SITUATION ANALYSIS OF CHILDREN AND WOMEN:
Amhara Region

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This briefing note covers several issues related to child well-being in Amhara 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.

[1] Most 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

Amhara region is situated in the north western and north central part of Ethiopia. It is one of the four largest regions and, as of 2019, has an estimated population of almost 22 million people, which constitutes 22 per cent of the Ethiopian population.[2] Like elsewhere in the country, the population of Amhara is young (see Table 1). The total fertility rate in Amhara region is relatively low, at 3.7 in 2016.[3] The average household size is the smallest in the country at 4.2 persons per household compared to the national average of 4.8. [4]The region is divided into 12 zones, three metropolitan cities, 140 woredas and 42 towns.[5] Its administrative capital is Bahir Dar.

> **"...The average household size is the smallest in the country at 4.2 persons per household compared to the national average of 4.8.[4]"**

Table 1: Population Amhara region, 2019. Source: Population Projections for Ethiopia 2007-2037, CSA (2013)

Year	Total population	Under 18 (%)	Under 5 (%)
EFY 2011 (2018/2019)	21,842,000 (22.1)	9,506,344 (43.5)	2,765,723 (12.7)

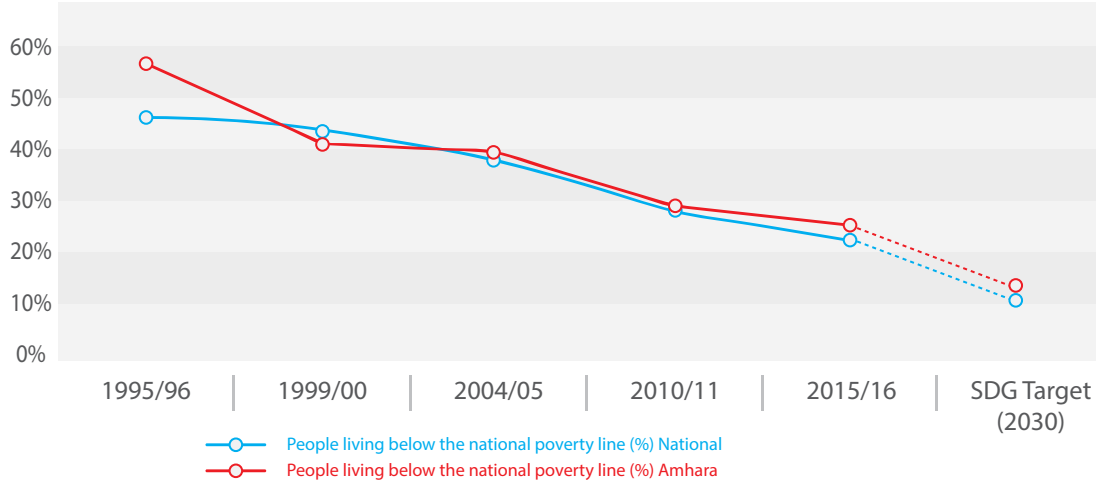
The Ethiopian Orthodox Church dominates in Amhara region, with approximately 82 per cent of the population being Orthodox. [6]More than 91 per cent of the population belongs to the Amhara ethnic group. Of the Amhara inhabitants, 81 per cent live in rural areas and most people are engaged in agriculture.[7] Crops that are grown include teff, barely, wheat, oil seeds, sorghum, maize, oats, beans and peas. People own a large number of livestock. The region has various water resources, such as Lake Tana, and several rivers that provide great potential for irrigation development.[8] The Amhara regional government promotes itself as an investment region in Ethiopia. For example, it prepared a regional development strategy to create a new hub for the flori- and horticulture industry, with emphasis on enhancing the efficiency of smallholder farmers and increasing yields and exports.[9]

2. Population Projections for Ethiopia 2007-2037, CSA (2013).
3. EDHS 2016, p. 84.
4. CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 8.
5. http://www.ethiopia.gov.et/amhara-regional-state (last accessed: 4 March 2019).
6. Percentage of the population (aged 10+). CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 8.
7. Planning Commission Projection based on 2007 CSA projection for 2019.
8. Lake Tana is the largest lake in Ethiopia.
9. Amhara National Regional State, Bureau of Agriculture, Amhara Region Horticulture Development Strategy 2015-2019.

2 POVERTY, DEPRIVATION AND VULNERABILITY

Over the past 20 years, Amhara has seen a consistent decline in monetary poverty, with a 38 per cent decline between 2000 and 2016 (Figure 1 and Table 2).[10] This poverty reduction in Amhara region is the result of strong agricultural growth and the number of households that have benefitted from the Productive Safety Net Programme (PSNP).[11] After a decade of increasing food poverty, the percentage of people living below the food poverty line declined between 2010/11 and 2015/16.

Figure 1: Trends in poverty headcount from 1995/96 to 2015/16, Ethiopia and Amhara region



Source: HCES 1995/96, 1999/2000 and 2004/05, HCES 2010/11 and 2015/16

Table 2: Trends in monetary and food poverty, Ethiopia and Benishangul-Gumuz, 1995/96-2015/16

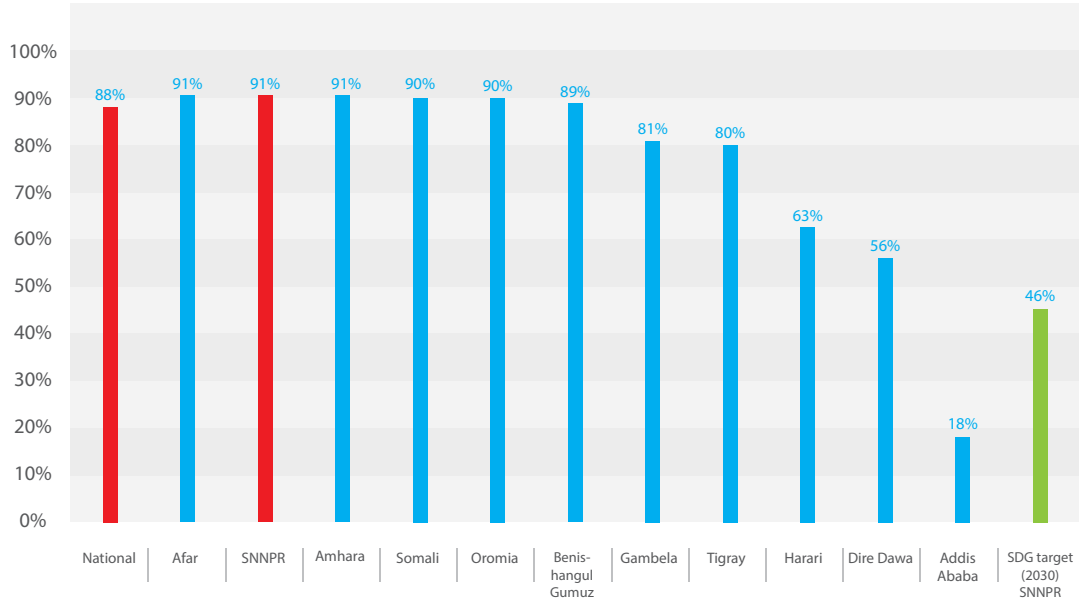
Poverty	HCES	1995/96	1999/00	2004/05	2010/11	2015/16	SDG 2030 target
People living below the national poverty line (%)	National	45.5	44.2	38.7	29.6	23.5	11.8
	Amhara	54.3	41.8	40.1		26.1	13.1
People living below the food poverty line (%)	National	49.5	41.9	38	33.6	24.8	12.4
	Amhara	57.4	32.5	38.8	42.5	31.3	15.7

10. 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.
11. World Bank, Ethiopia - Poverty assessment 2014, 2015, p. 58.

> **Despite this progress, Amhara has the third highest monetary poverty rate in the country. The headcount poverty rate stands at 26 per cent compared to a national average of 24 per cent.**

Despite this progress, Amhara has the third highest monetary poverty rate in the country. The headcount poverty rate stands at 26 per cent compared to a national average of 24 per cent. The food poverty rate in Amhara is the second highest of all regions, at 31 per cent. In 2015/16, 16 per cent of Amhara households reported food shortages in any month.[12] Amhara region has the largest inequality in monetary poverty between rural and urban areas, at 29 per cent versus 12 per cent, respectively.[13] The same applies to food poverty, with a 23 percentage-point difference between rural and urban food-poor people.[14]

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



Along with Afar and SNNPR, Amhara has the highest multi-dimensional child deprivation (MCD) incidence: 91 per cent of children under 18 years, or more than 7.7 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 incidence of MCD, deprivation intensity and large child population, Amhara's contribution to the adjusted MCD index (M0) in Ethiopia is the third highest, at 21 per cent, after Oromia (43 per cent) and SNNPR (23 per cent). The MCD rate among children under 5 years (93 per cent) is higher than the national average (89 per cent), as is the rate for children aged 5-17 years, at 90 per cent in Amhara compared to 87 per cent nationally. Between 2011 and 2016 the MCD rate decreased by only 1 percentage point, deprivation intensity decreased from an average of 4.6 to 4.5 out of 6 dimensions, and the adjusted MCD index from 0.7 to 0.67 (Table 3).

12. CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 49.
13. FDRE, National Planning Commission, Ethiopia's Progress Towards Eradicating Poverty: An interim report on 2015/16 poverty analysis study, 2017, p. 21.
14. Ibid., p. 22.

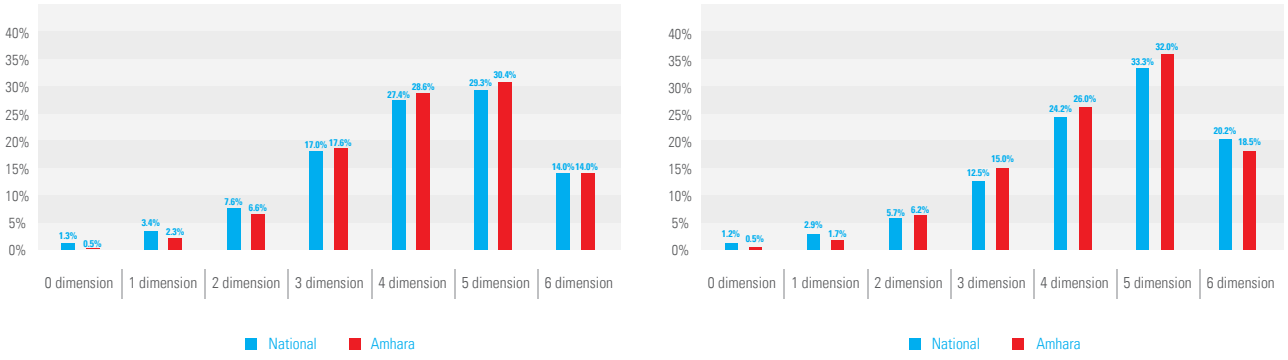
Table 3: Trends in multi-dimensional child poverty, 2011 and 2016, Ethiopia and Amhara region. Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018

MCD estimates in Ethiopia and Amhara 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
	Amhara	94	93	4.6	4.5	0.72	0.7
Children aged 5-17 years deprived in 3-6 dimensions	National	89	87	4.7	4.5	0.69	0.65
	Amhara	91	90	4.6	4.4	0.69	0.66
Children under 18 years deprived in 3-6 dimensions	National	90	88	4.7	4.5	0.7	0.65
	Amhara	92	91	4.6	4.5	0.7	0.67

“Children in Amhara are more likely to be deprived of more basic needs and services than the national average.”

