

GOVERNMENT OF ETHIOPIA

Report on Progress in Implementing the World Fit for Children

Plan of Action in Ethiopia

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ACRONYMS

AEPHCC	Accelerated Expansion of Primary Health Care Coverage
ANC	Ante Natal Care
ANPPCAN	African Network for the Prevention of and Protection against Child abuse and Neglect
ARV	Anti-retroviral
BEOC	Basic Essential Obstetric Care
CBO	Community based Organization
CEOC	Comprehensive Essential Obstetric Care
CHIF	Community Health Investment Fund
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CSA	Central Statistics Agency
CSTC	Community Skill Training Centers
DHS	Ethiopian Demographic and Health Survey
DPPA	Disaster Prevention and Preparedness Agency
EFA	Education for All
EFY	Ethiopian Fiscal Year
EHSP	Essential Health Service Package
EMIS	Education Management Information System
EOS	Enhanced Outreach Strategy
ESDP	Education Sector Development Programme
EUWI	European Union Water Initiative
FBE	Free Basic Education
FMOH	Federal Ministry of Health
FP	Family Planning
GAVI	Global Vaccine Initiative
GBV	Gender Based Violence
GER	Gross Enrollment Rate
GIVS	Global Immunization Vision and Strategy
GoE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HEW	Health Extension Workers
HMIS	Health Management Information System
HP	Health Post
HSDP	Health Sector Development Programme
HSEP	Health Service Extension Programme
IECD	Integrated Early Childhood Development
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
IYCF	Infant and Young Child Feeding

MCH	Mother and child health
MDG	Millennium Development Goals
MEFF	Macroeconomic and Fiscal Framework
MOE	Ministry of Education
MoFED	Ministry of Finance and Economic Development
MUAC	mid upper-arm circumference
NER	Net Enrollment Rate
NGO	Non-governmental organization
NOVCSC	National Steering Committee on Orphans and Vulnerable Children
NPAEC	National Plan of Action for Ethiopian children
NRWSSP	National Rural Water Supply and Sanitation Programme
NVP	Nevirapine
OECD	Organization for Economic Cooperation and Development
OVC	Orphans and vulnerable children
PASDEP	A Plan for Accelerated and Sustained Development to End Poverty
PHC	Primary Health Care
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Program
RBM	Roll back Malaria
RED	Reaching every district
RH	Reproductive Health
RHC	Rural Health Centre
SAEC	Sexual Abuse and Exploitation of Children
SDPRP	Sustainable Development and Poverty Reduction Program
SSA	Sub Saharan Africa
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TSF	Targeted Supplementary Food
TVET	Technical and vocational education and training
U5MR	Under-five mortality Rate
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNSCC	UN special Session of the General Assembly on Children
UPE	Universal Primary Education
VAC	Violence against children
VCT	Voluntary counseling and testing
WAD	Women's Affairs Department
WASHE	Water, Sanitation and Health Education
WFFC	World Fit for Children
WHO	World Health Organisation

EXECUTIVE SUMMARY

This report on the five-year (2003-2007) review of progress Ethiopia has made towards the goals of the WFFC gives an overview of the level of implementation of the WFFC plan of action and the efforts made to meet the MDGs. The report examines in detail progress in the four major areas of 'A world fit for Children'; namely Promoting Healthy Lives, Providing Quality Education, Providing Social Protection and Combating HIV/AIDS. The review process in Ethiopia was led by the Government of Ethiopia with the participation of the relevant stakeholders.

Achievement of most of the Goals of the WFFC and the MDGs ultimately rests on how the economy behaves in the next decade. Without sustainable and accelerated growth, Ethiopia's goal of reaching the MDGs and more generally fostering human development cannot be achieved. In this connection it has to be noted that poverty is a pervasive and persistent phenomenon in Ethiopia. The Human Development Index for 2006, which takes life expectancy, adult literacy, primary schooling and per capita income as a basis ranked Ethiopia 170 out of the 177 countries. Ethiopia also ranks 92 out of 95 on the Human Poverty Index. Recent estimates suggest that about 31 million people (44%) live below the poverty line, which is equivalent to US45 cents or 3 Birr per person a day. The main development objective of the Ethiopian Government is, therefore, poverty eradication. Hence, the country's development policies and strategies are geared towards this end.

Building on the achievements of the SDPRP and considering the big challenges the economy is facing, the government has formulated a new Five Year Plan – A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) - for the period of 2005/06-2009/10. PASDEP represents the second phase of the Poverty Reduction Strategy Program (PRSP) process.

1. Promoting Healthy Lives

WFFC has seven major goals that together aim to increase child survival and promote healthy lives. The WFFC goals are linked to the MDGs. This review covers progress made over the last five years (2003-2007), towards achieving these goals particularly goals linked to the MDGs.

In 2005, Infant mortality rate stood at 77 and under-five mortality rate (U5MR) at 123 per thousand live births (DHS 2005). The IMR has declined by 20.6 percent over the 5-year period from 97 deaths per 1000 live births (2000) to 77 (2005), while the U5MR has gone down by 25.9 percent from 166 deaths per 1000 live births (2000) to 123 (2005). The HSDP III (2009/10) target is to reduce the IMR to 45 per 1000 and the U5 MR to 85 per 1000 live births.

With implementation of RED strategies and intensified training and supportive supervision promoted by Global Immunization Vision and Strategy (GIVS), Ethiopia has made notable progress in routine immunization coverage in the last three years. The administrative DPT3 coverage increased from 52% in 2003 to 69% in 2005.

The MoH estimates that only about 15.1% of deliveries are attended by a skilled provider. This means the majority of deliveries (85%) are not attended by skilled professionals, who can offer emergency obstetric care including new born care.

A comparison of the data from the 2000 and 2005 DHS shows that there have been improvements in the nutritional status of children in the past five years. The percentage of stunted children fell by 10 percent, from 52% in 2000 to 47% in 2005. Similarly, the percentage of children underweight declined by 19%

from 47% in 2000 to 38% in 2005. There was, however, no change over the five-year period in the percentage of children who are wasted (11%).

As for water supply, the national target access figure as of September 2006 is 47.3% (41.2% rural, 78.8% urban). As shown in the Welfare Monitoring Survey (CSA, 2004), the national sanitation coverage is 30.63%. With respect to safe water supply and sanitation, the target is to reach 100% coverage by 2012 and 2011 respectively.

The Ethiopian government undertook a number of fundamental reform measures to address the main health problems and to meet the high unmet demand for health care in rural areas. In view of its commitment to meet the MDGs, the government has embarked on two flagship programs, namely: i) the Health Service Extension Program (HSEP) started in 2002 and ii) the Accelerated Expansion of Primary Health Care Coverage (AEPHCC) in 2005. It has also introduced the Essential Health Service Package (EHSP).

The government of Ethiopia endorsed the MPS strategy which is aimed at strengthening the health system to provide quality care, particularly skilled attendance at birth and emergency obstetrics care through a functional referral system. Strategy and analytical studies (RED strategy, IMCI, enhanced outreach strategy, community IMCI) have been developed in support of the child health program. The Ministry of Health endorsed IMCI in 1997 as a key strategy to reduce childhood mortality and morbidity and to promote child health and development.

With respect to Water and sanitation, a number of policies and regulations are in place, and the UAP and the Hygiene and Sanitation strategy are being implemented.

2. Providing Quality Education

97.3 % of the eligible children at the pre-primary level do not have access to pre-primary education. In 2005/06 the number of primary schools has reached 19,412 and the average annual growth rate is 12.6%. The number of senior secondary schools has grown from 455 in 2001/02 to 835 in 2005/06 with an annual growth rate of 16.4%.

The primary GER at national level has become 91.3% (98.6% for boys and 83.9% for girls). The NER for the year 2005-06 is 81.7% for boys, 73.2% for girls and 77.5% for both. The five years data on primary net enrollment rate shows an increasing trend for both boys and girls. The percentage of female students grew from 40.9 in 2001/02 to 45.3 in 2005/06 for primary education (1-8). The repetition rate of 6.7% in 2002/03 was reduced to 3.8% in 2004/05, and the drop out rate at primary level was reduced from 14.4% in 2003/04 to 11.8% in 2004/05.

The main thrust of ESDP is to improve quality, relevance, equity and efficiency of the system and to expand access with special emphasis on primary education in rural and under served areas as well as the promotion of education for girls in an attempt to achieve universal primary education by 2015. In view of this broad objective of the ESDP, some of the major actions taken by the Government include the following:

- Available data show that to increase access to schooling, 7323 primary (1-8) schools and 380 senior secondary (9-12) schools were built during the period 2001/02 to 2005/06. 76,158 teachers were deployed in primary schools. Thus enrollments in primary education, student/section ratio, pupil/teacher ratio, percentage of female students and percentage of female teachers have all improved.

- A three-year-fast track strategy has been developed in consultation with the regions in order to improve access in the pastoralist and semi-agriculturalist regions. The MoE has undertaken different initiatives that aim to increase access and narrow high gender and regional gaps in GER and urban-rural disparity in enrollment.
- Alternative Basic Education has been fully accepted as part of the strategy to address the low enrollment problem in rural and underserved areas. Alternative Basic Education Centers are constructed closer to the community and this encourages out-of-school children and children from pastoralist communities to attend school.
- To help upgrade quality quickly a national “Teacher Education System Overhaul” is being implemented.

3. Social Protection

Since there are no comprehensive and adequate data, the prevalence of worst forms of child labor in Ethiopia is not known. The appropriate strategy to reduce child labor and improve their working conditions to acceptable standards and at least to eliminate the worst forms of child labor is to tackle the root causes notably poverty and its related problems that force children to labor. In 2005, it was estimated that there were a total of 4,885,337 orphans aged 0-17 years of which 744,100 were AIDS orphans. The OVC Plan of Action has been developed to guide all stakeholders in addressing the issue of OVC care and support in a holistic, coordinated and integrated manner. OVC Task Forces were established by the Government both at federal and regional levels to facilitate the implementation of the plan. Development of an integrated strategy and plan of action for street children remains a challenge for the sector.

The Juvenile justice system is not yet developed in Ethiopia. To redress the situation, the Federal Supreme Court in collaboration with various NGOs, has established the “Juvenile Justice Project Office (JJPO) in June 1999. It is reported that a division within the Federal First Instance Court has been designated to handle cases of juveniles in Addis Ababa. In addition, the justice organs Professionals Training center that was established recently has started to provide a course on human rights.

At the present Ethiopia has no civil registration and vital statistics system in place. A “National Plan of Action for the Establishment and Development of Civil Registration and Vital Statistics System in Ethiopia” has been developed and awaits endorsement. Children are subjected to physical violence in private as well as in public life. Sexual abuse is a common form of violence perpetrated on children. Available information on SAEC is limited.

By way of intervention the government has performed the following: It has provided appropriate and relevant policies and laws. MoLSA has prepared and is implementing the National Action Plan for Children, National Action Plan on OVCs (2004-2006) and the National Action Plan on Sexual Abuse and Exploitation of Children (2006-2010).

4. Response to HIV/AIDS

WFFC has three major goals that aim to reduce the prevalence of HIV, particularly among mothers and infants and undertake integrated set of interventions to cope with the effects of HIV/AIDS on children and vulnerable families. These goals are directly aligned with MDG 6.

According to the calibrated single point estimate (2007), the National Adult HIV prevalence is reported to be 2.1%% (7.7 % in urban areas and 1.9 % in rural areas.). 977,394 Ethiopians are living with HIV/AIDS (41% male and 59% females.)

Estimated 75,420 HIV positive pregnant women are expected in 2007. The highest HIV prevalence is in persons between the ages of 15 and 24, and in both urban and rural areas prevalence is higher among

females compared to males. Prevalence appears to have leveled off in urban areas but continues to rise in rural areas, where 85% of the population lives.

5. Challenges

The challenges in achieving the goals and targets in the four major areas of the WFFC Plan of Action include the following:

- Deployment and retention of health professionals is a major challenge across sectors
- In the case of maternal and child nutrition harmonization of programs across ministries is a big challenge.
- Lack of inter-sectoral collaboration and coordination is a major challenge in the water sector; and in the provision of social protection for children under difficult circumstances.
- One of the important challenges facing the education sector is to ensure that there is a unitary education system within the whole country while at the same time devolving most functions and funds to the region, woreda and community levels.
- Major efforts have to be made to further improve the quality education
- Lack of sufficient number of qualified teachers is a persistent problem.
- The urban epidemic of HIV/AIDS is at an unacceptably high prevalence level of 7.7%, counseling and testing coverage is still low with only 5% of the general population 15-49 years of age being ever tested, ART has been accessed by only 13% of those who need ART; and only 0.8% of HIV infection among births to HIV positive mothers was averted in 2005/06 through PMTCT programs.

