Macro-level Operational Barriers to Family Planning Services in Ethiopia: Taxation and Importation of Contraceptives and the Role of NGOs

By

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October 2003

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

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Acknowledgments

This paper is the result of a cooperative effort to which many people contributed. The following members of the Operational Policy Advisory Committee (OPTAC) have been instrumental identifying issues to be addressed and the overall follow-up of the study: Ato Ali Beyene (EPHA), Dr. Ermias Getaneh (Family Health Department, MOH), Dr. Feiruz Surrur (ESOG), Ato Fikadu Chala (FGAE), Ato Hailu Belachew (COFAP), Dr. Mengistu Asnake (Pathfinder International), Ms. Sandra Gass (DKT-Ethiopia) and Wuleta Betemariam (EngenderHealth).

The following staff of the POLICY Project have been particularly helpful in reviewing and commenting on the report: Karen Hardee, Koki Agarwal, Carol Sheperd, Sumi Subramaniam, Chuck Pill, and Prof. Seyoum Selassie. Ato Girma Degife and Ato GebreEgziabher Bezabih are acknowledged for their support in the study. We are also grateful to all our key informants who were very generous to share their views with us.

Executive Summary

The family planning system in Ethiopia is hugely dependent on donors for contraceptives. Although the government has a supportive policy toward fertility reduction, the family planning system is highly entangled with macro-level operational barriers that have compromised the provision of effective family planning services in the country. These barriers have further fuelled the inaccessibility of contraceptives in Ethiopia, where unmet need for family planning stands at 36 percent, or equivalent to 3.2 million currently married who are in need of family planning services. Therefore, to expand access to family planning services and mitigate unmet need, all potential avenues that enhance the availability and accessibility of family planning services must be explored. The smooth importation of contraceptives and increased participation of the private sector and nongovernmental organizations (NGOs) are cases in point to be encouraged to increase effective provision of family planning services in Ethiopia.

Taxation of contraceptives and tedious customs clearance procedures are major barriers to better access to family planning services. During the taxation process, bureaucratic procedures and paperwork cause delays that have a negative impact on effective services. Moreover, unequal access to the Ministry of Health's (MOH's) duty payment prohibits many capable NGOs with international affiliation from importing contraceptives.

The POLICY Project conducted this study in 2002 to identify operational policy barriers toward taxation, importation, and clearance of contraceptive commodities in Ethiopia and to identify the barriers to provision of effective family planning (FP) services by NGOs and the private sector. Key informants—including high-level officials and program managers in the government and nongovernment sectors, international organizations, and selected private practitioners—were interviewed using a semi-structured questionnaire. In addition to these interviews, the authors conducted an extensive document review to capture additional information and insight, which that not be provided by informants.

Although the government has a supportive policy environment toward fertility reduction, the family planning system is highly entangled in operational barriers. These barriers have fuelled the inaccessibility of contraceptives in the country. Fostering contraceptive security in Ethiopia will contribute greatly to increasing access to and use of family planning by women and men who need and want to use contraception.

International donors are the main sources of contraceptives in Ethiopia. Donors supporting the importation of contraceptive commodities include the United Nations Fund for Population Activities (UNFPA), U.S. Agency for International Development (USAID), Department for International Development (DFID), the Royal Netherlands Government, and the Packard Foundation. The International Planned Parenthood Federation (IPPF) also serves as a source of commodities to its affiliate, the Family Guidance Association of Ethiopia (FGAE). Contraceptives are mainly distributed within Ethiopia through the public sector and through DKT's social marketing program. The involvement of the private sector in importing contraceptive commodities is almost nonexistent, in part because most private importers do not have sufficient resources to import and distribute contraceptives. Moreover, private importers are not aware that they can import contraceptives; even those who know that the sector can import such commodities do not consider it to be a viable option.

Tax policy in Ethiopia requires that duties be paid on all imported items regardless of what is imported and who imports them. This rule also applies to contraceptives, which has led to considerable complications with donor agencies. To deal with such complications, the government decided that the MOH should pay taxes even for contraceptives and related commodities imported into the country by external donors. However, not all organizations importing contraceptives into the country are covered under this provision. Even with the MOH assuming responsibility of paying import taxes, the procedure to be followed is so complex and time consuming that there is a considerable time lag between the arrival of the goods at the port of entry and the time that they reach service delivery points. Furthermore, although there is a fixed tax rate (15%) for contraceptive commodities, actual practice reveals that the tax rate varies from year to year, ranging between 9 and 27 percent.

The study identified the following macro-level operational barriers that affect the provision of effective family planning services in Ethiopia:

1. High tax levied on contraceptives
2. Limited access to the duty coverage of the MOH by NGOs and the private sector
3. Lengthy and bureaucratic clearance procedures of contraceptives at the Customs Authority
4. Private sector's limited interest and awareness regarding the importation of contraceptives
5. No clear policy or guidelines regarding the involvement of the private sector in FP/RH services
6. Delayed response and lack of support for the introduction and expansion of new and popular commodities/methods
7. Inability of NGOs to import contraceptives
8. Lengthy registration and operational procedures for NGOs
9. Poor collaboration, coordination and partnership among NGOs
10. Lack of NGO access to multilateral family planning funds

These barriers should be addressed by advocacy and policy dialogue activities targeted at both federal and regional levels. Public institutions that need to be addressed at the federal level include the Parliament, the MOH, Ministry of Finance and Economic Development, the Customs Authority, the Federal Disaster Preparedness and Prevention Commission, and National Office of Population. To spearhead these policy dialogue and advocacy activities, there is a need to revitalize the Population Subcommittee within the Parliament. The Population Subcommittee is the highest federal body that has a mandate to address these macro-level barriers.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BOFED	Bureau of Finance and Economic Development
CBD	Community-based distribution
COFAP	Consortium of Family Planning NGOs in Ethiopia
CPR	Contraceptive prevalence rate
CRDA	Christian Relief and Development Agency
CSO	Civil society organizations
CYP	Couple-years of protection
DACA	Drug Administration and Control Authority
DFID	Department for International Development
DHS	Demographic and Health Survey
DPPC	Disaster Preparedness and Prevention Commission
DSW	German Foundation for World Population
EPA	Ethiopian Pharmacy Association
EPHA	Ethiopian Public Health Association
ESOG	Ethiopian Society of Ob-Gyns
FGAE	Family Guidance Association of Ethiopia
FP	Family planning
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MOJ	Ministry of Justice
MSI-E	Mary Stopes International–Ethiopia
NGO	Nongovernmental organization
NOP	National Office of Population
OCP	Oral contraceptive pills
OPTAC	Operational Policy Technical Advisory Committee
OVO	Office of Voluntary Organizations
PLWHA	People living with HIV/AIDS
RDPPC	Regional Disaster Preparedness and Prevention Commission
RH	Reproductive health
RHB	Regional Health Bureau
RRC	Relief and Rehabilitation Commission
TFR	Total fertility rate
USAID	U.S. Agency for International Development
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

1. Background

Ethiopia's National Health Policy assigns high priority to the democratization and decentralization of the health service system and emphasizes family planning (FP) services for the optimal health of the mother, child, and family (MOH, 1993). The current National Population Policy aims for a contraceptive prevalence rate of 44 percent and a reduction in the total fertility rate (TFR) to 4 by 2015. It also emphasizes the expansion of FP through clinical and community-based services (NOP, 1993). However, the use of FP services in Ethiopia is among the lowest in the world. The contraceptive prevalence rate (CPR) is 8 percent and more than 3.2 million currently married women have an unmet need for FP services (CSA and ORC Macro, 2001).* In other words, Ethiopian married women with unmet FP needs constitute 3 percent of the global and 13 percent of sub-Saharan Africa's share of married women with unmet FP needs. The unmet FP need for women in Ethiopia is more pronounced in rural than in urban areas.