Children in Amhara 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 less than 1 per cent of children under 18 years in Amhara are not deprived in any of the six dimensions of deprivation analysed, while the national average is 1.3 per cent. In Amhara, 44 per cent of children under 18 and 43 per cent across Ethiopia are deprived of five up to six basic needs or services (Figure 3).

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



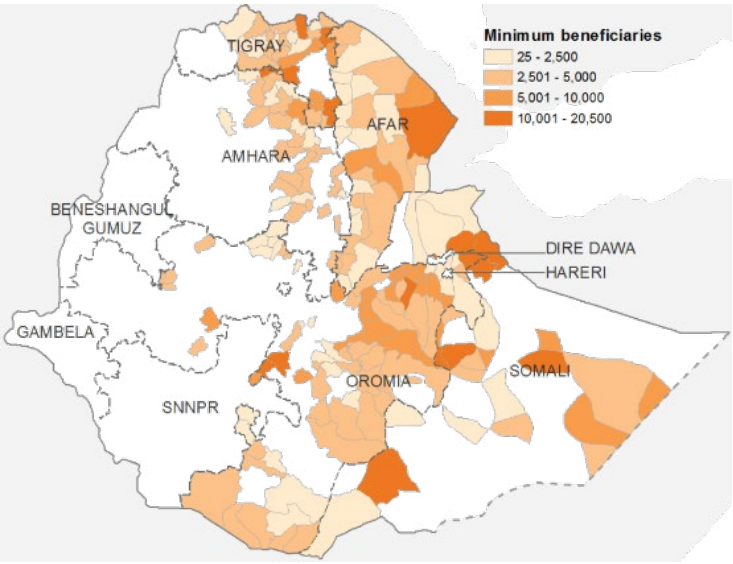
The largest contributors to MCD in Amhara among all children are deprivations in sanitation (96 per cent) and housing (93 per cent). Among children under 5, deprivation in nutrition (73 per cent) is the third largest driver of MCD, while among 5- to 17-year-olds it is deprivation in information and participation (65 per cent) (Table 4).

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

MCD	Single dimension deprivation in Amhara and Ethiopia, EDHS 2016 estimates						
Children under 5 years (%)	**Dimensions**	**Development (stunting)**	**Health**	**Nutrition**	**Water**	**Sanitation**	**Housing**
	National	38	68	73	59	90	90
	Amhara	47	62	73	63	96	93
Children aged 5-17 years (%)	**Dimensions**	**Education**	**Health-related knowledge**	**Information and participation**	**Water**	**Sanitation**	**Housing**
	National	50	69	66	56	89	89
	Amhara	43	64	66	61	96	93
Children under 18 years (%)	**Dimensions**	**Water**	**Sanitation**	**Housing**			
	National	57	89	89			
	Amhara	61	96	93			

Many people in Amhara region are vulnerable to chronic food insecurity. This is reflected in the high rates of malnutrition in children under 5 years, which is discussed below. The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) assessed that Amhara region occupies fifth place among the regions when it comes to most repeated beneficiaries of relief food (relief food needs of at least nine times between 2013 and 2018). As shown in Figure 4, the vulnerability mostly lies on the eastern side of Amhara. Between 2016 and 2018, a severe El Niño-induced drought hit the Horn of Africa.

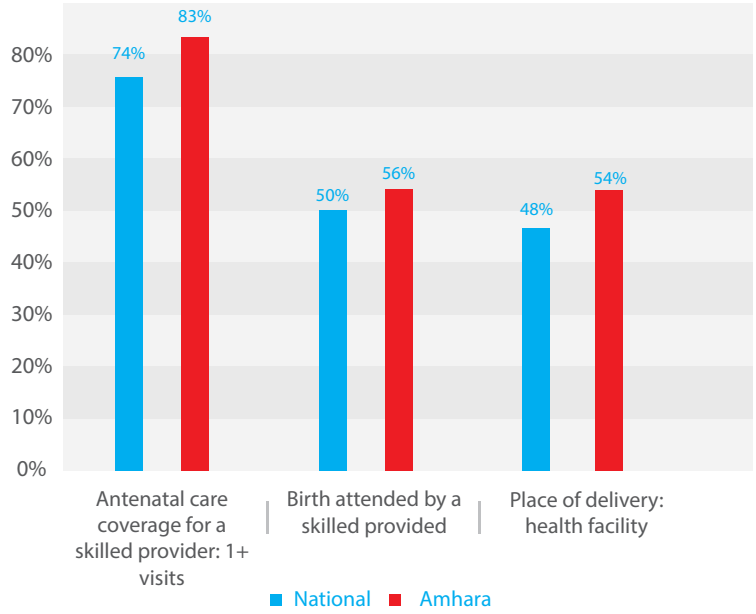
Figure 4: Woredas with relief food needs at least nine times between 2013 and 2018. Source: UNOCHA, HRD Relief Food Beneficiary Analysis (2013-2018)



3 NUTRITION, HEALTH AND SURVIVAL

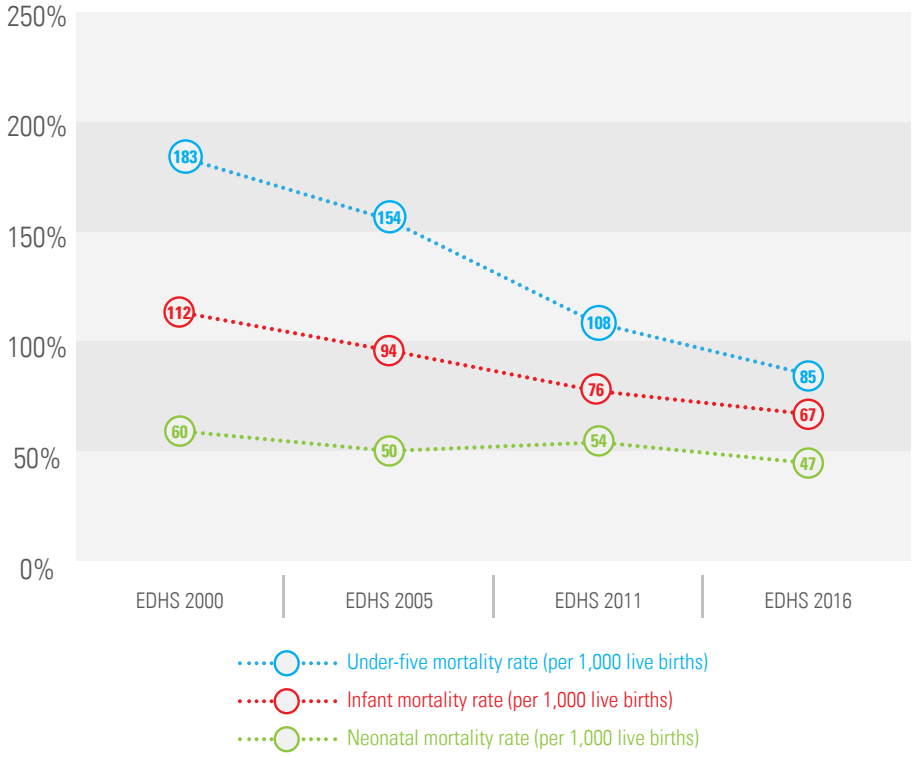
The EDHS 2019 shows that Amhara has made significant progress in several nutrition, and child and maternal health indicators.[15] The rate of pregnant women in Amhara who gave birth in the five years preceding the survey and received antenatal care during their pregnancy from a skilled health provider is 83 per cent. This rate was 67 in 2016 and 46 per cent in 2014 and is well above the national average (Figure 5) of 74.[16] Inequities related to geography, education and wealth remain pervasive. The incidence of skilled attendance during delivery increased by almost six times, from 10 per cent in 2011 to 56 per cent in 2019.[17] Similarly, delivery in a health facility increased from 12 per cent in 2014 to 54 per cent in 2019. While this rate has increased, almost one out of two women (46 per cent)[18] in Amhara still did not have a delivery attended by a skilled provider, and only 40 per cent of women had accessed early postnatal care in 2019.[19] About 89 per cent of newborns did not get postnatal care during the 48 hours after delivery.[20] One focus of Sustainable Development Goal (SDG) 3 is improving maternal health, with a documented reduction in the Maternal Mortality Ratio (MMR) and an increase in the proportion of births attended by skilled health personnel. It must be noted that the EDHS 2016 and the mini-EDHS 2019 did not publish the MMR across regions. While recognizing significant progress in parameters of maternal health, there are still challenges regarding access to and provision of quality antenatal, obstetric and postnatal health care services, especially in rural areas.

Figure 5: Maternal health care in Ethiopia and Amhara region. Source: EDHS 2019



15. Mini-EDHS 2019, pp. 13 and EDHS 2016, pp. 133-160.
16. Mini-EDHS 2014.
17. According to the EDHS 2016 and EDHS 2019, skilled providers include doctors, nurses, midwives, health officers and health extension workers. The EDHS 2000, 2005 and 2011 defined skilled providers as "doctors, nurses and midwives".
18. Mini EDHS 2019
19. Ibid.
20. EDHS 2016.

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



The EDHS 2016 shows that child mortality rates are high in Amhara region. Although there has been a steady declining trend (Figure 6), Amhara is contributing most in terms of under-five, infant and neonatal mortality. Together with Gambella and Benishangul Gumuz, Amhara recorded the largest decline in the under-five mortality rate between 2005 and 2016.[21] Neonatal mortality has declined but is still the highest in Ethiopia (47/1,000 deaths). It is worrying that 89 per cent of newborns have no postnatal check-up by a health care provider in the first two days after birth. Amhara has the highest rate of children with symptoms of acute respiratory infection (8 per cent) and the second highest rate of children under five with diarrhoea (14 per cent). It is concerning that only 29 per cent of children under 5 years who had symptoms of acute respiratory infection sought advice or treatment from a health provider, and only 3 per cent sought treatment for the same or next day, demonstrating that there is a delay in seeking health care. In Amhara, 62 per cent of children had all basic vaccinations (Table 6).[22] There is still low utilization of maternal and newborn health (MNH) services along the continuum of care (Figure 7); poor quality of MNH services in several areas, including health care providers' knowledge and skills, facility readiness, governance and leadership, and availability of essential supplies; and inequity both in service utilization and reduction of neonatal, infant and under-five mortality within the region and between wealth quintiles, etc.[23]

