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OPPORTUNITIES FOR ACHIEVING SUSTAINABLE FAMILY PLANNING FINANCING IN ETHIOPIA



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Abbreviations

CBHI	community-based health insurance
DHS	Demographic and Health Survey
ETB	Ethiopian birr
FMOH	Federal Ministry of Health
FP2020	Family Planning 2020
GDP	gross domestic product
HP+	Health Policy Plus
IUD	intrauterine device
mCPR	modern contraceptive prevalence rate
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PSCM	procurement and supply chain management
SHI	social health insurance
USAID	U.S. Agency for International Development
USD	U.S. dollars

Introduction

Ethiopia's family planning program is at a critical juncture. The country has experienced nearly two decades of rapid growth in modern contraceptive use. From 2000 to 2016, the number of women using modern contraceptive methods has grown from 600,000 to 6 million. Over the same period, the modern contraceptive prevalence rate (mCPR) among married women increased from 6% to 35%. Ethiopia aims to further accelerate this impressive progress to achieve 55% mCPR among married women by 2020 (FP2020, 2017). At the same time, Ethiopia faces an uncertain future for family planning financing. The massive gains made to date have been driven in large part by a continuous flow of external financing. While Ethiopia has committed domestic resources to expanding access to trained family planning providers through its Health Extension Program, as of 2014, an estimated 96% of family planning commodities provided in Ethiopia were purchased with external funds (USAID | DELIVER PROJECT, 2015).

Table 1. Ethiopia Family Planning Financing Profile (2016 Estimate)

Indicator	Data
Total fertility rate	4.3
mCPR, married women (all women)	35% (25%)
FP2020 mCPR target, married women	55%
Number of contraceptive users	6 million
Total family planning expenditure (U.S. dollars)	\$51 million
Government percentage of total family planning expenditure	28%
Donor percentage of total family planning expenditure	69%
Household percentage of total family planning expenditure	3%

Sources: CSA and ICF, 2016; HP+ calculations

External funding for family planning is currently in decline (Lief et al., 2017). As of 2018, the U.S. Agency for International Development (USAID), once the largest single funder of contraceptives in Ethiopia, has ceased funding for commodity procurement. Although other donors may step in to fill this gap in the short term, the long-term trajectory is clear; Ethiopia must begin to prepare itself for the end of external financing for family planning commodities and services. With the country's own goal of achieving lower-middle-income status by 2025, Ethiopia may face significant declines in both external financing for family planning and external support for the health sector overall.

Identifying and mobilizing new sources of sustainable, domestic financing for family planning must become a priority for Ethiopia. As the country confronts a sharp downward trend in external resources for the program, it also faces rapidly growing demand for contraceptives, driven by a variety of factors, including high population growth rates—in 2016, the total fertility rate was 4.3—and increasing mCPR. Achieving sustainable financing for family planning will require leveraging resources from a variety of domestic sources and financing mechanisms. At the same time, Ethiopia must consider ways to better target available resources for family planning so that it reduces financial barriers to access for the poor and mobilizes out-of-pocket expenditure for those with the ability to pay for care. The country's recent efforts to achieve universal health coverage through multiple modalities—including the expansion of public services through the Health Extension Program, community-based health insurance (CBHI), and a proposed social health insurance (SHI)

scheme—present an opportunity to improve quality, equity, and sustainability in the provision and financing of family planning services and commodities. With a sharp decline in external financing for various family planning program cost areas and Ethiopia’s growing demand for family planning, the solution to achieving sustainability will need to be multifaceted.

The USAID-funded Health Policy Plus (HP+) project considered recent trends in family planning prevalence, provision, and financing, as well as nascent and proposed health financing reforms to estimate future family planning demand and establish a framework for sustainable financing. The analysis examines the period of 2016–2025 and is structured in three stages, reflecting key dimensions of the family planning market:

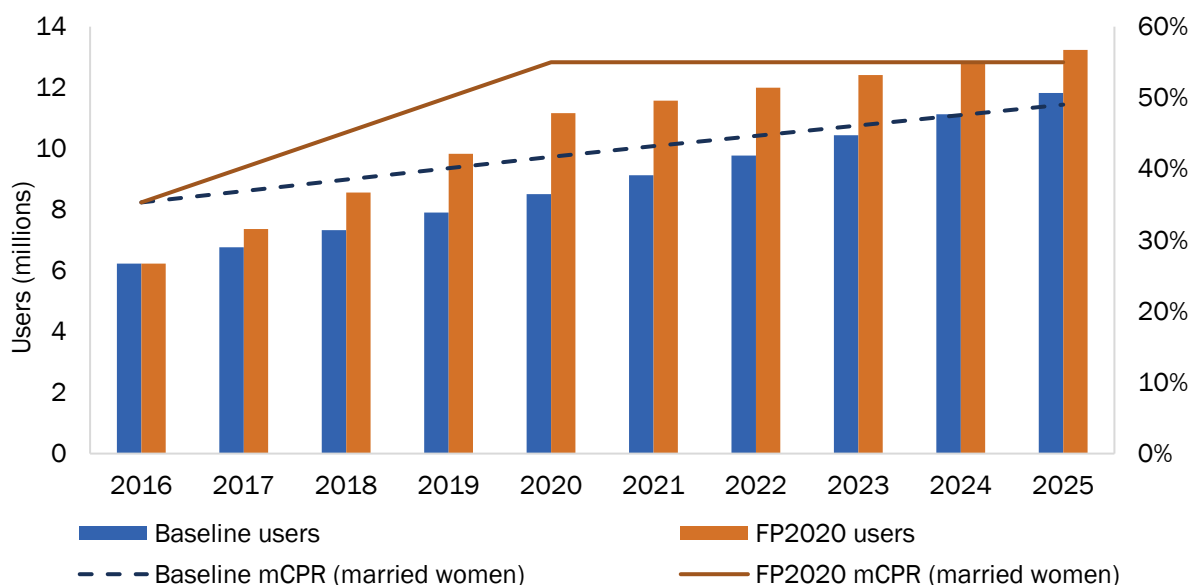
- **Clients.** What is the future demand for family planning and how can it be disaggregated by population segments, socioeconomic status, and geography (e.g., urban versus rural residence)?
- **Providers.** Where will this demand be satisfied (i.e., by public, private, or nongovernmental organization [NGO] facilities) and what will be the cost of the methods/commodities and services at each type of provider?
- **Payers.** Who can and should pay for family planning services at different points of service (i.e., clients, insurance, government, or donors), what will be the total cost to each, and how does this cost compare to the available resources for family planning?

Clients: Projecting Family Planning Demand

Overall Demand

Using historical data from Ethiopia’s 2011 and 2016 Demographic and Health Surveys (DHS), HP+ first projected overall family planning demand under two scenarios: a baseline scale-up scenario in which mCPR continues to increase at the same rate as during the 2011–2016 period; and a Family Planning 2020 (FP2020) scale-up scenario in which Ethiopia achieves its FP2020 target of 55% mCPR among married women by 2020 and maintains this level through 2025 (CSA and ICF International, 2012; CSA and ICF, 2016) (Figure 1).

Figure 1. Estimated Number of Contraceptive Users and mCPR, by Scenario (2016–2025)



Sources: HP+ projections based on 2011 and 2016 DHS (CSA and ICF International, 2012; CSA and ICF, 2016)

In the baseline scenario, by 2025, mCPR among married women increases from 35% to 49% (Figure 1); among all women, it increases from 25% to 36%. The total number of family planning users increases from 6.2 million in 2016 to 11.8 million in 2025.

In the FP2020 scenario, while mCPR among married women remains at 55% over 2020–2025 (Figure 1), among all women, it reaches 39% by 2020 and 40% by 2025. The total number of family planning users increases to 11.2 million family planning users in 2020 and 13.2 million by 2025.

In both scenarios, married women account for the majority of family planning users, increasing from 96% of all users in 2016 to 98% in our baseline scenario and 99% in the FP2020 scenario by 2025. Furthermore, traditional method users decline as a share of all users from 2% to nearly 0% from 2016 to 2025.

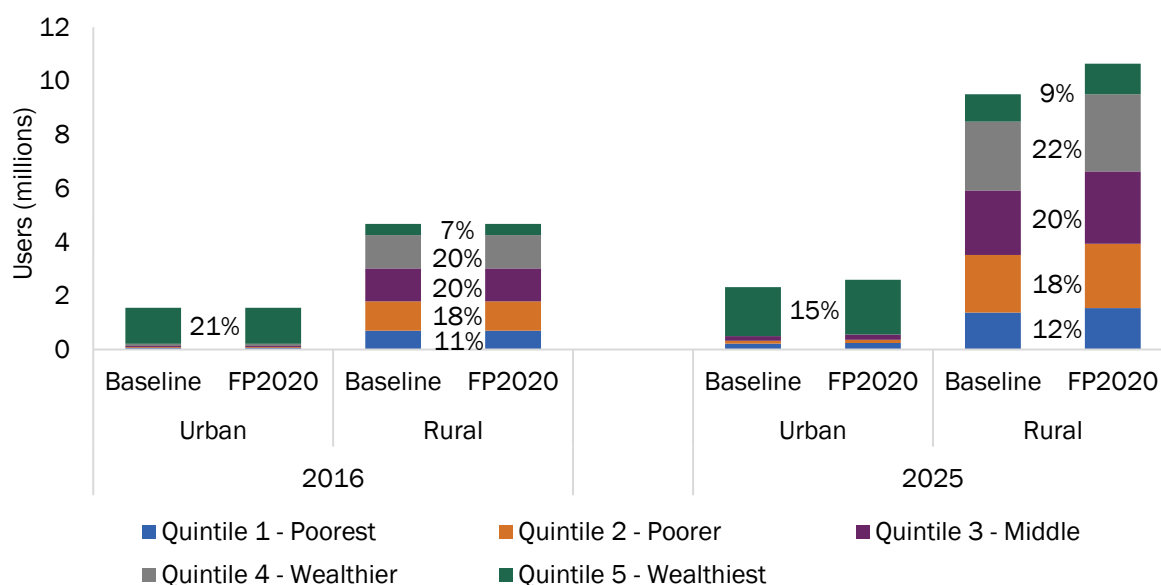
Market Segmentation

After estimating the overall family planning demand, HP+ projected where new users would come from based on their residence (urban versus rural) and wealth quintile. These projections were based on mCPR growth between 2011 and 2016 (CSA and ICF

International, 2012; CSA and ICF, 2016) and are similar under both the baseline and FP2020 scenarios. See Annex A for detailed methodology.

Based on historical trends, HP+ estimates that urban family planning users will decline as a share of total users from 25% in 2016 to 20% in 2025 and rural users will conversely increase from 75% to 80% during the same period. As a result of this shift, we estimate that urban and rural mCPR converge by 2025. In the baseline scenario, mCPR (all women) in rural areas increases from 23% to 36% compared to 35% to 36% in urban areas. In the FP2020 scenario, by 2025, mCPR will reach 41% in urban areas and 40% in rural areas. In terms of total users, we estimate that by 2025 there will be 9.5–10.6 million (baseline versus FP2020 scenario) rural family planning users and 2.3–2.6 million urban users (Figure 2).

Figure 2. Estimated Family Planning Users by Urban versus Rural Residence, National Wealth Quintile, and Scale-up Scenario (% of Total Family Planning Users) (2016–2025)



Sources: HP+ projections based on 2011 and 2016 DHS (CSA and ICF International, 2012; CSA and ICF, 2016)

HP+ also estimates that the use of modern contraception across wealth quintiles will become slightly more equitable between 2016 and 2025. In 2016, 28% of contraceptive users were in the wealthiest quintile. By 2025, HP+ estimates that this figure will fall to 24% while all other quintiles will increase as a share of contraceptive users, with the poorest quintile increasing by the largest percentage (110%). Overall, mCPR will increase from 15% to 24% among the poorest quintile and from 35% to 43% among the wealthiest quintile while two-thirds of new users will come from the middle three quintiles.