Several factors contribute to this unmet need, poor use of available services being a major factor. Barriers that limit access to services appear both on the demand and supply side. Barriers on the supply side include a weak system of logistics management, including erratic storage systems, an erratic system of placing orders, problems associated with transporting supplies to places where they are needed, limited service outlets, poor quality of services, and lack of adequate information on FP services. The demand constraints for FP services in Ethiopia include religious pressure to have more children and the deep-rooted cultural perception that more children means greater economic benefits for the family (Getahun, 2002)

The public sector is the leading provider of FP services in Ethiopia. It is the source of contraceptives for 78 percent of women currently using modern contraceptives (CSA and ORC Macro, 2001). However, there are several factors that could contribute to the inadequate provision of FP services through the public sector. The problems range from the limited mix of contraceptives available at any one particular service delivery point to the exodus of skilled manpower from the public sector (Asfaw, 1995; Kaba, 2000; WHO, 1999). A national contraceptive inventory and logistics system survey has shown that public institutions face problems such as unavailability of transportation for picking up contraceptives from the higher-level facilities (MOH, 2001).

The HIV/AIDS prevalence rate among adults in Ethiopia is 6.6 percent. Ethiopia has one of the largest populations of people living with HIV/AIDS (PLWHA) and AIDS orphans (MOH, 2002). It has been noted that the HIV/AIDS epidemic poses problems for FP services at different levels. The provision of effective FP services has been dropped as a priority by most sub-Saharan African countries (WHO, 1998). Although one can speculate that the situation in Ethiopia might not be different from other sub-Saharan African countries, precise documentation of the effects is not available.

*Unmet need for spacing includes pregnant women whose pregnancy was mistimed, ammenorrheic women whose last birth was mistimed, and women who are neither pregnant nor ammenorrheic and are not using any method of FP and want to wait two or more years for their next birth. Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, ammenorrheic women whose last child was unwanted, and women who are neither pregnant nor ammenorrheic and who are not using any method of FP and who want no more children.

The POLICY Project is working to increase political and popular support for FP/reproductive health (RH) in Ethiopia by identifying operational policy barriers and addressing them through policy dialogue, advocacy, and participation of broad-based stakeholders. Operational policies are the rules, regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services. These policies may pose barriers to service delivery because of a lack of policy guidance, misguided design of the policy, or misguided implementation of an appropriate policy (Cross et al., 2001). To solicit support and ensure the involvement of broad-based stakeholders, POLICY conducted a consultative workshop on operational policy barriers to effective FP services in Ethiopia on June 20, 2002, in which major stakeholders in the field of FP and RH participated.

After a thorough discussion of the existing barriers identified through a literature review and this consultative workshop, the Operational Policy Technical Advisory Committee (OPTAC) was established to set priorities of issues to be addressed and to monitor the progress of the study. In identifying priority issues, OPTAC considered the likelihood that positive changes could be achieved through advocacy and policy dialogue activities. These issues are discussed in the following section.

1.2. Statement of the Problem

The following five points draw attention to a number of important facts about the status of population issues in public policy:

- Both the imperial and the socialist governments had little or no interest in population issues.
- The transitional government of Ethiopia adopted a National Population Policy, which accorded due attention to demographic factors as important correlates of economic and social development.
- While responsibilities for policy formulation and creation of a favourable policy environment for implementation rested with the National Office of Population (NOP), actual implementation and facilitation became the responsibility of the Ministry of Health (MOH).
- The National Population Policy (April 1993) set the following goals:
    - Reduce TFR from 7.7 in 1993 to 4 by 2015;
    - Increase the rate of contraceptive use from an estimated 4 percent in 1993 to 44 percent by 2015.
- The National Population Policy opened the door for participation of nongovernmental organizations (NGOs).

Attainment of the above goals has proven to be quite elusive. By 2000, a CPR of approximately 8 percent was attained. TFR declined marginally to approximately six children per woman. If only this much is achieved in the early years of the 21st century, much more work needs to be done toward attaining the goals laid out by the National Population Policy.

The following problems were believed to have impeded the attainment of the fertility goals stipulated in the National Population Policy:

1. *Problems related to taxation and importation of contraceptive commodities.*

2. *Barriers affecting the role of NGOs and the private sector in the provision of effective FP services in Ethiopia.*

3. *Lack of clear guidelines and protocols* on the type of method mix (injectables, implants, pills, and voluntary surgical contraception), category of service providers who can administer contraceptives (doctors, nurses, front-line health workers, etc.), and the health institutions at which FP is available (drug vendors, health posts, clinics, social marketing, etc.).

4. *Medical norms, provider biases, and related factors in service delivery.* It is known that service providers in the country have inadequate training and protocols at hand for their practice. Likewise, there are no job descriptions of the categories of the service providers and health institutions. There are also self-introduced regulations by service providers at different levels (e.g., in many places, clients are asked to prove that they are menstruating to obtain FP services, and are often asked for spousal consent). Barriers that discourage male involvement in FP also need to be addressed.

5. *Persistent resistance to FP by key gatekeepers.* Silent resistance to contraception still persists in Ethiopia. For example, religious leaders who are now in the forefront in the fight against HIV/AIDS are nowhere to be seen when it comes to FP. This can be attributed to doctrinal issues. The Catholic and Orthodox churches, while not at all opposed to limitations of family size through abstinence and the use of natural contraceptive methods, are opposed to modern methods of contraception.

OPTAC suggested that POLICY consider conducting the study in three phases. Accordingly, the first step of the study addressed macro-level barriers, including taxation and clearance of commodities and barriers toward the provision of FP services by NGOs and the private sector. The second phase of the study should deal with barriers related to institutional guidelines, medical norms, and provider bias. The final segment of the study should address barriers to making use of existing opportunities and favourable conditions to enhance FP services in Ethiopia.

Each step of the study will be followed by an advocacy and policy dialogue activity to address the identified barriers. Detailed technical reports will be produced at the end of each phase of the study, followed by the development of advocacy briefs on the identified barriers. These advocacy briefs will be distributed to stakeholders, including high-level, decision-making bodies at both federal and regional levels.

The objective of this report is to identify operational barriers related to the importation and taxation of commodities, and provision of critical FP services by NGOs and the private sector.

2. Methodology

The study was conducted by POLICY's Ethiopia staff. Dr. Haileyesus Getahun and Ato Hailegnaw Eshete designed the interview protocols, conducted the key informant

interviews, collected and analyzed data from other secondary sources, and drafted the final report.

2.1. Key Informant Interviews

A purposive sample of key informants was identified following discussions with OPTAC. The key informants included high-level officials and program managers in the government and NGO sector, international organizations, and select private practitioners. A semistructured interview guide was used between September and October 2002 to interview the key informants and covered the following areas:

- Sources and distribution of contraceptives in Ethiopia;
- Importation and tax-related barriers to expanding the supply and distribution of contraceptives;
- Experiences and practical problems faced while importing and distributing contraceptives;
- Attitudes to tax-exempt status of contraceptive commodities;
- Suggestions on possible sources of opposition and support for tax-exempt status of contraceptives; and
- Perception of barriers to the enhanced involvement of the private and NGO sectors in the provision of FP services in Ethiopia.

Each interview lasted 50–90 minutes and varied slightly in emphasis depending on the key informant's role. Written notes were taken and analyzed under emerging themes. A nonstructured, in-depth interview was also conducted with a lawyer and a customs officer. All informants were assured that the report would preserve the anonymity of individuals.

2.2. Literature and Document Reviews

An electronic search of the *Medline* and *Popline* databases was performed for the literature review, and a manual search was undertaken of relevant journals identified by the electronic search. Additional items were identified from the reference list of key articles. Non-indexed, non-published articles and doctoral theses were also reviewed.

Documents and service statistics from relevant organizations that could address the objectives of the study were also used. Particular emphasis was given to review tax-related documents and official letters exchanged among different government and nongovernmental institutions. Researchers documented experiences that hinder the smooth importation and distribution of contraceptive commodities in the country. Laws, regulations, and other legal documents that govern the import and taxation of commodities and the NGO system in the country were also reviewed.

