078	20.8	152,043	23.1	388,121
Fatalistic	8.3	78,783	8.2	60,090	8.3	138,874
Opposition to use						
Respondent opposed	*	6,096	*	8,203	*	14,299
Husband/ partner opposed	9.8	92,547	(10.0)	73,418	9.9	165,964
Others opposed	*	16,256	*	4,877	*	21,133
Religious prohibition	*	3,171	*	5,353	*	8,524
Lack of knowledge						
Knows no method	10.9	102,831	10.0	72,830	10.5	175,661
Knows no source	19.3	183,235	22.5	164,666	20.7	347,902
Method-related reasons						
Health concerns	8.5	80,253	12.8	93,495	10.4	173,748
Fear of side effects	(5.2)	49,610	(9.1)	66,473	6.9	116,084
Lack of access/ too far	(4.2)	40,127	(5.5)	39,917	4.8	80,044
Cost too much	*	21,375	*	15,001	*	36,376
Inconvenient to use	*	11,034	*	7,002	*	18,036
Interferes with body's natural process	*	6,813	*	4,541	*	11,354
Total		947,032		73,113		1,678,145

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that the figure is based on fewer than 25 unweighted cases and has been suppressed.

Chapter 3

Family Planning Program and Policy Environment

3.1 Historical Perspective of the Family Planning Program

In Ethiopia, family planning programs were first started in the 1960s by a local nongovernmental organization (NGO), the Family Guidance Association of Ethiopia (FGAE). The primary aim of FGAE was to provide family planning information, counseling, and services to the families who voluntarily expressed their need to space or limit births. When the program started, it faced various social, cultural, and political constraints, and it did not get support from the government and the public. Particularly, during the first decade of the association, due to opposition from politicians within the government, religious leaders, and others, the program mainly focused on creating awareness about family planning, and services were limited to only a few clients. The association was providing family planning services on a part-time basis in government clinics. They opened the first family planning clinic in Ethiopia in 1975 in Addis Ababa. Since the early 1980s, FGAE has been slowly expanding its services, and today it is running 18 clinics in different parts of the country (FGAE, 2000).

The family planning service provision, through the public health institutions of the country, was started in the 1980s. During this period, the idea of integrating family planning service with maternal and child health services was introduced in many countries. In Ethiopia, the Ministry of Health (MOH) integrated family planning with the maternal and child health (MCH) services during the 1980s. This created some favorable conditions to strengthen and expand family planning services in the country. Since then, family planning services are provided in health institutions integrated with MCH services, and currently almost all hospitals and health centers have integrated family planning services (NOP, 1997). However, the availability of trained personnel and contraceptive commodities is critical in providing effective services to existing health institutions. In 1990, the contraceptive prevalence rate (CPR) in the country was only 5 percent among currently married women of childbearing age (CSA, 1993).

Because it aims to improve the quality of care and increase client satisfaction, the method mix has been diversified; this has widened the clients' choice of contraceptive methods. Currently, a broad range of modern contraceptives is available to clients: more than six brands of oral contraceptives, injectables, condoms, IUDs, sterilization, foaming tablets, and Norplant (MOH and WHO, 1999). However, despite the availability of a broad range of modern contraceptive methods, contraceptive prevalence remains very low and only a few methods (the pill and injectables) are predominantly used. The method mix is observed to be similar in rural and urban areas. This has been evident from the 2000 DHS and the studies conducted in various parts of the country (Assefa, 1998; Birhan, 2001a and 2001b; ROP, 2000). According to the 2000 DHS, among currently married women who are using contraceptives, 40 percent use the pill and 49 percent use injectables. Apparently, the use of other modern contraceptive methods, particularly long-term and permanent methods, such as the IUD, Norplant, and sterilization, is almost negligible (CSA and ORC Macro, 2001; FGAE, 2001). A reproductive health assessment for the country was conducted in 1999. The report suggests that the methods available through the public sector, such as injectables, condoms, surgical sterilization, and possibly Norplant and IUDs, appear to have the potential for increased utilization (MOH and WHO, 1999).

To expand and improve access to family planning services, FGAE initiated a community-based distribution (CBD) program through which community residents who are not health professionals deliver contraceptive methods and services. As various CBD sites show, the CBD approach has increased the availability and use of family planning. CBD agents provide family planning information, distribute condoms and oral contraceptives, and make referrals for other clinical methods. The CBD agents are selected by the community, and undergo the necessary training to serve the community by creating awareness and distributing contraceptive methods such as oral contraceptives and condoms. Normally, the program includes referral to other clinical contraceptives. In an effort to integrate reproductive health (RH) into all health service delivery, there is a shift from CBD to community-based reproductive health (CBRH) program. The CBRH agents receive training that enables them educate the community on sexually transmitted infections (STIs) including HIV/AIDS, maternal and child health services, eliminating harmful practices, and other relevant issues (FGAE, 2000).

The first CBD program was introduced in 1992 in Jimma (Gobena, 1998), where contraceptive prevalence increased from 1.3 percent to about 15 percent during the five-year project. Currently, the CBRH program is carried out both in rural and urban areas by governmental and nongovernmental institutions. FGAE is providing family planning services through 563 CBRH agents who are operating in 138 outreach sites; the services offered through this approach are contributing to a share of nearly 70 percent of acceptors (FGAE, 2001).

The number of institutions, NGOs, and private sectors that provide family planning services has been increasing. Since the adoption of the National Population Policy, a conducive environment has been created for expanding family planning programs in the country. The existing institutions are expanding the scope of their services by improving the method mix and by integrating new approaches, such as CBRH and youth programs. A number of international and local NGOs, such as Marie Stopes International–Ethiopia (MSIE), the German Development Agency (GTZ), the Ethiopian Evangelical Church Mekane Yesus–Southern Central Synod (EECMY–SCS), and Ethiopian Aid, have also been involved in the provision of family planning programs.