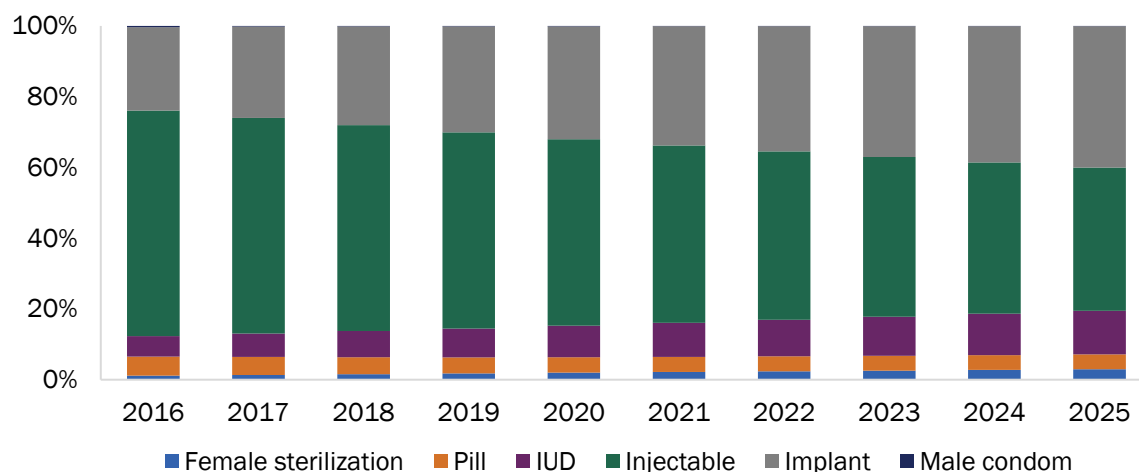
In rural areas specifically, HP+ estimates that the number of users in the bottom three national wealth quintiles will increase in roughly equal proportion by 96–97% under the baseline scenario and 119–120% under the FP2020 scenario. In rural areas, the number of users in the wealthiest and second wealthiest quintiles will increase in greater proportion, by 143–172% and 107–132%, respectively. In contrast, in urban areas, the greatest growth will be among the bottom three quintiles.

As a result of these trends, HP+ estimates that urban users in the wealthiest quintile will decline as a share of total family planning users from 21% in 2016 to 15% in 2025, while rural users in the wealthiest and second wealthiest quintiles will increase as shares of total users from 7% to 9% and 20% to 22%, respectively—the largest percentage point increase of any subgroup.

Method Mix

Based on historical trends in method mix, HP+ estimates that the number of users will increase for all methods, except condoms, between 2016 and 2025. Injectables, which currently account for the majority (64%) of family planning users, will increase in number of users from 4.0 million to 4.8–5.4 million, depending on the scenario. However, injectables will decline steadily as a share of users due to continuing scale-up (based on historical trends) of implants and intrauterine devices (IUDs). Implants alone will account for the majority (58%) of new users and will more than triple in terms of the total number of users by 2025, from 1.5 million to 4.7 million under the baseline scenario and 5.3 million under the FP2020 scenario. By 2025, implants will account for 40% of the method mix, an equal share to injectables. HP+ also projected a more than fourfold increase in the number of users of IUDs, from fewer than 400,000 in 2016 to 1.5–1.6 million in 2025 (Figure 3), and an increase in method share from 6% to 12%.

Figure 3. Estimated Share of Family Planning Users, by Method (2016–2025)



Sources: HP+ projections based on 2011 and 2016 DHS (CSA and ICF International, 2012; CSA and ICF, 2016)

Providers: Satisfying the Demand

Family Planning Method Source

Family planning users in Ethiopia are heavily reliant on the public sector for the provision of family planning. In 2016, 84% of users obtained their methods at public facilities, compared to 16% at private facilities (CSA and ICF, 2016). This is relatively unchanged from both 2005 and 2011, when the public sector market share was 80% and 85%, respectively. Of family planning services provided in the public sector, 95% were provided by health centers or posts and affiliated health extension workers. For-profit facilities account for 92% of private market share, broken down by for-profit clinics (73%), pharmacies (15%), and hospitals (3%); non-profit NGO facilities accounted for just 8% of private market share.

Private and NGO facilities that provide family planning are heavily concentrated in urban areas. In a recent survey of family planning providers, 88% of providers surveyed in Addis Ababa, the country's largest urban area, were private or nongovernmental (PSI and FPwatch, 2016). In 2016, 33% of urban family planning users, compared to just 10% of rural users, obtained their contraceptive methods from private or nongovernmental providers (Figure 4). This marked a slight increase from 2011, when 29% of urban users and 8% rural users obtained contraceptives outside of the public sector.

In 2016, use of the private and NGO sectors was substantially higher among the wealthiest quintile at 30%, compared to 7–12% in the lower four quintiles. This distribution is closely associated with the concentration of the wealthiest Ethiopians in Addis Ababa and other urban areas. In 2016, 89% of urban households belonged to the highest wealth quintile and 79% of households in the wealthiest quintile resided in urban areas (CSA and ICF, 2016).

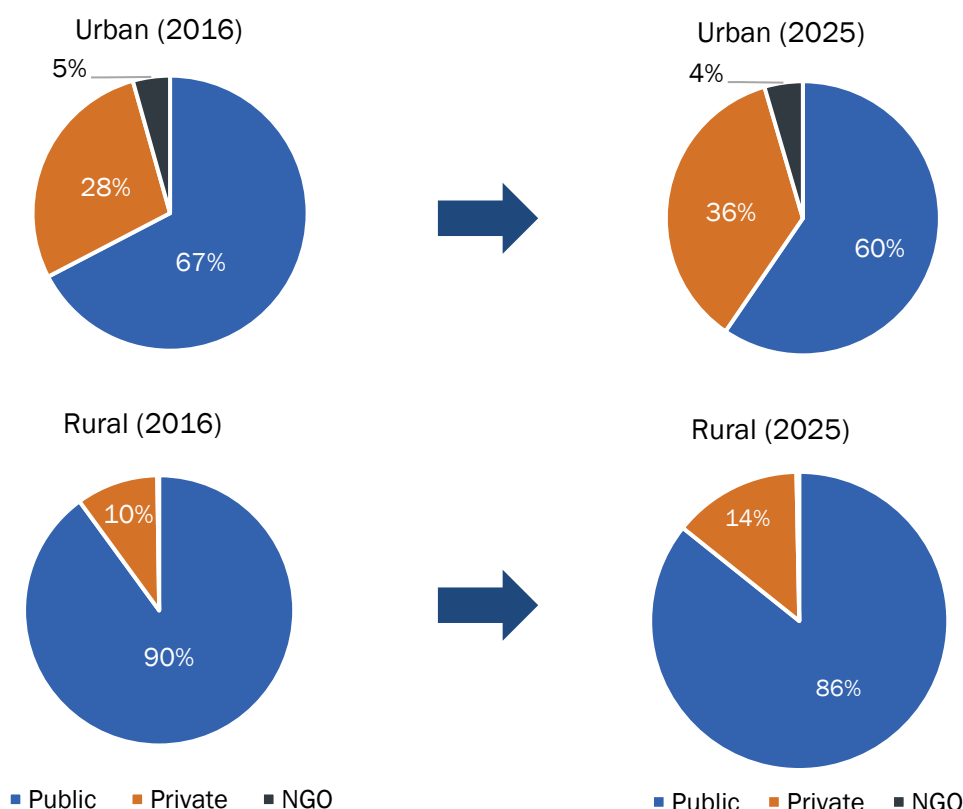
The continued reliance of family planning clients on the public sector has been made possible by significant investments in family planning inputs by the government of Ethiopia and international donors. In particular, the government has significantly increased access to the network of public facilities and health workers through its Health Extension Program. The program deploys an estimated 38,000 health extension workers and has contributed to the construction of more than 15,000 new health posts since 2003 (UNICEF, 2016; Workie and Ramana, 2013).

Among other services, health extension workers were trained to provide short-acting contraceptive methods and insertion of implants. They have contributed significantly to increased contraceptive prevalence and, in particular, to the increased prevalence of injectables. In 2016, the Ethiopian government began implementation of a second-generation Health Extension Program, which included, among other initiatives, upgrading training for health extension workers. The new level IV certification will allow extension workers to provide all non-permanent methods, including IUD and implant removal.

Projected Changes in Family Planning Provider Composition

The future mix of family planning method source was estimated based on historical trends from the 2011 and 2016 DHS, disaggregated by urban versus rural residence and wealth quintile (CSA and ICF International, 2012; CSA and ICF, 2016). By 2025, HP+ projects that overall the private and NGO sectors market shares will increase, accounting for 19% of all users—compared to 16% in 2016. In urban areas, the private sector (for profit, excluding NGOs) will increase across all quintiles from 28% to 36% of market share over 2016–2025 (Figure 4) and NGOs will decline slightly from 5% to 4%. In rural areas, the for-profit private sector will increase from 10% to 14%, while NGO participation will remain negligible at less than 1%.

Figure 4. Estimated Share of Family Planning Users, by Method Source and Residence



Sources: HP+ projections based on 2011 and 2016 DHS (CSA and ICF International, 2012; CSA and ICF, 2016)

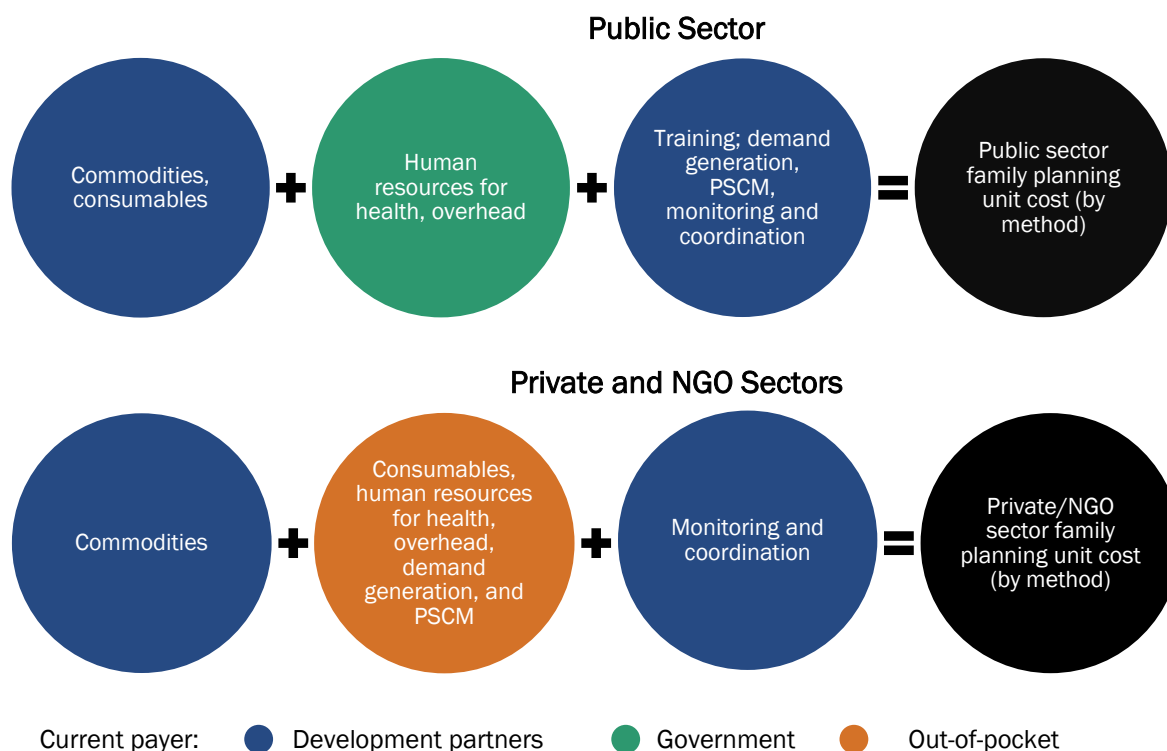
The total number of users accessing family planning methods from the private and NGO sectors by 2025 will be 2.3 million under the baseline scenario and 2.6 million under the FP2020 scenario. Of those, 94% will be from the private for-profit sector. The number of users accessing family planning methods from the public sector in 2025 will range from 9.5 million under the baseline scenario to 10.7 million under the FP2020 scenario.

