



Situation Analysis of Children and Women: Oromia Region

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This briefing note covers several issues related to child well-being in Oromia Regional State. It builds on existing research and the inputs of UNICEF Ethiopia sections and partners.¹ It follows the structure of the Template Outline for Regional Situation Analyses.

¹Most of the data included in this briefing note comes from the Ethiopia Demographic and Health Survey (EDHS), Household Consumption and Expenditure Survey (HCES), Education Statistics Annual Abstract (ESAA) and Welfare Monitoring Survey (WMS) so that a valid comparison can be made with the other regions of Ethiopia.

1 THE DEVELOPMENT CONTEXT

Oromia is the largest region in Ethiopia in terms of land mass and population.² It occupies approximately 34 per cent of the land in Ethiopia and accounts for 37 per cent of the population. In absolute numbers, this represents over 37 million people: 18,683,000 males and 18,584,000 females. The Oromia population is young: people between 0 and 5 years of age account for 15 per cent of the population (51 per cent male and 49 per cent female),³ while under 18 years of age account for 54 per cent of the population (51 per cent male and 49 per cent female).⁴ The fertility rate in Oromia is higher than the national average, with a total fertility rate of 5.4 (age 15-49 years) compared to the national rate of 4.6.⁵ Oromia is well positioned for a demographic dividend if fertility continues to decline and the current large youth population is able to find productive employment. The average household size in Oromia is large, at 5.2 people per household compared to the national average of 4.8 people per household.⁶ The dependency ratio is high (97 per cent) and most dependents come from the lower end of the age distribution.⁷

Table 1: Total population, Ethiopia and Oromia region, 2019. Source: Population Projections for Ethiopia 2007-2037, CSA (2013)

Year	Total population	Under 18 (%)	Under 5 (%)
EFY 2011 (2018/2019)	37,267,000 (37.8)	17,903,675 (48.0)	5,444,995 (14.6)

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Oromia has diverse agro-ecological zones. The highland areas are characterized by sedentary rain-fed agriculture and livestock production, while the lowlands are largely inhabited by pastoralist communities who depend on livestock production. In 2019, 84 per cent of the population lived in rural areas.⁸ The region is divided into 20 administrative zones, 30 town administrations, 287 rural and 46 town *woredas* (districts).⁹ Oromia has experienced high and sustainable economic growth, which is mostly attributable to growth in the agricultural sector. There are limited off-farm job opportunities in the region, especially for youth.

2. To illustrate, Oromia region is almost the size of Italy; almost 300,000 square kilometres.

3. 2017 projection based on the 2007 Census; Central Statistical Agency (CSA).

4. Ibid.

5. EDHS 2016, p. 84.

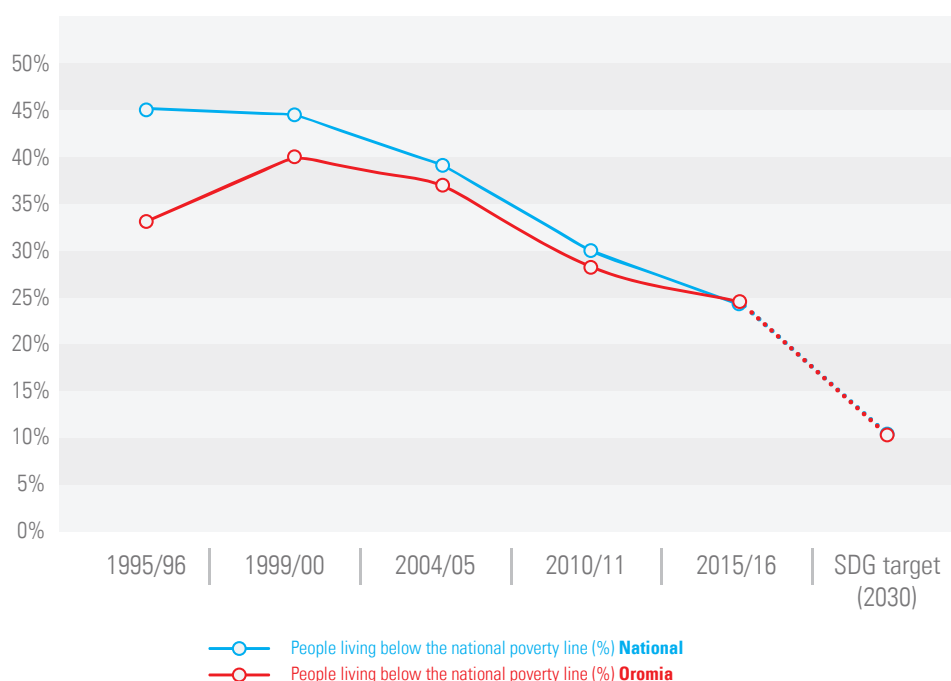
6. CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 8.

7. Ibid.

2 POVERTY, DEPRIVATION AND VULNERABILITY

According to the World Bank, Oromia has experienced both good agricultural growth and positive effects from the Productive Safety Net Programme (PSNP), which has resulted in poverty reduction. The implementation of broad and pro-poor economic social development policies and strategies has also contributed to an increased per capita income.¹⁰ The region saw a 16 per cent decline in monetary poverty between 2004/05 and 2015/16 (Figure 1 and Table 2).¹¹ The latest poverty analysis study found that the poverty headcount ratio in Oromia was 23.9 per cent, just above the national average of 23.5 per cent.¹² The rural/urban divide is 25 per cent versus 15 per cent, respectively. Oromia region saw the steepest decline of food poverty in the country, from 33 per cent in 2010/11 to 21 per cent in 2015/16.¹³

Figure 1: Trends in poverty headcount from 1995/96 to 2015/16, Ethiopia and Oromia region. Source: HCES 1995/96, 1999/2000 and 2004/05, HCES 2010/11 and 2015/16



8. 2019 projection based on the 2007 Census; CSA.

9. UNICEF ECO, Strategy Note Oromia 2018-2020, Dec. 2017.

10. World Bank, Ethiopia - Poverty Assessment 2014, 2015.

11. Federal Democratic Republic of Ethiopia (FDRE), National Planning Commission, Ethiopia's Progress Towards Eradicating Poverty: An Interim Report on 2015/16 Poverty Analysis Study, 2017, p. 21.

12. Ibid.

13. Ibid., p. 22

Table 2: Trends in monetary and food poverty, Ethiopia and Oromia region, 1995/96–2015/16

Poverty	HCES	1995/96	1999/00	2004/05	2010/11	2015/16	SDG target (2030)
People living below the national poverty line (%)	National	45.5	44.2	38.7	29.6	23.5	11.8
	Oromia	34	39.9	37	28.7	23.9	12
People living below the food poverty line (%)	National	49.5	41.9	38	33.6	24.8	12.4
	Oromia	41.9	38	36.9	33.1	20.5	10.3

“Like most other regions in Ethiopia, the multi-dimensional child deprivation (MCD) rate is high in Oromia...”

Like most other regions in Ethiopia, the multi-dimensional child deprivation (MCD) rate is high in Oromia: 90 per cent of children under 18 years, or nearly 15 million in absolute numbers, are deprived of fulfilment of an average of 4.5 basic needs, services and rights (Figure 2). Due to the high MCD incidence, deprivation intensity and large child population, Oromia’s contribution to the adjusted MCD index (M0) in Ethiopia is the highest across all regions, at 43 per cent. The MCD rate among children under 5 years (92 per cent) is higher than the national average (89 per cent), as is that of children aged 5-17 years (89 per cent compared to 87 per cent, respectively). Between 2011 and 2016, the MCD rate decreased slightly, from 94 per cent to 90 per cent respectively, deprivation intensity decreased from an average of 4.8 to 4.5 out of 6 dimensions, and the adjusted MCD index decreased from 0.74 to 0.67 (Table 3).

Figure 2: Rate of MCD (3 to 6 deprivations) in Ethiopia by region, 2016. Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018

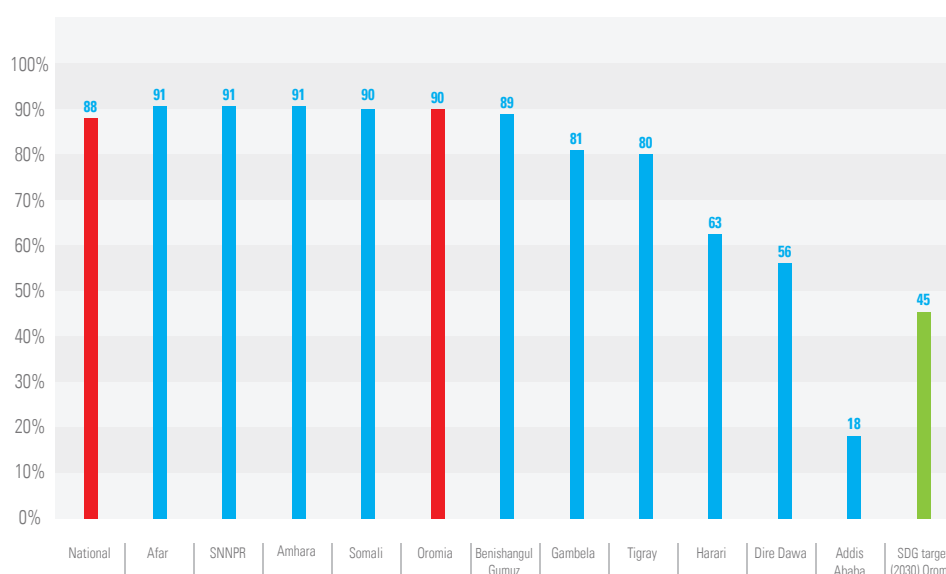
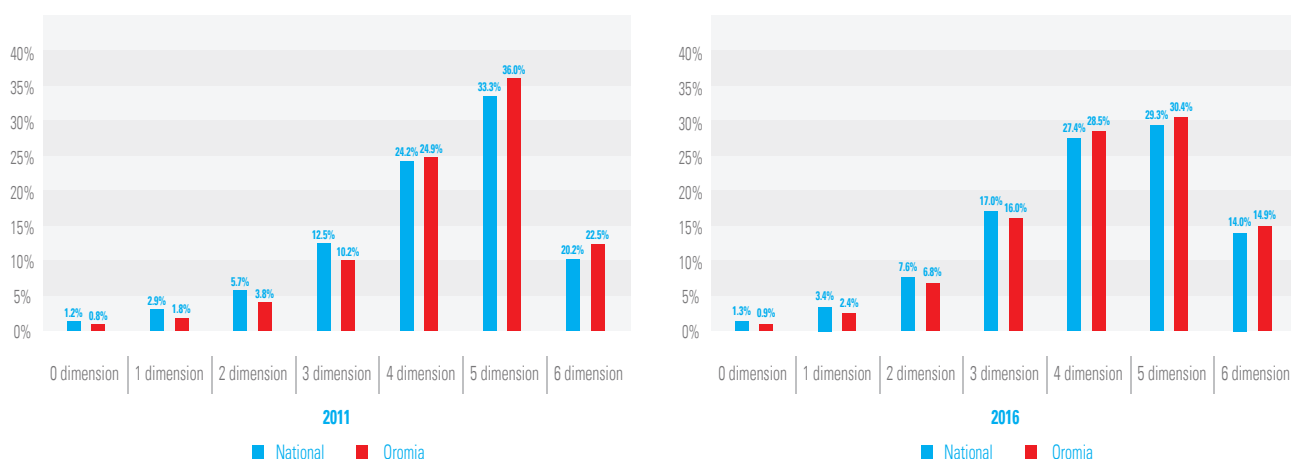


Table 3: Trends in multi-dimensional child poverty, 2011 and 2016, Ethiopia and Oromia region. Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018

MCD estimates in Ethiopia and Oromia using EDHS 2016 and 2011	MCD indices	MCD rate (H)		Average deprivation intensity		Adjusted MCD Index (M_0)	
	EDHS (year)	2011 (%)	2016 (%)	2011	2016	2011	2016
Children under 5 years deprived in 3-6 dimensions	National	94	89	4.7	4.5	0.73	0.66
	Oromia	97	92	4.8	4.5	0.77	0.7
Children aged 5-17 years deprived in 3-6 dimensions	National	89	87	4.7	4.5	0.69	0.65
	Oromia	92	89	4.7	4.5	0.73	0.66
Children under 18 years deprived in 3-6 dimensions	National	90	88	4.7	4.5	0.7	0.65
	Oromia	94	90	4.8	4.5	0.74	0.67

Children in Oromia are more likely to be deprived of more basic needs and services than the national average. Analysis of deprivation count and deprivation distribution shows that fewer than 1 per cent of children under 18 years in Oromia are not deprived in any of the six dimensions of deprivation analysed, while the national average is 1.3 per cent. The difference is larger for a higher number of deprivations: 45 per cent of children under 18 in Oromia are deprived of five to six dimensions, while this figure for Ethiopia is 43 per cent on average (Figure 3).