21. Ibid.
22. Mini-EDHS 2019.
23. Ibid.

Figure 7: MNH uptake across regions in Ethiopia. Source: EDHS 2016

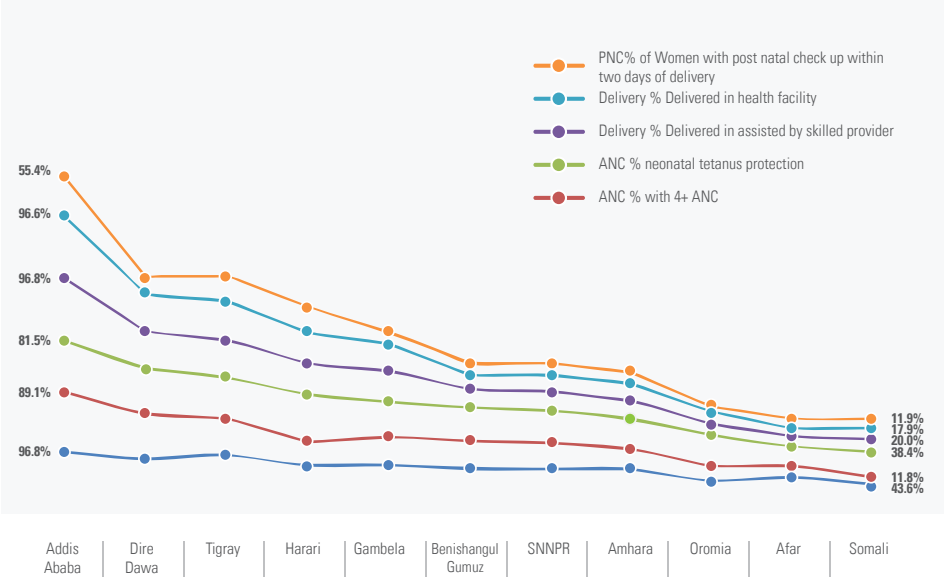


Table 5: Trends in child survival and maternal health indicators, Ethiopia and Amhara region, 2000-2019

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
	Amhara	18.9	26.5	33.6	67.1	82.6	100
Skilled attendance during delivery (%)*	National	5.6	5.7	10	27.7	49.8	100
	Amhara	3.1	3.7	10.1	27.7	55.7	100
Child mortality	**EDHS**	**2000**	**2005**	**2011**	**2016**	**2019**	**SDG target 2030**
Under-five mortality rate (per 1,000 live births)**	National	166	123	88	67	55	<25
	Amhara	183	154	108	85	-	<25
Infant mortality rate (per 1,000 live births)**	National	97	77	59	48	43	N/A
	Amhara	112	94	76	67	-	N/A

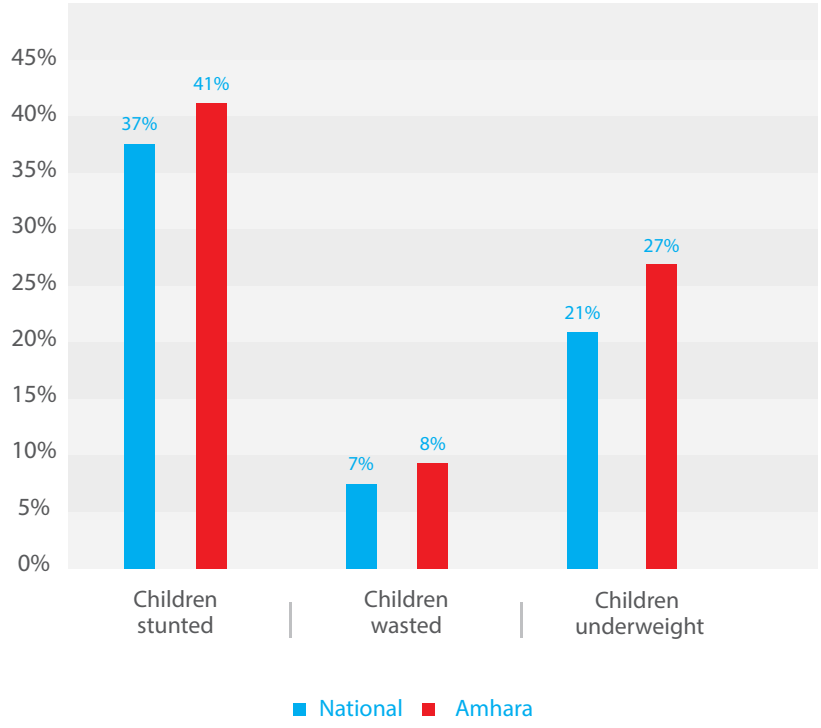
**Among women who had a live birth in the five years preceding the survey. According to the EDHS 2016, skilled providers include doctors, nurses, midwives, health officers and health extension workers. The EDHS 2000, 2005 and 2011 define skilled providers as "doctors, nurses and midwives".*
*** National figure is 5 years average, and regional figure is 10 years average.*

Although stunting rates have declined between 2011 and 2019, Amhara has the third highest prevalence rate in Ethiopia (41 per cent). Not surprisingly, urban areas across Ethiopia report lower stunting incidence (26 per cent) than rural areas (41 per cent). The rate of child stunting across the first three wealth quintiles in Ethiopia is above the average, ranging between 38 per cent and 42 per cent, while in the richest wealth quintiles it is 24 per cent. Education plays a clear role in the prevalence of child stunting in Ethiopia: 42 per cent of children whose mothers have not completed any education are stunted compared to 17 per cent of children whose mothers have completed higher education. Underweight in children under 5 years old is also above the national average. The wasting rate is slightly higher than the national average and has shown only marginal improvements since 2011.[24]

It is well recognized that the size and body composition of a mother at the beginning of a pregnancy strongly influences foetal growth.[25] Maternal malnutrition is widespread among women in Amhara. The level of chronic malnutrition among women (aged 15-49) is 23 per cent. The prevalence of anaemia among women of reproductive age (aged 15-49) was 17 per cent in 2016.[26]

“It is well recognized that the size and body composition of a mother at the beginning of a pregnancy strongly influences foetal growth.[25] Maternal malnutrition is widespread among women in Amhara.”

Figure 8: Under-five child under-nutrition in Ethiopia and Amhara region. Source: Mini-EDHS 2019



24. EDHS 2016 and Mini EDHS 2019.
25. Black et al., Maternal and Child Nutrition 1. ‘Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries’, The Lancet, 2013, p. 7.
26. EDHS 2011 and 2016.

Infant and young child feeding practices in Amhara continue to be poor and contribute to malnutrition. The EDHS 2016 shows that breastfeeding in Amhara is common, with 98 per cent of children under 2 being breastfed at some point and 66 per cent of newborns starting breastfeeding within one hour of birth. Children older than 6 months should receive complementary food, as by that age breast milk alone is no longer adequate to maintain optimal growth. Optimal complementary feeding, also called 'the minimum acceptable diet' (MAD), requires adequate frequency[27] of meal consumption (MMF) and dietary diversity (MDD) (at least four food groups). In 2016, the feeding practices of only 3 per cent of children in Amhara (aged 6-23 months) met the MAD standards, which is very low. EDHS data shows that 56 per cent of children (aged 6-23 months) received the MMF. It is noticeable that there is a serious lack of diversity in children's diets. The proportion of children (aged 6-23 months) who were fed an MDD was only 3 per cent, the second lowest in Ethiopia after Afar region.[28] According to a study by the International Food Policy Research Institute, "the most significant predictors of dietary diversity are household assets, parental education, cow ownership, antenatal care exposure, and maternal age, with older women giving their children less diverse diets".[29] The promotion of and support to infant and young child feeding continues, with the aim of improving the capacity of mothers and care givers in this area, and child caring practices. In Amhara, monthly growth monitoring and promotion of children under 2 years acts as a platform for identifying children whose growth is faltering, and providing tailored counselling based on identified issues.[30] The prevalence of anaemia, a proxy indicator for iron deficiency, among children under 5 years is concerning, with an increase between 2011 and 2016 from 35 per cent to 42 per cent.

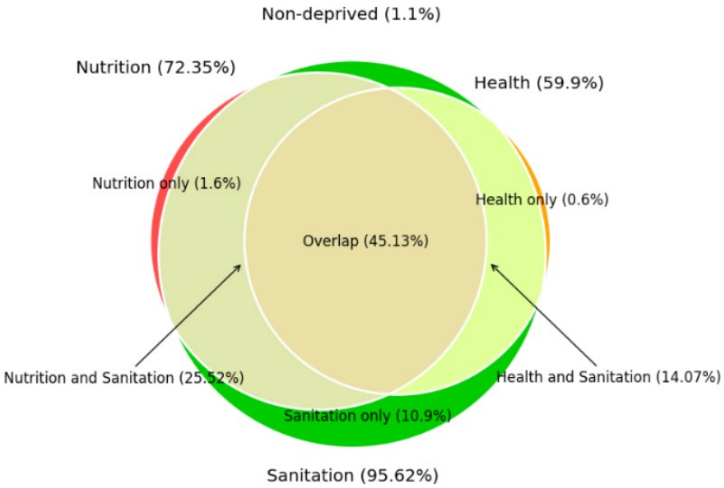
Table 6: Trends in child nutrition and health indicators, Ethiopia and Benishangul-Gumuz, 2000-2019

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
	Amhara	14.4	17.1	26.3	45.8	62.1	100
Stunting prevalence ***	National	57.8	51.5	44.4	38.4	36.8	22.1
	Amhara	57	56.6	52	46.3	41.3	24.8
Wasting prevalence ***	National	12.9	12.4	9.7	9.9	7.2	<5
	Amhara	9.5	14.2	9.9	9.8	7.6	<5
Underweight prevalence ***	National	42.1	34.9	28.7	23.6	21.1	N/A
	Amhara	51.8	48.9	33.4	28.4	26.7	N/A
Prevalence of anaemia (6-59 months)	National	N/A	53.5	44.2	56.9		N/A
	Amhara	N/A	52	35.1	42.2		N/A

**** Converted to WHO standards*

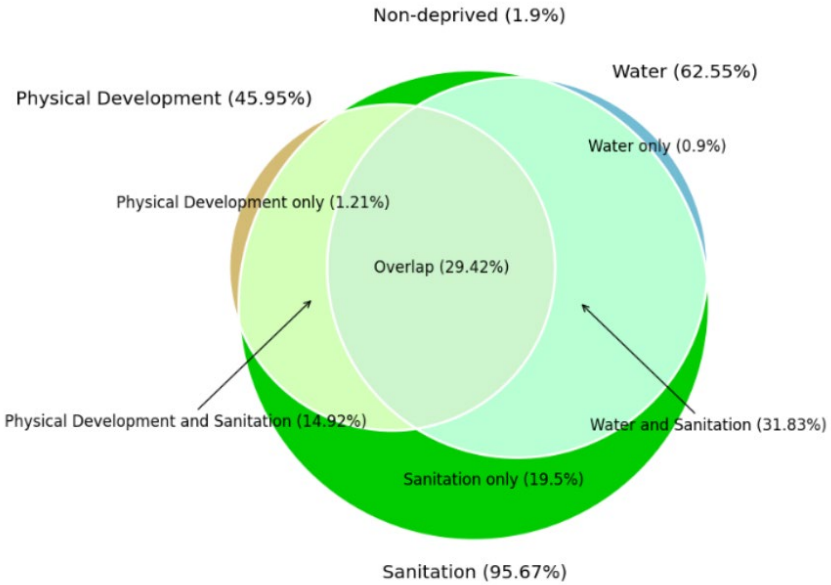
27. The minimum meal frequency is: at least four times for non-breastfed children between 6 and 23 months, at least two times for breastfed children between 6 and 8 months, and at least three times for breastfed children between 9 and 23 months.
28. EDHS 2016, p. 208.
29. Headey, D., An Analysis of Trends and Determinants of Child Undernutrition in Ethiopia, 2000-2011, Ethiopia Strategy Support Programme, 2014, p. 1.
30. UNICEF Ethiopia Country Office, Annual Report 2017, p. 30.

