

Country Analysis of Family Planning and HIV/AIDS: Ethiopia

Yared Mekonnen
Consultant
Addis Ababa, Ethiopia

Sarah Bradley
Morrisa Malkin
Karen Hardee
Washington, D.C., USA

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Executive Summary

This study is an investigation into the status and trends of family planning (FP) and reproductive health (RH) programs within the context of Ethiopia's heightening HIV/AIDS epidemic.

By helping individuals and couples control the number and timing of pregnancies, family planning provides far-reaching benefits (Dayaratna et al., 2000). In addition, by reducing unintended and high-risk pregnancies, family planning can lower the instances of maternal and child injury, illness, and death associated with childbirth and unsafe abortions (Shane, 1997). Ethiopia has not been able to expand FP services to satisfy the increasing unmet need in the country, and its maternal mortality ratio (MMR) ranks as one of the world's highest. At the same time, Ethiopia is among the countries that have been hardest hit by the HIV/AIDS epidemic. The findings of this study are expected to inform policy and program managers about the various dimensions of HIV/AIDS and family planning in Ethiopia.

This study, carried out in Ethiopia, Kenya, and Zambia examines the following aspects:

- The presence and functionality of FP programs in light of the current HIV/AIDS crisis, including issues such as service delivery and health personnel
- The status of political and official support for FP/RH and HIV/AIDS programs
- Funding trends for FP/RH programs in light of HIV/AIDS
- The role of nongovernmental organizations (NGOs) and the private sector in dealing with FP/RH and HIV/AIDS

The following points highlight some of this study's main findings:

- There is a great need for expansion and improvement of the FP program, made evident by the high unmet need for such services, high maternal mortality ratio (MMR), low use of FP methods, and high fertility rate.
- Poor management, infrastructure, and logistical systems are distinct problems in Ethiopia and prevent policies and programs from moving forward with implementation.
- There is a general feeling in all sectors that the advent of HIV/AIDS has created a shift in resources and attention away from FP/RH programs, both nationally and internationally.
- Funding for HIV/AIDS programs has increased over the past five years. It is not clear if Ethiopia has the capacity to absorb these funds.

Abbreviations

| | |
|-------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal care |
| ARV | Antiretroviral |
| BCC | Behavior change communication |
| CPR | Contraceptive prevalence rate |
| EDHS | Ethiopian Demographic and Health Survey |
| FGAE | Family Guidance Association of Ethiopia |
| FP | Family planning |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, education, communication |
| MCH | Maternal and child health |
| MMR | Maternal mortality ratio |
| MOH | Ministry of Health |
| NGO | Nongovernmental organization |
| PMTCT | Prevention of mother-to-child transmission |
| RH | Reproductive health |
| STI | Sexually transmitted infection |
| TFR | Total fertility rate |
| VCT | Voluntary counseling and testing |
| WHO | World Health Organization |

Background

With an estimated 63 million inhabitants, Ethiopia is home to the third largest population in Africa, 85 percent of which live in rural areas (UNDP, 2002). The country is among the least developed in the world, appearing at number 168 of 173 countries in the 2002 Human Development Report. Throughout its history, Ethiopia has experienced extensive social and political upheaval, recurrent drought and famine, war, and degradation of natural resources (Hogan et al., 1999). High mortality, low life expectancy, high fertility, constant population movement, and poor infrastructure characterize this country. In 1985, Ethiopia embarked on a massive decentralization effort that created nine regional states based on ethnic and national identities. Each state received significant responsibilities and autonomy in managing many sectors, including health. Within each state's health sector, regional health bureaus preside over the zonal health departments that supervise the local (or *warda*) health offices (Mbengue and Kelley, 2001).

Maternal Mortality

Despite Ethiopian women's integral social, economic, and familial roles, their health status remains among the poorest in the world. The MMR in Ethiopia is among the world's highest at 871 deaths per 100,000 live births¹ for the period 1994 to 2000 (CSA and ORC Macro, 2001). Pregnancy, poor health and nutritional status, communicable diseases, high workload, early marriage, high fertility, inadequate access to and underutilization of health services, and the low status of women in the society are among the many underlying causes of maternal mortality (MOH, 1996).