2.3. Telephone Interview Survey

A telephone survey was conducted in August 2002 to rapidly assess the attitudes of private drug importers toward importing contraceptive commodities to Ethiopia. A list of 57 pharmaceuticals importers with full telephone numbers and addresses were obtained from the database organized by the Ethiopian Pharmacy Association (EPA). All importers were based in Addis Ababa. A nonstructured brief guide was produced and professionals and

knowledgeable persons from the respective importing institutions were interviewed. The guide assessed the importers' previous experience and future intentions to import contraceptive commodities to Ethiopia. (Section 4.3 presents the information collected.)

3. Sources, Importation, and Taxation of Contraceptives

3.1. Sources of Contraceptives in Ethiopia

Contraceptive commodities are not manufactured in Ethiopia and, hence, are imported. The importation of contraceptive commodities has primarily been driven by international organizations and donor governments. The main donors supporting these imports include UNFPA, USAID (through Pathfinder International), Department for International Development (DFID), Royal Netherlands Government, and Packard Foundation (covering operational costs for DKT). The International Planned Parenthood Federation (IPPF) also serves as a source of commodities to its affiliate, the Family Guidance Association of Ethiopia (FGAE).

The major sources of contraceptive commodities within Ethiopia come mainly through the public sector and social marketing. Involvement of the private sector in the importation of contraceptive commodities is almost nonexistent. Social marketing by DKT occurs through an agreement with the MOH and the Disaster Preparedness and Prevention Commission (DPPC), which confers the privilege of duty coverage to DKT. Social marketing is also a major source of contraceptive commodities for the private and NGO sectors. However, the German Foundation for World Population (DSW), an NGO working on adolescent RH, is investing substantial finances every year to purchase condoms for distribution free-of-charge. The amount of money invested in condom purchases by DSW would have helped at least five youth clubs working on livelihood and RH issues for one year (DSW, 2002). NGOs may also purchase contraceptive commodities from other NGOs (mostly FGAE) to respond to urgent stock shortages in program areas.

Furthermore, the MOH distributes contraceptive commodities that it acquires through free donations to NGOs with extended FP programs in the country, including NGOs such as FGAE and Mary Stopes International–Ethiopia (MSI-E). This usually happens when stocks are in excess of demand from the public sector. The shunting of contraceptive commodities to these NGOs can also take place at regional and zonal levels. Sometimes, the MOH provides commodities for social marketing.

Study participants indicated that the importation of contraceptive supplies is perceived as the primary responsibility of the aforementioned agencies and government. Even among NGOs with expanded FP programs, there is a tendency to rely on contraceptive commodities imported by others that will be acquired either by donation or through the DKT social marketing program. The private sector's role in contraceptive supply is primarily through the DKT program.

There are also indications that contraceptive commodities are smuggled into the country illegally, evidenced by the distribution of unauthenticated contraceptive brands at lower prices than the subsidized social marketing prices in some of the private sector outlets. There were incidents in which agents and distributors in DKT's social marketing program

were able to identify these illegal contraceptive commodities in Addis Ababa, and in the southern and eastern parts of the country.

3.2. Taxation of Contraceptive Commodities

3.2.1. Review of Legal and Regulatory Environment

Laws regulating pharmaceuticals in general govern the distribution of contraceptives in Ethiopia (Centre for Reproductive Law and Policy, 1997). The definition of powers and duties of the executive organs of the Federal Democratic Republic of Ethiopia (Proclamation No. 4/1995) provides the MOH with the power to control the quality and standards of pharmaceuticals in the country. Articles 510 (1) and 786 (c) of the Penal Code regulate the importation of medicinal drugs, poisons, narcotics, and contraceptives through the MOH and more recently through the Drug Administration and Control Authority (DACA). DACA is the sole authority responsible for issuing import and manufacturing licences.[1] The Customs Authority comes into the scene after all these formalities are met.

Contraceptive commodities have only recently begun to be taxed. During the previous administration, contraceptive commodities and other non-capital goods imported by NGOs working on FP services enjoyed duty-free status, whereas tax was payable only for capital goods such as vehicles, office equipment, and so forth. Although Customs Tariffs Regulation No. 42/1976 has been in effect since 1976, it was found that FGAE (evidently the only NGO that imported contraceptives at that time) was enjoying tax exemption privileges for capital goods through letters written from high-level government officials to the Customs Authority.

It was difficult to document the historical accounts and experiences of other NGOs in this regard, as the mushrooming of NGOs working in FP services began well after the change of government in 1991. The majority (60%) of the members of the Consortium of Family Planning NGOs in Ethiopia (COFAP) were established after 1991 (COFAP, 2002).

The government of Ethiopia ratified the International Convention on the Harmonized Commodity Description and Coding System in 1993 and made it the law of the land under Proclamation No. 67/1993. Following this, a new Customs Tariffs Regulation (Council of Ministers Regulations No. 122/1993) was issued, repealing the Customs Tariffs Regulations of 1976. The new tariff regulation still did not clarify the issue of taxing contraceptives as it pertains to NGOs. It was also apparent that there was no official body or clear guidelines to handle the importation and distribution of contraceptives for a number of years, resulting in the spoilage of commodities stuck at ports and customs clearing sites for months, and thus hindering the provision of FP services.

In 1996, the government of Ethiopia endorsed the amendment to the Council of Ministers Regulations No. 122/1993, with particular emphasis on the duty-free status of

[1] Although DACA is authorized to control the standards and quality of imported contraceptives, advertising of contraceptives is subject to scrutiny by the MOH. A major area of restriction in advertising is the prohibition of advertising brand names. An example in point is the once popular and socially marketed "Sensation" condom. This product was banned from the market because of increased pressure from the MOH. On the package was a picture of an undressed couple, which was considered biased advertising. The "Sensation" brand of condom was highly popular, particularly with the younger generation. Since the condom was removed from the list of socially marketable items, it is sold underground and its price has increased.

goods imported by agencies of the government, NGOs, and other organizations. This amendment conferred the power of determining the duty-free status of governmental and nongovernmental agencies on the Ethiopian Investment Authority. The amendment included the unequivocal statement that contraceptive commodities did not qualify for duty-free status and, hence, were subject to taxation, regardless of who imported them, including the MOH.

Currently, the MOH is the major importer of contraceptive commodities in the country and pays the necessary duties to the Customs Authority. Although there are other importers, such as UNFPA, DKT, USAID (Pathfinder International), and FGAE, the tax is only paid by the MOH in accordance to a tripartite agreement between the NGOs, MOH, and DPPC, in which the MOH commits itself to pay the import taxes required for the contraceptive commodities. This exercise involves such lengthy bureaucratic procedures that the shelf lives of the commodities often expire before customs clearance is granted and the commodities reach the FP service outlets. In addition, there is no clear statement as to which of the NGOs will be covered by the amendment above, which accounts for the unwillingness of many NGOs to get involved in FP service delivery. Some respondents were not sure that the MOH would offer to pay import taxes for all NGOs. FGAE and DKT appear to be beneficiaries of this privilege of having import taxes paid by the MOH.

3.2.2. Taxes on Contraceptives

Contraceptive commodities are taxable in accordance to the Customs Tariffs Amendment Regulations No. 6/1996. The tax rate for contraceptives varies from year to year, despite a fixed rate of 15 percent stated in the "Customs Tariff Classification System of Goods and Rates." As shown in Table 1, between 1997 and 2000 the tax paid by the MOH for the importation of contraceptives by DKT ranged from 9 and 27 percent of the purchase cost of the taxed commodity. Likewise, the duty paid by the MOH for contraceptive commodities imported by FGAE ranged from 5 percent for intrauterine devices (IUDs) in 1998 to 34 percent for pills the same year (Table 2). Table 2 also shows the difference in tax rates between FGAE and DKT in the same year. Figure 1 shows the amount of tax paid by DKT to import commodities to Ethiopia.

