Situation Analysis of Children and Women: Dire Dawa Administration

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This briefing note covers several issues related to child well-being in Dire Dawa Administration. It builds on existing research and the inputs of UNICEF Ethiopia sections and partners. 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

Dire Dawa Administration is in the east of Ethiopia, bordering the regions of Oromia and Somali. The Dire Dawa Administrative Council consists of the city of Dire Dawa and the surrounding rural areas. In total, almost 0.5 per cent of the Ethiopian population lives in the Dire Dawa Administration, [2] and 10 per cent of its population are children under 5 years.[3] According to 2019 population projections, 313,000 people (63 per cent) live in the City of Dire Dawa and 180,000 people (37 per cent) live in the rural areas.[4] Dire Dawa city is one of the four 'medium' cities in Ethiopia Dire Dawa, Adama, Mekele and Gondor - meaning it has between 300,000 and 500,000 inhabitants. The total fertility rate is 3.1 for women of reproductive age (15-49 years).[5] This rate has declined from 3.4 in 2011 and 3.6 in 2005.[6]

> **"The Dire Dawa Administrative Council consists of the city of Dire Dawa and the surrounding rural areas. In total, almost 0.5 per cent of the Ethiopian population lives in the Dire Dawa Administration..."**

Table 1: Total population and population of children under 5 years, Ethiopia and Dire Dawa, 2019

Demographics	National	Addis Ababa
Total population (2019 projection based on the 2007 Census, CSA)	98,663,000	493,000
Total under-18 population (2019 projection based on 2007 Census, CSA)	44,714,454	170,034
Total under-5 population (2019 projection based on the 2007 Census, CSA)	13,605,728	50,062

The economy of Dire Dawa has grown considerably. A new industrial park is operating, designated for various industries, including textiles and apparel, vehicle assembly, food processing, fertilizers, electronics and paper. This is creating vast employment opportunities. As per March 2019, Dire Dawa is hosting 11,245 internally displaced people in two sites in the region. These people are displaced due to conflict; 1,893 are children under 5 years and 6,396 are under 18 years.[7]

2. 2019 projection based on the 2007 Census, Central Statistical Agency (CSA).
3. Ibid.
4. Ibid.
5. EDHS 2016, p. 84.
6. See EDHS 2005 and 2011.

2 POVERTY, DEPRIVATION AND VULNERABILITY

Since 2004/05, Dire Dawa has seen a 20-percentage-point decline in monetary poverty (Figure 1 and Table 2).[8] As Figure 1 shows, the reduction was substantially faster between 2010/11 and 2015/16. The total monetary poverty rate now stands at 15 per cent, which is the second lowest poverty rate in the country, after Harari.[9] Urban poverty is relatively low, at 11 per cent, versus rural poverty at 23 per cent.

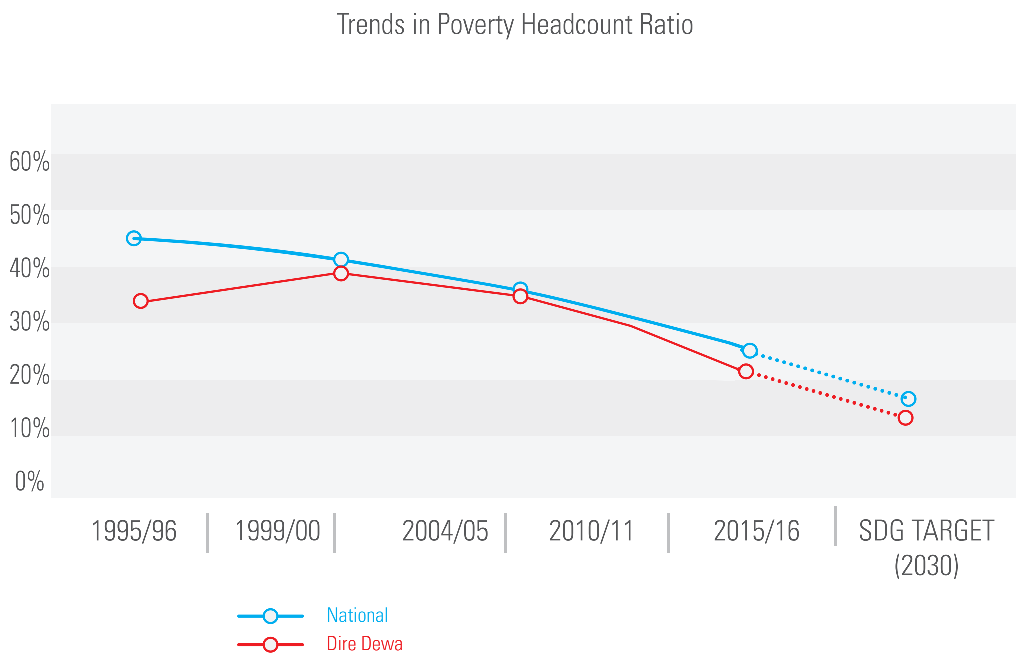
Similar to monetary poverty, the rate of people living below the food poverty line has declined since 2004/05, and stands far below the national average (12 per cent versus 25 per cent). This is the second lowest food poverty rate in Ethiopia.[10] The food poverty rate in urban areas is 10 per cent, while in rural areas it is 17 per cent.

Table 2: Trends in monetary and food poverty rates, Ethiopia and Dire Dawa, 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
	Dire Dawa	29.5	33.1	35.2	28.3	15.4	7.7
People living below the food poverty line (%)	National	49.5	41.9	38	33.6	24.8	12.4
	Dire Dawa	35.1	27.6	34.5	22	12.2	6.1

7. International Organization for Migration, Displacement Tracking Matrix, Round 15, March 2019.
8. 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.
9. Ibid.
10. Ibid., p. 22.

Figure 1: Trends in poverty headcount and food poverty from 1995/96 to 2015/16, Ethiopia and Dire Dawa. Source: HCES



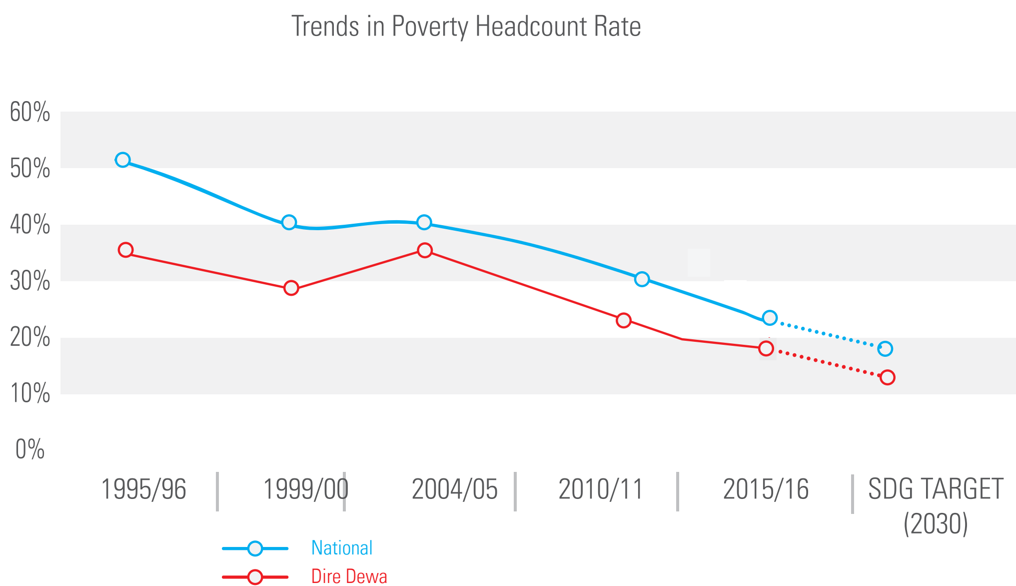
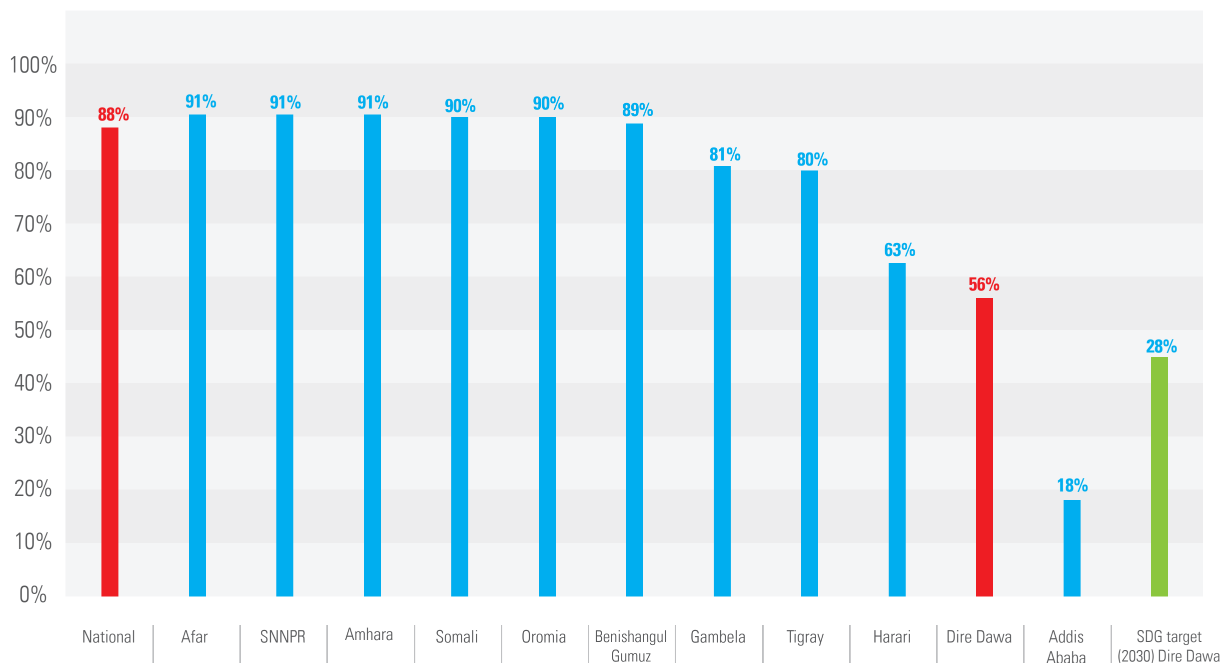


Figure 2: Rate of MCD (3 to 6 deprivations) in Ethiopia by region, 2016. Source: CSA and UNICEF, MCD in Ethiopia, First National Estimates, 2018



Dire Dawa has the second lowest multi-dimensional child deprivation (MCD) rate in Ethiopia, after Addis Ababa: 56 per cent of children under 18 years, or 88,046 in absolute numbers are deprived of an average of 4.3 basic needs and rights (Figure 2). Even though MCD incidence in the region is significantly lower than the national average of 88 per cent, it signifies that the most basic rights of more than half of the child population in Dire Dawa are not fulfilled. As a result of the relatively low incidence of MCD, deprivation intensity below the national average, and the small population size, Dire Dawa accounts for only 0.3 per cent of the adjusted MCD index (M0) in Ethiopia. The MCD rate among children under 5 (54 per cent) is lower than the national average (89 per cent). This is also true for 5- to 17-year-olds, at 57 per cent for Dire Dawa and 87 per cent for Ethiopia, on average. Between 2011 and 2016 there was a 1-percentage-point increase in the MCD headcount rate in the region, while the average deprivation intensity decreased from 4.5 to 4.3. The adjusted MCD index remained unchanged between 2011 and 2016.