Antenatal care (ANC) is an integral part of safe motherhood, but not widely used in Ethiopia. The percentage of women receiving ANC varies greatly throughout the country, between just 15 percent in the Somali region to 83 percent in Addis Ababa (CSA and ORC Macro, 2001). Similarly, just one in 10 women receiving ANC visits a clinic four or more times during her pregnancy, with a median of 2.5 visits. This is well below the recommendation of 12–13 visits. Another problem is that of women who do obtain ANC, the median time elapsed of the pregnancy before that first visit is quite late, at 5.5 months.

In addition to poor ANC quality and use, only about 5.6 percent of births are attended by a health professional, and 4 percent by a trained traditional birth attendant (CSA and ORC Macro, 2001). An overwhelming 95 percent of women give birth at home (CSA and ORC Macro, 2001), preventing many who live too far from a suitable health facility from receiving obstetric care.

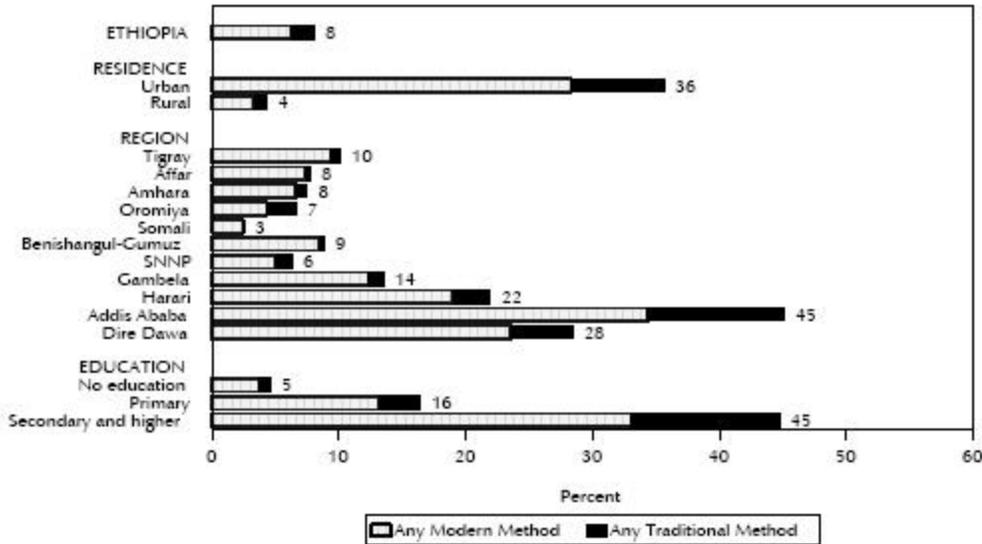
Contraceptive Prevalence and Unmet Need

In 1993, an explicit National Population Policy was adopted by the government of Ethiopia with the objective of harmonizing the country's population growth rate with that of the economy to improve the well-being of Ethiopia's people (Transitional Government of Ethiopia, 1993). However, the country's total fertility rate (TFR) from 1970 to 1975 was 6.8, and this number did not change between 1995 and 2000 (UNDP, 2002). The TFR has remained well above the mean ideal number of children of 5.3 (CSA and ORC Macro, 2001). With low use of family planning, fertility has remained high. According to the first national survey on fertility and family planning in 1990, only 4.8 percent of currently married women were using a FP method, of which fewer than 3 percent were using modern methods (CSA and ORC Macro, 2001). The contraceptive prevalence rate (CPR), though it remains low, has doubled in the last decade and by 2000 was estimated at 8 percent using all methods and 6 percent using modern methods, as shown in Figure 1 (CSA and ORC Macro, 2001).

¹ The maternal mortality ratio is the number of women who die as a result of complications of pregnancy or childbearing in a given year per 100,000 live births in that year.

Figure 1.

Current Use of Contraceptives Among Currently Married Women Age 15-49



Ethiopia DHS 2000

The two explicit goals of the National Population Policy are to lower the TFR to four and increase the CPR to 44 percent by the year 2015 (Getahun and Eshete, 2003). Given the country’s low CPR and high, stable TFR, these goals are highly ambitious. Ethiopia has 3.2 million women with an unmet need for contraception (Ahmed and Mengistu, 2002).