6. Key Areas for Future Action

Meeting the goals and targets of the WFFC PoA and the MDGs as well as other internationally agreed standards demands the undertaking of several measures with respect to designing the right strategy, making available adequate skilled personnel, financial resources and logistics as well as establishing and strengthening of support systems like HMIS and M&E mechanisms. With this in view, the Government of the FDRE has to address a number of issues. Some of the key areas for future action include the following:-

- Scaling-up IMNCI implementation through training of at least two health workers per health facility
- Capacity building at regional, woreda, training institutions and facility levels
- Accelerated development of appropriate human capacity in BEOC and CEOC
- Expanding the Essential Nutrition Action
- Mobilization of resources
- Staff recruitment and retention strategies
- Adoption of the present Alternative Basic Education Centre (ABEC) model,
- The role of the MoE should be strengthened in the areas of: quality control, guidelines on investment and utilization of funds, improving the curriculum and textbooks utilized in all regions, monitoring and evaluation of the system and development of a test bank.
- Employment of a cadre of community teachers i.e. Para-professionals or facilitators who will be gradually integrated into the teaching service as qualified teachers over a period of several years.
- With respect to HIV/AIDS, Prevention efforts must focus on high risk groups and regions with comparatively high prevalence and rural hot prevalence spots; and prevention efforts should also focus on interrupting urban to rural transmission and containing the rural epidemic at its current low levels through social mobilization.

7. Conclusion /Way Forward

Most of the right policies and strategies are already in place; and there are encouraging developments in terms of increased access to primary health care for the majority of the population, substantial increase in both the GER and NER, access to safe drinking water and sanitation, improved legislative framework for children etc. Under current Ethiopian health policies and the HSDP, the contribution of health services to the achievement of MDG targets could be substantial. By doubling the current public spending on health, health services could contribute to reducing child mortality and the life time risk of dying of mothers by about 40-45 percent. However, public spending on health services is very low.

Ethiopia has progressed a lot during the last decade in terms of provision of education. Comparing existing trends in enrollment rates, the country has great prospects of reaching the Goal of Universal Primary Education even before 2015. However, despite the three-fold increase in primary enrolments over the past decade, Ethiopia still faces serious and increasing challenges. It may have to more than double its present enrolments to achieve primary education for all. It will need to change its education cost structure, as continuation of the present pattern of educational expenditure is not viable in the long-term. At the same time Ethiopia will also have to improve the quality of education substantially. If the MDG education goals are to be achieved by 2015, then it is absolutely essential to pay special attention to how rural primary school provision can be improved in terms of both access and quality.

In conclusion it can be stated that Ethiopia is:

- Potentially on track with respect to ensuring universal primary education, reducing under-five mortality, and halving the proportion of people without access to safe drinking water and sanitation;
- More distant prospects due to depth of poverty and underdevelopment are achieving gender equality, reduction in the Maternal Mortality Rate; decrease the number of people who suffer from hunger and halting and reversing the spread of HIV/AIDS.

1. INTRODUCTION AND BACKGROUND

The UN special Session of the General Assembly on Children (UNSCC) held in May 2002 was a landmark for children and human development in general. At this session, nations reviewed progress towards the goals of the 1990 World Summit for Children (WSC), and reaffirmed their commitment to children's rights. The outcome document of the special session entitled 'A World Fit for Children', combines a declaration, a review of progress and a plan of action and establishes 21 specific goals and targets covering four overarching priorities: promoting healthy lives, providing quality education, protecting against abuse, exploitation and violence and combating HIV/AIDS.

The plan of action is expected to bridge the gap between the promises and the achievements of the 1990 World Summit for children and help achieve the Millennium Development Goals (MDGs) by the target year of 2015. UN member states have agreed to undertake follow up on the actions and achievements needed to fulfill their commitments and reach the agreed set of goals and targets. Five years have elapsed since the adoption of the declaration and plan of action. A review is now being made by each member state in order to measure the progress made so far and to lay the basis for renewing WFFC plans of action for the next decade

The review process in Ethiopia was led by the Government of Ethiopia through a Steering Committee coordinated by the Ministry of Finance and Economic Development (MOFED), with the participation of relevant sector Ministries and offices (Health, Education, Women's Affairs, Water Resources and HIV/AIDS Prevention and Control Office (HAPCO)). UNICEF was represented in the Steering Committee which oversaw the preparation of the report by a Consultant employed for this purpose. The draft report has been reviewed by each sector Ministry and agency and by a workshop comprising of concerned government institutions, civil society and development partners. Besides its participation in the Steering Committee, UNICEF also provided financial support towards the preparation of the report and the convening of a consensus workshop.

In Ethiopia the review of progress must consider the socio-economic environment and level of development of the country. As a signatory, to the Convention on the Rights of the Child (CRC) and the WFFC Plan of Action and its commitment to the Millennium Development Goals (MDGs), Ethiopia has been engaged in improving, to the extent possible, the lives of its children and women within the framework of internationally agreed standards and goals.

This five-year (2003-2007) review of progress Ethiopia has made towards the goals of the WFFC gives an overview of the level of implementation of the plan of action and the efforts made to meet the MDGs. The report examines in detail progress in the four major areas of 'A world fit for Children'. For each major area, the report:

- Describes the current situation in the country.
- Identifies the major actions that have been taken by the government, civil society, and development partners.
- Describes the challenges in the achievement of the objectives and targets of the WFFC plan of action (PoA) and related MDGs and targets, and
- Identifies key areas for future action necessary to ensure the success of Ethiopia's commitment to the global goals for children.

1.1 Background Context

Ethiopia is a landlocked country with a land area of 1.14 million km². The size of the country and its location has accorded it with diverse topography, geographic and climatic zones and resources.

With a projected population of 75.1 million in 2006, Ethiopia is the second most populous country in Sub-Saharan Africa (SSA). About 85% of the population resides in rural areas while the rest live in urban areas. Gender wise, females constitute about 50% of the population. According to the Central Statistical Agency (CSA), the Ethiopian population grows at about 2.75% pa. With this growth rate, Ethiopia's population is expected to be 100 million by 2018 and 130 million by 2030.

The age structure suggests that about 48% of the population is less than 15 years of age (CSA 2005). Urban and rural unemployment and underemployment is also large and rising. In many cases, social and economic infrastructure per capita is far lower than the average for SSA (Ministry of Finance and Economic Development (MoFED) 2005). Increasing population pressure has also continued to reduce the average land holdings from around 0.5 hectares per person in the 1960's to 0.11 hectares in 2006/07 (MoFED 2005), which continued to increase the vulnerability of the rural population to poverty and malnutrition.

Overall economic performance measured by growth in real GDP has registered continuous growth in the last three fiscal years. A 9.6 percent growth in the value added at constant basic prices of 1998/99 was registered during 2005/06 while the corresponding growth recorded in the 2004/05 and 2003/04 were 10.5 and 11.9 percent respectively; the latter being a recovery of the economy from severe drought shock of 2002/03. The growth registered during the last three years averaged 10.7 percent (MOFED, Dec. 2006). The largest contributor to GDP growth was agriculture, which accounted for approximately 42% of the total GDP (OECD, 2006).

The country's inflation rate in 2000/01 and 2001/02 was very low (below zero), however, the trend changed during the last four fiscal years with inflation averaging 10.7 percent with a peak of 15.1% in 2002/03 due to the drought that affected the economy tremendously. The following two years the inflation immediately went down to 8.6 and 6.8 percent. During the fiscal year under review (2006), inflation reached 12.3%.

Politically, Ethiopia is a federal state with nine regional national states empowered on a number of economic, political and social issues with the exception of foreign relations and defense matters which are the prerogative of the federal government. Ethiopia is a diverse country with nearly 80 language speaking nations and nationalities, and the regional states have been structured taking these diversities into consideration

Nonetheless, Ethiopia's development challenges look rather formidable. Low productivity, erratic GDP growth, heavy dependence on rain fed agriculture, low level of saving and investment, low level of human and institutional capacity, and poor state of infrastructure development generally characterize the economy.

Poverty is a pervasive and persistent phenomenon in Ethiopia. The Human Development Index for 2006, which takes life expectancy, adult literacy, primary schooling and per capita income as a basis ranked Ethiopia 170 out of the 177 countries.¹ Ethiopia also ranks 92 out of 95 on the Human Poverty Index.

¹ Government of Ethiopia-UNICEF: Country Programme Action Plan, 2007-2011

Following the deregulation and liberalization of the economy in the late 80s, overall GDP grew, on average, by 4-5 percent per annum. But due to rapid population growth, per capita income has risen to only 150 USD in 2005 from about 100 USD in the early 1990s.² A study by MoFED (2005) suggests that the long-term growth performance of the economy is largely explained by rainfall variability and to some extent by changes in the terms of trade and exchange rates. This is true in a situation where a low yielding subsistence oriented and small holder dominated agriculture accounts for about 45% of the GDP, for 90% of the export commodities, and employing for over 85% of the population.

As stated earlier, poverty is the fundamental problem in Ethiopia. Recent estimates suggest that about 31 million people (44%) live below the poverty line, which is equivalent to US\$ 0.45 or about 3 Birr per person a day (MoFED, 2005). hence, the main development policies and strategies of the Ethiopian Government are geared towards poverty eradication.

Based on the growing realization for a comprehensive approach to change the poverty landscape in the country, the Ethiopian government formulated a three-year poverty reduction program in 2002 known as the Sustainable Development and Poverty Reduction Program (SDPRP). One of the major goals of the SDPRP has been the reduction of poverty by 10% pa from the level in 1999/00. Building on the achievements of the SDPRP and considering the big challenges the economy is facing, the government has formulated a new Five Year Plan – A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) - for the period of 2005/06-2009/10. PASDEP represents the second phase of the Poverty Reduction Strategy Program (PRSP) process.

The PASDEP carries forward important strategic directions pursued under the SDPRP – related to infrastructure, human development, rural development, food security, and capacity-building – but also embodies some bold new directions. Foremost among them is a major focus on growth in the coming five-year period with a particular emphasis on greater commercialization of agriculture and enhancing private sector development, industry, urban development and a scaling-up of efforts to achieve the Millennium Development Goals (MDGs).

During the SDPRP period, government resource allocation and implementation was geared towards investments on development and pro-poor sectors (agriculture and food security, education, health, roads, HIV/AIDS and provision of clean water supply) as well as on infrastructure development, particularly in road construction. In general, as shown in Table 1, from the total government expenditure, spending on poverty-oriented sectors has increased from 43% in 2001/02 to 56.5% in 2004/05.³

² CBE: Getachew Teka M& Yitshak Mengesha: “Integrating Financial Services into the Poverty Reduction Strategy: The Case of Ethiopia presented at the East Africa Sub-regional Workshop” Integrating Financial Services into Poverty Reduction Strategies”. June 28-30, 2006

³ PASDEP- September 2006

Table 1: Trends in Pro-Poor Sectors Allocated Budget out of Total Government Expenditure (%)

<i>Sector</i>	<i>2000-01</i>	<i>2002-03</i>	<i>2003-04</i>	<i>2004-05</i>
Education	14.2	16.1	20.4	19.7
Health	5.9	4.9	4.3	4.8
Agriculture and food security	9.2	8.1	13.4	16.3
Road	10.7	9.9	9.6	11.2
Water and sanitation	2.8	2.9	2.0	4.5
Total	42.8	41.9	49.7	56.5

Source: MOFED: Ethiopia: Building on Progress - A Plan for Accelerated and Sustained Development to End Poverty (PASDEP), Addis Ababa, September 2006

The total projected program cost for development and poverty oriented sectors (recurrent and capital) is expected to reach at 44.3 billion Birr by the end of 2009/10 from 14.0 billion birr in 2004/05. Total projected allocations within the government's Macroeconomic and Fiscal Framework (MEFF) for the poverty-oriented sectors for the full period of the PASDEP (2005/06 to 2009/10) amount to about 174.9 billion Birr (76.9%) from the total projected expenditure of 232.1 billion Birr for the entire program period, with agriculture and rural development and education accounting for the lion's share of projected program costs.

The commitment of the Ethiopian Government to the MDGs is evidenced by the level of emphasis to these goals in the two PRSPs. Both the PASDEP (2006-10) and the SDPRP (2002-2005) adequately reflect all the MDG relevant sectors (health, education, water, roads). The relevant sector development programs are also in line with the MDG targets. This applies especially to the Health Sector Development Program (HSDP) and the Education Sector Development Program (ESDP), which are the pillars of the health and education components of the PASDEP.

2. PROMOTING HEALTHY LIVES

The Plan of Action of ‘A World Fit for Children’ adopted by the UN General Assembly Special Session on Children contains measures aimed at “breaking the inter-generational cycle of malnutrition and poor health by providing a safe and healthy start in life”. These include targets to reduce infant, under-five and maternal mortality rates, to improve access to safe drinking water and sanitation and to support early childhood and adolescent development.