Nationally, private and NGO sector use among the wealthiest quintile is projected to remain at 30% between 2016 and 2025, with increased use of the private sector in urban areas being offset by greater family planning utilization among rural users in the wealthiest quintile, who rely more heavily on the public sector. Among the lower four quintiles, private sector use will increase to between 13% and 18% and increase among all urban and rural strata except rural users in the poorest quintile.

Unit Cost of Family Planning Services

HP+ estimated the total cost of family planning services for each provider type: public, private, or NGO. Costs were calculated for five cost categories: (1) commodities; (2) other consumables; (3) human resources for health and overhead; (4) ancillary costs, including training, demand generation, and procurement and supply chain management (PSCM); and (5) monitoring and coordination. Figure 5 shows the cost components considered in both the public sector and the private and NGO sectors, the current payer for each component, and the source of data used.

Figure 5. Composition of Family Planning Unit Costs, by Public and Private and NGO Sectors



Sources: Canavan et al., 2018 (green circle); FMOH, 2016 (blue circles); PSI and FPwatch, 2016 (orange circle)

The cost of commodities in the public and private (including NGOs) sectors were calculated using annual unit costs from the *Costed Implementation Plan for Family Planning in Ethiopia 2015/16–2020* (FMOH, 2016). For users of long-acting methods, the cost is for the year in which the method is provided.

In the public sector, family planning unit costs included commodity and consumable costs, by method, from the costed implementation plan (FMOH, 2016). Also included were estimates for the cost of human resources and overhead—differentiated by urban and rural users—based on the cost per visit for family planning provision by health extension workers (Canavan et al., 2018), and cost per user for training, demand generation, PSCM, and monitoring and coordination (FMOH, 2016).

In the private sector, average retail prices were taken from the Ethiopia 2015 Outlet Survey and assumed to cover the cost of human resources, overhead, training, demand generation, and PSCM (PSI and FPwatch, 2016). The same cost per user for monitoring and coordination was used for the private sector and the public sector. Table 2 presents the total unit costs used in this analysis.

Table 2. Unit Cost of Family Planning Services, by Method (USD)

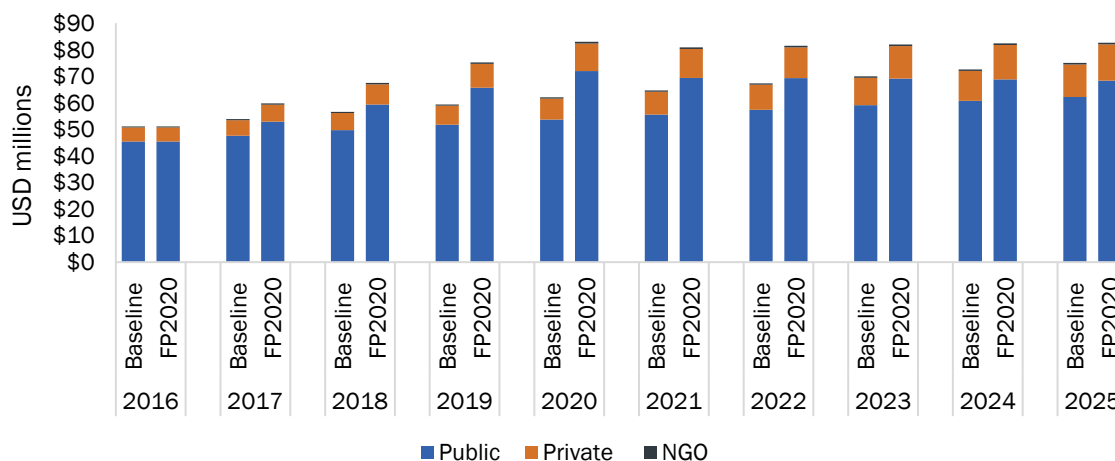
Method	Public Sector (Urban/Rural)	Private and NGO Sectors
Female sterilization	\$13.53/\$12.68	\$13.84
Pill	\$11.26/\$7.01	\$3.69
IUD	\$3.94/\$3.09	\$1.85
Injectable	\$13.09/\$9.69	\$6.36
Implant	\$13.86/\$13.01	\$10.39
Male condom	\$7.11/\$6.26	\$7.92

Sources: Canavan et al., 2018; FMOH, 2016; PSI and FPwatch, 2016

Cost of Family Planning Services by Provider Type

HP+ estimated the total cost of family planning services in Ethiopia to be \$51 million in 2016, with \$45 million (89%) incurred in the public sector and \$6 million (11%) incurred in the private and NGO sectors (Figure 6).¹ HP+ estimates that by 2025 the overall family planning resource need will grow to \$75 million under the baseline scenario and \$82.6 million under the FP2020 scenario. By 2025, the share of costs incurred by the public sector will decline from 89% to 83%, or \$62–68 million, and services provided by private sector facilities will increase as a share of cost from 10% to 17% or to \$12–14 million. Costs incurred in NGO facilities will remain at less than \$1 million and less than 1% of total.

Figure 6. Total Family Planning Expenditure, by Sector (2016–2025)



Sources: HP+ estimates based on Canavan et al., 2018; CSA and ICF, 2012; CSF and ICF International, 2016; FMOH, 2016; PSI and FPwatch, 2016

HP+ estimates that, in 2016, commodities accounted for 53% of all family planning costs. Human resources and overhead made up an additional 28%, while the rest came from ancillary costs (15%), other consumables (3%), and monitoring and coordination (1%).

Within the public sector specifically, commodities represented 50% of incurred costs (Figure 7). Human resources for health and overhead accounted for 32% of public sector for family

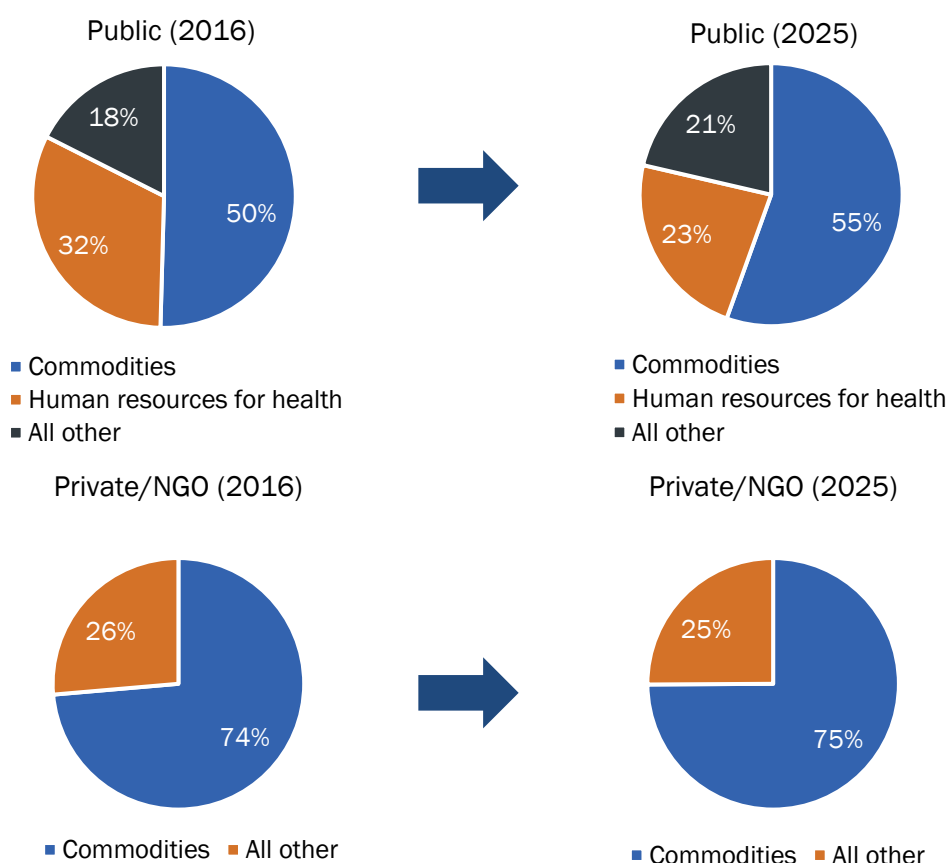
¹ All currency is provided in U.S. dollars unless otherwise specified.

planning costs, while all other costs accounted for just 18%. In the private and NGO sectors, commodities represented 74% of the total cost of family planning, while all other costs, including human resources for health, accounted for just 26% (Figure 7).

HP+ estimates that, by 2025, commodities will increase as a share of costs in both the public sector (from 50% to 55%) and the private and NGO sectors (from 74% to 75%). Particularly in the public sector, this is largely due to the shift toward longer-acting methods that require fewer facility visits and, subsequently, utilize fewer human resources for health and overhead.

The high share of private sector costs accounted for by commodities may be, at least in part, because private providers do not charge prices that fully recover human resource or overhead costs. Findings from the Ethiopia 2015 Outlet Survey suggest that retail prices are often below those recommended by DKT International, which serves as the primary procurer and distributor for private for-profit facilities (PSI and FPwatch, 2016) (Annex B). This is also in line with the suggestion of some experts that private facilities may sell family planning commodities at a loss to attract customers to purchase other profitable products and services.

Figure 7. Share of Family Planning Expenditure, by Sector and Cost Type (2016–2025)



Sources: HP+ estimates based on Canavan et al., 2018; CSA and ICF, 2012; CSF and ICF International, 2016; FMOH, 2016; PSI and FPwatch, 2016

Payers: Who Pays for Family Planning Services Now and in the Future?

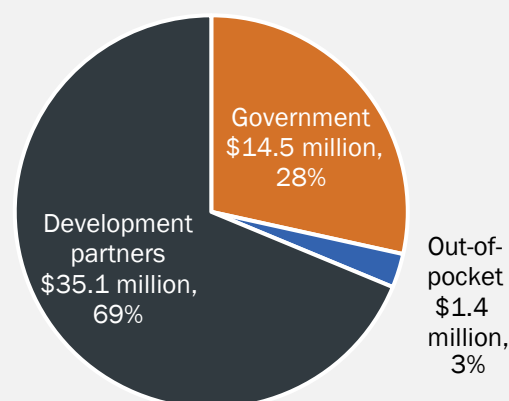
Current Family Planning Financing Sources

Financing for family planning services in Ethiopia currently comes from three main sources: the government (from general and domestic tax revenues), international development partners, and households (in the form of out-of-pocket payments). These sources pay for a mix of family planning costs, including family planning commodities, other consumables, and service delivery (e.g., human resources and overhead), depending on the sector (e.g., public, private, or NGO) in which services are provided.