Marie Stopes International–Ethiopia was established in 1990, and is one of the major NGOs providing reproductive health services in Ethiopia to improve family planning and reproductive health care for couples and individuals. Its first clinic was opened in Addis Ababa in the same year. MSIE has been expanding its service in Addis Ababa and in other parts of the country; seven additional clinics have become operational in Addis Ababa and in five other towns since 1994. Currently, its eight clinics are providing a wide range of reproductive health services in the six towns that are located in five different regions (COFAP, 2000). One of the major services being provided in these clinics is family planning. To increase access and impact, MSIE is offering family planning information and services through community-based reproductive health programs that include various nonclinic outlets in its operational areas. About 71 kebeles are covered by the CBRH program. MSIE has also extended its CBRH program to various high schools and workplaces, using peer promoters. MSIE believes that this approach serves as a link to the facilities, creating a workable referral system. MSIE identifies shortage of contraceptives, particularly Norplant and intrauterine contraceptive devices (IUCDs) as a major problem (MSIE, 2000). MSIE is expanding its services through different outlets, such as clinics, community-based and work-based services in seven towns (Packard Foundation–Ethiopia, 2001).

In 1999, regional development associations started providing family planning services through community-based programs. The Oromiya Development Association (ODA) is providing family planning services in two zones: Jimma and East Wellega of Oromiya Regional State, while the Amhara Development Association (ADA) is providing services in South Wollo, North Shoa, and the Oromiya zones of Amhara Regional State. These CBRH programs have referral and backup support from health facilities. The programs also undertake promotion of target-specific information, education, and communication (IEC) services as part of their activities (Packard Foundation-Ethiopia, 2001).

Community-based programs have been successful in delivering family planning services. In some rural villages, the level of knowledge about modern contraceptive methods and the contraceptive prevalence rate has increased considerably. In five weredas of the Eastern Shoa Zone of Oromiya, the CBD program has increased the contraceptive prevalence rate from 5 percent to 44 percent within three years (Sisay, 1998). In this CBD program, rural women development agents from the Ministry of Agriculture (MOA) supervised the agents and their contact with farmers. CBD programs in other parts of the country also registered a significant increase. For instance, in Yirgalem the CPR increased from 4 percent to 28 percent within five years, while in Bahir Dar it increased from nearly 0 to 55 percent within three years. Within six years of the introduction of the CBD program, FGAE's new and acceptor visits for family planning increased by more than 200 percent (FGAE, 2000). A CBD program by EECMY–SCS in two zones of the SNNP Region, showed an increase in the CPR from 4 percent to 36 percent in about three years (Mengistu et al., 1999). A study was carried out to assess the effectiveness of CBD family planning services by comparing randomly selected rural villages' current CBD program with past CBD programs and with villages where no CBD program was ever practiced. The study result indicated that knowledge and use of modern methods of contraceptives was significantly higher in the villages with CBD programs (Shimelse, 2000).

A social marketing program of contraceptive methods was introduced in Ethiopia in 1990 by DKT. DKT's social marketing strategies use commercial marketing techniques to make primary health care products accessible and affordable. DKT Ethiopia emphasizes voluntary fertility control and increased access to contraceptives and other essential health products. One of the objectives of DKT is to increase the contraceptive prevalence in the country by producing a continuous supply of high-quality contraceptives that are accessible and affordable (DKT, no date). Through this program, millions of condoms and oral contraceptives are being distributed through pharmaceutical outlets, clinics, rural drug vendors, and the CBRH programs. All retail outlets, including bars and hotels, are used as condom distribution outlets (mainly to control the spread of HIV/AIDS in the country). In an effort to improve the method mix, DKT has recently introduced *confidence,* a socially marketed injectable. As the document from DKT reveals, the social marketing program includes education and promotion of family planning in different local languages, using various educational materials and mass media. Market-day intervention has also been used as a strategy to educate the public and create awareness (DKT, no date). The program makes family planning methods easily accessible at shops and pharmacies. The program includes a component to provide social marketing of voluntary surgical contraceptive (VSC) methods in partnership with FGAE and MSIE (Packard Foundation-Ethiopia, 2001).

Workplace intervention is considered to be an important strategy to make reproductive health services accessible. There are some workplace interventions for family planning services in the country. For instance, FGAE is providing family planning services at 11 workplaces (FGAE, 2000) and MSIE is operating in 22 enterprises (MSIE, 2000).

The involvement of the private sector in providing family planning services is very important. An assessment was conducted on the reproductive health and family planning (RH/FP) service provision and on potentials in the private sector for Addis Ababa, where most of the private clinics are concentrated (Pathfinder International-Ethiopia, 1998). The study covered 105 "lower clinics" and 109 "medium and higher clinics," which constitute 90 percent of the private for-profit clinics in the city. The assessment indicated that, among the medium and higher clinics, 25 percent provided oral contraceptives, 14 percent injectables, and 8 percent IUCDs. Among the lower clinics, 19 percent provided oral contraceptives, 7 percent injectables, and 2 percent IUCDs. Pathfinder International–Ethiopia has also taken some initiatives to increase affordable and sustainable access to RH/FP services by replicating successful programs in the private for-profit sector (private clinics, workplaces, peer promoters, CBRHs, marketplaces, and petty traders). To improve the quality of family planning services provided by the private sector, Pathfinder International–Ethiopia is also providing management and service delivery training and supplies (Pathfinder International–Ethiopia, 2001). This project has increased the access to contraceptive users, and such support needs to be continued and expanded.

The NGOs working in the provision of reproductive health services in Ethiopia have established a membership organization called Consortium of Family Planning (COFAP) NGOs aiming to promote networking and assist coordination among the NGOs operating in the country (COFAP, 2000). COFAP brings together more than 50 NGOs involved in reproductive health programs to harmonize their activities, share resources, and provide technical assistance.

Government institutions and most NGOs involved in family planning programs have incorporated IEC activities into their program**.** The Health Education Center (HEC) of the Ministry of Health has been working to strengthen its IEC activities on family planning and other health-related issues. According to FGAE, information, education, and communication programs have been supporting its service delivery program since 1975 (FGAE, 2000). The IEC programs focused on the creation of public awareness and bringing about attitudinal change toward family planning.