According to Table 1, condoms were taxed at the rate from 9 and 23 percent; injectables at a rate from 17 to 27 percent, and oral contraceptives at a rate from 15 and 27 percent. Between 1997 and 2001, the lowest tax paid for one condom was 0.03 Birr and the highest was 0.13 Birr. During 2000 and 2002, taxes paid for one vial of Depo-Provera amounted to 1.9 Birr and 1.2 Birr, respectively. One cycle of OCP was taxed at the rate of 0.57 Birr and 0.44 Birr (2000 and 2001, respectively).

In 1996, the Tariff Regulation was amended; in 1997, tax was waived for DKT; and in 1999, the MOH donated one million cycles of OCP. Although this could be an indication of the existence of supportive goodwill and flexibility within the government amid stringent procedures, many respondents are reluctant to believe this goodwill and flexibility would be extended to other potentially interested importers of contraceptives (NGOs or private importers).

The MOH fulfils its commitment of paying the tax for commodities initially by asking the Ministry of Finance to deduct the amount due of from its annual budget for the fiscal year. Then, the Ministry of Finance authorizes the Customs Authority not to levy tax on specified commodities. Although it looks as if there is no actual transfer and flow of money,

costs are invariably incurred by the MOH. The government in turn may intervene in the planning and budget allocation. Moreover, even for those NGOs enjoying this goodwill gesture of the MOH, the bureaucratic procedures and exchange of letters is quite cumbersome and time consuming. It was reported recently that the MOH is trying to shorten this lengthy process by writing directly to the Customs Authority with a carbon copy of the letter going to the Ministry of Finance. Although this has shortened the lengthy process of exchanging correspondence, it has not helped the problematic clearance process at the Customs Authority. There have been reported incidents of spoiling, mishandling, and missing contraceptive commodities at the Customs Authority.

Table 1
Distribution of Prices and Taxes Paid for Contraceptive Commodities and Purchasable Commodities Using the Taxes Paid, DKT 1997–2001

Items	1997	1998	1999	2000	2001
Condoms					
Total amount purchased	20,010,000	37,878,000	69,810,000	54,468,000	93,852,000
Total purchasing price (Birr)	6,946,665	15,840,988	29,842,922	31,054,039	52,584,877
Unit price (Birr)	0.35	0.42	0.43	0.57	0.56
Total tax paid (Birr)	0	1,912,203	2,581,188	7,264,817	8,775,580
Unit tax (Birr)	0	0.05	0.03	0.13	0.09
Tax proportion to the price (%)	0	12	8.7	23.4	16.7
Number of condoms purchasable using amount of total tax paid	0	4,572,864	6,002,762	12,745,292	15,670,678
CYP* generated by purchasable condom (units per CYP=120)	0	37,940	50,023	106,210	130,588
Total condom that would be imported	0	42,430,864	75,812,762	67,213,292	109,522,678
Injectables (Depo-Provera)					
Total amount purchased (vials)	-	-	-	100,000	480,000
Total purchasing price (Birr)	-	-	-	707,344	341,0311
Unit price (Birr)	-	-	-	7	7
Total tax paid (Birr)	-	-	-	188,211	591,832
Unit tax (Birr)	-	-	-	1.9	1.2
Tax proportion to the price (%)	-	-	-	27	17
Depo purchasable using amount of total tax paid (vials)	-	-	-	26,508	83,356
CYP* generated by purchasable injectable (units per CYP=4)	-	-	-	6,627	5,206
Total Depo that would be imported	-	-	-	126,508	563,356
Oral Contraceptive Pills (OCP)					
Total amount purchased (cycles)	2,301,600	-	1,000,000	750,000	1,641,600
Total purchasing price (Birr)	2962159	-	Donation	1,604,409	4,715,185
Unit price (Birr)	1.3	-	NA	2.1	2.9
Total tax paid (Birr)	-	-	NA	432,486	72,4854
Unit tax (Birr)	-	-	NA	0.58	0.44
Tax proportion to the price (%)	-	-	NA	27	15.4
OCP purchasable using amount of total tax paid (cycles)	-	-	NA	202,096	25,2562
CYP* generated by purchasable OCP (units per CYP=15)	-	-	-	13,473	16,837
Total OCP that would be imported	-	-	-	952,096	1,894,162

*CYP (couple-years of protection) is the protection required by one couple using a contraceptive method for an entire year. One-hundred fifty condoms, four vials of Depo-Provera, or 15 cycles of OCP are needed to generate one CYP (Stover et al., 1997).

Table 2
Tax Rates Paid for Contraceptives Imported by the MOH for DKT and FGAE, 1998–2001

	1998		1999		2000		2001	
	DKT(%)	FGAE(%)	DKT(%)	FGAE(%)	DKT(%)	FGAE(%)	DKT(%)	FGAE(%)
Condom	12.0	14.0	8.7	-	23.4	19.0	16.7	-
Injectable	-	19.3	-	18.0	27.0	26.5	17.0	18.4
OCP	-	34.4	-	33.8	27.0	-	15.4	16.2
IUD	-	4.7	-	-	-	-	-	-

Figure 1. The Distribution of Tax in Percentage of the Price of Condoms, DKT 1997-2001

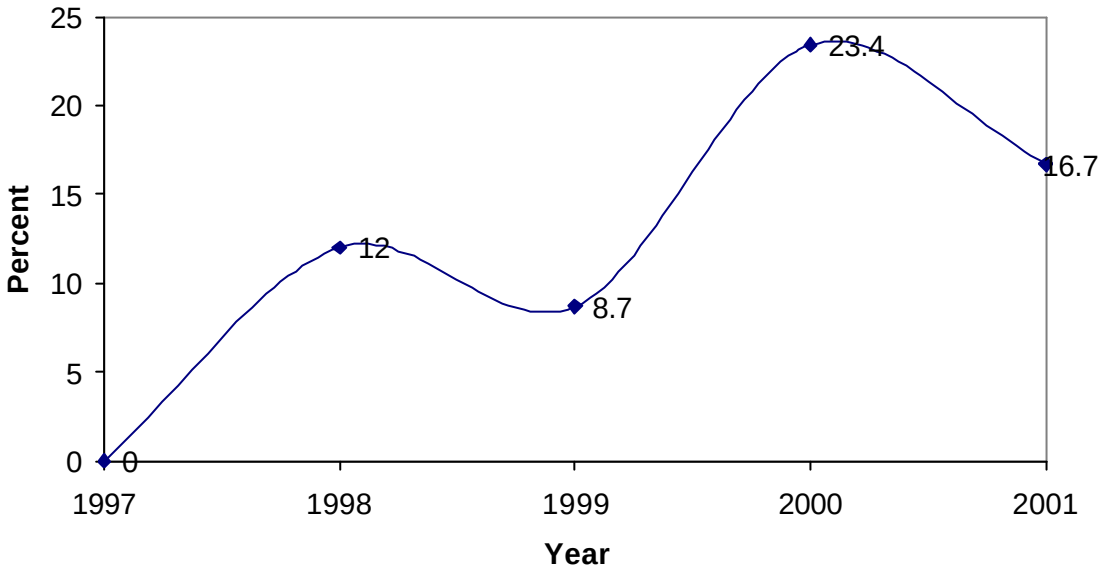
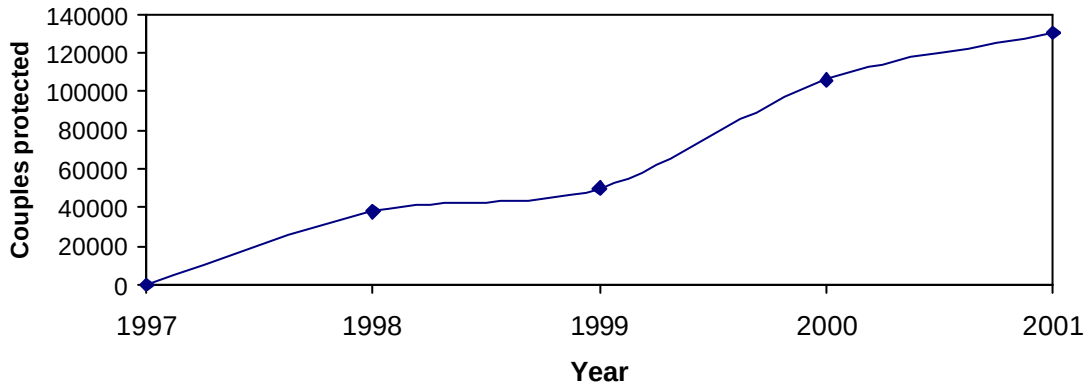