Figure 3: Deprivation count and distribution, children under 18, Ethiopia and Oromia region, 2011 (left) and 2016 (right). Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018



“**The largest contributors to MCD in Oromia among all children are deprivation in housing (90 per cent) and sanitation (93 per cent).**”

The largest contributors to MCD in Oromia among all children are deprivation in housing (90 per cent) and sanitation (93 per cent). Among children under 5, deprivation in health (79 per cent) is the third largest driver of MCD, while among 5- to 17-year-olds deprivation in health-related knowledge is 72 per cent (Table 4).

Table 4: Deprivation rates across dimensions of deprivation, by age group. Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018

MCD	Single dimension deprivation rates, Ethiopia and Oromia region, EDHS 2016 estimates						
Children under 5 years (%)	Dimensions	Development (stunting)	Health	Nutrition	Water	Sanitation	Housing
	National	38	68	73	59	90	90
	Oromia	36	79	75	59	94	92
Children aged 5-17 years (%)	Dimensions	Education	Health-related knowledge	Information and participation	Water	Sanitation	Water
	National	50	69	66	56	89	88
	Oromia	56	72	64	53	93	90
Children under 18 years (%)	Dimensions	Water	Sanitation	Housing			
	National	57	89	89			
	Oromia	55	93	90			

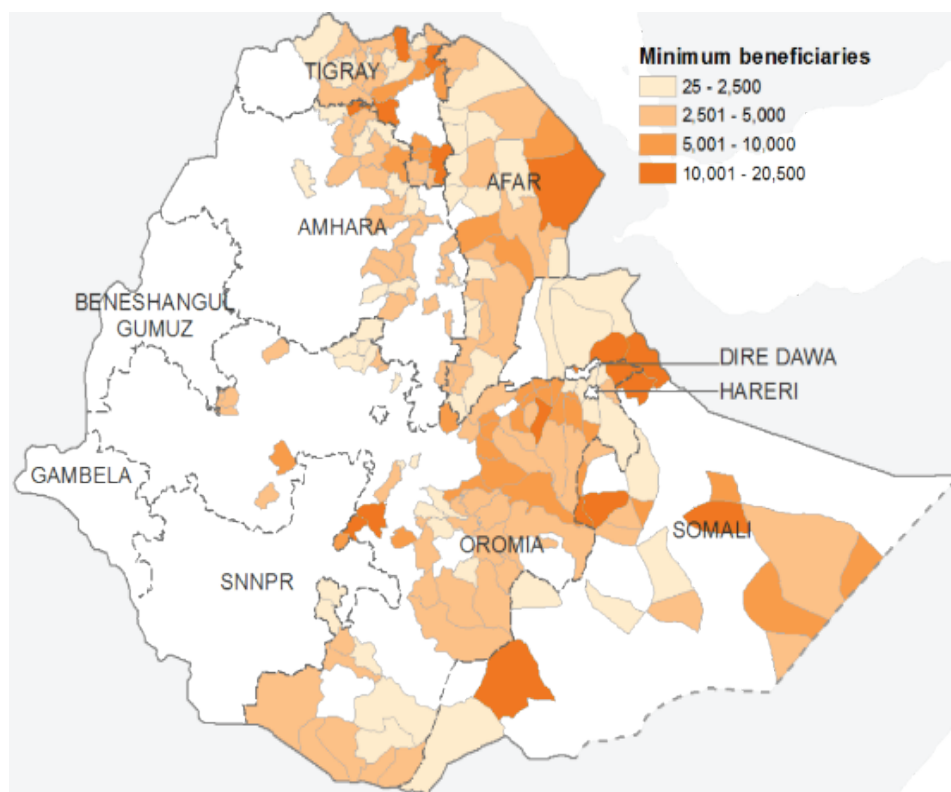
The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) assessed that in Oromia region, most repeated beneficiaries of relief food - relief food needs of at least nine times between 2013 and 2018 - rely on crop farming for their livelihood (a minimum of 251,597 beneficiaries). In second place are beneficiaries with an agro-pastoral livelihood system (a minimum of 55,227 repeated beneficiaries). Third are beneficiaries whose livelihood system is pastoral (a minimum of 37,065 repeated beneficiaries). In absolute numbers, Oromia region has the most repeated beneficiaries in Ethiopia (Figure 4).¹⁴ Especially between 2016 and 2018, the number of relief food beneficiaries was very high due to extreme droughts (1,273,899 beneficiaries).¹⁵ As of March 2019, the region hosts 859,313 internally displaced persons (IDPs) due to climatic shocks and conflicts (see Section 10). This puts additional pressure on the food security situation of host communities.¹⁶

14. UNOCHA, HRD Relief Food Beneficiary Analysis (2013-2018).

15. Ibid.

16. International Organization for Migration (IOM) Displacement Tracking Matrix (DTM) Round 15, March 2019.

Figure 4: Woredas with relief food needs at least nine times between 2013 and 2018. Source: UNOCHA, HRD Relief Food Beneficiary Analysis (2013-2018)

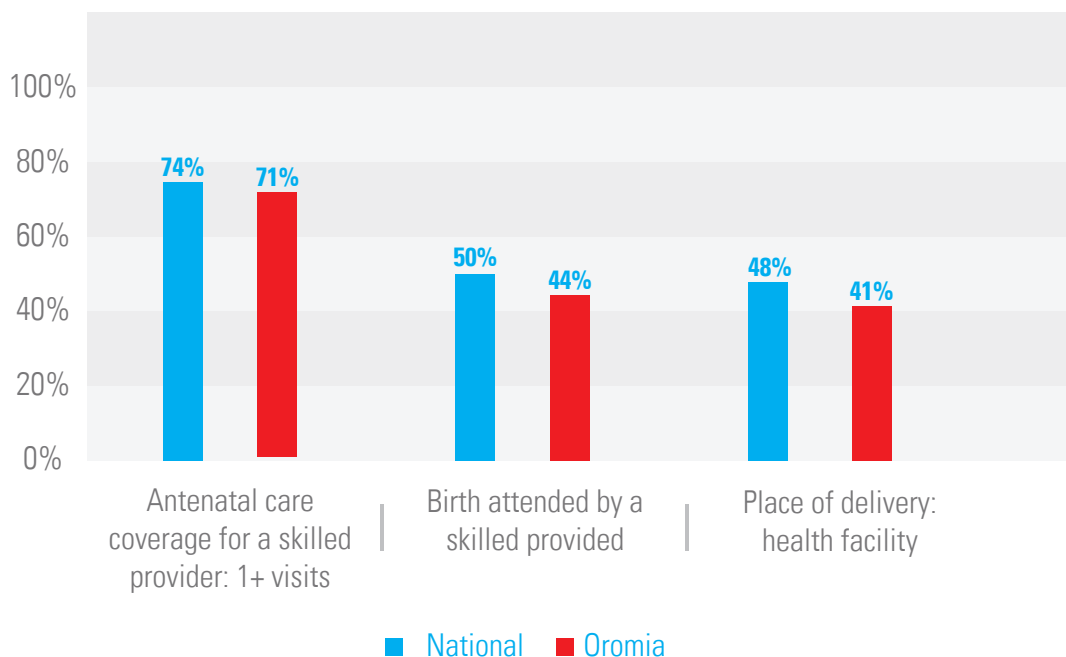


3 NUTRITION, HEALTH AND SURVIVAL

3.1 Health

While recognizing a positive trend, Oromia is still underperforming when it comes to maternal and child health outcomes (Figure 5). The rate of pregnant women who gave birth in the five years preceding the survey and received antenatal care from a skilled health provider during their pregnancy was 71 per cent, the fourth lowest rate in Ethiopia. Only 44 per cent of births are assisted by a skilled attendant (doctor or midwife), and 56 per cent of women give birth without any assistance during delivery. Oromia has the third lowest rates for women giving birth in a health facility (41 per cent) despite some improvements in availability of emergency obstetric and newborn care (EmONC) (percentage of minimum recommended EmONC facilities) from a baseline of 8 per cent in 2008 to 32 per cent in 2016.¹⁷ Likewise, the 2016 EDHS finds that the proportion of women receiving postnatal care within two days of delivery is the lowest of all regions in the country (9 per cent).

Figure 5: Maternal healthcare in Ethiopia and Oromia region. Source: EDHS 2019



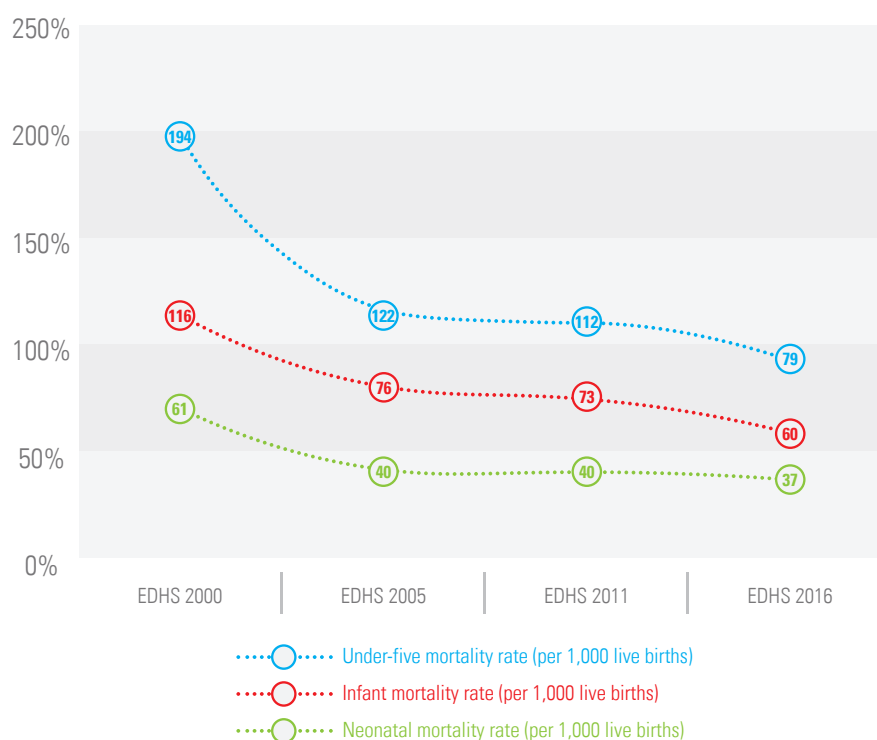
17. Regional Health Bureau, 2016, EmONC assessment. Note that the EmONC assessment reported 77 per cent of women delivering in a health facility in 2016.



Child mortality in Oromia is declining, but remains high (Figure 6). Neonatal mortality, particularly, showed very little decline between 2005 and 2016. The high rate of under-five mortality, at 79 per 1,000 live births, highlights serious issues with access to and availability of basic maternal and child health, and nutritional services, among others.¹⁸ For future improvement in reducing the under-five mortality rate, the focus should be on increasing coverage of maternal healthcare services, and improvements in health and nutritional outcomes and WASH indicators among children under 5 years of age. One positive step is the facility-based Newborn Corner and Neonatal Intensive Care Unit (NBC & NICU) programme, which is now running in all

public hospitals across the country. This programme has contributed to improving access to and coverage of essential newborn care, neonatal resuscitation and Level II NICU services. However, newborn mortality rates are still high; there is low utilization of maternal, newborn and child health (MNCH) services along the continuum of care; the quality of MNCH services is poor; and there is inequity in service utilization and reduction of neonatal, infant and under-five mortality within the region. Only 30 per cent of children between 12 and 23 months are fully immunized (Table 6). Since 2015, outbreaks of acute watery diarrhoea, measles and scabies have been among the top health emergencies.¹⁹

Figure 6: Trends in early childhood mortality rates in Oromia region, Ethiopia (deaths per 1,000 births in the 10 years preceding the survey). Source: EDHS 2000, 2005, 2011 and 2016



18. 2017 projection based on the 2007 Census; CSA.

19. UNICEF ECO, Strategy Note Oromia, 2018-2020, Dec. 2017.

Table 5: Trends in child survival and maternal health indicators, Ethiopia and Oromia region, 2000-2019

Maternal health	EDHS	2000	2005	2011	2016	2019	SDG target 2030
Antenatal care coverage from a skilled provider*: 1+ visits (%)	National	26.7	27.6	33.9	62.4	73.6	100
	Oromia	27	24.8	31.3	50.7	70.8	100
Skilled attendance during delivery (%)*	National	5.6	5.7	10	27.7	49.8	100
	Oromia	4.9	4.8	8.1	19.7	43.7	100
Child mortality	EDHS	2000	2005	2011	2016		SDG target 2030
Under-five mortality rate (per 1,000 live births)**	National	166	123	88	67		<25
	Oromia	194	122	112	79		<25
Infant mortality rate (per 1,000 live births)**	National	97	77	59	48		N/A
	Oromia	116	76	73	60		N/A

*Among mothers who had a live birth in the five years preceding the survey. According to the EDHS 2016, skilled providers include doctors, nurses, midwives, health officers and health extension workers. The EDHS 2000, 2005 and 2011 defines a skilled provider as “doctors, nurses and midwives”.