Many agencies are providing technical and financial support to family planning programs in Ethiopia. UNFPA and USAID are, and will continue to be, the major donors of contraceptive methods (MOH, 2001c). The other organizations that support family planning programs in Ethiopia include the International Planned Parenthood Federation (IPPF), GTZ, MSIE, the Packard Foundation, Pathfinder International, the German Funding Agency for International Development (KFW), and the British Department for International Development (DFID).

3.2 Policy Environment

Currently, there is a conducive policy environment to strengthen and expand family planning services in Ethiopia. Recognizing the pressure of rapid population growth rate on the social and economic life of the people, the government adopted the National Population Policy in 1993. The goal of the policy is to harmonize the population growth rate with that of the economy to improve the well-being of the people. The policy has taken into consideration the various aspects of population issues, including the many social, cultural, and economic factors that influence, and are in turn influenced by, population change (TGE, 1993a). Reducing the high fertility rate to 4 children per woman and increasing contraceptive prevalence to 44 percent in 2015 are among the specific objectives of the policy. The policy also aims to mount an effective countrywide IEC program addressing small family size and its relationship to human welfare and the environment. The policy encourages the expansion of family planning programs through health institutions and community-based programs, and makes population- and family life-related education and information widely available through formal and informal media. The policy gives due emphasis to the involvement of NGOs, private sectors, and the community to complement the government's efforts to expand and strengthen family planning services.

The institutional frameworks suggested by the policy are the establishment of population offices at the national, regional, and zonal level and of a committee at the wereda (district) level (TGE, 1993a). However, institutional frameworks have been set up only at the federal and regional levels. The National Office of Population (NOP) was set up at the federal level to coordinate population activities of the various sectors. The NOP has three departments that are responsible for the coordination of three major subprograms, namely reproductive health, IEC and advocacy; and population and development strategy. Since the population program is a multisectoral program, to ensure concerted action of relevant organizations, the policy has also suggested the establishment of population councils at national and regional level. However, no population council has been established at the federal level.

Following the International Conference on Population and Development (ICPD) held in Cairo in 1994, the Population Program for the Implementation of the National Population Policy was revised to incorporate the reproductive health concept and other important issues identified during the conference. In the National Population Program, reproductive health (RH) is one of the three core subprograms (NOP, 1997), and family planning has been identified as one of the priority components of the RH subprogram. Since the ICPD, efforts have been made to integrate reproductive health services in the existing health institutions. The National Population Information, Education and Communication and Advocacy Strategy (NOP, 2000) has incorporated reproductive health as a major thematic area giving emphasis to family planning and other RH issues. The Strategy has identified low participation of men in family planning as one of the critical issue that has to be addressed in the IEC and advocacy interventions. One of the Strategy's program goals is to increase access to, and utilization of, family planning services.

In addition to the National Population Policy, many other policies such as the Health Policy and the National Policy on Ethiopian Women, support the expansion of the family planning programs. The health policy and the Health Sector Development Program (HSDP) of the country give due emphasis to improving the access to and the quality of family planning services (TGE, 1993b; FDRE, 1999). The five-year health-sector development program of the Ministry of

Health has included a reproductive health program in its Health Service Delivery and Quality of Care component. In general, the component focuses on improving access and quality of health services in the country. The Ministry of Health is making efforts to integrate reproductive health services into all health institutions. As part of its efforts, the MOH has revised service provider's guidelines, curricula and manuals to be used at various levels; it has also conducted training for service providers. An effort was made to expand the family planning services of the country and improve the method mix. The involvement of NGOs and of the private sectors is also being encouraged. However, the country depends on donor agencies for contraceptive procurement. Considering the huge unmet need for family planning in the country, commitment of the necessary funds by the government is essential for expansion of the services.

The reproductive health subprogram of the UNFPA-assisted 5th country program for 2002–2006 aims "to contribute to increased utilization of reproductive health information and services, to bring about improvements in the reproductive health status of all population groups" (Ethiopia–UNFPA, 2002). As part of the effort to improve the access to family planning information and services, evaluation of the CBRH services will be conducted; there is also a plan to increase the number of existing CBRH sites based on the recommendation of the evaluation. Most of the existing family planning services are being offered with the MCH services, which are mainly for mothers and children. Hence, men have little access to such services. To make reproductive health services easily available to men, the MOH will introduce these services in other areas of service delivery, such as outpatient clinics and male wards.

The National Policy on Women states that "the government shall ensure women the right to have access to basic health care facilities, information about traditional and modern family planning method. . . " as one of its strategies to empower Ethiopian women (TGE, 1993c). Relevant institutional frameworks for the implementation of the policy have been established. There is a women's affairs office (WAO) in the prime minister's office that coordinates the implementation of the policy. Women's affairs departments (WADs) have been established in sectoral ministries mainly to ensure gender mainstreaming in various sector policies, programs, strategies, and development plans. Women's affairs bureaus (WABs) and offices have been established at the regional level; these bureaus are responsible for coordinating the implementation of the policy in their respective regions and for mainstreaming gender issues in various sector plans and programs, including health programs. The Women's Policy encourages the establishment of women's associations at various levels. Women's associations have been established in most regions, even in the kebeles.

In the 1957 Ethiopian Penal Code, Article 805 prohibited the widespread use and advertising of modern birth control methods. It was necessary to amend this law because it was not aligned with the economic, health, women and population policies. The government addressed this issue and the law was amended in December 1998 (Federal Negarit Gazeta, 1998).