For those using contraception, data from 2000 showed that injectables and implants were the most widely used methods, but only with a prevalence of 3 percent. The pill closely followed at 2.5 percent, after which came the rhythm method at 1.5 percent and condoms at 0.3 percent (United Nations, 2003). Geographic distribution also plays an important role in contraceptive use in Ethiopia. Married urban women “are nine times more likely to use a modern [contraceptive] method and seven times more likely to use a traditional method than their rural counterparts” (CSA and ORC Macro, 2001, p. 54). This serves to further highlight the great difficulty Ethiopian women experience in accessing contraceptives and helps explain the high TFR.

According to the 2000 EDHS, 17 percent of births were unintended and 20 percent were mistimed. Overall, 36 percent of currently married women have an unmet need for family planning—22 percent for spacing² and the remaining 14 percent for limiting.³

The diverse reasons for nonuse of FP are related to biological, social, economic, and political factors. Nonuse is often related to breastfeeding, postpartum amenorrhea, health concerns, poor logistical management, erratic

² “Unmet need for spacing includes pregnant women whose pregnancy was mistimed, ammenorrhic women whose last birth was mistimed, and women who are neither pregnant nor ammenorrhic and are not using any method of FP and want to wait two or more years for their next birth” (Getahun and Eshete, 2003, p. 1).

³ “Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, ammenorrhic women whose last child was unwanted, and women who are neither pregnant nor ammenorrhic and who are not using any method of FP and who want no more children” (Getahun and Eshete, 2003, p. 1).

availability, poor service quality, and lack of FP knowledge (Korra, 2002). Religion plays a dual role in women's use of FP by both promoting large families and condemning modern methods. There are also deeply rooted cultural pressures to have many children, and the belief exists that "more children means greater economic benefits for the family" (Getahun and Eshete, 2003, p. 1).

Although almost every hospital and health center in Ethiopia provides some kind of FP service (NOP, 1997), there are only about 115 hospitals and 412 health centers in the country. Moreover, just over half of the population actually has access to these locations (Ethiopia AIDS Resource Center, 2003). The Family Guidance Association of Ethiopia (FGAE) has been a key provider of FP services in Ethiopia since its inception in 1966. The organization now operates 18 clinics, 24 youth service centers, 671 community-based reproductive healthcare sites, and hundreds of other sites for healthcare provision (Planned Parenthood Federation of America, Inc., 2003), reaching even remote rural areas.

HIV/AIDS and Sexually Transmitted Infections

The first cases of HIV were reported in 1984, and the first AIDS cases were diagnosed in 1986 (CSA and ORC Macro, 2001). The following year, Ethiopia's central Ministry of Health (MOH) began directing HIV control and prevention activities primarily in Addis Ababa. By 1988, high rates of HIV prevalence were detected among long-distance truck drivers (13 percent) and commercial sex workers (17 percent) that worked and lived along the main trading route to the Red Sea (Mehret et al., 1990a; Mehret et al., 1990b).

Starting in 1993, activities were expanded and decentralized with the hope of extending greater coverage to rural Ethiopians. The National AIDS Council, headed by the President, was established in 2000 to implement a national policy through 10 different strategies that included education, sexually transmitted infection (STI) prevention and control, HIV testing, and psychosocial support for those affected (USAID, 2002). "Members of government, sector ministries, religious organizations, nongovernmental organizations, the private sector, and people living with HIV/AIDS" also make up this council (UNAIDS, 2002, p. 181). As of 2002, Ethiopia's HIV prevalence rate was at 7.6 percent, which translates into an infected population of 2.8 million. According to the MOH, heterosexual contact (87 percent) and perinatal transmission are the primary methods fueling the epidemic (USAID, 2002). Despite Ethiopia's efforts, the epidemic has expanded rapidly. The virus is killing people in both their reproductive and most productive years, severely disrupting social and economic systems.