Promoting healthy lives incorporates the most basic rights expressed in the CRC and includes the undertaking and fulfillment of a set of inter-related actions and targets. WFFC has seven major goals that together aim to increase child survival and promote healthy lives.

The WFFC goals are linked to the MDGs. This review covers progress made over the last five years (2003-2007), towards achieving these goals particularly goals linked to the MDGs. The data found in the four major areas of this report are mainly from DHS (2005), Welfare Monitoring Survey (2004), Report of Final Evaluation of HSDP II (2006), and routine information systems (HMIS, EMIS, etc.). These data are useful for tracking progress over time. The government and civil society have made tremendous efforts during the period 2003 to 2007 as evidenced in the forthcoming section and additional support has been provided by development partners and the international community. These efforts and the main achievements as compared to the base year are described in the following section.

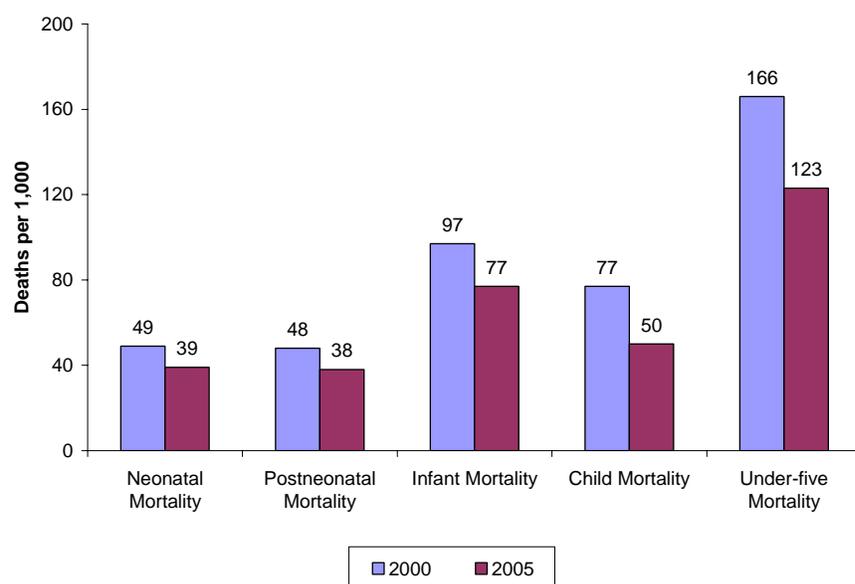
2.1 Reduce Infant and Child Mortality

2.1.1 Status of Child Health in Ethiopia

In 2005, Infant mortality rate stood at 77 and under-five mortality rate (U5MR) was 123 per thousand live births (DHS 2005).⁴ The following table shows the range of early childhood mortality rates for the three recent five-year periods before the survey (2005).

⁴ CSA. ORC Macro: Ethiopia, Demographic and Health Survey (2005), August 2006

Figure 1 Early Childhood Mortality Rates for the Period 0-4 Years Preceding the Survey 2000 and 2005



Source - Ethiopia: DHS, 2005

As shown in Figure 1, the IMR has declined by 20.6 percent over the 5-year period preceding the survey from 97 deaths per 1000 live births (2000) to 77 (2005), while the U5MR has gone down by 25.9 percent from 166 deaths per 1000 live births (2000) to 123 (2005). Despite these improvements, one in every 13 babies born in Ethiopia does not survive to celebrate its first birthday, and one in every eight children dies before its fifth birthday.

There are significant regional variations in infant and U5 mortality that reflect regional disparities, urban-rural differences and educational and wealth levels. For instance U5MR ranges from a low of 72 in Addis Ababa to high of 157 per 1,000 live births in Benishangul Gumuz followed by Gambella (156) and Amhara Region (154). U5MR among children born to mothers with no education (139 per 1,000 live births) is more than twice that of children born to mothers with secondary and higher level of education (54 per 1,000 live births). The U5MR for children who live in rural areas is 135 per 1000 live births versus 98 per 1000 live births for those who live in urban areas.

Based on DHS and FMOH data, the following illnesses are responsible for the U5MR in Ethiopia: 28% of deaths are due to pneumonia, 25% due to neonatal conditions (e.g. sepsis and asphyxia), 20% due to malaria, 20% due to diarrhea, 4% due to measles and 1% due to AIDS.⁵ Malnutrition is also a major underlying cause of death in approximately 57% and HIV/AIDS underlies 11% of other deaths, particularly those due to pneumonia.

The levels of mortality are worsened particularly by poverty, inadequate maternal education, deficiencies in water and sanitation and high fertility and inadequate birth spacing.

IMR is strongly influenced by improvements in basic health care. This is because most of the more direct and immediate causes which primarily affect infants can be tackled by activities that are part of primary

⁵ FMOH/WHO-“Child Health in Ethiopia-Background Document for the National Child Survival Conference, April 24-26, 2004, Addis Ababa.

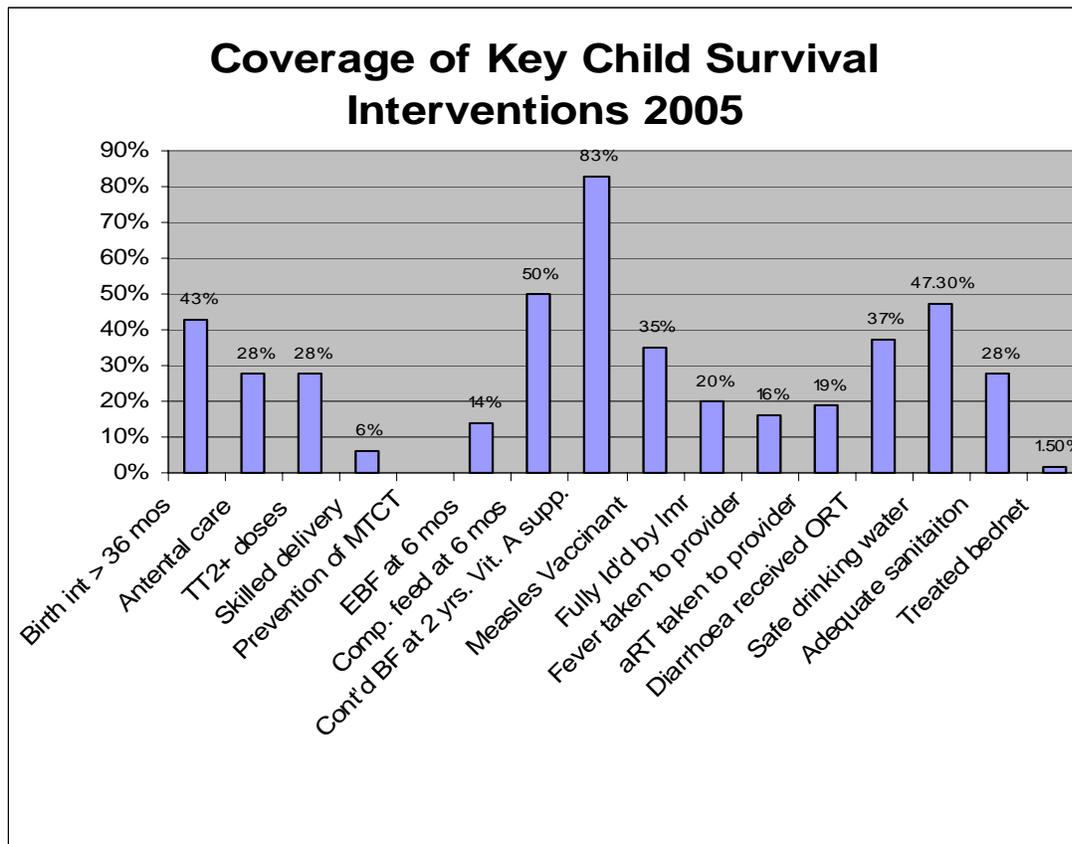
health care programs.⁶ U5MR is on the other hand influenced more by the socio-economic status of a nation. As mentioned earlier, pneumonia, malaria and diarrhea, high maternal fertility, especially early first pregnancy and short birth intervals, are also strongly associated with increased U5 mortality. Other factors that contribute to reductions in child mortality are socio-economic development such as improvements in women’s education and literacy, household income, safe water supply, sanitation and housing as well as improvements in nutrition.

DHS results indicate that short birth intervals, high birth order, low birth weight, and young age of mothers are strongly linked to high child mortality levels. Children whose mothers were less than 20 years of age when they gave birth have a 30% higher mortality rate than those whose mothers were in their 20’s (161 versus 124), and children born less than two years after their older siblings have an U5MR 215% higher than those born four or more years later (208 versus 66).

According to the DHS – 2005, the overall perinatal mortality rate is 37 still births per 1000 live births down from 52 still births per 1,000 live births in the 2000 DHS

Major causes of neonatal mortality are infections (32%), birth asphyxia (29%) and complications of prematurity (24%).⁷ These deaths could be averted through the application of a number of health systems interventions. Ethiopia can achieve dramatic reduction of under-five mortality by focusing intensively on the key child survival interventions whose coverage at present is shown below.

Figure 2: Coverage of Key Child Survival Interventions, 2005



⁶ FMoH: Ethiopia HSDP II-Report of the Final Evaluation of HSDP II, Vol. 1, 2002/03 to 2004/05, Addis Ababa

⁷ FMoH/WHO – Ibid Child Health in Ethiopia, 2004

Source: DHS, 2005

2.1.2 Actions taken by the Government and Partners

The actions taken by the government and its development partners are based on the situation analysis of child health and are aimed at reducing or changing the causative factors accounting for high infant and under-five mortality rates.

Since 1991, the Ethiopian government has undertaken a number of fundamental reform measures to address the main health problems and to meet the high unmet demand for health care in rural areas. The first steps in this direction were taken with the development of a new health policy and strategy, democratization and decentralization of the health system and the introduction of a twenty-year health sector investment program (1998-2018). The HSDP was launched in 1998 with the basic objective of improving the coverage and quality of health services; be primarily implemented and managed by regional, zonal and woreda level health officials and be financially sustainable. HSDP II (2002/03 – 2004/05) covers the health policy interventions under the SDPRP, as well as the period in question under the WFFC+5 progress report. HSDP III (2005/06-2009/10), in line with the PASDEP and guided by the MDGs, is currently being implemented. The major areas of focus in HSDP III are maternal health, child health, prevention and control of HIV/AIDS/TB and malaria and the strengthening of health systems.

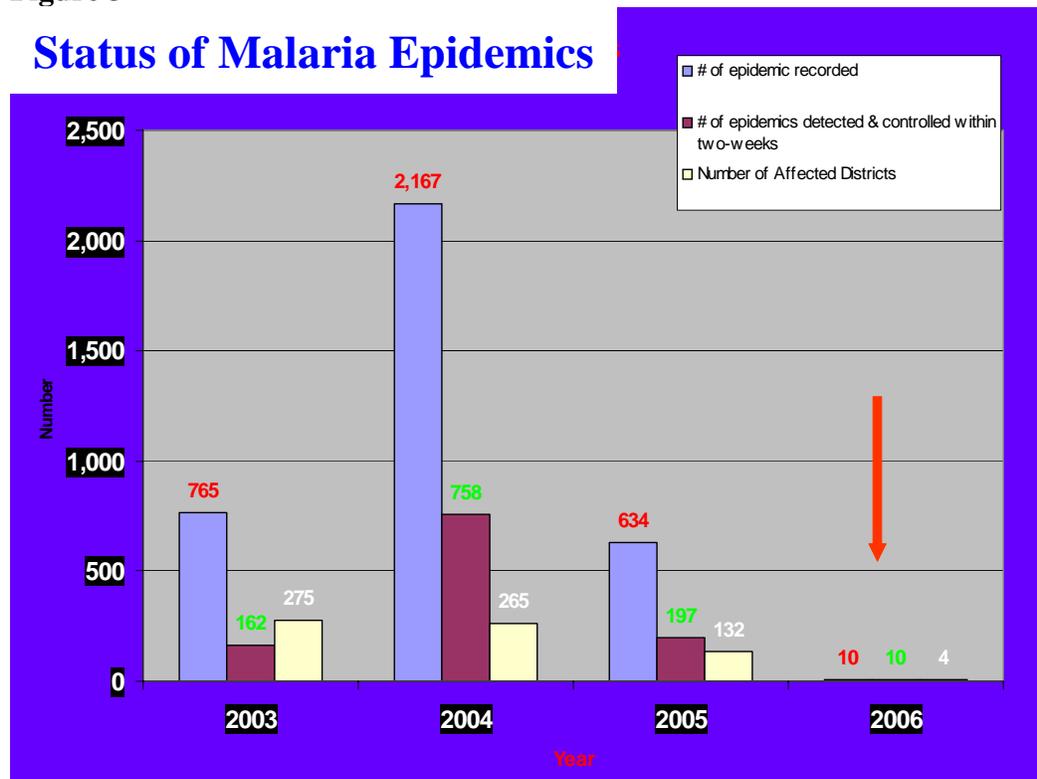
Recognizing the low level of health development in Ethiopia and to improve the services in this sector, the Government's health strategy has targeted the most common poverty-related diseases including malaria, Tuberculosis (TB), childhood illnesses, and HIV/AIDS. It has also been shifting services to improve the health needs of rural people, who make up 85% of the population.

