

**National Survey on Availability of Modern
Contraceptives and Essential Life Saving
Maternal/RH Medicines in Service Delivery Points
in Ethiopia**

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FOREWORD

The current policy environment is very supportive of RHCS. Several policies and strategies are being developed while others have already been adopted calling for support to reproductive health and family planning services and availability of contraceptives. The Health Policy and Health Sector Development Plan for instance make provisions for reproductive health, and family planning is mentioned in the basic health package. The health plan also stresses the importance of access to essential drugs and distribution of contraceptives and RH commodities at SDPs through effective and efficient logistics supply management system. The Government believes that RHCS can only become a reality when every person is able to choose, obtain, and use quality contraceptives and other reproductive health commodities whenever she or he needs them.

Many factors ranging from the socio-economic context of the country, to the policy environment for RH services, the availability of funds to procure commodities, the capacity of the health system to procure, store, and distribute them effectively to people when and where they are needed, affects RHCS. People need to know about RH services and contraceptive options and to seek them, which requires information. Service providers need the skills to deliver quality services.

In this regard, the vision of the Government can only become a reality if the implementation process of the RHCS/LMIS is participatory and accelerated. We trust the survey on “Availability of Modern Contraceptives and Essential Life Saving Medicines in Service Delivery Points in Ethiopia” will build on the existing endeavors of strengthening the logistics management information systems and the national RH commodities quantification and forecasting initiatives at all levels. The complementary role of partners, NGOs, and other stakeholders will be very useful not only in the participation of undertaking this survey but in carrying forward the key recommendations reflected in the survey.

Since 2007 UNFPA has been supporting the strengthening and mainstreaming of RHCS into the existing health system through the GPRHCS program. The purpose is to provide special support to close gaps in reaching the targets set by the Health Sector Development Plan and the health MDGs. UNFPA provided technical and financial support to undertake this important survey and will continue its support in improving RHCS of the country.

Finally, on behalf of the Federal Ministry of Health and UNFPA-Ethiopia we would like to take this opportunity to express our gratitude to all partners for their continued support in this endeavor. We

also appeal to all of our partners in health sector to use the findings of this survey to improve the country's RHCS.

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At this juncture, the Firm would like to surface that the good work done remains a credit of all who were engaged in the survey: FMOH, RHBs, ZHDs, WoHO, and service providers at the respective SDPs. BETA also acknowledges the field data collectors and supervisors who discharged the assignments given to them to the required standard.

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ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
AMTSL	Active Management of Third Stage Labour
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Agency
CSPRO	Census and Survey Processing
EDHS	Ethiopian Demographic and Health Survey
EHNRI	Ethiopian Health and Nutrition Research Institute
EmONC	Emergency Obstetrics and New-born Care
FMOH	Federal Ministry of Health
FP	Family Planning
GPRHCS	Global Program to Enhance Reproductive Health Commodity Security
HCS	Health Centres
HEP	Health Extension Program
HEWs	Health Extension Workers
HIV	Human Immune-deficiency Virus
HPs	Health Posts
HSDP	Health Sector Development Program
ICPD	International Conference on Population and Development
IUCD	Intra-Uterine Contraceptive Device
Kms	Kilometres
LIAT	Logistics Indicators Assessment Tool
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MPH	Masters in Public Health
NGO	Non Governmental Organizations
PATH	Program for Appropriate Technology for Health
PFSA	Pharmaceutical Fund and Supply Agency
PPS	Probability Proportionate to Size
RH	Reproductive Health
RHB	Regional Health Bureau
RHCS	Reproductive Health Commodity Security
SDP	Service Delivery Point
SNNP	Southern Nations, Nationalities, and Peoples
SPSS	Statistical Packages for Social Sciences
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WoHO	Woreda Health Office
ZHD	Zonal Health Department

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EXECUTIVE SUMMARY

Background: Ensuring the availability of modern contraceptive methods and life-saving maternal/reproductive health medicines in health service delivery points is crucial in the provision of quality primary health care. It is also one of the important tasks policy makers and program managers need to consider in the design of appropriate intervention strategies toward reducing maternal mortality and achieving MDG 5. A program should ensure adequate access to methods of choice both by type and quantity. However, in a country like Ethiopia where the unmet need is very high and source of funding for supply of contraceptives is almost totally donor dependent, ensuring availability of modern contraceptive methods and other life-saving maternal/reproductive health medicines is a major challenge.

The United Nations Population Fund (UNFPA) commissioned BETA Development Consulting Firm to assess the state of availability of modern contraceptives and essential life saving maternal/RH medicines in service delivery points in Ethiopia. The survey was carried out in October 2010 in nine Regional States (Amhara, Oromia, South Nations Nationalities and Peoples (SNNP), Tigray, Somali, Harari, Gambella, Benshangul Gumuz, and Afar), and two city administrations (Addis Ababa and Dire Dawa).

The objective of the assessment was to examine the availability of modern contraceptives and essential life saving maternal / reproductive health medicines in SDPs in Ethiopia, with the principal aim of obtaining information about the:

- i) Number of Service Delivery Points (SDPs) offering at least three modern contraceptive methods;
- ii) Number of SDPs where five life-saving maternal /RH medicines from UNFPA list is available in all facilities providing delivery services; and
- iii) Number of SDPs with 'no stock outs' of contraceptives within the last six months prior to the survey.

The method of data collection was a descriptive, cross-sectional design. The study subjects included a representative sample of Service Delivery Points (SDPs) that provide modern contraceptive methods and maternal/Reproductive Health (RH) services in all regions of Ethiopia. The service delivery points of the country were categorized as: Primary Level SDPs (health posts and health centres); Secondary Level SDPs (rural, zonal and regional hospitals/general hospitals); and Tertiary Level SDPs (referral/specialized hospitals). The survey applied a modified version of a standard questionnaire developed by GPRHCS.

A total of 255 SDPs comprised of government, private, and NGO were randomly selected from all regions of the country. The total sample size for each category of SDPs was distributed among the regions based on probability proportionate to size (PPS) scheme, where size refers to the number of health facilities by type in each region.

The sample distribution included SDPs run by government (94.1%), private firms (3.5%), and NGOs (2.4%). There were 66.3%, 24.7% and 9% primary, secondary, and tertiary level SDPs, respectively.

Main Findings: It was found out that 98.8% of the surveyed SDPs had integrated family planning, 92.2% child delivery, and 87.8% services to fight against the HIV/AIDS pandemic. A great majority of the facilities offer oral pills (98.8%) and injectables (98.0%) followed by male condom (95.2%), implants (75.0%), IUDs (53.6%), female sterilization (22.6%), male sterilization (16.7%), and female condom (4.0%). Oral pills and injectables are offered in all of the tertiary level facilities; while secondary level facilities provide male and female condoms, and implants. IUDs and sterilization for both sexes are being offered by tertiary level facilities. Female condom, in general, is the least offered family planning method due to the scarcity of supply (87.2%) and low demand (8.3%) to the service.

Of the total 255 facilities surveyed, three were not providing family planning services at the time of the survey. Almost all of the facilities that provide family planning services (98.0%) offer at least three modern contraceptive methods. Modern contraceptives are likely being offered by a higher tier level than lower level. All of the tertiary level facilities (100%) provide at least three modern contraceptive methods. Secondary and primary level service delivery points provide contraceptives by 1.6% and 2.4% less than tertiary levels respectively. This finding is higher as compared to the National Assessment on Emergency Obstetrics and New Born Care that was conducted in 2008, where 90% of hospitals and health centres in the country did provide at least three types of modern contraceptive methods and about 98% of the health facilities reported delivering any type of modern contraceptive methods.

Out of the 52 health posts surveyed, 51 (98.1%) of them offer at least three types of modern contraceptives. With the exception of SNNP (97.9%), Addis Ababa (92.9%), Somali (80.0%), and Gambella (66.7%), all the facilities surveyed in the seven regions provide at least three modern contraceptive methods.

Location of facilities has little effect in the provision of modern contraceptive methods. Almost similar percentage distribution is observed in urban - rural classification of facilities.

All the surveyed Mission/NGO facilities and 99% of the Government facilities provide at least three modern contraceptive methods. On the other hand, more than three-quarters (77.8%) of private-for-profit facilities provide at least three types of modern contraceptives.

Facilities that do not offer modern contraceptive methods reported that lack of supply and trained personnel are the major reasons for not providing family planning services.

Life-saving maternal/reproductive health medicines were available in the majority of the service delivery points surveyed. About three-quarters of the service delivery points had antibiotics (Amoxicillin (75.7%-193 facilities), Doxycyclin (74.5% -190 facilities), Metronidazole (74.9% -191 facilities) and Oxytocin (75.7% - 193 facilities) while about two-thirds (67.1% - 171 facilities) possessed Benzathine Penicillin, Clotrimazole, Iron/Folate and Ergometrine. However, some drugs such as Azithromycin, Cefexime and Magnesium Sulfate were available in less than 15% - in 36 facilities only of the service delivery points. The availability of these maternal/ reproductive health medicines varies by type of facilities, the region where the facilities are found, urban-rural residence, health facility ownership/management and its distance from the source of supply/warehouse. The survey showed that Oxytocin, the drug of choice for active management of the third stage of labor (AMTSL), was available in all secondary and tertiary level hospitals while only about seven in ten (70.4%) of the health posts and health centres reported of having these medicines. More health centres reported the availability of Oxytocin in the current survey than the National Baseline Assessment for Emergency Obstetric Care where only 43% of the health centres reported to have Oxytocin in stock while 31% were either out of stock at the time of the

interview or had had a stock out in the last 12 months, and about a quarter of health centres reported of never having had Oxytocin in stock.

It was found out that Ergometrine was available in more than 90% of the secondary and tertiary level hospitals while only less than 6 in 10 (58%) health centres and health posts reported to have the drug during the survey. There is a slight improvement in the availability of Ergometrine at service delivery points compared to the National Baseline Assessment for Emergency Obstetric Care where 70% and 50% of the hospitals and health centres, respectively, reported to have Ergometrine in the stock at the time of the survey. Anticonvulsant was available in a very few health facilities that were included in the survey. Only 3 out of 10 tertiary and 1 out of 4 secondary level hospitals reported to have had magnesium Sulfate during survey time while less than 1 in 10 (8.6%) health centres and health posts had this important life-saving drug. This finding is similar to that of the National Baseline Assessment for Emergency Obstetric Care where no or very few facilities have reported utilization of magnesium Sulfate to save the lives of mothers.

Urban-rural residence was found to affect the availability of these life-saving drugs. All the three life-saving maternal/reproductive health medicines were more than two times available in urban health facilities than they are in rural health facilities.

This survey indicated that while 100% of secondary and tertiary level health facilities reported to have the five (including 3 essentials) life-saving maternal/reproductive health medicines, only 64% of health centres and health posts reported to have these medicines at the time of the survey.

Regional variations were observed in the availability of the five (including 3 essential) life-saving maternal/reproductive health medicines. Three-quarters of health service delivery points in all regions had all the five (including 3 essential) life-saving maternal/reproductive health medicines in the stock during the survey time. All the five (including 3 essential) life-saving maternal/reproductive health medicines were available in all health facilities in Harari while only two-thirds (67%) health service delivery points in Dire Dawa and Gambella reported to have all the five (including 3 essential) life-saving maternal/reproductive health medicines in stock.

Rural-urban residence of service delivery points is one of the factors affecting the availability of maternal/reproductive health medicines. This survey showed that five (including 3 essential) life-saving medicines were about three times more available in urban service delivery points (94%) as compared to rural service delivery points (34%).

The main reasons as to why service delivery points are not offering maternal/reproductive health medicines include 'no supply', 'not requested' and 'not in the facility drug list'. The main reasons for not offering Oxytocin, for example, were cited as 'no supply' by 33%, and 'not in the facility drug list' by 62.5% of the health service delivery points. Similarly, the main reasons for not offering Ergometrine was cited as 'no supply', 'not requested, and 'not in the facility drug list' by 38%, 7% and 32% of the service delivery points, respectively. The reasons for not offering magnesium Sulfate by service delivery points were mainly due to 'no supply' (48.5%) or 'not in the facility drug list' (44%). Only 5.4% of the service delivery points mentioned 'not requested' as a reason for not offering this maternal/reproductive health medicine.

At the time of the survey, physical inventory of maternal/reproductive health medicines was carried out in all health service delivery points included in the survey. In this regard Oxytocin and Ergometrine were

in stock in 81% and 71% of the service delivery points, respectively, while magnesium Sulfate was in stock only in 17% and Antibiotics (Amoxicillin, Benzathin Penicillin, Doxycyclin and Metronidazole) were in stock in 70-80% of the service delivery points. The most commonly cited reasons for not having maternal/reproductive health medicines in stock were “no supply” (61.2%), “not in facility drug list” (58%), and “not requested” (26%).

Almost all the surveyed facilities (98.8%) had at least one type of modern contraceptive method in stock. The mean number of modern contraceptive methods available in stock at the time of the survey was estimated at 4.5. Only 1.6% of SDPs were found fully stocked with all contraceptive methods, while nearly one third (31.8%) of SDPs had five of the most common contraceptive methods in their stock at the time of the survey. Specifically, the findings indicated that large proportion of the facilities were stocked with oral pills (97.2%) followed by injectables (96.0%), male condoms (94.1%), implants (79.5%), IUCD (55.3%), female sterilization kits (21.7%), male sterilization kits (17.4%) and female condoms (5.2%). All tertiary level SDPs, 99.4% of primary level SDPs, and 96.8% of secondary level SDPs have stocks of modern contraceptive methods.

Variations in stock status of contraceptive method among urban versus rural settings were observed. Only 3.9% of the SDPs operating in rural settings of the country have reported current stock out of modern contraceptive methods in contrast to no stock out at SDPs in urban residence.

Although availability of male condom, oral pills, and injectable were reported in more than 90 % of SDPs in rural localities, female condom, and male and female sterilization kits were out of stock in more than 95% of these SDPs.

Great variation was observed in the duration of stock out of modern contraceptive methods that ranged from 1 to 180 days with an average of 121 days (about 4 months). Five of the eight modern contraceptive methods (female condoms, male and female sterilization kits, IUCD and implants) were reported as out of stock for about five months on average. On the other hand, male condoms, oral pills and injectable were out of stock for less than two months.

In the last six months prior to the survey, stock out of modern contraceptive methods was not reported in all of the primary and tertiary level SDPs; whereas, only 3.2% of secondary level SDPs experienced stock out. Regarding urban-rural stock status, only 2.6% of rural SDPs had stock out of any one of modern contraceptive methods in the last six months prior to the survey.

The most frequently cited reasons for stock out were attributed to logistics management (shortage of supply, delay in delivery, SDPs specific drug list standard, delay in order placement and lack of budget), lack of trained personnel and product expiry.

In conclusion, despite the Government’s effort to reduce maternal and child mortality through scaling-up reproductive health services at the grassroots, health posts and other service delivery points are still challenged by poor supply of modern contraceptive methods. Not all of the health posts, health centres and even regional hospitals (at secondary level) offer at least three types of modern contraceptive methods. Female condoms, male and female sterilization kits and IUDs remained scarce in most service delivery points. Even tertiary level SDPs are not serving fully the community with temporary modern contraceptive methods like male condom, and long acting methods like IUDs implants, female, and male sterilization.

Though maternal/reproductive health medicines were less available in most service delivery points, the situation is worse at the primary level. Compared to other maternal/reproductive health medicines, essential life-saving maternal/reproductive health medicines were less available in most service delivery points.

Availability of maternal/reproductive health medicines at service delivery points is influenced by factors such as type of health facility, the region in which the service delivery is located, urban-rural residence, and facility ownership. However, distance of SDPs from the nearest warehouse/source of supplies was not found to be a major cause for the lack or availability of the medicines.

Main Recommendations: In general, to improve the provision of modern contraceptives and essential life saving maternal/RH medicines in SDPs in Ethiopia, more should be done to:

- Ensure that all SDPs provide at least normal child delivery service to curtail maternal mortality caused by unskilled deliveries.
- Avail at least one form of family planning service at all levels.
- Ensure method choice at all service delivery points.
- Further expand SDPs and maintain quality of services at all levels.
- Coordinate sustainable supply of modern contraceptive methods to all service delivery points.
- Ensure timely forecasts and requests for modern contraceptives.
- Materialize proper planning of basic and refresher training on family planning; particularly on long-acting and permanent methods as more than half of the facilities mentioned lack trained human resource to offer modern contraceptives.
- Ensure the availability of maternal/reproductive health medicines in all health facilities in general and essential life-saving maternal/reproductive health medicines in particular.
- Allocate budget for FP commodities and maternal health drugs and ensure that a budget line is created at all levels.
- Strengthen the supply chain management systems to avail FP commodities and life saving maternal drugs to the end users at all times.
- Improve functioning logistics system (avoid delay in order processing, and improve availability and supply of modern contraceptive methods at central warehouse).
- Reduce average duration of stock outs for all products, minimize expiry of all products through continuous stock tracking and re-distribution mechanisms.
- Ensure number of skilled human resources for the management of supplies and delivery of services.
- Provide in-service training to health providers on family planning methods/products, stock and inventory management principles, customer handling and skills to practice specific methods such as IUCD insertion, implant administration, etc.
- Maintain effective monitoring and evaluation for tracking the results of interventions and for deriving lessons learned to be used in guiding program implementation.

SECTION I: INTRODUCTION

1.1 Background

One of the Millennium Development Goals (MDGs) which most countries of the developing fourth world strive to achieve by 2015 is MDG 5 that targeted reduction of maternal mortality by three-fourth between 1990 and 2015. African countries in general and Sub-Saharan countries in particular are far behind to achieve this ambitious goal. Ethiopia is one of the Sub-Saharan African countries with highest MMR with 673 maternal deaths per 100,000 live births. [1] The maternal mortality ratio in Ethiopia has declined steadily from 1,040 per 100, 000 live births in 1990, down to 673 in 2005. [2] Even though the level of reduction in MMR seems to be significant it is still far below the annual reduction rate of 5.5% each year.