One of the many far-reaching effects of this virus is dramatically decreased life expectancy. The MOH estimates that by 2014, Ethiopia's life expectancy will be 46.5, instead of the 56.4 years it would have been without AIDS (Tsfaye et al., 2002). The epidemic is further ravaging Ethiopia's future by orphaning children. The number of children that had lost either one of both parents to AIDS by the end of 2001 was approaching 1 million (UNAIDS, 2002). In addition to losing parents, 230,000 children⁴ were estimated to have the virus themselves as of 2001, and the disease has inflated Ethiopia's infant mortality rate by 7 percent between 1995 and 2000 (USAID, 2002).

Incidence and prevalence statistics capture only a fraction of HIV/AIDS cases and are subject to reporting delays. As in many countries throughout Africa, HIV prevalence rates among pregnant women attending ANC clinics are the most reliable sources of data to monitor the epidemic and assess the impact of interventions (Zaba et al., 2000). According to the MOH, prevalence rates as of 2001 averaged from 4 percent in rural areas to 14 percent in cities (Ethiopia AIDS Resource Center, 2003). The most alarming numbers have come from the population of sex workers in Addis Ababa, where the prevalence rate in

⁴ Children up to 14 years old

1998 was approximately 73 percent (Aklilu et al., 2001). These data confirm both the severity and diversity of the HIV epidemic in Ethiopia.

One of the largest impediments to reducing the burden of HIV/AIDS is that few Ethiopians are being tested. In 2000, the Ethiopian Demographic and Health Survey (EDHS) found that despite the fact that 65 percent of Ethiopian men wanted to be tested, only 2 percent had been tested (CSA and ORC Macro, 2001). As with other statistics, there is a large discrepancy between rural and urban populations. While 9 percent of urban men had been tested, this was true of only 1 percent of their rural counterparts (CSA and ORC Macro, 2001).

Contributing to the devastation of HIV/AIDS in Ethiopia is the general absence of adequate clinical management for HIV-positive individuals. The severe lack of both human and physical resources, combined with the nonexistence of any program to provide antiretroviral (ARV) drugs, prevents millions of people from receiving any kind of treatment (Mbengue and Kelley, 2001).

In general, few data are available on the magnitude of STIs in Ethiopia. However, the number of reported STIs has increased since the beginning of the HIV epidemic (Eshete and Sahlu, 1996). In 1990, a study of female sex workers in Addis Ababa found high prevalence rates of syphilis (37.4 percent), gonorrhea (30 percent), and trichomoniasis (24 percent) (Desta et al., 1990). In 1997, a study in two factories found that 25 percent of males and females tested positive for syphilis. More than 50 percent of these factory workers were positive for herpes simplex 2 antibodies (Mekonnen et al., 2002). These data are significant, because countless studies have established a positive correlation between the presence of ulcerative STIs and HIV infection (Assefa et al., 1994; Kidane et al., 1995; Zewdie et al., 2002; Mekonnen et al., 2002).

Breastfeeding Practices

Breastfeeding is an important part of overall maternal and child health (MCH). Among many other benefits, it provides infants with nutrition and antibodies to fight disease and prolongs the mother's period of postpartum amenorrhea. In Ethiopia, approximately 96 percent of children are breastfed at some time, and this is generally not influenced by the child's sex (CSA and ORC Macro, 2001). However, only 38 percent of Ethiopian children aged four to five months meet the World Health Organization's (WHO) recommendations for exclusive breastfeeding (CSA and ORC Macro, 2001). The time at which an infant is breastfed is also of importance, ideally it is within the first hour of birth. In Ethiopia, 52 percent of infants are breastfed within this first critical hour, and 75 percent within the first 24 hours of birth (CSA and ORC Macro, 2001). Due in part to the short median duration of breastfeeding in Ethiopia (2.5 months), child malnutrition is pervasive. Eleven percent of children under age five are wasted,⁵ 47 percent are underweight,⁶ and 16 percent are severely underweight (CSA and ORC Macro, 2001).