The steps taken and results achieved during HSDP II and SDPRP period include the following:

- Trained over 10,500 new nurses, technicians, and front-line health workers;
- Increased health budget from 12 Birr per person in 2001/02 to about 19 Birr per person today (by the end of 2004/05);
- Built over 1,900 new health posts and centers, increasing the share of the population living within a radius of 10 km from 51% to 64%;
- Developed and put into effect a Multi-sectoral HIV/AIDS Plan, along with a Social Mobilization Strategy against HIV/AIDS which is a policy for supplying Anti-Retroviral Treatment (ART) to advanced AIDS cases in addition to expanded service delivery facilities and better tracking, measurement, and prevention programs;
- In 2005 and 2006, 7 million vulnerable children received Vitamin A supplementation, deworming, nutrition screening and primary health support twice a year. In addition, the capacity of the Government's Therapeutic Feeding Units/Outreach therapeutic Feeding Programmes to treat severely malnourished children had increased from 1,000 to 21,000 children by 2006. 15 million children were covered by house-to-house polio immunization campaigns in 2005 with 12 million children under the age of five receiving measles vaccine in 2006.
- One of the major achievements of the past 2 years has been the scaling-up of the Malaria programme, which contributed to a dramatic reduction in Malaria epidemics in 2006 (see Figure 3). The Ethiopian government, aided by UNICEF and partners, procured and distributed 8.6 million long-lasting insecticide treated nets to malaria-prone households, and it is now possible to reach the full target of 20 million nets by end of 2007.
- Introduced a new system of health care financing, where the private sector and donors are encouraged to participate in generating additional income in the form of drug donation

- Met all targets set for malaria control, child immunization, and family planning programs as well as the establishment of health centers.
- In 2005 the Ministry of Health developed the “National Strategy for Child Survival” with the assistance of the WHO, UNICEF, USAID, the World Bank and CIDA. The overall objective of the strategy is to reduce under-five mortality to 67/1000 by 2015 – this being a reduction of two-thirds from the 1990 rate of 200/1000 live births.

Figure 3



As evidenced above, Ethiopia’s Health Sector Development Program has the potential to make a major contribution to achieving the child survival MDGs. In view of its commitment to meet the MDGs, the government embarked on two flagship programs, namely: i) the Health Service Extension Program (HSEP) in 2002 and ii) the Accelerated Expansion of Primary Health Care Coverage (AEPHCC) in 2005. It has also introduced the Essential Health Service Package (EHSP).

The HSEP is a community based primary health care service which includes a package of basic preventive, promotive and curative services. The package includes health education and communication, maternal and child health (community IMCI), immunization services, nutrition extension package, water and environmental health, prevention and control of HIV/AIDS, TB and Malaria and adolescent reproductive health. The HSEP targets households at kebele level (average 5000 people) and aims in particular to reach mothers and children. Guidelines of HSEP for urban areas have been prepared and await finalization.

The HSEP services are provided by two female Health Extension Workers (HEWs) per kebele. These are new cadre of health workers who are formally employed and salaried by the respective woredas.

Over the last four years (2002 to 2006) the HSEP has evolved into a full scale program that is being implemented in an accelerated way in most of the regions. In the HSEP the target is to build 10,000 health posts (HPs) in rural areas and to train 30,000 HEWs until the end of 2008. With regard to HPs 2027 were built in 2006/07 and along with the former HPs the total has reached 6175, or 41% of the requirement for the universal health post coverage. In terms of HEWs, 9900 have been trained and deployed, and 7505 were enrolled in 2005/06 bringing the total number of HEWs deployed and enrolled to around 17,405. This is 58% of the target and given the current pace of performance, the 30,000 target will be achieved by 2008.

The second flagship program is the AEPHCC, which aims to address the service coverage problem of the health care system through an accelerated expansion and strengthening of primary health care (PHC) services focusing on both physical availability and accessibility of essential health services by sufficiently reducing physical distance between primary health care facilities and health care users and by making essential health services available in the facilities. The focus of this program is also to expand the essential health services to rural Ethiopia and to enhance the health care system inputs towards the achievement of the MDGs. This program is part of HSDP III. It proposes to accelerate the expansion of PHC facilities in order to attain universal coverage by 2008, as defined in the Health Policy and Strategy.⁸

The following table presents an overview of the status of some relevant MDG indicators

Table 2. Relevant MDG Indicators within HSDP II and III

Indicators relevant for the MDGs	Baseline 2001-02 HSDP II	Status 2004-05 End of HSDP II	Status 2006-07 Mid-HSDP III	Target 2009-10 End of HSDP III
Primary health service coverage	61.1%	72.1%	76.9% (2005-06)	100%
% births attended by skilled staff	10%	12%	16%	32%
Contraceptive acceptor rate	14%	21%	35.8%*	>=60%
% < 1yr. immunized for DPT3	51%	70%	79%	80%
% < 1yr. immunized for measles	42%	61%	65.6%	75%
% of fully immunized children	30%	44%	54%	85%
TB cure rate	66%	65%	65%	85%
Outpatient visits/pp/yr.	0.27(1993)	0.30	0.33*	0.50
GoE per capita expenditure on health (Birr/pp in public sector)	NA	16.3		

* These rates refer to the beginning of HSDP III

Source: - HSDP II Final Evaluation Report, Vol. 1, p. 5.

⁸ FMOH – Accelerated Expansion of Primary Health Care Coverage in Ethiopia (2005-2009), Addis Ababa, November 2004.

Even though the period of implementation has been short, both HSEP and the AEPHCC have made substantial progress in the majority of the regions in a relatively short period and both programs have been well received and supported. The Federal Ministry of Health (FMoH) has already begun a training program for Health Officers and in terms of infrastructure development, Health Center Expansion has surpassed targets set in 2005/06. The progress made so far reflects the enormous efforts that have been made to set the whole process in motion.^{9,10}

The FMoH also introduced the Essential Health Service Package. The goal of delivering an EHSP is to contribute to poverty reduction and sustainable development by promoting efficient, effective and equitable access to essential health services of the population, particularly the poor. This will also contribute to enhancing the country's advance towards meeting the MDGs targets.

Finally, the FMoH has taken several initiatives to develop other health systems issues. With regard to Health Management Information System (HMIS), a national HMIS reform is underway. The objective of the reform is to develop a system based on common set of indicators and standardized data collection procedures leading to enhanced information use for decision making. A Health Commodity Logistics Master Plan has been developed and is being implemented and a Harmonization Manual (HHM) for HSDP has been prepared. The Code of Conduct signed between the FMoH and donors is part of this manual. A Human Resources Development Strategy has been developed and is at a draft stage. Each of these initiatives improves processes and efficiencies while responding to the challenge of promoting healthy lives in Ethiopia.

Child Immunization: Routine immunization services in Ethiopia are provided to children under 1 year of age for the six preventable childhood diseases (tuberculosis, poliomyelitis, tetanus, diphtheria, pertussis and measles) as well as tetanus toxoid (TT) to pregnant and childbearing age women to prevent newborns from neonatal tetanus.

The public health care system in Ethiopia is able to provide basic service to about 72% of the population.¹⁰ The capital city Addis Ababa and several of other earlier established regions have gone further in expanding the EPI and improving access of population to immunization services than have the newer emerging regions, whose populations are generally more dispersed and nomadic.

Immunization services in the country are provided by about 2,000 fixed health facilities and more than 10,000 outreach posts. Apart from availability of health infrastructure, the access to immunization services is also influenced by the client demand and communication with communities.

In 2004, the Reaching Every District (RED) approach was implemented to strengthen the immunization program, and the EPI coverage improved after many years of stagnation. With implementation of RED strategies and intensified training and supportive supervision promoted by Global Immunization Vision and Strategy (GIVS), Ethiopia made notable progress in routine immunization coverage in the last three years. The administrative DPT3 coverage increased from 52% in 2003 to 69% in 2005.

An EPI coverage cluster survey¹¹, conducted every 5 years in Ethiopia, is an important monitoring tool to verify administrative coverage rates and assess reasons for immunization failure. There is remarkable consistency between administrative and survey coverage rates.

⁹ FMoH – Report of the Final Evaluation of HSDP II

¹⁰ FMoH – Health and Health Related Indicators, 2004/05

¹¹ FMoH - EPI Coverage Cluster Sampling Survey, June 2006

The regional values of DPT3 coverage of children by the age of 1 year by card with valid doses ranged from 68.9% in Addis Ababa to 5.6% in Afar Region; and the card plus history coverage ranged from 97.4% in Addis Ababa to 20.8% in Somali Region. Judging from “Card+History < 1 year of age” indicator, Addis Ababa, Tigray, SNNPR, Harari and Dire Dawa regions have met the WHO African Region child immunization target of DPT3 \geq 80% coverage rate.

Modest achievements were also registered by this survey regarding immunization of women for child protection at birth from neonatal tetanus: the national weighted TT2+coverage rate by card was 41.5% and by card plus history was 75.6%. Regional variations of this indicator by card were 58.1% in Tigray Region and 8.2% in Afar Region whereas the range of Card+H indicator was between 92.0% in Addis Ababa and 40.0% in Somali Region. The latter indicator values of \geq 80% were registered in six regions: Tigray, Ben Gumuz, SNNPR, Harari, Addis Ababa and Dire Dawa regions.

The children of urban dwellers got more chance to be vaccinated (DPT3- 77.6%) than their rural counterparts (63.2%). The results of the EPI Cluster Survey could be summarized as follows:

- The immunization coverage has improved in the last five years as evidenced by immunization coverage cluster sampling surveys in 2001 and 2006: DPT3 taken as an indicator for overall programme assessment has reached 66.0% in 2006 survey from 56.3% in 2001 survey.
- The survey clearly demonstrated a remarkable consistency between administrative and survey coverage rates (by card plus history): evidence of a functional reporting system.
- As evidenced from discussions with community leaders and Health Extension Workers there is strong commitment of kebele administration and community volunteers towards immunization.
- Lack of information on immunization as a whole and especially on the need to return to complete immunization series according to national EPI schedule were the dominating reasons for immunization failure in almost all survey clusters. Most of the identified obstacles for immunization failure were related to health service provision and management at immunization sites (lack of vaccines, absence of the vaccinator, inconvenient time for immunization sessions, etc.).

One of the prominent gaps was found to be the low immunization coverage for measles in many regions measured both by “Card+history in <1 year old” and high “DPT1/Measles” dropout rate (42.9% nationally for valid doses).

The vaccination coverage reported by the FMOH is much better than that reported by DHS¹². For 2006 FMOH data show that the immunization coverage for DPT1 was 84.3%, DPT3 66%, for BCG-83.4%, Measles-54.3%, OPV1 82.8%, OPV3 66.8% and for TT2+ 75.6%. The proportion of children fully immunized was 49.9%.

Reducing U5MR to 67/1000 by 2015 can only be achieved if cost effective and high impact interventions are implemented at very high levels of coverage. Integrated Management of Childhood Illness (IMCI) is one of the delivery approaches of the National strategy for child survival and is incorporated within HSDP III. The strategy is contingent on the implementation of the HSEP and the PHC expansion plan.

¹² Data from the DHS generally show vaccination coverage to be lower than data collected from the 2004 Welfare Monitoring Survey and data reported in the service statistics from the Ministry of Health. However, when comparing data from various sources, consideration should be given to differences in the sampling frame, design, sample size, representativeness of the sample, and selection methodology as well as differences in the source of information, phrasing of questions, and reporting of data that could explain these differences.

Strategy and analytical studies (RED strategy, IMCI, enhanced outreach strategy, community IMCI) have been developed in support of the child health program. The Ministry of Health of the government of Ethiopia endorsed IMCI in 1997 as a key strategy to reduce childhood mortality and morbidity and to promote child health and development. In May 2000 a 5-year IMCI strategic plan was developed and incorporated in HSDP II action plan; moreover, all regions included IMCI in their Annual Plan of Actions. All regions are implementing IMCI and there has been progress in all the three components of IMCI. A total of 3254 health professionals have been trained in the pre-service trainings; 2252 diploma nurses, 144 post-basic BSc Nurses, 826 health officers and 64 medical doctors. A progressive increase in the annual output of pre-service IMCI trained health workers has been observed during the last five years.