More than 120 million women worldwide want to prevent pregnancy. Despite great progress in family planning service delivery over the last several decades, large proportion of women in their reproductive age and their partners are not using contraception. Among the very many reasons for unmet need, lack of services and supplies, limited choices, partner's opposition, worries of side effects and health concerns, and lack of knowledge about contraceptive methods pose dreadful barriers. [3] By helping women avoid unwanted and poorly timed pregnancies, contraception can save the lives of millions of women and infants each year. However, most family planning programs, particularly in Africa, are bottlenecked by the ill-continued supply of contraceptives; they commonly rely on supplies from international donors for the foreseeable future. [4,5,6]

Functioning of the system for obtaining adequate supply of contraceptives and other RH supplies including delivery mechanisms to SDPs remained a critical element of family planning and other RH programs. Without the commodities, services, and the logistics system, no program can meaningfully improve the reproductive health needs of the people it serves; in short 'No product, No program'. Anecdotal evidences depict that more than 20 million women lack access to basic contraception globally. Often, these women are forced to travel long distances to access health facilities, which most of the time suffer from stock outs. [7] Stock out is a situation whereby products are temporary unavailable on the shelf or in the warehouse. Incidence of stock out occurs as a result of poor stock planning and unavailability of products. Furthermore, limited human capacity, weak transportation and poor inventory systems lead to delays in supply of delivery to SDPs. [8] Moreover, warehousing capacity could be another bottleneck for regular supply. [9]

Improvement of maternal health service delivery system should be addressed by all stakeholders if the country is to meet the MDG 5. Service delivery improvement implies the construction of adequate infrastructure and improving quality of services provided in health facilities. In addition, equipping health facilities, availing trained health personnel, and adequate supply of modern contraceptives and life-saving maternal/reproductive health medicines are crucial to improve service delivery. In this regard, the government of Ethiopia has been aggressively increasing service coverage through construction of primary service delivery points and deployment of health extension workers at community level. [6]

1.2 Rationale and Objectives of the Study

Ensuring the availability of life-saving maternal/reproductive health medicines in health service delivery points is one of the important tasks that policy makers and program managers need to consider in the design of appropriate intervention strategies toward reducing maternal mortality and achieving MDG 5. There are little or no studies done to determine the availability of modern contraceptives and life-saving maternal/reproductive health medicines in health facilities on large scale in Ethiopia. This survey was, therefore, conducted to assess the availability of modern contraceptives and maternal/reproductive health medicines at service delivery points in Ethiopia.

Specifically, the survey examined the availability of modern contraceptives and essential life saving maternal / RH medicines in 255 SDPs, with the major aim of obtaining information about the:

1. Number of Service Delivery Points (SDPs) offering at least three modern contraceptive methods;
2. Number of SDPs where five life-saving maternal /RH medicines from UNFPA list is available in all facilities providing delivery services; and
3. Number of Service Delivery Points with 'no stock outs' of contraceptives within last six months.

1.3 Survey Organization and Management

The Federal Ministry of Health issued a letter to all the Regional Health Bureaus requesting their support in the national survey on availability of modern contraceptive methods and essential life-saving maternal/RH medicines in service delivery points in Ethiopia. The field work including determining the routes that the teams would take to visit the selected facilities, field supervision/spot check and communication with regional, zonal and woreda health offices was organized by BETA Development Consulting Firm. UNFPA facilitated all transportation and travel arrangements for the data collectors and closely followed up the day-to-day progress of the data collection activity.

1.4 Survey Methodology

This national sample survey is based on interviews conducted at selected health facilities of the country in October 2010. Information was also collected through observation and physical count of commodities at stores of the selected facilities.

1.4.1 Survey design and sampling of facilities

Study design: The study was conducted using a descriptive, cross-sectional design. The study areas included a representative sample of Service Delivery Points (SDPs) that provide modern methods of contraceptives and maternal/Reproductive Health (RH) medicines in all regions of Ethiopia. The service delivery points of the country were categorized as:

- a) Primary level care SDPs/facilities (health posts and health centres);
- b) Secondary level care SDPs/facilities/hospitals (rural, zonal, regional/general hospitals); and
- c) Tertiary level care SDPs/facilities/hospitals (referral/specialized hospitals).

Sampling frame: List of all service delivery points that provide family planning and maternal health services in each of the regions of the country was obtained from the World Health Organization (WHO) Country Office. This list served as a sampling frame for the selection of sample facilities.

Sample size: The total sample size was determined on the basis of minimum sample size required to allow the levels of analysis desired and national and regional representation of the health facilities offering modern contraceptive methods and life saving maternal/reproductive health medicines. The following formula was applied to determine the required sample size:

$$n = \frac{Z^2 p(1 - p)}{d^2}$$

Where n = minimal sample size for each domain,
 Z = Z score that corresponds to a confidence interval,
 p = the proportion of the attribute (*type of SDP*) expressed in decimal, and
 d = per cent confidence level in decimal.

The formula was used to obtain the minimal sample size for the proportions of each category of SDPs (primary, secondary and tertiary) under the assumptions of normal distribution; making/rendering comparison between populations possible.

The total sample size was estimated at 255 facilities including allowance to non-responses (under Z score for 95 per cent confidence interval and 5 per cent confidence limit). The total sample size for each category of SDPs was distributed among the regions according to the region’s share of a particular category of SDP. In other words, probability proportionate to size (PPS) scheme was employed, where size being the number of health facilities by type in each region.

The specific service delivery points (SDPs) included in the study were chosen using systematic sampling scheme, in which an SDP had equal chance of being selected for the sample. The health facilities of each region were listed alphabetically and a sampling interval (i) was determined for each region. This was done by dividing the total number of facilities in the region by the sample size for that region:

$$i = \frac{N}{n}$$

Where: i = sampling interval for the domain,
 N = number of SDPs in the domain, and
 n = sample size for that domain

A starting point K was selected by randomly selecting a number between 1 and i (the sample interval). Then successive SDPs for inclusion in the sample were selected by moving at the interval K+i; K+2i; K+3i; K+4i; K+5i; etc., until the required sample size from the region was obtained.

1.4.2 Data collection

Recruitment of data collectors: BETA reviewed its roster of data collectors (who previously worked for the firm) and asked them for their availability for the task. In addition, some new data collectors were approached to send their curriculum vitae, interviewed and briefed on the time frame, commitment and disciplines that the task requires. As a result, 42 data collectors were identified and recruited for the training.

Data collection instrument: Data were collected using structured data collection tool. The instrument was based on the generic questionnaire developed by Global Program to Enhance Reproductive Health Commodity Security (GPRHCS). The survey questionnaire included mostly close-ended questions and consisted of five sections. The questionnaire collected information on name, location and distance of SDPs to the nearest warehouse; SDP type and service provided; modern contraceptive methods provided at SDPs; availability of maternal/ RH medicines; and on stock status of modern contraceptive methods at SDPs.

Training of data collectors: A training manual was developed and used in facilitating the training. The curriculum is designed in such a way that data collectors understand the concepts used in the data collection tool, purpose of the survey and how to administer the questionnaire. Brief descriptions of each RH and essential maternal health commodities have been included in the manual to make data collectors well informed about the medicines.

A total of 42 data collectors, who have health related background (Nurses, Health Officers and MPH holders) showed up for a three-day training. This training was conducted between October 7 and 9, 2010. The training focused on the concept and methodology of the survey so that data collectors would be able to conduct the data collection task efficiently and effectively. The mock interview exercise particularly helped the data collectors to better understand each question included in the questionnaire and to come up with very relevant issues for clarification.

Immediately after the training, the data collectors were organized into 21 teams (2 data collectors per team) and were assigned to the eleven regions throughout the country. Data collectors were supplied with the necessary data collection tools including list of selected health facilities and a copy of support letter from the Federal Ministry of Health (FMOH). Contact persons of the teams, who also served as supervisors, were given mobile cards to facilitate easy communication with BETA and UNFPA technical teams.

Data quality: Data collection started on October 11, 2010 and completed on October 22, 2010. BETA technical team established close and regular contact with the supervisors to follow up their movements, problems encountered, and give them feedback on issues they raised both from administrative and technical perspectives. In addition, BETA technical team visited some areas to check data quality. Accordingly, some consistency checks were made and corrective measures were taken on the spot.

A dependable supervisor among the teams who had completed the field work was contracted and assigned to follow up with the standards and clarity of the data completed and, when necessary, to visit sites (the specific health facility) to clarify some points in the questionnaire.

1.4.3 Data management and analysis

Review of the filled-in questionnaires: To ensure the quality of the survey data, the filled-in questionnaires retrieved from the field were reviewed and checked for consistency and completeness prior to the data entry process. During this activity some inconsistencies and incomplete responses were encountered and fixed through consulting the respective data collectors and field supervisors.

Data entry application development: After checking the filled-in questionnaires manually and making them ready for data capture, the data entry application was developed using Census and Survey Processing System (CSPPro) version 4.0. CSPPro is a software package that has data entry, batch editing and tabulation modules including other tools that are useful in analyzing and organizing survey and census datasets.

In preparing the data entry application, a data dictionary, questionnaire-oriented entry screens, and appropriate skip patterns were developed and tested using some completed questionnaires. The data entry process was also automated to minimize human errors that can be introduced in accessing application programs and data files.

Orientation to the entry clerks: A brief orientation was given to the data entry clerks before carrying out the actual data entry work. This included a brief introduction to the survey questionnaire, the data entry screens and how the entry system works. Finally, before starting the actual work, the data entry clerks were given some time to enter data from some filled-in questionnaires and familiarize themselves with the data entry procedures.

Data entry process: The data entry work was done on double entry basis, i.e., both entry operators did the first phase of data entry and then data entered by one operator was verified by the other, by re-entering the data. This significantly helped in improving the quality of data. The overall data entry and verification work took about ten working days.

Conversion to SPSS format: Before converting the data to SPSS, basic consistency and completeness checks were done on the data in CSPPro or text format using the CSPPro batch editing facility. Then, variables and value set labels were reviewed and the data was converted to SPSS format.

Data cleaning: The data cleaning process included checking and fixing inconsistent and incomplete responses through making necessary references to the filled-in questionnaires. Frequency distributions of all variables in the dataset and additional cross tabulations were produced to facilitate the cleaning process. Another important part of cleaning the survey data was making necessary checks to ensure the correctness of the distribution of service delivery facilities in the survey by region and type of facility. To this effect, health facilities in the dataset were checked against the filled-in questionnaires in detail and some discrepancies found between the expected and actual health posts were resolved.

Data analysis: Data analysis was done using SPSS version 10. Descriptive statistics was made and results are presented in tables and graphs using summary measures such as percentages and means. In as much as possible the data is disaggregated by different variables to see the relationship between these variables.

1.4.4 Limitation of the survey

Readers should keep in mind the following study limitations. While collecting data at the service delivery points, we observed some limitations in the questionnaire layout. For instance, the spaces provided for the open ended responses in questions 10, 12, 12a, 14, and 17 were not sufficient to accommodate the responses. Moreover, incompleteness of records on stock and bin cards accompanied with service providers that have served for less than six months may affect the quality of data on stock out for the reference period.

1.5 Outline of the Report

This report is organized in three broad sections. The first section is the introduction part which covers background information including rationale and objective of the study and survey methodology. Section two covers the findings of the survey pertaining to general information about the surveyed facilities, modern contraceptives offered by the facilities, availability of maternal and RH medicines, and availability as well as incidence of stock out of modern contraceptives. The last section concludes the report by summarizing the study findings and providing programmatic recommendations.

SECTION II: SURVEY FINDINGS

2.1 General Information about the Facilities

Overview: With an estimated population of about 77 million, the physician-population ratio in Ethiopia was 1:36,158, accessed through 16,898 health facilities (including 195 hospitals, 1,362 health centres, and 12,488 health posts). [10] In the survey, the health service delivery points (SDPs) have been classified as primary (health posts and health centres), secondary (rural, zonal and regional hospitals), and tertiary (referral and specialized hospitals).

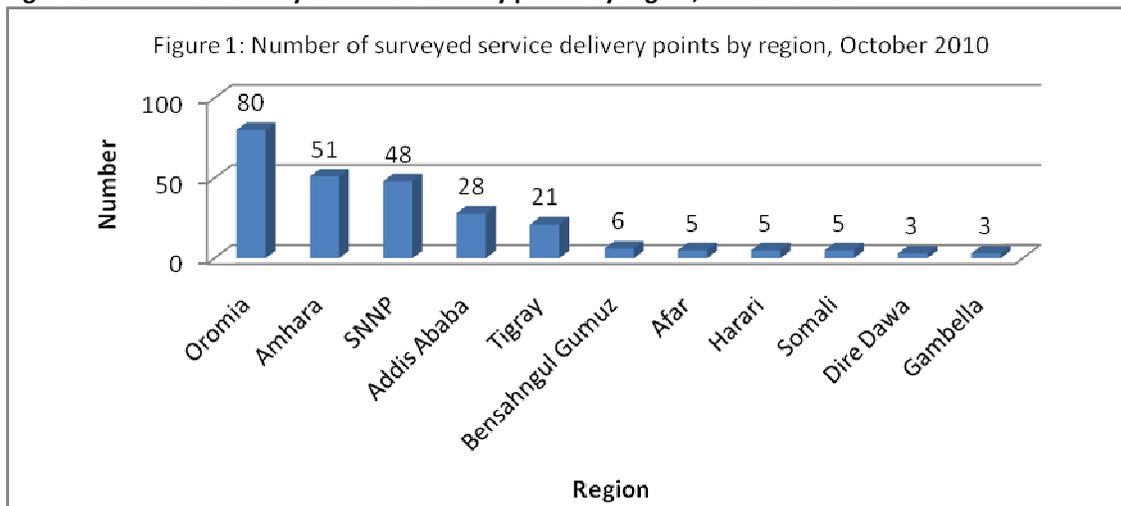
The first point of contact in the health care system in the rural setting, where about 82% of the total population resides, [1] is the health post, which provides preventive health care comprising 16 packages (the major areas being family health, disease prevention and control, hygiene and environmental health, and health education). The catchment population size that one health post addresses is about 5,000 [10] and staffed by two female Health Extension Workers (HEW), who have completed 10th grade schooling and one year training in the promotion of preventive health care at the grassroots level.

The health centres mainly provide basic curative care services and act as referral and technical assistance centres for five HP. [11] Hospitals at secondary levels are the backstops for the health centres as the tertiary levels are for the former.

2.1.1 Geographic / Regional distribution

The survey was conducted in nine regional states (Amhara, Oromia, South Nations Nationalities and Peoples (SNNP), Tigray, Harari, Gambella, Benshangul Gumuz, Somali and Afar), and two city administrations (Addis Ababa and Dire Dawa).

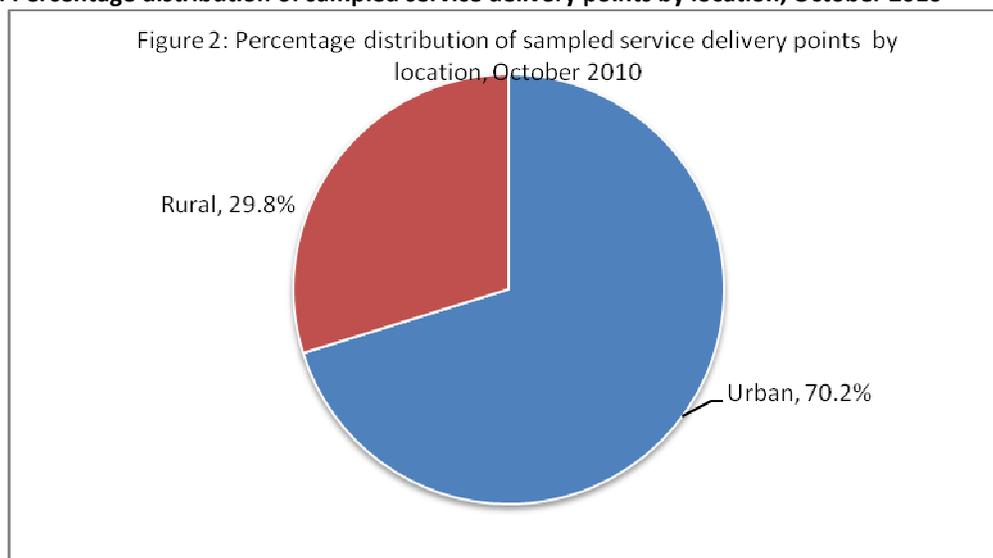
Figure 1: Number of surveyed service delivery points by region, October 2010



Of the total number of surveyed health facilities, the majority were from Oromia Region (80 facilities) followed by Amhara (51 facilities) and SNNP (48 facilities). The least number of facilities were drawn from Dire Dawa and Gambella (three facilities each).

On the other hand, 70.2% (179/255) of the surveyed health facilities were located in urban settings as opposed to 29.8% in the rural (see graph below).

Figure 2: Percentage distribution of sampled service delivery points by location, October 2010



The findings also show that no HPs were surveyed in Harari and Addis Ababa. By the same token, regional hospitals in Amhara and Dire Dawa, referral hospitals in Afar, Benshangul Gumuz, Gambella , and Tigray had slipped of the random selection, as was the case with the rural and zonal hospitals in about six of the regions.