⁵ Low weight for their height

⁶ Low weight for their age

Findings and Discussion

Methodology

Twenty respondents with expertise in Ethiopia's FP and HIV/AIDS programs were interviewed in 2003. Interviewees worked at a variety of governmental, nongovernmental, private, and donor organizations (see Annex I). Respondents were not selected to form a representative sample from every possible sector but were instead selected on the basis of their expertise and involvement in the study's subject. Respondents were questioned on the status, trends, and needs of the FP programs, service delivery, political support, funding, personnel issues, and the roles of NGOs and private sector groups, especially in light of the HIV/AIDS epidemic.

Status and Trends of Family Planning

Family planning is [an issue of] human rights, women's rights, [and] women's empowerment. [It is] key to development. (Family Health Department)

According to respondents, the long-standing high fertility rate, low rate of contraceptive use, and the high level of unmet need for family planning are key indicators in gauging the status and trends of FP in the country. Speaking about these indicators, one respondent said, "It has been three decades since Ethiopia began its FP program, but there is little change" (Ipas). Mentioned among the problems were:

- Minimal service coverage
- Limited FP information available
- Cultural inappropriateness of some aspects of the FP program
- High illiteracy rate, limited educational opportunities
- Poor communication strategies

Every interviewee felt that FP services were still strongly needed in Ethiopia in light of the country's HIV/AIDS crisis. Several felt that family planning must be improved to reduce fertility, especially given the high fertility rate. Those that tied family planning to fertility reduction cited the negative environmental, health, and economic impacts of population growth, including Ethiopia's constant battle with food insecurity. This is especially true because at the country's current rate of growth its population will double in size in just over two decades (Ahmed and Mengistu, 2002). Other reasons respondents felt FP services are still needed include:

- Family planning and HIV/AIDS can be integrated.
- HIV/AIDS is a crosscutting issue.
- HIV/AIDS programs also help family planning. Abstinence is a good strategy for family planning, and it also helps to lower the age of sexual debut.
- Condoms have a dual purpose: fertility regulation and HIV/AIDS prevention.
- Family planning is a key component of health.
- Family planning can improve the lives of mothers and children.

Every respondent asked to compare the support for HIV/AIDS with that of family planning felt strongly that much more support was being given to HIV/AIDS programs. The general feeling was that the advent of HIV/AIDS had diverted both national and international attention from family planning to HIV/AIDS in recent years. Interviewees stressed that HIV/AIDS has become a global priority and is subsequently allocated more resources. The establishment of the National HIV/AIDS Council Secretariat under the

Prime Minister's office is considered an important indicator of political commitment to HIV/AIDS at the national level. There is, however, no such council for population or FP/RH in the country. Interestingly, most respondents stressed that political commitment to HIV/AIDS was upheld by the fact that the President of Ethiopia heads the National HIV/AIDS Council. Other indicators that HIV/AIDS is given more political support than FP/RH include:

- There is workplace HIV/AIDS control.
- There is no national strategy for FP/RH.
- An international loan was taken out for HIV; no similar loan for family planning was taken out.
- More attention is paid to HIV/AIDS from the World Bank and the Global Fund for AIDS, Tuberculosis and Malaria, making it easier to get consistent funding for HIV/AIDS. Plus, the government seeks out global resources.
- There is increasing involvement in HIV/AIDS by high-level government officials.
- HIV/AIDS is seen as a serious threat to Ethiopia that affects everybody.

AIDS is the biggest challenge of our time. (World Bank)

Political and Official Support for Family Planning

Respondents disagreed as to whether political support for family planning changed given the high rate of HIV prevalence in the country. Thirteen of 17 respondents that answered the question on the status of political support for family planning felt that there is minimal commitment, with some saying that although policies exist, they are failing due to lack of support. Only four respondents felt that political attention to this issue was adequate, citing endorsement through the National Population Policy. In addition, the formation of national and regional offices responsible for coordinating and implementing population activities in the country was also mentioned as another important indication of commitment from the government. As most respondents said, however, such encouraging activities have not been translated into action. Some respondents stated that even before the advent of HIV/AIDS, the country was unable to expand FP/RH programs and the existing situation is a reflection of the continued lack of political commitment.