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



Improving nutritional and health outcomes for children under 5 years to increase their survival chances requires a multi-sectoral approach and interventions. Deprivation overlap analysis shows that 45 per cent of children under 5 in Amhara are simultaneously deprived of nutrition and basic health services, and of adequate sanitation. An additional 26 per cent are deprived of both health and sanitation, and 14 per cent of nutrition and sanitation, whereas fewer than 1 per cent are not deprived in any of these three dimensions (Figure 9). Deprivation overlap between physical development (stunting), water and sanitation shows that deprivation across sectors is interrelated; nearly one third of children under 5 in Amhara are stunted and deprived of water and sanitation simultaneously, while an additional one third are deprived in water and sanitation, and 15 per cent are stunted and deprived in sanitation (Figure 10).

Figure 10: Deprivation overlap between development (stunting), water 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 net enrolment ratio (NER) for pre-primary education in Amhara were 43.4 per cent and 17.7 per cent, respectively. To meet the national GER target of 80 per cent by 2020, accelerated enrolment is necessary. The majority of "0" classes in the region are below standard for pre-school education, for example 67 per cent of centres have no separate outdoor ground and play materials, there is a lack of trained teachers, and classroom facilities are inadequate, etc.[31] In 2018/19 the GER and NER for Amhara primary schools stood at 102 per cent and 91 per cent, respectively.[32] The GER rate has increased compared to 2012/13.[33] In 2018/19, the Gender Parity Index (GPI) for Amhara primary schools was 1.05, which shows that more females are attending school than males. The GPI at national level is 0.87. In 2012/13 the GPI was 1.01 in the region, which was also in favour of girls.[34]

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

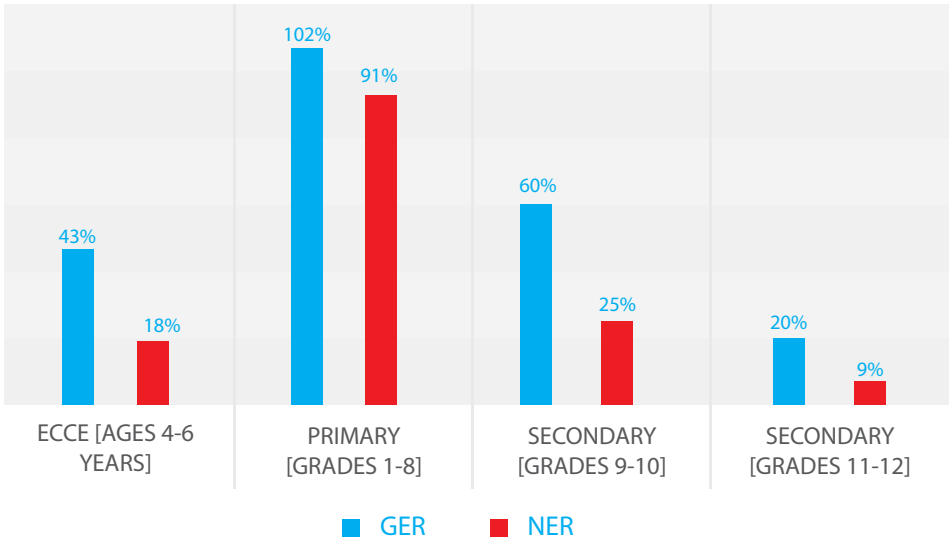
Indicator	Region	ESAA 2008/09 (%)	ESAA 2010/11 (%)	ESAA 2012/13 (%)	ESAA 2018/19 (%)	SDG target 2030 (%)
Primary school gross enrolment rate (Grades 1-8)	National	94.4	96.4	95.3	104.6	100
	Amhara	112.5	-	100.7	102.4	100
Primary school net enrolment rate (Grades 1-8)	National	83	85.3	85.9	94.7	100
	Amhara	102.2	93.5	91.7	91.2	100
Indicator	**MCD report**			**ESAA 2011 (%)**	**ESAA 2016 (%)**	**SDG target 2030 (%)**
Delay in schooling (age 9-17 years)[35]	National			37.3	33.6	N/A
	Amhara			32.7	27.3	N/A
Illiteracy rate (age 15-17 years)[36]	National			45.2	45.5	0
	Amhara			38.7	29.2	0

31. See ESDP V for all national targets on education. Dessie CTE, Practices, Opportunities and Challenges of ECCE in Eastern Amhara Region, not published, 2016, pp. 60 and 61.
32. MoE, ESAA 2011 E.C. (2018/19). pp. 20-24 MoE, ESAA 2009 E.C. (2015/16). An NER higher than 100 per cent is strange, as it would mean that more 7- to 14-year-old students are enrolled than there are in Amhara.
33. MoE, ESAA 2005 E.C. (2012/2013).
34. Ibid.
35. 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.
36. Child could not read or could read only parts of a sentence provided during the survey.

“Many children who attend school fail to acquire basic skills, such as literacy and numeracy.”

Many children who attend school fail to acquire basic skills, such as literacy and numeracy. Even though the illiteracy rate among 15- to 17-year-olds is lower than the national average (46 per cent), nearly one third (29 per cent) of these adolescents in Amhara are illiterate. The Education Sector Development Programme (ESDP V) recognizes the challenges of the low quality of the Ethiopian education system, including unskilled teachers, irrelevant teaching and inadequate learning materials, etc.[37] In Amhara region there are challenges to the quality of education, student achievement and dropouts. The survival rate to Grade 5 the percentage of students who completed the first cycle of primary education was 62 per cent in 2017/18. In 2015/16, 14 per cent of Grade 8 students failed their final exam (13 per cent girls and 14 per cent boys), which is below the national average of 12 per cent.[38] Dropout and repetition rates in the region at primary level in 2017/18 were 10.4 per cent and 3.4 per cent, respectively. The national averages are 17.5 per cent and 4.1 per cent, correspondingly.[39] The main reason cited by students for being absent from school is “illness or death in the family” (73 per cent). Another reason is work (17 per cent).[40] It follows that these indicators signal significant wastage in the education system. Even though below the national average, 27 per cent of children aged 9-17 years attend school with two or more years of delay, indicating issues with grade retention in the region (Table 7).

Figure 11: GER and NER for early childhood care and education, primary and secondary education, Amhara region, 2017/18. Source: ESAA 2018/19



37. ESDP V, p. 17.
38. MoE, ESAA 2009 E.C. (2016/17), p. 70.
39. MoE, ESAA 2011 E.C. (2018/19)
40. CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 13.

“Gender parity in Amhara secondary schools stood at 1.08 in 2017/18 and is higher than the ESDP target of 0.96 for that year.[41] A GPI above one means that more girls in this region are enrolled in secondary school.”

In 2018/19, the GER in secondary education in Amhara was 60 per cent for Grades 9 and 10, and 20 per cent for Grades 11 and 12, which is above the national average.[41] While the NER of 30 per cent for Grades 9 to 12 is very low, it exceeds the national average of 25 per cent. Gender parity in Amhara secondary schools stood at 1.05 in 2018/19 and is higher than the ESDP target of 0.98 for that year.[42] A GPI above one means that more girls in this region are enrolled in secondary school. Child marriage and gender-based violence (GBV) are still major challenges that hinder girls' completion, and their transition to higher secondary education. GBV at school and on the way to and from school contributed to girls' low educational performance in the region. Girls' attendance is also hampered by prevailing poverty and the associated opportunity costs of sending girls to school.[43]

Distances to primary and secondary schools in Amhara woredas can be significant. In 2015/16, 72 per cent of primary students and 64 per cent of secondary students took less than 30 minutes to reach school;[44] 25 per cent of primary and secondary students took between 31 and 60 minutes to reach school; and 3 per cent of primary students took one hour or more to reach school. This figure was almost three times higher for secondary school aged children, at 11 per cent.

41. MoE, ESAA 2010 E.C. (2017/18).
42. Ibid.
43. Bahir Dar University, Situational Analysis of SRGBV and its Impact on Learning in Amhara Region, 2018, p. 81.
44. CSA, LSMS—Integrated Surveys on Agriculture, Ethiopia Socioeconomic Survey (ESS) 2015/16, 2017, p. 12.

5 WATER, SANITATION, HYGIENE (WASH) AND HOUSING

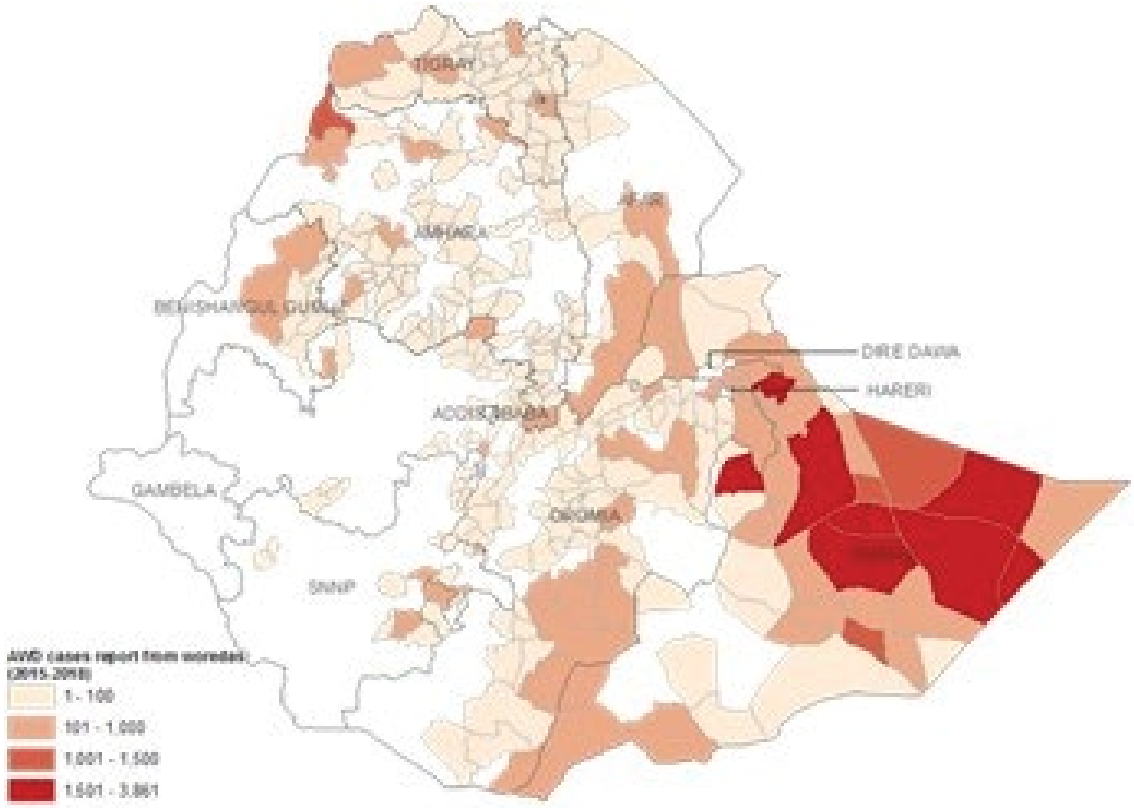
According to the 2016 EDHS, 64 per cent of households used improved drinking water sources in Amhara. This is almost the same as the national average of 65 per cent.[45] About 17 per cent of water sources in Amhara are piped compared to, for example, 27 per cent in Tigray region.[46] The Ethiopia Socioeconomic Survey (ESS) 2017 presents the time needed to collect water. In Amhara, 37 per cent of households spend 30 minutes or more reaching the nearest water source, fetching water and returning to their dwelling. Even though access to water sources in the regions has improved significantly compared to 2011 – when the incidence in this indicator was 67 per cent – it is above the national average of 32 per cent, and signifies that more than one third of the population in the region is deprived of water sources. Like elsewhere in the country, women and girls are mainly responsible for fetching water.[47] The availability and sufficiency of drinking water is 82 per cent and 75 per cent, respectively.[48] While there are efforts to construct water points and schemes, water point functionality is a challenge.[49] There are large inequities within the region, and particular zones have very low coverage rates due to complex hydrogeology and the need for high tech, solid investments. This is true for Waghimra zone, north and west Gonder and Oromo zone, and the Blue Nile gorge.