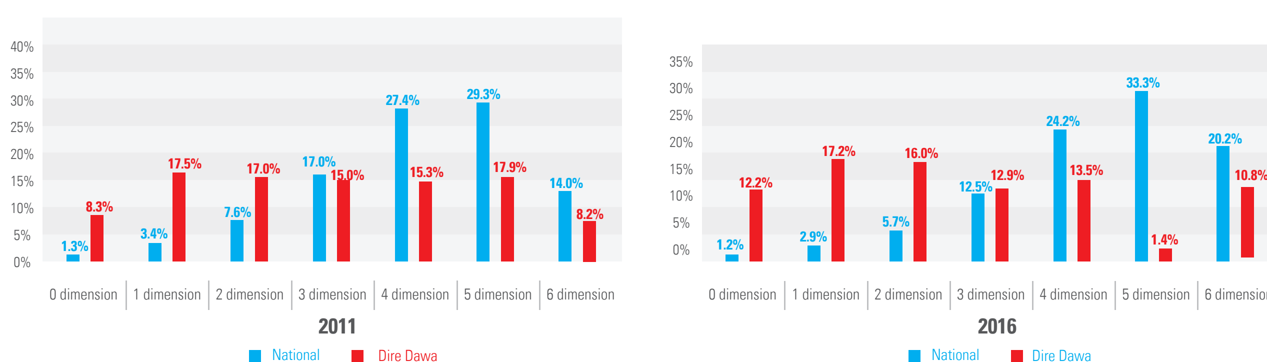
> **Dire Dawa has the second lowest multi-dimensional child deprivation (MCD) rate in Ethiopia.....**

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

MCD estimates in Ethiopia and Dire Dawa using EDHS 2016 and 2011	**MCD indices**	**MCD rate (H)**		**Average deprivation intensity**		**Adjusted MCD Index (M0)**	
	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
	Dire Dawa	63	54	4.5	4.3	0.47	0.38
Children aged 5-17 years deprived in 3-6 dimensions	National	89	87	4.7	4.5	0.69	0.65
	Dire Dawa	51	57	4.5	4.4	0.38	0.42
Children under 18 years deprived in 3-6 dimensions	National	90	88	4.7	4.5	0.7	0.65
	Dire Dawa	55	56	4.5	4.3	0.41	0.41

Children in Dire Dawa are less likely to be deprived of a larger number of basic needs and services than the national average, as the distribution is skewed to the left, that is, a smaller number of deprivations. More than 8 per cent of children in the region are not deprived in any of the six dimensions analysed, compared to the national average of 1.3 per cent. Moreover, 26 per cent of children in Dire Dawa are deprived in at least five dimensions compared to 43 per cent of children across Ethiopia on average (Figure 3).

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



The largest contributors to MCD among children under 5 in Dire Dawa are deprivations in housing, sanitation and nutrition, while among children aged 5 to 17 years it is deprivations in health-related knowledge, information and participation, and housing (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 Dire Dawa and Ethiopia, EDHS 2016 estimates**						
Children under 5 years (%)	**Dimensions**	**Development (stunting)**	**Health**	**Nutrition**	**Water**	**Sanitation**	**Housing**
	Dimensions	Development (stunting)	Health	Nutrition	Water	Sanitation	Housing
	National	38	68	73	59	90	90
Children aged 5-17 years (%)	**Dire Dawa**	**40**	**43**	**64**	**34**	**51**	**54**
	Dimensions	Education	Health-related knowledge	Information and participation	Water	Sanitation	Housing
	National	50	69	66	56	89	89
Children under 18 years (%)	**Dire Dawa**	**36**	**70**	**70**			**52**
	Dimensions	Water	Sanitation	Housing			
	National	57	89	89			
	Dire Dawa	33	50	53			

3 NUTRITION, HEALTH AND SURVIVAL

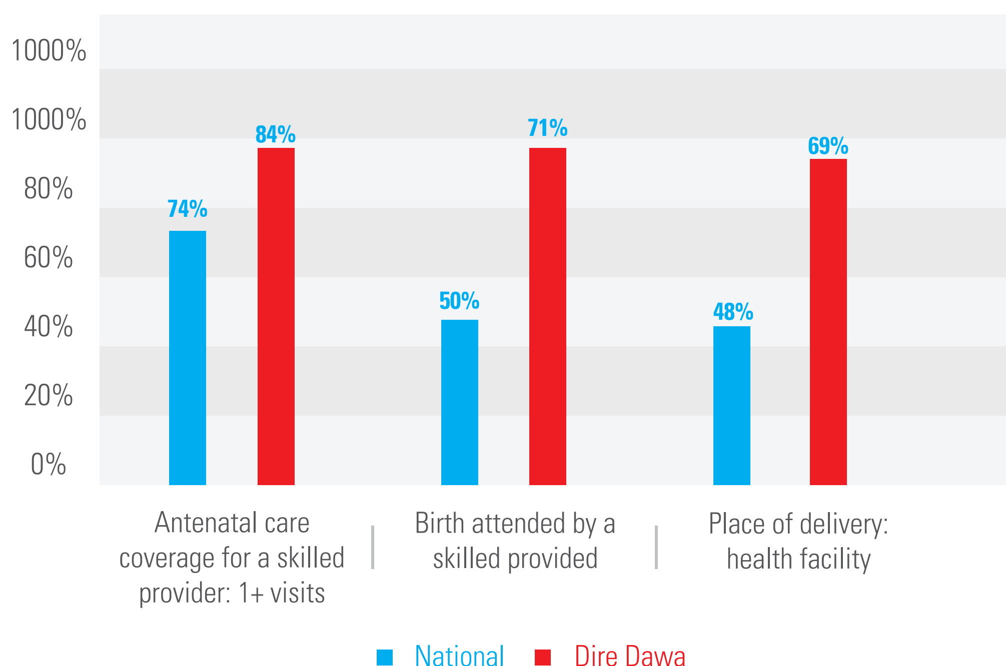
Dire Dawa has made consistent progress in maternal health care. The rate of pregnant women in the region who gave birth in the five years preceding the survey and received antenatal care during their pregnancy from a skilled health provider increased from 57 per cent in 2011 to 84 per cent in 2019 (Figure 4). EDHS 2016 showed that, educational attainment and wealth are factors: 77 per cent of women in Dire Dawa with no education and 77 per cent of women in the lowest wealth quintile received antenatal care from a skilled provider compared to 100 per cent of women with a higher education and 94 per cent of women in the richest wealth quintile.[11] The rate of skilled attendance during delivery increased from 40 per cent in 2011 to 71 per cent in 2019. [12] Still, one out of every 10 women in Dire Dawa did not have any assistance during delivery. The rate of women who delivered in a health facility increased from 40 per cent in 2011 to 69 per cent in 2019. [13] Women in Dire Dawa receiving postnatal care within 48 hours is low, at 28 per cent.[14]

The issue of child mortality in Dire Dawa needs to be flagged. The under-five mortality rate is the fourth highest in the country, with 93 deaths per 1,000 births after Afar, Benshangul-Gumuz, and Somali. This has decreased only slightly since 2011 (Figure 5). It is very concerning that infant and neonatal morality rates increased between 2011 and 2016, to 67 and 36 deaths per 1,000 live births, respectively. This is striking, as 63 per cent of the Dire Dawa region is urban, and it could be assumed that people have better access to health care in urban areas. There appear to be other hindering factors in play that result in low access, such as:[15]

- There are pastoral development challenges in the rural areas of Dire Dawa Administration, including limited access to health services due to high mobility
- Limited knowledge and recognition of childhood illnesses
- Traditional medicine is the first-line choice of treatment. There is pressure on mothers from elders to use home remedies and traditional medicine instead of seeking medical care at a health institution.
- There is a cultural belief that mothers should keep babies at home during the first 40 days and should keep visitors away from babies
- Lack of awareness about integrated community case management and community-based newborn care services offered at health facilities
- Prioritizing daily activities and earning a living over visiting a health institution
- Gender roles: Taking a sick child to a health institution may depend on the husband's approval, the money available, and the husband's readiness to accompany mother and child (protection, communication)

11. EDHS 2016.
12. Compare EDHS 2011 and EDHS 2019, p. 14.
13. According to the EDHS 2016, 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".
14. EDHS 2019, p. 14.
15. UNICEF Ethiopia Country Office, Barrier Analysis Study in Selected Woredas of Tigray and SNNP Regions, Ethiopia.

Figure 4: Maternal health care in Ethiopia and Dire Dawa. Source: EDHS 2019



- Poor service promotion: Lack of appropriate and respectful care, explanations, examination of the child
- Drug shortages, including vaccines
- Service interruptions
- Limited programme ownership by the health system and the government.

To increase access to high-impact essential newborn care interventions for every newborn, the Government of Ethiopia, in collaboration with its partners, has been implementing several facility-based newborn care interventions. These include the Newborn Corner (NBC) Initiative at health centre level, and the establishment of Level II Neonatal Intensive Care Units (NICU) at all public hospitals across the country. The facility-based newborn care programme has contributed to improved access and coverage for essential newborn care, neonatal resuscitation and Level II NICU services. However, there is still high newborn mortality, low utilization of maternal, newborn and child health (MNCH) services along the continuum of care, and poor quality maternal and newborn health (MNH) services in several areas. There is also inequity in service utilization and reduction of neonatal, infant and under-five mortality within the Dire Dawa region and between wealth quintiles.

The prevalence of acute respiratory infection declined, from 7 per cent in 2000 to 4 per cent in 2016. The rate of children under 5 years with diarrhoea increased from 8 per cent in 2011 to 12 per cent in 2016, and 68 per cent of children under 5 years with diarrhoea sought advice or treatment from a health provider. [16] Dire Dawa has managed to increase the rate of children with all basic vaccinations from 59 per cent in 2011 to 76 per cent in 2016[17] (Table 6).