There is a duplication of efforts and resources—the bottom line is a lack of proper coordination. (National Office of Population)

[There is a] lack of infrastructure to deliver family planning services. The country relies on the public sector for the provision of family planning. (DKT)

The perceived bolstering of HIV/AIDS programs also influenced respondents' reactions when asked if official support for family planning has changed in light of the epidemic. Responses were equally split. However, every person who answered yes added that HIV/AIDS was the reason for the change in official support.

Yes. More attention [is given] to AIDS [because it is a] donor-driven situation. (Family Health Department)

AIDS is a serious problem, killing adults and young people. [The] change is due to the seriousness of AIDS. (Population Media Center)

Funding Trends

[Funds for FP/RH have been] stable, but [they are] virtually donor dependent. At the Ministry of Health we are unable to utilize the fund[s] allocated through [one donor]. [The] Ministry of Health lacks proper financial management.
(Family Health Department, Ethiopian Ministry of Health)

Given the vast attention HIV/AIDS programs are currently receiving, many FP/RH proponents fear their programs will suffer as international funding shifts to meet other demands. Surprisingly, however, when asked about the funding trends for FP/RH programs over the past five years, eight of the 15 respondents felt that funding was actually stable. However, several people added that although funds are stable, the pervasive problem of poor logistics and management does not allow those funds to translate into stable FP/RH services (MOH, 1996). To the same question, four interviewees responded that FP/RH funding had increased, while three believed it had declined. Unfortunately, no substantial comments were added to support these beliefs.

The data obtained from the federal MOH showed a modest increase in government funding to FP/RH and HIV/AIDS programs between 1996 and 2002. In 1996, the government allocated a total of 1.78 million birr [1 USD=8.5 birr] to the FP/RH program of the federal MOH. By 1998, this budget increased to 2.24 million birr, and by 2002 it had reached 3.22 million birr. Likewise, the budget allocated to the federal HIV/AIDS program was 2.04, 2.33, and 3.4 million birr for the years 1996, 1998, and 2002, respectively. Similarly, the budget that donors allocated to FP/RH and HIV/AIDS programs of the federal MOH has increased over the years. The budget allocated to FP/RH has increased from 1.10 million birr in 1996 to 4.39 million birr in 2002. The corresponding figures for HIV/AIDS ranged from 1.92 in 1996 to 7.57 in 2002. These data suggest that, over the years, donor funding to HIV/AIDS has increased at a faster rate than the funding trend for FP/RH. Although these data do not represent all funding for FP/RH and HIV/AIDS in Ethiopia, they give some indication of the funding trends of FP/RH and HIV/AIDS in the country. Most important, the observed increasing trend of donors' assistance to FP/RH at the federal level is in contrast to the judgments of some of the respondents.

Respondents were also asked if the funding trend for FP/RH programs had been affected by increased funding for HIV/AIDS programs. Nine of the 15 interviewees who answered this question said no, with several explaining that HIV/AIDS money is coming from new and different sources, thus not affecting FP/RH programs.

Interviewees universally agreed that the funding trend for HIV/AIDS had increased over the past five years prior to this study. Two respondents cited increased funding from the World Bank (POLICY/Ethiopia, National Office of Population) to explain where this money was coming from. However, responses may depend on location, as the majority of HIV/AIDS resources have been concentrated in the capital city. In addition, much of the resources that would be available in the autonomous regional states have been pushed up to the federal level due to tax reforms. Therefore, these states are unable to fund even their priority—including HIV/AIDS—programs (Mbengue and Kelley, 2001).

Staffing and Personnel Issues

Questions in the section on loss of staff through AIDS-related deaths, re-deployment of staff into HIV/AIDS programs, and staff recruitment were difficult to answer for most respondents from NGOs. Of the seven people who answered this set of questions, three thought that the HIV crisis had affected the health-staffing pattern in Ethiopia, two thought that staff had been unaffected by the crisis, and two were

unsure. Staff transferring from other programs, such as FP/RH to HIV/AIDS programs, is rare. Two respondents reported the loss of staff through death from AIDS.