** National figure is five years average, and regional figure is 10 years average.

Major challenges to maternal and child health in Oromia include a shortage of skilled health care professionals, including midwives, poor practices among health staff, low utilization of public health facilities, irregular supply of drugs and equipment, an absence of electricity and water in facilities, a weak referral system at health centre level, a lack of awareness of the importance of skilled care, cultural norms, including harmful practices and gender inequality, insufficient health care facilities close to the population/unavailability of services in some geographical areas, and financial or other barriers that prevent households from accessing services (transport to a facility, money for treatment, etc.). Moreover, Oromia has experienced various emergencies, conflicts, disease outbreaks and droughts since 2015. Many Oromos are displaced, including children (Section 10). These emergencies have heavily impacted the availability, accessibility and quality of health services.

“The implementation of the Health Extension Programme (HEP) has been slow in the pastoralist areas of Oromia; there are 33 pastoral and agro-pastoral woredas in six zones in the region.”²⁰

The implementation of the Health Extension Programme (HEP) has been slow in the pastoralist areas of Oromia; there are 33 pastoral and agro-pastoral woredas in six zones in the region.²⁰ Importantly, the Federal Ministry of Health (FMOH) has developed a detailed and well-written strategy to optimize the HEP in pastoralist areas, including the Oromia region. This strategy underlines the importance of exploring and using existing formal and informal social capital networks/platforms in pastoralist communities, such as the Geda system.²¹ The FMOH recognizes the need to develop resilient strategies to respond to Ethiopia’s recurrent emergencies and to reduce national inequity.

20. Bale, Borana, Guji, West Hararghe, East Hararghe and East Shewa.

21. Federal Ministry of Health, HSTP 2015/16–2019/20. Mid-Term Review (VOL. I). Comprehensive Report. DRAFT REPORT, 2018, p. 34.

In response to the general low motivation and high turnover of health extension workers due to low remuneration and lack of career structure, the regional government of Oromia developed successful human resource management practices in health care services. It created and implemented a new system to motivate and retain health workers by grouping health facilities into three categories, depending on the location and quality of the facility. Workers placed in more remote, low-quality facilities are given improved access to training opportunities and career advancement, as well as higher top-up pay.²² The mid-term review of the Health Sector Transformation Plan 2015/16-2019/20 (HSTP) stated that the Oromia system should serve as a best practice example for other regions in Ethiopia.²³

3.2 Nutrition



“The EDHS 2016 showed that 28 per cent of child deaths were associated with under-nutrition.”

The EDHS 2016 showed that 28 per cent of child deaths were associated with under-nutrition. The high prevalence of various forms of malnutrition among vulnerable groups has serious implications for social development and economic growth. In Oromia, 36 per cent of children under 5 are stunted; 5 per cent are wasted; and 16 per cent are underweight in 2019. While there was a downward trend in the proportion of stunted and underweight children over the five EDHS surveys (Table 6 and Figure 7), the rate is still very high. The rate of wasting (acute malnutrition) increased from 9.7 per cent in 2011 to 10.6 per cent in 2016. Stunting in rural areas is significantly higher than in urban areas: at the national level it is 41 per cent versus 26 per cent in 2019, respectively. Children of lower socio-economic status are particularly affected by stunting.

The EDHS 2019 showed that children in the lowest wealth quintile were more likely to be stunted (42 per cent at the national level) than children in the highest wealth quintile (24 per cent at the national level). Stunting is also associated with mother’s educational attainment. Children of mothers with no education are more than two times more likely to be stunted than those whose mothers have completed secondary or higher education.²⁴ The prevalence of anaemia — a proxy indicator for iron deficiency — among children under 5 is concerning and has been increasing since 2005. The rate is 66 per cent versus a national average of 57 per cent.

²² Ibid., pp. 70 and 72.

²³ Ibid.

²⁴ EDHS 2019

Figure 7: Under-five child under-nutrition in Oromia region 2000-2019. Source: EDHS 2000, 2005, 2011, 2016 and 2019

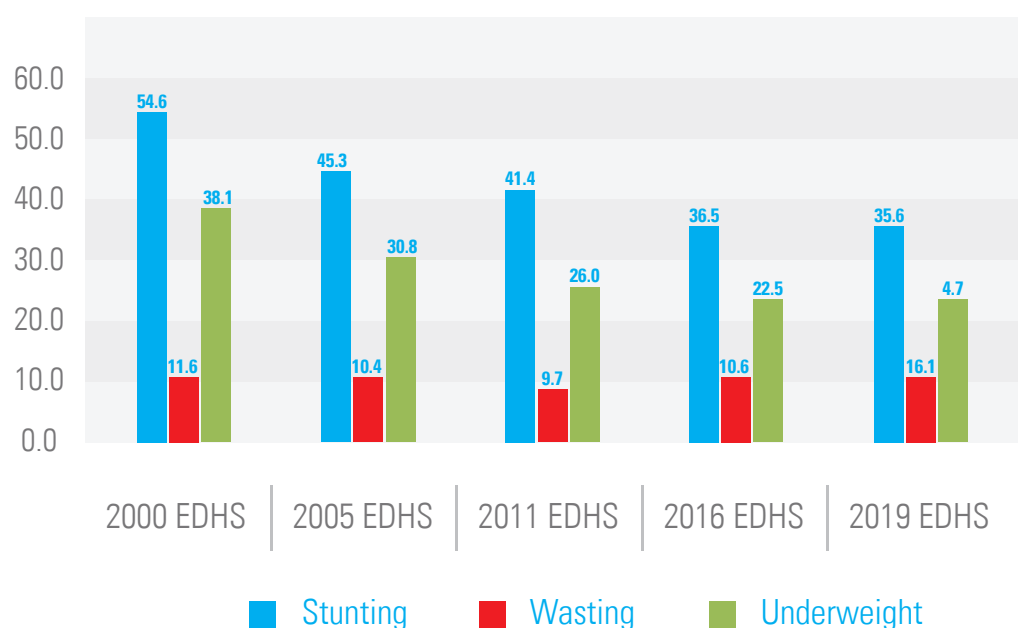


Table 6: Trends in child nutrition and health indicators, Ethiopia and Oromia region, 2000-2019

Child nutrition and health	EDHS	2000 (%)	2005 (%)	2011 (%)	2016 (%)	2019 (%)	SDG target 2030/Global targets 2025 (%)
Full immunization (12-23 months)	National	14.3	20.4	24.3	38.5	43.1	100
	Oromia	9.8	20.2	15.6	24.7	29.9	100
Stunting prevalence (under 5) ***	National	57.8	51.5	44.4	38.4	36.8	22.1
	Oromia	54.6	45.3	41.4	36.5	35.6	21.4
Wasting prevalence (under 5) ***	National	12.9	12.4	9.7	9.9	7.2	<5
	Oromia	11.6	10.4	9.7	10.6	4.7	<5
Underweight prevalence (under 5) ***	National	42.1	34.9	28.7	23.6	21.1	N/A
	Oromia	38.1	30.8	26	22.5	16.1	N/A
Prevalence of anaemia (6-59 months)	National	N/A	53.5	44.2	56.9		N/A
	Oromia	N/A	56	51.7	65.5		N/A

*** Converted to WHO standards

Only 55 per cent of infants under 6 months are exclusively breastfed²⁵, and 77 per cent started breastfeeding within one hour of birth. Only 9 per cent of children aged 6-23 months meet the minimum acceptable dietary standards, 18 per cent of children have an adequately diverse diet, 27 per cent of children have iron-rich food and 42 per cent have Vitamin A-rich food. About 38 per cent of children aged 6-59 months received a Vitamin A supplement over the six months preceding the EDHS. About 30 per cent of pregnant women receive iron folic acid during ANC and nearly 3 per cent receive it for more than 90 days.²⁶

“ Poor availability of and access to diverse foods, lack of access to fortified food and poor awareness of the importance of a diversified diet (cultural/knowledge) are among the major contributors to the high stunting rate. ”

Poor availability of and access to diverse foods, lack of access to fortified food and poor awareness of the importance of a diversified diet (cultural/knowledge) are among the major contributors to the high stunting rate. Thirty-five per cent of households are food insecure and are repeatedly stricken by high rates of malnutrition due to their increased vulnerability.²⁷ Limited access to basic sanitation and poor hygienic practices lead to childhood diseases, such as diarrhoea. Coupled with poor access to treatment, this significantly contributes to malnutrition. Other socio-economic and political processes contributing to under-nutrition include widespread poverty, limited employment opportunities, poor infrastructure, high population pressure, low education levels, inadequate access to clean water and sanitation, high rates of internal displacement and poor access to health services.²⁸

Existing multi-sectoral coordination to reduce stunting is still premature. Coordination is weak due to a lack of awareness, frequent turnover of focal persons and management, lack of accountability and responsibility, and lack of nutrition structures in each of the signatory sectors. The nutrition information system is also weak at capturing, analysing and using data for decisions.

Improvements in nutritional and health outcomes for children under 5 years to increase their chances of survival require a multi-sectoral approach and interventions. Deprivation overlap analysis shows that 58 per cent of children under 5 years are simultaneously deprived of nutrition, basic health services and adequate sanitation. An additional 16 per cent are deprived of both health and sanitation, and 12 per cent are deprived of nutrition and sanitation, whereas less than 1 per cent are not deprived in either of these three dimensions. Overlap between nutrition, health and water shows similar results, with 40 per cent of children deprived of all three of these basic needs and services. Only 5 per cent of children under 5 are not deprived in either of these dimensions.

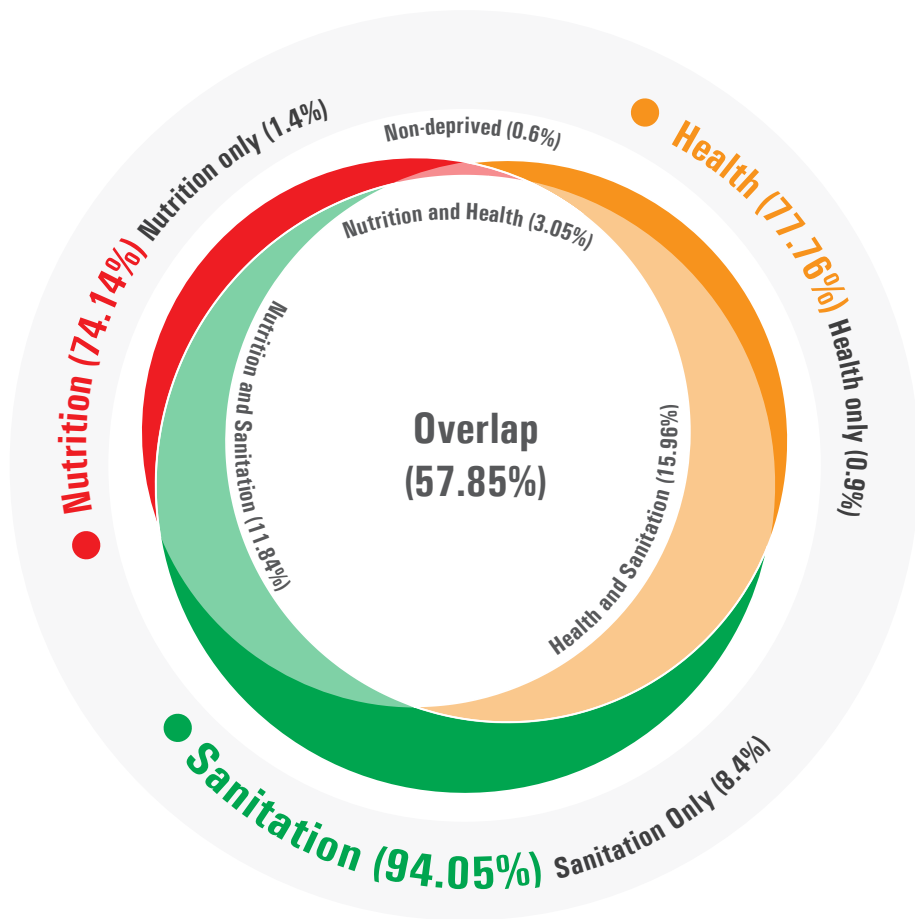
25. Disaggregated from EDHS 2016

26. EDHS 2016.

27. Nutrition Baseline Survey for NNP Report, 2009/10.

28. Ethiopia Situation Analysis for Transform Nutrition, Getahun 2001, Bhutta 2008.

Figure 8: Deprivation overlap between nutrition, health and sanitation, children under 5 years. Source: Calculations using MCD analysis and EDHS 2016 data



4 EARLY CHILDHOOD DEVELOPMENT AND EDUCATION

According to the Education Statistics Annual Abstract (ESAA) 2018/19, the gross enrolment ratio (GER) and the net enrolment ratio (NER) for pre-primary education in Oromia were low (29.4 per cent and 16.4 per cent, respectively) and far below the national average of 40.7 per cent and 23.9 per cent, respectively. However, these rates have increased significantly, with the GER for pre-primary education in Oromia nearly doubling since 2012/13.²⁹ Similarly, the 2018/19 GER and NER in Oromia primary schools showed an increasing trend (Table 7).