Table 8: Trends in improved drinking water sources, sanitation facilities and housing conditions, Ethiopia and Amhara region, 2005-2016.

Indicator	Region	EDHS 2005 (%)	EDHS 2011 (%)	EDHS 2014 (%)	SDHS 2016 (%)	SDG targets 2030 (%)
Households using improved drinking water sources	National	61.4	53.7	56.9	64.8	100
	Amhara	62.5	56.1	53.4	64.4	100
Time to water source 30+ minutes from the dwelling[50]	National		41.1		32.3	N/A
	Amhara		67.1		37	N/A
Households using improved sanitation facilities	National	6.8	8.3	4.2	6.3	100
	Amhara	4.7	10.6	2.2	1.7	100
Households with adequate housing[51]	National		2.9		12	
	Amhara		6.7		7.3	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
	Amhara		59.1		27.1	0

45. EDHS 2016.
46. CSA, Drinking Water Quality in Ethiopia. Results from the 2016 Ethiopia Socioeconomic Survey, 2017, p. 11. Note that the ESS found 62 per cent of households with improved water sources.
47. UNICEF, Integrated WASH/MUS/CBN Programme Baseline and Midline Survey Report, 2017, p. 37.
48. CSA, Drinking Water Quality in Ethiopia. Results from the 2016 Ethiopia Socioeconomic Survey, 2017, p. 18.
49. 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.
50. Necessary to reach the water source, fetch water and return to the dwelling.
51. Floor, exterior walls and roof of the dwelling where the child resides are made of durable and sustainable structures.

Figure 12: Acute watery diarrhoea. Source: UNOCHA, HRD Relief Food Beneficiary Analysis (2013-2018)



“EDHS data shows a worrying trend in the percentage of people in Amhara region who do not have access to improved sanitation facilities. At 1.7 per cent, it is the lowest in Ethiopia.[51]”

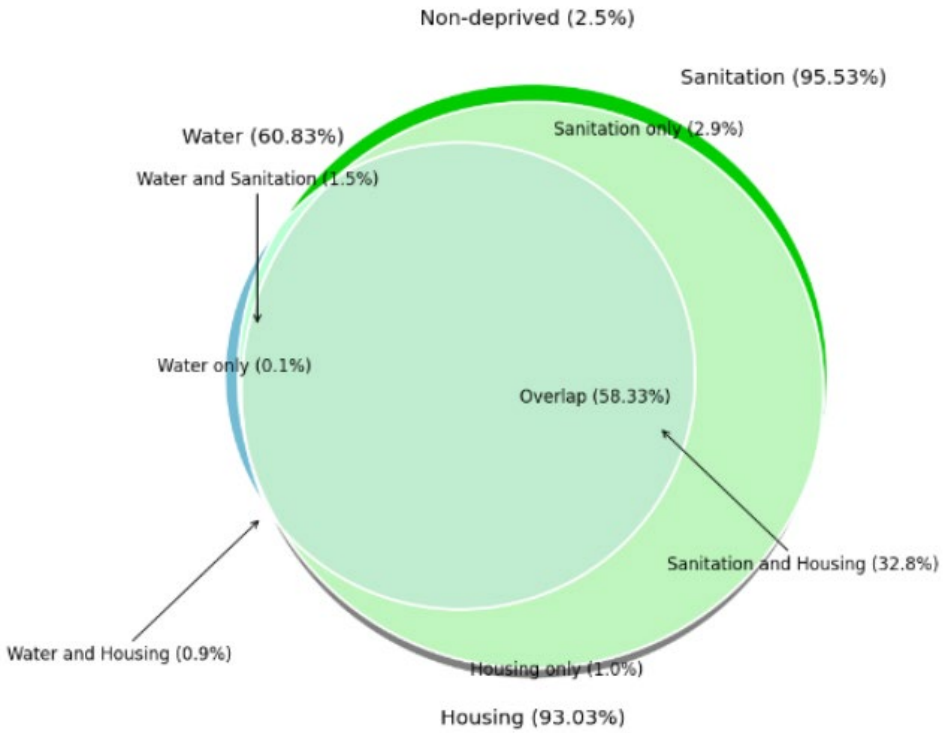
EDHS data shows a worrying trend in the percentage of people in Amhara region who do not have access to improved sanitation facilities. At 1.7 per cent, it is the lowest in Ethiopia.[52] In 2016, many people still practiced open defecation (32 per cent).[53] According to a 2017 UNICEF knowledge, attitudes and practices (KAP) study, even though there is no culture that encourages open defecation, it has been practiced for a very long time and is considered normal. The qualitative research for the KAP study found 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, whereas in areas where they are available, poor maintenance discourages people from using them.[54] Hygiene, measured with the indicator of hand washing with soap, seems to be a major challenge in the region, as Amhara has the second highest rate of children under 5 years with diarrhoea.[55] The region has repeatedly been affected by acute watery diarrhoea, which has led to many child deaths (Figure 12). Scabies is prominent in Amhara. According to the 2016 EDHS, 79 per cent of households in Amhara have a place for washing hands (2 per cent fixed and 77 per cent mobile), which is, except for Addis Ababa, the highest in Ethiopia. However, only 5 per cent of these households had water and soap, which represents the lowest rate in the country.[56] Another factor for the limited practice of hand washing is the lack of knowledge about critical moments when hands should be washed. Only 7 per cent of women and 3 per cent of men in Amhara knew that hands should be washed before breastfeeding/feeding a child, while 7 per cent and 0.5 per cent of women and men, respectively, knew that hands needed to be washed after cleaning a child's bottom who had defecated. Less than half, 45 per cent of women and 40 per cent of men, knew that hands should be washed after defecation (UNICEF & DAB, 2017, pp.34-45).

"Children and adults are susceptible to health risks in their dwellings due to inadequate housing conditions and indoor pollution from using solid fuel for cooking inside the house."

Children and adults are susceptible to health risks in their dwellings due to inadequate housing conditions and indoor pollution from using solid fuel for cooking inside the house. Only 7.3 per cent of households in Amhara compared to the national average of 12 per cent live in dwellings constructed with adequate material necessary to protect them from adverse weather conditions and health and structural hazards. Progress in this area since 2011 has been insignificant (Table 8). In 27 per cent of households in the region compared to 31 per cent at the national level, cooking is done inside the house with solid fuel, which exposes children (and adults) to a number of health risks, such as acute respiratory infection. Improvements in this indicator since 2011 have been significant: the percentage of households with indoor pollution from solid fuels used for cooking has decreased by more than half (Table 8).

52. EDHS 2016.
53. 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. 62, with a reference to EDHS 2016.
54. UNICEF, KAP Baseline Survey on Water, Sanitation and Hygiene in Eight Regions of Ethiopia, 2017, p. 61.
55. Bhutta et al., Maternal and Child Nutrition 2. 'Evidence-based Interventions for Improvement of Maternal and Child Nutrition: What can be done and at what cost?' The Lancet, 2013, p. 10.
56. EDHS 2016, p. 23.

Figure 13: Overlap between water, sanitation and housing, children under 18. Source: Calculations using MCD analysis and EDHS 2016 data

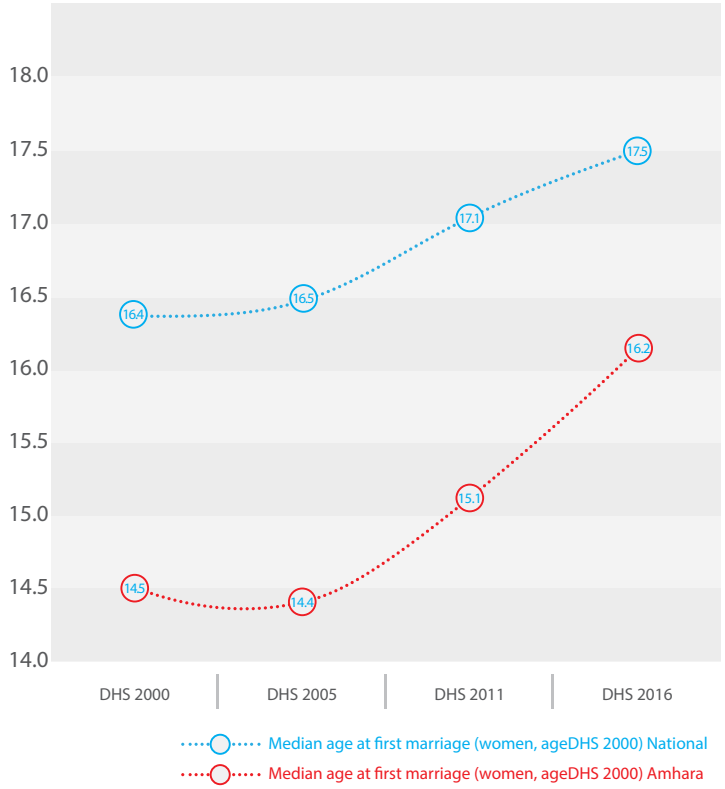


Any interventions aimed at improving the well-being of children in Amhara region should use a multi-sectoral approach that includes all components of WASH and improvements in housing conditions, and that raise awareness about the importance of each. Analysis shows that there is a high overlap in deprivation between water, sanitation and housing for all children under 18. In Amhara, 59 per cent of children under 18 are deprived of adequate water, sanitation and housing conditions simultaneously, and an additional 33 per cent are deprived in both sanitation and housing at the same time. Less than 3 per cent of children in the region are not deprived in any of the three dimensions analysed (Figure 13).

6 CHILD PROTECTION

The EDHS 2016 shows an increase in the average median age of marriage between 2000 and 2016 in Amhara region (Figure 14). Nonetheless, the median age of 16.2 years among women aged 20-49 years is still very low, and is the lowest in the country. There has been a significant decline in child marriage rates reported by women in the age group 20-24 years, from 75 per cent in 1991 to 43 per cent in 2016.[57] This puts Amhara in the fifth position (shared with Tigray) of 11 regions. In the 10 years before the EDHS 2016, there was an annual reduction rate of 5 per cent.[58] Progress in Amhara needs to be five times faster to eliminate child marriage by 2030 and achieve SDG 5.3.[59] The rationale of child marriage in Amhara region relates to a local strategy to form family alliances. It is believed that marriage reduces the risk that daughters engage in pre-marital sex, exposing them to sexually transmitted diseases and pregnancy while unmarried, which would lead to family disgrace and social stigmatization.[60]

Figure 14: Trends in median age at first marriage (women, aged 20-49), Ethiopia and Amhara region, 2000-2016



57. The EDHS 2016 does not include data on child and early marriage across regions in Ethiopia. This data is provided by UNICEF, Ending Child Marriage: A profile of progress in Ethiopia, 2018, p. 8.
58. Ibid., p. 10.
59. Ibid.
60. Save the Children a.o., Child Marriage and Female Circumcision: Evidence from Ethiopia, Young Lives Policy Brief, 2014, p. 2 and Coffey, Every Last Girl Strategy, 2013. pp. V and X.