Preliminary data¹³ indicated that 39% of hospitals and health centers had at least one health worker trained in IMCI and 28.9% of the woredas had at least one health facility providing IMCI. However, this is behind the HSDP II target of 80% facilities providing IMCI.

In relation to the implementation of the child survival strategy the following major activities have been performed¹⁴

- EPI policy guidelines updated;
- Nation-wide measles follow-up campaign conducted for 5.6 million children (6-14 years);
- Cold storage space expanded (4 cold rooms, 1500 fridges and 5000 vaccine carriers);
- EOS undertaken in drought affected woredas;
- IMNCI training package developed.
- HIV/AIDS incorporated into IMNCI training materials for health workers and health extension workers;
- C-IMCI expanded to 13 new woredas (1300 CRPs trained); which brings the total to 23 woredas.

Compared to the previous years, the performance of the health sector on a number of Family Health Indicators has been good in 2007-08. CPR has reached 36% compared to 25% in 2004/05. 80% of children who were eligible have been immunized in 2005/06 compared to 62% in 2004/05.

With regard to long-lasting nets, out of the required 20 million nets (2 per household for 10 million households), 14.4 million has been distributed and the remaining gap will be covered until August 2007. So in terms of access there will be universal coverage by the end of 2007 and the main challenge will be ensuring proper utilization and replacing of the worn out nets.

Tackling childhood poverty can break long-term cycles of poverty -both life-course poverty and the inter-generational transmission of poverty. Accordingly, Ethiopia has given focus to universal access to primary education, primary health services, reproductive health, rural growth, food security and gender equity all of which have positive impact on children.

In order to address the concern of children in a coordinated manner, Ethiopia has formulated the National Plan of Action for Ethiopian Children (2003-10 and beyond). During the period of the PASDEP, the National Plan of Action for Ethiopian Children (NPAEC) will be reviewed, implemented and monitored. The plan includes many of the elements relevant to children's welfare -for example, through improved

¹³ FMoH: Presentation on Maternal, Neonatal and Child Health at ARM-2006

¹⁴ FMoH Report on the Proceedings and Results of the Eighth Annual Review Meeting of HSDP, October 2-6, 2006, November 2006

school participation, child health and HIV/AIDS interventions as well as selected programs designed to protect children from abuse, exploitation, and violence; to improve the situation of children in especially difficult circumstances, such as those orphaned or affected by conflict; and to protect children from harmful traditional practices.

2.1.3 Achieving the Child Survival MDGs – Challenges Ahead

According to the World Bank, “reaching child survival MDGs at the current pace will be challenging. In order to reach the child survival MDG target by 2005, Ethiopia would have to reduce under-five mortality at the rate of 5.2 per 1,000 live births each year starting in the 1990s. However, between 1990 and 2000, the rate of decrease of under-five mortality has only been about 1.9 per 1,000 live births per year. Moving forward, Ethiopia would have to reduce child mortality by 7.4 per 1,000 live births per year during the period 2003-2015 to achieve the MDG target. This is extremely challenging given the country’s past track record as well as the plethora of unmet needs for child survival in Ethiopia. Even then, through appropriate, cost-effective strategies, many of the factors contributing to child mortality can be mitigated”.

The HEP and HSDP III must overcome several health systems constraints to improve child health in Ethiopia. These include organization and management of the health sector at the federal and regional levels, the production, distribution, retention and capacity of health providers and managers; and functioning of the health information and drug management systems. There also needs to be increased financial investments in child health, particularly in the regions of greatest need.

The management of the child survival strategy requires actions to build and maintain capacity at all three levels of the health system starting with the community and the strengthening of the Woreda Health Office so that it can effectively plan, support and monitor the necessary actions and inputs at all three levels. The major challenges in this respect are related with overcoming the bottlenecks to access to care, availability of skilled human resources, supplies and logistics, effective supervision and a functional referral system for women and children who need higher level care. The high turnover and frequent rotation of staff in general and IMCI trained staff in particular is a serious constraint hampering the expansion of IMNCI. The practical coordination and collaboration with relevant programs including roll-back Malaria (RBM), EPI, nutrition, Make pregnancy Safer (MPS), and HIV/AIDS remains a challenge.

2.1.4 Key Areas for Future Action

Meeting the child survival MDGs demands the undertaking of several measures with respect to designing the right strategy, making available adequate skilled personnel, financial resources and logistics as well as establishing and strengthening of health support systems like HMIS and M&E mechanisms. During the last five years, the FMoH has been involved in launching and implementing flagship programs that will make a difference with respect to reduction of infant, child and maternal mortality in Ethiopia. With this in view, some of the key areas for future action include the following:-

- Scaling-up IMNCI implementation through training of at least two health workers per health facility
- providing maternal and child health services to bring about impact;
- Capacity building at woreda and regional level for planning, training, follow-up and support supervision;
- Capacity building of training institutions to scale-up pre-service IMNCI training;
- Optimal involvement of NGOs and the private sector to scale-up IMNCI implementation;

- Collaboration between relevant programs including EPI, RBM, nutrition, MPS, and HIV/AIDS etc...
To avoid duplication of efforts and maximize impact.

2.2 Improve Maternal Health

2.2.1 Status of Maternal Health in Ethiopia

The total projected female population in Ethiopia for the year 2005/06 accounted for about half of the total population of 75.1 million Ethiopians. Of these 17,941,013 are in the reproductive age group (15-49), elucidating the need for comprehensive reproductive health services for the large population of women. High-risk fertility characteristics of early child bearing, high parity and short birth interval (less than two years of the previous birth) contribute to ill health and in some instances premature death of both the mother and the child.

The total fertility rate (TFR) for Ethiopia for the period 2003-2005 is 5.4 births per woman. As expected, fertility is considerably higher in the rural areas than urban areas (6.0 versus 2.4). An Ethiopian woman bears on average around five children by the end of her reproductive life. There are also regional disparities in TFR with a high of 6.2 in Oromia and 1.4 in Addis Ababa. There is significant variation by residence (2.4 in urban versus 6.0 for rural areas), and education (2.0 among those with at least secondary schooling versus 6.1 among those with no schooling).

Fertility has fallen substantially among all age groups over the past two decades. The decline observed in Ethiopia could be attributed in part to increasing use of contraceptives. There has been a decline in fertility from 6.4 births per woman in the 1990 National Family and Fertility Survey (NFFS) to 5.4 births in the 2005 DHS, a one-child drop in the past 15 years. The decline in fertility was more pronounced in the 10 years between 1990 and 2000 than in the five years between 2000 and 2005 and more pronounced in urban than rural areas. A comparison of the three-year TFR calculated from the 2000 DHS and the 2005 DHS shows little change for the country as a whole (5.5 births in 2000 versus 5.4 births in 2005). With the exception of the 15-19 age groups, fertility has declined in every age group over the past 15 years¹⁵.

It is crucial to address high fertility levels because there is a strong link between poverty and high fertility. An ILO study (2003) confirmed that a strong relationship exists in Ethiopia between demographics and the health of a household. Households with larger family size and older heads of family are more likely to fall into poverty than households with smaller family size and younger heads. The addition of each additional child increases the incidence of poverty.

Another complicating factor is that women have low status in Ethiopia. They have limited access to education, limited representation in government (7.7%) and limited access to employment (45%). With respect to education, female literacy rate is 66 %, female primary school enrollment 78.5 % and secondary school enrollment 24.5 %.

Human resources available for providing quality reproductive health care are grossly inadequate. One physician caters for over 35,000 people and one midwife attends to over 3,756 expected deliveries. The need for midwives has been met for less than half of the population and there are also shortfalls among other categories of health workers.¹⁶

¹⁵ Ibid – DHS 2005 p. 50.

¹⁶ Ethiopia: Synthesis of Recent & Relevant Reviews and Studies Conducted in the Health Sector, June 2004

Maternal and newborn health is identified as a priority area in the health policy as well as in the current HSDP III. Priority was given to the provision of safe motherhood services to cater for normal pregnancies, deliveries and referral centers for high-risk pregnancies, appropriate maternal and child nutritional education, provision of family planning services, post abortion care, addressing sexual and reproductive health needs of adolescents, encouraging paternal involvement and discouraging harmful traditional practices.

According to FMOH data, the contraceptive prevalence rate (CPR) in 2002-03 was 22%, a substantial increase from 8% in 1998-99. By 2005/06 the contraceptive prevalence rate reached 36% compared to 25% in 2004. In 2005–06, the FMOH estimated that 50.4% of pregnant women had one or more antenatal care visits. Current TT₂ coverage is estimated at 51.8% of pregnant women.

According to DHS 2005, the CPR for married Ethiopian women who are currently using a method of family planning is 15 percent. With respect to trends in contraceptive use, use of contraceptive methods tripled in the 15-year period between the 1990 NFFS and the 2005 DHS from 5 percent to 15 percent. The increase is especially marked for modern methods in the five years between 2000 and 2005. This increase is attributed primarily to the rapid rise in the use of injectables from 3 percent in 2000 to 10 percent in 2005.

Delivery Attendance: Assistance during delivery has strong health implications for mothers and children. Trained personnel do not assist delivery outside health institutions in most cases. In the 2004 survey, the majority of children under five years of age (58%) had been born assisted by a traditional birth attendant (TBA). At country level; only 11% had been attended during delivery by either a delivery nurse; trained traditional birth attendant (TTBA) or other health personnel (7% in rural and 53% in urban). The proportion of children born attended by trained personnel is highest in Addis Ababa (76%); while in rural areas it ranges from 4% in Afar to 25% in Harari.

One-fourth of rural women and roughly 10 percent of urban women were found to have been self-assisted during delivery – meaning they had no one to assist them with delivery.

According to DHS 2005, an overwhelming majority of births (94 percent) were delivered at home, compared to 95% in the DHS 2000. Five percent of births were delivered in a public facility and less than one percent of births were delivered in a private facility. In rural areas 97 percent of deliveries are in the home, while in urban areas 57% of women gave birth at home.

The MoH estimates that only about 15.1% of deliveries are attended by a skilled provider. This means the majority of deliveries (85%) are not attended by skilled professionals, who can offer emergency obstetric care including newborn care. There is marked regional variation in the percentage of women receiving skilled attendance at birth.

The percentage of deliveries attended by skilled health professionals is taken as an indicator of MMR. DHS 2005 estimates that the maternal mortality ratio for Ethiopia for the period 1998-2004 is 673 deaths per 100,000 live births (or alternatively 7 deaths per 1000 live births). The true MMR for 2005 ranges from 548 to 799. Similarly collected data from the 2000 DHS show the MMR for the period 1994-2000 to be 871 deaths per 1,000 live births or 9 deaths per 1,000 live births. The true ratio of the 95 percent confidence intervals ranges between 703 and 1039. The DHS 2005 report notes that “although it appears that maternal mortality may be declining in Ethiopia, the rates are both subject to a high degree of sampling error. Because 95 percent confidence intervals around the two estimates overlap, it is not possible to conclude that there has been a decline”.

The five major direct causes of maternal deaths have been documented (FMoH) and these account for 85% of causes of maternal death with abortion ranking highest at 32%, obstructed labor at 22%, sepsis 12%, hemorrhage 10%, hypertension 9% and other causes 15%. Contributing factors to maternal deaths include adolescent pregnancy, HIV/AIDS, malaria, malnutrition and harmful traditional practices (e.g. female circumcision). Other potential factors contribute to child birth and pregnancy related risks. The first is the low percentage of pregnant women who receive antenatal care from trained professionals (50.4 percent nationwide). Secondly very few births are attended by skilled professionals (15.1%). Female genital mutilation is also widely practiced, which creates greater health risks for women.¹⁷

The high fertility profile of the Ethiopian woman and the prevailing high-risk fertility characteristics expose the woman to repeated risks of unnecessary death. These major direct and indirect causes of death compounded by poor utilization of maternal services and lack of appropriately skilled health personnel have resulted in the high maternal mortality ratio of 673/100,000 live births. The MMR MDG is to reduce MMR by three quarters between 1990 and 2015. This means a reduction of MMR from 673/100,000 live births to about 450/100,000 between 2005 and the year 2015, which will be a tremendous challenge for the country.

2.2.2 Actions Taken by the Government

Ethiopia is one of the ten countries globally (five in Africa) selected for WHO's assistance for the implementation of the 'Making Pregnancy Safer' (MPS) strategy aimed at strengthening the capacity of the health system to provide adequate care for an accelerated reduction of maternal and neonatal mortality.