Table 1: Percentage distribution of surveyed service delivery points by region and facility type, October 2010

Region	Percentage/ type of health facility						Total
	Health post	Health centre	Rural hospital	Zonal hospital	Regional hospital	Referral (specialized) hospital	
Tigray	23.8	38.1	19.0	14.3	4.8	0.0	21
Afar	20.0	40.0	20.0	0.0	20.0	0.0	5
Amhara	23.5	49.0	13.7	3.9	0.0	9.8	51
Oromia	25.0	41.3	8.8	16.3	2.5	6.3	80
Somali	20.0	40.0	0.0	0.0	20.0	20.0	5
Benshangul Gumuz	16.7	50.0	0.0	16.7	16.7	0.0	6
SNNP	20.8	47.9	14.6	10.4	2.1	4.2	48
Gambella	33.3	33.1	0.0	0.0	33.3	0.0	3
Harari	0.0	20.0	0.0	0.0	20.0	60.0	5
Addis Ababa	0.0	64.3	0.0	0.0	14.3	21.4	28
Dire Dawa	33.3	33.3	0.0	0.0	0.0	33.3	3
Total	20.4	45.9	10.2	9.4	5.1	9.0	255

The HPs that had formed 20.4% of all surveyed SDPs were all government owned structures. Among the SDPs surveyed and segregated by level, the HCs formed the highest proportion (45.9%) followed by the HPs. The zonal regional, and referral / specialized hospitals formed 10.2%, 9.4%, 5.1%, and 9.0% of all surveyed facilities, respectively (see Table 1).

2.1.2 Management of Facilities

The survey has addressed government, NGO and private health facilities understanding that the latter two complement efforts of the FMOH to address the health needs of the people.

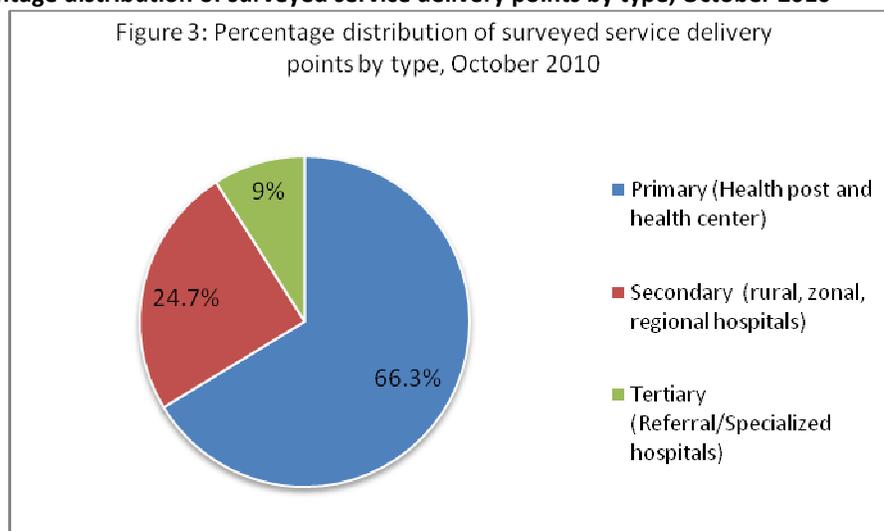
“ The major foci of the health policy are democratization and decentralization of the health care system, development of the preventive, promotional and curative components of health care, assurance of accessibility of health care for all segments of the population and the promotion of private sector and NGOs participation in the health sector. The national health policy focuses on a comprehensive health service delivery system to address mainly:

- *Communicable diseases,*
- *Malnutrition, and*
- *Improving maternal and child health. The health service delivery system is decentralized with responsibility for implementation being largely devolved to the districts which plan on the basis of block funding for the sector.*

The Policy emphasizes inter-sectoral collaboration, particularly in ensuring family planning for optimal family health and population planning, in formulating and implementing an appropriate food and nutritional policy and in accelerating the provision of safe and adequate water for urban and rural populations....” [12]

Therefore, among the SDPs that were surveyed, 94.1% of them represented government as opposed to 3.5% privates and 2.4% NGOs. In a nut shell, the primary SDPs were represented in the survey by 66.3%, the secondary by 24.7%, and the tertiary by 9% (see Figure 3 below).

Figure 3: Percentage distribution of surveyed service delivery points by type, October 2010



2.1.3 Distance of SDPs from source of supplies

The SDPs run their programs through budgeted and non - budget supplies. Among the non-budgeted supplies, one is the modern contraceptive commodity. The facilities collect their unbudgeted supplies either from woredas, zonal, or regional stocks of the FMOH. Therefore, facilities answerable to the Woreda Health Office (WoHO) collect their commodities from the Woreda Health Offices. Those answerable to the zone collect from Zonal Health Departments (ZHD), and the regional ones from the Regional Health Bureau (RHB).

Therefore, distance of the SDPs from their source of supplies was found to be varying from less than one kilometre to 50 and more kilometres. In this regard, 44.3% of them, that form the highest proportion, were situated about 50 and more kilometres from the source; followed by 16.1% that were situated at 00 to 4 kilometres, and 11% between 5 and 9 kilometres from the source; and the rest, ranging from 0.4 % to 8.6% were situated within the reach of 1 to 22 kilometres (see Table 2).

Table 2: Percentage distribution of surveyed facilities by distance from nearest warehouse/source of supplies (in Km), October 2010

Distance from nearest warehouse/source of supplies (in Km)	Percentage	n
0-4	16.1	41
5-9	11.0	28
10-14	8.6	22
15-19	5.9	15
20-24	4.3	11
25-29	1.2	3
30-35	3.9	10
35-39	2.4	6
40-45	0.4	1
45-49	2.0	5
50 and over	44.3	113

2.1.4 Services related to family planning, child delivery and HIV/AIDS prevention and control

Given the focus area of the survey (availability of contraceptive commodities and maternal life saving essential drugs), the survey finding reflected that 98.8% of the surveyed SDPs had integrated family planning, 92.2% child delivery, and 87.8% of them one or more types of services to fight against HIV/AIDS pandemic (see Table 3).

Table 3: Percentage distribution of surveyed facilities that provide FP, delivery and HIV/AIDS services, October 2010

Disaggregation	Percentage	n
Provide family planning services		
Yes	98.8	240
No	1.2	15
Provides delivery services		
Yes	92.2	235
No	7.8	20
Provides any HIV/AIDS prevention services		
Yes	87.8	224
No	12.2	31
Total	100.0	255

2.2 Modern Contraceptives Offered by Facilities

Overview: Anecdotal evidences show that there has been an overall increase in the use of modern contraceptive methods in the past 30 years. The contraceptive prevalence rate (CPR) has increased for a significant number of countries, including Ethiopia, Lao People’s Democratic Republic (Lao PDR), Madagascar, Mongolia and Niger. In Ethiopia, the contraceptive prevalence rate rose from 6 per cent in 2003 to 14 per cent in 2005 to 30 per cent in 2009. [5,6] In the other countries the CPR increased by 10 percentage points in Lao PDR; 11.2 points in Madagascar; 12.8 points in Mongolia and 4.8 points in Niger.[6]

Though contraceptive prevalence rate has been increasing in the last three decades, Ethiopia has still one of the highest maternal mortality ratios in Africa. In addition, the country has still high unmet need for family planning. The reasons include desire to have more children, lack of knowledge about contraceptive use and where to find contraceptives, health concerns, religious prohibition, husband opposition and low involvement of men.[13] Many potential clients in Ethiopia lack information or have misconceptions about long-acting methods and permanent methods, though most people know about family planning. Myths and misconceptions about these methods are also widespread. [5]

The Government of Ethiopia has been exerting tremendous effort to reduce maternal and child mortality through integrated reproductive health and family planning services. The Health Extension Program (HEP) has been given high emphasis in the Health Sector Development Program (HSDP) IV of the country. [14] In 2009, the FMOH and partners including UNFPA embarked on this program that is expected to reach all woredas (districts). This program aims to tackle the high unmet need for family planning. An estimated 34 per cent of sexually active women in Ethiopia want to stop childbearing or delay their next birth by at least two years. In the same year, UNFPA’s “*Global Program to Enhance Reproductive Health Commodity Security*” funded Ethiopia 520,000 sets of Implanon, and more than 600 Health Extension Workers (HEWs) received training to provide family planning services. The Global Program has been supporting the Government to ensure that facilities are adequately stocked with contraceptives and essential reproductive health medicines. [5, 6]

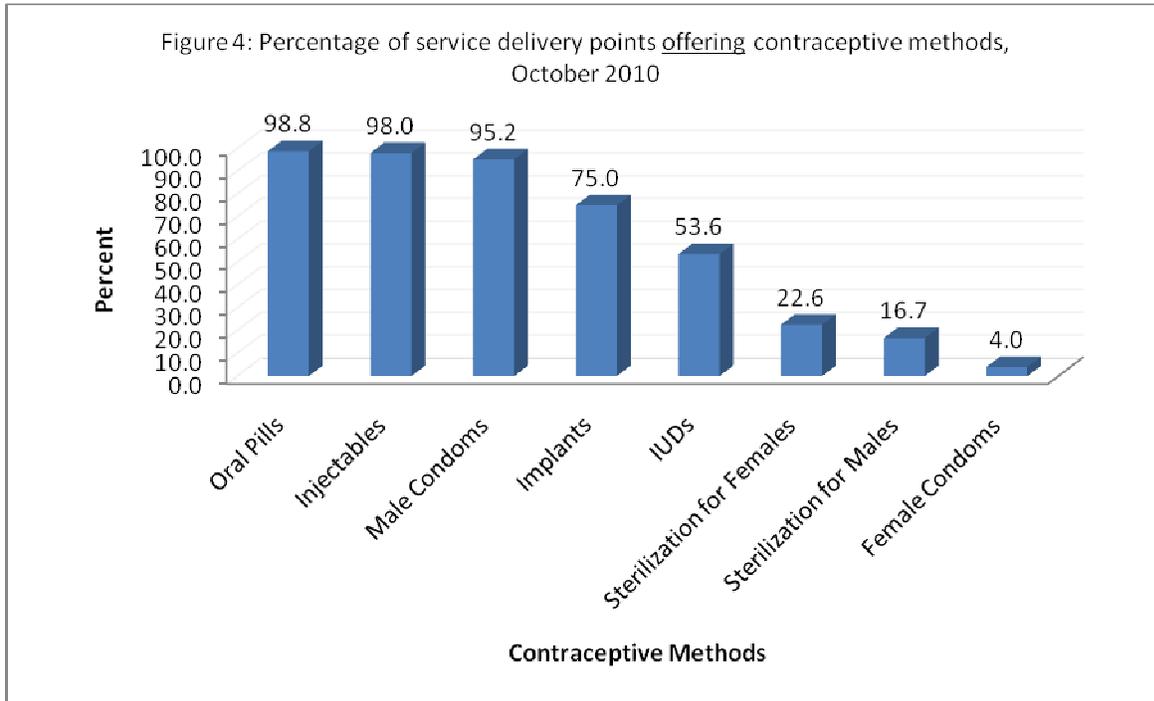
2.2.1 Contraceptives offered by types of facilities

Table 4 describes the types of modern contraceptives offered by facility types, region, residence, management and distance from the nearest warehouse. According to the findings, great majority of the facilities offer oral pills (98.8%) and injectables (98.0%) followed by male condom (95.2%), implants (75.0%), IUDs (53.6%), female sterilization (22.6%), male sterilization (16.7%), and female condom (4.0%). Oral pills and injectables are offered in all of the tertiary level facilities that include referral and specialized hospitals; while secondary level facilities (rural, zonal and regional hospitals) are likely to provide male and female condoms, and implants. IUDs and sterilization for both sexes are likely to be offered by tertiary level facilities (Figure 4). Female condom, in general, is the least offered family planning service due to scarcity of supply (87.2%) and low demand (8.3%).

The low proportion of sterilization, IUDs and implants in the primary level of care could be attributed to the fact that health posts are not expected to provide these services. Facility set-up, equipment and trained human resource for these services are missing at health post level. In the Ethiopian situation,

these services are commonly offered either through referral to secondary and tertiary level care centres or through community outreach sites at regular times- with mobile equipment and trained personnel.

Figure 4: Percentage of service delivery points offering contraceptive methods, October 2010



Regional disparity is high in terms of contraceptive service provision. Considering all types of facilities in a region, all of the facilities surveyed in Tigray, Afar, Amhara, Benshangul Gumuz, Gambella, and Harar offer male condoms. Female condom is not available at all in Tigray, Afar, Benshangul Gumuz, Gambella, Harar, and Dire Dawa. Oral pills are accessible in all surveyed facilities of all regions except SNNP (97.9%) and Addis Ababa (92.9%). Similarly, injectables are provided in all surveyed facilities of all regions except SNNP (97.9%), Addis Ababa (89.3%), and Gambella (66.7%). IUDs are found to be scarce in all regions except Harar (100%) and Addis Ababa (92.9%). All of the surveyed facilities in Tigray do provide implants while the least offering region is Gambella (33.3%) followed by Afar (40.0%). Sterilization is not performed in Somali region and Dire Dawa city administration. It is also the least utilized service next to female condom in all the regions.

Table 4: Percentage distribution of service delivery points offering modern contraceptive methods, October 2010

Disaggregation	Modern contraceptive methods							
	Male Condoms	Female Condoms	Oral Pills	Injectables	IUDs	Implants	Sterilization for Females	Sterilization for Males
Type of Facility								
Primary level care SDPs (n=168)	94.6	3.6	98.8	97.6	42.3	70.8	3.6	3.0
Secondary level care SDPs (n=61)	98.4	4.9	98.4	98.4	68.9	83.6	54.1	39.3
Tertiary level care SDPs (n=23)	91.3	4.3	100.0	100.0	95.7	82.6	78.3	56.5
Administrative Unit (Region)								
Tigray (n=21)	100.0	0.0	100.0	100.0	42.9	100.0	19.0	9.5
Afar (n=5)	100.0	0.0	100.0	100.0	0.0	40.0	20.0	20.0
Amhara (n=51)	100.0	7.8	100.0	100.0	49.0	74.5	15.7	13.7
Oromia (n=78)	96.2	3.8	100.0	100.0	55.1	71.8	21.8	15.4
Somali (n=5)	80.0	20.0	100.0	100.0	40.0	60.0	0.0	0.0
Benshangul Gumuz (n=6)	100.0	0.0	100.0	100.0	50.0	66.7	50.0	33.3
SNNP (n=47)	97.9	2.1	97.9	97.9	38.3	72.3	21.3	17.0
Gambella (n=3)	100.0	0.0	100.0	66.7	33.3	33.3	33.3	33.3
Harari (n=5)	100.0	0.0	100.0	100.0	100.0	80.0	40.0	40.0
Addis Ababa (n=28)	78.6	3.6	92.9	89.3	92.9	82.1	39.3	25.0
Dire Dawa (n=3)	66.7	0.0	100.0	100.0	66.7	100.0	0.0	0.0
Residence								
Urban (n=179)	96.1	5.0	98.3	97.2	68.7	86.0	30.7	22.3
Rural (n=73)	93.2	1.4	100.0	100.0	16.4	47.9	2.7	2.7
Management								
Government (n=240)	96.2	4.2	99.6	98.8	52.9	76.2	20.8	15.8
Private for profit (n=9)	100.0	0.0	77.8	77.8	66.7	44.4	44.4	22.2
NGO/Mission (n=3)	66.7	0.0	100.0	100.0	66.7	66.7	100.0	66.7
Distance from nearest warehouse/source of supplies (in Km)								
0-4 (n=41)	97.6	2.4	100.0	97.6	61.0	85.4	19.5	12.2
5-9 (n=28)	85.7	0.0	100.0	100.0	35.7	57.1	21.4	10.7
10-14 (n=22)	77.3	4.5	100.0	100.0	50.0	68.2	27.3	22.7
15-19 (n=15)	93.3	0.0	93.3	86.7	26.7	53.3	6.7	6.7
20-24 (n=11)	100.0	0.0	100.0	100.0	54.5	54.5	9.1	0.0
25-29 (n=3)	66.7	0.0	66.7	66.7	33.3	33.3	0.0	0.0
30-35 (n=10)	100.0	10.0	100.0	100.0	50.0	90.0	20.0	0.0
35-39 (n=5)	100.0	0.0	100.0	100.0	60.0	60.0	20.0	20.0
40-45 (n=1)	100.0	0.0	100.0	100.0	0.0	0.0	0.0	0.0
45-49 (n=5)	100.0	0.0	100.0	80.0	40.0	80.0	20.0	20.0
50 and over (n=111)	100.0	6.3	99.1	100.0	61.3	82.9	27.9	23.4
Total (n=252)	95.2	4.0	98.8	98.0	53.6	75.0	22.6	16.7

Analysis was made to see whether residence, ownership or management of facilities, and distance from the nearest warehouse of supplies of contraceptives influence provision of each contraceptive method (Table 4). There is no significant difference in urban and rural disaggregation for contraceptive delivery except for implants and sterilization, which are more likely to be offered in urban areas than rural.

A great majority of government facilities (96.2%), all surveyed private-for-profit, and two of the three surveyed mission/NGO facilities do provide male condoms to clients. Female condom is available only in 4.2% of Government facilities and not at all available in private-for-profit and mission/NGO facilities. Quite a large proportion of Government facilities provide pills (99.6%) and injectables (98.8%). The same is true for private-for-profit facilities. All of the three surveyed mission/NGO facilities (a health centre and two hospitals) provide pills, injectables and female sterilization; while two of the three facilities do provide male sterilization, IUDs, and implants.

Distance of the surveyed health facilities from the warehouse of supplies is not a significant factor for contraceptive service delivery. A fairly large number of facilities (111) are far from their supply warehouses with 50 and more kilometres. All of the 111 facilities offer male condoms and injectables. In addition, large proportion of these facilities offer pills (99.1%) followed by implants (82.9%), and IUDs (61.3%). The highest proportions of facilities providing both female and male sterilizations fall in this distance category.

2.2.2 Facilities offering at least three types of contraceptives

Tables 5 to 10 describe facilities offering at least three modern contraceptive methods by facility tier level, region, residence, ownership of facilities and distance from supplies warehouses.