Because exact figures on the amount of family planning financing from different sources in Ethiopia are not readily available, HP+ estimated family planning funding by source by mapping which financing sources pay for which cost components (as defined previously) in which sector (Figure 5). The resulting mapping of costs and key assumptions was then used to disaggregate the total family planning program costs previously calculated. This mapping of costs was advised by available data and key stakeholder interviews and is described in greater detail in Annex B. Based on this information, HP+ estimated that development partners currently account for 69% of total family planning financing, or \$35.1 million (Figure 8). Of this amount, the majority (77%) was allocated for commodities, followed by ancillary costs (e.g., training, PSCM) (17%). Development partners also contribute to consumables and monitoring and evaluation.

The government contributes an estimated \$14.5 million primarily for human resources for health and overhead costs, including operational and infrastructure costs. A small share—3% or \$1.4 million—comes from out-of-pocket expenditure on family planning in the private and NGO sectors.

Figure 8. Estimated Family Planning Financing, by Source (2016)



Sources: HP+ estimates based on Canavan et al., 2018; CSA and ICF, 2012; CSF and ICF International, 2016; FMOH, 2016; PSI and FPwatch, 2016

Baseline Projection of Family Planning Financing Need by Source

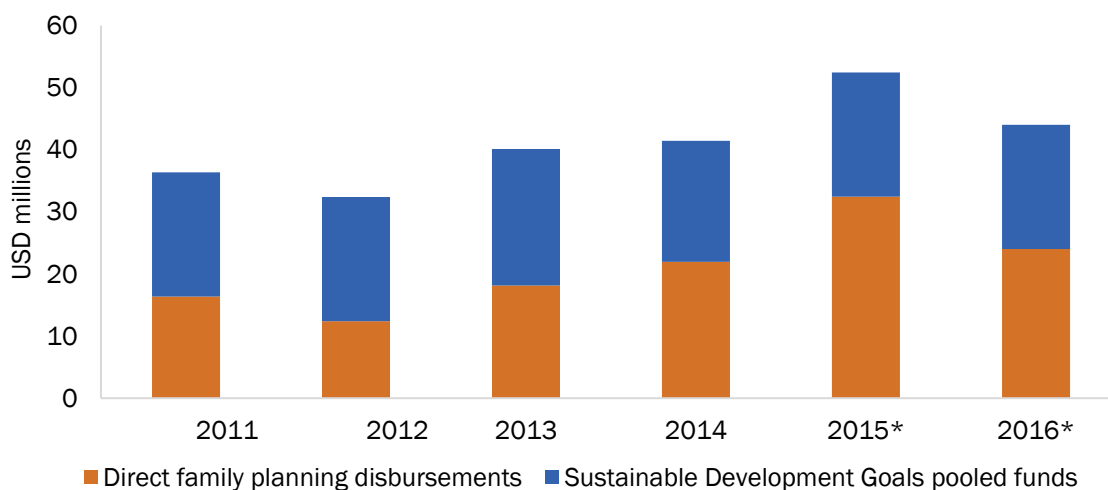
To understand the prospects for sustainable family planning financing, HP+ first estimated the family planning resource needs by source, assuming that family planning would continue to be financed in the way that it has historically—meaning, with no change to which financing sources pay for which cost components in each sector. In this case, we assumed that development partners would continue to be expected to finance commodities, consumables, and auxiliary costs including family planning-specific training, PSCM, demand generation, and monitoring and evaluation. In the private and NGO sectors, donors would continue to provide contraceptive methods, while other service delivery costs, including other consumables, and PSCM costs would be expected to be covered by clients in the form of out-of-pocket expenditure.

In this baseline projection, the resource requirement for development partners continues to increase by \$22–28 million, from \$35 million in 2016 to \$58–63 million by 2025, depending on the scale-up scenario. Over the same period, the resource requirement for domestic resources—from government and clients, in the form of out-of-pocket expenditure—will increase by just \$1.6–2.0 million. This is primarily driven by increased out-of-pocket expenditure by additional private sector users. In the baseline scale-up scenario, the resource requirement for government declines as users shift toward long-acting methods requiring fewer facility visits and lower long-term costs for human resources for health and overhead.

However, it is highly unlikely that external financing for family planning will increase to meet this resource requirement. Data from the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System indicates that while development partner disbursements for family planning increased steadily from 2012 to 2015, it declined in 2016 (OECD, 2019) (Figure 9). Furthermore, in 2018, USAID stopped funding family planning commodities in Ethiopia, which was estimated as \$6 million in 2017, suggesting that the overall level of external financing has declined even further in recent years.

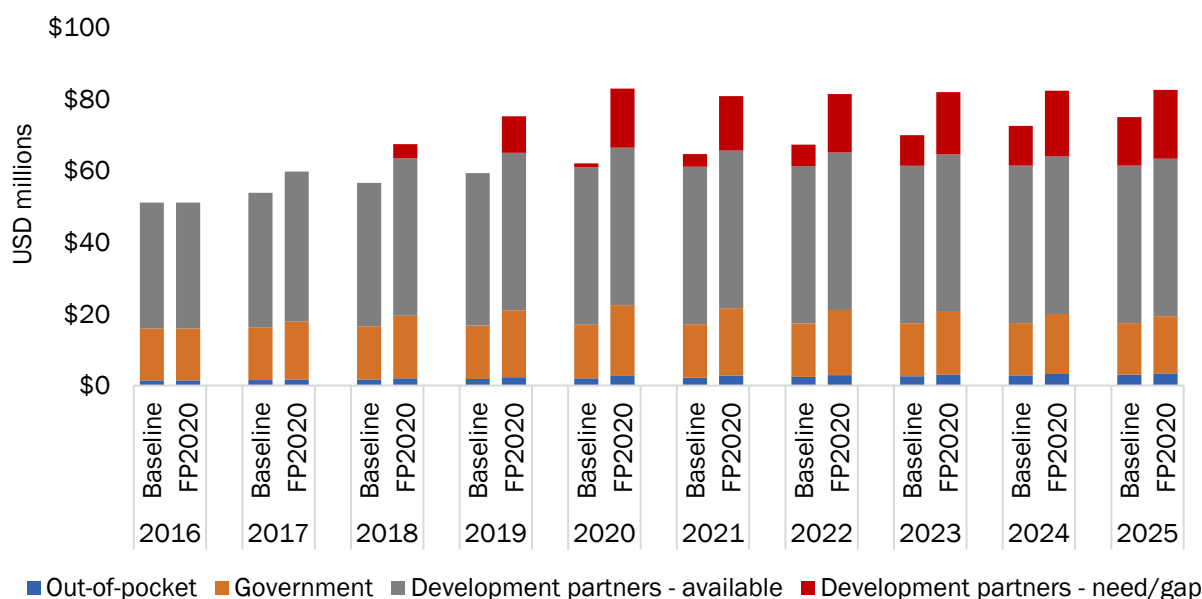
Based on this, we assume that, in the most optimistic scenario, financing from development partners remains constant at approximately \$44 million (the estimated total spent in 2016) over 2016–2025. In this case, beginning between 2018 and 2020 (depending on scale-up scenario) a financing gap develops and grows to \$14–19 million by 2025 (Figure 10). This scenario highlights the challenges facing family planning financing in the current international donor environment, a context with a growing reliance on external financing at a time when the availability of both family planning-specific and overall development sector funding has plateaued and begun to decline. To overcome this dependence and move toward more sustainable, domestic financing for family planning, Ethiopia will need to explore new financing sources and understand realistic prospects for domestic resource mobilization. The following section explores possible scenarios for meeting Ethiopia’s family planning resource needs.

Figure 9. External Financing for Family Planning (2011–2016)



*Financing from Sustainable Development Goals pooled fund estimated based on historical trends.
Sources: OECD, 2019 and USAID | DELIVER PROJECT, 2012–2015

Figure 10. Family Planning Resource Need, Baseline Projection (2016–2025)



Sources: HP+ estimates based on Canavan et al., 2018; CSA and ICF, 2012; CSF and ICF International, 2016; FMOH, 2016; OECD, 2019, PSI and FPwatch, 2016, and USAID | DELIVER PROJECT, 2012–2015

Alternative Family Planning Financing Scenarios

To understand the capacity to finance Ethiopia’s family planning program through domestic resources, we propose two alternative financing scenarios.

Budget financing scenario

In our first scenario, budget financing, we assume that new domestic financing for family planning comes solely from an increase in government budgetary allocations. We also assume that domestically generated government expenditure on family planning accounts for 3.4% of general government health expenditure (Box 1) and that government health expenditure remains at 6.9% of total government expenditure.² As such, total funding for family planning increases with growth in total government revenues and expenditure.

Under these assumptions, we estimate that total government funding for family planning could be twice the current level (\$15–18 million) at \$34 million in 2018. Further, considering projected growth in government revenue and expenditure overall, government

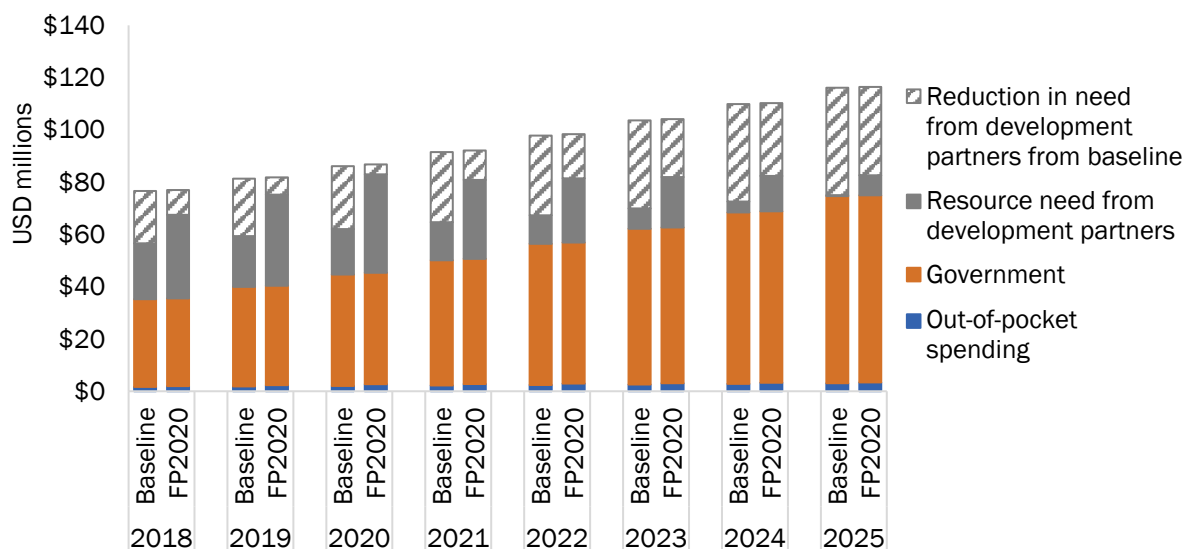
Box 1. Government Budget Prioritization of Family Planning

Key stakeholders from the FMOH indicated that family planning was a major priority and that if external funding was insufficient to cover family planning needs, domestic funds would be reoriented to help cover the gap. Based on data from the OECD Creditor Reporting System, HP+ estimates of human resources for health and overhead costs for family planning (adjusted for 2014), and the 2014 DHS, HP+ estimates that in 2014 3.4% of total donor and government health spending was on family planning. The budget financing scenario assumes that, going forward, the government allocates the same share of its own domestic source funding to family planning.