Accordingly the government of Ethiopia endorsed the strategy which is aimed at strengthening the health system to provide quality care, particularly skilled attendance at birth and emergency obstetrics care through a functional referral system that includes zonal hospitals and the four HCs that refer to it as well as health posts and communities.

MPS has two components: facility based MPS where the referral linkage is between the health centers and hospitals, and community based MPS, where the referral linkage is between the community (TBAs) and health posts and health centers. In collaboration with its major partners in reproductive health (UNICEF, WHO and UNFPA), the FMoH launched MPS in four zones of the four big regions (Oromia, Amhara, SNNPR and Tigray) in June 2001. Since then, these four regions have begun implementation of MPS in selected health facilities.

As a signatory to the program of action of the 1994 international conference on population and development (ICPD), the government of Ethiopia has been committed to improving the reproductive health (RH) status of women, men and young people in the country. Towards this end, in March, 2006, the FMoH designed a "National Reproductive Health Strategy (2006-2015)" which builds on the existing health policy, HSDP, and the HEP, while at the same time seeking to enhance the effectiveness of the health system in meeting the targets of PASDEP and the MDGs. It is the outcome of a continuous consultative process involving relevant governmental agencies, NGOs, stakeholders at international, national, federal and regional level and community members across the country.

¹⁷ Ethiopia: Synthesis of Recent & Relevant Reviews and Studies Conducted in the Health Sector, June 2004

The RH strategy has identified targets to gauge the progress being made to reach the desirable goals by 2015. A RH task force has been set up; BEOC/CEOC training of General Practitioners and Health Officers has commenced and plans are being developed to equip health centers with CEOC capacity through provision of trained staff and equipment. The FMOH has prepared a national contraceptive forecast (2004/10) designed to ensure the availability of FP commodity all the time.

An Adolescent and Youth Health Unit has been established at the FMOH and this is a welcome development in a situation where there is limited awareness of the RH needs of young people in a high risk environment. Another positive development is the integration of youth health in the HSEP and HEWs package of work.

The Women's Affairs Department (FMOH) with the financial support of the WHO, had sponsored a study on the "impact of poverty on women's health in selected localities of Ethiopia", which was published in September 2003. This department and the WHO Regional Office for Africa have prepared Women's Health and Development Indicators for Ethiopia (2001). The WAD has prepared a "Gender Mainstreaming Guideline in the Health Sector (2002).

A National Youth Policy has been developed by the Ministry of Youth, Sports and Culture in 2003/04. This policy has sections that prescribe measures in relation to youth and health, youth and HIV/AIDS and youth and drugs and other harmful substances.

The FMOH recently developed a "National Adolescent and Youth Reproductive Health Strategy (2007-2015)" in 2007. The strategy outlines the major youth RH issues in Ethiopia and charts a way forward¹⁸. It builds on notable initiatives undertaken to serve the health needs of all young Ethiopians 10-24 years old. Among these are:

- The Youth Policy which calls for major interventions to enhance youth participation in the development of the country.
- The Policy on HIV/AIDS, launched in 1998, recognizes the increased vulnerability of young people.
- The Revised Family Laws, amended in 2000, protect young women's rights such as against forced marriages.
- The Revised Penal Code penalizes sexual violence and many of the harmful traditional practices.
- The Government's vision is to provide youth reproductive health services through the Health Extension Package at the community level and through the health interventions.

2.2.3 Challenges Ahead

As clearly stated in the Report of the Final Evaluation of HSDP II (2002/03 to 2004/05), the health service MMR factors are mainly related to inadequate skilled staff, equipment, supplies and inefficient health referral system compounded by poor access and utilization of maternity services. Even though more than 10 hospitals and over 40 health centers were equipped with basic essential equipment and supplies and the number of health posts increased substantially; there were major challenges *in the deployment and retention of all health professionals*. Peripheral and mid-level health facilities are still in critical shortage with regard to appropriately skilled health personnel for assisting deliveries.

¹⁸ FMOH- National Adolescent and Youth Reproductive Health Strategy, 2007-2015

Strengthening the weak integration of RH services that is one factor that undermines quality of care, and the ability of the service delivery system to meet current demands is still a challenge for the sector. Weak coordination of population-related activities of the NGO and public sectors is a constraint that limits increase in contraceptive coverage.

2.2.4 Key Areas for Future Action

A lot of activities have been undertaken by the FMoH aimed at reducing the unusually high MMR. However, areas for future action include:

- Development of a maternal and neonatal mortality and morbidity (MNMM) strategy at all
- Levels (community leaders, decision makers, health managers);
- Accelerated development of appropriate human capacity in BEOC and CEOC through the development of guidelines, manuals, norms, standards, flow charts and the provision of specific training to Health Officers and General Practitioners. Harmonization of protocols for PMTCT, ANC, PNC, STI, FP and ITN.
- Securing substantial funding to implement the MNMM action plans.
- Ensuring contraceptive availability through the FP logistics system.
- Implementing the National Adolescent and Youth RH strategy and establishing youth-centered services in the public sector.

2.3 Improve Maternal and Child Nutrition

2.3.1 Nutritional Status of Children and Women

Chronic malnutrition poses a serious obstacle to economic development in Ethiopia, and is one of the most common health problems affecting a large percentage of children and adults. In both normal and emergency periods the most common victims of malnutrition are infants, children less than five years old, and pregnant and lactating women. Children and women are in particular most vulnerable to malnutrition due to low dietary intakes, infectious diseases, and lack of appropriate care and inequitable distribution of food within the household. Children who suffer from malnutrition during pregnancy and the first two years of their life suffer from a wide range of long-term consequences. Malnutrition is the underlying cause in more than half of all child deaths. Changes in child survival are strongly associated with decreases in malnutrition in countries like Ethiopia that are characterized by high rates of general malnutrition.¹⁹

A. Nutritional Status of Children

Anthropometric measurements (weight and height) are used to assess the degree of malnutrition among population groups. Malnutrition among children in Ethiopia is among the highest in the world.

Stunting: Height-for-age, or stunting, is an indicator of chronic malnutrition. It indicates long-term or accumulated nutritional deficiency resulting from lack of adequate dietary intake over a long period of time, or recurrent illness. At country level, the share of children aged 3 to 59 months that suffer from chronic malnutrition declined from 57% in 1999 to 47% in 2004.

The prevalence is much higher among rural children (40%) than urban (30%). Distribution of stunted children by gender also suggests that at country level and in rural areas male children are slightly more

¹⁹ FMoH: Report of the Final Evaluation of HSDP II, May 2006

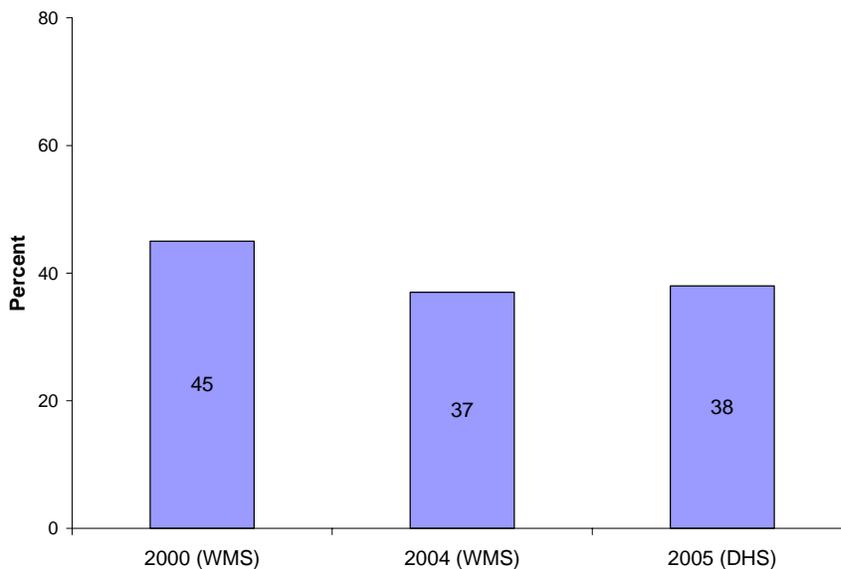
malnourished on average than female children. According to the DHS (2005), 47% percent of children under-five are stunted and 24 percent are severely stunted. As expected the status of rural children is much worse than urban children (for severe stunting 48% versus 30%) as do children of uneducated versus well educated mothers (49.1% versus 4.7%). Stunting (chronic malnutrition) increases with the age of the child; this is evidenced by the increase in stunting from 27% among children 6-8 months to 62% among children age 18-23 months.

Nutritional status also varies greatly by region with the highest rates of stunting found in Amhara (57%) and SNNPR (52%); and the lowest rates found in Addis Ababa (18.4%), Gambella (29%), and Dire Dawa (30.8%).

Wasting: Wasting, a condition of low weight-for-height is a reflection of recent malnutrition, and may be caused by acute food shortage or serious infections. According to the findings of the Welfare Monitoring Survey (2004), the prevalence of wasting at country level is about 8%. Wasting is higher among rural children (8%) than urban (7%), and the prevalence of wasting for boys is higher by about 1% than girls in both urban and rural areas. According to DHS, 2005, 11% percent of children under-five are wasted and 2 percent are severely wasted. Rural children are consistently more underweight (40% versus 23%) and wasted (11% versus 6%) than their urban counterparts. Wasting (acute malnutrition) is higher than the national average in Somali (24%), Benishangul-Gumuz (16%), Amhara (14%), Tigray (12%) and Dire Dawa (11%). The level of wasting decreases with increasing wealth.

Under Weight: Weight-for-age, based on the principle that a child has an expected weight for his/her age, measures the general nutritional status of children. According to the WMS, the prevalence of underweight children in the country was 37% in 2004. This considerable proportion of underweight children; which reflects both wasting and stunting, signals the extensive distribution of malnutrition among young children of the country.

**Figure 4: MDG 1 Nutrition
Trend in Under-five Underweight Prevalence**



Source: CSA (WMS, 2000 and 2004 & DHS 2005)

The prevalence of underweight children across regional states varies from as low as 13% in Addis Ababa to as high as 45% in Amhara region. On the other hand the DHS shows that 38% percent of children

under-five are underweight and 11% are severely under weight. The percentage of underweight children in Somali (51%), Amhara (49%) and Benishangul-Gumuz (45%) are above the national average.

A comparison of the data from the 2000 and 2005 DHS shows that there have been improvements in the nutritional status of children in the past five years. The percentage of stunted children fell by 10 percent, from 52% in 2000 to 47% in 2005. Similarly, the percentage of children underweight declined by 19% from 47% in 2000 to 38% in 2005. There was, however, no change over the five-year period in the percentage of children who are wasted.

Prevalence of Malnutrition over Time: The good news is that all four consecutive WMS surveys show a consistent decline in malnutrition over time; with a tremendous decrease in stunting in both urban and rural areas. The rate of stunting in urban areas fell from 58% in 1996 to 30% in 2004; and fell from 67% to 48% in rural areas.²⁰

B. Nutritional Status of Women

A woman's nutritional status is both an important indicator of a woman's overall health and a predictor of pregnancy outcome. According to DHS 2005, the mean height of Ethiopian women is 157 centimeters; which is above the critical height of 145 centimeters. Overall, 3 percent of women are shorter than 145 cm. There are very small differences in the mean height of women by background characteristics. Women in the Somali and Gambella regions, on the average are taller than women in the other regions. Women in Amhara have the shortest mean height, and along with Afar, the highest proportion below 145 cm. Women with at least some secondary education are at least 1cm taller than women who have not attended school.

DHS 2005 showed that there are large differentials across background characteristic in the percentage of women assessed as malnourished (body mass index – BMI less than 18.5) or “thin” and overweight (BMI 25 or higher). Twenty-seven percent of women were found to be chronically malnourished (BMI less than 18.5) indicating a relatively high level of chronic energy deficiency, while only 4 percent were overweight or obese. Three in ten women age 15-49 and women age 45-49 are thin or undernourished.

Variation between urban and rural women is marked. More women have a BMI less than 18.5 in rural areas (28%) than in urban areas (19%). However, the percentage of overweight or obese women is higher in urban areas (14%) than in rural areas (2%). Gambella (39%) and Tigray (38%) have the highest percentage of undernourished women, while Addis Ababa has the lowest (15 percent). The percentage of overweight or obese women increases with increasing educational level. It is also elevated for the highest wealth quintile.

2.3.2 Actions Taken by the Government and Partners

Nutrition has long been accepted as a fundamental human right, enshrined in key international conventions. The right to nutrition security is also upheld in the Constitution of Ethiopia, entrusting the government to take appropriate measures to ensure that these nutritional rights are adequately protected especially among the most vulnerable:- children, the elderly, and the infirm.