Of the total 255 facilities surveyed, three did not provide family planning services at the time of the survey. These facilities are all mission/NGO owned. Almost all of the facilities that provide family planning services (98.0%) offer at least three modern contraceptive methods. Modern contraceptives are likely to be offered by a higher tier level than lower level. All of the tertiary level facilities (100%) provide at least three modern contraceptive methods. Secondary and primary level service delivery points provide contraceptives in a 1.6% and 2.4% less proportion points, respectively, than tertiary levels (Table 5).

According to a national assessment on Emergency Obstetrics and Newborn Care, conducted in 2008, about 90% of hospitals and health centres in the country did provide at least three types of modern contraceptive methods and about 98% of health facilities reported delivering any type of modern contraceptive methods. [2] Similarly, a UNFPA document reported that the proportion of facilities offering at least three methods of contraceptives in Ethiopia increased from 60% in 2006 to 90% in 2009. [5] The main attribution for the increase is the rapid increase of Health Extension Workers (HEWs) in the country. Since HEWs are working at the kebele (lowest administrative unit in Ethiopia) level (two HEWs per kebele), their main supply of contraceptives are the primary health care level; health posts in particular. In this survey, the proportion of primary level facilities providing at least three types of modern contraceptives increased by 8% in just a year. More specifically, out of the 52 health posts surveyed, 51 (98.1%) of them offer at least three types of modern contraceptives (Figure 5).

Figure 5: Percentage of service delivery points offering at least three types of modern contraceptive methods, October 2010

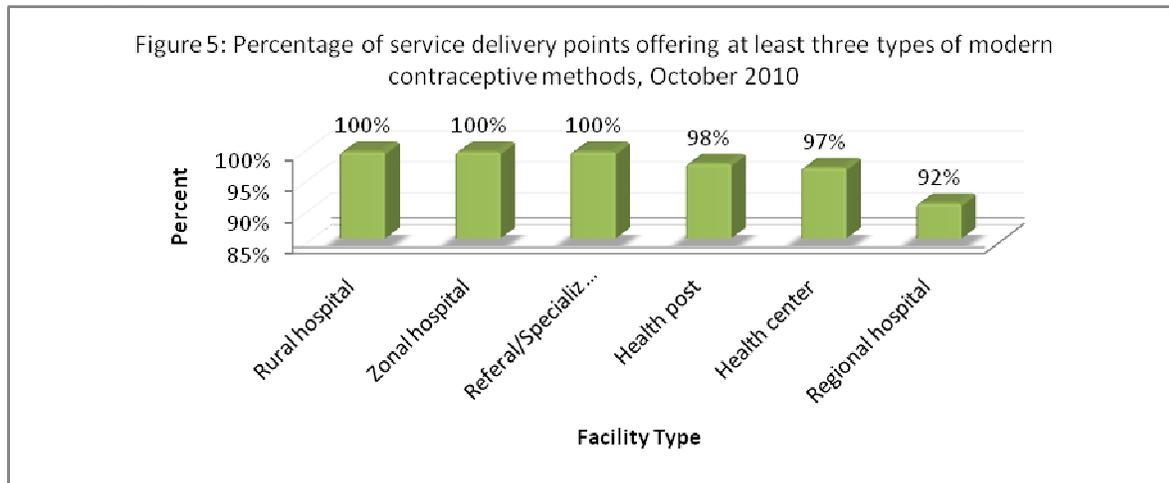
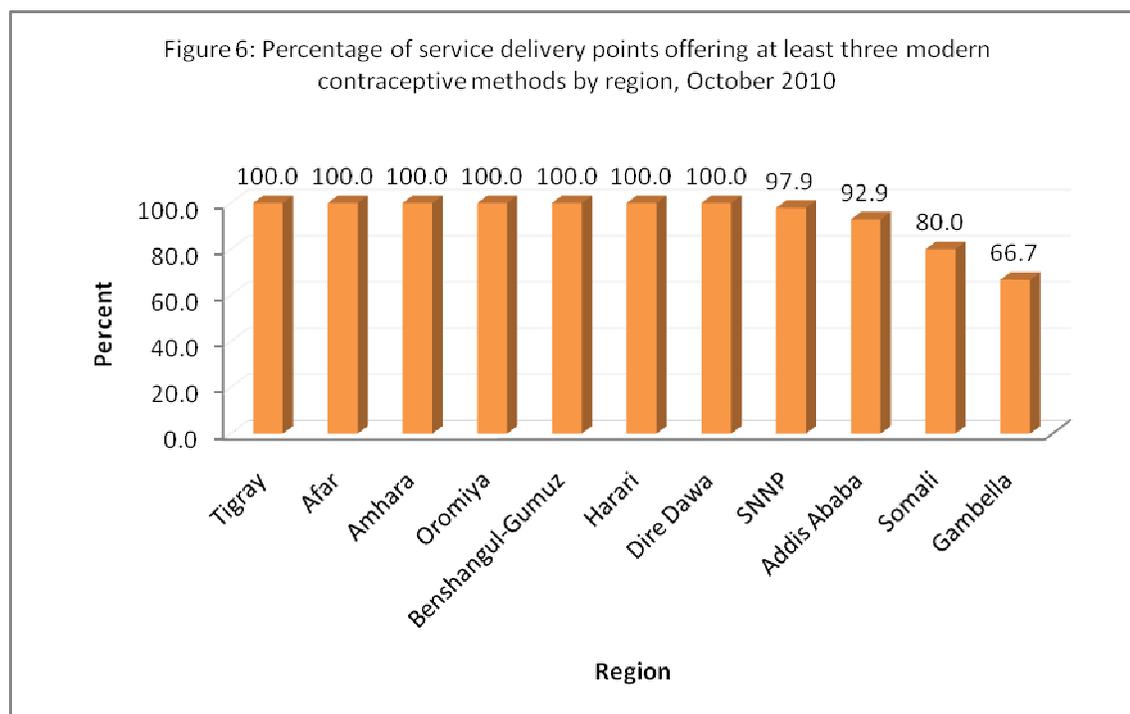


Table 5: Percentage distribution of service delivery points offering at least three modern contraceptive methods by type of facility, October 2010

Type of Facility	Percentage		Total (n)
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	
Primary level care SDPs	97.6	2.4	168
Secondary level care SDPs	98.4	1.6	61
Tertiary level care SDPs	100.0	0.0	23
Total	98.0	2.0	252

According to Figure 6, all facilities surveyed in seven regions provide at least three modern contraceptive methods except SNNP (97.9%), Addis Ababa (92.9%), Somali (80.0%), and Gambella (66.7%). One out of three facilities in Gambella does not provide at least three modern contraceptive methods.

Figure 6: Percentage of service delivery points offering at least three modern contraceptive methods by region, October 2010



Location of facilities has little impact in the provision of modern contraceptive methods. Of the total facilities that do provide family planning services, about 98% offer at least three modern contraceptive methods (Table 6). Similar percentage distribution is observed in urban and rural facilities.

Table 6: Percentage distribution of service delivery points offering at least three modern contraceptive methods by urban/rural residence, October 2010

Residence	Percentage		Total (n)
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	
Urban	97.8	2.2	179
Rural	98.6	1.4	73
Total	98.0	2.0	252

Although sample of facilities from NGO/mission and private-for-profit is very small, findings of the survey show that all of mission/NGO facilities (n=3) and 99% of Government facilities do provide at least three modern contraceptive methods. On the other hand, more than three-quarters (77.8%) of private-for-profit facilities do provide at least three types of modern contraceptives, which is lower than that of government and mission/NGO facilities.

Table 7: Percentage distribution of service delivery points offering at least three modern contraceptive methods by management of facility, October 2010

Management of facility	Percentage		Total (n)
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	
Government	98.8	1.2	240
NGO/Mission	100.0	0.0	3
Private- for- profit	77.8	22.2	9
Total	98.0	2.0	252

According to Table 8, distance from the nearest warehouse of supplies is another variable to measure availability of modern contraceptive methods. Like residence of facilities, distance has also little or no impact in the provision of modern contraceptives. The proportion of facilities that offer at least three types of modern contraceptives is sporadic with the least in the distance range of 25-29 kilometres (66.7%, n=3) and the highest (100%) in ranges of 0-4, 10-14, 20-24, 30-35, 35-39, 40-45, and more than 50 kilometres. Hence, distance is not a barrier to provide services of modern contraceptives in all types of facilities in the country.

Table 8: Percentage distribution of service delivery points offering at least three modern contraceptive methods by distance from nearest warehouse/source of supplies, October 2010

Distance from nearest warehouse/source of supplies (in Km)	Percentage		Total (n)
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	
0-4	100.0	0.0	41
5-9	96.4	3.6	28
10-14	100.0	0.0	22
15-19	86.7	13.3	15
20-24	100.0	0.0	11
25-29	66.7	33.3	3
30-35	100.0	0.0	10
35-39	100.0	0.0	5
40-45	100.0	0.0	1
45-49	80.0	20.0	5
50 and over	100.0	0.0	111
Total	98.0	2.0	252

2.2.3 Reasons for not offering certain contraceptives

The survey revealed that there are facilities that do not offer modern contraceptive methods. Table 9 analyzed the main reasons for not offering contraceptives to clients. Lack of supply and lack of trained personnel are the most commonly cited bottlenecks for temporary (male and female condoms, oral pills

and injectables) and long-acting and permanent (IUDs, implants and sterilizations) contraceptive methods, respectively.

As anecdotal evidences show, the main supply of modern contraceptives is international donors including UNFPA. In most cases, facilities run-out of contraceptive methods due to erratic supplies. [3-5,15] So, the “no-supply” (even if requested and put orders before depletion of contraceptives) happens most of the time irrespective of distance and residence of facilities. “Never been requested” and “no demand for the contraceptive” are the less frequent responses provided by facilities for not providing family planning services. Unavailability of equipment is one reason why the facilities are not providing male and female sterilization and implants.

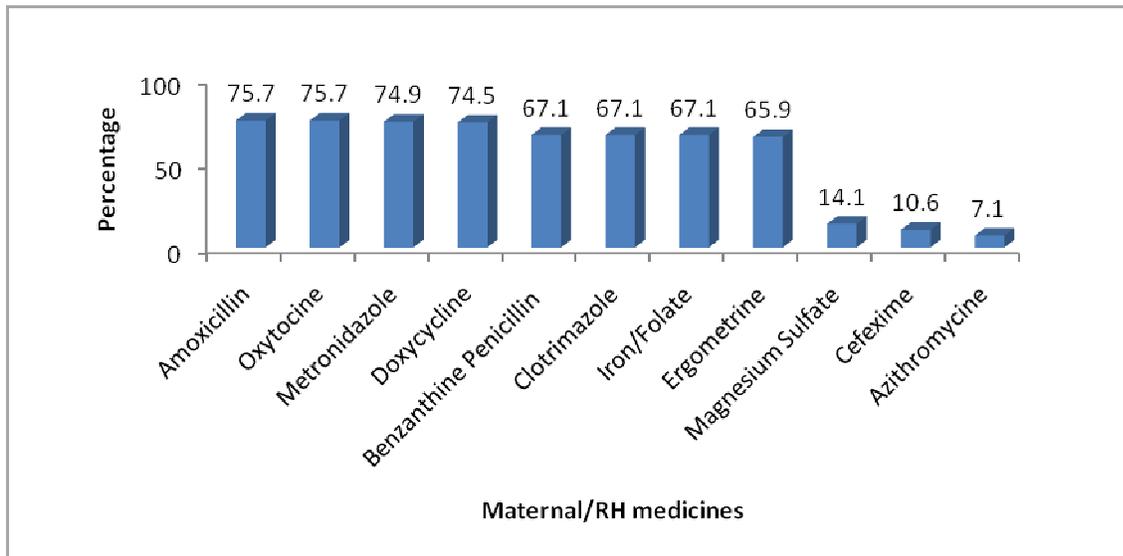
Table 9: Reasons for not offering modern contraceptive methods, October 2010

Contraceptive Method	No supply	No trained personnel	Not requested	No demand	Service not provided	Equipment not available	n
Male Condoms	41.7	-	33.3	16.7	8.3	-	12
Female Condoms	87.2	1.7	2.5	8.3	0.4	-	242
Oral Pills	66.7	-	-	-	33.3	-	3
Injectables	20.0	20.0	-	20.0	40.0	-	5
IUDs	8.5	71.8	14.5	4.3	0.9	-	117
Implants	9.5	69.9	1.6	6.3	6.3	6.3	63
Sterilization for Females	-	57.2	-	2.1	29.9	10.8	194
Sterilization for Males	-	53.6	-	6.2	29.7	10.5	209

2.3 Availability of Maternal and Reproductive Health Medicines

As a pre requisite for decreasing maternal mortality, all health facilities need to be equipped with life-saving maternal/reproductive health medicines with adequate quantities all the time. The findings of this survey indicated that life-saving maternal/reproductive health medicines were available in the majority of the service delivery points that are assessed by the survey. About three-quarters of the health delivery points were equipped with antibiotics (Amoxicillin (75.7%), Doxycyclin (74.5%), Metronidazole (74.9%) and Oxytocin (75.7%) while about two-thirds (67.1%) were equipped with Benzathine Penicillin, Clotrimazole, Iron/Folate and Ergometrine. However, some drugs such as Azithromycin, Cefexime and Magnesium Sulfate were available in less than 15% of the service delivery points. Figure 7 shows the percentage distribution of service delivery points with any available maternal/ reproductive health medicines.

Figure 7: Percentage distribution of service delivery points with any available maternal/ reproductive health medicines, October 2010



2.3.1 Availability of maternal and reproductive health medicines vis-a-vis types of facilities

The three most important life-saving drugs known to affect maternal mortality include Oxytocin, Ergometrine and Magnesium Sulfate. The availability of these life-saving maternal/reproductive health medicines/drugs varies depending on various factors. In this survey the availability of these maternal/reproductive health medicines varies by type of facilities, the region where the facilities are found, urban-rural residence, health facility ownership/management and its distance from the source of supply/warehouse. The survey showed that Oxytocin, the drug of choice for active management of the third stage of labour (AMTSL), was available in all secondary and tertiary level hospitals while only about seven in ten (70.4%) of the health posts and health centres reported of having these medicines. More health centres reported the availability of Oxytocin in the current survey than the National Baseline Assessment for Emergency Obstetric Care where only 43% of the health centres reported to have

Oxytocin in stock while 31% were either out of stock at the time of the interview or had had a stock out in the last 12 months, and about a quarter of health centres reported of never having had Oxytocin in stock.

The second most important drug used for the management of the third stage of labour is Ergometrine, a critical drug for emergency situation which should be available in all service delivery points. This survey indicated that Ergometrine was available in more than 90% of the secondary and tertiary level hospitals while only less than 6 in 10 (58%) health centres and health posts reported to have the drug during the survey. There is a slight improvement in the availability of Ergometrine at service delivery points compared to the National Baseline Assessment for Emergency Obstetric Care where 70% and 50% of the hospitals and health centres, respectively, reported to have Ergometrine in the stock at the time of the survey.

Magnesium Sulphate ($MgSO_4$) is the drug of choice for the management of pre-eclampsia/eclampsia – a leading cause of maternal mortality in facilities in Ethiopia. The survey showed that this important life-saving maternal/reproductive health medicine (anticonvulsant) was available in a very few health facilities that were included in the survey. Only 3 out of 10 tertiary and 1 out of 4 secondary level hospitals reported to have had Magnesium Sulfate during survey time while less than 1 in 10 (8.6%) health centres and health posts had this important life-saving drug. This finding is similar to the finding of the National Baseline Assessment for Emergency Obstetric Care where no or very few facilities have reported utilization of Magnesium Sulfate to save the lives of mothers.

The availability of these life-saving maternal/reproductive health medicines also varies by region. The proportion of facilities that reported the availability of Oxytocin varies from 67% in Gambella to 100% in Afar, Somali, Harari and Dire Dawa. Ergometrine was the second most available life-saving medicine the availability of which varies regionally. Its availability was highest in Addis Ababa where most health facilities (84.6%) reported of having the drug at the time of the survey. On the other hand, only 50% of health facilities in Dire Dawa had Ergometrine available in stock at the time of the survey. The least available life-saving drug at the service delivery points was Magnesium Sulfate with significant regional variation. The proportion of health facilities which reported the availability of Magnesium Sulfate varies from 0% in Tigray, Afar, Benshangul Gumuz and Gambella to 80% in Addis Ababa.

Urban-rural residence was found to affect the availability of these life-saving drugs. All the three life-saving maternal/reproductive health medicines were more than two times available in urban health facilities than they are in rural health facilities.

Facility ownership and management was also found to affect the availability of maternal/reproductive health medicines at the service delivery points. The survey showed that these life-saving maternal/reproductive health medicines were available most at NGO and privately owned/managed service delivery points compared to the government owned health service delivery points. Ergometrine was available in all health facilities owned by NGO and private sectors while only 69% of health facilities owned/managed by Government reported of having the drug at the time of the survey. Similarly, Oxytocin was available in all health facilities owned/managed by NGOs and private sectors while the drug was available in only 80% of government owned/managed health facilities. Magnesium Sulphate was the least available drug with most NGO owned/managed health facilities (60%) reporting the availability of the drug at the time of the survey and with 11% of privately owned/managed service delivery points reporting the availability of the drug.

The availability of these life-saving maternal/reproductive health medicines can also be affected by the distance of service delivery points from the source of supply/warehouse. It is reasonable to mention that facilities that are too far from the source of supply/the warehouse are less likely to have all the life-saving maternal/reproductive health medicines like facilities that are very close to the warehouse. In this survey, however, distance didn't seem to affect the availability of maternal/reproductive health medicines at the service delivery points. Table 10 shows the percentage distribution of service delivery points with any maternal/reproductive health medicines available by various variables.