² HP+ estimated government health expenditure as a percentage of total government expenditure based on the National Health Accounts 2013/14 and historical data on government expenditure from the IMF Article IV reports (FMOH, 2017; IMF, 2018).

funding for family planning could more than double to \$72 million by 2025 (IMF, 2018; Annex C). As a scenario, we accept that this is a very ambitious increase. This increase would dramatically reduce the need for external resources to close the funding gap (Figure 11). By 2025, the remaining financing need beyond available government resources would be between \$400,000 and \$7.6 million. Under this scenario, the total amount of external funding needed to fully close the funding gap from 2019 to 2025 would be \$75–168 million, compared to \$350–421 million with no increase in government allocation of domestic resources to family planning.

Figure 11. Budget Financing Scenario: Resource Availability and External Resource Need (2016–2025)



Sources: HP+ estimates based on Canavan et al., 2018; CSA and ICF, 2012; CSF and ICF International, 2016; FMOH, 2016; PSI and FPwatch, 2016

Under this scenario, the government would have to quickly assume the cost of family planning program activities. From 2019, the government could immediately cover all non-commodity costs for family planning services provided in the public sector, which is estimated at \$25–31 million. Commodities, however, are likely to be the last component of the family planning program financed domestically, as Ethiopia faces monetary challenges to procuring family planning commodities on the international market (Box 2). At the same time, given Ethiopia’s decentralized government structure, the mobilization of budgetary resources would need to be closely coordinated at different levels of government. While the FMOH would likely need to assume responsibility for commodities procurement, it controls only a limited amount of resources currently allocated for health. Regional and local governments would likely need to play a key role in financing training, supportive supervision, supply chain, and demand creation for family planning services.

Box 2. Monetary and Foreign Exchange Challenges to Commodity Procurement

Ethiopia faces a double-edged challenge to commodity procurement. The country’s monetary policy enforces tight restrictions on foreign exchange, artificially inflating the value of the birr. On one hand, this severely limits the country’s foreign currency reserves and makes it difficult for importers to obtain the currency (primarily U.S. dollars) needed to procure on the international market. On the other hand, loosened restrictions would result in a severe depreciation of the birr against foreign currencies, which lost 17% of its value against the dollar over 2017–2018 and further reduce government purchasing power for family planning commodities.

Nonetheless, this scenario suggests that if the government of Ethiopia makes a concerted effort to prioritize family planning to the levels we have assumed—in the presence of flat-lined development partner financing—a significant amount of the financing needed to fully fund the country’s program could be met through domestic resources by 2025.

Diversified funding scenario

Ethiopia is currently pursuing major health financing reform through efforts to rapidly scale up CBHI and implement a proposed SHI scheme. At the same time, government stakeholders recognize that the private sector will have to play a role in the delivery of health services, particularly given the rapid the country’s strong growth in gross domestic product (GDP) per capita and subsequent increasing purchasing power of households. HP+, therefore, proposed a diversified funding scenario in which family planning is integrated into the CBHI and SHI benefits packages and customers gradually assume the full cost of family planning services they obtain in the private sector.

This scenario maintains the same assumptions related to government prioritization of family planning as in the budget financing scenario (shown in Figure 11) as well as four additional assumptions.

- SHI is implemented, as currently proposed, with an 11% population coverage and CBHI achieves 64% coverage by 2025 (Box 3).
- Under both SHI and CBHI, only the costs of commodities and consumables are reimbursed by the scheme. These reimbursements reflect the full cost procurement (i.e., the market price paid by government or development partners) plus a markup for procurement and supply chain costs.³
- The private sector does not participate in CBHI and SHI, either due to formal exclusion or inadequate reimbursement rates.
- Private sector users are able to gradually assume the cost of family planning commodities without reducing private sector utilization.

These assumptions are further discussed in Annex D.

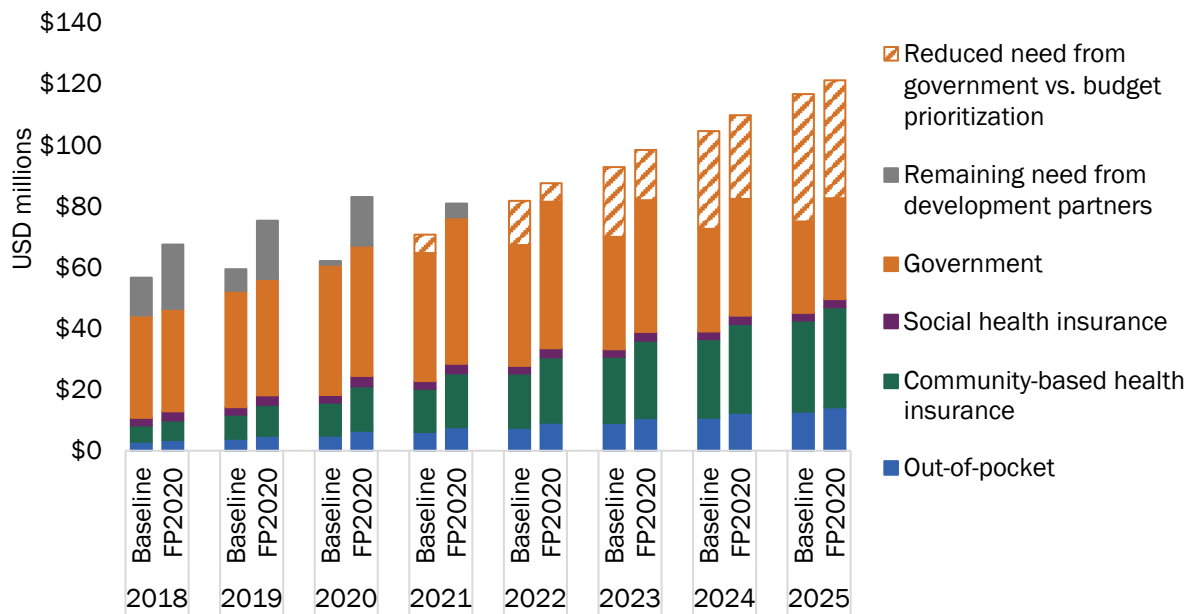
Given these assumptions around growing coverage of the scheme, we project that CBHI could mobilize \$30–33 million or 40% of the annual family planning program resource requirement by 2025 (Figure 12). We also project that SHI would contribute an additional \$2–3 million (3%) and households will contribute \$13–14 million (15–16%), or \$10–11 million more than in the baseline projection.

Box 3. Scaling-Up CBHI

The Ethiopian Health Insurance Agency’s formal target is to increase CBHI coverage to 64% of households—80% of woredas and 80% of households in those woredas—by 2020. However, the current draft of the health financing strategy provides a more conservative target for total coverage of prepayment schemes (i.e., both CBHI and SHI) of 40% by 2020. Considering this, HP+ assumes that CBHI instead will achieve 64% coverage in 2025. Assumed annual coverage rates for both CBHI and SHI are available in Table D1.

³ This is in line with current reimbursement rates for CBHI, which are based on public sector user fees schedules. Current user fees are intended to cover only commodity and consumable costs, including a mark-up by Pharmaceutical Fund Supplies Agency for their PSCM costs. The markup used in HP+ calculations is based on estimated PSCM costs from the costed implementation plan and is equivalent to 8–9% of the average commodity cost per user.

Figure 12. Financing Projections by Funder: Diversified Funding Scenario



Sources: HP+ estimates based on Canavan et al., 2018; CSA and ICF, 2012; CSF and ICF International, 2016; FMOH, 2016; PSI and FPwatch, 2016

As a result of this increased alternative financing and the additional fiscal space from government, as estimated under the budget financing scenario, we project that under the diversified funding scenario the need for external development partner resources (i.e., the gap between estimated family planning costs and available domestic resources) would be completely eliminated by 2020–2021 (Figure 12). Furthermore, from 2021 onward, the need for government budgetary resources for family planning would be reduced from the amount projected to be available in the budget financing scenario. This “surplus fiscal space” is shown in Figure 12.

However, mobilizing resources for family planning through these alternative sources is heavily contingent upon significant policy change and, in the case of CBHI and SHI, on the successful implementation, scale up, and financial sustainability of the schemes. The following section explores the feasibility of, and necessary conditions to realize, the financing scenarios defined previously.

Feasibility of Sustainable Financing Solutions for Family Planning

These alternative scenarios demonstrate that there are multiple potential pathways for how Ethiopia can achieve sustainable, domestic financing of family planning by 2025. In the long term, as Ethiopia's health financing system matures, it will be necessary to ensure integration of vertically financed programs, including family planning, into formal prepayment mechanisms that promote strategic purchasing and more effectively target subsidies for health. CBHI and SHI appear to be the vision for health financing in Ethiopia and consideration of how family planning and other priority health programs and services can be integrated into them should begin sooner, rather than later. However, these schemes are still nascent and face many challenges and practical and financial considerations. In the short term, it will likely be necessary to mobilize additional government resources to support family planning vertically, through the general government budget (including the Federal Ministry of Health [FMOH], regional health bureaus, and local health offices). At the same time, improvements must be made in identifying and targeting the poor with subsidies, while incentivizing out-of-pocket expenditure from those with the ability to pay. For each of the potential family planning financing sources examined in this analysis, we summarize key considerations required to ensure its sustainability and contribution to family planning financing.

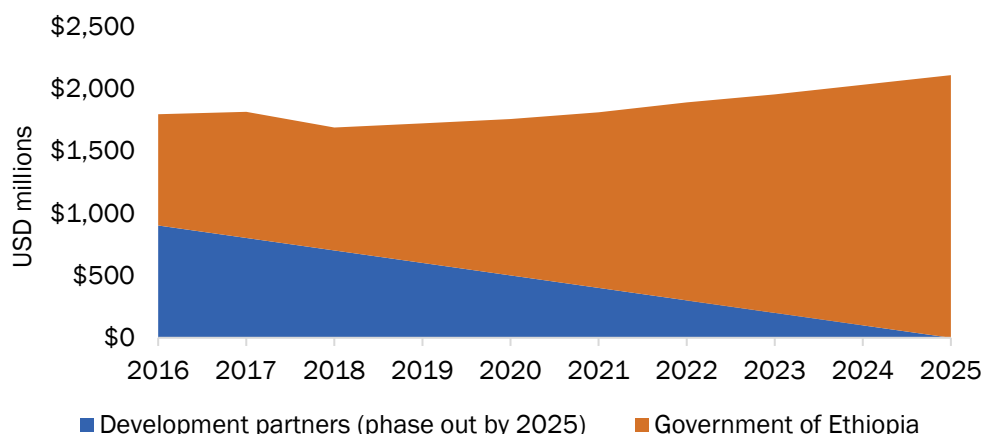
Government Fiscal Space for Health

Mobilizing additional, domestic government resources for family planning will be a first step in ensuring the sustainability of Ethiopia's family planning program. Combined spending on health by the Ethiopian government and development partners was approximately \$1.6 billion in 2014, according to the National Health Accounts, with donors accounting for approximately \$900 million (FMOH, 2017). However, given Ethiopia's high rates of economic growth and improving revenue collection, there is the potential for significant growth in government fiscal space for both health overall and family planning specifically (Box 4). Given this growth, it is highly feasible that the government could mobilize sufficient resources to offset or fully replace any potential decline in external financing for family planning by 2025. Figure 13 shows the estimated government budget allocation for family planning given the projected increase in government fiscal space—assuming constant prioritization of health and family planning—contrasted against a possible phase out of external financing by 2025. If the same level of budget prioritization of family planning was to be maintained beyond 2025, we anticipate that available fiscal space would exceed program resource requirements.