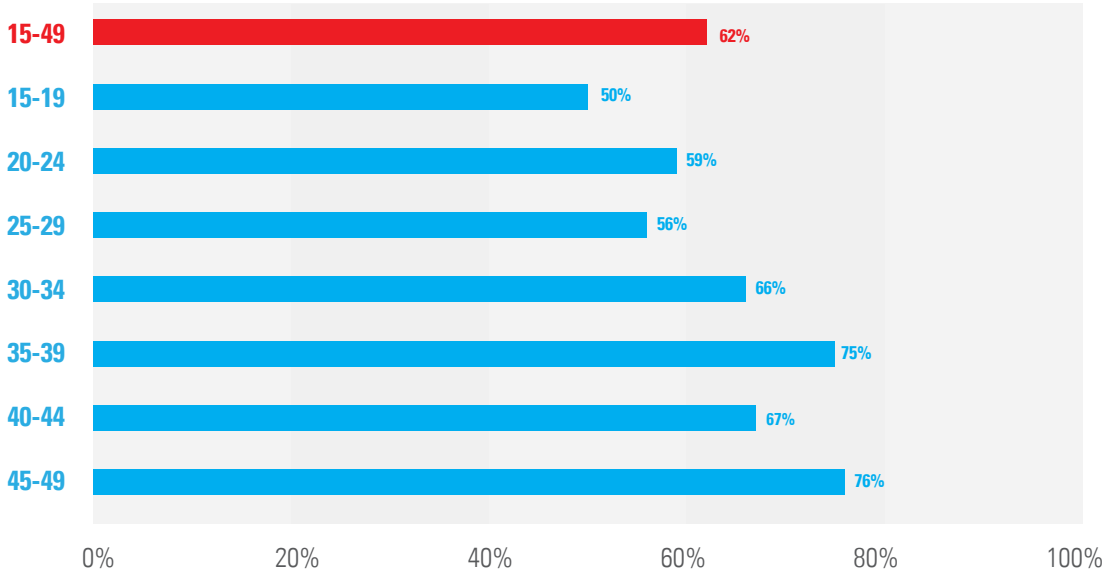
Table 9: Trends in indicators on child marriage and female genital mutilation/cutting (FGM/C), Ethiopia and Amhara region, 2000-2016

Child marriage and FGM/C	Region	EDHS 2000	EDHS 2005	EDHS 2011	WMS 2011	EDHS 2016	SDG 2030 targets
Women married by age 15 among women currently aged 15-19 (%)	National	14.4	12.7	8	-	-	0
	Amhara	-	28.7	15.3	-	-	0
Women married by age 18 among women currently aged 20-24 (%)	National	49	49	41	-	40	0
	Amhara	-	-	-	-	43*	0
Median age at first marriage (women, aged 20-49)	National	16.4	16.5	17.1	-	17.5	N/A
	Amhara	14.5	14.4	15.1	-	16.2	N/A
Female genital mutilation/cutting (aged 0-14) (%)	National	-	-	-	23	15.7	0
	Amhara	-	-	-	47.2	34.8	0
Female genital mutilation/cutting (aged 15-49) (%)	National	79.9	74.3	-	-	65.2	0
	Amhara	79.7	68.5	-	-	61.7	0

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

The practice of female genital mutilation/cutting (FGM/C) has decreased at a yearly average of 1 per cent in the 10 years before the EDHS 2016. The reduction is not fast, but at 62 per cent, the prevalence rate in Amhara region stands under the national rate of 65 per cent among women aged 15 to 49 (Table 9). In order to meet SDG 5.3 and eliminate FGM/C by 2030, Amhara should step up efforts and should reduce the percentage of girls aged 15 to 19 years who have undergone FGM/C by 26 per cent per year. Analysis across age groups shows that the younger age group (15-19 years) has a lower prevalence rate than older age groups (Figure 15), which means that FGM/C is decreasing.

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



men in rural areas of Ethiopia are more likely to be circumcised than their urban peers: 68 per cent versus 54 per cent, respectively. Wealth does not seem to influence the prevalence rate of FGM/C in Amhara, with 48 per cent of women (aged 15-49) in both the poorest and richest wealth quintiles having undergone FGM/C. It is noteworthy that FGM/C is especially carried out when girls are young (aged 0-14) (35 per cent).[61]

A study by the International Organization for Migration on trafficking in women and children in and from Ethiopia identified that there is a trend of trafficking women and children from rural areas of Amhara region to Addis Ababa and other regional towns. The main purpose is sex work and domestic work. All parts of Amhara region are affected by trafficking, although the Este and Farta woredas in the Southern Gondar Zone are the most affected.[62] The percentage of children aged 5 to 14 years who are engaged in child labour is also high. A 2015 study by CSA and the International Labour Organization found 31 per cent of children (aged 5-17) were involved in child labour compared to the national rate of 24 per cent.[63]

> **“... All parts of Amhara region are affected by trafficking, although the Este and Farta woredas in the Southern Gondar Zone are the most affected.[61]”**

In 2016, the rate of children under the age of 5 who had their births registered with civil authorities in Amhara was 1.3 per cent, of whom 0.8 per cent had a birth certificate.[64] The low rate can be explained by the fact that, until recently, Ethiopia did not have a conventional system of civil registration. Since August 2016, a national registration system for vital events has been operating. As of August 2018, 3,907 registration centres in Amhara region are providing vital events registration services. In 2010 E.C. (2017/18), 266,712 births were registered, of which 59 per cent were registered within 90 days, 30 per cent were registered after 90 days but within one year, and 11 per cent were registered after one year (the backlog). In 2017/18, 98 per cent of birth registrations in Amhara met the required standards.[65]

61. EDHS 2016.
62. International Organization for Migration, Assessment of Trafficking in Women and Children in and from Ethiopia, pp. 5 and 25.
63. CSA and International Labour Organization, Ethiopia National Child Labour Survey 2015, p. 79.
64. The percentage of de jure children under age 5 whose births are registered with civil authorities, Ethiopia EDHS 2016.
65. UNICEF Ethiopia Country Office, Birth Registration Graphs and Tables, 2018, based on FVERA's August 2018 administrative data.

There are challenges regarding separating juvenile offenders and adults in prisons, and children who accompany their mothers to prison. According to a report by the bureau of the regional attorney, in Amhara, a total of 1,335 children are living in prisons (1,231 children due to being in conflict with the law and 104 children living with their imprisoned mothers). The regional courts in Amhara do not have child-friendly benches and police stations do not have child-friendly protection units for cases of children coming into contact with police or courts (except in 20 courts that are supported by UNICEF).

In Amhara regional state, like most of the regions in the country, one in 10 children under age 18 are not living with a biological parent, and 7 per cent of these children are orphans (one or both parents dead), although the percentage of children who are orphans declined slightly from 9 per cent in 2011 to 7 per cent in 2016.[66] In 2017, a total of 3,665 street children (3,390 male and 275 female) were identified in big cities and some woreda towns in the region.[67] The current case management system is not sufficiently designed and established to address the needs of these children, although the regional government plans to deploy one community service worker per kebele at the end of the second Growth and Transformation Plan (GTP II).[68]

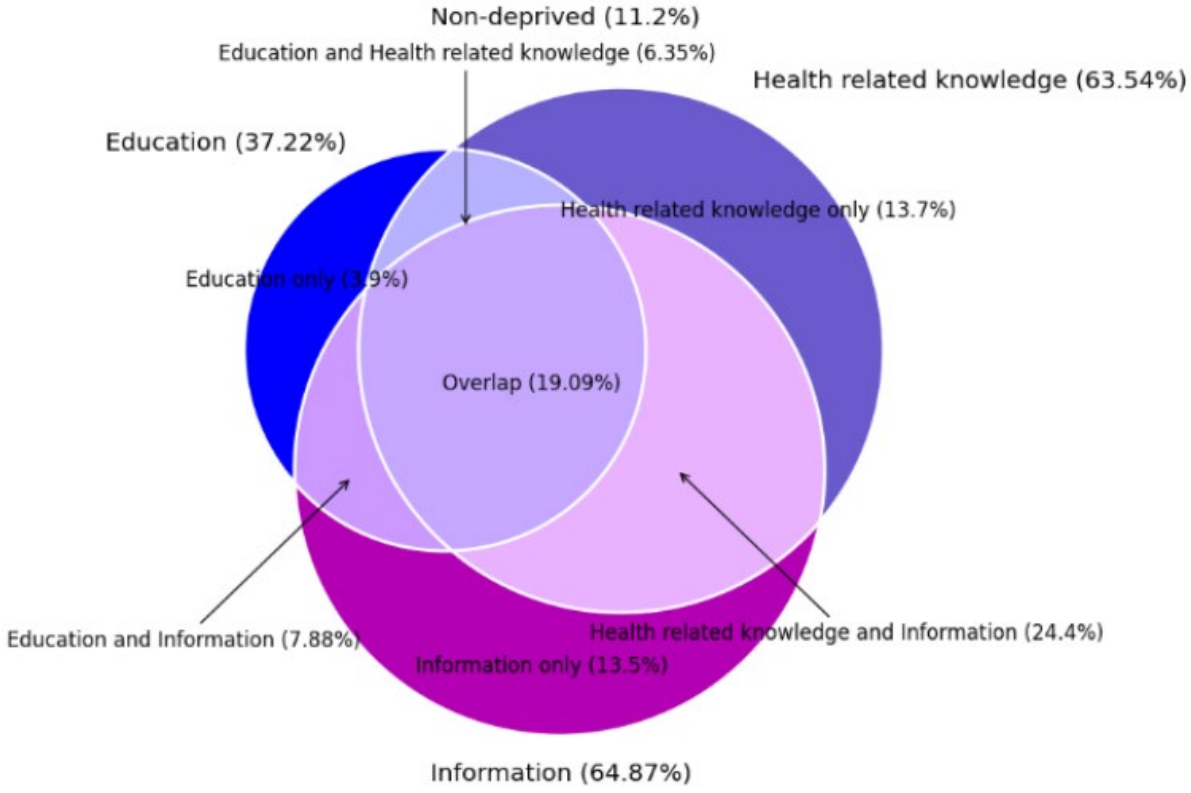
Violence against children and GBV are commonly observed human rights violations that girls and women face in the region. According to the 2016 EDHS, 35 per cent of ever-married women in Amhara region experienced physical, sexual or emotional violence in the 12 months preceding the EDHS. Of ever-married women aged 15-49 years who experienced sexual violence, 11 per cent reported it occurring in the 12 months prior to the survey.

Table 10: Trends in knowledge about HIV/AIDS and participation in community events or conversations, adolescents aged 15-17 years, Ethiopia and Amhara 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
	Amhara	24.3	34.3	100
Participation in community events or conversations where family planning is discussed	National	31	23.7	100
	Amhara	38.5	25	100

66. EDHS 2016.
67. African Child Day Commemoration Report, Amhara Bureau of Women, Children and Youth Affairs, June 2017.
68. Social Protection Action Plan, Ministry of Labour and Social Affairs 2017.