Table 10: Percentage distribution of service delivery points with any maternal/reproductive health medicine available by different variables, October 2010

Disaggregating	Maternal/reproductive health medicines										
	Amoxicillin	Azithromycine	Benzathine Penicillin	Cefexime	Clotrimazole	Ergometrine	Iron/Folate	Magnesium Sulfate	Metronidazole	Oxytocine	Doxycycline
Type of Facility											
Primary (<i>Health post & health centre</i>) (n=169)	70.4	5.3	63.8	2.6	58.6	57.9	65.1	8.6	69.1	70.4	70.4
Secondary (<i>Rural, zonal & regional hospitals</i>) (n=63)	100	14.3	88.9	22.2	95.2	92.1	85.7	25.4	100	100	95.2
Tertiary (<i>Referral/ specialized hospitals</i>) (n=23)	100	4.3	78.3	39.1	95.7	95.7	78.3	30.4	100	100	100
Region											
Tigray (n=21)	76.2	0.0	71.4	4.8	76.2	66.7	90.5	0.0	76.2	81.0	76.2
Afar (n=5)	100	25.	100	0.0	75.0	75.0	50.0	0.0	100	100	100
Amhara (n=51)	77.6	2.0	65.3	4.1	69.4	69.4	63.3	8.2	77.6	77.6	79.6
Oromia (n=80)	77.0	5.4	71.6	12.2	71.6	67.6	75.7	23.0	77.0	79.7	75.7
Somali (n=5)	100	75	100	75	100	75.0	100	75.0	100	100	100
Benshangul Gumuz (n=6)	100	0.0	66.7	0.0	66.7	66.7	83.3	0.0	100	83.3	83.3
South Nations, Nationalities and People (SNNP) (n=48)	81.8	11.4	65.9	11.4	61.4	70.5	63.6	11.4	79.5	72.7	77.3
Gambella (n=3)	33.3	33.3	100	0.0	66.7	66.7	33.3	0.0	100	66.7	33.3
Harari (n=5)	100	40.0	100	60.0	80.0	80.0	100	80.0	100	100	100
Addis Ababa (n=28)	92.3	3.8	76.9	7.7	84.6	84.6	73.1	7.7	84.6	96.2	92.3
Dire Dawa (n=3)	100	0.0	100	100	100	50.0	50.0	50.0	50.0	100	100
Residence											
Urban (n=179)	94.3	9.2	83.9	14.4	86.8	82.2	77.0	17.8	93.7	96.0	93.1
Rural (n=76)	45.3	3.1	39.1	3.1	31.3	39.1	57.8	7.8	43.8	40.6	43.8
Management											
Government (n=240)	80.4	7.6	72.3	10.7	70.5	68.8	70.5	14.3	79.5	79.9	79.5
NGO (n=6)	100	0.0	80.0	20.0	100	100	100	60.0	100	100	80.0
Private (n=9)	88.9	11.1	55.6	22.2	88.9	100	88.9	11.1	88.9	100	88.9
Distance from nearest warehouse/source of supplies (in Km)											
0-4 (n=41)	89.2	2.7	75.7	10.8	75.7	75.7	73.0	8.1	86.5	86.5	86.5
5-9 (n=28)	50.0	0.0	40.9	18.2	40.9	31.8	63.6	9.1	45.5	45.5	40.9
10-14 (n=22)	52.4	0.0	52.4	0.0	47.6	42.9	57.1	9.5	52.4	52.4	52.4
15-19 (n=15)	64.3	7.1	42.9	14.3	50.0	50.0	64.3	14.3	64.3	57.1	64.3
20-24 (n=11)	66.7	11.1	55.6	0.0	66.7	66.7	66.7	11.1	66.7	66.7	66.7
25-29 (n=3)	100	0.0	100	0.0	100	100	100	50.0	100	100	100
30-35 (n=10)	66.7	0.0	55.6	0.0	66.7	66.7	55.6	11.1	77.8	66.7	77.8
35-39 (n=6)	83.3	0.0	66.7	16.7	66.7	83.3	66.7	33.3	83.3	83.3	83.3
40-44 (n=1)	0.0	0.0	0.0	0.0	0.0	0.0	100	0.0	0.0	0.0	0.0
45-49 (n=5)	80.0	20.0	80.0	0.0	80.0	100	80.0	20.0	100	100	80.0
50 and over (n=113)	94.6	12.5	86.6	14.3	84.8	83.0	77.7	18.8	92.9	96.4	93.8
Total (n=225)	75.7	7.1	67.1	10.6	67.1	65.9	67.1	14.1	74.9	75.7	74.5

2.3.2 Availability of five essential life-saving maternal and reproductive health medicines

The availability of life-saving maternal/reproductive health medicines in health facilities can be affected by various factors. The type of facilities, the region in which the facilities are located, urban-rural residence, ownership/management and the distance the facility had from the source of supply/warehouse could affect the availability of those essential life-saving maternal/reproductive health medicines in the facilities. This survey indicated that while 100% of secondary and tertiary level health facilities reported to have the five (including 3 essentials) life-saving maternal/reproductive health medicines, only 64% of health centres and health posts reported to have these medicines at the time of the survey.

Table 11: Percentage distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines available by type of facility, October 2010

Type of Facility	Percentage		Total
	Five (including 3 essential) life-saving maternal/reproductive health medicines available	Five (including 3 essential) life-saving maternal/reproductive health medicines not available	
Primary (<i>health post & health centre</i>)	63.9	36.1	169
Secondary (<i>rural, zonal & regional hospitals</i>)	100	0.0	63
Tertiary (<i>Referral/ Specialized hospitals</i>)	100	0.0	23
Total	76.1	23.9	255

Regional variations were observed in the availability of the five (including 3 essential) life-saving maternal/reproductive health medicines. Three-quarters of health service delivery points in all regions had all the five (including 3 essential) life-saving maternal/reproductive health medicines in the stock during survey time. All the five (including 3 essential) life-saving maternal/reproductive health medicines were available in all health facilities in Harari while only two-thirds (67%) health service delivery points in Dire Dawa and Gambella reported to have all the five (including 3 essential) life-saving maternal/reproductive health medicines in the stock. Table 12 shows the distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines by region.

Table 12: Percentage distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines available by region, October 2010

Region	Percentage		Total (n)
	Five (including 3 essential) life-saving maternal/reproductive health medicines available	Five (including 3 essential) life-saving maternal/reproductive health medicines not available	
Addis Ababa	89.3	10.7	28
Afar	80.0	20.0	5
Amhara	76.5	23.5	51
Benshangul Gumuz	83.3	16.7	6
Dire Dawa	66.7	33.3	3
Gambella	66.7	33.3	3
Harari	100	0.0	5
Oromia	72.5	27.5	80
SNNP	70.8	29.2	48
Somali	80.0	20.0	5
Tigray	76.2	23.8	21
Total	76.1	23.9	255

Rural-urban residence of service delivery points is one of the factors affecting the availability of maternal/reproductive health medicines. This survey showed that five (including 3 essential) life-saving medicines were about three times more available in urban service delivery points (94%) as compared to rural service delivery points (34%). Table 13 shows the distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines by urban-rural residence.

Table 13: Percentage distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines available by urban/rural residence, October 2010

Residence	Percentage		Total (n)
	Five (including 3 essential) life-saving maternal/ reproductive health medicines available	Five (including 3 essential) life-saving maternal/ reproductive health medicines not available	
Urban	93.9	6.1	179
Rural	34.2	65.8	76
Total	76.1	23.9	255

Health facility ownership (who owns and manages the facility) is also an important factor that determines the availability of maternal/ reproductive health medicines. The survey indicated that five (including 3 essential) life-saving maternal/ reproductive health medicines were most available in service delivery points owned and managed by NGOs (83.3%) and private sectors (89%). The five (including 3 essential) life-saving maternal/ reproductive health medicines were available in three-quarters of the service delivery points owned by government. Table 14 shows percentage distribution of service delivery points.

Table 14: Percentage distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines available by management of facility, October 2010

Management of facility	Percentage		Total (n)
	Five (including 3 essential) life-saving maternal/reproductive health medicines available	Five (including 3 essential) life-saving maternal/reproductive health medicines not available	
Government	75.4	24.6	240
NGO	83.3	16.7	6
Private	88.9	11.1	9
Total	76.1	23.9	255

The location of service delivery points is believed to affect the availability of maternal/reproductive health medicines with more service delivery points closer to the source of supply/warehouse assumed to have more maternal/reproductive health medicines compared to those located far away. In the current survey, however, the pattern of the relationship between the availability of life-saving medicines and the distance of the service delivery points from the source of supply/warehouse seems to be reversed. With the exception of those service delivery points located below five kilometres from the nearest warehouse/source of supplies, the percentage of service delivery points where five (including 3 essential) life-saving maternal/reproductive health medicines available increases with increasing distances from the nearest warehouses. Service delivery points that are located closer to the nearest warehouses may not think of keeping these medicines at their stock for they wrongly believe that they can get the medicines from the warehouse whenever they are in need. Table 15 shows the percentage distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines available by distance from nearest warehouse/source of supplies.

Table 15: Percentage distribution of service delivery points with five (including 3 essential) life-saving maternal/reproductive health medicines available by distance from nearest warehouse/source of supplies, October 2010

Distance from nearest warehouse/source of supplies (in Km))	Percentage		Total (n)
	Five (including 3 essential) life-saving maternal/reproductive health medicines available	Five (including 3 essential) life-saving maternal/reproductive health medicines not available	
0-4	80.5	19.5	41
5-9	35.7	64.3	28
10-14	50.0	50.0	22
15-19	53.3	46.7	15
20-24	54.5	45.5	11
25-29	66.7	33.3	3
30-35	70.0	30.0	10
35-39	83.3	16.7	6
40-45	0.0	100	1
45-49	100	0.0	5
50 and over	94.7	5.3	113
Total	76.1	23.9	255

2.3.3 Reasons for not offering certain life-saving maternal and reproductive health medicines

There are different reasons why service delivery points are not offering maternal/reproductive health medicines. In this survey, reasons for not offering maternal/reproductive health medicines were identified. The main reasons for not offering Oxytocin, for example, were cited as 'no supply' by 33%, 'not requested' by 4.4% and 'not in the facility drug list' by 62.5% of the health service delivery points. Similarly, the main reasons for not offering Ergometrine was cited as 'no supply', 'not requested', and 'not in the facility drug list' by 38%, 7% and 32% of the service delivery points, respectively. Significant proportion of service delivery points (13%) cited other reasons for not offering Ergometrine. The reasons for not offering Magnesium Sulfate by service delivery points were mainly due to 'no supply' (48.5%) or 'not in the facility drug list' (44%). Only 5.4% of the service delivery points mentioned 'not requested' as a reason for not offering this maternal/reproductive health medicine. Table 16 shows percentage distribution of service delivery points by reasons for not offering maternal/reproductive health medicines.

Table 16: Percentage distribution of service delivery points with main reasons for not offering maternal/ reproductive health medicines, October 2010

Maternal/ reproductive health medicines	Reason				n
	No supply	Not requested	Not in the facility drug list	Other	
Amoxicillin	20.0	6.7	68.9	4.4	45
Azithromycine	27.9	9.6	40.6	22.2	219
Benzanthine Penicillin	19.4	19.4	55.2	4.5	67
Cefexime	26.1	6.6	51.2	15.7	211
Clotrimazole	28.4	9.0	58.2	3.0	67
Ergometrine	37.7	7.2	31.9	13.0	69
Iron/Folate	40.3	32.8	19.4	4.5	67
Magnesium Sulfate	48.5	5.4	44.1	1.0	202
Metronidazole	21.3	10.6	63.8	4.3	47
Oxytocine	33.3	4.4	48.9	4.4	45
Doxycycline	16.7	10.4	62.5	6.3	48

At the time of the survey, inventory of maternal/reproductive health medicines was done in all health service delivery points included in the survey. Oxytocin and Ergometrine were in stock in 81% and 71% of the service delivery points, respectively, while Magnesium Sulfate was in stock only in 17% of the service delivery points. Antibiotics (Amoxicillin, Benzathin Penicillin, Doxycyclin and Metronidazole) were in stock in 70-80% of the service delivery points. Figure 8 shows the percentage distribution of service delivery points by different maternal/reproductive health medicines available in the stock at the time of the survey.

Figure 8: Percentage distribution of service delivery points maternal/ reproductive health medicines available in stock at the time of survey, October 2010

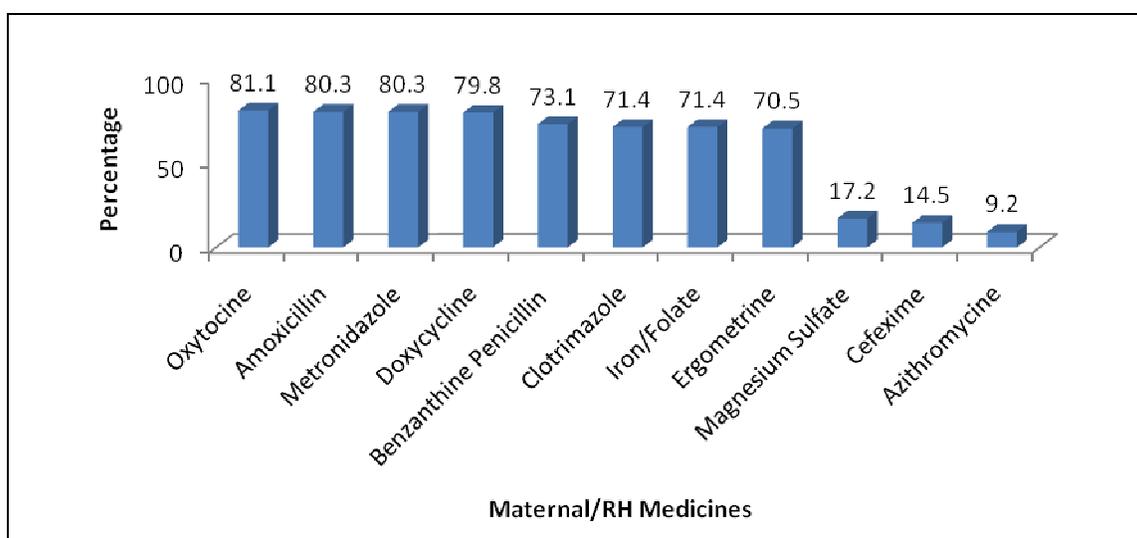


Table 17 shows the main reasons for maternal/reproductive health medicines not currently available in the stock. The most commonly cited reasons for not having sufficient maternal/reproductive health

medicines in the stock were “no supply” (61.2%), “not in facility drug list” (58%) and “not requested” (26%).

Table 17: Percentage distribution of service delivery points' reasons for not having maternal/ reproductive health medicines in the stock, October 2010

Reasons	Percentage	Number
No supply	61.2	156
Not requested	25.9	66
Not in facility drug list	58.0	148

2.4 Incidence of 'No Stock Out' of Modern Contraceptives

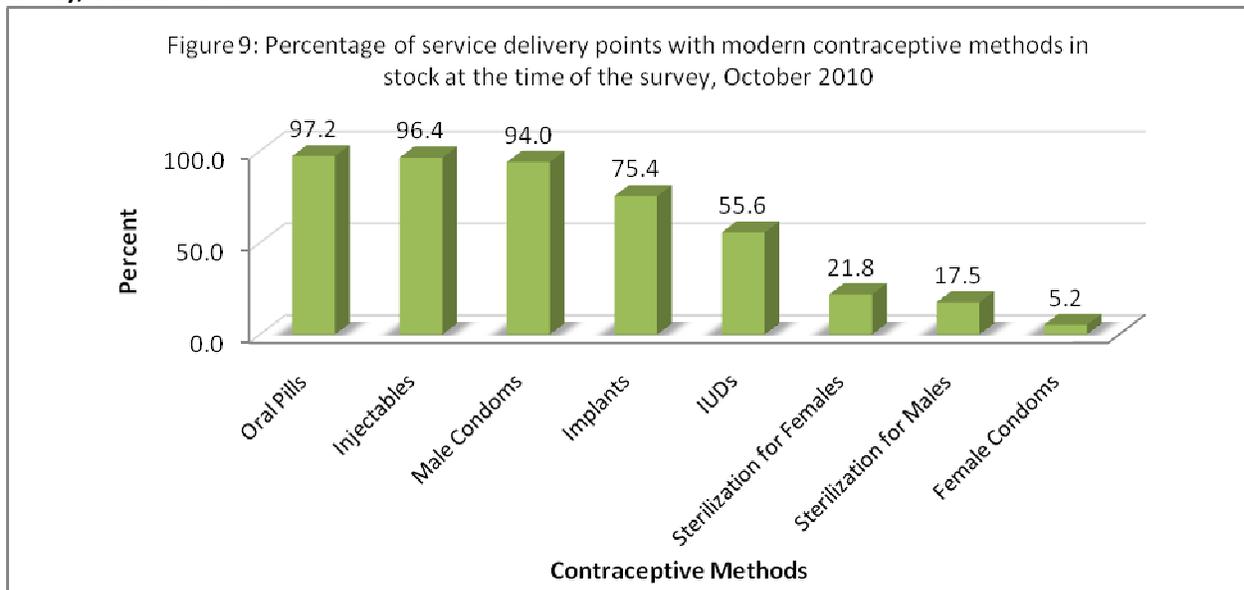
Overview: A stock-out can occur at one point in time or over a period of days, weeks or months. When there is a good stock management system in place, the stock-out duration will be minimal. Incidence of 'No stock out' of modern contraceptives refers to *'the situation in which a family planning service delivery point in a country does not run out of supplies of any one or more of the modern contraceptive methods in the last/previous six months and, therefore, had supplies on hand to serve clients at all times.*

This survey focused on assessing availability/'no stock out' of modern contraceptive methods (oral pills, injectables, male condoms, female condoms, implants, IUCD, female sterilization and male sterilization) in the service delivery points. In particular, the survey examined incidence of 'stock out' of modern contraceptive methods at the time of the survey and in the last six months prior to the survey. Reasons for stock out were also identified.