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It is a challenge to reach pastoralist children in Oromia. The regional government pays special attention to pastoralist areas and remote woredas, for example by providing hostels and introducing mobile schools. An alternative basic education system for pastoralist children is being implemented, and in 2017/18 there were 1,075 alternative basic education centres in the region. Despite regional policies and affirmative action to improve girls' participation in school, the Gender Parity Index (GPI) for Oromia primary schools was 0.86 compared to a national average of 0.9 in 2018/19. There is a noticeable downturn in the GPI, and this is even lower than it was one decade ago.³⁰ In 2018/19, the GER for secondary education in Oromia was 42 per cent for Grades 9 and 10, and 14 per cent for Grades 11 and 12. The NER for Grades 9 to 12 was very low, at 22.8 per cent, below the national average of 25.3 per cent. Gender parity in Oromia secondary schools, at 0.76, demonstrates that girls are left behind in secondary education.³¹

²⁹ Ministry of Education (MoE), Education Statistics Annual Abstract (ESAA), 2005 E.C. (2012/2013), p. 21, and MoE, ESAA, 2010 E.C. (2017/18).

³⁰ The GPI in primary schools was 0.88 in 2008/09 and 0.91 in 2012/13. MoE, ESAA, 2001 E.C. (2008/2009), and MoE, ESAA, E.C. (2012/2013).

³¹ MoE, ESAA, 2011 E.C. (2018/19), p. 51.

Figure 9: Deprivation overlap between nutrition, health and water, children under 5 years. Source: Calculations using MCD analysis and EDHS 2016 data

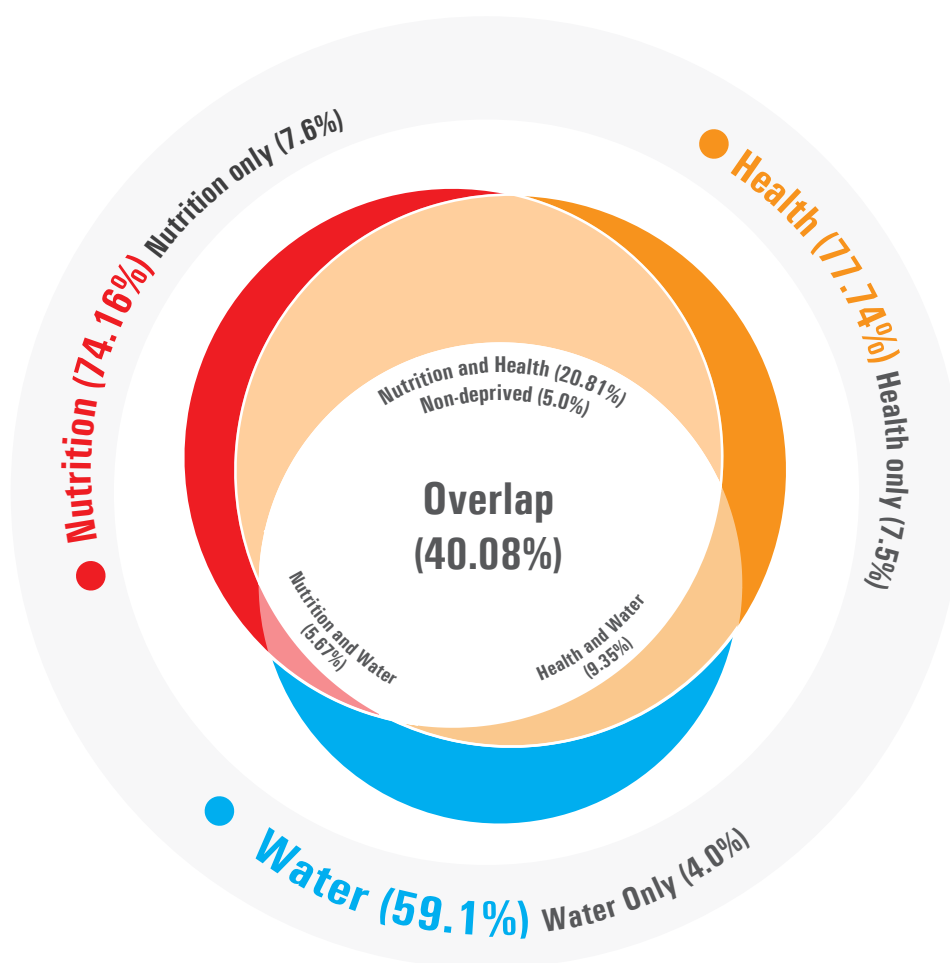
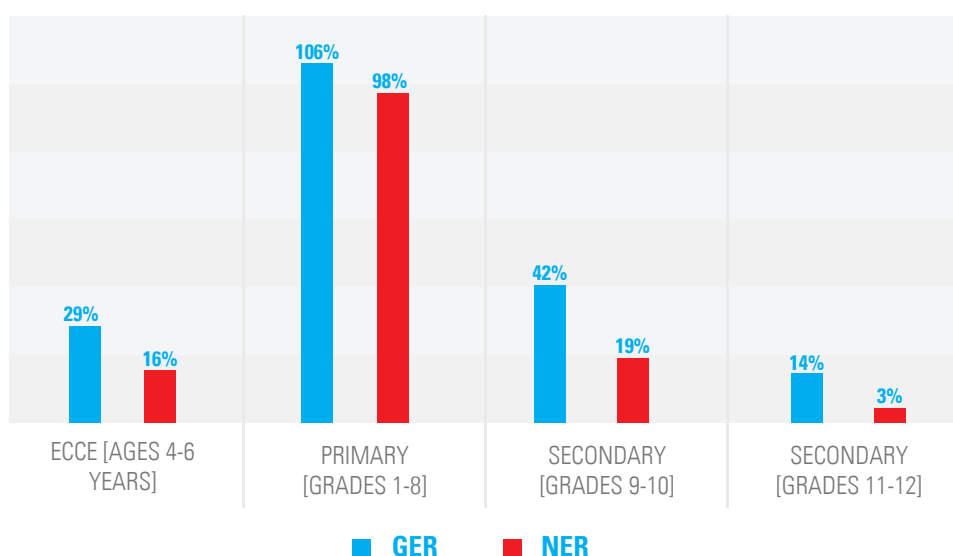


Table 7: Trends in GER and NER for primary education, Ethiopia and Oromia region, 2008/09-2018/19

Indicator	Region	ESAA 2008/09 (%)	ESAA 2010/11 (%)	ESAA 2012/13 (%)	ESAA 2018/19 (%)	SDG target 2030 (%)
Primary school gross enrolment rate (Grades 1-8)	National	94.4	96.4	95.3	104.6	100
	Oromia	88.9	-	91.2	106.2	100
Primary school net enrolment rate (Grades 1-8)	National	83	85.3	85.9	94.7	100
	Oromia	77.9	84.5	83.9	98.3	100
Indicator	MCD report			ESAA 2011 (%)	ESAA 2016 (%)	SDG target 2030 (%)
Delay in schooling (age 9-17 years) ³²	National			37.3	33.6	N/A
	Oromia			41.7	39.8	N/A
Illiteracy rate (age 15-17 years) ³³	National			45.2	45.5	0
	Oromia			49.8	47.6	0

Figure 10: GER and NER for early childhood care and education, primary and secondary education, Oromia region, 2017/18. Source: ESAA 2017/18



The survival rate to Grade 5 (the percentage of students who completed the first cycle of primary education) was 46 per cent in 2016/17. Only Afar region has a lower rate.³⁴ The ESAA has not published disaggregated survival rate in 2018/19. In 2017/18, the dropout rate was very high in primary schools in Oromia (20.3 per cent), higher than the national average 17.5 percent.³⁵ Incidence of delays in schooling is higher than the national average and shows only a slight improvement between 2011 and 2016. Forty per cent of children aged 9-17 years attended school with two or more years of delay, compared to the national average of 34 per cent in Ethiopia (Table 7).

Grade repetition and high dropout rates in Oromia region are particularly worrying, as they affect a huge number of children. Some of the causes include the high demand for child labour by rural households, child marriage, abduction of girls, the long distances to school, climate change (children on the move, internal migration), drought, internal and external conflicts resulting in displacement, resettlement, increased children in street situations, and poverty.

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In 2015/16, only 5 per cent of Grade 8 students failed their final exam (6 per cent girls and 5 per cent boys), which is a good result compared to the national average of 12 per cent.³⁸ However, illiteracy rates among secondary school age children indicate major issues with the quality of primary education in both Oromia region and nationally. In 2016, illiteracy in Oromia was 48 per cent compared to the national average of 46 per cent, showing meagre progress from 2011 (Table 7).

32. For children of primary school age (9-14 years), measured as a percentage of children attending school with 2+ years of delay. For children aged 15-17 years, measured as a percentage of children attending school with 3+ years of delay.
33. Child could not read or could read only parts of a sentence provided during the survey.
34. The regional rate is not published in ESAA, 2010 E.C. (2017/18).
35. MoE, ESAA, 2011 E.C. (2018/19), p. 33.
36. CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 13.
37. Ibid., 2017, p. 12.
38. MoE, ESAA, 2009 E.C. (2016/17), p. 70. The 2017/18 rates are not published in the ESAA.

5 WATER, SANITATION, HYGIENE (WASH) AND HOUSING

According to the 2016 EDHS, 63 per cent of households use improved drinking water sources in Oromia compared to the national average of 65 per cent.³⁹ At the national level, in rural areas 57 per cent of households use improved drinking water sources versus 97 per cent of urban households. About 17 per cent of water sources in Oromia are piped. In Oromia, 28 per cent of households spend more than 30 minutes bringing water to their houses compared to the national average of 32 per cent, showing progress in water infrastructure and the availability of water sources since 2011 (Table 8). As elsewhere in the country, women and girls are mostly responsible for fetching water.⁴⁰ The availability and sufficiency of drinking water is 76 per cent for both indicators.⁴¹

Despite efforts by the regional government and partners to carry out water supply projects, sustainability of water services is a concern. The non-functionality of water supply is high, especially with motorized schemes, because of depletion of ground water and over-use of schemes. This is due to the dry season, drought and the increased needs of the growing population and livestock.⁴² There is a lack of spare parts, poor design and maintenance, and insufficient post-construction support.⁴³

Table 8: Trends in improved drinking water sources, sanitation facilities and housing conditions, Ethiopia and Oromia region, 2005-2016. Source: Figures for time to the water source, housing and indoor pollution obtained from MCD estimates report

Indicator	Region	EDHS 2005 (%)	EDHS 2011 (%)	EDHS 2014 (%)	EDHS 2016 (%)	SDG target 2030 (%)
Households using improved drinking water sources	National	61.4	53.7	56.9	64.8	100
	Oromia	60.6	47.1	50.5	62.8	100
Time to water source 30+ minutes from the dwelling ⁴⁴	National		41.1		32.3	N/A
	Oromia		35.6		28	N/A
Households using improved sanitation facilities	National	6.8	8.3	4.2	6.3	100
	Oromia	5	5.9	3.7	5.6	100
Households with adequate housing ⁴⁵	National		2.9		12	100
	Oromia		2.7		10	100
Households exposed to indoor pollution from use of solid fuels for cooking inside the dwelling where there is no separate room used as a kitchen	National		49.2		31.4	0
	Oromia		39.9		33.2	0

³⁹ EDHS 2016. Note that a rate of 66 per cent was found in the CSA, Drinking Water Quality in Ethiopia: Results from the 2016 Ethiopia Socioeconomic Survey, 2017, p. 38.

⁴⁰ UNICEF, Integrated WASH/MUS/CBN Programme Baseline and Midline Survey Report, 2017, p. 37.

⁴¹ CSA, Drinking Water Quality in Ethiopia: Results from the 2016 Ethiopia Socioeconomic Survey, 2017, p. 18.

⁴² World Bank, Maintaining the Momentum while Addressing Service Quality and Equity: A Diagnostic of Water Supply, Sanitation, Hygiene and Poverty in Ethiopia. WASH Poverty Diagnostic, 2018, p. 30.

⁴³ Ibid.; UNICEF Development Research and Training, Report on KAP Baseline Survey on Water, Sanitation and Hygiene in Eight Regions of Ethiopia, 2017, p. 22.

⁴⁴ Necessary to reach the water source, fetch water, and return to the dwelling.

⁴⁵ Floor, exterior walls and roof of the dwelling where the child resides are made of durable and sustainable structures.

Inadequate water supply compounds limited awareness on hygiene and sanitation, and a lack improved toilet. These are key factors in low sanitation and hygiene coverage and are closely associated with children's nutritional, developmental and health outcomes.

Table 8 shows that the rate of households using improved sanitation facilities is improving at a very slow pace. The rate of households using an improved toilet facility that is not shared with other households is about 6 per cent for both Oromia and the Ethiopian average. Households in urban areas are more likely to have access to improved sanitation (20 per cent at the national level) compared to households in rural areas (3 per cent at the national level).