Figure 2. CYP Achievable by Using Taxes Levied on MOH 1997-2001 for Condom Procurement, DKT

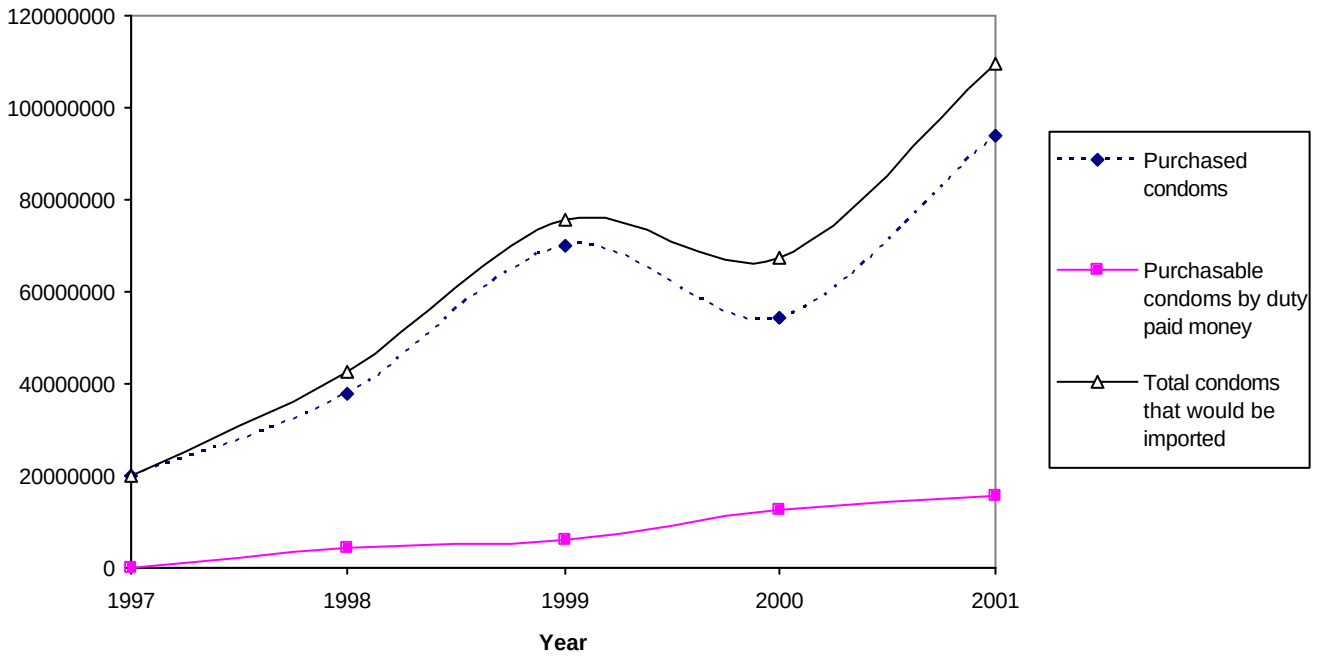


If one uses the amount of duty paid to purchase contraceptive commodities, it could generate quite a significant number of CYP. Table 1 depicts the amount of commodities that could have been purchased using the duty paid for all commodities and the corresponding CYP that would have been generated using the data obtained from DKT. Figure 2 shows the CYP that could have been generated by condoms purchased using the amount of import taxes paid by MOH for DKT imports, and figure 3 shows the total number of condoms that could be purchased with the money used to pay import taxes

From 1997–2001, the taxes paid by the MOH for condoms imported by DKT could have been used to purchase condoms for more than 325,000 couples. Likewise, the import taxes for injectables and OCP would have protected nearly 60,000 couples. If one assumes these beneficiaries were currently married women of reproductive age (15–49 years), it would reduce Ethiopia's unmet need for FP by 6 percentage points. The current 36 percent of unmet need for FP would drop to 30 percent, and the contraceptive prevalence rate would increase to 14 percent. In view of these simple calculations, one can argue the crucial role that exempting contraceptive commodities from import taxes plays in increasing access to FP services in Ethiopia.

In addition, the tax exemption may encourage some NGOs with international affiliations and donor access to import commodities to strengthen their programs. It would also help in reducing the lengthy bureaucratic procedures, and time and product wasted in customs clearance.

Figure 3. The Number of Condoms that Could Have Been Purchased If the Money Paid in Taxes Was to Be Used for this Purpose, DKT 1997-2001



3.2.3. Support and Opposition to Tax-exempt Status for Contraceptives

The Ethiopian government is modernizing its tax system, and a new Ministry of Revenue has been established to carry out this highly publicized tax reform activity. The government is trying to broaden its tax base to promote economic growth by encouraging savings and investment (Income Tax Proclamation 286/2002).

Most respondents agreed that the recent measure taken by the government to allow the duty-free importation of antiretroviral drugs could be used in arguing for the removal of import taxes on contraceptive commodities (FDRE, 2002).

4. Private-for-Profit Sector in Family Planning Services

4.1. Review of the Legal and Regulatory Environment

Health services in Ethiopia have been transformed from a socialist orientation to a system that espouses free market principles (WHO, 1999). However, this development is still in its infancy, and the attitudes of those who seek to provide services in the private sector have not yet come to full maturity. The private sector offers mostly curative services (Pathfinder International, 1999).

As part of health sector reform, the MOH introduced regulations that prohibit civil servant practitioners from simultaneously working both in the public and private for-profit sectors. This has resulted in an exodus of highly experienced health workers from the public sector and contributed to an increase in the number of private for-profit institutions. Moreover, the economic policy of the government that encourages private investment in the health care system has also helped in the mushrooming of private for-profit institutions, mainly in urban areas.

Pursuant to the authority vested in the MOH by the government, the MOH has introduced a system of licensing that specifies the minimum requirements for operating private health facilities (Proclamation (No. 4/1995). The Proclamation grants licenses to those facilities deemed to meet the minimum requirements. However, there is no clear policy and operational guidelines concerning the involvement of the private sector in FP/RH services in Ethiopia.

4.2. Private For-profit Sector and FP Services

The primary involvement of the private sector is in the provision of curative rather than preventive services. The same is true with the provision of FP. According to the Demographic and Health Survey (DHS) (CSA and ORC Macro, 2001), the private for-profit sector was a source of FP commodities for only 12 percent of women currently using FP. However, our study shows that private practitioners are willing to be involved in the provision of FP/RH services, as has been previously noted (Hailu, 1998).

There are current attempts to increase the involvement of the private sector in the provision of FP services, spearheaded by Pathfinder International and the Packard Foundation, which fund programs in a number of zones of the Amhara Region and one zone of the Oromiya Region. Further attempts are under way to foster public–private partnership

through referrals. The Ethiopian Drug Administration and Control Authority recently provided licenses to three private firms planning to import condoms into the country.

4.3. Role of Private For-profit Sector in Importing Contraceptives

Involvement of the private sector in the importation of contraceptives in Ethiopia has been negligible. The reasons for this, however, were not well understood until this study was conducted. As an attempt to assess the status and attitude of private for-profit pharmaceutical importers toward importing contraceptives, a telephone survey was conducted by the POLICY Project in August 2002 to assess the reasons for the negligible involvement of the private sector in the importation of contraceptives.