3.3 The Situation of Ethiopian Women

Ethiopian women have very limited access to education, paid employment, and economic resources. According to the 2000 DHS (CSA and ORC Macro, 2001), about 57 percent of women are working; of these working women, nearly half are self-employed and only 33 percent are paid in cash. Although there is some improvement in the accessibility of education in both rural and urban areas, a large majority of Ethiopians have little or no education, with females

being less educated than men. As the findings from the 2000 DHS revealed, more than three-quarters of females and 62 percent of males have no education and 27 percent of males and 17 percent of females have only some primary education. The survey also indicated that, among women of childbearing age, only 19 percent are literate. However, the statistics from the Ministry of Education (MOE, 2001) showed that there is a considerable improvement in girls' education; the net enrolment ratio in primary schools increased from 20 percent in 1997 to 42 percent in 2001.

Various social, economic, and cultural barriers limit women's travel outside the community for medical care. Rural women are engaged in agricultural and domestic activities on an average of 15 to 18 hours daily (NOP, 1999). Women have low decisionmaking status on family matters, including use of contraceptives and whether or when they want to have more children. Most of the time, the men make the decision to use contraceptive methods, as was seen in the responses of women in the 2000 DHS (CSA and ORC Macro, 2001).

Harmful practices are common in the country and cause serious health problems for girls and women. According to the recently revised family law, the legal age of marriage is 18 years for both males and females (Federal Negarit Gazeta, 2000). However, most women enter into marriage at a very young age. The 2000 DHS has revealed that 63 percent of women age 15–49 are currently married and, at the age of 30-34, nearly all women (98 percent) are ever married. The median age at first marriage is estimated at 16 years for women age 30–49 and it has slightly increased to 17 years for women age 25-29. Since girls are expected by their husbands' families and communities to have a child as soon as they enter into marriage, childbearing starts at an early age and continues throughout their reproductive age. According to the 1990 Family and Fertility Survey conducted by the Ethiopian Central Statistical Authority (CSA), the percentage of women who became mothers before the age of 20 was 63 percent in rural areas and 57 percent in urban areas (CSA, 1993). According to the 2000 DHS, more than half of the women age 30 and above had their first birth in their teens, and among women age 15-19, 16 percent have already become mothers or were pregnant with their first child (CSA and Macro, 2001). There is a substantial difference in age at first birth between rural and urban women. Among women age 15-19, 18 percent in rural areas and 9 percent in urban areas have already become mothers or were pregnant with their first child (CSA and ORC Macro, 2001). Thus, early marriage leads women to early childbearing, before they are physically and emotionally mature to be mothers. Early marriage is contributing to the prevailing high fertility level in the country, and this in turn is affecting the social and economic status of women.

Ethiopian women have very limited access to modern health services. About 95 percent of births are delivered at home; only 5 percent of women give birth in a health institution. Among pregnant women, only one in ten makes four or more antenatal care visits during her entire pregnancy. Only 1 in 10 mothers who have a live birth receives postnatal care.

In Ethiopia, as in many developing countries, pregnancy- and childbirth-related complications are believed to be one of the leading causes of death of women of reproductive age. The maternal mortality rate of the country is among the highest in sub-Saharan Africa. For every 100,000 live births, there are 875 deaths during pregnancy or within four months of birth (CSA and Macro, 2001). Studies have indicated that the incidence of unsafe abortion is high and constitutes a major cause of maternal morbidity and mortality, and that it is more common among young women. A study conducted in five hospitals in Addis Ababa revealed that abortion-related

maternal deaths contributed to 52 percent of all maternal deaths in the study hospitals (Seyoum, et al., 1993). Furthermore, a similar study conducted in Jimma Hospital showed that 31 percent of admissions to obstetric and gynecology wards result from complications of unsafe abortions (Ahmed, 1996). A study on unsafe abortions by the Ethiopian Society of Obstetrician and Gynecologist indicated that 58 percent of all the women who had unsafe abortions were in the age range of 20-30 years and that 50 percent of the pregnancies that ended in abortion were unwanted (ESOG, 2001).

In Ethiopia, media exposure is generally low. The Ethiopia 2000 DHS survey showed that 86 percent of women and 73 percent of men have no exposure to the mass media, i.e., read a newspaper once a week, watch television once a week, or listen to the radio once a week (CSA and ORC Macro, 2001). However, the radio is still the most commonly available type of media in the country and should be used to create awareness and promote family planning services.

During the biannual meeting of WADs, WABs, women's associations, women's professional associations and NGOs working on gender issues held in Awassa from December 21-28, 2001, which was organized by the WAO, the issue of making family planning accessible to women was raised and discussed. The participants expressed their concerns about the huge unmet need for family planning that was revealed by the Ethiopia 2000 DHS survey . The regional women's associations has showed interest in providing family planning information and services to their members if the right training and technical support are provided by the relevant health institutions.

3.4 Existing Health System and Facilities

To improve access to health services, the health sector reform was initiated in 1992, and the National Health Policy was adopted in 1993. The policy focuses on expanding access to community-based primary health care services and restructuring the health delivery system. The Health Sector Development Program, which is a general health care strategy, and an action plan to translate the new policy statement into action were launched in 1997. The program has a 20-year health service delivery-development strategy, aimed at attaining certain set targets within these 20 years. Consequently, the former six-tier health delivery system is being reorganized into a four-tier system, which includes primary health care units, with satellite community health clinics, wereda (district) hospitals, zonal hospitals and specialized hospitals. Primary health care units and their five satellite health stations are intended to serve a population of 25,000 people within a 10 kilometer radius catchment area (MOH and WHO, 1999).

Although there are some improvements in the health sector, most of the population still has little access to health services. Only about 51 percent of the population has access to basic health services (MOH, 2001a). Particularly for most rural parts of Ethiopia, access to health services is limited by distance, since clients have to travel long distances to seek medical help. Furthermore, there is a very uneven distribution of health facilities. Most of the health facilities are concentrated in urban areas, mainly in the capital cities of the country and regions. The private-sector health services and the services of NGOs are also concentrated in the urban areas. According to data from MOH (2001a), there are 110 hospitals, 382 health centers, 2,393 health stations, and 1,023 health posts in the country. About 84 percent (73 percent by MOH and 12 percent by other government agencies) of the hospitals in the country are public, while

7 percent and 8 percent are NGOs and private, respectively. Almost all the clinics (1,170 clinics), ranging from lower to special clinics, are privately owned. Involvement of the private sector in the provision of health service has been expanding recently, but there are still very few participants. As for pharmaceutical retail outlets, there are 311 pharmacies, 249 drug shops, and 1,917 rural drug vendors. The average number of persons per doctor and persons per nurse for the country is 47,836 and 8,461, respectively. This is a poor condition in comparison with the World Health Organization (WHO) standard (a physician to 10,000 persons and a nurse to 5,000 persons). Since most of the health services are concentrated in urban areas, access to health services in rural areas is even worse.