Even though the magnitude of malnutrition and its impact on health are substantial, no specific objectives were set for the nutrition component in HSDP II and III. However, there have been encouraging developments in the past five years such as the following:-

²⁰ CSA: Welfare Monitoring Survey, 2004

- A National Nutrition Strategy has been designed.
- A Nutrition Unit has been established within the Family Health Department of the MoH.
- The Infant and Young Child Feeding (IYCF) Strategy has been prepared. The strategy document highlights the situation of IYCF in Ethiopia, the technical guidance of IYCF, how to feed infants and children in emergency situations, different interventions to improve IYCF and roles and responsibilities of partners to improve IYCF practices.
- The Enhanced Outreach Strategy (EOS) has been implemented as a bridging strategy since 2004 in 325 drought prone woredas.

The Enhanced Outreach Strategy (EOS)²¹ of the Ministry of Health of the Government of Ethiopia is supported by UNICEF to provide a package of essential preventive health services every six months to children aged 6 – 59 months and to pregnant and lactating women. The current services for children are vitamin A, deworming and measles vaccination. Where malaria occurs, pregnant women and women with children less than 6 months old may also be given up to two mosquito nets. Health education is provided to parents on a wide variety of issues. These services are delivered at more than 20,000 village EOS centers in all woredas of Ethiopia, except in Addis Ababa.

At EOS centers in 325 woredas in which food insecurity has been identified by the Disaster Prevention and Preparedness Agency (DPPA), all children and pregnant or lactating women are also screened for acute malnutrition using measurements of mid upper arm circumference (MUAC). All acutely malnourished children (MUAC < 12 cm) and women (MUAC < 21 cm) are given a card that entitles them to collect two rations of food provided by the World Food Programme (WFP) through the DPPA. This Targeted Supplementary Food (TSF) programme provides to each beneficiary on two occasions three months apart a ration of 25 kg of flour and 3 liters of oil. Severely acutely malnourished children (MUAC < 11 cm) are referred for therapeutic feeding as well as being eligible for these rations.

This is the first national programme to link community-based preventive health services delivered in villages every six months with a ration of supplementary food for women and children who are identified as malnourished during screening. If it can be shown to be effective, then it could become a model for similar programmes in other countries. The objectives of the EOS are to reduce morbidity and mortality; the objectives of the TSF are to improve nutritional status or prevent moderately malnourished children from becoming severely malnourished. The EOS/TSF programme is maturing to become an important means of delivering essential health services to children and women in Ethiopia, and could provide a model for other countries.

The one feature that remains constant however is that, despite the commendable growth in number and scale of therapeutic care programmes in Ethiopia over the last 3 years, which represent a six-fold increase in capacity, the gap remains large between the numbers of children being identified and the capacity for treating them. In the EOS woredas there is currently capacity to treat 14,555 children at any one time.

UNICEF is supporting the EOS project. For example the first round in SNNPR was largely successful in reaching the target population and over a million children under 5 years of age received vitamin A supplementation. Over 135,000 children were immunized against measles and over 100,000 malnourished children, pregnant and lactating women received supplementary food. This activity is coordinated between the FMoH, the Regional Health Bureaus, the USAID micronutrient project, UNICEF and other key partners including WFP and DPPB.

²¹ UNICEF – Report on the Evaluation of The Enhanced Outreach Strategy of Targeted Interventions and the Targeted Supplementary Food Programme, Final Draft, 2007

The EOS is contributing to the broader Government Food Security Coalition initiative led by the Prime Minister's Office. This initiative is considered as an important initiative for child survival because health and nutrition interventions have been included in the food security objectives.

“Guidelines for the Management of Severe Acute Malnutrition” which was developed by MoH in collaboration with UNICEF, has been adopted in a national consensus meeting in June 2003. The document outlines the steps and procedures for treating a severely malnourished person in a Nutritional Rehabilitation Unit (NRU), hospital or other facilities. A detailed training module for Ethiopia on the management of severe acute malnutrition also complements the National guidelines. The Disaster Prevention and Preparedness Commission have developed new guidelines for emergency nutrition interventions in Ethiopia in 2003. Additionally, a National Guideline for control and prevention of micronutrient deficiency (June 2005) has been developed. After endorsing the Global Goal for the year 2000, the Ethiopian Government formulated its own action plan and a national program was launched towards the end of 1995. As part of the National Micronutrient Deficiency Disorders prevention and control program the Ministry of Health launched an iodine deficiency disorder prevention and control program in 1996. In order to use resources most effectively, it was decided to first intervene with regard to vitamin A and iodine deficiencies and later to include iron deficiency anemia (IDA) which requires multiple strategies and more resources. These activities are anchored within the health sector. As a continuation of this effort in 2003 vitamin A was distributed in all drought affected areas together with measles immunization for children from 6 months to 14 years of age in response to the emergency situation. Through this approach about 20 million children in drought affected areas aged 6 months to 14 years were provided with one dose of vitamin A. Currently routine vitamin A delivery with EPI plus and other avenues is being strengthened. The HSEP is believed to provide an excellent opportunity for creating community awareness on the importance of vitamin A and creating demand for services.

Several studies have been conducted as background documents for the child survival strategy and for the formulation of a National Nutrition Strategy e.g. assessments on the causes of malnutrition, the macro and crosscutting issues of malnutrition in Ethiopia, linkage between malnutrition and food security in Ethiopia etc. A Health and Nutrition Emergency Task Force has been established. This has facilitated better transparency and dialogue with partners.

2.3.3 Challenges

- Many efforts to improve nutrition involve coordination at the woreda and kebele level in order to communicate effectively with stakeholders and service providers. Harmonization of programs across ministries is a big challenge.
- Lack of trained staff in the area of nutrition is a major challenge hampering the implementation of any nutrition initiative.
- Nutrition is inadequately addressed in education and curricula of health professionals.
- Lack of adequate data for analysis of nutrition as a cross cutting issue is another problem.
- Promotion of the use of iodized salt has been extremely limited and/or almost absent in all regions indicating that this will remain a major public health issue. One constraint is the lack of clarity on the roles that the various levels of health structures must play in the promotion of iodized salt.

2.3.4 Key Areas for Future Action

The following are some of the key areas to be acted upon by the concerned bodies:

- Expanding the country's nutritional expertise through training programs for nutritionist, is necessary in order to support implementation of extension package and better coordinate policy and strategies that would tackle the multi-dimensionality of malnutrition.
- Improving the capacity of health workers in the management of severe acute malnutrition as well as their capacity to deal with overall nutrition problems,
- Expanding the Essential Nutrition Action
- Compilation of disaggregated data on gender and children's issues
- Designing an emergency preparedness and response strategy for the health sector
- Initiation of risk mapping and vulnerability assessment
- Extending micronutrient deficiency control activities into sectors that are important for nutrition such as agriculture, food security, education and micro-enterprise
- Design an institutional framework for mainstreaming care from the household to the national level by all sectors of development.

2.4 Improve Access to Clean Water and Sanitation

2.4.1 Status of Water Supply

The provision of safe and adequate water supply for the population has far reaching effects on health, productivity and quality of life, as well as on the socio-economic development of the nation. Lack of clean/potable water supply and sanitation services in the country has been a serious problem and statistics show that more than 60% of health related deaths are caused by water borne diseases. Rural people especially women and children spend considerable time every day in fetching water. This is further complicated during periods of drought when communities are forced to cover long distances for getting water for themselves and their livestock.

At the beginning of 2005, out of the country's 73.04 million people, 11.56 million or 15.8% was estimated to live in towns. Out of this, close to 9.26 million or 80% had access to water supply. In general due to various problems water schemes in urban areas are not providing the designed services. For example, in urban areas the majority of the existing urban water supply systems are grossly outdated for the rapid urbanization. Hence, the current supply is much less than the demand. Besides low production levels, inadequate distribution systems and pipeline leakages as well as low investment and poor institutional arrangements have been the major causes of implementation capacity for low water supply coverage in towns.

The Ethiopian Water Resources Management policy advocates full cost recovery for urban water supply systems (UWSSs). The financial management of UWS projects is facilitated by the newly established institution i.e. Water Fund. More recently, funds have been made available from the World Bank, AFDB, the Arab Bank and government budget to improve the urban water supply system in the country. To alleviate the situation, considerable efforts have been made by governmental and non-governmental organizations to implement rural water supply program in the first phase of SDPRP period. Similarly various efforts have been made to rehabilitate, and expand the existing systems, as well as construct new ones to improve the water supply situation in urban areas. Moreover, a new approach in the form of Woreda Water Desk, Town Water Boards, local consulting groups and contractors has been designed and adopted to develop the capacity of the beneficiaries to enable them carryout the water supply programs and development activities at their locality. Different manuals, which include operation and maintenance, community management, woreda-training manuals, procurement guideline, were completed while some others are under preparation. These initiatives would contribute a lot towards bringing efficient water services to the people in need of such services.

The proportion of the population that that benefits from clean water has not increased beyond 35 percent.

Several factors are mentioned as causes for low coverage. These include:

- Lack of due attention to appropriate technologies that can be built with community labor and participation
- Expense of drilling and water supply construction works and lack of capacity of private and governmental organizations (water works enterprises),
- Scattered settlement of population and geological complexity
- Expense of development cost and financial constraints
- Lack of adequate trained personnel at different levels etc.

2.4.2 Status of Sanitation

Improved hygiene and sanitation is one of the sub-sectors accorded high priority in the current PASDEP, which will contribute to poverty eradication over the coming years. Despite the reform measures taken in the sector, the level of sanitation coverage in the country is still low except in Southern region where latrine coverage has increased from 14% to >90% in 4 years (2003-2006) through a mix of inspired leadership, political commitment and dedicated field work.²² As given in the Welfare Monitoring Survey (CSA, 2004), the national sanitation coverage is 30.63%. Achieving universal coverage represents a serious challenge.

There is shortage of reliable and up to date data, but according to the Universal Access Programme assessment, rural household latrine access stands at >17.5% and urban at >57%. There is significant regional and even inter-woreda variation and no data on hygienic use. The sanitation coverage given by the CSA for 2004 shows that 69.37% of households in the country do not have toilet facilities (78.66% rural and 19.82% urban).²³ The Improved Hygiene and Sanitation Programme aims to raise rural and urban sanitation from 17.45% and 57% to 100% coverage respectively by the year 2012.

According to the National Sanitation Strategy for Ethiopia (2005) and the Health and Health Related Indicators (2003/04), more than 250,000 children die every year from sanitation and hygiene related diseases. 60% of the overall disease burden is related to poor sanitation and hygiene. The number of households that have access to improved sanitation is very low. Less than 1% of the health budget is dedicated to improvements in sanitation and hygiene. Reports show that the sanitation service in the country is very poor. Access to latrines is very low in the country. The main reasons for low access to sanitation service are low implementation rate and lack of awareness of the people to sanitation services. Much attention has not been given to sanitation programs in the past years. Not more than 30-40 towns carry out waste disposal services, while others have no system of waste disposal of any type. Sewerage has been introduced only in some parts of Addis Ababa. Some of the reasons for this low level of sanitation include: lack of awareness of communities on sanitation service, lack of linkage between water and sanitation, and limited resource allocated for development etc.

2.4.3 Actions Taken by the Government, Civil Society and Partners

The Water Resources Management Policy has been formulated in 2006/07 to guide the development of the sector. The National Water Sector Strategy has been prepared and implemented by the government. This strategy provides a road map to translate the policy into action. To achieve the water policy objectives, the Water Sector Development Program has been prepared using the guidelines set under the national sector strategy. The planning horizon of the program is 15 years (2002-2016).

²² FDRE Ministries of Health, Water Resources, Education & Urban Development & EUWI- Needs Assessment to Achieve Universal Access to Improved Hygiene and Sanitation by 2012, Final Draft, May, 2007.

²³ There is discrepancy in coverage figures between the CSA and MoWR. For the sake of consistency the coverage figures used by MoWR for the UAP assessment have been used.

The implementation of the Water Sector Development Program for the period 2002/03 to 2005/06 covers the overall efforts and achievements undertaken by the Ministry of Water Resources and Regional Water Bureaus. The regional achievements also include activities carried out by NGOs. Other programs which are based on the policy include: the National Water Supply and Sanitation Master Plan, the MDGs Needs Assessment, establishment of the Water Resources Development Fund, preparation of manuals, guidelines, and training materials that assist the work of executive board members, water utilities and regional water bureau heads and recently the Universal Access Program (UAP).