Addresses of 57 importers were obtained from the Ethiopian Pharmacy Association database, and 32 importers (56%) were contacted. The remaining 25 (44%) were not accessible for several reasons, including changes of address, incorrect telephone numbers, and nonfunctioning telephone lines. It was also evident that some of the importing institutions had abandoned their businesses. Of the 32 importing institutions contacted, two (6.3%) disclosed that they are importing only medical instruments and other non-drug pharmaceutical supplies. Thus, only 30 pharmaceutical importers were included in the survey.

The survey revealed that only three (10%) of the respondents had previously imported contraceptives. The imported commodities were pills and injectables (n=1) and injectables alone (n=2). All three importers imported the contraceptives after paying taxes to the Customs Authority. The respondent who had imported contraceptive pills said that he was not able to sell a single OCP cycle because pills are now available through social marketing outlets at subsidized rates. Imported injectables were sold with a retail price of more than 15 Birr per vial; however, it was stated that the market was not attractive. One respondent said that he "would not commit the grave mistake of importing contraceptives into the country."

Otherwise, the majority (90%) of private importers of pharmaceuticals never imported contraceptive commodities. A wide range of reasons was given for this, the most frequent being the lack of demand and the presumption that the business might not be profitable. Some respondents also emphasized the availability of contraceptives in the public and NGO sectors, thereby ruling out involvement of the private for-profit sector. Some respondents held the view that it was only the MOH, FGAE, and DKT that were allowed to import contraceptives. Other respondents said that they were not sure that importing contraceptives was allowed for the private sector. Only 12.5 percent said that they would consider importing contraceptives in the future if there was a demand.

Contraceptives imported to Ethiopia for social marketing are highly subsidized by donors. Table 3 shows that commodities sold are highly subsidized both at the trader and client levels. The highest subsidy both at trader and client levels was for condoms, which were subsidized at 96 and 83 percent, respectively, of their purchasing price. By comparison, Depo-Provera was the least subsidized, both at the trader and client levels, with a subsidy of 72 and 58 percent, respectively, of the purchasing price. The high level of subsidy for the importation of contraceptive commodities and the relative high market price would invariably discourage private importers as it is clearly not profitable. It is also possible that most of the private importers might not have strong financial capacity to negotiate for bulk purchases and reduced prices with manufacturers.

Table 3
Distribution of Purchasing and Selling Price of Commodities by Social Marketing, DKT–Ethiopia, 2002

Commodity	Unit purchasing price (Birr)	Retail price to trader (Birr)	Retail price to client (Birr)	Subsidized price to trader (Birr)	Subsidized price to client (Birr)
Condoms	0.46	0.02	0.08	0.44 (96%)*	0.38 (83%)*
OCP	2.50	0.65	1.00	1.85 (74%)*	1.50 (60%)*
Depo-Provera	7.10	2.00	3.00	5.10 (72%)*	4.10 (58%)*

*Percentage of the subsidy as compared to the purchasing price of the commodity.

DKT–Ethiopia recovered only 4 percent of what it spent on social marketing of contraceptive commodities (condom, pills, and injectables) per annum from 1999–2000. External donors covered the remaining costs.

Although additional studies are needed to assess the different forces involved in deterring private drug importers from importing contraceptives, it can be concluded that the current efforts and willingness of private drug importers to import contraceptives to Ethiopia is almost negligible. One reason for this is the lack of capital among many private importers for importation and distribution of contraceptives. Unlicensed contraceptives distributed in the market, as a result of illegal smuggling, could also contribute to the lack of interest of private drug importers to import contraceptives.

There is a need to encourage and support private drug importers to import contraceptives as a step toward increasing access to FP services. These importers should have the financial capacity to invest in bulk purchases directly from manufacturers. Since logistics is one of the many problems restricting access to FP, the prevailing policy on who should distribute contraceptives should be amended as to permit the private sector to serve as an outlet to donor-provided commodities. A supportive policy environment should be created to allow private sector entrepreneurs to manufacture contraceptives within the country. Naturally, this should be preceded by a feasibility study to determine domestic absorptive capacity; however, this is unlikely to work unless the contraband market is curtailed, manufacturing is under strict quality control, and donors are solicited to purchase donations from local manufacturers.

5. The NGO Sector in Family Planning Services

5.1. Review of the Legal and Regulatory Environment

The huge influx of NGOs coincided with the famine that the country experienced in the mid-1970s and mid-1980s. These unfortunate events attracted a lot of international NGOs to work on relief and development activities in Ethiopia. The first involvement of NGOs in FP/RH services dates back to 1966 when the Pathfinder Fund (now Pathfinder International) made an exploratory visit to Ethiopia to find out how FP services could be started. The delegation was able to meet the Emperor, who quietly provided an imperial order to pursue these issues because of the prevailing pronatalistic feelings among government officials, religious leaders, and the community at large.

The 1991 change in government and the 1994 International Conference on Population and Development (ICPD) paved the way for the increasing number of NGOs working on FP/RH. The alarming increase in magnitude of the HIV/AIDS epidemic and the huge influx of donor money into Ethiopia has also increased the rate at which NGOs (both indigenous and international) are involved in development activities.

During Imperial times, the Department for the Coordination of Voluntary Organizations within the Ministry of Community Development and Social Welfare supervised NGO activities in Ethiopia. Later, during the time of the Derg (the Revolutionary Committee of 120 members of the armed forces that overthrew the Imperial Regime in 1974), this ministry was liquidated and NGO supervision was transferred to the Relief and Rehabilitation Commission (RRC). The RRC was the predecessor of Disaster Preparedness and Prevention Commission (DPPC), which currently supervises the operational activities of NGOs in Ethiopia.

The Definition of the Powers and Duties of the Executive Organs of the Federal Democratic Republic Proclamation (No. 4/1995) bestowed on the Ministry of Justice (MOJ) the authority to register nonprofit NGOs. Once registered with the MOJ, NGOs must renew their licenses and receive new certificates of registration every year. The certificate certifies that the NGO has complied with the provisions of the Civil Code of Ethiopia of 1960 and the Registration of Associations Regulation (Legal Notice No. 321 of 1996). Many respondents disclosed that the MOJ registration process is lengthy and time consuming. Many said that original registration with the MOJ could take several years and that the renewal procedure is time consuming. In addition, registration with the MOJ does not make the NGO operational; therefore, NGOs are obliged to sign an operational agreement with DPPC. This agreement was necessitated by the need to minimize the tendency of NGOs to select more accessible regions for introducing their programs. DPPC wanted it determined whether the proposed services were actually needed and whether they were likely to address unmet needs. Reviews at the regional and zonal levels take an inordinately long time, often discouraging any new initiatives.

In the operational agreement, DPPC commits itself to support and facilitate the activities of the NGOs through liaison between the NGO and regional governments, line departments, and other government organizations. It further facilitates duty-free importation of capital goods and pays duties on foodstuffs, medical equipment, and other relevant supplies imported in response to emergency relief. However, the exemption of contraceptive commodities from payment of import duties is not provided for under this arrangement since contraceptives are not considered to be emergency items.

Apart from the rules and regulations mentioned in the operational agreement between DPPC and NGOs, there is no clearly defined guideline or policy that governs NGO activities in Ethiopia. However, there has been recent activity spearheaded by the MOJ and the NGO community to draft NGO legislation to address most of the legal and regulatory issues that pose barriers in the smooth functioning of NGOs. This includes the establishment of an Office of Voluntary Organizations (OVO), to be an autonomous focal governmental agency that facilitates NGO involvement in FP/RH. This idea has been fully supported by all of our informants. It was further commended to be instrumental in enhancing the involvement of NGOs in FP/RH services by reducing the bureaucratic procedures.

5.2. NGOs in Family Planning Services

There are 453 registered NGOs in Ethiopia, of which only 287 (63%) are operational. Although the regional distribution of theses NGOs is not equitable, they are functional in all regions of the country. The number of NGOs working in FP/RH services is small—not more than 80. However, most of the community-based distribution (CBD) programs in Ethiopia are supported by NGOs (WHO, 1999).