Several of the seven respondents reported that the AIDS crisis had affected staff morale, explaining that health workers were scared and did not always use universal precautions when dealing with patients, at least in part because “there are no proper guidelines” (Communicable Disease Control). All seven respondents agreed that the MOH has been facing a staffing shortage due to overseas recruitment. Physicians, nurses, and pharmacists are reported to be the main groups of professionals who have left the country so far. Respondents indicated that South Africa, Botswana, and the United States were the major destinations for these professionals. With just one doctor for every 36,000 individuals (Ethiopia AIDS Resource Center, 2003), Ethiopia cannot afford even a small loss of medical staff.

Concerning the need for more staff, respondents were not sure how much of an increase there had been in HIV-positive patients in their clinics. This is not surprising, as only 2 percent of men said they had ever been tested for HIV in the 2000 EDHS (women were not asked) (CSA and ORC Macro, 2001). Almost all respondents, however, noted that the number of FP clients had been increasing in recent years and provided the following reasons for the increase:

- A community-based approach [to family planning] exists.
- Awareness of family planning has increased.
- Service delivery points are more available.
- Information, education, and communication (IEC) have been emphasized.
- A commitment to family planning has been made.

With regard to FP commodity security in their programs, most respondents indicated that contraceptives were not always available. Reasons given included lack of continuous supply and logistical problems, such as a shortage of transportation and storage facilities. The country’s poor management system was also mentioned as a deterrent to the continuous availability of FP commodities. In contrast, most respondents said that condoms are always available, primarily through social marketing. Data obtained from DKT, a social marketing organization, showed that condom sales have dramatically increased in the last decade in Ethiopia. In 2000, DKT, in partnership with Population Services International, sold more than 49 million condoms (USAID, 2002).

Service Delivery

In Ethiopia, family planning and reproductive health are integrated in almost all programs and at service-delivery points. The idea of integrating HIV/AIDS with family planning, however, has become a new agenda item in Ethiopia. Yet, few organizations have thus far attempted to integrate any aspects of HIV/AIDS programming into their FP programs. Several respondents said that efforts to integrate the two programs were “just beginning” or that “there are some plans to start soon.” One respondent pointed out that those who got a slow start integrating family planning and HIV/AIDS at the service delivery level are still moving faster at higher levels. The MOH responded that:

At the operational level there is integration, but at the federal level [FP/RH and HIV/AIDS] are in different departments. (MOH)

According to the respondents, voluntary counseling and testing (VCT) and counseling and treatment of STIs have been integrated with family planning in some organizations. Some programs have also incorporated the treatment of opportunistic infections into their programs. A few organizations have integrated postabortion care and prevention of mother-to-child transmission (PMTCT) into their MCH and ANC clinics.

Four respondents commented that the feasibility of FP and HIV/AIDS program integration has yet to be evaluated. Two were enthusiastic about the prospects but cited the need for more and better information.

We want integration. There is limited knowledge regarding integration, but there is motivation. (CORHA)

There are no proper guidelines on how to integrate the two services. (PACT)

Those who have begun integrating their programs were concerned that integration may have some repercussion for the staff involved, despite its many advantages. Staff may not have enough time to carry out their many activities as their responsibilities increase and no additional staff are hired.

Health workers are overloaded and are not motivated to carry out additional assignments. (MOH)

Role of NGOs and the Private Sector

The integral role of NGOs in Ethiopia cannot be ignored. Because of the condition of the public health sector, NGOs are the primary providers of HIV/AIDS services and support and have been critical in breaking the silence of Ethiopia's epidemic (Mbengue, 2001). Eight of the 10 respondents (mostly from international NGOs) believed that NGOs operating in Ethiopia had been increasingly focused on HIV/AIDS. More than 48 international and 55 local NGOs have been involved in the prevention and control of HIV/AIDS in Ethiopia (Meche, 2002). Some NGOs, such as FGAE, DKT, and Pathfinder, have integrated HIV/AIDS with the pre-existing FP/RH programs.

Respondents were unable to specify about the contributions of NGOs and the private sector to HIV/AIDS in Ethiopia. However, a recent report on mapping HIV/AIDS activities in the country revealed that out of 200 ongoing HIV/AIDS projects, 40 percent are sponsored by bilateral and UN agencies, 24 percent by international NGOs, 27.5 percent by local NGOs, and the remaining 8.5 percent by government organizations (Meche, 2002). IEC, behavior change communication (BCC), care and support, and VCT are the most important components of HIV/AIDS services provided by NGOs. Even with their crucial involvement in HIV/AIDS, NGOs are experiencing major constraints and competition, in part as a result of decentralization. For example, when the federal government provides an NGO with funds, the amount given is subtracted from the total quota allowed to the state as a whole (Mbengue, 2001).