Since the health coverage in the country is limited, MOH is initiating various strategies to reach the Ethiopian population, particularly the rural population. These strategies include outreach services involving traditional birth attendants, healers, and other agents from the communities. As of 2001, there are 4,379 community health agents, traditional birth attendants and PHWs (MOH, 2001a)**.** Currently, MOH is designing a health sector extension package program. In the package program, three individuals who completed high school will be selected from each rural cooperative (locality of around 10,000 persons) and will be trained for one year to serve the community as health extension workers. The duties of the health extension workers include providing assistance in child immunization, antenatal and postnatal care, and family planning services.

The Reproductive Health Needs Assessment (MOH and WHO, 1999) identified the weakness of the public sector system as shortage of human resources due to high staff turnover and a limited amount of field-based staff with appropriate technical or sociocultural backgrounds. Stock-outs of basic supplies and equipment are also recognized as a major problem.

The public sector is the predominant source of contraceptive methods in the country; 78 percent of women obtain family planning methods from the public sector (CSA and Macro, 2001). Among the public sector facilities, the government health center is the most important source of contraceptives. NGOs and pharmacies are also found to be important sources of contraceptive methods. Moreover, shops are important sources, particularly for condoms; 23 percent of the women obtain condoms from this outlet.

3.5 Problems Encountered during Implementation

Various explanations have been given for the limited use of contraceptives. Frequent shortages of contraceptive supply at service delivery points, inadequately trained personnel, and fear and concern over side effects are among the major factors affecting the use of contraceptives (MOH and WHO, 1999). Shortage of contraceptive supply at service delivery points is repeatedly mentioned as one of the weaknesses of FP services in the country. The contraceptive inventory and logistic system survey (MOH, 2001b) revealed that facilities experienced a high level of stock-outs for all contraceptives (32-58 percent), while these contraceptives are available in the system in adequate quantities. The MOH will not need additional contraceptives other than Norplant in 2002. Furthermore, the survey indicated that there is no standard logistics management information system (LMIS) for contraceptives in Ethiopia, and only 41 percent of facilities are sending logistic information to the next higher level of the system. Among the facilities that send information, less than half send accurate information (MOH, 2001b).

An evaluation of Norplant insertion and removal services in Ethiopia found that there are concerns over 1) the ability of existing training programs to transfer appropriate knowledge and skills, 2) high user demand resulting in contraceptive method stock-outs; and 3) lack of adequate client follow-up. During the evaluation, some providers reported that they had performed many insertions but had not been trained in removals (MOH and WHO, 1999). The availability of various brands of contraceptive pills has also been reported as one of the reasons why many women stop using modern methods.

According to the critical assessment of POP/IEC activities in Ethiopia (NOP, 1996), the majority of institutions dealing with POP/IEC did not segment their audiences, and many of the messages developed for dissemination were lacking sociocultural, religious, and age and gender sensitivity. Furthermore, the study found that mass media channels were frequently used, while the traditional media were not, and that interpersonal communication is low. As the study also indicated, very few institutions conducted any form of assessment in selecting the media or in monitoring and evaluating their IEC programs. Pretesting of IEC materials was also rarely done (NOP, 1996).

A study on perception of intermediate target audiences in family planning, which covered the following four regions: Amhara, Oromiya, Addis Ababa, and SNNP Regions, identified the restriction of family planning education to health institution as a weakness of the existing programs (Eyerusalem and Yoseph, 1996). Information, education and communication materials are mostly available at health institutions and do not reach the majority of the population who do not come to the service delivery points. Other important issues that were identified as weaknesses of family planning programs are that IEC materials are not always appropriate and do not take into consideration languages, culture, and educational levels of the target groups and that existing programs do not target important groups, such as community leaders. A study jointly conducted by the NOP and HEC of the MOH also reported that IEC materials are available and used in towns; yet they are inadequate and in short supply in rural communities (HEC and NOP, 2000). The study also indicated that some materials are not understandable. According to the study, the most acceptable communication methods and strategies suggested by communities are: utilization of religious institutions, schools, and local community organizations; peer education; extensive use of IEC materials; and effective use of mass media as well as the traditional media and role models.

Chapter 4

Program Options

The previous sections of this document attempted to examine the history and current situation of the family planning program, the existing health system and facilities, the status of Ethiopian women, and the characteristics of currently married women with unmet need. This section will examine the various program options to meet the unmet need for family planning as observed in the 2000 DHS, in view of the previous discussions.

Developing a strategy that focuses on women with unmet need as a distinct target group is critical to the success of the program. But the program should be able to respond to the concern of these women. Therefore, it is essential to understand the causes of unmet need and the various cultural, social, and other barriers that prevent women from using contraceptives. This paper intends to analyze the situation of existing family planning programs and the data from the 2000 DHS to suggest program options to meet the unmet need of Ethiopian women.

In Ethiopia, where public health services are limited, most women with unmet need reside in rural areas, a large area of the countryside is inaccessible, most men and women are illiterate, and women have little decisionmaking power on family matters, meeting the unmet need for family planning is a serious challenge. Therefore, it is necessary to consider the various program options that address the needs of the different groups.