Most NGOs have begun integrating FP/RH into their community development programs after the paradigm shift following the ICPD in 1994. By 2001, of 194 members of Christian Relief and Development Agency (CRDA), a consortium of NGOs in Ethiopia, 77 (40%) were providing FP services. In contrast, all 57 members of COFAP presently provide FP services. However, NGOs were sources of FP commodities for only 7 percent of women who are currently using contraceptives (CSA and ORC Macro, 2001). The main source of supplies is the government, which receives commodities through bilateral and multilateral assistance.

Most NGOs working in FP/RH often start their programs with limited financial and trained human resources. These limitations compromise their potential impact in the provision of FP/RH services. However, there are encouraging NGO success stories, particularly in the area of FP. In the northern and southern parts of the country, where NGOs are providing FP services mainly through the CBD approach, there are reports showing CPR of more than 40 percent in certain zones.

5.3. Coordination and Partnership Activities

In a national assessment of RH services, WHO (1999) reported on the significant roles likely to be played by NGOs in the expansion of FP/RH services. However, in spite of these commendations, there was virtually no recognized body to coordinate their activities. The government recently acknowledged the existence of problems with NGOs in a press release by the Ministry of Information, in which most NGOs were criticized for lack of transparency and accountability in their activities and for designing programs that are not in harmony with the development strategies of the country (Addis Zemen, September 3, 2002).

Despite this strong government statement, however, most of our respondents agreed that there is an increasingly positive attitude toward NGOs from the public sector at all levels. In the field of FP/RH, there are NGOs enjoying the support of the MOH in strengthening their services. Support is extended to NGOs by the MOH's paying import taxes on contraceptive commodities. The recent partnership between the NGO community and the MOJ in drafting NGO legislation is another example demonstrating the emerging and encouraging partnership. Likewise, the involvement of many NGOs in the national RH task force, overseen by the MOH, is yet another example of good partnership between NGOs and the public sector in the area of FP/RH services.

The absence of effective communication prevents a stronger partnership between the government and NGOs. NGOs are required to submit periodic reports about their activities, including challenges and opportunities faced in the course of program implementation. Yet there is no system that requires the government to provide feedback to the NGOs. A high degree of dissatisfaction was reported among our respondents concerning personnel at all

levels of the government who do not adequately use the information and data provided to them.

Coordination is also weak among the NGOs themselves. Duplication of effort and competition for activities in a limited area has hampered the smooth and effective functioning of FP/RH NGOs in Ethiopia. Although limited and influenced by several factors, COFAP's attempts to strengthen coordination and collaboration among NGOs and to create partnerships with the public sector are encouraging. COFAP has been involved in developing training curricula, protocols, and guidelines in consultation with the public sector. It has also introduced a standardized monitoring and evaluation system to be used within its membership.

5.4. Access to Multilateral and Other Donor Funds by NGOs

Although UNFPA is the major source of multilateral funds for FP services in Ethiopia, funds for the country program are exclusively used by the public sector. However, UNFPA is trying to support NGOs through the leveraging of funds from other bilateral agencies. This lack of access to multilateral funds, in fact, was believed to compromise the contribution of NGOs in enhancing FP services in Ethiopia. The Packard Foundation, the major private donor for FP services in Ethiopia, supports many NGOs and COFAP.

6. Identification of Operational Barriers

On the recommendation of OPTAC, data were collected on the following 10 possible problem areas. The findings are described below and summarized in Table 4.

6.1. High Tax Levied on Contraceptives

Contraceptives are taxable commodities, and the tax rate is not only high but it also fluctuates. Although contraceptives are taxable, the MOH pays taxes for contraceptives through a tripartite agreement among the MOH, DPPC, and the importing NGOs. It was possible to show that the taxes paid by the MOH could purchase a sizeable amount of contraceptives that would bring about a difference in generating CYP, and hence increase the CPR. Moreover, most NGOs are not in a position to import commodities because of the lengthy procedures surrounding the importation and taxation of contraceptives. Most of our respondents in this study are of the opinion that exempting contraceptives from import duties is a litmus test for the seriousness with which the government takes its own policy in respect to fertility reduction.

The government of Ethiopia bestowed the authority of monitoring the implementation of the population policy to the Ministry of Finance and Economic Development (MOFED). However, many respondents agreed that the NOP (that is situated within the MOFED is more or less nonfunctional and lacks the capacity to discharge its duties. Therefore, in order to obtain an objective such as a tax-exempt status for contraceptives, advocacy efforts need to be targeted to a higher authority such as the Parliament, and include organizations such as DACA, MOFED, and the MOH. The Parliament is the highest decision-making body in the country that can draw up and endorse a tax-free status for contraceptives.

6.2. Limited Access to Duty Coverage of the MOH by NGOs and the Private Sector

The MOH supervises FP/RH programs, and as such it is the agency in whose name contraceptives are imported. This means that essentially the MOH is the only agency that pays import taxes on contraceptives. Although the ideal solution for this problem is to grant tax-exempt status to all importation of contraceptives, the MOH should open its doors to more NGOs and private sector establishments that are in a position to import contraceptives through their international connections. If this is allowed, access and availability of contraceptive commodities will be facilitated far beyond the public sector and public institutions.

6.3. Lengthy and Bureaucratic Clearance Procedures of Contraceptives at the Customs Authority

Even to those NGOs and importers that have an agreement with the MOH to cover the duty for imported contraceptives, the paperwork associated with the clearance procedures is lengthy and time consuming. Unlike other perishable items that are cleared in the shortest amount of time, contraceptives do not receive special consideration. Several incidents involving missing contraceptives, spoilage, and damage from poor storage at the Customs Authority warehouse have been documented. The Customs Authority, which is responsible for facilitating the clearance of contraceptives, and the MOH, which is responsible for facilitating the paperwork, are the target organizations for addressing this barrier.

6.4. Private Sector's Limited Interest and Awareness Regarding the Importation of Contraceptives

Although there are several intrinsic and extrinsic factors that deter the private sector from importing contraceptives, the private sector in general was not aware that contraceptives are importable commodities. Ethiopia, as many other developing countries, has been exclusively dependent on external donors for its contraceptive supply. However, in-country efforts have to be initiated to ensure contraceptive security and more effective engagement of the private sector.

Enhancing the awareness and involvement of the private sector through innovative strategies might be an initial step in bringing about the participation of the private sector. Policy dialogue has to be initiated with civil society organizations (CSOs), such as the EPA, to explore ways to increase the involvement of the private sector either to import or manufacture contraceptive commodities in the country.

6.5. No Clear Policy or Guidelines Regarding the Involvement of the Private Sector in FP/RH Services

The private sector's involvement in the provision of FP/RH services is limited to facilities functioning mainly in urban areas. There are a number of factors that inhibit the proper functioning of this sector, including the lack of clarity in the regulatory system and the absence of an effective coordinating body. The solution lies with the MOH in simplifying the operational environment by developing clear guidelines aimed at removing unnecessary bureaucratic bottlenecks.

6.6. Delayed Response and Lack of Support for the Introduction and Expansion of New and Popular Commodities/ Methods

There has always been great resistance to having new and popular commodities and methods available to the community. Although not prohibited, there were considerable obstacles to overcome when FGAE tried to introduce *minilaparatomy.*[*]

Although strict quality control of imported commodities is important, there should be a transparent system to ensure this. The condom with the brand name "Sensation," distributed by DKT, was banned from the market because "it was culturally insensitive." However, taking "Sensation" out of the market was not quite transparent and was not done convincingly. Brands of condoms with similar problems of sensitivity are being marketed in modern supermarkets. Clearly, there is a need not to be unduly stringent on the part of those who are charged with the responsibility of screening incoming commodities.