According to qualitative data from key informants at the woreda level for the 2017 UNICEF knowledge, attitudes and practices (KAP) study, lack of awareness and limited economic capacity are the main reasons that sanitation is given low priority, as households prioritize other basic needs.⁴⁶

According to qualitative data from key informants at the woreda level for the 2017 UNICEF knowledge, attitudes and practices (KAP) study, lack of awareness and limited economic capacity are the main reasons that sanitation is given low priority, as households prioritize other basic needs.⁴⁶ Open defecation is still rampant. According to the KAP study, 55 per cent of households in Oromia had indiscriminately disposed of human faeces in their compounds. Even though there is no culture that encourages open defecation, it has been practiced for a very long time and is considered normal. Findings from the qualitative research for the KAP study revealed that even families who have toilets practice open defecation during times when their toilets are not fully functional. Unavailability of public latrines aggravates open defecation, while in areas where they are available, poor maintenance discourages people from using them.⁴⁷ According to the 2016 EDHS, 51 per cent of households in Oromia have a place for washing hands (3 per cent fixed and 48 per cent mobile), which is under the national average of 60 per cent. Only 12 per cent of these households have water and soap.⁴⁸ One factor that hinders hand washing is people's limited knowledge about the critical times when hands should be washed. Only 11 per cent of women and 10 per cent of men in Oromia knew that hands should be washed before breastfeeding/feeding a child, while 13 per cent and 8 per cent of women and men, respectively, knew that hands needed to be washed after cleaning a child's bottom after defecation. Less than half, 44 per cent, of women and 48 per cent of men know that hands should be washed after defecation (UNICEF & DAB, 2017, p.34-45).

46. UNICEF, KAP Baseline Survey on Water, Sanitation and Hygiene in Eight Regions of Ethiopia, 2017, p. 25.

47. Ibid.

48. EDHS 2016, p. 23.

Regarding WASH facilities in schools, a lack of water supply and proper facilities for managing menstruation (e.g. a lack of separate toilets that offer privacy, unclean facilities, no means to dispose of used menstrual pads, and a lack of water to wash hands) coupled with a general lack of affordable menstrual pads, constitute major challenges for girls, particularly in rural areas and among pastoralist communities. The 2017 KAP study found that in Oromia 90 per cent of schools never had water available and 100 per cent of schools never had soap available. This impacts menstrual hygiene.⁴⁹ Girls sometimes miss school during menstruation.⁵⁰ Girls may even drop out of school entirely due to menstruation. Over the course of a year, the number of school days lost has a large impact and may hold girls back academically.⁵¹ There is a clear need for a gender-inclusive approach to improving WASH infrastructure in schools, to address school absenteeism, performance and completion.



Another challenge is the provision of WASH in health facilities. The lack of access to enough and reliable water sources limits the functionality of health facilities and reduces investments made in health infrastructure. This negatively affects the quality of health services and leads to poor hygiene. Investments in WASH need to be included in the design and budget of health facilities.

Ethiopia has a long history of environmental disasters resulting in humanitarian crises. In 2015/16 an El Niño-induced drought hit Ethiopia and was followed by the 2016/17 Indian Ocean Dipole (IOD)-induced drought.⁵² Dependency on good land and weather for agricultural and livestock production is a key vulnerability for

many households in Oromia.⁵³ Climatic shock is a major driver of vulnerability in children. This could also contribute to increased internal conflict between population groups, because of trans-boundary competition over resources; for example, disputes over grazing and arable land as well as water (see also Sections 8 and 10).⁵⁴ Building resilience in children requires a holistic approach to all development interventions. It requires the use of a 'resilience lens' across different sectors and systems, including WASH. Development programmes and interventions have already expanded to include resilience components, for example UNICEF supported the drilling of deep boreholes in Oromia to enable access to sustainable water supplies and to reduce reliance on water trucking. To address the chronic shortage of water in the lowland areas, the Ministry of Water, Irrigation and Electricity (MoWIE) developed a US\$ 5 billion sub-programme called, 'Development of sustainable water supply, sanitation and hygiene in drought-prone areas of Ethiopia'. This is now integrated under the ONE WASH National Programme (OWNP). The second phase of the OWNP has a strong focus on mainstreaming the concept of climate resilience across the sector.

49. UNICEF, KAP Baseline Survey on Water, Sanitation and Hygiene in Eight Regions of Ethiopia, 2017, p. 61.

50. University of North Carolina (UNC) Water Institute and UNICEF, Integrated WASH, MUS and CBN Programme in Amhara, Oromia, SNNPR and Tigray Regions: Baseline and Midline Report, 2017, p. 64 and 66.

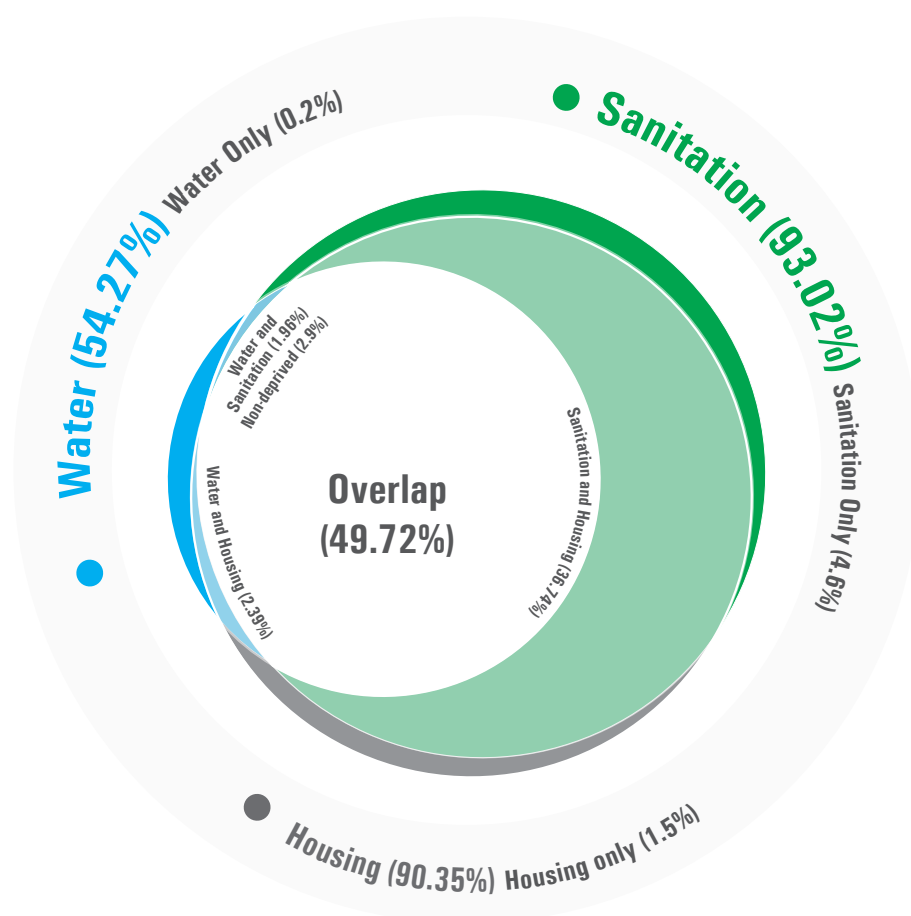
51. This also impacts social and economic opportunities.

52. UNICEF, Ethiopia's New Harmonized Nutrition Plan Saves Children's Lives: From famine to food and nutrition security, 2013, p. 1.

53. World Bank, Ethiopia - Poverty Assessment 2014, 2015, p. xix.

54. UNICEF Eastern and Southern Africa Region, Briefing Note on Climate Change in Eastern and Southern Africa, 2014, p. 1-6. See also Heidelberg Institute for International Conflict Research, Conflict Barometer 2017, p. 84.

Figure 11: Deprivation overlap between water, sanitation and housing, children under 18 years. Source: Calculated using MCD analysis and EDHS 2016 data



Children and adults are susceptible to other health risks in their homes, due to inadequate housing conditions and indoor pollution from the use of solid fuel for cooking inside the house. Only 10 per cent of households in Oromia region, compared to the national average of 12 per cent, live in dwellings constructed with adequate material that can protect them from adverse weather conditions and health and structural hazards. Progress in this area has been slow since 2011 (Table 8). In nearly one third of households in Oromia (33 per cent compared to 31 per cent at the national level) cooking is done inside the house with solid cooking fuel. This exposes children and adults to several health risks, such as acute respiratory infection. Improvements in this indicator since 2011 have been slow (Table 8).

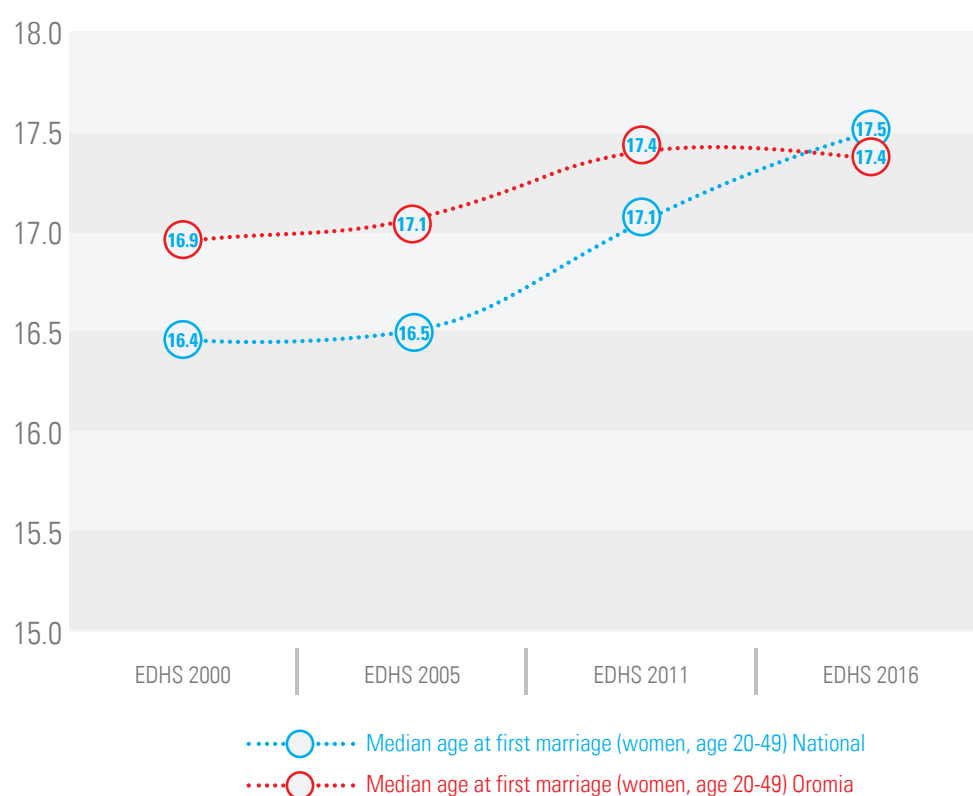
Any interventions aimed at improving the wellbeing of children in Oromia region should use a multi-sectoral approach. Approaches should include all components of WASH, as well as improvements in housing conditions and raising awareness about the importance of these. In addition to deprivation overlaps between water, sanitation and health, and nutritional outcomes in children under 5 years, analysis shows that there is a high overlap in deprivation between water, sanitation and housing for all children. Fifty per cent of children under 18 in Oromia region are simultaneously deprived of an improved and/or proximal drinking water source, adequate sanitation, and adequate housing conditions, while an additional 37 per cent are deprived of adequate sanitation and housing. Only 3 per cent of these children are not deprived in either of these basic needs (Figure 11).

6 CHILD PROTECTION

According to the 2016 EDHS, Oromia region has the highest rate of physical violence against girls/women (aged 15-49) in Ethiopia. The proportion of girls/women (aged 15-49) who have ever experienced physical violence since age 15 is 28 per cent, of whom 5 per cent experienced violence often.⁵⁵ The proportion of those who have ever experienced sexual violence is also the highest in the country, at 13 per cent, while 9 per cent of girls/women had experienced sexual violence in the 12 months before the survey.⁵⁶

The 2016 EDHS revealed that Oromia region had the highest rate of physical and sexual violence against girls/women (aged 15-49) by an intimate partner in Ethiopia. The proportion of girls/women (aged 15-49) who had ever experienced psychological, physical or sexual violence by their current or most recent husband/partner was 25 per cent, 30 per cent, and 13 per cent, respectively.⁵⁷

Figure 12: Trends in median age at first marriage (women, aged 20-49), Ethiopia and Oromia region, 2000-2016



⁵⁵. EDHS 2016, p. 299.

⁵⁶. EDHS 2016, p. 302.

⁵⁷. EDHS 2016, p. 306.

The percentage of girls/women who believed that a husband/partner was justified in hitting or beating his wife in various circumstances⁵⁸ was 69 per cent, the highest rate in the country. However, a relatively low percentage of boys/men (26 per cent) agreed that wife beating was justified in some circumstances.⁵⁹ Of women married before the age of 15, less than 35 per cent had ever discussed HIV with their husbands, compared to 56 per cent of women married at 18 or 19 years of age.⁶⁰

There was an increase in the average median age of marriage in Oromia region between 2000 and 2011, however progress has stagnated and stands at 17.4 years (Figure 12). There has been a decline in child marriage rates reported by women aged 20 to 24 years, from 58 per cent in 1991 to 48 per cent in 2016,⁶¹ well above the national average of 40 per cent. This reduction has been slower than in other regions,⁶² and needs to be six to ten times faster than the rate observed over the past 10 years to eliminate child marriage by 2030 and achieve Sustainable Development Goal (SDG) 5.3.⁶³ For example, Girja district (Guji zone) has one of the highest child marriage rates of all districts, at 33 per cent of girls being married before their 18th birthday.⁶⁴ Girls usually marry at the age of 15 or 16, although marriage at 13 and 14 is also common. Boys usually get married between the ages of 18 and 22 to girls several years younger than themselves.