2.4.1 'No Stock Out' at time of survey

The findings revealed that almost all the surveyed facilities (98.8%) availed at least one type of modern contraceptive method in the stock. The mean number of modern contraceptive methods available in stock at the time of the survey was estimated at 4.5. Only 1.6% of SDPs were found fully stocked with all modern contraceptive methods, while nearly one third (31.8%) of SDPs have five of the modern contraceptive methods in their stock at the time of survey. Specifically, the findings indicated that large proportion of the facilities were stocked with oral pills (97.2%) followed by injectables (96.0%), male condoms (94.1%), implants (79.5%), IUCD (55.3%), female sterilization (21.7%), male sterilization (17.4%) and female condom (5.2%) (see Figure 9 below).

Figure 9: Percentage of service delivery points with modern contraceptive methods in stock at the time of the survey, October 2010



The survey result further revealed that all tertiary SDPs, 99.4% of primary level SDPs, and 96.8% of secondary level SDPs had stocks of modern contraceptive methods at the time of survey (see Table 18 below).

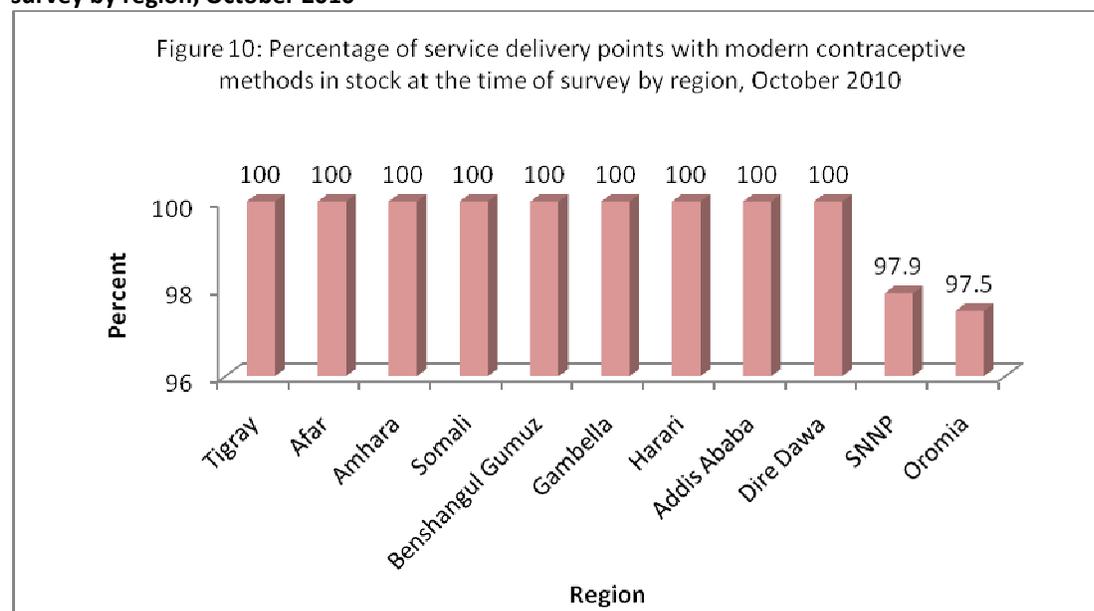
Table 18: Percentage distribution of service delivery points with modern contraceptive methods in stock at the time of the survey by type of facility, October 2010

Type of Facility	Percentage		Total (n)
	Modern contraceptive method in stock at the time of the survey	Modern contraceptive method not in stock at the time of the survey	
Primary level care SDPs	99.4	0.6	169
Secondary level care SDPs	96.8	3.2	63
Tertiary level care SDPs	100.0	0.0	23
Total	98.8	1.2	255

Availability of IUCD and injectables was reported in all of the tertiary level SDPs. Male condom, oral pills and injectable were in stock in more than 95% of the surveyed SDPs at the time of the survey. Over 95% of both primary and secondary level SDPs had experienced stock out of female condoms. On the other hand, both male and female sterilization kits were found in only 3% of the primary level SDPs.

As shown in Figure 10, all SDPs except those in SNNP (97.1%) and in Oromia (97.5%), were stocked with at least one type of modern contraceptive method. Female condoms were out of stock in all regions except in Amhara, SNNP and Somali at the time of the survey; whereas, male and female sterilization kits were reported out of stock in Somali Region and Dire Dawa City Administration. On the other hand, no stock out of male condom, oral pills and injectables was reported in less than half of the regions.

Figure 10: Percentage of service delivery points with modern contraceptive methods in stock at the time of survey by region, October 2010



Variations were observed in availability of modern contraceptive methods between urban and rural settings. Stock out of modern contraceptives was observed in only 3.9% of the rural SDPs as opposed to no stock out among the urban facilities (Table 19).

Table 19: Percentage distribution of service delivery points with modern contraceptive methods in stock at the time of the survey by urban/rural residence, October 2010

Residence	Percentage		Total (n)
	Modern contraceptive method in stock at the time of the survey	Modern contraceptive method not in stock at the time of the survey	
Urban	100.0	0.0	179
Rural	96.1	3.9	76
Total	98.8	1.2	255

Availability of male condoms, oral pills, and injectables was reported in more than 90 % of the rural SDPs, whereas, in over 95% of these SDPs, female condom, male and female sterilization kits were out of stock.

Variations in stock status were also observed with regard to ownership of SDPs surveyed. As described in Table 20, all government and NGO/mission owned SDPs had at least one type of contraceptive method in stock at the time of the survey. On the other hand, three of the six privately owned SDPs had experienced stock out of any one of the contraceptive methods. Male condoms, oral pills and implants were found in 100% of NGO/Mission owned SDPs and female condoms were not in stock in both the NGO/Mission and private SDPs. While 75% of NGO/Mission SDPs had reported availability of male and female sterilization kits, these kits were available in less than 20% and 45% of government and private SDPs, respectively.

Table 20: Availability of modern contraceptive methods in stock at the time of the survey by management of facility, October 2010

Management of facility	Percentage		Total (n)
	Modern contraceptive method in stock at the time of the survey	Modern contraceptive method not in stock at the time of the survey	
Government	100.0	0.0	240
NGO/Mission	100.0	0.0	9
Private	50.0	50.0	6
Total	98.8	1.2	255

The data presented in Table 21 shows no significant difference in availability of modern contraceptive methods among SDPs to the nearest warehouse/sources of supplies.

Table 21: Availability of modern contraceptive methods in stock at the time of the survey by distance from nearest warehouse/source of supplies, October 2010

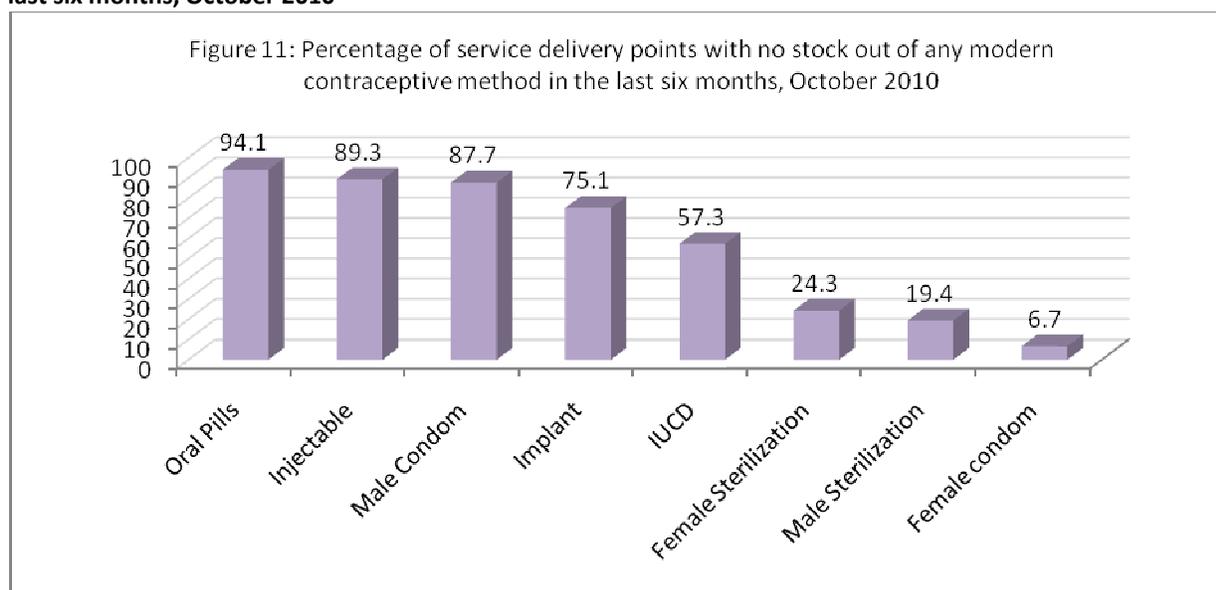
Distance from nearest warehouse/source of supplies (in Km)	Percentage		Total (n)
	Modern contraceptive method in stock at the time of the survey	Modern contraceptive method not in stock at the time of the survey	
0-4	100.0	0.0	41
5-9	100.0	0.0	28
10-14	100.0	0.0	22
15-19	100.0	0.0	15
20-24	100.0	0.0	11
25-29	100.0	0.0	3
30-34	100.0	0.0	10
35-39	83.3	16.7	6
40-45	100.0	0.0	1
45-49	100.0	0.0	5
50 and over	98.2	1.8	113
Total	98.8	1.2	255

2.4.2 'No Stock Out' in the last six months

Another indicator used to measure availability of modern contraceptive methods in SDPs is the six-month stock out rate, which is the percentage of facilities experiencing stock out of a particular product for six months prior to the survey. Among the SDPs surveyed, an overall rate of 99.2% 'no stock out' of modern contraceptive methods was reported.

As shown in figure 11, a large proportion of SDPs reported no stock out of oral pills (94.1%) followed by injectables (89.3%), male condoms (87.7%) and implants (75.1%); whereas female condoms (6.7%), male sterilization (19.4%) and female sterilization (24.3%) were found to be scarce in these facilities.

Figure 11: Percentage of service delivery points with no stock out of any modern contraceptive method in the last six months, October 2010



Great variation was observed in the duration of stock out of modern contraceptive methods that ranged from 1 to 180 days with an overall average of 121 days (about four months). Five of the eight modern contraceptive methods (female condom, male and female sterilization kits, IUCD and Implants) were found to be out of stock for about five months on the average. On the other hand, male condoms, oral pills and injectables were out of stock for less than two months.

As shown in Table 22, none of the primary and tertiary level SDPs had stock out of any of the contraceptive methods in the last six months prior to the survey; whereas, only 3.2% of secondary level SDPs experienced stock out. Analysis of stock out status of individual contraceptive methods against type of facility revealed that none of the tertiary level SDPs had stock out of oral pills and injectables. In contrast, over 90% of primary level care SDPs reported stock out of female condom (94.6%), male sterilization kits (94.0%), and female sterilization kits (92.2%).

Table 22: Percentage distribution of service delivery points with no stock out of a modern contraceptive method in the last six months by type of facility, October 2010

Type of Facility	Percentage		Total (n)
	No stock out of modern contraceptive method in the last six months	Stock out of modern contraceptive method in the last six months	
Primary (<i>health post & health centre</i>)	100	0.0	169
Secondary (<i>rural, zonal & regional hospitals</i>)	96.8	3.2	63
Tertiary (<i>referral/specialized hospitals</i>)	100	0.0	23
Total	99.2	0.8	255

Findings presented in Table 23 show no remarkable regional variation was observed in the stock status of modern contraceptive methods.

Table 23: Percentage distribution of service delivery points with no stock out of a modern contraceptive method in the last six months by Region, October 2010

Region	Percentage		Total (n)
	No stock out of modern contraceptive method in the last six months	Stock out of modern contraceptive method in the last six months	
Addis Ababa	100	0.0	28
Afar	100	0.0	5
Amhara	100	0.0	51
Benshangul Gumuz	100	0.0	6
Dire Dawa	100	0.0	3
Gambella	100	0.0	3
Harari	100	0.0	5
Oromia	98.8	1.2	80
SNNP	97.9	2.1	48
Somali	100	0.0	5
Tigray	100	0.0	21
Total	99.2	0.8	255

Regarding urban-rural stock status, only 2.6% of rural SDPs had stock out of at least one of the modern contraceptive methods in the last six months prior to the survey.

Table 24: Percentage distribution of service delivery points with no stock out of a modern contraceptive method in the last six months by urban/rural residence, October 2010

Residence	Percentage		Total
	No stock out of modern contraceptive method in the last six months	Stock out of modern contraceptive method in the last six months	
Urban	100	0.0	179
Rural	97.4	2.6	76
Total	99.2	0.8	255

As shown in Table 25, all of the surveyed government and private owned SDPs had no stock of at least one type of modern contraceptive method in the last six months prior to the survey. On the other hand, four of the six surveyed NGO/Mission owned SDPs reported no stock out in the period specified.

Table 25: Percentage distribution of service delivery points with no stock out of a modern contraceptive method in the last six months by management of facility, October 2010

Management of facility	Percentage		Total
	No stock out of modern contraceptive method in the last six months	Stock out of modern contraceptive method in the last six months	
Government	100	0.0	240
NGO/Mission	66.7	33.3	6
Private	100	0.0	9
Total	99.2	0.8	255

Table 26 shows percentage distribution of SDPs with 'no stock out' of modern contraceptive methods in the last six months by distance from nearest warehouse/source of supplies. Accordingly, 1.8% of SDPs that were far from the nearest warehouse/ source of supplies by 50 and more kilometres experienced stock out of modern contraceptive methods in the last six months prior to the survey.

Table 26: Percentage distribution of service delivery points with no stock out of a modern contraceptive method in the last six months by distance from nearest warehouse/source of supplies, October 2010

Distance from nearest warehouse/source of supplies (in Km)	Percentage		Total (n)
	No stock out of modern contraceptive method in the last six months	Stock out of modern contraceptive method in the last six months	
0-4	100	0.0	41
5-9	100	0.0	28
10-14	100	0.0	22
15-19	100	0.0	15
20-24	100	0.0	11
25-29	100	0.0	3
30-34	100	0.0	10
35-39	100	0.0	6
40-45	100	0.0	1
45-49	100	0.0	5
50 and over	98.2	1.8	113
Total	99.2	0.8	255

2.4.3 Reasons for 'stock out'

One of the major challenges to effective provision of family planning services has been persistent stock-outs of contraceptives and other reproductive health supplies. Stock out is a chronic concern that affects continued use of modern contraceptive methods and quality of services. Although the rates of 'stock out' both at the time of survey and in the last six months prior to the survey seem to be insignificant, stock out analysis of individual contraceptive methods revealed that some methods such as female condoms, male and female sterilization kits and IUCDs were out of stock in most of the surveyed SDPs. The most frequently cited reasons for stock out were attributed to logistics management (shortage of

supply, delay in delivery, delay in order placement and inadequate budget), SDP specific drug list standards, lack of trained personnel and product expiry.

Shortage of supply was mentioned by the great majority of surveyed SDPs as one of the major reasons for stock out of modern contraceptive methods. Injectables, female condoms, and male condoms were out of stock in 77.8%, 61.9%, and 60.0% of SDPs, respectively, due to shortage of supply. Similarly, supply problem accounted for 73.9% and 66.7% of SDPs for stock out of female condoms and injectables, respectively, in the last six months prior to the survey. About 44.0% of SDPs had stock out of oral pills both at the time of survey and in the six months period due to supply problem. 'No-request' for supplies was also reported as one of the reasons for stock out. Some 42.9%, 20.0% and 11.9% SDPs had out of stock of oral pills, male condoms and injectables, respectively, because of failure to put order for refill. Delay in delivery of supply from the source was reported as another contributing factor for stock out of modern contraceptive methods at SDPs. Hence, delay in supply was reported for stock out of oral pills, male condoms, and injectables in 18.8%, 16.1% and 14.8% of SDPs, respectively, in the last six months prior to the survey. Also, 7.4% and 3.2% of the SDPs reported lack of transportation as a reason for stock out of injectables and male condoms, respectively, in the period specified.

Modern contraceptive methods are provided based on the national drug list standards specific to each level of SDP. Hence, IUCD, female and male sterilization were reported as out of stock as a result of unavailability of these services in the facilities. Absence of trained health practitioners to provide services of IUCD insertion, female and male sterilization, and implant accounted for 55.0%, 52.3%, 51.9% and 42.6% of SDPs, respectively, as causes of stock out at the time of the survey. Similarly, female and male sterilization services were not available in 45.6% and 38.8% of SDPs, respectively, due to absence of trained health practitioners.

Product expiry of male condoms, oral pills, injectables, and implants was reported as the other cause for stock out in 19.4%, 12.5%, 11.1%, 1.8% and 1.6% of the SDPs, respectively, at the time of survey and in the last six months prior to the survey. Besides, unavailability of equipment to provide female and male sterilization was reported in 9.3% and 11.7% of SDPs, respectively, as reason for not accessing the services. Table 27 below summarizes percentage of SDPs for stock out of modern contraceptive methods.

Table 27: Reasons for stock out of modern contraceptive methods, October 2010

Contraceptive Method	No supply	Not requested	Delay from supply source	Lack of transport	Not in the facility drug list	Expired	No trained personnel	Shortage of budget	No demand	Equipment not available	Others	n
Male Condoms	60.0	20.0			-	13.3	6.7	3.2	-	-		15
Female Condoms	61.9	25.0	16.1	3.2	2.3	0.4	10.0	1.3	22.6	-	6.5	239
Oral Pills	43.8	42.9	18.8		14.3	-	-	-	-	-	6.3	7
Injectables	77.8	11.1	14.8	7.4	-	11.1	-	-	-	-	3.7	9
IUDs	29.7	2.7	0.9	-	10.8	10.3	55.0	-	-	-	45.8	111
Implants	39.7	3.3	1.6	-	14.8	1.6	42.6	-	-	-	41.3	61
Sterilization for Females	2.0	1.6	-	-	39.4	-	52.3	-	3.6	9.3	2.6	197
Sterilization for Males	9.1	6.3	-	-	27.9	-	51.9	-	6.3	11.7	12.1	208

SECTION III: CONCLUSION

3.1 Summary of Findings

Ensuring the availability of life-saving maternal/reproductive health medicines in health service delivery points is one of the important tasks policy makers and program managers need to consider in the design of appropriate intervention strategies toward reducing maternal mortality and achieving MDG 5. There are little or no large scale studies done to determine the availability of modern contraceptives and life-saving maternal/reproductive health medicines in health facilities in Ethiopia. This survey was, therefore, conducted to assess the availability of modern contraceptives and maternal/reproductive health medicines at the service delivery points in Ethiopia.