The public sector is the major source of FP services in Ethiopia, followed by private sector NGOs. According to the 2000 EDHS, about 78 percent of the FP services are provided by the public sector, 15 percent by the private sector, and the remaining 7 percent by NGOs (CSA and ORC Macro, 2001). Although all respondents agreed that the public sector is the major provider of FP services in the country, some suspected that the EDHS data might overestimate the public sector's contribution while underestimating that of other sectors. In surveys such as DHS, respondents may not be able to identify the source of family planning, and, in most cases, women tend to report that they received services from government sources.

Summary and Conclusion

In this study, 20 respondents offered expert opinions on the status of the FP and HIV/AIDS programs in Ethiopia. The respondents came from various backgrounds in Ethiopia's FP and HIV/AIDS programs, and worked at various governmental, nongovernmental, private, and donor organizations in the country. While not intended to be a representative sample of people working in family planning and HIV/AIDS in the country, their views do offer important insights into the status of family planning in light of HIV/AIDS in Ethiopia.

The picture emerges of a FP program that has never been particularly strong in Ethiopia. Half of the respondents said that political support for family planning has not changed in light of HIV/AIDS. Yet, respondents gave the sense that family planning is losing the spotlight to HIV/AIDS in terms of political support and donor interest. The country has a National AIDS Committee attached to the Prime Minister's Office but no similar committee for family planning. The country has a national population policy, but no strategy for implementation. Information on funding for family planning and HIV/AIDS was difficult to obtain, but it appears that financial support for family planning has remained steady while support for HIV/AIDS programs has grown.

There is a continued unmet need for family planning in Ethiopia. In 2000, only 8 percent of women were using contraceptives and 36 percent expressed an unmet need for spacing or limiting births. Access to services is uneven with people in rural areas having inadequate access to family planning. This study emphasizes that improvements are necessary in a number of areas—and that opportunities for integration should be sought. First, logistical management, including transportation, storage, and adequate supplies, must be developed and expanded. Second, both coverage and quality of care need to be strengthened. With 85 percent of Ethiopians living in rural areas, it is an absolute necessity that facilities be located in difficult-to-reach places. An equally challenging task for Ethiopia is to increase coverage and simultaneously improve the quality of care. As highlighted earlier regarding poor ANC, quality of care—including issues such as confidentiality and cultural sensitivity—are major determinants of use. Lack of trust in the health sector hampers use of services and results in discontinuation of contraceptive use.

These improvements cannot occur without significant bolstering of political and official support for family planning at both the national and local levels. The advent of HIV/AIDS has complicated, and, according to some opinions, endangered family planning in Ethiopia. The crisis nature of the epidemic attracts more donor and NGO attention, thereby threatening to take away already limited funds from family planning. HIV/AIDS often receives more political and official commitment, again driving already stretched support away from other health fields.

This study concludes that the family planning program in Ethiopia is currently inadequate to meet both the goals of the National Population Policy and the needs of women and men. Many improvements must be implemented before Ethiopia can experience the widespread benefits that will come with adequate FP/RH health programs in light of the HIV/AIDS epidemic.

Annex I. Organizations Represented in the Interviews

Donor Organizations:

- USAID [HIV/AIDS]
- USAID [FP/RH]
- World Bank
- UNAIDS

Governmental Organizations:

- Plan and Program Bureau, MOH
- Family Health Department, MOH
- Family Health Department, Region 14 Health Bureau
- Communicable Diseases Control Department, Region 14 Health Bureau
- Zewditu Hospital
- National Office of Population

Nongovernmental Organizations:

- Pathfinder International
- Family Health International
- CORHA
- Pact International
- Ipas
- Plan Ethiopia
- POLICY/Ethiopia

Private Organizations:

- Population Media Center
- DKT
- Bete-Zata private hospital

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