In developing countries, millions of women have an unmet need for family planning. China notwithstanding, about 20 percent of married women in the reproductive age group in these countries have an unmet need for family planning (Robey and Piotrow, 1994). The level of unmet need is the highest in Sub-Saharan African countries; in some countries up to one-third of married women have unmet need. The level of unmet need for family planning in Ethiopia is among the highest in Sub-Saharan Africa; 36 percent of currently married women have unmet need. It is estimated that among the 9 million currently married women in the reproductive age group, 3.2 million women have an unmet need for spacing and limiting. Of these, 2.9 million and 0.3 million women reside in rural and urban areas, respectively. Of the total women with unmet need, 2 million have an unmet need for spacing and 1.2 million have an unmet need for limiting. Family planning programs designed to meet the unmet need of these women should take into consideration the size of the population with unmet need to estimate the service required.

It has been argued that family planning programs could serve women better if they adopted a broader view of reproductive health. The provision of integrated reproductive health care services, including family planning, would enable many women to meet more of their needs with a single visit to a single clinic (Robey and Piotrow, 1994). In Ethiopia, since the ICPD, provision of integrated reproductive health services at the health institution level has been the major focus of the program. Strengthening such a program will contribute significantly to reducing the unmet need of family planning. In rural Ethiopia, where health services are largely inaccessible, women travel a long distance to reach a health service delivery point. Although the MOH and the NGOs have attempted to provide integrated reproductive health services at existing health institutions, evidence from assessments carried out by the government and the NGOs on reproductive health

and family planning and related issues have revealed the major weaknesses of the programs. To strengthen the service, the effort should continue by taking actions based on lessons learned from experience and findings from the various assessments. Thus, active involvement of various sectors such as NGOs, the private sector, community groups, and community leaders at different levels is critical.

In general, a family planning program must make available a full range of safe and effective contraceptive methods so that couples or individuals with different needs can have access to the appropriate methods to satisfy their needs. A study has indicated that the prevalence of contraceptives is observed to be high in developing countries where access to all the methods is high (Ross et al., 2002). Examining the unmet need by the age of the women from the 2000 DHS revealed that a substantial percentage of young women have an unmet need for spacing and that this group of women includes a large percentage of the population. About 1.2 million women age 15 to 29 have an unmet need for spacing. As age increases, the percentage of women with an unmet need for spacing declines; 36 percent of women in the 15 to 19 age group have an unmet need; the percentage declined to 3 percent for the 45 to 49 age group. The opposite is true for women with an unmet need for limiting; the percentage increased from 3 percent for women age 15-19 to 22 percent for women age 40-44. The DHS survey results also show that about one-quarter of the women with four or more children have an unmet need for limiting births. Family planning programs should focus on providing long-term family planning methods to the women in the older age groups and those with an unmet need to limit their family. A wide range of contraceptive methods should also be made available at service delivery institutions so that clients can obtain appropriate methods according to their needs.

Among married female contraceptive users in Ethiopia, 78 percent use modern methods and the rest (22 percent) use traditional methods. Of all the users of modern methods, about 44 percent use the pill and condoms, 49 percent use injectables and only 6 percent use other clinical methods. This is a similar pattern among developing countries with a low level of CPR (Ross et al., 2002). Family planning programs have to focus on changing the pattern so that more women rely on permanent methods. In this regard, the availability and accessibility of high-quality family planning services is crucial. According to the 1990 National Family and Fertility Survey of Ethiopia, contraceptive use was mainly limited to the pill; more than 70 percent of modern contraceptive users were using the pill and injectable users were negligible. As indicated above, in ten years there was a significant change, the percentage of injectable users increased to 49 percent. The increase in contraceptive prevalence rate in the country, from five in 1990 to eight in 2000, was mainly due to the use of injectables. This may indicate that the availability and accessibility of injectables have given women another choice.

As observed earlier, a wide range of methods is available in Ethiopia, i.e., various types of oral contraceptives, injectables, Norplant, and IUDs. In addition, various institutions, such as public health institutions, FGAE, MSIE, and private health institutions, are providing both male and female sterilization. The choice of methods is affected by many factors. It can be assumed that contraceptive users do not use permanent methods either because they do not have information about these methods, they do not have the access to such services, or they may have access to the methods but do not use them because of a negative impression of the methods mainly due to fear resulting from rumors. The service providers' attitude toward providing certain methods to clients with different needs is also important. At least, in a setting where such services are

available, the program should be assessed and redesigned to serve more women. The observed poor method mix can be improved by educating clients and the community on the available contraceptive methods and by strengthening the FP counseling and the referral system, particularly for CBRH programs, and for clinical and permanent methods.

The program intervention to meet the unmet need should seriously focus on strengthening the services of long-term and permanent methods such as Norplant, IUCD and sterilization (male and female). Family planning education and advocacy activities should promote these methods; this will give a better choice to women. Furthermore, use of long-term and permanent methods minimizes cost. A Norplant evaluation (MOH, 2001b), indicated that the number of Norplant users had exceeded 4,000 women within three years. But, due to stock-out, the expansion of the service could not continue at the same speed.

One cannot expect to meet the unmet need for family planning without making available enough supply of contraceptive methods, with method mix, at least at the existing health services in the country. To meet the unmet need for family planning, adequate supplies of contraceptives with different choices at service delivery points will be needed. To ensure this, putting up an effective contraceptive logistic management information system in place is crucial. According to the assessment conducted in 2001, there is no standard LMIS for contraceptive methods in Ethiopia, a large quantity of contraceptives methods expired on December 2001 throughout the country, while there were shortages at different service delivery points (MOH, 2001c). The frequent shortage of contraceptive supply at service delivery points is considered a major reason why clients were unable to obtain the most appropriate form of contraception. To solve the problem of shortage of supplies at service delivery points, although there are more than adequate supplies in contraceptive warehouses in the country, the MOH must immediately establish a LMIS involving relevant partners, such as governmental organizations, NGOs, and international agencies and donors. The MOH is concerned about the issue, and is planning to conduct various activities to establish effective LMIS so that the FP supplies will reach the needy. The LMIS system should also take into consideration the distribution of the unmet need across the country.