The survey revealed that family planning services, in most cases, mal-functioned from lack of or erratic supply of modern contraceptive methods. Though the Government has given emphasis to reducing maternal and child mortality through scaling-up reproductive health services at the grassroots level, health posts and other service delivery points are challenged by poor supply of modern contraceptive methods. Lack of trained personnel has further aggravated the situation. Not all of the health posts, health centres and even regional hospitals (at secondary level) offer at least three types of modern contraceptive methods. Female condoms, male and female sterilization, and IUDs remained scarce in most service delivery points. Even tertiary level SDPs are not serving fully the community with temporary modern contraceptive methods like male condoms, and long acting methods like IUDs, implants, female and male sterilization.

Though maternal/reproductive health medicines were less available in most service delivery points, the situation is worse in primary level service delivery points (health posts and health centres). Compared to other maternal/reproductive health services, essential life-saving maternal/reproductive health medicines are less available in most service delivery points.

Availability of maternal/reproductive health medicines at service delivery points is influenced by factors such as type of health facility, the region in which the service delivery is located, urban-rural residence, and facility ownership/management. However, distance of the SDPs from the nearest warehouse/source of supplies was not found the major factor affecting availability of the medicines.

Stock out indicators measure product availability over a period of time, and serve as proxy indicators of the ability of a program to meet clients' needs with a full range of products and services. It is highly plausible that better systems and increased product availability enable increased use and improved health outcomes. Product availability is the most vital logistics result from the clients' perspective and may be the most important parameter to ensure sustainable family planning services.

Findings of this survey showed improvements in availability of modern contraceptive methods at the SDPs compared to the previous findings. [6,16] The observed high magnitude of 'no stock out' of modern contraceptive methods at SDPs implies a promising progress towards achieving the country's target of 100% 'no stock out' by the year 2012. [6] In this survey, substantial improvement (99.2%) on overall 'no stock out' situation of modern contraceptive methods in the last six months was observed as opposed to 60% in 2006 and 90% in 2009. [6] The proportion of 'no stock out' at the time of the survey and in the last six months before the survey has also shown marked increase on some of the

contraceptive methods as compared to the 2006 survey using the Logistics Indicator Assessment Tool (LIAT). [16] Accordingly, percentage of SDPs stocked out of contraceptive methods any time in the last six months prior to the survey had shown reduction from 20.2% to 12.3% for male condoms; 58.7% to 10.7% for injectables; 62.9% to 24.9% for implants and 30.2% to 5.9% for oral pills. Similar reduction in percentage of SDPs stocked out at the time of the survey was observed: male condoms (from 12.1% to 6.0%), injectables (from 24.6% to 5.6%), implants (from 51.4% to 24.6%), and oral pills (from 15.5% to 2.8%). In contrast, the proportion of SDPs, which were stocked out of IUD and female condoms both at the time of the survey and in the last six months prior to the survey, have shown increase over the findings of 2006. [16]

The survey data on reasons of stock out (no supply, not requested, no transportation, no trained provider and equipment not available) augmented the challenges of stock out and needs special attention in the process of expanding services and securing availability of a wide range of modern contraceptive methods.

High percentage of female condoms available in stock is 20% in Somali Region. However, zero stock of female condoms (both at the time of the survey and in the last six months prior to the survey) was reported in many of the regions except Amhara, Oromia, and SNNP. Besides the reasons reported as causes for stock out of female condom (no demand, not requested, etc.), there remains a need for investigating both the cultural influence and health providers' involvement to promote and encourage their clients. In addition, the stock status of female and male sterilization kits in many of the regions requires due attention.

3.2 Recommendations

The survey presented an encouraging picture that Ethiopia is in a promising position in implementing national strategies “to implement more sustainable approach to RHCS” to reach ‘no stock out’ of modern contraceptive method/products at SDPs by 2012. Based on findings of this survey, syntheses of recommendations are presented as follows:

- The Federal MOH, regional health bureaus, zonal health departments and woreda health offices should make concerted efforts to avail at least one form of family planning service at all levels and to ensure that all SDPs must provide at least normal child service delivery to curtail maternal mortality caused by unskilled deliveries.
- Ensuring method choice at all service delivery points is crucial to reducing maternal and child mortality in relation to risks associated with unwanted pregnancy. Thus, all temporary contraceptive methods (male and female condoms, oral pills and injectables) should be available at all service delivery points irrespective of facility tier system. In addition, long-acting (IUDs, implants) and permanent methods (male and female sterilizations) should be available at all secondary and tertiary levels and health centres.
- Ideally, all family planning services should be accessible to clients at their localities. The Government of Ethiopia and its partners should further expand service delivery points and maintain the existing ones to improve and ensure continuity of quality of services at all levels.

- Family planning (FP) providers must be viewed as critical factors to optimize acceptability, uptake, and continued use of modern contraceptive methods.
- Logistics system should be strengthened to coordinate sustainable supply of modern contraceptive methods to all levels of SDPs.
- Male and female condoms, IUDs and implants were not offered in some facilities as they were never requested. Therefore, facility directors/managers, regional health bureaus, zonal and woreda health offices should be responsible for the follow-up and monitoring of timely requests and forecasts of modern contraceptives.
- Building the capacity of health workers at the service delivery points is essential as it was reflected in this survey. There should be proper planning of basic and refresher training for these professionals on family planning; particularly on long-acting and permanent methods as more than half of the facilities mentioned lack trained personnel to offer modern contraceptives.
- About 11% of the facilities do not offer male and female sterilization due to lack of equipment. Therefore, the FMOH should work towards equipping both secondary and tertiary level SDPs to provide permanent family planning services.
- First level service delivery points are the first choice of mothers to obtain reproductive health services including child delivery services. Thus, availing essential maternal/reproductive health medicines at the primary level of SDPs (health posts and health centres) remains critical to decrease maternal mortality.
- Efforts should be made by the FMOH and all stakeholders to ensure the availability of maternal/reproductive health medicines in all health facilities in general and essential life-saving maternal/reproductive health medicines in particular.
- The Federal Ministry of Health and regional health bureaus must allocate budget for FP commodities and maternal health medicines and ensure that a budget line is created at all levels.
- The supply chain management systems should be strengthened to avail FP commodities and life saving maternal medicines to the end users at all times.
- Stock out is one of the critical barriers to contraceptive access. It can be reduced by:
 - Improving functioning logistics system (avoid delay in order processing, improve availability and supply of modern contraceptive methods at central warehouse)

- Reducing average duration of stock outs for all products (minimizing expiry of all products through continuous stock tracking and re-distribution mechanisms).
- Increasing the number of skilled personnel for the management of supplies and delivery of services.
- Providing in-service training to health providers on family planning methods, stock and inventory management principles, customer handling and skills to practice specific methods such as IUCD insertion, implant administration, etc.
- Maintaining effective monitoring and evaluation system for tracking the results of interventions and for deriving lessons learned to be used in guiding program implementation.

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SECTION V: ANNEXES

Annex A: Survey Questionnaire

AVAILABILITY OF MODERN CONTRACEPTIVES AND ESSENTIAL LIFE SAVING MATERNAL/RH MEDICINES IN SERVICE DELIVERY POINTS IN ETHIOPIA

INFORMATION ABOUT THE INTERVIEW	
Country	
Date of the Survey (year and month)	
Name of Interviewer	
Date of Interview.....	
Questionnaire checked and attested to be properly completed	
Name of Supervisor.....	
Signature	Date

AVAILABILITY OF MATERNAL/RH MEDICINES											
Item	Maternal/RH Medicines										
	Amoxicillin	Azithromycine	Benzathine Penicillin	Cefexime	Clotrimazole	Ergometrine	Iron/Folate	Magnesium Sulfate	Metronidazole	Oxytocine	Doxy
011: For each of the maternal/RH medicines please indicate whether it is currently available in this health facility.	1 Yes										
	2 No										
	(Circle only one option)										
012: If the medicine is not currently available in this health facility, please indicate the reasons.											

INTERVIEWER VERIFICATION for ITEM 010											
For each response provided for item 011 , the interviewer should validate the response by a physical inventory and note the appropriate finding.	1. Inventory taken, Medicine is in stock										
	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock	2. Inventory taken, Medicine is NOT in stock

NO STOCK OUT OF MODERN CONTRACEPTIVE METHODS AT SDP

Item	Male condoms	Oral Pills	IUDs	Implants	Injectables	Female Condoms	Sterilisation for Male	Sterilisation for Females
013) For each of the contraceptive methods please indicate whether it is currently in stock in this health facility.	1 Yes 2 No (Circle only one option)							
014) If the contraceptive method is not currently in stock at this health facility, please indicate the reason .								
015) For each of the contraceptive methods please indicate whether it has been out of stock at this health facility at any given day, in the last six months preceding the survey, and therefore unavailable to give to clients at that time .	1 Yes 2 No (Circle only one option)							
016) If yes, please indicate the number of days the contraceptive method was out of stock in your health facility in the last six months preceding the survey.
017) If the contraceptive method was out of stock at any given time at this health facility, in the last six months, please indicate the reason .								

For each response provided for item 013 , the interviewer should validate the response by a physical inventory and note the appropriate finding.	1. Inventory taken, contraceptive is in stock							
	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock	2. Inventory taken, contraceptive is NOT in stock

Annex B: List of service delivery points surveyed

No.	SDP Name	Type of Facility	Region
1	BRASS MCH HOSPITAL	Health centre	Addis Ababa
2	BOLE HEALTH CENTRE	Health centre	Addis Ababa
3	BOLE 17/20 HEALTH CENTRE	Health centre	Addis Ababa
4	KALITI HEALTH CENTRE	Health centre	Addis Ababa
5	MARIE INTERNATIONAL (KIRKOS) CLINIC	Health centre	Addis Ababa
6	NIFAS SILK LAFTO NO 1 HEALTH CENTRE	Health centre	Addis Ababa
7	MESHUALKIA HEALTH CENTRE	Health centre	Addis Ababa
8	NIFAS SILK LAFTO K/K NO2	Health centre	Addis Ababa
9	ARADA HEALTH CENTRE	Health centre	Addis Ababa
10	KOLFE HEALTH CENTRE	Health centre	Addis Ababa
11	GULELE HEALTH CENTRE	Health centre	Addis Ababa
12	KOTEBE HEALTH CENTRE	Health centre	Addis Ababa
13	ANAMIYA MATERNAL & CHILD HEALTH	Health centre	Addis Ababa
14	TEKLE HAIMANOT HEALTH CENTRE	Health centre	Addis Ababa
15	KAZANCHIS HEALTH CENTRE	Health centre	Addis Ababa
16	BELETSHIACHEW HEALTH CENTRE	Health centre	Addis Ababa
17	WOREDA 7 HEALTH CENTRE	Health centre	Addis Ababa
18	ADDIS KETMA HEALTH CENTRE	Health centre	Addis Ababa
19	GANDI MEMORIAL HOSPITAL	Referral/Specialized hospital	Addis Ababa
20	YEKATIT 12 HOSPITAL	Referral/Specialized hospital	Addis Ababa
21	ADDIS MATERNITY & CHILDREN HOSPITAL	Referral/Specialized hospital	Addis Ababa
22	FEDERAL POLICE REFERRAL HOSPITAL	Referral/Specialized hospital	Addis Ababa
23	KIDUS PAULOS HOSPITAL	Referral/Specialized hospital	Addis Ababa
24	TIKUR ANBESA SPECIALIZED HOSPITAL	Referral/Specialized hospital	Addis Ababa
25	KADISO GENERAL HOSPITAL	Regional hospital	Addis Ababa
26	HAYAT GENERAL HOSPITAL	Regional hospital	Addis Ababa
27	ASEGEDECH MCH HOSPITAL	Regional hospital	Addis Ababa
28	DINBERUA MATERNAL AND CHILD HOSPITAL	Regional hospital	Addis Ababa
29	SEMERA HEALTH CENTRE	Health centre	Afar
30	AWASH HEALTH CENTRE	Health centre	Afar
31	DUBTI HEALTH POST	Health post	Afar
32	DUBTI REGIONAL HOSPITAL	Regional hospital	Afar
33	NATIONAL DISTRICT HOSPITAL	Rural hospital	Afar
34	WALIDYA HEALTH CENTRE	Health centre	Amhara
35	MERSE HEALTH CENTRE	Health centre	Amhara
36	HAMUSIT HEALTH CENTRE	Health centre	Amhara
36	HAIK HEALTH CENTRE	Health centre	Amhara
37	WUCHALE HEALTH CENTRE	Health centre	Amhara
38	KELELA HEALTH CENTRE	Health centre	Amhara

No.	SDP Name	Type of Facility	Region
39	GEMBA HEALTH CENTRE	Health centre	Amhara
40	GOREBELA HEALTH CENTRE	Health centre	Amhara
41	KOMBOLCHA HEALTH CENTRE	Health centre	Amhara
42	SENBETE HEALTH CENTRE	Health centre	Amhara
43	SHEWAROBIT HEALTH CENTRE	Health centre	Amhara
44	DEBRE BERHAN HEALTH CENTRE	Health centre	Amhara
45	KEYIT HEALTH CENTRE	Health centre	Amhara
46	INJIBARA HEALTH CENTRE	Health centre	Amhara
47	DURBETE HEALTH CENTRE	Health centre	Amhara
48	AMANUEL HEALTH CENTRE	Health centre	Amhara
49	OMERAW HEALTH CENTRE	Health centre	Amhara
50	DEMBECHA HEALTH CENTRE	Health centre	Amhara
51	BAHIR DAR HEALTH CENTRE	Health centre	Amhara
52	MERTO LEMARIAM HEALTH CENTRE	Health centre	Amhara
53	DELGI HEALTH CENTRE	Health centre	Amhara
54	GONDER HEALTH CENTRE	Health centre	Amhara
55	ENTRANYE HEALTH CENTRE	Health centre	Amhara
56	GONDER UNIVERSITY	Health centre	Amhara
57	ADDIS ZEMEN HEALTH CENTRE	Health centre	Amhara
58	CHEFE HEALTH POST	Health post	Amhara
59	DOBLE MARIAM HEALTH POST	Health post	Amhara
60	TISSA HEALTH POST	Health post	Amhara
61	MITAK HEALTH POST	Health post	Amhara
62	CHORISSA HEALTH POST	Health post	Amhara
63	GERBI HEALTH POST	Health post	Amhara
64	YINESA HEALTH POST	Health post	Amhara
65	YETNORA HEALTH POST	Health post	Amhara
66	CHEMO WEGA KEBELE (07) HEALTH POST	Health post	Amhara
67	MAYNET HEALTH POST (FARTA WOREDA)	Health post	Amhara
68	BELAGET DABARKA HEALTH POST	Health post	Amhara
69	AWZET HEALTH POST	Health post	Amhara
70	DESSIE HOSPITAL	Referral/Specialized hospital	Amhara
71	DEBRE BIRHAN REFERRAL HOSPITAL	Referral/Specialized hospital	Amhara
72	DEBRE MARKOS REGIONAL HOSPITAL	Referral/Specialized hospital	Amhara
73	FELEGE HIWOT REFERRAL HOSPITAL	Referral/Specialized hospital	Amhara
74	GONDER REFERRAL HOSPITAL(GONDER UNIVERSITY HOSPITAL)	Referral/Specialized hospital	Amhara
75	TEFERA HAILUS MEMORIAL HOSPITAL	Rural hospital	Amhara
76	HIDAR 11 HOSPITAL	Rural hospital	Amhara
77	BOROMEDA HOSPITAL	Rural hospital	Amhara
78	FINOTESELAM HOSPITAL	Rural hospital	Amhara

No.	SDP Name	Type of Facility	Region
79	SHEGAW MOTTA RURAL HOSPITAL	Rural hospital	Amhara
80	DEBARK DISTRICT HOSPITAL	Rural hospital	Amhara
81	MELEMA DISTRICT HOSPITAL	Rural hospital	Amhara
82	WOLDIYA HOSPITAL	Zonal hospital	Amhara
83	DEBRE TABOR ZONAL HOSPITAL	Zonal hospital	Amhara
84	KAMASHI HEALTH CENTRE	Health centre	Benshangul Gumuz
85	FELGE SELAM HEALTH CENTRE	Health centre	Benshangul Gumuz
86	ASSOSA HEALTH CENTRE	Health centre	Benshangul Gumuz
87	KETENA 2 MENDER 131 HEALTH POST	Health post	Benshangul Gumuz
88	ASOSA HOSPITAL	Regional hospital	Benshangul Gumuz
89	PAWE HOSPITAL	Zonal hospital	Benshangul Gumuz
90	LEGEHARE HEALTH CENTRE	Health centre	Dire Dawa
91	MUDI ANANA HEALTH POST	Health post	Dire Dawa
92	DILCHORA HOSPITAL	Referal/Specialized hospital	Dire Dawa
93	ETANG HEALTH CENTRE	Health centre	Gambella
94	ABO HEALTH POST	Health post	Gambella
95	GAMBELLA HOSPITAL	Regional hospital	Gambella
96	ERER HEALTH CENTRE	Health centre	Harari
97	HARAR JEGOL HOSPITAL	Referal/Specialized hospital	Harari
98	SOUTH EAST ARMY HOSPITAL	Referal/Specialized hospital	Harari
99	HIWOT FANA HOSPITAL	Referal/Specialized hospital	Harari
100	HARAR POLICE HOSPITAL	Regional hospital	Harari
101	SHENO HEALTH CENTRE	Health centre	Oromia
102	SIRETIC HEALTH CENTRE	Health centre	Oromia
103	CHANCHO HEALTH CENTRE	Health centre	Oromia
104	GINDO AMEYA HEALTH CENTRE	Health centre	Oromia
105	WOLISO HEALTH CENTRE	Health centre	Oromia
106	DEMBI DOLO HEALTH CENTRE	Health centre	Oromia
107	TULU WAYU HEALTH CENTRE	Health centre	Oromia
108	ARJO HEALTH CENTRE	Health centre	Oromia
109	GIMBI HEALTH CENTRE	Health centre	Oromia
110	KERSA HEALTH CENTRE	Health centre	Oromia
111	ASELA HEALTH CENTRE	Health centre	Oromia
112	ITEYA HEALTH CENTRE	Health centre	Oromia
113	MOJO HEALTH CENTRE	Health centre	Oromia
114	BARED HEALTH CENTRE	Health centre	Oromia
115	ROBE HEALTH CENTRE	Health centre	Oromia
116	DUKEM HEALTH CENTRE	Health centre	Oromia
117	MEGA HEALTH CENTRE	Health centre	Oromia
118	ABAYA HEALTH CENTRE	Health centre	Oromia