16. EDHS 2016, p. 180.
17. Ibid., p. 172.

Figure 5: Trends in early childhood mortality rates in Dire Dawa, Ethiopia (deaths per 1,000 births in the 10 years preceding the survey). Source: EDHS 2000, 2005, 2011 and 2016

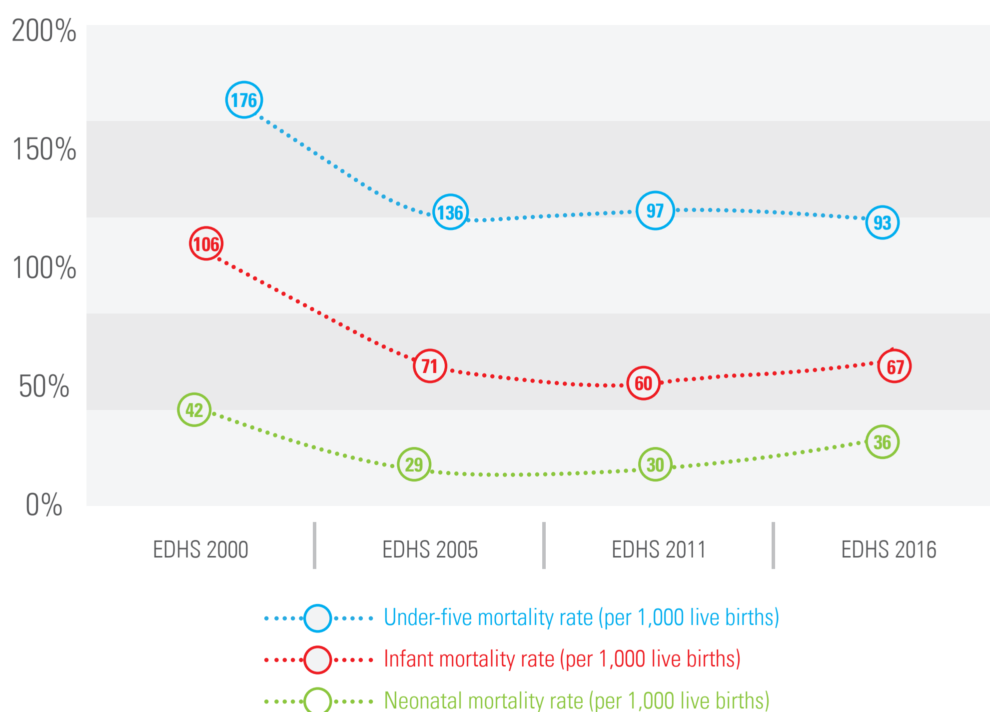


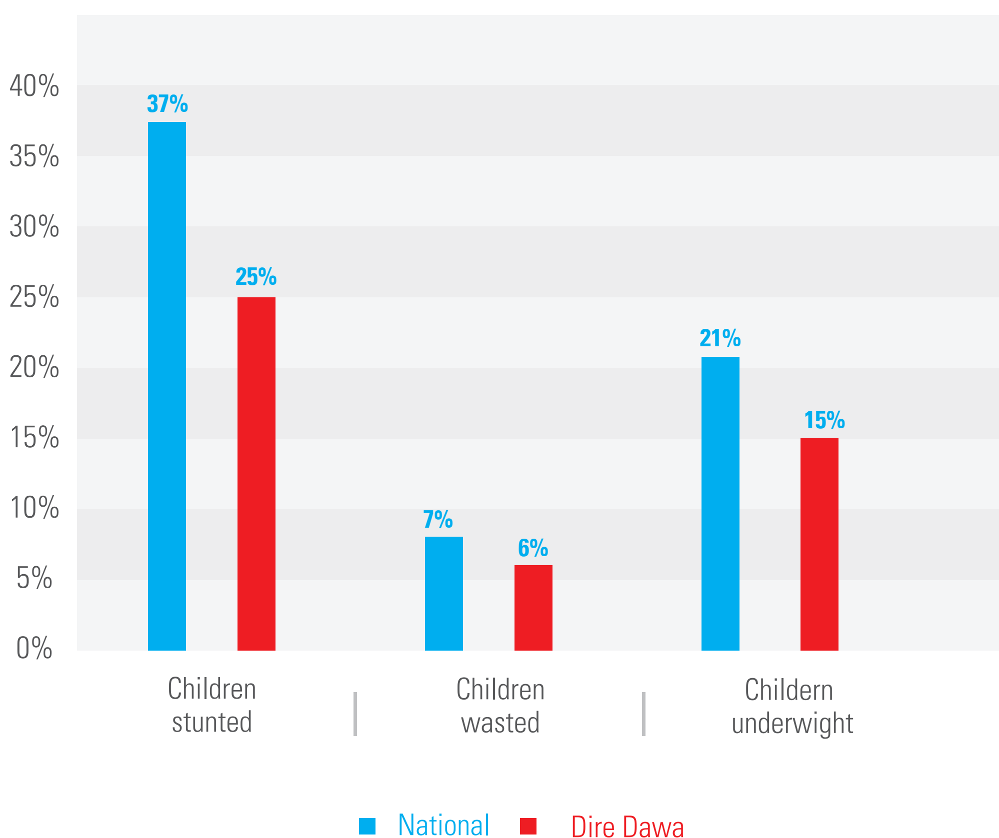
Table 5: Trends in child survival and maternal health indicators, Ethiopia and Dire Dawa region, 2000-2016

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
	Dire Dawa	57.6	52.9	57.2	87.4	83.8	100
Skilled attendance during delivery (%)*	National	5.6	5.7	10	27.7	49.8	100
	Dire Dawa	33.5	26.7	40.3	56.7	70.7	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
	Dire Dawa	176	136	97	93		<25
Infant mortality rate (per 1,000 live births)**	National	97	77	59	48		N/A
	Dire Dawa	106	71	60	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.*

Despite its urban character and its relatively low food poverty rate, malnutrition in children in Dire Dawa is a very concerning issue. The stunting prevalence of children under 5 years increased from 36 per cent in 2011 to 40 per cent in 2016 but declined to 25 per cent in 2019(Figure 6)[18] . As indicated in EDHS 2016, the level is particularly high among children between 18 and 35 months, at 55 per cent. Children's socio-economic status affects stunting, as does mother's education.[19] The EDHS 2016 also shows that stunting among children whose mother has not completed any formal education is 49 per cent, compared to 28 per cent among children whose mother has completed secondary or higher education. Interesting to observe is that only children in the richest wealth quintile have a significantly lower chance of being stunted: the stunting rate in the richest wealth quintile is 26 per cent, versus 51 per cent in the four other wealth quintiles.

Figure 6: Under-five child under-nutrition in Ethiopia and Dire Dawa. Source: EDHS 2019



18. EDHS 2019.
19. Ibid.

Table 6: Trends in child health and nutrition indicators, Ethiopia and Dire Dawa, 2000-2016

Child health and nutrition	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
	Dire Dawa	35.3	34.4	58.6	75.9	53	100
Stunting prevalence (%)***	National	57.8	51.5	44.4	38.4	36.8	22.1
	Dire Dawa	30.5	30.8	36.3	40.2	25.4	15.2
Wasting prevalence (%)***	National	12.9	12.4	9.7	9.9	7.2	<5
	Dire Dawa	11.1	11.4	12.3	9.7	5.8	<5
Underweight prevalence (%)***	National	42.1	34.9	28.7	23.6	21.1	N/A
	Dire Dawa	30.8	29.6	27.6	26.2	15.2	N/A
Prevalence of anaemia (6-59 months)	National	N/A	53.5	44.2	56.9		N/A
	Dire Dawa	N/A	60.7	62.9	71.5		N/A

**** Converted to WHO standards*

The rate of wasting in Dire Dawa decreased between 2011 and 2019, by more than half. It now stands at 6 per cent, which is less than the national average. According to EDHS 2016, wasting is especially problematic among very young children, with one in four children under 6 months and one in three children between 9 and 12 months being wasted. Factors like education and wealth show a mixed picture. Underweight in children under 5 years has also decreased significantly, from 28 per cent in 2011 to 15 per cent in 2019.[20] The underweight rate is highest among four-year-old children, at 29 per cent. The prevalence of anaemia - a proxy indicator for iron deficiency - among children under 5 years is 72 per cent, compared to the national average of 57 per cent (Table 6). The prevalence of anaemia in women is 30 per cent, and 22 per cent of women are thin (BMI below 18.5).[21]

According to the 2016 EDHS, 96 per cent (among last-born children born in the two years before the survey) were breastfed at some point, and 91 per cent started breastfeeding within one hour of birth. Only 6 per cent of children aged 6 to 23 months in Dire Dawa met the minimum acceptable dietary standards, and 14 per cent of children had an adequately diverse diet.[22] About 71 per cent of children (aged 6-59 months) receive supplementation with Vitamin A and 15 per cent are given iron supplements.[23] Limited availability of and access to diversified 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 access to basic sanitation and poor hygienic practices lead to childhood diseases like diarrhoea, which contributes to malnutrition. Other socio-economic and administrative factors contributing to under-nutrition include widespread poverty, limited employment opportunities, poor infrastructure, low education levels and inadequate access to clean water and sanitation.[24] The existing multi-sectoral coordination to reduce stunting is still inadequate. 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 management information system (MIS) is also weak at capturing and analysing data, and using it in decision making.

Improvements in nutritional and health outcomes for children under 5 years to increase their survival chances require a multi-sectoral approach and interventions. Deprivation overlap analysis shows that 21 per cent of children under 5 in Dire Dawa are simultaneously deprived of nutrition, basic health services, and adequate sanitation. An additional 15 per cent are deprived of both nutrition and sanitation, 10 per cent are deprived of health and sanitation, and less than 17 per cent are not deprived in any of these three dimensions (Figure 7).

Deprivation overlap between physical development (stunting), water and sanitation shows that deprivation across sectors is interrelated: 13 per cent of children under 5 in Dire Dawa are stunted and deprived of water and sanitation simultaneously, 18 per cent are deprived in water and sanitation at the same time, and 10 per cent are stunted and deprived of sanitation simultaneously (Figure 8).

20. EDHS 2011 and EDHS 2019.
21. EDHS 2016.
22. EDHS 2016, p. 208.
23. Vitamin A supplements in the six months before the EDHS. Iron supplements in the seven days before the survey. EDHS 2016, P. 211.
24. Ethiopia Situation Analysis for Transform Nutrition, Getahun 2001, Bhutta 2008.