Table 9: Trends in indicators on child marriage and female genital mutilation/cutting (FGM/C), Ethiopia and Oromia region, 2000-2016

Child marriage and FGM/C	Region	DHS 2000	DHS 2005	DHS 2011	WMS 2011	DHS 2016	SDG 2030 targets
Women married by age 15 among women currently aged 15-19 (%)	National	14.4	12.7	8	-	-	0
	Oromia	-	8.3	6.6	-	-	0
Women married by age 18 among women currently aged 20-24 (%)	National	49	49	41	-	40	0
	Oromia	-	-	-	-	48 *	0
Median age at first marriage (women, aged 20-49)	National	16.4	16.5	17.1	-	17.5	N/A
	Oromia	16.9	17.1	17.4	-	17.4	N/A
Female genital mutilation/cutting (aged 0-14) (%)	National	-	-	-	23	15.7	0
	Oromia	-	-	-	17.3	7.6	0
Female genital mutilation/cutting (aged 15-49) (%)	National	79.9	74.3	-	-	65.2	0
	Oromia	89.8	87.2	-	-	75.6	0

* Data provided by UNICEF, *Ending Child Marriage: A profile of progress in Ethiopia, 2018*

58. If a woman goes out without telling her husband/partner, if she neglects the children, if she argues with her husband/partner, if she refuses sex with her husband/partner, and if she burns food.

59. EDHS 2016, pp. 283 and 284.

60. Ethiopia Young Adult Survey: A study in seven regions, Erulkar, 2010.

61. This is the international indicator selected to monitor progress on Target 5.3 of the SDGs.

62. The EDHS 2016 did not publish data on this indicator across regions in Ethiopia. This data is provided by UNICEF, *Ending Child Marriage: A profile of progress in Ethiopia, 2018*, p. 8.

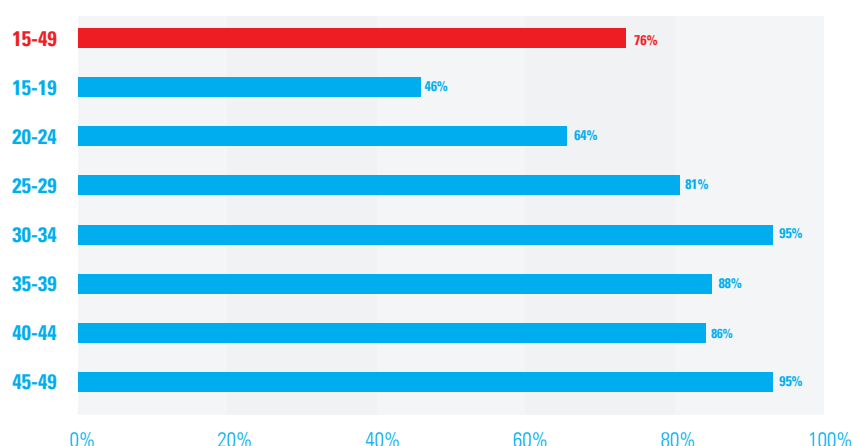
63. Ibid., p. 10.

64. Jones et al. and Presler-Marshall et al., 2015, *Child Marriage in Ethiopia: A review of the evidence and an analysis of the prevalence of child marriage in hot spot districts*.

While the incidence of female genital mutilation/cutting (FGM/C) decreased on average 5 per cent per year over the 10 years before the EDHS 2016, three out of four women in Oromia (76 per cent) have undergone FGM/C (Table 9). This figure is far above the national rate of 65 per cent among women aged 15 to 49.

In order to meet SDG 5.3 and eliminate FGM/C by 2030, Oromia should reduce the percentage of girls aged 15 to 19 years who have undergone FGM/C by 26 per cent per year.⁶⁵ On a positive note, the FGM/C prevalence across age groups shows that the younger age group (15-19 years) has a much lower prevalence of FGM/C than all older age groups (Figure 13).

Figure 13: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Oromia, by age group, 2016.
Source: UNICEF, EDHS 2016; FGM/C Further Analysis: Sub-national Results, 2018



Women in rural areas of Oromia have a higher risk of FGM than the rest of the women in Ethiopia. At the national level, incidence of FGM/C in rural areas (68 per cent) is higher than urban areas (54 per cent).⁶⁶ Similarly, the incidence is higher in rural areas of Oromia (77 per cent) than urban areas (68 per cent). There is also a positive association with household wealth, but it is weak. While the prevalence rate is lower among women in the richest wealth quintile, 68 per cent compared to 76 per cent among women in the poorest wealth quintile, it is high in absolute terms.⁶⁷ In Oromia, FGM/C is usually carried out under the age of 15 years and is performed by traditional circumcisers.⁶⁸

Harmful practices are pervasive in Oromia. Besides child marriage and FGM/C, there is a prevalence of marriage by abduction, polygamy, marriage by succession, and milk teeth extraction, among others. Violence against children and child labour is also widespread. A 2015 study by CSA and ILO found that 28 per cent of children aged 5 to 17 engaged in child labour compared to a national rate of 24 per cent.⁶⁹ An assessment by the Oromia branch of the Institution of the Ombudsman revealed that a high number of children below the age of 13 in Welete kebele of Sebeta city were engaged in weaving work, with from one to five children per household working. Most of these children came from the SNNPR. Oromia children are particularly vulnerable to commercial sexual exploitation, as the region hosts major investments and serves as a corridor. Internal and external trafficking in children is pervasive. Many children flock from other regions to Oromia, particularly from Boditi and Areka in the SNNPR.

⁶⁵ UNICEF, EDHS 2016, FGM/C Further Analysis: Sub-national results, Nov. 2018.

⁶⁶ EDHS 2016, p. 321

⁶⁷ Disaggregated from EDHS 2016

⁶⁸ EDHS 2016, p. 322.

⁶⁹ CSA and ILO, Ethiopia National Child Labour Survey 2015, p. 79.



In Oromia region, only 2.1 per cent of children under age 5 years have their births registered, and only 1.1 per cent of those who are registered have a birth certificate.⁷⁰ The government faces challenges in protecting children, including from child marriage, criminal responsibility (many children are sent to prison as adults), prevention of child labour and other issues. Since August 2016 a national registration system for vital events has been operating. A Federal Vital Events Registration Agency (FVERA) was established for the coordination and support of civil registrations. While a regional agency has been put in place (RVERA) to register and provide

birth certificates, the number of children captured remains low, for example by end of January 2019 the regional RVERA reported that only 276,382 were registered as of December 2018.⁷¹

The percentage of people aged 15-49 infected with HIV is 0.7 per cent, compared to a national average of 0.9 per cent. This rate is much lower among the younger population (aged 15-24), at 0.3 per cent. Between 2011 and 2016, HIV prevalence among youths increased from 0.2 per cent to 0.3 per cent. Because of the large population size, the absolute number of people infected with HIV is high. Many new paediatric HIV infections are the result of mother-to-child transmission. Knowledge of prevention of mother-to-child transmission of HIV is low, with only 42 per cent of women (aged 15-49) in Oromia having knowledge on prevention. Many pregnant women living with HIV are not identified, with only 12 per cent of pregnant women in Oromia being tested for HIV during antenatal care visits and receiving their results and post-test counselling. This is the second lowest rate in the country after Somali region.⁷² Only 5 per cent of children aged 0-14 years are tested for HIV.⁷³ The Federal Ministry of Health states that, "self-medication, shortage of money, perceived poor quality of health care are main reasons for not seeking health care services during illness".⁷⁴ Stigma and discrimination, a lack of information on treatment and the distance to a health institution may form barriers to seeking treatment.

Table 10: Trends in knowledge about HIV/AIDS and participation in community events or conversations, adolescents aged 15-17 years, Ethiopia and Oromia region, 2011 and 2016

Health-related knowledge and community participation among adolescents (15-17 years)	Region	EDHS 2011	EDHS 2016	SDG 2030 targets* (%)
Comprehensive knowledge about HIV/AIDS transmission and prevention	National	27.4	29.8	100
	Oromia	27.2	30.2	100
Participation in community events or conversations where family planning is discussed	National	31	23.7	100
	Oromia	22.7	20.5	100

*Women of reproductive age

70. EDHS 2016.

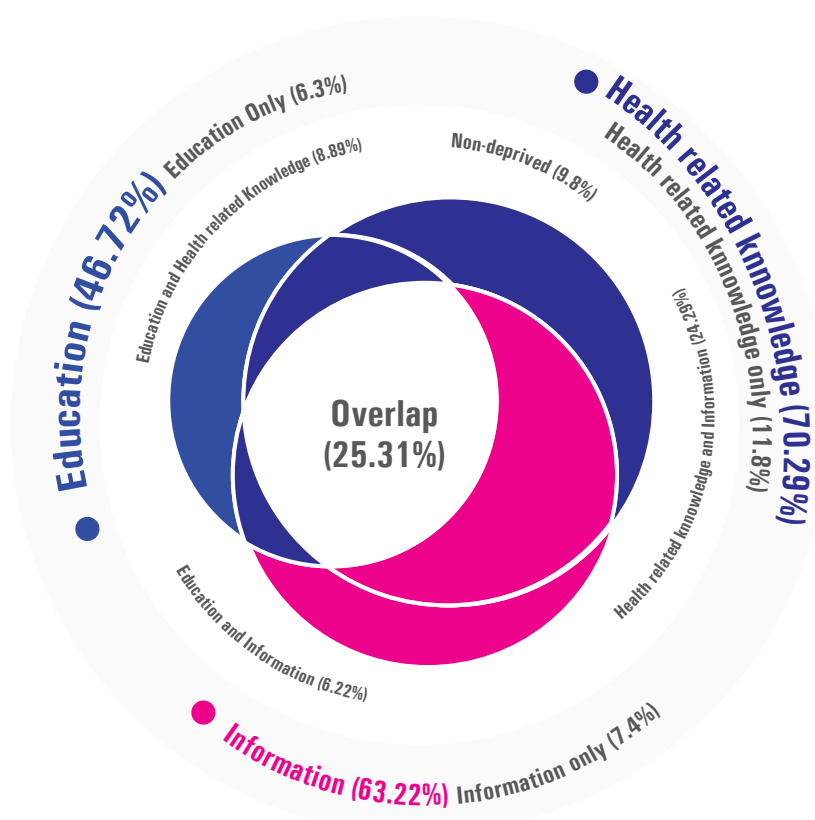
71. Federal Vital Events Registration Agency, Admin Data.

72. Ibid.

73. Ibid.

74. Federal Ministry of Health, Health Service Utilization and Expenditure Survey among People Living with HIV (PLHIV) 2015/16, 2017, p. 43.

Figure 14: Deprivation overlap between education, health-related knowledge, and information and participation, children aged 5-17 years. Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018



Comprehensive knowledge among adolescents aged 15-17 years about HIV/AIDS transmission and prevention is in line with the national average, at 30 per cent, and shows little improvement since 2011. A worrying finding is the declining trend of participation in community events and conversations where adolescents can obtain information about various topics related to their wellbeing, including family planning. This suggests issues with sustainability of existing programmes. In the few months preceding the survey, only 21 per cent of adolescents aged 15-17 years participated in a community event or conversation where family planning was discussed, compared to the national average of 24 per cent (Table 10).

Considering the importance of knowledge on reproductive health and rights, family planning, health- and nutrition-related knowledge for children's and women's outcomes, as well as on reducing gender inequality, investment in improving educational outcomes should include revisions to the curriculum to include health- and nutrition-related knowledge. More than one quarter of children aged 5-17 years in Oromia region are simultaneously deprived of education, health-related knowledge and information, and participation. An additional 24 per cent are deprived of both health-related knowledge and information and participation (Figure 14).