Box 4. Estimating Increased Government Health Spending

The International Monetary Fund projects that from 2016 to 2022, Ethiopia will maintain a real GDP growth rate above 8% and government revenues as a percentage of GDP will increase from 15.2% to 16.3% (IMF, 2018). By projecting these trends linearly and assuming constant prioritization of health at 6.9% of government expenditure, HP+ calculated that annual government health expenditure could increase by approximately \$1.2 billion over 2016–2025.

Figure 13. Fiscal Space for Health: Replacement of Development Partner Funding (2016–2020)



Source: Author’s estimates based on IMF, 2018; FMOH, 2017; and OECD, 2019

While HP+ analysis suggests that the creation of sufficient fiscal space is possible, ensuring the adequate prioritization of family planning in tax-based financing may remain a challenge. To address this, FMOH may consider the use of innovative financing mechanisms to provide a guaranteed funding stream for family planning, learning from other successful country examples. Earmarking tax revenues, particularly for commodity procurement, may be a long-term financing solution (Box 5), but shorter-term solutions, such as concessionary loans and debt swaps, may also help to bridge the financing gap if donor resources decline.

However, solutions that focus on the vertical financing of the family planning program may not be the best option for ensuring sustainable, long-term financing.

Their inherent rigidity makes it more difficult to respond to evolving health sector needs and their existence may crowd out discretionary budget allocations and discourage ministries of health or finance from allocating additional funding, if they believe that programs are already adequately prioritized and funded.

Therefore, Ethiopia should also consider how more systemic reforms that provide guaranteed or demand-driven financing for family planning can be leveraged to both mobilize new resources and more efficiently allocate resources currently available. To these ends, the potential of insurance schemes and the private sector to contribute to family planning financing must be explored.

Box 5. Earmarking Resources for Family Planning

In Guatemala, an earmark of 15% of alcohol tax revenues for family planning and reproductive health services—and 30% of the amount for family planning commodities—successfully increased the share of contraceptives financed with domestic resources from 5% to 100% over 10 years (2002–2011) (Carr et al., 2017).

Insurance Expansion and Integration

Community-based health insurance

CBHI is only in its third year of scale-up. Although CBHI, on aggregate, has thus far been financially feasible with premiums exceeding reimbursements, its long-run sustainability is uncertain. The surplus in revenues is, at least in part, due to the rapid scale up of CBHI, with new schemes collecting premiums before they begin paying claims. Schemes have also noted challenges in the issuance of identification cards and, in at least one CBHI scheme, only 60%

of members had cards as of early 2018 (Soddo Dacchi Health Office staff, 2018). Those without cards were unable to access services. Furthermore, the current scheme structure at the woreda level limits risk pooling. As a result, while CBHI as a whole may be in surplus, many individual schemes are operating in deficit. The integration of CBHI schemes, first at the zonal level and then by the 24 Ethiopian Health Insurance Agency branch offices, to increase pooling and promote cross-subsidization across schemes has been proposed but is challenging due to decentralized budgeting and administration at the woreda level.

Despite some localized deficits, there is a need to increase the overall value of reimbursements. In fiscal year 2017, approximately \$23 million in premiums was collected, while just \$10 million was paid out in reimbursements (EHIA unpublished dataset). Current regulation dictates that premium payments can only be used for the reimbursement of healthcare services; the operational cost of the schemes is subsidized by the woreda health office. Schemes have noted that increased health facility revenues from CBHI have helped to improve quality and increase patient satisfaction (Aleltu Health Office staff, 2018). Ensuring that facility revenue from CBHI payments can continue to be reinvested in health facilities to improve quality and confidence in the health system will be critical to retaining current enrollees and further increasing demand for CBHI. Increasing the list of reimbursable services to include “exempted services,” such as family planning, may be one way to ensure that CBHI revenues are spent (Box 6).

Box 6. Financial Feasibility of CBHI and Family Planning Integration

In 2017, CBHI schemes paid out just 45% of premiums collected in reimbursements. If this medical loss ratio remains the same and CBHI achieves 64% coverage by 2025, assumed in our previous scenario, we estimate that surplus revenues (excluding subsidies by woreda and regional governments) will total \$205 million over 2017–2025, compared to an estimated cost of family planning to CBHI of \$127–149 million over that period. By 2025, family planning costs would represent 33–37% of premium revenue and 37–39% of all CBHI reimbursement costs.

While there has been some political resistance noted to the integration of family planning into public insurance schemes, the Government of Ethiopia has acknowledged that the current dependence on donor funds is unsustainable and that new, domestic financing sources must be identified (Avenir, 2016). The Ethiopian Health Insurance Agency has expressed its openness to consider the future integration of family planning.

Social health insurance

SHI faces more severe, or at least more imminent, challenges than CBHI. Unlike CBHI, which has been implemented at scale and is actively continuing to scale up, SHI has faced more than six years of delays and does not currently have a clear timeframe for implementation. Among the obstacles to implementation is the desire, on the part of potential members, for SHI to cover services obtained in the private sector. While CBHI has been implemented in predominantly rural areas with little private sector presence, SHI will cover primarily urban, and wealthier, beneficiaries who rely more heavily on the private sector. Incentivizing private sector participation in SHI will require reimbursement rates that reflect not only the variable cost of service provision (e.g., consumables) but also overhead and human resources costs. Establishing higher rates that more accurately reflect the full cost of service provision will also be important as Ethiopia considers how to transition away from the supply-side financing of public facilities to an insurance-based model, particularly as the country aims to achieve near-universal health insurance coverage through the combination of CBHI and SHI.

Lastly, even if SHI overcomes its barriers to implementation, it is not projected to be financially feasible under the current proposal. Significant revisions will need to be made to premium rates cover to projected scheme costs. The Ethiopian Health Insurance Agency and other stakeholders will need to determine whether to include family planning and other services currently exempted from user fees in the public sector. Including these services for reimbursement under SHI would increase the schemes liabilities, specifically its costs. Future proposals to expand the SHI package of service will need to consider appropriate adjustments in premium rates and/or government subsidies to avoid worsening the projected deficit (Box 7 and Annex D).

Box 7. Financial Feasibility of SHI and Family Planning Integration

SHI's projected revenues for 2018 would have been \$151 million, compared to \$181 million in projected expenditure, according to the scheme's most recent feasibility assessment. According to HP+ estimates, the cost of family planning inclusion would represent just 1% of this amount (\$2 million). By 2025, the family planning costs would still represent only 1% of reimbursements and 2% of revenues and would increase the deficit by only 4%, from \$82 million to \$85 million.

Improved Targeting of Government Resources

Mobilizing greater out-of-pocket expenditure from those with the ability to pay will be important to ensure that the government can target limited resources to the poorest clients who face the greatest financial barriers to access. Such targeting of resources has already been promoted by the Health Extension Program, which has expanded access to key primary care services, including family planning, to predominantly poorer rural populations. CBHI presents a further opportunity to improve targeting by identifying poor households at the kebele (subdistrict) level for government subsidization of premiums. Unlike the model of user fee exemptions for priority services for all users, this model allows exemptions only to clients without the ability, or with the least ability, to pay. The further creation of tiered premiums can better align contributions with members' ability to pay, increase cross-subsidization of socioeconomic groups, and maximize the resources raised for health. One overarching challenge is the lack of existing national or regional, multisectoral mechanisms for socioeconomic classification or identification of poor households. For health, and family planning specifically, limited evidence is available on the ability of clients to pay for services, particularly across geographic regions and urban/rural areas. The concentration of nearly four-fifths of those in the highest wealth quintile in urban areas does suggest that geographic targeting of investments in family planning and the primary healthcare network that supports rural areas (e.g., through the Health Extension Program) can ensure that subsidies are directed toward poorer clients.

On the other hand, in urban areas where clients have a greater ability to pay (89% of urban residents belong to the highest national wealth quintile) and are more likely to use private/NGO facilities, there may be potential for greater cost recovery. Despite this, the PSI 2015 Outlet Survey found no significant geographic differences in retail prices (PSI and FPwatch, 2016). Improved pricing strategies by private outlets, particularly in urban areas, may help to maximize the contribution of clients with the ability to pay. Gradually reducing subsidies on private sector commodities may be an effective way to mobilize private resources while also allowing for the better targeting of government and donor resources to those with the least ability to pay, particularly those in rural areas.

If retail prices are increased to fully or partially recover the cost of commodities, foreign exchange challenges will also need to be addressed to ensure that importers and wholesalers are able to procure contraceptive commodities with their own revenues.

Conclusion

Key Findings

The purpose of this analysis is to propose a framework within which family planning can be sustainably financed in Ethiopia primarily by domestic sources. Our analysis demonstrates that a variety of mechanisms are available for increasing domestic contributions to family planning at a time when donor financing faces an uncertain future and is expected to decline.

In our first budget financing scenario, we find that growth in government revenues and health expenditure alone may create sufficient fiscal space to assume the cost of Ethiopia's family planning program. If the Government of Ethiopia was to prioritize family planning within its health budget at the same proportion of support currently funded by the government and on-budget donors (i.e., equivalent to 3.4% of their combined health spending), this would allocate \$379 million for family planning over 2019–2025 and \$72 million annually by 2025. This change in funding would nearly eliminate the resource gap in 2025, leaving a resource need of only \$1–9 million, depending on the family planning scale-up scenario (Figure 10). For donors to completely meet the projected resource gap over 2019–2025, they would require \$75 million under the baseline scale-up scenario and \$168 million the FP2020 scale-up scenario.

However, our diversified funding scenario demonstrates that, by tapping into ongoing health financing reforms and improving targeting of resources, the resource need could be fully met by domestic sources by as early as 2021. Including contraceptive methods and other consumables as reimbursable within the current CBHI and proposed SHI schemes would raise \$128–151 million and \$17–21 million, from CBHI and SHI, respectively, over 2019–2025. Furthermore, phasing out donor subsidization of commodities provided in the private/NGO sector by 2025 could mobilize an additional \$38–45 million in domestic resources (above a baseline of \$17–20 million) over 2019–2025 from households with the ability and willingness to pay for family planning.

With these additional domestic resources, the government, under our previous assumptions about budget prioritization, could fully meet the remaining family planning resource need by 2021–2022. Under this scenario, only 1.4–1.6% of generally government health expenditure would need to be allocated to family planning by 2025.

In general, it is crucial to consider how family planning will shift from vertical financing sources toward integration into demand-driven financing mechanisms that will provide steady and secured financing into the future. The current supply-side model—where human resources, infrastructure, and other overhead costs continue to be financed by budget line items—makes financing heavily dependent on fleeting political will and national priorities and significantly limits targeting government subsidies in a way that maximizes impact and mobilizes private resources. A shift toward an insurance-based model can ensure that subsidies for all health services better reach the poor, while, at the same time, leveraging private infrastructure and human resources for health.

Recommendations: Policy and Research

Unlocking new resources for family planning will require a series of additional steps to ensure the feasibility and proper implementation of health financing reforms. To better understand future budget allocations to family planning and what resources might feasibly be mobilized through innovative financing mechanisms, FMOH should consider fiscal space and political economy analyses of the prospects for prioritization of health, and specifically user fee-exempted health services, in the context of competing national priorities.

If the Government of Ethiopia does consider CBHI and SHI as the long-term path for health financing—or as a step toward national health insurance—it will be necessary to:

- Establish a fee/reimbursement schedule for family planning services based on the cost for commodities and consumables
- Conduct further costing of family planning service delivery, including in the private sector, to better understand the full cost of services (including human resources and overhead costs) and establish reimbursement rates that incentive private sector participation
- Consider the removal of user fee exemptions for family planning, particularly in woredas with active CBHI schemes, instead using premium exemptions (e.g., through the classification of households as indigent) to better target government subsidies to the poor
- Conduct or update actuarial feasibility analyses of CBHI and SHI to assess the financial sustainability of these schemes and, more specifically, assess the financial implications of including family planning services in both CBHI and SHI
- Consider a phased approach to family planning integration into CBHI and SHI, focusing on reimbursement of methods with lower commodity costs, such as IUDs and pills, which will not overburden schemes financially.