Figure 7: Deprivation overlap in nutrition, health and sanitation, children under 5. Source: Calculations using MCD analysis and EDHS 2016 data

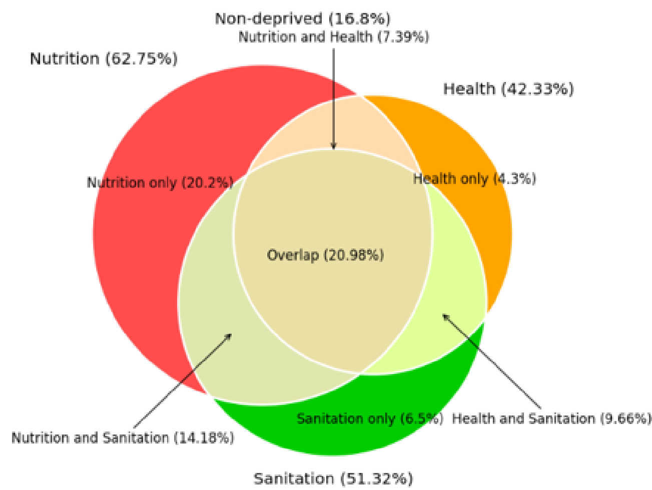
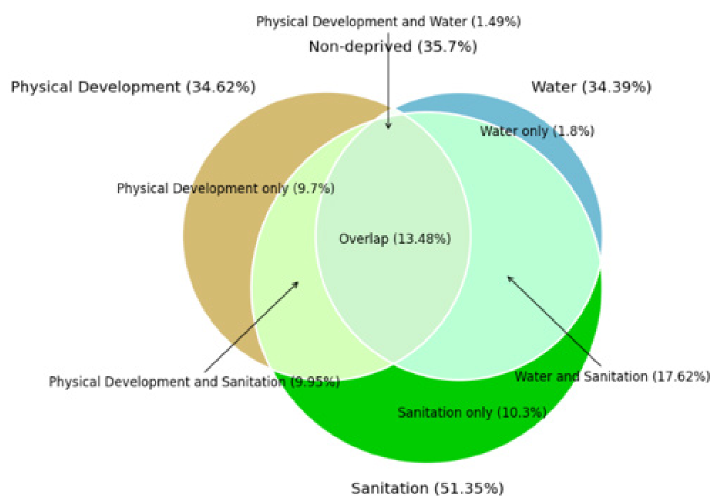


Figure 8: Deprivation overlap between stunting, water and sanitation, children under 5. Source: Calculations using MCD analysis and EDHS 2016 data



4 EARLY CHILDHOOD DEVELOPMENT AND EDUCATION

Early Childhood Development

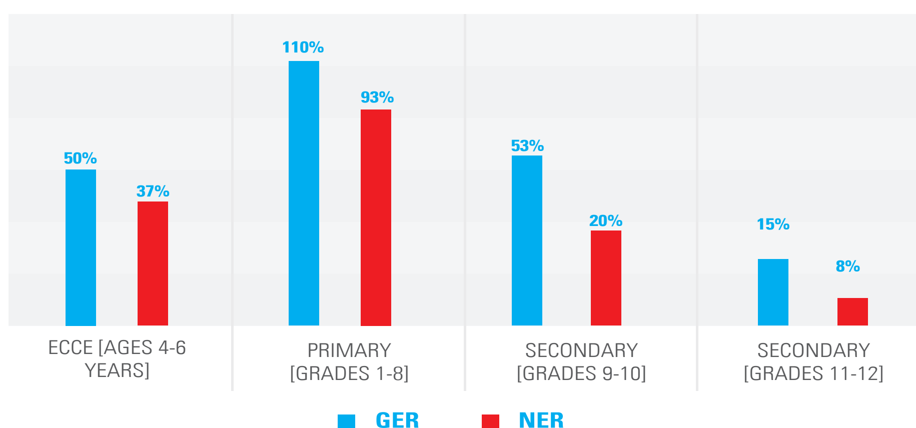
For some years now, the Government of Ethiopia has prioritized the delivery of early childhood care and education (ECCE).[25] It adopted the National Early Childhood Care and Education Policy Framework, followed by the Strategic Operational Plan and Guidelines for ECCE. An ECCE Inspection Framework has been adopted. The government is currently developing the National Strategy for Non-formal Accelerated Child Readiness and Child-to-Child programmes. To ensure ECCE quality, a multi-year training programme for pre-primary teachers at Colleges of Teacher Education has been introduced, and ECCE standards for learning materials and the curriculum are being developed. According to the Education Statistics Annual Abstract (ESAA) 2018/19, the gross enrolment ratio (GER) and net enrolment ratio (NER) for pre-primary education (ages 4-6) in Dire Dawa is low, at 50 per cent and 37 per cent, respectively. By comparison, the national average of the pre-primary GER is 41 per cent and NER is 24 per cent. The rates in Dire Dawa are far below the national GER target of 80 per cent by 2020. Dire Dawa is not on track to meet Sustainable Development Goal (SDG) 4.2: "Ensure that all children have access to quality early childhood development, care and pre-primary education so that they are ready for primary education by 2030."[26] A low enrolment rate means that most children are not prepared to enter Grade 1 in formal schools. Pre-primary education in Dire Dawa mostly concerns "O-classes" (54 per cent) attached to primary schools, and privately run kindergartens for which fees apply (32 per cent). It appears there is no child-to-child programme, as, according to the ESAA, its enrolment is 0.1 per cent.[27]

Primary Education

The Education Sector Development Programme has entered its fifth phase (ESDP V) for 2015/16-2019/20. This is aligned with the Growth and Transformation Plan II (GTP II), which is being implemented. The policy focuses on further expansion of equitable access to high-quality primary and secondary education. One of the key objectives of ESDP V is to improve access to the second cycle of primary education (Grades 5-8) through prioritizing the improvement of retention rates in Cycle 1 (Grades 1-4). The objective is also to increase access to schools for students to transition to Cycle 2, for example by extending the number of grades offered in primary schools and alternative basic education centres. In 2018/19, the GER and NER for Dire Dawa primary education stood at 110 per cent and 93 per cent, respectively.[28] A GER above 100 per cent shows that there are more children in primary grades than there are children between 7 and 14 years. It indicates that children younger than 7 years and older than 14 years are enrolled in primary schools. The national GER target for primary school is 103 per cent by 2020, which seems possible to achieve. The Gender Parity Index (GPI) for Dire Dawa primary education is 0.88, compared to a national average of 0.9, meaning there are fewer girls enrolled in primary education than boys.

25. For example, ESDP V.
26. See ESDP V for all national targets on education.
27. Ministry of Education (MoE), ESAA 2011 E.C. (2018/19), pp. 10-11.
28. Ibid.

Figure 9: GER and NER for early childhood care and education, primary and secondary education, Dire Dawa, 2018/19. Source: ESAA 2018/19



Secondary Education

In 2018/19, the GER in secondary education in Dire Dawa was 53 per cent for Grades 9 and 10 and 15 per cent for Grades 11 and 12. The national averages are 50 per cent and 15 per cent, respectively.[29] The NER was 20 per cent for Grades 9 and 10 and 8 per cent for Grades 11 and 12. Gender parity in secondary education in Dire Dawa stood at 0.89 in 2018/19, meaning that girls are also left behind in secondary education.[30] The GPI at national level for the same year was 0.87.[31] Ensuring the right to education for girls is one of the most important investments that can be made to guarantee their immediate and long-term development.[32] It will create a lasting impact on girls' development and empowerment, and that of their children. It contributes to women's participation in public life, productive employment and poverty reduction. It results in various long-term health benefits, including lower infant mortality, child stunting and fertility rates, and reduced domestic violence and HIV/ AIDS prevalence.[33] Keeping girls in school protects them against child and forced marriage, and early pregnancy.

29. Ibid., p. 46.
30. Ibid., p. 60.
31. Ministry of Education (MoE), ESAA 2011 E.C. (2018/19), p.50.
32. UNICEF, The State of the World's Children 2011, Adolescence: An age of opportunity, 2011.
33. Ibid., pp. 26-31.

The key priority of the ESDP V is geared towards the "transition problem". It aims to improve access to the first cycle of secondary education, to enable sustained participation in general education. The Ministry of Education states: "As more children complete primary school, the next step for the country is to sustain equitable access to quality secondary education services as the basis and bridge to the demands of the economy for middle- and higher-level human resources."[34] The transition from primary to lower secondary school, that is, the transition from Grade 8 to Grade 9, forms a particular bottleneck for girls and rural children. Girls experience an extra impediment to go to secondary school due to child marriage, early pregnancy, gender-based violence, lack of adequate sanitation and water, and other gender-based inequalities.[35] Sexual harassment and coercive sex are commonly experienced and rarely reported. This is underpinned by gender norms, shame and stigma about sex, and by a lack of understanding of the role of power and consent in determining violence.[36] Lack of adequate nutrition impacts adolescents' ability to learn and effects educational outcomes, especially for girls.[37]

Quality of Education

The quality of public schools continues to be an issue.[38] Many children who attend school fail to acquire basic skills, such as literacy and numeracy. The illiteracy rate among children of secondary school age (15-17 years) in Dire Dawa is 38 per cent. Even though it is below the national average of 46 per cent, it signifies that more than one third of children cannot read and write, suggesting serious issues with the quality of education. Even more concerning is the fact that the illiteracy rate has increased since 2011 (Table 7). The ESDP V recognizes the challenges of the low quality of the Ethiopian education system, including unskilled teachers, irrelevant teaching and inadequate learning materials.[39]

34. ESDP V, p. 82.
35. CSA, Ethiopian Welfare Monitoring Survey 2011: Summary Report, 2012, pp. 4-7 and FDRE, Ministry of Women, Children, and Youth Affairs, Assessment of Condition of Violence Against Women (VAW) in Ethiopia (draft) 2013, pp. 19 and 20.
36. Heslop, et al., The Code of Conduct on Prevention of School-Related Gender-Based Violence: A study of policy enactment in Ethiopia, 2017.
37. UNICEF, Gender Action Plan 2018-2021, p. 16.
38. UNICEF, Situation of Urban Destitute Populations and their Access to Social Services and Safety Net Programmes in Ethiopia, DRAFT REPORT, Oct. 2018, p. 33.
39. ESDP V, p. 17.

In Dire Dawa, there are challenges with regard to the quality of education, student achievement and dropout. The percentage of appropriately qualified teachers in primary education is 85 per cent for Grades 1 to 4 and 87 per cent for Grades 5 to 8. The rate of qualified teachers in Grades 9 and 10 is 98 per cent. For Grades 11 and 12, the rate is also 98 per cent.[40] In 2015/16, 21 per cent of Grade 8 students failed their final exam (18 per cent girls and 23 per cent boys), which is far above the national average of 12 per cent.[41] In 2016/17, the survival rate to Grade 5 the percentage of students who completed the first cycle of primary education was only 51 per cent. The ESAA 2018/19 showed that the dropout for grades 1-8 in 2017/18 was 10.6 per cent while the repetition rate was 7.9 per cent in Dire Dawa. The MCD report calculated the incidence of delay in schooling, which is also a proxy indicator for the two. In Dire Dawa, 20 per cent of children aged 9 to 17 years attended school with two or more years of delay, compared to the national average of 34 per cent. Progress on this indicator has been meagre since 2011.