Figure 16: 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 of adolescents aged 15-17 years about HIV/AIDS transmission and prevention is above the national average, at 34 per cent versus 30 per cent, respectively, and shows great improvement since 2011. A worrying finding is the declining trend in participation in community events and conversations where adolescents can obtain information about various topics related to their well-being, including family planning. This suggests issues with sustainability of existing programmes. Only 25 per cent of adolescents aged 15-17 years participated in a community event or conversation in the few months preceding the survey 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 in reducing gender inequality, investment in improving educational outcomes should include revisions to the curriculum to include health- and nutrition-related knowledge. Nearly 20 per cent of children aged 5-17 years in Amhara are deprived in education, health-related knowledge, and information and participation, simultaneously. An additional 24 per cent are deprived in both health-related knowledge and information and participation at the same time (Figure 16).

7 SOCIAL PROTECTION

Amhara has benefitted from the PSNP. In 2014, 15 per cent of rural households were in the PSNP compared to 11 per cent of households at the national level.[69] In general, the PSNP has targeted the poorest population groups well in Amhara, and it has contributed to increased food security and household dietary diversity.[70] Since 2014, the government has implemented community-based health insurance (CBHI) in rural areas of Ethiopia, which provides financial protection against health shocks. In Amhara, CBHI enrolment rates are high among the poor, compared to the other big regions (Oromia, SNNPR and Tigray). In 2016, 38 per cent of poor households in Amhara were participating in CBHI although not in the PSNP. In addition, 42 per cent of PSNP households were also participating in CBHI.[71] A UNICEF study on the synergies and complementarities between these two social protection programmes found that, "in areas where the programmes overlapped, only minimal operational linkages were established".[72] It appears that not all PSNP households can afford the CBHI premiums. According to the study, "CBHI participation by PSNP households was largely linked with free access to CBHI (as indigent).[73] Of all PSNP households that participated in CBHI, 44 per cent did not have to pay for their premiums. This was especially the case in Amhara, which had the highest proportion of CBHI participants and indigents".[74]

Since 2015, under the umbrella of the 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. A similar programme began in Amhara in 2017.[75] The programme aims to reinforce the uptake by PSNP clients of basic social services, such as education, health care, nutrition, child protection and WASH. It particularly targets vulnerable children, adolescent girls and pregnant and lactating women. The programme tests a case management model in which 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 information management 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.[76]

69. Mini EDHS 2014, p. 15.
70. UNICEF, Reaching the Poor: Synergies and complementarities of the productive safety net programme and community-based health insurance, 2017, p. 9.
71. Ibid., p. 24.
72. Ibid., p. 9.
73. To enhance CBHI affordability, local governments are expected to cover the cost of providing free access to CBHI to the poorest 10 per cent, or the 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.
74. UNICEF, Reaching the Poor: Synergies and complementarities of the productive safety net programme and community-based health insurance, 2017, p. 10.
75. See UNICEF SPESI, Programme Strategic Note. Mid-Term Review, 2017, p. 9.
76. Food and Agriculture Organization and UNICEF, Production choices and nutrition-related implications in Ethiopia. Baseline report on the Improved Nutrition through Integrated Basic Social Services with Social Cash Transfer (IN-SCT) Pilot Programme, 2018. See also UNICEF Ethiopia Country Office, 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.

There are various educational support programmes that focus on the most disadvantaged and vulnerable children, populations and localities. Examples of social protection service delivery in education are: education fee waiver schemes; establishing and strengthening boarding/hostels for hard-to-reach children; opening mobile schools to meet the needs of hard-to-reach children; providing scholarships to at-risk, poor and disadvantaged children to support their progression to the second cycle of primary education; the National School Feeding Programme (NSFP) 2016-2020, which focuses on primary school children; the inclusion of adolescent nutrition in school health programmes, including an adolescent de-worming campaign and the promotion of dietary diversity, hygiene and sanitation; the supply of educational materials; and school feeding and financial support for children from poor and low-income family backgrounds.[77]

Ethiopia is strongly committed to expanding equitable access to water and sanitation as part of its social protection policy. The food security programme and the PSNP (public works) are major contributors to WASH. A 2018 World Bank WASH Poverty Diagnostic in Ethiopia states that there has been geographical targeting of WASH investments to areas with a higher concentration of children with poor nutrition status and health access. This has resulted in increased water access in food insecure agrarian areas.[78] Access to water in urban areas shows an inequitable uptake due to a lack of infrastructure for unconnected households and barriers in the form of unaffordable connection charges for poor households. To improve sanitation services for the poorest households in urban areas, government subsidies channelled through the Urban PSNP might be considered; that is, subsidies that would focus on reducing borrowing costs for improving household sanitation infrastructure.[79]

77. ESDP V, p. 81. Second National Nutrition Programme (NNP II) p. 20. UNICEF Ethiopia Country Office, UNICEF Annual Report 2017, Ethiopia, p. 7.
78. World Bank, Maintaining the Momentum while Addressing Service Quality and Equity: A diagnostic of water supply, sanitation, hygiene and poverty in Ethiopia, 2018, p. xiv.
79. Ibid.

“Another focus area of Ethiopia’s social protection strategy targets reducing abuse, violence (GBV), exploitation, neglect and discrimination, and providing legal protection and support to victims.”

Another focus area of Ethiopia’s social protection strategy targets reducing abuse, violence (GBV), exploitation, neglect and discrimination, and providing legal protection and support to victims. It focuses on the rights of marginalized people, in particular women and children. According to the strategy, the social protection sector will focus on working with communities and survivors of abuse and their families. Key instruments in the area of prevention are communication and raising awareness to prevent abuse, violence, neglect and exploitation, as well as the insurance of a protective legal and policy environment. Key instruments in the area of response are support for survivors of violence, abuse, exploitation and neglect; drop-in centres and hotlines; the establishment of a network of specialized service providers; and care for people living outside protective family environments.

Social protection interventions are still largely financed by international donor agencies and implemented by the government. Nevertheless, the government is progressively increasing domestic financing for social protection.[80] A UNICEF Budget Brief underlines the problem of tracking budgets and expenditure for social protection in the state budget.[81] The systems approach for social protection should include the use of common administrative mechanisms to avoid budgetary fragmentation. Currently, budgets and expenditure for social protection are spread across various categories and ministries/agencies.[82] While acknowledging the development of a comprehensive social protection system, insufficient funding and inefficient spending are barriers to implementing social protection measures that reduce economic and social barriers for children accessing basic services. These include education, health care, nutrition, child protection and WASH. Considering Ethiopia has one of the highest MCD rates of Sub-Saharan Africa, scaling up social protection for children is a necessity that demands continued investment in child-sensitive social protection measures.[83]

80. UNICEF Ethiopia Country Office, National Social Protection Budget Brief: 2011-2016, 2017, pp. 1 and 7. See Ministry of Finance and Economic Cooperation, Research Agenda on Fiscal Policy Reform in Ethiopia 2018, for more information on its research and capacity building needs.
81. UNICEF Ethiopia Country Office, National Social Protection Budget Brief: 2011-2016, 2017, p. 1.
82. Ibid., p. 4
83. UNICEF, Analysing Child Poverty and Deprivation in Sub-Saharan Africa: CC-MODA – Cross Country Multiple Overlapping Deprivation Analysis, Innocenti Working Paper No. 2014-19, 2014, pp. 1-41.

8 CLIMATE CHANGE AND CHILD RIGHTS

The climate in Amhara region is affected significantly by weather variations. Traditionally, the region has a hot zone (lowlands), a warm zone (areas between 1,500m-2,500m) and a cold zone (2,500m-4,620m). In the coming years, it is expected that an increase in projected temperatures and a decrease in rainfall will result in more hot days and fewer cold and rainy days. The high prevalence of poverty, high rates of malnutrition, high population growth and low climate adaptive capacities increase vulnerability to climate change in Amhara Regional State.[84] 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.[85]

> **"Amhara farmers are already facing droughts, frost, hailstorms, flooding and landslides. Very localized flooding of fields under hillsides by rainfall run-off is a frequent problem, but in the foothills of the high mountain areas of north-west Amhara it is a particularly widespread hazard."**

Amhara farmers are already facing droughts, frost, hailstorms, flooding and landslides. Very localized flooding of fields under hillsides by rainfall run-off is a frequent problem, but in the foothills of the high mountain areas of north-west Amhara it is a particularly widespread hazard. It was estimated that more than 100,000 people were at risk of flooding and more than 25,000 people were likely to be displaced in 2018.[86] Drought has been a major agricultural production constraint in low rainfall areas in Amhara. There is also a scarcity of drinkable water.

The 2015-2016 El Niño episode significantly affected farmers in the eastern cropping areas of Amhara. Failure of rain led to failure of entire harvests. This impacted children in Amhara, 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, etc.[87] It appears that economic migration of children intensified, including to Addis Ababa or overseas locations, such as the Gulf States.[88]

84. Ayalew et al., Outlook of Future Climate in Northwestern Ethiopia, in: Agricultural Sciences, Vol. 3. No. 4, 2012, p. 623. See also World Bank, Economics of Adaptation to Climate Change, Ethiopia, 2010.
85. 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).
86. Joint Government and Humanitarian Partners, Flood Response Plan Ethiopia, Sept. 2018.
87. See e.g. UNICEF, Generation El Niño: Long-term impacts on children's well-being, Final Report, 2018.
88. Ibid., p. 30.

9 GENDER EQUALITY

As in other regions of Ethiopia, Amhara 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 regarding 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 as nurturers and carers, thus childcare responsibilities often fall exclusively to them.