To mobilize additional private resources in the form of out-of-pocket expenditure, it is, first and foremost, necessary to understand what prices the market can absorb. Available data indicate that current retail prices are below suggested levels and that many private sector clients could and would be willing to absorb even higher prices (PSI and FPWatch, 2016; DKT, 2018). However, it is clear that additional research is needed on the willingness to pay and the elasticity of demand for family planning in Ethiopia, particularly in urban settings. It will be important that these types of market analyses be available to private retailers to help them to maximize cost recovery for contraceptives and to maximize the total value of out-of-pocket mobilized resources.

Overall, mobilizing additional funds from private/NGO sector users will making retail prices more commensurate with willingness and ability to pay, while better targeting subsidies, by focusing user fee or insurance premium exemptions on the poor rather than the provision of subsidized commodities in both public and private sectors.

Limitations of the Analysis

The current lack of evidence around the motivations and elasticity of demand for family planning in the private sector is one of the major limitations of this analysis. Some experts have suggested that, particularly in urban areas, a range of non-economic factors motivate clients' decisions to seek services in the private sector. However, it is probable that future reforms or changes to health systems will drive either increased (e.g., in the number of private facilities and greater participation of private facilities in insurance schemes) or decreased (e.g., quality improvement in the public sector or increased private sector prices for family planning) demand. Furthermore, with the potential for increasing prices in the private sector to be more reflective of the actual cost of family planning commodities and services, we may expect a shift toward those methods with a lower cost, either up-front or per couple year of protection. In the absence of evidence on these effects, we have assumed that private sector utilization—as a share of overall family planning utilization—and method mix will continue to follow historical trends.

Furthermore, the costing of family planning services in this analysis is limited by scarce evidence of the non-consumable cost of providing family planning services, particularly the cost of human resources. The use of a cost-per-client interaction methodology, as applied

using data from Canavan et al., may overstate the cost of methods that require recurring visits, specifically oral and injectable contraceptives, while understating the cost of methods that require relatively few but more time-intensive visits (e.g., IUDs and implants) (Canavan et al., 2018). However, as Ethiopia shifts toward a heavier reliance on long-acting methods, it is reasonable to expect a long-term downward trend in the human resources requirement of providing them, as noted in our analysis.

In the private sector, the cost of provision may be understated slightly. Prices used from the 2015 PSI Ethiopia Outlet Survey were the average by contraceptive method across facility types and did not distinguish between prices that included the cost of the commodity and the service and those that included just the commodity (PSI and FPwatch, 2016). Experts have noted that patients obtaining injectables, implants, or IUDs at pharmacies or drug shops may be “double paying” for family planning: once for the commodity and once for the consultation. Based on the 2016 DHS, these account for approximately 6% of private sector users.

The Way Forward

Overall, this analysis demonstrates that Ethiopia’s reliance on donor financing for family planning is not inevitable; significant, potential sources of domestic financing do exist through multiple financing mechanisms. However, the political and financial feasibility of these mechanisms must be further analyzed. Mobilizing additional resources to achieve sufficient and sustainable long-term financing for family planning will require a coordinated effort by the FMOH, its development partners, family planning implementers, and the private sector as well as the significant political will to do so. While the Ethiopian government has expressed an interest in attracting new donors and donor financing, it has also acknowledged the high risk of a “sudden decline in donor source financing” (HSTP, 2015). If the government wishes to ensure a more certain future for critical health programs, like family planning, and for its citizens, it must begin to promote domestic financing sources and transition away from donor dependence. As Ethiopia continues to pursue its goal of becoming a lower-middle income country by 2025, its focus on family planning must be twofold. It must continue to invest in family planning—which has been shown to be a “best buy” and has significant positive effects on both health and economic growth—to support the country in achieving its national development goals and the Sustainable Development Goals and ensure that these investments are sustainably financed so this progress can be maintained through 2020, 2025, and beyond.

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Annex A. Estimating Family Planning Users, by Residence, Wealth Status, and Method

Projections of the number of family planning users were conducted in five stages.

- 1) Estimate total of number of modern family planning users.** The total number of modern family planning users was estimated from the total number of women of reproductive age (projections from the World Population Prospects) and modern contraceptive prevalence rate (mCPR) for all women. All scenarios used Demographic and Health Survey (DHS) data from 2011 and 2016 (CSA and ICF International, 2012, CSA and ICF, 2016).

For the baseline scenario, mCPR was projected linearly for 2017–2025 based on DHS data. For the FP2020 scenario, we first estimated mCPR for women not currently married or in union based on historical trends, the percentage of women not currently married or in union who are sexually active, and mCPR among these women. We then interpolated mCPR for women married or in union, assuming that mCPR reached 55% by 2020 (Ethiopia's Family Planning 2020 target) and remained constant thereafter. We then took the weighted average mCPR among these two groups to calculate mCPR among all women.

We then multiplied the mCPR among all women by the number of women of reproductive age to calculate the total number of modern contraceptive users.

- 2) Disaggregate family planning users by urban and rural residence.** We projected the percentage family planning users living in urban areas linearly based on historical data, then applied this percentage to the total number of contraceptive users to obtain the number of urban and rural contraceptive users.
- 3) Disaggregate family planning users by wealth quintile.** Based on historical data, we cross-tabulated mCPR by national wealth quintile separately among urban and rural women and projected linearly the mCPR among each stratum for 2017–2025. We then multiplied that data by the share of women from each residence (urban or rural) belonging to each wealth quintile and projected linearly for 2017–2025 based on historical data. This provided the share of all women (by urban and rural areas) who would belong to each quintile and use a modern contraceptive method. For each quintile, the percentage calculated was then divided by the sum for all quintiles (by urban or rural) to obtain the share of modern method users who would belong to each national wealth quintile.
- 4) Disaggregate family planning users by provider type (i.e., public, private, or NGO).** We cross-tabulated method source by sector (public, private, or NGO) by urban versus rural residence and national wealth quintile. We then projected linearly the percentage of users by source across each of these strata for 2017–2025.
- 5) Disaggregate users by method.** For each strata of users (by residence, wealth quintile, and method source) we cross-tabulated the share of users by method and projected linearly for 2017–2025.

References:

Central Statistical Agency (CSA) and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, MD: CSA and ICF.

Central Statistical Agency (CSA) and ICF International. 2012. *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia, and Rockville, MD: CSA and ICF International.

Annex B. Mapping of Family Planning Costs and Payers

Mapping of family planning costs to payers was advised by existing family planning expenditure and cost data as well as key informant interviews. The study team identified nine components of family planning program costs:

- Contraceptive commodities
- Other consumables
- Demand generation
- Service delivery and access, including provider training
- Procurement and supply chain management (PCSM)
- Financing
- Monitoring and coordination
- Human resources
- Overhead (including administrative and operating costs)

These categories were primarily informed by the *Costed Implementation Plan for Family Planning*, with the addition of other costs typically considered to contribute directly to the family planning program (e.g., human resources and overhead). HP+ then grouped these components into five categories, based on available cost data key stakeholder input: (1) commodities; (2) consumables; (3) ancillary costs, including service delivery, training, demand generation, PCSM and financing; (4) monitoring and coordination; and (5) human resources and overhead. HP+ then reviewed available expenditure and financing data and consulted with key stakeholders to determine how each of these cost components was currently paid for.

Commodities: Available data demonstrates that nearly all family planning commodities in Ethiopia are procured using external financing. For 2014, the last year for which comprehensive data is available (USAID | DELIVER PROJECT, 2015), development partners contributed \$14 million in-kind for family planning commodities. An additional \$19 million was allocated by the government of Ethiopia from the Sustainable Development Goals (SDG) pooled fund. The SDG pooled fund is a basket fund into which development partners contribute and is managed by the Federal Ministry of Health (FMOH). The use of the funds must be aligned with the achievement of the SDGs and is verified by the United National Development Program. In 2014, the government of Ethiopia allocated just \$800,000 of its own funds—equivalent to 3% of total expenditure of contraceptive commodities—however, these funds were not spent (USAID | DELIVER PROJECT, 2015). Given this, all funding for commodities in the public sector was considered to currently come from development partners. This assumption was validated by key stakeholders.

Key informants from DKT and Marie Stopes International indicate that commodities provided in the for-profit and non-profit private sector are also procured with external funds, either as part of the centralized procurement process or by DKT itself. DKT serves as the primary procurer and distributor for private for-profit facilities, supplying between 80–100% of all methods provided in these facilities. Both DKT and Marie Stopes International, which provides subsidized contraceptives and services in its own clinics and associated Blue Star franchises, expressed to the HP+ study team that several factors, including price and foreign exchange challenges, limit the prospects for procuring contraceptive commodities with their own revenues. Therefore, we assume that all commodities provided in the private sector are currently paid for by donors.

Consumables: Key informants indicated that most consumables for the provision of family planning in the public sector were also procured by donors as part of a package. Based on

DKT's product offerings, we assume that private sector facilities procure their own consumables, the cost of which is passed on to consumers and is part of the retail price of methods. HP+ estimates that, in 2016, non-commodity consumable costs were equivalent to just 6% of family planning commodity costs (growing to 10% by 2025), making this overall a small share of total costs.

Table B1. Payers by Cost Component and Sector

Cost Component	Public Sector	Private/NGO Sector
Commodities	Development partners	Development partners
Consumables	Development partners	Users (out-of-pocket)
Ancillary costs	Development partners	Users (out-of-pocket)
Monitoring and coordination	Development partners	Development partners
Human resources for health and overhead	Government	Users (out-of-pocket)

Ancillary costs: Key informants indicated that cost family planning program costs managed by the FMOH, including training, supportive supervision, and demand generation, are primarily funded by development partners, with the government contributing for some salaries and office costs. Although local governments have been instructed to incorporate demand generation activities into their budgets, stakeholders noted this has yet to be implemented broadly. Furthermore, family planning services are designated as exempted services by the FMOH and public facilities are not permitted to charge user fees to provide them. Therefore, family planning commodities are not procured through the Pharmaceutical Fund and Supply Agency revolving drug fund. Instead, donors finance procurements and a large share of distribution cost. Accordingly, we assume that all ancillary costs, accounting for 15% of total family planning costs (2016 estimate), are currently support by development partners.

In the private sector, DKT charges retailers a subsidized wholesale price to retail outlets. Key informants from DKT indicated that this wholesale price is intended to cover procurement, distribution, and marketing costs (the cost of the commodities themselves are covered by development partners, as previously indicated). Given this, we assume that all ancillary costs incurred in the private sector are paid for through out-of-pocket expenditure by clients.

Monitoring and coordination: Monitoring and coordination of the country's family planning program is conducted primarily by the FMOH. Similar to other ancillary costs, these activities are heavily supported by external financing. We assume that these costs, which account for just 1% of estimated total family planning costs in 2016, are presently fully funded from external sources for both the public and private sector.

Human resources and overhead: In the public sector, human resources and overhead costs, are primarily paid for with general tax revenues. Development partners have fully transitioned away from direct salary support for providers. Furthermore, as family planning is an exempted service, user fees are not collected for these services and do not contribute their financing.

In the private sector, human resource and overhead costs are, theoretically, included in the retail prices charged by providers. We, therefore, assume that in the private sector these costs are paid by clients in the form of out-of-pocket expenditure, although the current retail prices may be subsidized by providers themselves and not fully reflect the cost of service provision.