On a positive note, the pupil-teacher ratio is 29 students per teacher in Grades 1 to 8 and 20 students per teacher in Grades 9 to 12.[42] High repetition and survival rates reduce the efficiency of the education system. Even in the case that children succeed until Grade 8, many discontinue their education for various reasons.

Table 7: Trends in delay in schooling and illiteracy, Ethiopia and Dire Dawa, EDHS 2011 and 2016

Indicator	MCD report	EDHS 2011 (%)	EDHS 2016 (%)	SDG target (2030) (%)
Delay in schooling (aged 9-17 years)[43]	National	37.3	33.6	N/A
	Dire Dawa	21.4	19.9	N/A
Illiteracy rate (aged 15-17 years)[44]	National	45.2	45.5	0
	Dire Dawa	32	38.4	0

40. Computed based on figures from MoE, ESAA 2011 E.C. (2018/19), pp.75-76.
41. MoE, ESAA 2009 E.C. (2016/17), The ESAA 2010 E.C. (2017/18) does not provide disaggregated data on survival rates and Grade 8 examination.
42. MoE, ESAA 2011 E.C. (2018/19), p. 30 and p. 52.
43. 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.
44. Child could not read or could read only parts of a sentence provided during the survey.

5 WATER, SANITATION AND HYGIENE (WASH)

According to the 2016 EDHS, 90 per cent of households use improved drinking water sources in Dire Dawa compared to the national average of 65 per cent. [45] About 41 per cent of households have water sources piped into the dwelling or yard. Despite the high usage rate in Dire Dawa, there are differences in water access within the region. For example, 69 per cent of households in rural areas use an improved water source, compared to 99 per cent in urban areas. Thus, Dire Dawa almost has universal usage in urban areas. Only 5 per cent of rural households have water sources piped into the dwelling or yard. Accessibility seems to be an issue when measured with the indicator of the time required to reach the water source, fetch water, and return to the dwelling. Nearly one third of households in Dire Dawa, 30 per cent compared to the national average of 32 per cent, need more than 30 minutes to access the closest water source. Improvements in this indicator have been notable since 2011. It must be emphasized that there are still poor communities in Dire Dawa who do not have access to improved water sources. Of households in the poorest wealth quintile, 53 per cent use an improved water source, compared to 78 per cent of households in the poorer wealth quintile, 84 per cent in the middle wealth quintile, 98 per cent in the richer wealth quintile and 99 per cent in the richest wealth quintile. [46]

Table 8: Trends in improved drinking water sources, sanitation facilities and housing conditions, Ethiopia and Dire Dawa, 2005-2016

Indicator	Region	EDHS	EDHS 2011 (%)	EDHS 2014 (%)	EDHS 2016 (%)	SDG targets 2030 (%)
Households using improved drinking water sources	National	61.4	53.7	56.9	64.8	100
	Dire Dawa	84.2	93.8	87.5	89.5	100
Time to water source 30+ minutes from the dwelling [47]	National		41.1		32.3	N/A
	Dire Dawa		38.6		29.5	N/A
Households using improved sanitation facilities	National	6.8	8.3	4.2	6.3	100
	Dire Dawa	1.2	19.5	22.6	24	100
Households with adequate housing [48]	National		2.9		12	100
	Dire Dawa		50.2		49.2	100
Households exposed to indoor pollution from using solid fuels for cooking inside the dwelling where there is no separate room used as a kitchen	National		49.2		31.4	0
	Dire Dawa		17.5		13.7	0

45. EDHS 2016.
46. Ibid.
47. Necessary to reach the water source, fetch water, and return to the dwelling.
48. Floor, exterior walls and roof of the dwelling where the child resides are made of durable and sustainable structures.

> **Of general concern are the frequent interruptions to water services due to breakdowns and delays in maintenance.**

Of general concern are the frequent interruptions to water services due to breakdowns and delays in maintenance. There are capacity limitations in terms of experts, finance and organizational structure. To address the chronic shortage of water, the Ministry of Water, Irrigation and Electricity (MoWIE) developed a US$ 5 billion sub-programme, "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.

EDHS data shows that the proportion of households using improved sanitation facilities increased from 20 per cent in 2011 to 24 per cent in 2016 (Table 8); 13 per cent rural households and 29 per cent urban households. Although this rate is relatively high compared to the national average, it still means that about three out of four households do not use an improved toilet facility. Wealth is a clear factor influencing coverage: only 2 per cent of households in the poorest wealth quintile use an improved toilet facility compared to 30 per cent of households in the richest wealth quintile.[49] The rate of households that have an improved but shared toilet facility is 38 per cent. Many people are still practicing open defecation (29 per cent in 2014), [50] which is particularly dangerous for public health in densely populated urban settlements, for example in relation to acute watery diarrhoea outbreaks.

Washing hands with soap and water is a global priority. It can significantly reduce the risk of diarrhoea. The SDG indicator, "Proportion of population with hand-washing facilities with soap and water at home" means the presence of a device to contain, transport or regulate the flow of water to facilitate hand washing with soap and water. [51] The percentage of households with a hand-washing facility in Dire Dawa is low. According to the 2016 EDHS, 48 per cent of households in Dire Dawa have a place for washing hands (4 per cent fixed and 44 per cent mobile), which is below the national average of 60 per cent. Only 13 per cent of these households have water and soap.[52]

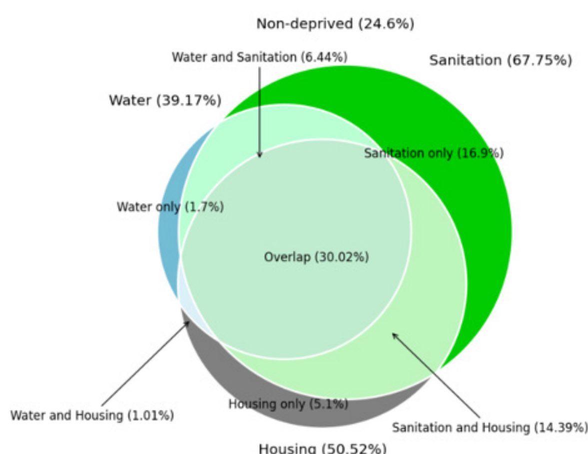
49. Ibid.
50. Mini-EDHS 2014.
51. Joint Monitoring Programme, WASH in the 2030 Agenda, New Global Indicators for Drinking Water, Sanitation and Hygiene, p. 6.
52. EDHS 2016, p. 23.

The federal government adopted the Integrated Urban Sanitation and Hygiene Strategy in 2017, with a corresponding action plan and implementation guidelines. There is attention on menstrual health and hygiene management in this strategy. One of the pillars of the One WASH National Programme is urban WASH. The Urban Health Extension Programme (UHEP) is now under review, addressing its shortcomings.

Children and adults are susceptible to other health risks in their dwellings, due to inadequate housing conditions and indoor pollution from using solid fuel for cooking inside the house. Nearly half of all households in Dire Dawa, 49 per cent, 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. Even though this figure is high compared to the national average, it implies that half of children in the region live in dwellings that do not protect them from various health and other risks. No significant changes were achieved in this indicator compared to 2011 (Table 8). In Dire Dawa, 14 per cent of households are exposed to indoor pollution from cooking inside the house with solid fuels, compared to 31 per cent at the national level. Improvements in this indicator since 2011 have been slow (Table 8).

Any interventions aimed at improving the well-being of children in Dire Dawa 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 years: 30 per cent of children under 18 in Dire Dawa are deprived of adequate water, sanitation and housing conditions simultaneously, and 15 per cent are deprived in both sanitation and housing at the same time (Figure 10).

Figure 10: Deprivation overlap between water, sanitation and housing, children under 18. Source: Calculations using MCD analysis and EDHS 2016 data



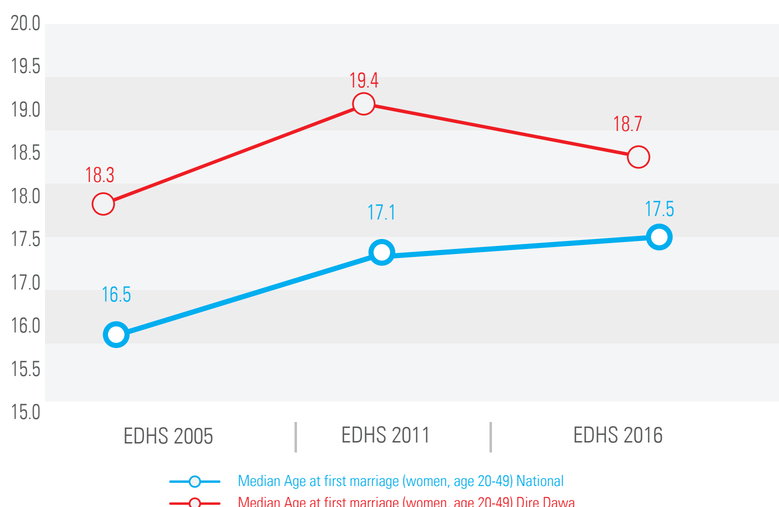
6 CHILD PROTECTION

According to the EDHS 2016, Dire Dawa has a high rate of physical violence against girls/women (aged 15-49). The proportion of girls/women (aged 15-49) who have ever experienced physical violence since age 15 is 20 per cent, of whom 2 per cent experienced violence often.[53] The percentage of girls/ women in the region who have ever experienced sexual violence is 7 per cent, while 4 per cent of girls/women had experienced sexual violence in the 12 months before the survey. [54] See Section 9 for psychological, physical and sexual violence against married women.

The EDHS 2016 shows that in Dire Dawa the median age at first marriage is 18.7 years among women aged 20 to 49 years, which is relatively high, and the highest in the country. Figure 11 shows that the average median age decreased between 2011 and 2016. In 1991, Dire Dawa region had a prevalence rate of 53 per cent in child marriage among women aged 20 to 24 years. Since then the rate has declined significantly, to 32 per cent.[55] Still, almost one out of every three girls in Dire Dawa are married before the age of 18 years. Progress needs to be nine times faster to eliminate child marriage by 2030 and meet SDG 5.3. [56] It appears that this acceleration scenario is not realistic.