7 SOCIAL PROTECTION

“In 2014, 2 per cent of rural households in Oromia were included in the PSNP compared to 11 per cent of households at the national level.⁷⁵ In general, the PSNP has targeted the poorest population groups well in Oromia, and it has contributed to increased food security and household dietary diversity.⁷⁶”

In 2014, 2 per cent of rural households in Oromia were included in the PSNP compared to 11 per cent of households at the national level.⁷⁵ In general, the PSNP has targeted the poorest population groups well in Oromia, and it has contributed to increased food security and household dietary diversity.⁷⁶

Since 2014, the government has implemented community-based health insurance (CBHI) in rural areas of Ethiopia, which provides financial protection against health shocks. A UNICEF study on the synergies and complementarities between the PSNP and CBHI found that, in Oromia, CBHI enrolment rates were low among the poor, especially compared to Amhara and Tigray. In 2016, 12 per cent of poor households in Oromia were participating in CBHI, though not in the PSNP. In addition, 11 per cent of PSNP households were participating in CBHI.⁷⁷ Permanent Direct Support PSNP households were not participating in CBHI (8 per cent). This could be explained by their inability to pay the CBHI premium. Permanent Direct Support PSNP households are generally poorer than households enrolled in the Public Works component of the PSNP. This explanation is supported by the finding that, out of all PSNP households enrolled in the CBHI in Oromia, 65 per cent were enrolled as ‘indigent’ and therefore had free access to CBHI.⁷⁸ The low enrolment rate among PSNP households in Oromia may also be explained by the limited efforts to promote CBHI among PSNP clients.⁷⁹

Since 2015, under the umbrella of PSNP 4, a pilot programme called, ‘Improved Nutrition through Integrated Basic Social Services with Social Cash Back’ (IN-SCT) has been implemented by the Ministry of Labour and Social Affairs, with support from UNICEF in four woredas, two in Oromia and two in SNNPR. The programme aims to reinforce the uptake of basic social services, such as education, health care, nutrition, child protection and WASH, by PSNP clients. In 2018, the IN-SCT targeted

75. Mini EDHS 2014, p. 15.

76. UNICEF, *Reaching the Poor: Synergies and complementarities of the Productive Safety Net Programme and Community Based Health Insurance*, 2017, p. 9.

77. *Ibid.*, p. 24.

78. To enhance CBHI affordability, local governments are expected to cover the cost of providing free access to CBHI for the poorest 10 per cent, or so-called ‘indigents’ through a targeted subsidy. The target of 10 per cent of the CBHI-eligible population will not support all of those living under the national poverty line.

79. UNICEF, *Reaching the Poor: Synergies and Complementarities of the Productive Safety Net Programme and Community Based Health Insurance*, 2017, p. 28.

9,750 children under 1 year of age, 30,000 adolescent girls, and 12,000 pregnant and lactating women.⁸⁰ The programme tests a case management model where social workers and community care coalitions (CCC) promote, monitor and administer so-called 'co-responsibilities' of individual PSNP clients. Co-responsibilities means that households are encouraged to fulfil pre-defined activities, such as seeking health and nutrition services, though no penalties are enforced when co-responsibilities are not carried-out (there are no deductions from transfers). The case management of the social workers and CCC is supported by a web-based management information system. This model facilitates links to services by informing clients of their co-responsibilities and providing follow-up advice or support in cases of non-compliance.⁸¹ The case management model can be considered good practice in terms of increased uptake of basic social services by PSNP households, particularly in education and health. It also contributes to child protection cases, such as abduction.⁸²

80. UNICEF ECO, Cash Plus in Practice, Integrating Nutrition and Access to Services in the PSNP in Ethiopia. Lessons Learned from Qualitative Mid-Term Research on the IN-SCT Pilot in SNNP Region, p. 2.

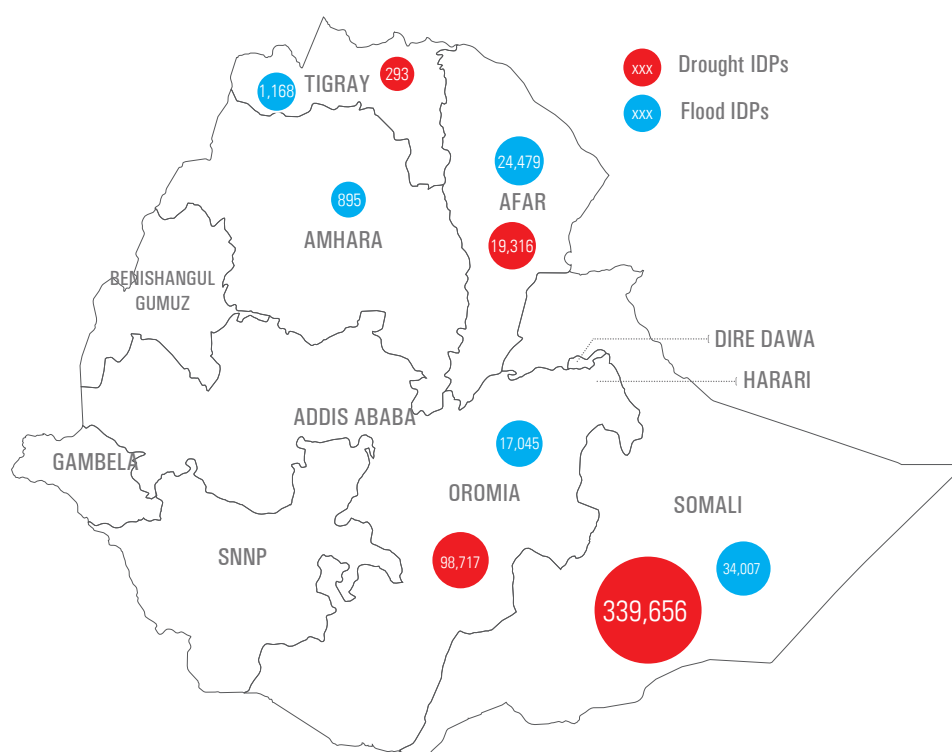
81. Ibid. See also Food and Agriculture Organization (FAO) and UNICEF, Production Choices and Nutrition Related Implications in Ethiopia. Baseline Report on Improved Nutrition through Integrated Basic Social Services with Social Cash Transfer (IN SCT) Pilot Programme, 2018.

82. There were some cases where abducted girls were returned to their families due to close monitoring and coordination based on the case management system. UNICEF ECO, Cash Plus in Practice, Integrating Nutrition and Access to Services in the PSNP in Ethiopia. Lessons Learned from Qualitative Mid-Term Research on the IN-SCT Pilot in SNNP Region, p. 2 and IDS & Centre for Social Protection, Evaluation of the UNICEF Social Cash Transfer Pilot Programme in SNNPR, Ethiopia, Midline Report, Final, July 2017, p. 41.

8 CLIMATE CHANGE AND CHILD RIGHTS

Oromia has a diverse climate. Mountainous areas above 1,500m dominate the region. There are also river valleys, rolling plains and lowlands. The prevailing climatic types can be grouped into three major categories: the dry climate, the tropical rainy climate, and the temperate rainy climate. The mountain area of eastern Oromia (Arsi-Bale) generally receives less rainfall than the middle-highlands of western Oromia.⁸³ In the coming decades, rising temperatures, extraordinary rainfall events and more intense and prolonged droughts and floods are projected.⁸⁴ The high prevalence of poverty, high rates of malnutrition, high population growth and low climate adaptive capacities increase vulnerability to climate change.⁸⁵ Children are most vulnerable to climate change, as they are at a higher risk of mortality and poor health, growth and development. Women and girls experience greater risks, burdens and impacts of climate change, as emergencies exacerbate existing gender inequalities.⁸⁶ During climate change-induced emergencies, formal and informal protection mechanisms break down and human rights abuses increase, resulting in increased gender-based violence that affects women and girls disproportionately.

Figure 15: Climate-induced IDPs by region in Ethiopia (drought and flood) as per July 2018. Source: IOM and partners, Categorization of IDPs, Oct. 2018



⁸³. MOARD et al., An Atlas of Ethiopian Livelihoods, Livelihoods Integration Unit.

⁸⁴. World Bank, Economics of Adaptation to Climate Change, Ethiopia, 2010.

⁸⁵. Ibid.

⁸⁶. CEDAW Committee, General recommendation No. 37 on the gender-related dimensions of disaster risk reduction in the context of climate change, 2018, (File no. CEDAW/C/GC/37).

“ Oromo people have faced climatic shocks, such as droughts, frost, hailstorms, flooding and landslides. As of July 2018, 17,045 people were displaced because of floods and 98,717 people were displaced because of drought (Figure 15). ”

Oromo people have faced climatic shocks, such as droughts, frost, hailstorms, flooding and landslides. As of July 2018, 17,045 people were displaced because of floods and 98,717 people were displaced because of drought (Figure 15).⁸⁷ This adds to the high number of conflict-induced displacements, which is discussed below. In Oromia, there are shortages of pasture, cropland, water and market access in many areas due to the cumulative impacts of weather. There is also conflict-induced pasture degradation.⁸⁸

The 2015-16 El Niño episode affected farmers and pastoralists dramatically in Oromia. Failure of rain led to failure of entire harvests, and cattle famine/herd reduction. It affected Oromo children, resulting in chronic and acute hunger, poor health, water-related illnesses, school absenteeism, poor school performance, poor diet, poor hygiene, lack of clean clothing, protection risks, and child labour.⁸⁹ In pastoralist and agro-pastoral areas, older boys, particularly, (13-18 years) were forced into longer and further transhumance migration in search of better pastures and water for their livestock. It appears that economic migration of children intensified, including to Addis Ababa or overseas locations, such as the Gulf States.⁹⁰ These were key factors that contributed to school dropouts.⁹¹

87. IOM and partners, Categorization of IDPs, Oct. 2018. See also Joint Government & Humanitarian Partners, Flood Response Plan Ethiopia, Sept. 2018.

88. HRD, Humanitarian and Disaster Resilience Plan. Mid-Year Review, 2018, p. 11.

89. See for example, UNICEF, Generation El Niño: Long-Term Impacts on Children's Well-Being. Final Report, 2018.

90. Ibid., p. 30.

91. Ibid., pp. 27-32.

9 GENDER EQUALITY

The Oromia regional legal framework includes various provisions that protect women's rights and promote gender equality. Gender equality interventions, such as promoting economic empowerment of women, promoting girls' education, etc., are integrated into Oromia's sectoral programmes. Nevertheless, there are serious concerns related to gender equality in the region. As in other regions of Ethiopia, Oromia Regional State has a patriarchal society in which men hold primary power in private and public life. This social system influences cultural norms, practices and traditions and has rooted gender stereotypes on the roles and responsibilities of women and men in the family and in society. Women and girls have traditionally performed their roles in the domestic sphere, and those activities are often considered inferior. Women and girls are labelled nurturers and carers, thus childcare responsibilities often fall exclusively to them.

According to the 2016 EDHS, in Oromia 35 per cent of women (aged 15-49) decide themselves on their first marriage and 61 per cent of women state that their parents made the decision for their first marriage. Both rates are the same as the national average.⁹² There is a worryingly high rate of girls/

...There is a worryingly high rate of girls/women who stop attending school after marriage, coupled with a high rate of child marriage (see Section 6).

women who stop attending school after marriage, coupled with a high rate of child marriage (see Section 6). In Oromia, 84 per cent of women (aged 15-49) stop school, which is the highest rate in the country. Of girls who were enrolled in school at the time of their marriage, only 27 per cent were still enrolled one year later.⁹³ When asked what the main reason was for discontinuing school, 71 per cent of women (one of the highest rates in the country) cited that they were too busy with family life. At 17 per cent, the percentage of girls (aged 15-19) that had begun childbearing is high compared to other regions. This relatively high rate corresponds with the low rate of married Oromo women using modern contraceptive methods (29 per cent) compared to a national average of 36 per cent.⁹⁴ Another reason women discontinued schooling was that their husbands refused to let them continue their education (19 per cent).⁹⁵

Figure 16 shows the unequal distribution of power between women and men in decision-making and ownership. Note that more women than men have their names on the deeds of their house.

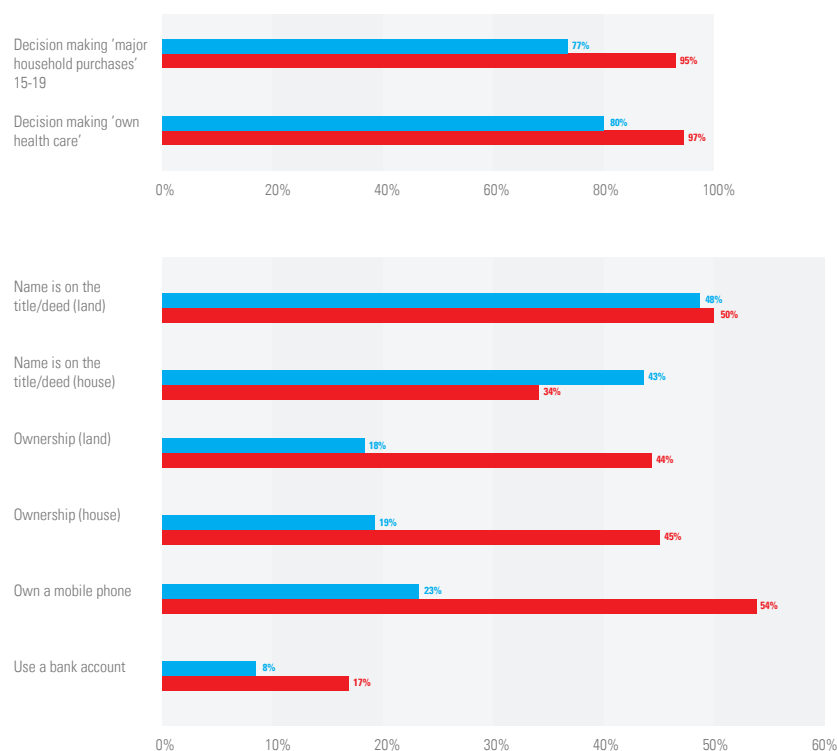
⁹² EDHS 2016, p. 278.