The distribution of so many different brands of contraceptive pills has been a concern for FP programs. When a client comes to take the next month's supply of pills, she may not be able to get the same brand. This creates frustration and the desire to wait until the same brand is available. This has been identified as one of the reasons why clients stop using contraceptive methods. The concerned institutions should create some forum to discuss how limited brands can be imported to reduce confusion.

Training of service providers is critical; as the need assessment of reproductive health in Ethiopia indicated, some service providers are offering services without being trained (MOH and WHO, 1999). While some service providers who perform Norplant insertions are trained to do so, they are not trained on removals. The quality of service provision is partly based on the skills of the service providers; training of the service providers is one of the areas that needs to be strengthened.

As noted earlier, accesses to health services is very limited and is concentrated in the urban areas. Family planning service is primarily being offered through health institutions, mostly through public health institutions. The community based family planning program was started recently and is not more than then years old. Since the coverage of health institutions is limited,

it is necessary to have other outlets for family planning services to meet the unmet need, both in rural and urban areas. In the rural part of Ethiopia, it is unthinkable to reach all the women with an unmet need for family planning through health institutions only. It is, therefore, crucial to use other possible outlets, particularly to meet the need of the 2 million currently married women who have an unmet need for family planning in the rural part of the country; expanding and strengthening community based programs involving various sectors of the community is among the major program options.

There is no doubt that CBRH programs for family planning should be encouraged and expanded, particularly in a setting where clinical facilities are not available. The experiences in this country, and elsewhere have shown that community based family planning programs are especially successful in reaching those women who have very limited or no access to family planning services. The CBRH programs in various parts of the country have made the service easily accessible, and the contraceptive prevalence rate has increased significantly in the covered areas (Sisay, 1998; Mengistu et al., 1999; FGAE, 2000). But in view of the large size of the population, the existing CBRH programs are in their rudimentary stage. For effective implementation of the CBRH program, a strong backup system is very important. Establishing a referral system for clinical FP methods is essential to the sustainability of the program and the provision of a wider range of method choices for the client. Studies on family planning community services in Mali and Bangladesh indicate that contraceptive use increased when CBD workers offered a wide variety of methods to clients, either directly or through a referral service (FHI, 1999). In a CBD program in Mali, the contraceptive prevalence rate increased from 12 percent to 31 percent in 18 villages, six months after the pill was added to the barrier methods. In a CBD program in rural Bangladesh, one year after injectables were added to the pill and condoms and a referral system was established, the contraceptive prevalence rate rose from 10 percent to 32 percent.

The regional women's associations have shown an interest in family planning programs. These associations are involved in various activities to improve the economic and social status of their members. Some of the association leaders believe that reproductive health, particularly family planning, is one of the interventions that can make a difference in the life of Ethiopian women; thus, they reinforce other such measures. They would like to be actively involved in creating awareness and in educating women on the issue. These associations have many members and a structure up to the kebele level (lower-administration level). Thus, these associations can be important outlets for creating awareness and for educating women on reproductive health issues, including family planning. Selected individuals among the members may be trained as CBRH agents to provide family planning services to their peers.

As indicated earlier, the quality and relevance of IEC materials has been one of the concerns for effective implementation of family planning programs. There is also a need for a collaborative concerted effort between government agencies and NGOs to strengthen service provision along with the IEC and advocacy activities, to bring behavioral and attitudinal change at various levels. As the 2000 DHS indicate, only 16 percent of women in the childbearing age group covered in the study had heard a family planning message on the radio during the last few months, while only 6 percent had been exposed to FP messages in the print media (newspaper, magazine, articles, posters or leaflets). The very low exposure of these women to the print media is due to their low educational level and the limited distribution of print materials about family planning

information. Women who reside in urban areas and women who are better educated are more likely to be exposed to the print media. Hence, the program intervention should consider choosing more appropriate channels, such as traditional media, to reach uneducated women in rural areas.

As the 2000 DHS findings indicate, the major reasons why women with an unmet need for family planning do not act on their desire to limit fertility include religious prohibition, and the opposition of respondents or of their husbands to the use of contraceptive methods. As the survey also reveals, there is little communication between couples on family planning. The majority of women (65 percent) never discussed family planning with their partner, while another 20 percent of women discussed family planning only once or twice. Furthermore, about 60 percent of women do not know any source of family planning methods. Programs must develop strategies, such as educating and reaching these women through target-specific IEC and appropriate channels to reduce these social barriers.

There is need for improved and expanded target-specific IEC efforts in family planning. IEC materials should be improved to be more sensitive to local culture, and visual tools rather than text should be emphasized (Eyerusalem and Yoseph, 1996). IEC programs should consider the variations in culture and language and attempt to use traditional media rather than mass media. The availability of radios in the rural community is very low. More than three-quarters of women with unmet need do not have a radio. The IEC messages should also take into consideration the level of education of the rural community.

In Ethiopia, where women have very little decisionmaking power, and the decision to use contraception is strongly influenced by men, it is crucial to consider involving men in family planning programs to meet the unmet need for family planning. In the previous section, it was mentioned that the involvement of women in decisionmaking, including family matters such as how many children to have and when to have them, is very little. Men are already heavily involved; they often make the major decisions regarding sexual relations, childbearing, and contraceptive use.

There is also a need to promote male methods, including sterilization, as part of the program. The fact that family planning programs, particularly in the public health services, are integrated with maternal and child health services makes them easily accessible to mothers; whereas for men and young women, it is difficult to use the services. In addition, family planning education usually targets the needs of women. Establishing men-friendly clinics and work place interventions may create easy access to family planning information and services for men. This may strengthen the communication between couples, and men may support their partners in using family planning methods if their needs involve them in decisionmaking matters. Therefore, the objective for male involvement programs should be to encourage men to share responsibility and to support their partners. According to Green and Danforth (1996), the goal of promoting positive male involvement in reproductive health can be addressed from three perspectives: 1) changing the social norms that govern male behavior in sexual relations and parenthood, 2) incorporating male involvement into the overall planning of reproductive health, and 3) adapting service delivery programs to make them more male-friendly.