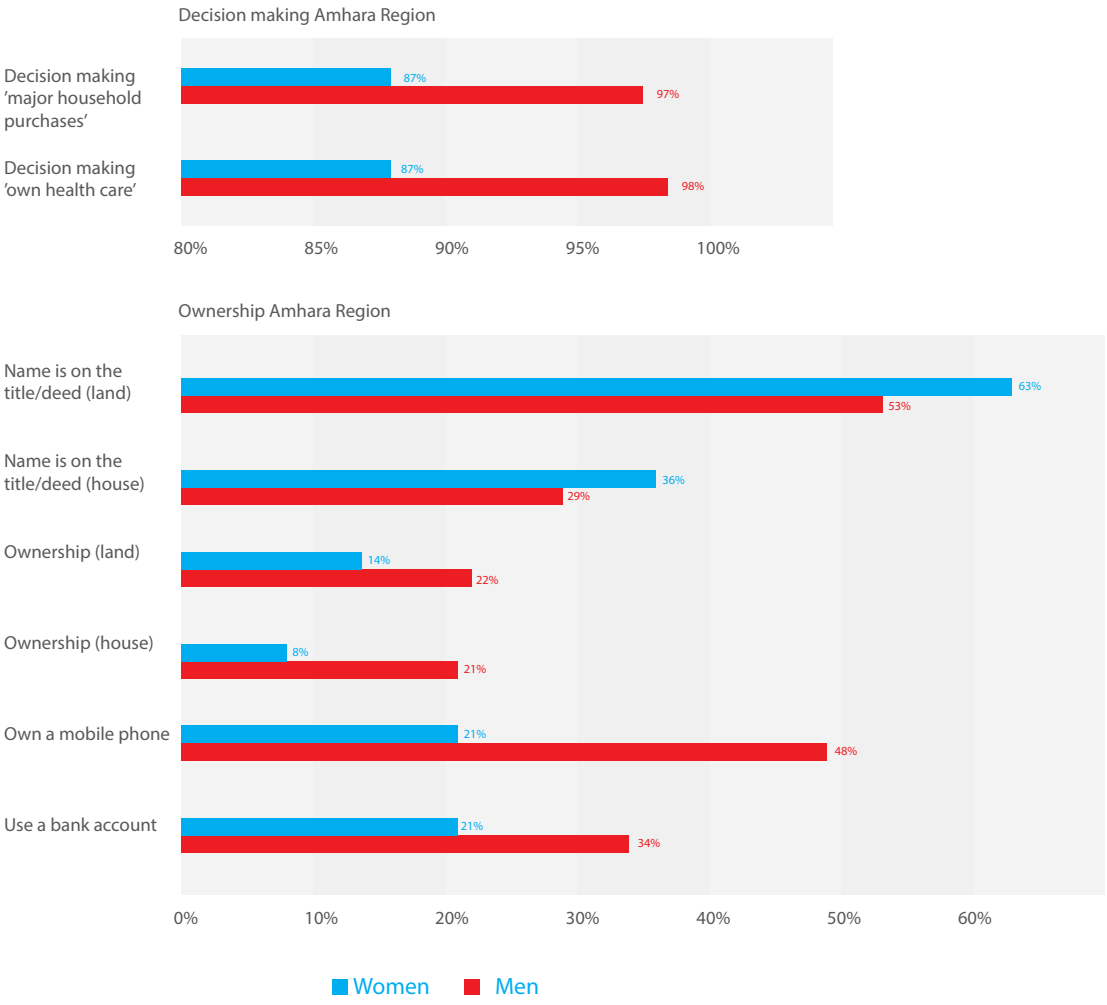
"According to the EDHS 2016, in Amhara region, 15 per cent of women (aged 15-49) decided themselves on their first marriage (the lowest rate in the country), while 83 per cent of women stated that their parents made the decision for their first marriage (the highest rate in the country)."

According to the EDHS 2016, in Amhara region, 15 per cent of women (aged 15-49) decided themselves on their first marriage (the lowest rate in the country), while 83 per cent of women stated that their parents made the decision for their first marriage (the highest rate in the country).[89] Interestingly, the rate of women (aged 15-49) who stopped attending school after marriage is one of the lowest in the country, at 64 per cent. When asked what the main reason was for discontinuing school, 41 per cent of women cited that they are too busy with family life; this is again the lowest rate in the country. Therefore, on the one hand, girls/women in Amhara have very limited say in the decision to get married, yet, a relatively high rate of girls/women continue education after marriage. An explanation can be found in the fact that only 8 per cent of girls (aged 15-19) have begun child bearing, which is very low compared to other regions. This relatively low rate corresponds with the high rate of use of modern contraceptive methods among women in Amhara (47 per cent), second only to Addis Ababa.[90] Another reason cited by women for discontinuing school is that their husbands refused to let them continue (36 per cent).[91] In Amhara, husbands and mothers-in-law hold significant power over young wives/daughters-in-law, controlling where they go and what they do outside of the domestic sphere. Married adolescent girls are often the most vulnerable individuals in their communities.[92] Similar to other regions, Amhara women are often denied their share of inheritance when their parents or husbands die. It is common for women to be excluded from decisions on common property in marriage and be denied their due share during divorce.[93] Child support is commonly refused after divorce. Women are routinely denied their rights in relation to land, for example leasing land, sharecropping, selling products of the land, etc.[94] Figure 17 shows the unequal distribution of power between women and men in decision making and ownership. It is interesting that more women than men have their names on deeds of land and houses.

The proportion of women in Amhara whose husband participates in household chores is 44 per cent, of whom 17 per cent participate every day.[95] The EDHS 2016 shows that women are more deprived of information than men. The Internet is a critical tool to access information, and Amhara women are almost four times less likely to use it than men.[96] In Amhara, women are less exposed to mass media than men: 2 per cent of women and 3 per cent of men read a newspaper at least once per week; 10 per cent of women and 20 per cent of men watch television at least once per week; and 8 per cent of women and 25 per cent of men listen to the radio at least once per week.[97].

89. EDHS 2016, p. 278.
90. Ibid., p. 114.
91. Ibid., p. 279.
92. International Center for Research on Women, Improving the Lives of Married Adolescent Girls in Amhara, Ethiopia: A summary of the evidence, 2014, p. 1
93. FDRE, Ministry of Women, Children and Youth Affairs, Assessment of Conditions of Violence Against Women (VAW) in Ethiopia, draft report, 2013.
94. Ibid.

Figure 17: Percentage of married women and men (aged 15-49) in Amhara region who make specific decisions either alone or jointly with their spouse; and percentage of women and men (aged 15-49) in Amhara region by use of bank account and ownership of mobile phones and real estate. Source: EDHS 2016



Rates of GBV are high in Amhara region.[98] The proportion of women (aged 15-49) who have ever experienced psychological, physical or sexual violence committed by their current or most recent husband/partner is 26 per cent, 22 per cent, and 10 per cent, respectively.[99] The percentage of women who believe that a husband is justified in hitting or beating his wife in various circumstances is 65 per cent. In contrast, 46 per cent of men agree that wife beating is justified in some circumstances.[100] These figures are high, but a declining trend has occurred since 2011.

95. Ibid., p. 280.
96. Ibid., pp. 49 and 50. Percentage of women and men aged 15-49 who have used the Internet in the past 12 months.
97. Ibid., pp. 47 and 48. Percentage of women and men aged 15-49 who are exposed to specific media on a weekly basis.
98. FDRE, Ministry of Women, Children and Youth Affairs, Assessment of Conditions of Violence Against Women (VAW) in Ethiopia, draft report, 2013.
99. EDHS 2016, p. 306.
100. Ibid., pp. 283 and 284.

10 OTHER SPECIFIC ISSUES

According to UNOCHA, "longstanding tensions and sporadic conflict between the Amhara and Qemant communities spiked in September 2018 across the Central and West Gondar zones of the region, leading to the displacement of around 56,000 people as of the 4th week of February 2019".[101] As a result of insecurity due to conflict, basic social services such as education and health were suspended in some woredas. The security situation improved, following the deployment of the Ethiopian Defence Force.

As of the last week of February 2019, the total number of internally displaced persons (IDPs) in Amhara region was approximately 90,000, the majority of whom were displaced since September 2018. Displaced Amharas also come from other regions. A number of IDPs are displaced due to climatic shocks. Most of the displaced population is settled across the region with host communities (70 per cent), while the other 30 per cent are in temporary settlement sites.

101. UNOCHA, Amhara Flash Update, 1 March 2019. See also Joint Government and Humanitarian Partners, Flood Response Plan Ethiopia, Sept. 2018. UNOCHA, Ethiopia. Overview of Recent On-going Inter-Communal Violence and Displacement No. 2, Oct. 2018.

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

- 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.
- Deprivations in water, sanitation and housing for children under 18 in Amhara are above the national average. These sectors should be given dedicated attention in policy and programme design at the regional level.

- Amhara has the highest rate of stunting among children under 5 in Ethiopia and the highest deprivation rates for information devices (radio, television, mobile phone) at the household level. Incidence of exclusive breastfeeding and improved toilet types show a decreasing trend between 2011 and 2016. These indicators should have dedicated special attention in terms of policy planning and budgeting at the regional level, including optimizing the range of interventions that can jointly tackle more vulnerabilities simultaneously.
- Promote a multi-sectoral approach to programme and policy design for effective poverty reduction. Coordination of sectors at different levels of governance, as well as across different administration and service delivery structures, is paramount.
- To curb the high burden of under-five, infant and neonatal mortality there is a need to: 1) improve equity-focused coverage of lifesaving MNCH services through capacity building, strengthening community platforms with C4D, and rigorous programme monitoring across the continuum of care, 2) continue to support immunization with an equity-focused programme planning and analysis approach that reaches every child, including the high number of unimmunized children, and 3) strengthen the health system and improve the quality of MNCH services with a focus on the primary health care system.
- Considering the high stunting, wasting and overweight rates in children, the government should strengthen its focus on accelerating a reduction of child malnutrition by giving attention to infant and young child feeding practices, micronutrient intake and nutrition awareness.[102] Sustain the decline of people living under the food poverty line, and strengthen nutrition governance and accountability to increase multi-sectoral coordination between nutrition implementing sectors to enforce policy. Strengthen the health system to provide quality health and nutrition services and enhance health system resilience to respond to health and nutrition emergencies.
- Continue to encourage the development of early childhood education by scaling up quality pre-school programmes that help prepare children for primary school, such as kindergarten programmes and the opening of pre-primary schools. Give attention to girls' education, as the GPI in primary school is widening. Education will create a lasting impact on girls' development and empowerment, and of their children.

[102] The SUN movement introduced a methodology that distinguishes nutrition-specific interventions (those that address the immediate determinants of nutrition) and nutrition-sensitive interventions (those that address the underlying causes of under-nutrition). The Lancet developed a framework for action that shows "the potential effects of nutrition-sensitive interventions that address the underlying determinants of malnutrition and incorporate specific nutrition goals and actions. It also shows the way that an enabling environment can be built to support interventions and programmes to enhance growth and development and their health consequences". Note the framework for actions to achieve optimum foetal and child nutrition and development. The Lancet 2013 (Black et al.), Maternal and Child Nutrition 1, Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries.

- Considering the high number of malfunctioning water schemes, continue efforts to sustain water schemes by strengthening community awareness, participation and ownership of WASH interventions at woreda level. Taking into account the high rate of children under 5 years of age with diarrhoea and the low rate of households that have soap and water available at their hand-washing facility, it is important to focus on basic hygiene practices.
- Children should be equipped with key climate change adaptation skills to build their resilience. Teachers and caregivers should be supported to teach children about climate change and how they can make a difference in their schools, homes and local communities. Climate change adaptation should include the voices of children.
- Increase efforts to reduce harmful practices in the region, especially child marriage, FGM/C and GBV, including through: scaling up community-level interventions that target the cultural acceptance of GBV and harmful practices; considering different community-based organizations and male roles in promoting, protecting and responding to GBV; raising awareness about the damaging nature of these practices; strengthening women's economic empowerment; and recording and managing data at all levels regarding GBV cases. Increase efforts to equip children with basic skills to respond to FGM/C and GBV by creating legal awareness of child rights and protection issues, including for in- and out-of-school girls and the community at large.
- On social protection, strengthen the Integrated Safety Net Programme (ISNP) or social cash transfer programmes with a special focus on permanent direct support and temporary direct support. Establish a sub-national social protection system and ensure links between CBHI and PSNP to increase access to health for permanent direct support clients.
- Prioritize budget allocation to poverty reduction for children with the aim of enhancing equality and making progress in reducing child poverty. Enhance evidence-based policymaking in the area of child poverty and deprivation reduction through continuous support of data collection activities and improvements to existing tools.

SITUATION ANALYSIS OF CHILDREN AND WOMEN:
Amhara

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