No.	SDP Name	Type of Facility	Region
119	DIDEM PRIMARY HEALTH CARE	Health centre	Oromia
120	BULE HORA HEALTH CENTRE	Health centre	Oromia
121	HIGHER 2 HEALTH CENTRE	Health centre	Oromia
122	BATU HEALTH CENTRE	Health centre	Oromia
123	EJERE HEALTH CENTRE	Health centre	Oromia
124	KARAMILE HEALTH CENTRE	Health centre	Oromia
125	ADAMA HEALTH CENTRE	Health centre	Oromia
126	KUNNI HEALTH CENTRE	Health centre	Oromia
127	SHEBE HEALTH CENTRE	Health centre	Oromia
128	ATANGO HEALTH CENTRE	Health centre	Oromia
129	YAYO HEALTH CENTRE	Health centre	Oromia
130	BEDELE HEALTH CENTRE	Health centre	Oromia
131	DUGA (DARIMU) HEALTH CENTRE	Health centre	Oromia
132	KOMBLCHA HEALTH CENTRE	Health centre	Oromia
133	BADESSA HEALTH CENTRE	Health centre	Oromia
134	AWASO HEALTH POST	Health post	Oromia
135	MOYE GAJO HEALTH POST	Health post	Oromia
136	KORA HEALTH POST	Health post	Oromia
137	AWUMER HEALTH POST	Health post	Oromia
138	BITATA HEALTH POST	Health post	Oromia
139	KILTU JELE HEALTH POST	Health post	Oromia
140	ABAJARA HEALTH POST	Health post	Oromia
141	LAKO HEALTH POST	Health post	Oromia
142	ZALO HEALTH POST	Health post	Oromia
143	ASHENA HEALTH POST	Health post	Oromia
144	BILALO HEALTH POST	Health post	Oromia
145	HALE ANDODE HEALTH POST	Health post	Oromia
146	ALECHA AREBATIE HEALTH POST	Health post	Oromia
147	ANO KERE HEALTH POST	Health post	Oromia
148	GOLAWACHU HEALTH POST	Health post	Oromia
149	DIRE KARA HEALTH POST	Health post	Oromia
150	SOMBOMANA HEALTH POST	Health post	Oromia
151	KODOHIRI HEALTH POST	Health post	Oromia
152	JAWIS HEALTH POST	Health post	Oromia
153	BRINDA HEALTH POST	Health post	Oromia
154	NEKEMTE HOSPITAL	Referral/Specialized hospital	Oromia
155	ASELA HOSPITAL	Referral/Specialized hospital	Oromia
156	ADAMA SPECIALIZED HOSPITAL	Referral/Specialized hospital	Oromia
157	METU KARL REGIONAL HOSPITAL	Referral/Specialized hospital	Oromia
158	JIMMA UNIVERSITY SPECIALIZED HOSPITAL	Referral/Specialized hospital	Oromia

No.	SDP Name	Type of Facility	Region
159	GAMBO GENERAL RURAL HOSPITAL	Regional hospital	Oromia
160	SHASHEMENE GENERAL HOSPITAL	Regional hospital	Oromia
161	NEJO HOSPITAL	Rural hospital	Oromia
162	AIRA HOSPITAL	Rural hospital	Oromia
163	GIMBI ADVENTIST HOSPITAL	Rural hospital	Oromia
164	DODOLA HOSPITAL	Rural hospital	Oromia
165	GINDEBERET HOSPITAL	Rural hospital	Oromia
166	DEDER HOSPITAL	Rural hospital	Oromia
167	LIMMU GENET HOSPITAL	Rural hospital	Oromia
168	AMBO HOSPITAL	Zonal hospital	Oromia
169	BISIDIMO HOSPITAL	Zonal hospital	Oromia
170	NEGELE BORENA HOSPITAL	Zonal hospital	Oromia
171	DEMBIDOLO HOSPITAL	Zonal hospital	Oromia
172	SHAMBU HOSPITAL	Zonal hospital	Oromia
173	GOBA HOSPITAL	Zonal hospital	Oromia
174	GINIR ZONAL HOSPITAL	Zonal hospital	Oromia
175	BISHOFTU HOSPITAL	Zonal hospital	Oromia
176	YABELLO HOSPITAL	Zonal hospital	Oromia
177	BULE HORA HOSPITAL	Zonal hospital	Oromia
178	FICHE HOSPITAL	Zonal hospital	Oromia
179	GELEMSO HOSPITAL	Zonal hospital	Oromia
180	CHIRO ZONAL HOSPITAL	Zonal hospital	Oromia
181	GARSA HEALTH CENTRE	Health centre	SNNP
182	LANTE HEALTH CENTRE	Health centre	SNNP
183	BEDESSA HEALTH CENTRE	Health centre	SNNP
184	BOLE HEALTH CENTRE	Health centre	SNNP
185	HADARO HEALTH CENTRE	Health centre	SNNP
186	JINKA MILLENIUM HEALTH CENTRE	Health centre	SNNP
187	YINA HEALTH CENTRE	Health centre	SNNP
188	DECA HEALTH CENTRE	Health centre	SNNP
189	BITA HEALTH CENTRE	Health centre	SNNP
190	SHISHINDA HEALTH CENTRE	Health centre	SNNP
191	SHEKO HEALTH CENTRE	Health centre	SNNP
192	TOCHA HEALTH CENTRE	Health centre	SNNP
193	HOMECHEO HEALTH CENTRE	Health centre	SNNP
194	DOESHA HEALTH CENTRE	Health centre	SNNP
195	ARSHO HEALTH CENTRE	Health centre	SNNP
196	MUGO HEALTH CENTRE	Health centre	SNNP
197	ENDIBIR HEALTH CENTRE	Health centre	SNNP
198	HWARIAT HEALTH CENTRE	Health centre	SNNP

No.	SDP Name	Type of Facility	Region
199	YAYIE HEALTH CENTRE	Health centre	SNNP
200	ALETA WONDO HEALTH CENTRE	Health centre	SNNP
201	TEFERI KILA HEALTH CENTRE	Health centre	SNNP
202	ADADO HEALTH CENTRE	Health centre	SNNP
203	DARARA HEALTH CENTRE	Health centre	SNNP
204	TURGA HEALTH POST	Health post	SNNP
205	AMETESEDU HEALTH CENTRE	Health post	SNNP
206	KEYESA HEALTH POST	Health post	SNNP
207	GOLE HEALTH POST	Health post	SNNP
208	ELE HEALTH POST	Health post	SNNP
209	NEKIRY HEALTH POST	Health post	SNNP
210	SHASHO HEALTH POST	Health post	SNNP
211	WERABE SHAMA HEALTH POST	Health post	SNNP
212	HASIE HARO HEALTH POST	Health post	SNNP
213	AWDA HEALTH POST	Health post	SNNP
214	YIRGALEM HOSPITAL	Referral/Specialized hospital	SNNP
215	HAWASA REFERRAL HOSPITAL	Referral/Specialized hospital	SNNP
216	DILLA UNIVERSITY REFERRAL HOSPITAL	Regional hospital	SNNP
217	CHENCHA HOSPITAL	Rural hospital	SNNP
218	SAWAL HOSPITAL	Rural hospital	SNNP
219	GIDOLE DISTRICT HOSPITAL	Rural hospital	SNNP
220	DURAME HOSPITAL	Rural hospital	SNNP
221	ATAT HOSPITAL	Rural hospital	SNNP
222	TERCHA DISTRICT HOSPITAL	Rural hospital	SNNP
223	BONA DISTRICT HOSPITAL	Rural hospital	SNNP
224	ARBA MINCH HOSPITAL	Zonal hospital	SNNP
225	WOLAITA SODO HOSPITAL	Zonal hospital	SNNP
226	JINKA ZONAL HOSPITAL	Zonal hospital	SNNP
227	MIZAN AMAN GENERAL HOSPITAL	Zonal hospital	SNNP
228	BUTAJIRA ZONAL HOSPITAL	Zonal hospital	SNNP
229	AMBARE HEALTH CENTRE	Health centre	Somali
230	KEBRE BEYA HEALTH CENTRE	Health centre	Somali
231	KARA MARA HEALTH POST	Health post	Somali
232	JIJIGA KARAMARA HOSPITAL	Referral/Specialized hospital	Somali
233	MILLENIUM HOSPITAL	Regional hospital	Somali
235	KOREM HEALTH CENTRE	Health centre	Tigray
236	SAMARE HEALTH CENTRE	Health centre	Tigray
237	ADWA HEALTH CENTRE	Health centre	Tigray
238	AXUM HEATH CENTRE	Health centre	Tigray
239	MULU HEALTH CENTRE	Health centre	Tigray

No.	SDP Name	Type of Facility	Region
240	ADIGRAT HEALTH CENTRE	Health centre	Tigray
241	FEREWYIN HEALTH CENTRE	Health centre	Tigray
242	BIR SHEWS HEALTH CENTRE	Health centre	Tigray
243	MENKERE HEALTH POST	Health post	Tigray
244	MYDELE HEALTH POST	Health post	Tigray
245	ADI MESANU HEALTH POST	Health post	Tigray
246	DEBANO HEALTH POST	Health post	Tigray
247	MAYE MESANU HEALTH POST	Health post	Tigray
248	ADWA HOSPITAL	Regional hospital	Tigray
249	ALAMATA DISTRICT HOSPITAL	Rural hospital	Tigray
250	WUKRO HOSPITAL	Rural hospital	Tigray
251	QUIHA HOSPITAL	Rural hospital	Tigray
252	MEAREG HOSPITAL	Rural hospital	Tigray
253	MEKELE HOSPITAL	Zonal hospital	Tigray
254	LEMLEM KARL HOSPITAL	Zonal hospital	Tigray
255	ADIGRAT ZONAL HOSPITAL	Zonal hospital	Tigray

Annex C: Percentage distribution of service delivery points with modern contraceptive methods in stock at the time of the survey, October 2010

Disaggregation	Percentage of modern contraceptive method in stock at the time of the survey								
	Male condom	Oral pills	IUCD	Implant	Injectable	Female condom	Male sterilization	Female sterilization	Total (n)
Type of Facility									
Primary (<i>Health post and health centre</i>)	93.5	97.6	42.0	72.2	95.9	4.7	3.0	3.0	169
Secondary (<i>rural, zonal, regional hospitals</i>)	96.7	96.7	75.4	82.0	95.1	4.9	41.0	54.1	63
Tertiary (<i>Referral/Specialized hospitals</i>)	91.3	95.7	100.0	82.6	100.0	8.7	60.9	73.9	23
Region									
Tigray	100.0	100.0	47.6	65.2	100.0	0.0	9.5	19.0	21
Afar	100.0	100.0	60.0	60.0	80.0	0.0	20.0	20.0	5
Amhara	100.0	98.0	49.0	74.5	100.0	7.8	13.7	15.7	51
Oromia	93.7	100.0	57.0	72.2	93.7	7.6	19.0	21.5	80
Somali	80.0	100.0	40.0	60.0	100.0	20.0	0.0	0.0	5
Benshangul Gumuz	100.0	83.3	33.3	83.3	100.0	0.0	33.3	33.3	6
SNNP	93.6	91.5	40.4	72.3	100.0	4.3	14.9	21.3	48
Gambella	100.0	100.0	33.3	33.3	66.7	0.0	33.3	33.3	3
Harari	100.0	100.0	100.0	80.0	100.0	0.0	40.0	40.0	5
Addis Ababa	82.1	96.4	92.9	82.1	89.3	0.0	25.0	35.7	28
Dire Dawa	66.7	100.0	66.7	100.0	100.0	0.0	0.0	0.0	3
Residence									
Urban	95.5	97.8	72.1	86.0	95.5	5.6	23.5	29.6	179
Rural	90.5	95.9	14.9	50.0	97.3	4.1	2.7	2.7	76
Management									
Government	94.6	97.5	54.6	76.3	97.1	5.4	16.3	20.0	240
NGO	77.8	88.9	66.7	44.4	77.8	0.0	22.2	44.4	9
Private	100.0	100.0	75.0	100.0	75.0	0.0	75.0	75.0	6
Distance from nearest warehouse/ source of supplies (in Km)									
0-4	95.1	92.7	63.4	85.4	92.7	2.4	12.2	17.1	41
5-9	85.7	96.4	39.3	60.7	100.0	7.1	17.9	21.4	28
10-14	77.3	100.0	54.5	68.2	100.0	0.0	22.7	27.3	22
15-19	86.7	93.3	26.7	53.3	93.3	0.0	6.7	6.7	15
20-24	100.0	100.0	54.5	63.6	90.9	0.0	0.0	9.1	11
25-29	100.0	100.0	33.3	33.3	100.0	0.0	0.0	0.0	3
30-34	100.0	100.0	60.0	80.0	100.0	10.0	0.0	10.0	10
35-39	100.0	100.0	50.0	66.7	83.3	0.0	16.7	16.7	6
40-45	100.0	100.0	0.0	0.0	100.0	0.0	0.0	0.0	1
45-49	100.0	100.0	40.0	80.0	80.0	0.0	20.0	20.0	5
50 and over	98.2	98.2	62.2	82.9	97.3	8.1	23.4	27.9	113
Total	94.1	97.2	55.6	75.4	96.4	5.2	17.5	21.8	255

Annex D: Percentage distribution of service delivery points with no stock out of any modern contraceptive method in the last six months, October, 2010

Disaggregation	No stock out of any modern contraceptive method in the last six months							
	Male Condoms	Female Condoms	Oral Pills	Injectables	IUDs	Implants	Sterilization for Females	Sterilization for Males
Type of Facility								
Primary (<i>Health post and health centre</i>)	84.6	5.4	94.1	89.3	46.2	74.0	7.8	6.0
Secondary (<i>rural, zonal, regional hospitals</i>)	95.1	8.2	91.8	85.2	73.8	75.4	50.8	41.0
Tertiary (<i>Referral/Specialized hospitals</i>)	91.3	13.0	100	89.3	95.7	82.6	73.9	60.9
Region								
Tigray	85.7	4.8	100	85.7	38.1	85.7	19.0	9.5
Afar	80.0	0.0	100	20.0	60.0	60.0	40.0	20.0
Amhara	92.2	7.8	92.2	96.1	47.1	74.5	13.7	11.8
Oromia	89.9	7.6	94.9	88.6	58.2	73.4	26.9	22.8
Somali	80.0	40.0	100	100	40.0	60.0	20.0	20.0
Benshangul Gumuz	100	0.0	83.3	100	50.0	83.3	33.3	33.3
SNNP	89.4	8.7	89.4	91.5	53.2	74.5	23.9	19.6
Gambella	100	0.0	100	66.7	33.3	33.3	33.3	33.3
Harari	100	0.0	100	100	100	80.0	40.0	40.0
Addis Ababa	71.4	0.0	96.4	85.7	92.9	78.6	35.7	25.0
Dire Dawa	66.7	0.0	100	100	66.7	100	0.0	0.0
Residence								
Urban	88.8	7.8	94.4	88.8	72.6	83.8	31.5	24.6
Rural	85.1	4.1	93.2	90.5	20.3	54.1	6.8	6.8
Management								
Government	88.3	7.1	94.2	90.0	56.7	75.8	22.3	18.0
NGO	0.0	0.0	100	75.0	75.0	100	100	100
Others	37.3	0.0	88.9	77.8	66.7	44.4	44.4	22.2
Distance from nearest warehouse/source of supplies (in Km))								
0-4	90.2	4.9	90.2	87.8	63.4	82.9	19.5	12.2
5-9	82.1	0.0	96.4	96.4	42.9	57.1	25.9	18.5
10-14	68.2	0.0	95.5	100	54.5	72.7	27.3	22.7
15-19	80.0	0.0	93.3	80.0	26.7	53.3	6.7	6.7
20-24	90.9	0.0	72.7	81.8	72.7	81.8	9.1	9.1
25-29	100	0.0	100	100	33.3	33.3	33.3	33.3
30-34	90.0	10.0	100	90.0	60.0	90.0	10.0	0.0
35-39	100	0.0	83.3	83.3	50.0	66.7	33.3	33.3
40-45	100	0.0	100	100	0.0	0.0	0.0	0.0
45-49	80.0	0.0	100	80.0	40.0	80.0	20.0	20.0
50 and over	91.9	12.6	96.4	88.3	64.0	80.2	30.0	25.2
Total	87.7	6.7	94.1	89.3	57.3	75.1	24.3	19.4