Effective family planning programs can play a major role in preventing unplanned pregnancies, thus reducing the number of maternal deaths. Unmet need results in unwanted births and remains a more serious problem in many developing countries. About one-fifth to one-quarter of the births in the developing world are unwanted; the number of unwanted pregnancies is even higher because some are aborted, leading to further complication and life threatening danger. As noted above, abortion is one of the major causes of maternal mortality in Ethiopia. Meeting unmet need means saving women's lives by avoiding unwanted pregnancies and unsafe abortion, particularly in Ethiopia, where termination of pregnancy is restricted by law. As the 2000 DHS indicated, over three-quarters of the women with an unmet need for family planning responded that it is would be a big problem if they became pregnant. These women are at a risk of being pregnant because they are married but are not using any FP method. Some of these women may seek an abortion as a means of avoiding an unwanted pregnancy.

As the demand for family planning is met for those women with unmet need, more women who do not currently space or limit their births will move to the group with unmet need. About 39 percent of currently married women are nonusers of family planning who desire to have their next birth within the next two years (CSA and Macro, 2001). Further examination of the data on intention to use family planning among nonusers indicates that nearly half (46 percent) of currently married women who were not using any contraception at the time of the survey intend to use family planning methods at some time in the future. The percentage is even slightly higher (50 percent) among women with one child. With the increase in knowledge of family planning and with improved access to services, the proportion of women who use contraception will increase. The other issue is that the current number of women in the childbearing age group, estimated to be 15 million, will be increasing because of two reasons. 1) there is a high momentum for future population growth because the proportion of the population under the age of 15 years is very high, and 2) the country's population is growing very rapidly because of high fertility.

With regard to the level of unmet need, as Robey and others (1996) indicated, it first rises and then falls as a population passes through four stages during the demographic transition. It seems that Ethiopia is at the second stage, where more couples want to control their fertility; unmet need rises because attitudes change faster than the use of contraceptives.

Reproductive health and reproductive rights are vital to of empower women and improve their health status; they reinforce the other measures taken to improve the economic and social status of women. Family planning is a major component of reproductive health, and appropriate attention should be given to improving the service. As various studies have revealed, many women die because of pregnancy- and childbirth-related complications; unsafe abortion also contributes to a significant share of deaths to women. An effective family planning program may play a major role in preventing these deaths. Hence, improving access to reproductive health information and services will substantially contribute to improving the social and economic status of women. Those institutions and associations working in gender issues, such as the WABs, the WADs, and the women's associations, should integrate reproductive health and family planning into their program. They can play an advocacy role and educate women on the issue. Family planning programs can be integrated into activities such as income generation.

In the case of Peru, Jain has presented two possible strategies; a commonly used strategy in family planning programs is to help women with unmet need begin using contraceptives (Jain, 1999). Another potential strategy recommended is to help those women already using a method use it more effectively by providing accurate information for them on how to use their methods, by informing women about the possibility of switching methods if they are unsatisfied, and by educating women about alternative sources of contraceptive supply. As Jain argues, it is easier to deal with women who have already started using contraceptives because they have already overcome some of the hurdles associated with the initiation of contraceptive use.

The increase in contraceptive prevalence, combined with the large increase in the number of married women in the reproductive age group, produces a substantial increase in the contraceptive supply required. This implies a huge financial need. The government's commitment in allocating a budget for such procurement and donors' assistance in this matter is important. Due to the large size of the population, to meet the unmet need for family planning of Ethiopian women, substantial resources will be required, for procuring contraceptive supply (with better mix), training of service providers, expanding service delivery, and improving the logistic management system. In this regard, the involvement of international NGOs and donors' contribution is crucial. Although the contribution of the major donors of contraceptives in this country—UNFPA and USIAD—is critical, there is a need to mobilize resources from other sources, particularly from the government.

Chapter 5

Recommendations

Based on the findings discussed above, the following recommendations (ranked according to their importance) are suggested:

1. Strengthen and expand family planning services. Strengthen family planning services in the existing health institutions: public, NGO, and private. Make available a wide range of modern methods. Expand and diversify service delivery outlets, such as community-based programs (CBRH programs, health extension agents, social marketing, workplace interventions, market-place interventions, women's associations, youth associations, and community groups, particularly to reach those who are underserved. CBRH services should be greatly expanded and strengthened so that they can offer clients a wide variety of family planning methods either directly or by referral.

2. Increase government commitment in strengthening reproductive health and family planning programs through the formulation of a reproductive health policy, the expansion of family planning service delivery institutions, and the allocation of funds for the procurement of contraceptives.

3. Integrate reproductive health/family planning into gender programs. The women's affairs bureaus, the women's associations, the women's affairs departments, and the institutions working on women's issues should integrate reproductive health/family planning into their programs, be actively involved in sensitizing and educating women on the issue, and advocate to get support for the program. There is a need to establish networking among regional WABs, regional health bureaus, regional offices of population, and regional women's associations.

4. Establish an effective logistic information and management system to ensure effective distribution of contraceptives to service delivery points and to monitor the quality of care.

5. Develop and implement programs that encourage the involvement of men in family planning. Encourage men to support their partners and use the services.

6. Improve the skills of service providers through in-service training and followup.

7. Improve the type of counseling that is provided to family planning users about the side effects and availability of various methods to minimize discontinuation rates and to improve communication between partners.

8. Develop target-specific messages that take the social and cultural situation into consideration and use the appropriate channels to increase use of family planning information and services by both women and men.

9. Establish effective coordination and networking among government agencies, NGOs, and the private sector institutions that are involved in the provision of family planning service.

10. Conduct in-depth research. It cannot be assumed that if couples who have unmet need had access to a contraceptive method, that they would use it The causes and solutions are more complicated than just a lacking access. Even when contraception is available, many potential users lack knowledge and support, are scared, and face formidable social and cultural barriers to using contraception. Therefore, there is a need to conduct an in-depth study to understand the various social and cultural reasons for not using contraceptives. In particular, this would help design more effective target-specific IEC messages.

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