Reference:

USAID | DELIVER PROJECT. 2015. *Contraceptive Security Indicators 2015*. Available at: <https://www.k4health.org/toolkits/fp-logistics/contraceptive-security-indicators-2012>.

Annex C. Budget Financing Scenario Details, Assumptions, and Feasibility Analysis

Calendar Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Fiscal Year (Ethiopia)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
<i>Government Fiscal Space</i>												
	Actual			IMF Projections						HP+ Projections		
GDP (USD million, constant prices) (% annual growth)	55,612 (10.3%)	64,465 (10.4%)	72,372 (8.0%)	79,291 (9.0%)	79,379 (8.5%)	88,662 (8.3%)	98,791 (8.1%)	109,738 (8.0%)	121,773 (8.0%)	133,748 (7.3%)	146,265 (7.2%)	159,696 (7.2%)
Government revenues, excluding grants (USD million) (% of GDP)	7,463 (13.8%)	9,068 (14.4%)	10,667 (15.2%)	11,221 (14.4%)	11,489 (14.7%)	13,253 (15.1%)	15,070 (15.5%)	17,087 (15.8%)	19,612 (16.3%)	21,820 (16.3%)	24,155 (16.5%)	26,794 (16.8%)
Government expenditure (USD million) (% GDP)	9,480 (17.5%)	10,913 (17.3%)	12,937 (18.4%)	14,669 (18.5%)	14,288 (18.0%)	16,225 (18.3%)	18,178 (18.4%)	20,411 (18.6%)	23,015 (18.9%)	25,394 (19.0%)	27,956 (19.1%)	30,521 (19.1%)
<i>Fiscal Space for Health and Family Planning</i>												
GHE (USD million) (% of TGE)	654 (6.9%)	753 (6.9%)	893 (6.9%)	1012 (6.9%)	986 (6.9%)	1120 (6.9%)	1254 (6.9%)	1408 (6.9%)	1588 (6.9%)	1752 (6.9%)	1929 (6.9%)	2106 (6.9%)
GOE family planning expenditure (USD million) (% of GHE)	22 (3.4%)	25 (3.4%)	30 (3.4%)	34 (3.4%)	33 (3.4%)	38 (3.4%)	42 (3.4%)	47 (3.4%)	54 (3.4%)	59 (3.4%)	65 (3.4%)	71 (3.4%)
<i>Exchange Rate</i>												
Exchange rate (ETB/USD)	19.59	20.58	21.73	22.87	27.69	29.16	30.72	32.35	34.07	35.88	37.79	39.79

Acronyms: ETB, Ethiopian birr; GDP, gross domestic product; GHE, government health expenditure; GOE, Government of Ethiopia; HP+, Health Policy Plus; IMF, International Monetary Fund; TGE, total government expenditure; USD, U.S. dollars.

Annex D. Diversified Funding Scenario Details, Assumptions, and Feasibility Analysis

Community-Based Health Insurance

Community-based health insurance (CBHI) was first piloted in 13 woredas (districts) in 2011 (Feleke, 2015). It has since scaled up significantly and, as of February 2018, 374 woredas were enrolling beneficiaries, of which 271 were “active,” i.e., processing and reimbursing claims (Abate, 2018). As of early fiscal year 2018, approximately 3.5 million households and 11.9 million CBHI beneficiaries were enrolled—approximately 11% of the population (EHIA unpublished dataset). The Ethiopian Health Insurance Agency’s formal target is to increase CBHI coverage to 64% of households—80% of woredas and 80% of households in those woredas—by 2020. However, the current draft of the health financing strategy acknowledges that this target may be overly ambitious and instead estimates that total coverage of both CBHI and SHI prepayment schemes will be 40% by 2020. Considering this, we assume that CBHI instead achieves 64% coverage in 2025 and interpolate scale up linearly from 2016 to 2025 (Table D1).

Although this coverage remains focused in rural areas, as of early 2018, it was piloted in at least one urban woreda. In woredas with active schemes, 10% of the population assumed to belong to the poorest quintile is automatically enrolled as “indigent,” under the subsidized regime. Beyond this segment, we assume that additional enrollment begins in the wealthiest quintile (based on a higher ability to pay) and progressively spills over to lower quintiles as scale-up increases. Currently 79% of households pay into the scheme, while the remaining 21% are subsidized by the woreda and regional government. Lastly, we assume that use of the public sector follows historical trends and is not determined by the number of private or public facilities or quality improvements due to increased funding through CBHI/SHI.

Although CBHI does not currently include family planning in its package of services—as it is considered an “exempted service” provided free of charge by public facilities—we assume that family planning follows that same reimbursement structure as other services currently covered by CBHI. CBHI’s current reimbursement structure is based on the user fee schedules approved by the regional ministries of health, which are themselves intended to reimburse facilities only for the cost of commodities and other consumables. Currently CBHI does not include any reimbursement for operational, infrastructure, or salary costs, which are covered by supply-side subsidies from local government, or top-up/incentive payments for staff. These rates provide a disincentive for private sector participation in CBHI. Although, in select cases, schemes have begun to contract with private facilities, family planning is not considered a contracted service.

For assessments of financial sustainability, the contribution rate is assumed to remain at 240 birr annually per household. This is the rate currently recommended by the Ethiopian Health Insurance Agency, although rates can be adjusted at the regional level. In fiscal year 2017, approximately \$23 million⁴ in premiums was collected, while just \$10 million was paid out in reimbursements (EHIA unpublished dataset). In our consideration of financial sustainability, we assume that this medical loss ratio remains constant, although, as noted, utilization rates are likely to continue to rise. We further assume that CBHI schemes are only responsible for reimbursements and not their own operating costs. Current regulation

⁴ All currency is provided in U.S. dollars unless otherwise specified.

dictates that premium payments can only be used for the reimbursement of healthcare service; the operational cost of the schemes is subsidized by the woreda health office.

Table D1. Assumed Coverage Rates for Social Health Insurance

	2017	2018	2019	2020	2021	2022	2023	2024	2025
CBHI ^a	11.0%	17.6%	24.3%	30.9%	37.5%	44.1%	50.8%	57.4%	64.0%
SHI ^b	10.5%	10.6%	10.6%	10.8%	11.4%	11.5%	11.7%	11.8%	12.1%

Sources: ^aHP+ projections based on historical coverage and targets; ^bEHIA, Unpublished

Social Health Insurance

A social health insurance (SHI) scheme targeting public and private formal sector employees was proposed in 2010 and formally created in 2012, but has faced numerous delays in implementation (Avenir, Unpublished). When launched, the scheme is estimated to cover approximately 11% of Ethiopians. We assume that SHI enrollees will primarily come from the top quintile and reside in urban areas and that their family planning utilization will be representative of this segment.

Although current proposals indicate that users will have access to private sector facilities, our model assumes only participation of public facilities. As current fee schedules only reflect the cost of commodities and consumables, private facilities have little incentive to participate in insurance (Avenir, Unpublished). To incentive private providers to participate in SHI there is a need to amend the reimbursement structure to more accurately reflect the complete cost of service provision (including salaries, infrastructure, and operating costs), including for family planning services.

Like CBHI, SHI does not currently include family planning in its package of services and current proposals indicate that reimbursement for health services under the scheme will be based on a combination of fee-for-service and case-based groups. Therefore, we assume that SHI follows the same fee schedule as CBHI, wherein SHI reimburses facilities for contraceptive commodities and other consumables. In accordance with SHI regulation for outpatient co-payments, 5% of the cost of family planning services provided through SHI are assumed to be paid by the user.

For analysis of financial sustainability (Section 4. *Feasibility of Financing Reform*) all projections of scheme revenues and expenditure (excluding for family planning) were taken from the 2015 draft SHI financial sustainability assessment (EHIA, Unpublished). Contributions to the scheme come from a 3% payroll deduction levied on both on formal sector employees and their employers, with pensioners contributing 1% (Federal Negarit Gazette, 2012)

Cost Recovery and Out-of-Pocket Resource Mobilization

As of 2016, an estimated 1 million family planning users in Ethiopia contribute to the cost of family planning provision through out-of-pocket expenditure. HP+ estimates—based on surveyed retail prices (PSI and FP Watch, 2016) and private sector utilization—that these users pay, on average, an estimated \$1.47 annually for family planning services. The cost of family planning in the private sector remains heavily subsidized by donors, which provide commodities for distribution through DKT. DKT's own wholesale prices are intended to cover their operating and distribution costs, but, for a variety of reasons, are not cost recovering for commodities.

We assume that the true cost of family planning commodities and services in the private/nongovernmental organization (NGO) sector is their current, average retail price (by method) plus the cost of commodities. We assume that commodity costs are the same as those paid for those provided in the public sector.

Considering these factors, we assume that the retail price paid by of family planning services in the private/NGO sector increases incremental from 2016 until fully covering the cost of commodities in 2025. The prices assumed to be paid by method and year are presented in Table D2.

Table D2. Assumed Private/NGO Sector Retail Prices, by Method and Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Pill	\$2.19	\$2.36	\$2.52	\$2.69	\$2.86	\$3.02	\$3.19	\$3.35	\$3.52	\$3.69
IUD	\$1.46	\$1.50	\$1.55	\$1.59	\$1.63	\$1.68	\$1.72	\$1.76	\$1.81	\$1.85
Injectable	\$1.36	\$1.92	\$2.47	\$3.03	\$3.58	\$4.14	\$4.69	\$5.25	\$5.80	\$6.36
Implant	\$1.46	\$2.45	\$3.44	\$4.44	\$5.43	\$6.42	\$7.41	\$8.40	\$9.39	\$10.39
Male condom	\$3.89	\$4.34	\$4.78	\$5.23	\$5.68	\$6.13	\$6.57	\$7.02	\$7.47	\$7.92

In considering the feasibility of this increase and ability to pay, these are relatively little data on clients' ability or willingness to pay for family planning services. One 2011 study on women's willingness to pay for injectable contraception in the Tigray region of Ethiopia found that more than half of women who had used or were interested in using injectable contraception were willing to pay at least \$0.30 per injection, \$1.18 annually, and on average were willing to pay \$0.65, or \$2.60 annually (Prata, 2013). Of these women, 20% indicated that they would pay \$0.83 per injection, or \$3.56 annually. Although willingness to pay is distinct from ability to pay, these data provide some indication that many women may be willing and able to pay more for their methods.

In our assumptions about cost recovery in the private sector, we assume that willingness and ability to pay are roughly equivalent and that at least 20% of women are willing and able to pay \$3.56 annually for any method in 2016. We further assume that this price point increases proportionately with increases in gross domestic product per capita. Adjusting accordingly, we estimate that at least 20% of women—a greater share than that projected to use the private/NGO sector overall by 2025—would be willing and able to pay at least \$7.12 for their method in 2025. This is greater than the fully cost-recovering estimated price for the pill, IUDs, and injectables, which collectively account for 87% of non-surgical methods provided in the private/NGO sector. As in previous aspects of our model, we assume that use of the private sector to obtain family planning methods follows historical trends and is not adversely affected by increases in price, at least for incremental price changes.

In further analysis, we estimated total willingness to pay for family planning methods accounting for variation in willingness to pay across wealth quintiles, regional variation in socioeconomic composition, and gross domestic product per capita growth. Based on this, we estimated that contraceptive users would be willing to pay a total of \$10 million for family planning in 2016, increasing to \$17–20 million in 2025, depending on the modern contraceptive prevalence rate scale-up scenario. This figure is substantially higher than the \$13–14 million estimated under our scenarios. This discrepancy is primarily due to the fact that most users continue to not pay any cost out-of-pocket for family planning due to the continued high use of and user fee exemption of family planning services in the public sector.

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