The deeply rooted practice of female genital mutilation/cutting (FGM/C) is a concerning issue in Dire Dawa region. FGM/C prevalence is 75 per cent among women aged 15 to 49 years, which is higher than the national average of 65 per cent. There is a variation in prevalence of FGM/C by residence: 68 per cent of women (aged 15-49) who live in urban areas of Dire Dawa have undergone FGM/C,

Figure 11: Trends in median age at first marriage (women, aged 20-49), Ethiopia and Dire Dawa, 2005-2016



53. Ibid., p. 299.
54. Ibid., p. 302.
55. 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.
56. Ibid., p. 10.

compared to 95 per cent of women in rural areas. Wealth is associated with FGM/C: 96 per cent of women (aged 15-49) in the poorest wealth quintile have undergone FGM/C compared to 68 per cent in the richest wealth quintile. Among circumcised women, 10 per cent have undergone infibulation.

The rate of FGM/C has declined faster among the younger generations. Figure 12 shows FGM/C prevalence across age groups, and it is noticeable that FGM/C prevalence is lower among adolescent girls (15-19 years) at 61 per cent, and youths (20-24 years) at 70 per cent. FGM/C in girls aged 15 to 19 years has declined at an annual average of 2.3 per cent per year in the past 10 years, compared to 1.5 per cent in the past 25 years. In order to meet SDG 5.3 and eliminate FGM/C by 2030, Dire Dawa should step up efforts and reduce the percentage of girls aged 15 to 19 years undergoing FGM/C by 27 per cent per year.

The EDHS shows that in 2011, 14 per cent of children between 5 and 14 years in Dire Dawa were involved in child labour. [57] A 2015 study by the CSA and the International Labour Organization (ILO) found 5 per cent of children (aged 5-17) were involved in labour compared to a national rate of 24 per cent.[58] Children involved in labour may have also fallen victim to internal child trafficking, which is mainly related to migration from rural to urban areas. Families play an important role in financing irregular migration and may pressure their children to go to urban areas for employment. Most traffickers are small local operators, and often from the victims' own communities, although organized crime groups exist. Girls may end up in domestic servitude or prostitution. Boys may be forced to work in the traditional weaving industry, farming, as guards or street vendors.[59] The severe drought in 2015/16 increased instances of internal trafficking. [60] The percentage of orphaned children in Dire Dawa of whom one or both parents are dead is the third highest in Ethiopia (10 per cent). The proportion of children who are not living with their parents, but both their parents are alive is the second highest in the country, at 12 per cent after Addis Ababa. [61] Many of these children are abandoned or disowned, are at high risk of abuse or ill treatment, and are vulnerable to child labour and trafficking. Children may be heads of households and primary caregivers.

The proportion of people (aged 15-49) who are infected with HIV is 2.5 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 0.7 per cent. Between 2011 and 2016, the HIV prevalence of female youths (aged 15-24) increased from 1.2 per cent to 1.3 per cent. In contrast, the HIV prevalence of their male counterparts decreased from 0.7 per cent to 0.0 per cent. Many new paediatric HIV infections are the result of mother-to-child transmission. Knowledge of prevention of mother-to-child transmission of HIV in Dire Dawa is low: one out of two women aged 15 to 49 in Dire Dawa have knowledge on prevention. Moreover, 42 per cent of pregnant women in the region are tested for HIV during ANC and receive results and post-test counselling. [62] Only 11 per cent of children under 15 years were tested for HIV.

Comprehensive knowledge among adolescents aged 15 to 17 years about HIV/AIDS transmission and

57. Note that the EDHS 2016 is silent on child labour.
58. CSA and ILO, Ethiopia National Child Labour Survey 2015, p. 79.
59. African Child Policy Forum, Gender and Child Rights in Africa: A survey of laws and policies in three thematic areas in five Eastern African Countries, Draft report, 2013, p. 36.
60. US Department of State, Human Trafficking Report, Ethiopia, 2018, p. 185.
61. EDHS 2016, p 25.
62. Ibid.

prevention is slightly higher than the national average, at 31 per cent versus 30 per cent, but it has regressed since 2011.[63] 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 well-being, including family planning. This suggests there are issues with sustainability of existing programmes. Only 17 per cent of adolescents aged 15 to 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. However, this figure should be interpreted with caution, as the decreasing rate of community participation may stem from changes in the modes of communication used to reach out to adolescents and youths in Dire Dawa (Table 9).

> **"Comprehensive knowledge among adolescents aged 15 to 17 years about HIV/AIDS transmission and prevention is slightly higher than the national average,"**

Figure 12: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Dire Dawa, by age group, 2016. Source: UNICEF, EDHS 2016. FGM/C Further Analysis: Sub-national results, 2018

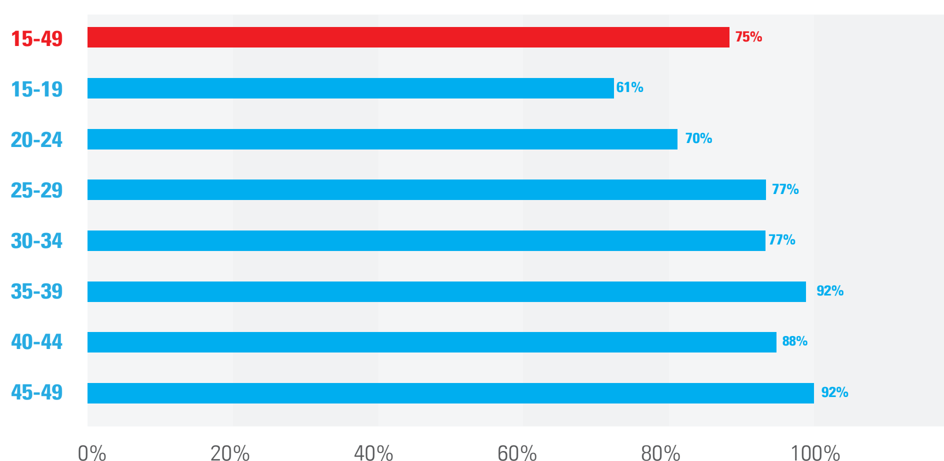
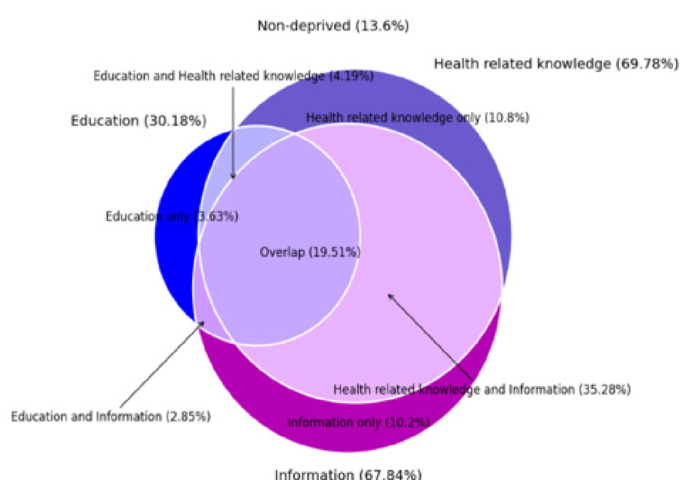


Table 9: Trends in knowledge about HIV/AIDS and participation in community events or conversations, adolescents aged 15-17 years, Ethiopia and Dire Dawa, 2011 and 2016

Health-related knowledge and community participation among adolescents	Region	EDHS 2011	EDHS 2016	SDG 2030
Health related knowledge - Adolescents aged 15-17 years (%)	National	27.4	29.8	100
	Dire Dawa	38.3	31.3	100
Participation in community events or conversations where family planning is discussed (%)	National	31	23.7	100
	Dire Dawa	36.9	17.1	100

63. UNICEF and CSA, MCD in Ethiopia, First National Estimates, p. 99.

Figure 13: 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



Considering the importance of knowledge on reproductive health and rights, family planning, health- and nutrition-related knowledge for children's and women's outcomes, and in reducing gender inequality, investments 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 to 17 years in Dire Dawa are deprived in education, health-related knowledge, and information and participation simultaneously. An additional 35 per cent are deprived in both health-related knowledge and information and participation at the same time (Figure 13).

In 2016, the rate of children under 5 years who had their birth registered with civil authorities in Dire Dawa was 19 per cent, of whom 12 per cent had a birth certificate.[64] 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, 47 registration centres in Dire Dawa are providing vital events registration services. Coverage/availability of civil registration services is 100 per cent, compared to the national average of 89 per cent. In 2010 E.C. (2017/18), 1,652 births were registered in Dire Dawa, of which 22 per cent were registered within 90 days, 13 per cent were registered after 90 days but within one year, and 65 per cent were registered after one year (backlog).[65] In Dire Dawa, 16 per cent of registers have quality issues, the second highest rate in the country.[66]

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.
66. Ibid.

7 SOCIAL PROTECTION

The federal government has been implementing an impressive Productive Safety Net Programme (PSNP). The PSNP is seen as the cornerstone of Ethiopia's social protection policy. Currently, the programme is in its fourth phase: PSNP 4 (2015-2020). It targets selected vulnerable woredas in food-insecure and disaster-prone rural areas. In Dire Dawa in 2014, 59 per cent of rural households were in the PSNP compared to 11 per cent of households at the national level.[67] Dire Dawa has the second highest coverage rate in the country.

> **"Urbanization is an emerging priority in Ethiopia. While Ethiopia is still predominantly rural, urbanization is taking place at a pace of 5 per cent per year between 2015 and 2020."**

Urbanization is an emerging priority in Ethiopia. While Ethiopia is still predominantly rural, urbanization is taking place at a pace of 5 per cent per year between 2015 and 2020. [68] Dire Dawa region is largely urban. As mentioned previously, the projection for 2019 is that 63 per cent of the population is urban and 37 per cent is rural. Many children and youth enjoy the advantages of city life in Dire Dawa, however it also poses considerable challenges and risks. Urban challenges include poverty, inadequate basic services and infrastructure, inequality, youth unemployment, living in slums, and changes in social structures. Urbanization must be managed for both its opportunities and challenges. An investment in basic services for children is a necessity. Children will become socially and economically empowered and will bring well-being and opportunities to Dire Dawa. Many social protection measures benefit children without explicitly targeting them, nevertheless by using a 'child lens' in the design of social protection programmes a more significant impact for children can be reached. Examples are:

- Avoiding adverse impacts on children
- Intervening as early as possible where children are at risk to avoid irreversible impacts [69]
- Considering age- and gender-specific risks and vulnerabilities of children throughout the life-cycle

67. Mini-EDHS 2014, p. 15.
68. United Nations Department of Economic and Social Affairs, Population Division (2018), World Urbanization Prospects: The 2018 Revision, File 6.
69. Children have other and specific needs, and being deprived of those needs impacts their short-term development, as well as their growth potential later in life.