⁹³ Gage, 2009.

⁹⁴ Ibid., p. 114.

⁹⁵ Ibid., p. 279.

Figure 16: Percentage of married women and men (aged 15-49) in Oromia region who make specific decisions either alone or jointly with their spouse, and percentage of women and men (aged 15-49) in Oromia region by use of bank account, ownership of mobile phone, house and land, possession of title/deed of house and land. Source: EDHS 2016



In Oromia, 31 per cent of husbands participate in household chores, of whom 14 per cent participate every day.⁹⁶ The EDHS 2016 shows that women are more deprived of information than men. The Internet is a critical tool to access information, and Oromo women are four times less likely to use the Internet than men.⁹⁷ Furthermore, women are less exposed to mass media than men: 4 per cent of women and 12 per cent of men read a newspaper at least once per week; 13 per cent of women and 20 per cent of men watch television at least once per week; and 20 per cent of women and 32 per cent of men listen to the radio at least once per week.⁹⁸

^{96.} Ibid., p. 280.

^{97.} Ibid., pp. 49 and 50. Percentage of women and men aged 15-49 who have used the Internet in the past 12 months.

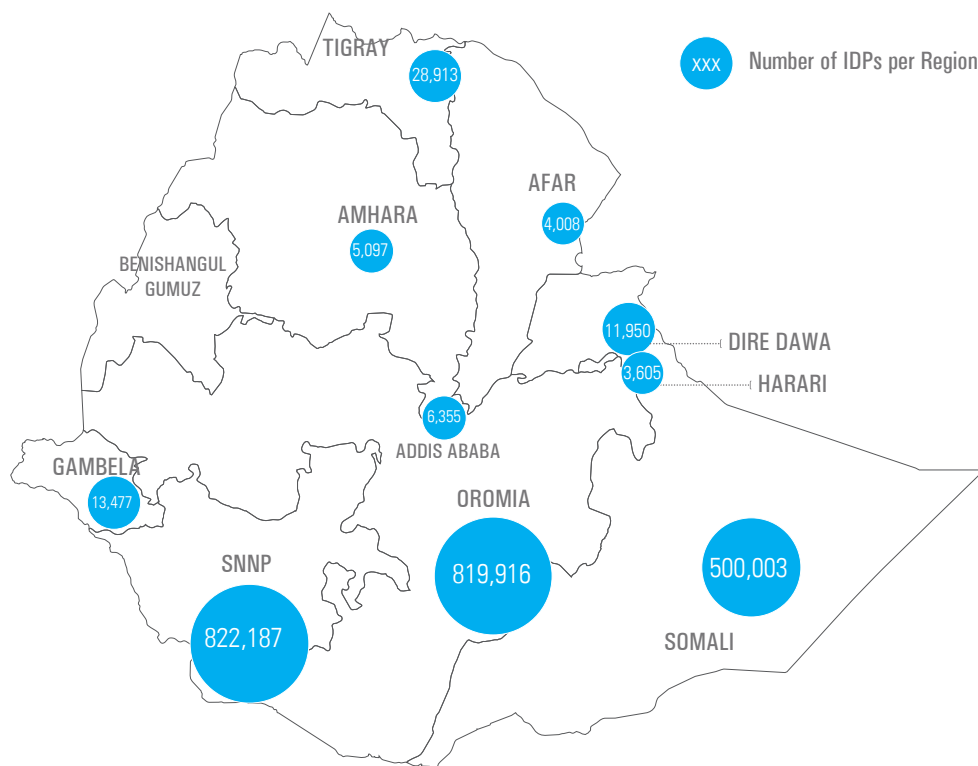
^{98.} Ibid., pp. 47 and 48. Percentage of women and men aged 15-49 exposed to specific media on a weekly basis.

10 OTHER SPECIFIC ISSUES

There have been some key changes in Ethiopia's political landscape. The Ethiopian People's Revolutionary Democratic Front (EPRDF) has led the government since the downfall of the dictatorial Derg regime in 1991. The EPRDF is an alliance of four groups: the Tigrayan People's Liberation Front (TPLF), the Amhara National Democratic Movement, the Oromo Peoples' Democratic Organization and the South Ethiopian Peoples' Democratic Front. Traditionally, the EPRDF was dominated by the TPLF. However, a large shift of power took place and, following the resignation of Hailemariam Desalegn in April 2018, the Oromo reformist, Abiy Ahmed, was inaugurated as the new Prime Minister of Ethiopia.

There is no doubt that the recent conflicts in Oromia have had a negative impact on all dimensions of child well-being. Since 2017, a major conflict has taken place along the regional Somali-Oromia border between the Oromo and Somali people. This conflict erupted over sub-national predominance and resources. These events happened during and after large anti-government protests in Oromia that initially began over land rights but later broadened to include calls for greater political representation at the federal level. This led to a state of emergency in 2016 and 2017.⁹⁹

Figure 17: Conflict-induced IDPs by region, as per July 2018, Ethiopia. Source: IOM and partners, *Categorization of IDPs, Oct. 2018*



⁹⁹ Violent protests also erupted in Amhara, SNNPR and Benishangul-Gumuz.

Between April and June 2018, there were localized conflicts in Gedeo zone (SNNPR) and West Guji zone (Oromia region). Since September 2018, inter-communal violence has erupted along the Benishangul Gumuz and Oromia regional borders.¹⁰⁰ In November 2018, renewed violence occurred in Moyale town, which belongs to both Oromia and Somali regions.¹⁰¹ Ethnically based violence is expected to continue throughout 2019.¹⁰²

The conflict has led to a very high number of IDPs in Ethiopia. The majority of conflict-induced IDPs are displaced due to the Somali-Oromia conflict (55 per cent, 1.2 million IDPs) followed by IDPs due to the Gedeo-West Guji conflict (45 per cent, 1 million IDPs).¹⁰³ As of July 2018, in Oromia there were 819,916 conflict-induced IDPs (Figure 17), and 98,717 drought-induced and 17,045 flood-induced IDPs spread across the region (Figure 15).

Displaced households were forced to abandon their land even during the planting season. They lost their agricultural livelihoods, farming assets, and/or other sources of income. Pastoralists' livestock was lost or displaced, and they have been forced to reside in permanent shelters, contradictory to their lifestyle. Sometimes children were separated from their families during their flight. IDPs are food insecure and require continuous humanitarian support.¹⁰⁴ In addition, the situation of IDPs puts pressure on the many host communities who are already food insecure. When IDPs return to their locality, they may find their houses destroyed and fields uncultivated, and they may face security issues if the root causes of conflicts have not been addressed.

“Children constitute more than half of the displaced population.¹⁰⁵ According to the Humanitarian Requirement Document, the level of acute malnutrition among displaced children is of grave concern.¹⁰⁶”

Children constitute more than half of the displaced population.¹⁰⁵ According to the Humanitarian Requirement Document, the level of acute malnutrition among displaced children is of grave concern.¹⁰⁶ For example, in IDP sites in West Guji zone, there was a prevalence of 27 per cent global acute malnutrition (GAM) and 3 per cent severe acute malnutrition (SAM) in children under 5 years of age, well over emergency thresholds. In addition, 51 per cent of pregnant and breastfeeding mothers were malnourished in these sites.¹⁰⁷ Pregnant women and children under 5 years are failing to access antenatal care and immunization services, as basic services are overwhelmed by increased populations. Many school-aged children between 4 and 14 years are currently displaced and not attending school, or do not have access to education. Several schools have been destroyed due to conflict.¹⁰⁸

100. UNOCHA, Ethiopia: Overview of recent ongoing inter-communal violence and displacement No.2, 22 Oct. 2018, pp. 1-4

101. UNOCHA, Humanitarian Bulletin Ethiopia, Issue 68, 11-25 November 2018, p. 3.

102. Economic Intelligence Unit, Country Report Ethiopia 2018, 2018, pp. 2 and 4.

103. IOM and Partners, Categorization of IDPs, Oct. 2018.

104. HRD, Humanitarian and Disaster Resilience Plan. Mid-Year Review, 2018, p. 19.

105. UNHCR, Operational Update on Ethiopia, Sept. 2018. See also ACAPS, Briefing Note: Displacement in Ethiopia, Oct. 2018.

106. HRD, Humanitarian and Disaster Resilience Plan. Mid-Year Review, 2018, p. 26.

107. Ibid.

108. Ibid., p. 14



11 KEY PRIORITIES AND RECOMMENDATIONS TO IMPROVE THE SITUATION OF WOMEN AND CHILDREN IN OROMIA

- Mainstream child rights from the Convention on the Rights of the Child (CRC) in regional planning documents. As a starting point, deprivation rates across indicators and dimensions can be used for this purpose, as they derive from the CRC.
- Child-sensitive budgeting at the regional level to enhance equality and equity.
- Deprivation in health and nutrition among children under 5 years, deprivation in education and information and participation among children aged 5-17 years, and deprivation in sanitation and housing among children under 18 years in Oromia is above the national average. These sectors should be given dedicated attention in policy and programme design.

- Oromia has the highest deprivation rates across regions in knowledge of treating diarrhoea with oral rehydration salts – both among mothers of children under 5 (40 per cent) and among female household members of children 5-14 years (38 per cent). The percentage of children aged 9-14 years who are attending school with two or more years of delay is also the highest. Health-related knowledge and the education sector should therefore have special attention dedicated to policy design and budgeting.
- Promote multisectoral approaches to programme and policy design for effective poverty reduction. Coordination of sectors at different levels of governance, as well as across different administrations and service delivery structures, is paramount.
- While acknowledging the decreasing trend in child mortality, continue efforts to reduce the high rate of child mortality in Oromia by focusing on maternal, neonatal and child health service delivery. Expand coverage of basic services, such as skilled birth attendance, antenatal care and immunization, among others, through investment in health facilities. This would bring services closer to the population, increase the quality of services, and provide health-related knowledge and knowledge on feeding practices, especially to young mothers.
- Support nutrition-sensitive interventions (which play a vital role in reducing stunting by 80 per cent) in important sectors like agriculture, education, health and social protection to improve access to and utilization of diversified diet. Promote appropriate feeding practices, micronutrient intake through supplementation or fortifications, nutrition and health education, access to PSNP services and resilience building by linking humanitarian responses to development.
- Continue to support the health system to provide quality Comprehensive Integrated Nutrition Services (CINuS).
- Enforce nutrition and food policies to implement the second National Nutrition Programme (NNP II) in all important sectors, with strong leadership in line with new policy direction.
- Scale up the Unified Nutrition Information System for Ethiopia (UNISE) in NNP implementing sectors to access quality and timely data for decision-making.
- Encourage the development of early childhood education by scaling up quality pre-school programmes that help prepare children for primary school.
- Continue to increase enrolment in schools by taking appropriate measures that address barriers to out-of-school children, especially children who are engaged in child labour and pastoralist children. Include girls' education as an essential component of regional development efforts and take special measures to reach girls.

- Incorporate education on nutrition, health, child protection and family planning in official school curricula.
- Considering the high number of non-functioning water schemes, continue efforts to sustain water schemes by strengthening community awareness, participation and ownership of WASH interventions at woreda level. The regional government should strengthen its WASH programming by: improving coordination between regional and woreda levels; paying attention to water scheme rehabilitation and maintenance; continuing to build community ownership of water schemes to ensure sustainability of water availability; and training and employing technicians at woreda level.
- Considering the limited and slow sanitation and hygiene coverage in the region, the Oromia regional government should prioritize investment and decentralization to implement the development of a sanitation and hygiene micro plan, including mainstreaming menstrual health and hygiene facilities in schools and budgeting for WASH in health facilities.
- Support more resilience interventions that would secure food and water availability during the dry season and provide alternative livelihoods to improve income diversification of households at risk of future climate shocks and conflicts. Economic development based on investment in infrastructure is likely to be the first line of defence against climate change impacts.¹⁰⁹ Therefore: invest in climate-resilient water supply systems, with special emphasis on identification and use of water sources that are resilient to climatic extremes; invest in ground-water mapping to collect reliable information; and provide an enabling environment to engage the private sector in managing water supply systems.
- To respond to child protection issues raised in this brief, there is a need to strengthen systems and to address these issues through a coordinated holistic intersectoral prevention and response approach, bringing together informal systems, such as community-based structures. Additionally, it is necessary to strengthen the social service workforce to prevent and respond to child protection issues.
- Continue efforts to end gender-based violence and harmful practices, including through strengthening community-based awareness raising activities. As there is limited data on gender-based violence in the region, there is a need to identify woredas with a high prevalence of violence and harmful practices. Design programmes tailored to the situation in these woredas and strengthen victim assistance and rehabilitation services.

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109. World Bank, *Economics of Adaptation to Climate Change: Ethiopia*. 2010, p. xxii-xxv.

**Situation Analysis of Children and Women:
Oromia Region**

