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INTERNATIONAL CONFERENCE ON FAMILY PLANNING

NOVEMBER 12-15, 2013 ADDIS ABABA, ETHIOPIA

Fact: ETHIOPIA

Location: Horn of Africa

Area: 1,104,300 Sq.km (426,371 Sq.miles)

Administrative Division: Federal system with 9 Regional States and 2 City Administrations (Addis Ababa & Dire Dawa)

Population: 73.8 million in 2007 census; 2013 estimate is84.0 million

Population Growth Rate: 2.6%

Bordering countries: Sudan, South Sudan, Eritrea, Djibouti, Somaliland, Somalia and Kenya

Capital City: Addis Ababa (seat of Ethiopian Government, Africa Union Commission and the UN Economic Commission for Africa)

Economy: Free market economy, one of the 10fastest growing countries in the world with a GDP growth of 11% for 9 successive years[1]

Health System: Three-tier health care delivery system: Primary Health Care Unit (PHCU), General Hospital and Specialized Hospital

Addis Ababa

Population: 2.7 million at the 2007 census (estimated at 3.2 million in 2011)

Altitude: 2300-2400 meters

Average temperature: Around 16 ^{0}C (60.8 ^{0}F) [2]

Ethiopian population has grown steadily over the last three decades, from 39 million in 1984, when the first census was conducted, to 53.5 million in 1994 and 73.8 million in 2007, in the subsequent censuses. The population growth rate has declined slightly, from 3.0% per annum in 1984 to 2.9% in 1994 and 2.6% in 2007.The current population is estimated at 84 million (projected from the 2007 census). This makes Ethiopia the second most populous country in Africa. Ethiopia has a very young population with 44% of its total population under the age of 15. Women of reproductive age constitute 24% of the population. About 84% of the population lives in rural areas [3].

Cognizant of the link between population growth and economic development, the Transitional Government of Ethiopia adopted a National Population Policy in 1993(TGE, 1993a). The primary objective of the 1993 National Population Policy is to harmonize the rate of population growth with the rate of socio-economic development in order to achieve a high level of welfare. The main long-term objective is to close the gap between high population growth and low economic productivity and to expedite socio-economic development through holistic, integrated programs. Other objectives include preserving the environment, reducing rural-to-urban migration and reducing morbidity and mortality, particularly maternal, infant and child mortality, which is in line with the MDGs. Population and development is considered a cross cutting issue in the Growth and Transformation Plan (GTP) and due emphases is given to integrating population issues in all sector development plans [4].

Family Planning Successes and Challenges

Ethiopia has made significant progress in family planning as well as in maternal and child health. The contraceptive prevalence rate has doubled over the past five years (from 15% in 2005 to 29% in 2011). Ethiopia renewed its commitment to increasing access at the 2012 London Summit on Family Planning by reaching over 6 million women and adolescent girls(as part of FP 2020). Ethiopia is committed to reaching its target of 66% contraceptive prevalence rate by 2015 [5] supported by increasing national funding for family planning as well as donor support. The National Conference on Family Planning held in BahirDar, Amhara region (2012) and Ethiopia's commitment to host

1. *Ministry of Finance and Economic Development,2010*
2. *Ethiopian Ministry of Foreign Affairs,Country Profile, www.mfa.gov.et*
3. *Health Sector Development Program IV 2010/11-2014/15,Addis Ababa, October 2010*
4. *National Population Policy of Ethiopia, Addis Ababa, Ethiopia, Office of the Prime Minister, April 1993.*
5. *Health Sector Development Program IV 2010/11-2014/15,Addis Ababa, October 2010*

the Third International Conference on Family Planning also demonstrate Ethiopia's commitment to making family planning a priority.

The Federal Ministry of Health (FMOH) has prioritized family planning through increased access to services and availability of method mix at the community level using rights based principles. Based on a pro-poor approach, the Ministry implemented the Health Extension Programme (HEP). The HEP serves as the primary vehicle for delivering community-centered essential health care packages and as an effective referral system. In recent years, government has also initiated the Health Development Army, which involves the community in the scale up of the essential health care packages to augment successes of the HEP[6].

The EDHS 2011 shows that contraceptive use in Ethiopia is still highly dependent on short-term family planning methods. The FMOH is working to address this by increasing access to long acting family planning methods.

Progress in family planning also requires progress in gender equality and reducing socio-cultural and religious barriers. In previous years, rural women could only access pills and injectable. Today, method choice has improved for someone who wishes to use other family planning methods by making the services available through the HEP. Through this effort, Ethiopia achieved a marked decline in TFR from 6.9 in 1990 to 5.4 in 2005 and to 4.8 children in 2011[7].

Key Demographic and Health Indicators in Ethiopia

Indicators		Source
Population	84.0 million	2007 Census (projection)
Proportion of population living in rural areas	84%	2007 Census
Per capita income	$374.20 USD	World Bank,2012
Life expectancy	59.2 years	2012 World Bank Development Indicators
Total fertility rate	4.8	EDHS 2011
Contraceptive prevalence rate	29%	EDHS 2011
Unmet need for family planning	25%	EDHS 2011
Maternal mortality ratio	676/100,000 live births	EDHS 2011
Neonatal mortality rate	37/1000 live births	EDHS 2011
Infant mortality rate	59/1000 live births	EDHS 2011
Underfive mortality rate	68/1000 live births	UN Estimates 2012

Challenges

The two most pressing challenges to expanding family planning are:

Socio economic constraints: Illiteracy, early child bearing, gender based disparities, religious and traditional influences deter women from accessing family planning services.

Programmatic constraints: As the need for FP increases, funding gaps(domestic),the logistics and commodity supply chain system, sufficient skilled health manpower to provide long term family planning services such as IUCD all need to be strengthened to meet the growing demand.

Priority Actions

To build on Ethiopia's successes and the efforts of different stakeholders and to maximize the economic benefits from Ethiopia's demographic transition, with a decline in birth and death rates, the Ethiopian government has identified the following priority actions:

➤Strengthen the capability of the health systems and the supply chain to address the demand for service using a cross sectorial approach to secure family planning commodities

➤Improve the capacity of health workers to provide a wider array of services and extend services further to communities through community level delivery modalities, such as Health Extension Program, with strong referral linkages with health centers for longer acting methods

➤Build stronger partnerships with religious, opinion and traditional leaders and others who have the power to influence attitudes and decisions including encouraging male involvement in family planning services.

➤Increase domestic funding to uphold the rights of all people to access and choose voluntary family planning through the strong network of primary health care providers.

➤Scale up delivery of services for isolated pastoralist communities/hard to reach communities and work towards reducing unmet need for family planning services

➤Focus on meeting the needs of adolescent girls as well as expanding youth-friendly services.

The Ethiopian government welcomes participants to the 3rd International Conference on Family Planning!!

6. *Health Extension Programme in Ethiopia Profile, Addis Ababa, Government of Ethiopia, Ministry of Health,2007*
7. *1990 National Fertility Survey and Ethiopian Demographic Health Survey 2011*