- Recognizing that families raising children need support to ensure equal opportunities
- Considering the mechanisms and intra-household dynamics that may affect how children are reached, for example, the balance of power between women and men
- Including the voices and opinions of children in the understanding and design of social protection systems and programmes.[70]

"An economically productive urban transformation is necessary for Ethiopia to reach middle-income status, end poverty, and improve shared prosperity." [71] Therefore, as of 2015, the Urban Productive Safety Net Programme (UPSNP) has been operating in Ethiopia's major regional cities, including Dire Dawa, to reduce poverty and vulnerability among the urban poor. The main components of the UPSNP are safety net transfers, livelihood services and institutional strengthening. [72] The UPSNP recognizes the importance of supporting (female) youths in finding productive employment to help break the cycle of poverty. A critique on the UPSNP is that not all urban poor households benefit from the programme. A main barrier appears to be the use of a quota system for participating households, which leaves poor households out, once the quota has been reached. There also seems to be a lack of awareness among all community members about the existence of the UPSNP.[73]

There are various other social protection programmes with a focus on the most disadvantaged and vulnerable children. Since 2014, the government has implemented community-based health insurance (CBHI) in rural areas of Ethiopia, which provides financial protection against health shocks. Social protection services in education are: education fee waiver schemes; establishing and strengthening boarding/hostels; providing scholarships to at-risk, poor and disadvantaged children; the National School Feeding Programme (NSFP) 2016-2020 with a focus 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 and hygiene and sanitation; and the supply of educational materials and financial support for children from poor and low-income families.

Another focus area of Ethiopia's social protection strategy is targeted at reducing abuse, violence (gender-based violence), 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

70. Joint Statement on Advancing Child-Sensitive Social Protection, 2010, p. 2, available at: https://www.unicef.org/aids/files/CSSP_joint_statement_10.16.09.pdf (last accessed April 2019).
71. World Bank, Ethiopia - Urban Productive Safety Net Project, Project Appraisal Document, 2015, p. 2.
72. World Bank, Poverty & Equity Brief, Ethiopia, 2018, p. 1. See also FDRE, National Planning Commission, Ethiopia's Progress Towards Eradicating Poverty: An interim report on 2015/16 poverty analysis study, 2017, pp. 16 and 20.
73. UNICEF, Situation of Urban Destitute Populations and their Access to Social Services and Safety Net Programmes in Ethiopia, DRAFT REPORT, Oct. 2018, pp. 27-29. See also UNICEF Social Policy and Evidence for Social Inclusion (SPESI), Programme Strategic Note, Mid-term Review, 2017, p. 9.
74. World Bank, Economics of Adaptation to Climate Change, Ethiopia, 2010.

their families. Key instruments in the area of prevention are communication and awareness raising to prevent abuse, violence, neglect and exploitation, and the insurance of a protective legal and policy environment. The 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.
care coalitions (CCC) promote, monitor and administer so-called 'co-responsibilities' of individual UPSNP clients. Co-responsibilities means that households are encouraged to fulfil pre-defined activities, such as seeking health and nutrition services, although no penalties are enforced if co-responsibilities are not carried out (there are no deductions from transfers). The case management of the social workers and CCCs 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.
There are various other urban social protection programmes that focus on the most disadvantaged and vulnerable children. Examples of social protection service delivery in education are: education fee waiver schemes; establishing and strengthening boarding/hostels; providing scholarships to at-risk, poor and disadvantaged children; the National School Feeding Programme (NSFP) 2016-2020 with a focus 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 and hygiene and sanitation; the supply of educational materials; and financial support for children from poor and low-income families.

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8 CLIMATE CHANGE AND CHILD RIGHTS

In the coming decades, rising and extreme temperatures, extraordinary rainfall events and more intense flooding and prolonged droughts are projected in Ethiopia.[74] Continuous water stress results in permanent water sources being overexploited. Climate change is also projected to increase diseases in humans, as well as affecting the health of livestock. While drought triggers crisis, underlying vulnerability worsens the situation.[75] Coping mechanisms are deteriorating due to high population growth, competition over land and water, and migration of uneducated youths to urban centres. Other factors that make people vulnerable are widespread poverty, poor infrastructure, environmental degradation, low levels of farming technology and limited education. Children are most vulnerable to climate change. They are much more likely to die than adults and are at a higher risk of poor health, and negative impacts on growth and development. Women and girls experience greater risks, burdens and impacts of climate change, as emergencies exacerbate existing gender inequalities.[76]

The 2015/16 El Niño episode affected the population of Dire Dawa region. It pushed them into food insecurity and ongoing water shortages. It affected children, resulting in chronic and acute hunger, poor health, water-related illnesses, school absenteeism, poor school performance, poor diets, poor hygiene, lack of clean clothing, protection risks, and child labour. [77]

Globally, climate change is a growing driver of migration. Ethiopia is no exception and children are increasingly migrating due to lower water and food availability. Under a climate-friendly scenario, internal climate migration in Ethiopia is projected to involve 1.5 million people by 2050. It is expected that hotspots of in- and out-migration will emerge by 2030. [78] These hotspots will have substantial implications for child service delivery, such as education, health care

75. UNICEF, Generation El Niño: Long-term impacts on children's well-being. Final report, 2018, p. 46.
76. 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).
77. Ibid.
78. Climate migrants are projected to constitute a smaller portion of all internal migrants (12 per cent by 2050). World Bank, Groundswell: Preparing for internal climate migration, 2018, p. 126.

and WASH services. According to the World Bank's latest research on internal climate migration, out-migration hotspots include northern parts of the Ethiopian highlands. The eastern highlands of Ethiopia will be an in-migration hotspot.[79]

The World Risk Report specifically looks at vulnerability against extreme natural disasters in urban areas. It reports that urbanization may increase vulnerability, namely exposure (cities may be built in dangerous areas), susceptibility (inadequate housing conditions, inadequate sanitation and access to water, limited access to health care, education and formal employment), coping capacities (ineffective municipal administration, corruption) and adaptive capacities (weak strategies and measures to address the negative impacts of future natural disasters and climate change). The Index puts Ethiopia in 63rd place out of 171 countries. The World Risk Report ranks Ethiopia as very high in the dimension of vulnerability in urban areas. Ethiopia is in the top 15 most-risky countries in terms of susceptibility, and there is a lack of adaptive capacity to disasters (12th place). Exposure to natural hazards in urban areas is listed as low.[80]

The World Bank estimated that if no adaptation measures are taken, climate change may result in a GDP loss of 6 per cent to 10 per cent by 2050.[81] Although Ethiopia is investing in climate adaptation - the Ethiopian government has already put in place a number of policies, strategies and programmes aimed at enhancing adaptive capacity and reducing climate variability and change- it still remains a weak spot.[82] 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. Children may act as agents of change to generate innovative ideas to respond to climatic shocks, based on local knowledge.

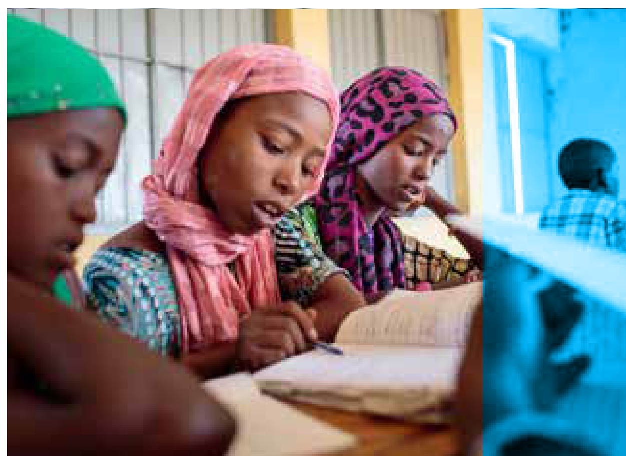
79. The World Bank Group, Groundswell: Preparing for internal climate migration, 2018.
80. United Nations University a.o., World Risk Report, 2014, pp. 1-68.
81. World Bank, Economics of Adaptation to Climate Change, Ethiopia, 2010, pp. xvi and xvii.
82. See e.g., Bündnis Entwicklung Hilft, World Risk Report Analysis and Prospects 2017, pp. 1-48.
83. FDRE, Ethiopia 2017 Voluntary National Review on SDGs: Government commitments, national ownership and

9 GENDER EQUALITY

The 2030 Agenda for Sustainable Development, adopted by all UN member states in 2015, provides a stand-alone goal on gender equality and women's empowerment. SDG 5 states that efforts must be made to cut the roots of gender discrimination wherever they appear. In addition to SDG 5, gender targets have been set for every goal, confronting the gender dimensions of poverty, hunger, health, education, water and sanitation, employment, safe cities and peace and security. The Ethiopian Government is committed to the 2030 Agenda. Recently, it carried out a voluntary national review of progress against selected SDGs, which was presented to a UN high level political forum on the SDGs in 2017.[83] The government has mainstreamed selected SDGs into its GTP II and is committed to fully mainstreaming them in future development plans out to 2030.

> **"The 2030 Agenda for Sustainable Development, adopted by all UN member states in 2015, provides a stand-alone goal on gender equality and women's empowerment."**

There are different Ethiopian laws that include provisions on gender equality and the protection of women and girls. Ethiopia's Constitution (1995) includes a provision on the equal rights of women (Art. 35). The overarching GTP II includes an eighth pillar on the promotion of women's empowerment.[84] For the first time, it includes a priority on ending violence against women. The National Children's Policy (2017) recognizes the vulnerability of girls in several paragraphs. In 2016, the Women's Development and Change Strategy and Revised Package was adopted. It offers guidelines to sectors to deliver for women and girls. It also includes direction on protection, prevention and provision of services for women survivors of violence. Recently, Standard Operating Procedures on the Elimination of All Forms of Gender-Based Violence, and a National Free Legal Aid Strategy were adopted. The Strategic Plan for an Integrated and Multi-sectoral Response to Violence Against Women and Children and Child Justice (2011) and the National Coordinating Body on Violence Against Women and Children (2008) are still functional. The National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia (2013) is being implemented.



performance trends, 2017.

84. GTP II (2015/16-2019/20), pp. 208-211.

85. EDHS 2016, p. 278.

A major challenge is Ethiopia's deeply rooted 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. The realization of behavioral change in relation to harmful traditional practices, gender-based violence and women's participation in politics and decision making remains difficult.