6.7. Inability of NGOs to Import Contraceptives

There are some NGOs working in the delivery of FP services that have international connections that put them in a position to import contraceptives either through purchase or donation. However, the high and fluctuating rate of import taxes levied on contraceptives and the inequitable access to the goodwill of the MOH to pay the taxes, have prevented such NGOs from importing either purchased or donated commodities. There is much to be gained from the government removing the import taxes on contraceptives.

6.8 Lengthy Registration and Operational Procedures for NGOs

Registration procedures for NGOs have been quite tedious and involve much paperwork. There is anecdotal evidence from respondents that there are some public sector officials who are not supportive and often pose bottlenecks in the smooth functioning of NGOs, including those providing FP services. The Ethiopian government has admitted this fact in a recent press release by the Ministry of Information, which is serving as the government's point-of-contact on this matter (Addis Zemen, September 3, 2002).

The annual registration renewal by the MOJ has also been a source of discouragement and discontent among many NGOs. This is quite different from the situation in other countries, in which NGOs are required to renew their licenses less frequently. For example, in Uganda, NGOs renew their registration every three years after the first year, and every five years after the first three years of operation. FP/RH projects are sent to offices and bureaus for review at regional and zonal levels, often resulting in operational delays. Establishment of an Office of Voluntary Organizations (OVO) as an autonomous governmental agency to cater to operational matters of NGOs would address these problems. Parliament, federal and regional DPPCs, the MOH, and health and other line bureaus and offices at the regional level are entities that can provide oversight of NGO operations.

[*] Minilaparotomy is a procedure used for tubal ligation, involving a small incision [usually less than 2 in. long]. The cut is made just at or above the pubic hairline. The fallopian tubes are pulled up into or out of the incision and tied off, then put back into place.

6.9. Poor Collaboration, Coordination, and Partnership among NGOs

There is poor coordination, collaboration, and partnership between the public sector and NGOs, and among the NGOs themselves. NGOs compete and engage in similar activities that give rise to inefficient use of scarce resources and duplication of services. As suggested earlier, one solution to this issue would be the establishment of the OVO as an autonomous governmental agency. Moreover, in the field of FP/RH services, there is a need to enhance participation of NGOs in strategic planning and other activities of the public sector so that that they feel they are a part of a larger scheme. Advocacy work should focus on changing the whole policy and programmatic environment by influencing various kinds of decision makers: Parliament, federal and regional DPPC, investment authorities, etc.

6.10. Lack of NGO Access to Multilateral FP Funds

UNFPA funds are exclusively used by the public sector, principally the MOH and the NOP. Access of NGOs to such funds is a common thing in many countries. Increasing NGO access to such funds in Ethiopia is likely to open up many more doors to FP/RH services. In order to bring about increased NGO involvement, targeted advocacy work aimed at the MOH, NOP, and MOPED is needed.

Target audiences to address this barrier include the MOH, NOP, and MOFED. Involvement of civil society institutions and professional associations would be essential in this effort as well.

Table 4
Matrix of Suggested Policy-level Interventions to Address Macro-level Barriers to FP Services in Ethiopia

Barrier	Federal Level							Regional Level		
	Parliament	MOH	MOFED	Customs Authority	DPPC	NOP	CSO/PA	RHB	BOFED	RDPPC
1. High tax levied on contraceptives	▨	▨	▨	▨	▨	▨				
2. Limited access of NGOs and private sector to duty coverage by MOH	▨	▨	▨	▨						
3. Lengthy clearance at customs			▨	▨				▨		
4. Limited interest of the private sector to import contraceptives		▨					▨			
5. Lack of clear policy and guideline for involvement of private sector in FP	▨	▨				▨	▨			
6. Delayed response and lack of support for the introduction and expansion of new and popular commodities		▨								
7. NGOs are able to import contraceptives		▨		▨	▨	▨				
8. Lengthy registration and operational procedures for NGOs					▨			▨	▨	▨
9. Poor collaboration, coordination, and partnership in NGO activities	▨	▨	▨		▨	▨		▨	▨	▨
10. Lack of NGO access to multilateral FP funds	▨	▨	▨			▨	▨			

1. MOH= Ministry of Health
2. MOFED= Ministry of Finance and Economic Development
3. DPPC= Disaster Preparedness and Prevention Commission
4. NOP= National Office of Population
5. CSO/PA= Civil Society Organizations /Professional Associations
6. RHB= Regional Health Bureau
7. BOFED= Bureau of Finance and Economic Development
8. RDPPC= Regional Disaster Preparedness and Prevention Commission

▨ Level where barrier could most effectively be addressed

7. Conclusions and Recommendations

The FP system in Ethiopia is hugely dependent on donors for contraceptives. Although the government has a supportive policy toward fertility reduction, the FP system is highly entangled with macro-level operational barriers that have compromised the provision of effective FP services in the country. These barriers have further fuelled the inaccessibility of FP contraceptives in Ethiopia, in which unmet FP need stands at 36 percent, or equivalent to 3.2 million currently married women who are in need of FP services. Therefore, to expand FP services and mitigate unmet need, all potential avenues that enhance the availability and accessibility of FP services must be explored. The smooth importation of contraceptive commodities and increased participation of the private sector and NGOs in service provision are to be encouraged to increase effective provision of FP services in Ethiopia.

Taxation of contraceptives and tedious customs clearance procedures are major barriers to better access to FP services. During the taxation process, bureaucratic procedures and paperwork cause delays that have a negative impact on the provisions of services. Moreover, unequal access to the MOH's duty payment poses a barrier prohibiting many capable NGOs with international affiliation from importing contraceptives.

Bulk purchases of contraceptives could be advantageous for Ethiopia, since it is possible to negotiate a reasonable price with manufacturers. While encouraging the private sector to import contraceptives, it would be wise to encourage huge private sector firms to negotiate with manufacturers and import contraceptives in bulk. Furthermore, a conducive policy environment has to be created to encourage the manufacturing of contraceptives within the country.

Increased policy dialogue and advocacy activities are needed to address the identified barriers at the federal and regional levels. There is also a need to establish or revitalize the population/RH subcommittee within the Parliament as a step in an effort to initiate advocacy and policy dialogue activities that will address all the identified barriers.

Annex 1:
Contraceptives Listed on the Ethiopian National Drug List, 2002, Drug Administration and Control Authority

Combined Oral Contraceptives		
1	*Levonorgestrel (D-Norgestrel) + Ethinylestradiol and Iron*	*Tablet, 0.5mg + 0.03mg; 0.25mg + 0.05mg; 0.5mg + 0.05mg; 0.3mg +0.03mg*
2	*Motrthidrone (Norethisterone) + Ehinylestradiol*	*Tablet, 0.5mg + 0.035mg*
3	*Norethindrone (Norethisterone) + Mestranol and Iron*	*Tablet, 1mg+0.05mg*
Progestogen Only Contraceptives		
1	*Ethynodiol Diacetate*	*Tablets, 0.5mg*
2	*Etonogestrel*	*Implant (subdermal) 68 mg/capsule, pack of 1 capsule*
3	*Levonorgestrel (D-Noregestrel)*	*Implant Capsule (Subdermal); 36mg/capsule pack of 6 capsules, 108mg/capsule pack of 2 capsules; 75mg/capsule, pack of 2 capsules Tables, 0.03mg*
4	*Lynestrenol*	*Tabler, 0.5mg*
5	*Medroxyprogesterone acetate*	*Injection (aqueous suspension), 150mg/ml in 1 ml vial*
6	*Norethindrone (Norethisterone)*	*Tables, 0.35mg*
7	*Norethindrone enanthate (Norethisterone)*	*Injection (Oily),200mg/ml ampoule*
Contraceptive Devices, Barriers and Spermicides		
1	*Condoms (Male, Female)*	
2	*Copper T 380 A*	
3	*Diaphragms with Spermicide*	
4	*Menfegol*	*Tablets (Foaming), 60mg*
5	*Nonoxinol, Octoxinol*	*Creams, Foams, Gels.*

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