According to the EDHS 2016, in Dire Dawa 63 per cent of women (aged 15-49) decide themselves on their first marriage and 36 per cent of women state that their parents made the decision for their first marriage.[85] The rate of women who stopped attending school after marriage is 69 per cent (aged 15-49). When asked what the main reason was for discontinuing school, 79 per cent of women cited that they were too busy with family life. Another reason was that their husbands refused to let them continue school (8 per cent).[86] In Dire Dawa, 13 per cent of girls aged 15 to 19 years have begun childbearing, which is equal to the national average. The rate of married women in Dire Dawa using modern contraceptive methods is 29 per cent.[87]

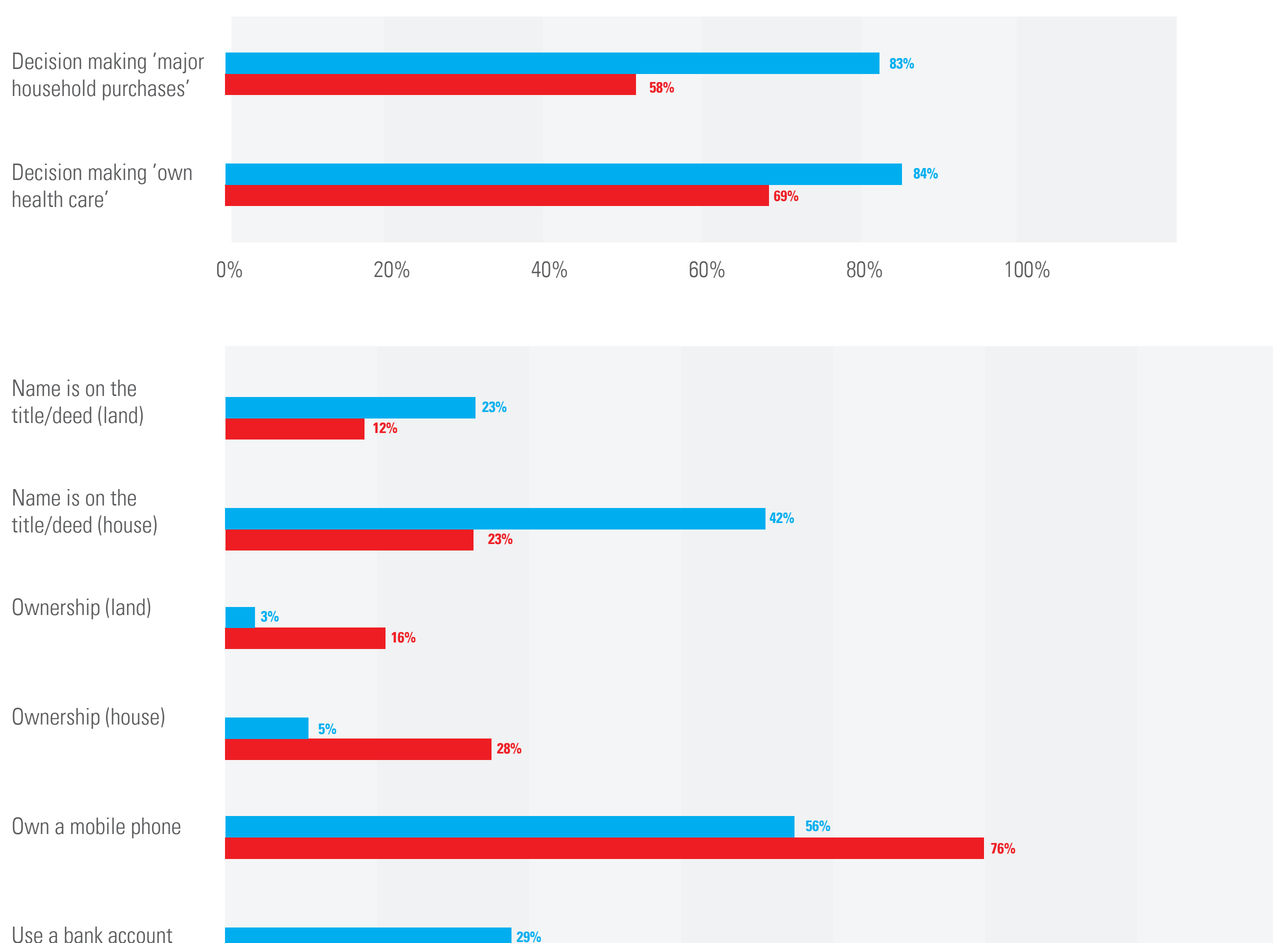
In Dire Dawa, the proportion of women (aged 15-49) who have ever experienced psychological, physical or sexual violence committed by their current or most recent husband/partner is 19 per cent, 20 per cent, and 7 per cent, respectively.[88] The percentage of women who believe that a husband is justified in hitting or beating his wife in various circumstances is 47 per cent. This rate is lower than most other regions in Ethiopia, with the national average being 63 per cent. Likewise, a relatively low percentage of men (15 per cent) agree that wife beating is justified in some circumstances.[89]

Polygamy is practiced in Dire Dawa (6 per cent).[90] The percentage of women whose husband participates in household chores is 32 per cent, of whom 14 per cent participate every day.[91] It is a common occurrence that women are excluded from decision making on common property in marriage. Women are routinely denied their rights in relation to ownership. Figure 9 shows an unequal distribution of power between women and men in ownership. However, it also shows that a higher percentage of women than men make specific decisions on major household purchases and own health care, in contrast to the other regions where a higher percentage of men have more say in these decisions.

86. Ibid., p. 279.
87. Ibid., p. 114.
88. Ibid., p. 306.
89. Ibid., pp. 283 and 284.
90. Ibid., p. 66.
91. Ibid., p. 280.
92. Ibid., pp. 49 and 50.

The EDHS 2016 shows that women are more deprived of information than men. The Internet is a critical tool for accessing information. In Dire Dawa, 16 per cent of women had used the Internet in the 12 months before the survey, compared to 39 per cent of men.[92] Women in Dire Dawa are less exposed to mass media than men: 6 per cent of women and 16 per cent of men read a newspaper at least once per week, and 20 per cent of women and 35 per cent of men listen to the radio at least once per week.[93] More women than men watch TV at least once per week (52 per cent versus 48 per cent, respectively).

Figure 14: Percentage of married women and men (aged 15-49) in Dire Dawa who make specific decisions either alone or jointly with their spouse; and percentage of women and men (aged 15-49) in Dire Dawa by use of bank account, ownership of mobile phone, house and land, possession of title/deed of house and land, Ethiopia. Source: EDHS 2016



93. Ibid., pp. 47 and 48. Percentage of women and men aged 15-49 who are exposed to specific media on a weekly basis.

10 KEY PRIORITIES AND RECOMMENDATIONS TO IMPROVE THE SITUATION OF WOMEN AND CHILDREN IN ADDIS ABABA

- 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.
- Promote a multi-sectoral approach in 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.
- Deprivation incidence in health-related knowledge and information, and participation among children aged 5 to 17 years in Dire Dawa are the only examples of poorer performance than the national average. They should be given dedicated attention in regional and sub-regional planning and budgeting.
- Considering the high rates of early childhood mortality and the slow reduction of neonatal mortality, the regional government should take strong action to reduce child mortality by focusing on maternal, neonatal and child health service delivery. Immunization should remain one of the health sector priorities.

Particular attention should be given to reducing the high rate of acute under-nutrition through increased access to nutrition education (infant and young child feeding) aiming at early initiation, exclusive breastfeeding, micronutrient supplementation (including iron folic acid), and enhanced outreach services for nutrition screening, referrals and appropriate case management. There is a need to strengthen and scale up integrated management of acute malnutrition, and links with nutrition-sensitive agriculture, WASH and education, using risk-informed and resilience programming that focuses on systems, as well as multi-sectoral coordination to implement the second National Nutrition Programme (NNP II).

Strengthen mobile health and nutrition teams to improve access to nutrition and health services in pastoralist areas. Expand basic preventative and curative nutrition services to pastoralist and other vulnerable areas.

Strengthening the health system should be a top priority, including addressing evidence-based planning, monitoring and evaluation, the Health Information System (HIS)/DHIS data quality, and the use of data for decision-making. Considering the increased frequency of natural and human-made disasters, efforts to build a resilient health system should be supported.

- Strengthen the government's capacity to improve educational quality through the development of a continuous assessment system at primary level, and with the country participating in learning assessments. The results of these will feed into curriculum reform and teacher training programmes leading to improved learning achievement.

  Support a reduction in the number of out-of-school children by scaling up policies and programmes, and implementing differentiated and innovative approaches to reaching disadvantaged children, focusing on retention strategies at primary levels.

  Encourage the development of early childhood education by scaling up quality pre-school programmes that help prepare children for primary school. Include girls' education as an essential component of regional development efforts. Take special measures to reach girls.

- In rural settings, water and sanitation supply are lagging, especially among pastoralist communities. This points to systematic problems and the inability of decentralized service delivery mechanisms to reach pastoralists. Prioritize:

  - ◊ Implementing the Pastoralist Strategy
  - ◊ Improving water quality to ensure that rural water services deliver their potential health benefits
  - ◊ Ensuring the reliability of water supply by addressing mechanical functionality. Focus on water scheme rehabilitation and maintenance. In particular, build the capacity of various professionals, such as hydro-geologists, engineers and technicians with adequate knowledge, skills and software usage.

- ◊ Ensuring more systematic approaches to water resource assessment and monitoring, both to respond to the increase in demand for water and to reduce vulnerability to extreme climate events. Support and strengthen the WASH MIS.
- ◊ Continue to build community ownership of water schemes to ensure sustainability of water availability.

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 connection charges, which are unaffordable for poor households. To improve sanitation services for the poorest households in urban areas, government subsidies channelled through the UPSNP might be considered, that is, subsidies would focus on lowering borrowing costs to improve household sanitation infrastructure.

Strengthen institutional capacities to develop and manage long-term sanitation programmes with close involvement of communities. Sanitation and water supply programmes should build in links with child survival efforts.

- To respond to child protection issues raised in this brief, there is a need for systems strengthening and addressing these issues through a coordinated, holistic, inter-sectoral prevention and response approach, bringing together informal systems. It is necessary to strengthen the social service workforce to prevent and respond to child protection issues, and to strengthen victim assistance and rehabilitation services.[94]

  Prioritize ending child marriage, FGM/C and gender-based violence, including through strengthening community-based awareness-raising activities, raising awareness about the criminal and damaging nature of these practices, and strengthening women's economic empowerment.

- 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 women and children. Children may act as agents of change to generate innovative ideas to respond to climatic shocks, based on local knowledge. All programmes in the region need to mainstream climate change.

- Prioritize the implementation of the Pastoralist Area Education Strategy 2016/17, which stipulates alternative education strategies that are geared to the pastoralist way of life. The implementation of mobile schools is proposed, which could be an appropriate solution for providing basic education to highly mobile pastoral communities.

sanitation, hygiene, and poverty in Ethiopia, 2018, p. xiv.

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Dire Dawa Administration