One of the key programmes included in the PASDEP is on water supply and sanitation services. The Millennium Development Goals for water supply and sanitation aim to reduce the existing proportions of unserved people by half from the end of the century. This not enough and it has been found important to design and implement a programme that enables rapid expansion of services to all members of the community. This program is thus called the “Universal Access Program” (UAP). The UAP for rural and urban water supply and sanitation covers the period 2006 to 2012. The goal of the program is to raise the water coverage of towns that stands at 80.6% at the beginning of the plan period in 2005 to 100% at the end of the plan period in 2012. A goal is also set to raise the sanitation service coverage from 57% in 2005 to 100% in 2011. Achieving these plan targets requires better and wider preparation, capacity and finance. The main objective of the UAP is to enable residents of towns to reliably get access to 20 liters of water per day within half a kilometer distance from their residences and to avail toilet services to all residents of towns and enable some to benefit from sewerage systems. Within the seven year period close to 50.9 million people who until now have had no access to water supply and 66.9 million who up to now have had no access to adequate sanitation facilities will be fully served.

All the stakeholders including the government have exerted maximum efforts to improve access to safe water and sanitation so as to increase the number of healthy and productive citizens. To reduce poverty and to ensure sustainable socio-economic development; the government of Ethiopia, NGOs, the public, and the private sector have been and are still engaged in water supply and sanitation projects i.e. study and design, construction, rehabilitation and maintenance, as well as capacity building activities at various levels.

In order to make a good use of water resources in the country, the Government has launched a long-term plan focused on provision of clean water supply, development of irrigation systems and electric power generation. Notable results include:

- Provision of access to clean water supply has increased from 23% to 35% in rural areas and from 74% to 80% in urban areas during the period 2001/02 to 2004/05;
- With regard to expansion of rural drinking water supply schemes, construction of 553 deep wells, 1,581 shallow wells, and 150,904 hand-dug wells, 3,977 spring development activities were undertaken;
- In respect to urban drinking water supply, pre-design studies for 266 projects, construction of 44 projects and rehabilitation of 46 projects have been undertaken; and
- Water supply systems were built or rehabilitated in 83 towns, benefiting some estimated 1.6 million people, studies or design work are underway for another 47 towns.

In a bid to realize plans at the lowest administrative unit, Woreda Water Desks and Woreda Health Offices are established. To meet the sector’s demand for intermediate level human resources, eight Technical and Vocational Training Centers have been established already in Afar, Somali, Oromia, Amhara, SNNPR and Tigray states. Preparations are being made to open similar training centers in Benishangul Gumuz State. In order to carry out community level minor construction and maintenance services on a broad front, training of artisans who could enter into work after short term training will be

carried out extensively. A multi-stakeholder forum has been established and a mid-term review has been conducted. During the period 2002/03 to 2005/06 the following water supply and sanitation activities have been carried out in different rural and urban areas and in different regions throughout the country:-
A. Water²⁴

Rural Water Supply

758 deep wells, 2205 medium and shallow wells, 151,267 hand-dug wells, 10 soil dams, 4424 springs and 3 multi-village water utilities have been constructed. In addition, 9615 existing non-functional or semi-functional water utilities have been maintained and rehabilitated during this period. This has significantly reduced the percentage of non-functional water utilities by 5% from 30% in 2004/05 to 25% in 2005/06. Thus out of the rural population, 41.2 percent accessed safe drinking water at the end of June 2005.

Urban Water Supply²⁵

During the plan period, the Ministry of Water Resources and Regional Water Bureaus have coordinated and implemented the study, design, rehabilitation and construction of urban water supply projects. In 2002/03 to 2004/05 period, the study and design of 266 UWSS projects (planned 102), rehabilitation of 46 UWSS projects (planned 36) and construction of 44 UWSS projects (planned 63) have been carried out. Thus there has been satisfactory achievement of planned activities.

9.57 million People are estimated to have benefited from the improvement of the urban water supply system. In 2005/06, rehabilitation of water supply facilities of 50 small towns has been carried out. In 2005/06 the number of people in urban areas who got access to safe drinking water was 78.8%. The overall 2005/06 water supply and sanitation services performance shows that the national access to safe drinking water (i.e. both Urban and Rural) has increased from the previous year's 42% to 47.3%.. The following table shows those achievements by region.

Table 3. Access to Water Supply by Region, 2005/06 (Percent)

<i>No.</i>	<i>Regions</i>	<i>Rural</i>	<i>Urban</i>	<i>Total</i>
1.	Amhara	36.6	80*	41.5
2.	Oromia	40.2	87.6	46.5
3.	SNNPR	53.0	64.5	54.0
4.	Tigray	42.8	50.9	44.3
5.	Afar	41.1	73.0	44.0
6.	Somali	21.5	60.0	28.0
7.	Benishangul-Gumuz	46.0	66.2	48.0
8.	Gambella	41.4	37.0	40.6
9.	Harari	29.0	21.0*	24.0
10.	Dire Dawa	57.0	72.0	68.2
11.	A.Ababa	-	90.1*	90.1
National Average		41.2	78.8	47.3

²⁴ MoWR – Water Sector Development SDPRP Report (2002/03-2004/05), June 2005.

²⁵ MoWR – Water Sector 1998 E.C PASDEP Implementation Report (2005/2006) September 1998 E.C

Note * Due to the low level of investments in urban Water Supply System, the corresponding access figures for Amhara, Harari and Addis Ababa towns show lower values compared to the previous year.

The national target access figure for the year 2005/06 was 49.86% (44% rural, 80.65% urban). As shown in the table, the achievement as of September 2006 is 47.3% (41.2% rural, 78.8% urban) which is lower than the target by only 3%. This is an encouraging development especially in view of the commitment of the government to meet PASDEP and MDGs goals and targets. However, to raise the rural water supply coverage to 98%, there is a need to build 21,289 new water schemes with an outlay of Birr 1,099,183,967 capital in each of the coming 7 years.

B. Sanitation

The Government of Ethiopia has created an enabling platform through the Health Policy, the Public Health Proclamation and the Health Extension Programme. This platform has been further strengthened by the National Improved Hygiene and Sanitation Strategy and Protocol and more recently, the Memorandum of Understanding signed between the three Ministries of Health, Water Resources and Education. While the National HIS strategy clearly establishes key principles and step by step guidelines, the focus has been primarily on rural hygiene and 'on-site' sanitation. With this in view, the Ministry of Health has developed an urban health extension programme and is about to initiate work on the development of a comprehensive urban strategy for improved hygiene and sanitation. It has to be noted that government cannot afford to subsidize individual household latrines. Government will facilitate coordinate and regulate with financial support from donors, NGOs and the Private sector but the onus is on the household to develop and preserve a safe minimum standard of improved hygiene and sanitation.

The Hygiene and Environmental Health Department has been progressing well with the preparation of a policy framework during HSDP II and has clearly tuned its focus to the development of innovative and effective strategies. The formulation of the National Hygiene and Sanitation Strategy, the Public Health Proclamation, the Public Health Regulation, the draft Environmental Health Policy and the formulation of National Hygiene and Sanitation Protocols indicate the progress made by the Hygiene and Environmental Health department. According to the report of the Final Evaluation of HSDP II, the HSDP II targets for access to safe water and improved sanitation have been achieved to a large extent (although they remained below the national target).

The Hygiene and Sanitation Strategy is implemented through several major programs such as: i) the HSEP. This new program is perceived to be the primary vehicle for driving sanitation improvements at the kebele level; ii) the FMOH/RHB/UNICEF supported water and sanitation community based program (disease prevention for women and children); and iii) the World Bank supported Rural Water Supply and Environment Program (RWSEP) and the Water Sanitation and Hygiene Initiative (WASH). The Hygiene and Sanitation Program gets financial support in the short-term (2005/06-2007/08) from the World Bank, NGOs/Civil Society, WHO and other donors.

In the UAP with regard to sanitation, focus will be made on building sewerage system (where they are affordable) and disposal of waste from common and private toilets as well as septic tanks without polluting the environment. The UAP is not an independent program; rather it is a package that includes water and sanitation programs already started, and those that will be started by relevant stakeholders. Birr 1,835,587,695 is required for the construction of toilets and for hygiene education in the coming 7 years.

2.4.4 Challenges

The challenges in the water sector include:

- Keeping rural systems operational and maintained,
- Financing the large up-front investment costs of city and town schemes. To address this, the Government is moving towards a system of organizing communities to take responsibility for

- village water supplies, and for commercialization of urban water supply systems.
- To improve inter-sectoral collaboration and coordination;
- Capacity building with specific emphasis on human resource development.

2.4.5 Key Areas for Future Action

These include the following:-

- Advocacy for continued support to hygiene and environmental health programs at all levels.
- Addressing core problems such as inadequate budget allocations, limited human resources, and insufficient transport and supplies;
- Clarifying roles of RHBs, WoHOs and the municipalities on the management of environmental hygiene;
- Staff recruitment and retention strategies;
- Establishing a ‘maintenance’ culture in the sector.

3. PROVIDING QUALITY EDUCATION

WFFC has six major goals that aim to provide access to quality education. These goals are directly related with the Dakar Declaration on education, and directly linked to MDG 2 (Universal Primary Education) and MDG 3 (promoting gender equity and empowering women).

Progress in meeting these goals is measured by the relevant educational indicators which play an important role in providing a clear picture about the performance of the education system. The main source of data for these indicators is the Education Statistics Annual Abstract for 2005-06 published by the Ministry of Education in February 2007.

Children's right to education is a central concern of the MDGs as well as the CRC. It focuses specially on two dimensions of the rights to education: - 1) that education is available to all (art. 28) as reflected by enrolment rates, retention rates and non-formal education opportunities; and 2) that education is of sufficient quality to promote "the development of the child's personality, talents and mental and physical abilities to their fullest potential" (art. 29). Progress made in this respect is discussed in the following section.

3.1 Early Childhood Care and Education

As described in ESDP III, pre-primary education introduces children to basic learning skills that are needed in primary schools and enhances their chances of success in the education system. Expanding access to pre-school program will serve two purposes i.e. enhancing the quality of education and improving the internal efficiency of primary schools.

This level normally includes children of ages 4-6 enrolled in the pre-primary education. Government is not involved in the construction and operation of such schools but it has a critical role in policy development, curriculum design, standard setting, supervision etc. These institutions are, therefore, run by NGOs, communities, private enterprises, faith-based organizations etc. Although the number of pre-primary schools is increasing every year; their distribution is limited to the major urban centers.

In 2005/06 out of the estimated 6,959,935 children of the appropriate age group (4-6) only about 186,728 children have been reported to have access to pre-primary education in 1,794 kindergartens all over the country. The level of enrollment is therefore, negligible when compared to the appropriate age group. Since these data do not cover all schools (data from some NGO schools are not captured) total enrolment could be a little higher than the above figure. The Gross Enrollment Rate (GER) for kindergarten level is 2.7% in 2005/06 which is a little higher than the previous year's 2.3%. This means, 97.3 % of the eligible children at these level do not have access to pre-primary education.

The highest and the lowest GER for this level are shared by Addis Ababa (40.3%) and Afar (0.5%) respectively. With the exception of Harari, Dire Dawa, Benishangul-Gumuz and SNNPR, all other regions have GER less than the National average (2.7%). This clearly shows not only the regional disparity in access to this level of education, but also that a lot remains to be done in this area in the future.

Taking teacher qualification as one of the quality indicators, the 2004/05 data shows that 21.2% of teachers are not trained to teach at this level. The share of untrained teachers was 26% in 2003/04, which shows an increase of 4.8 percentage points in the share of trained teachers in one year. As the role of the

government at this level is to set standards and maintain quality, the Regional Education Bureaus have provided supervision services to kindergartens, and created a supportive environment for the private sector and the community to enhance the delivery of pre-primary education.

With respect to the expansion of pre-primary education the target is to double the current participation rate of 2.1% by the end of the plan period (2010). If current growth rates in GER (from 2.1% in 2001 to 2.7% in 2005) continue unchanged, the target for 2010 could be within reach. This, however, does not guarantee the fulfillment of the MDGs, the CRC or the African Charter on the Rights and Welfare of the Child (1990).

3.2 Universal Primary Education

Universal access to primary education is of fundamental importance for achieving the Government's strategic objective as education is a powerful instrument for reducing poverty and inequality, improving health and social well-being and laying the basis for sustained economic growth. Ensuring that all children are able to enroll in schools opens up new opportunities for disadvantaged children including girls, children with special needs, and children from pastoralist, semi-agriculturalist and hard-to-reach rural areas where access has been limited.

During ESDP I and II there has been a substantial expansion at the primary level and as a result enrollment in primary schools (grades 1-8) has shown significant increase. During ESDP I the target was to increase primary enrollment to 7 million from 3.7 million in 1995/96. However, the achievement was 8.1 million, which implies an average growth rate of 12.8% in enrollment. This trend has also continued in ESDP II with the annual average growth rate of 11.7%.

Accordingly, the primary school enrollment in 2004/05 has reached to 11.4 million. With regard to the number of primary schools, there were 10,394 primary schools in 1996/97 and this number has reached 16,078 in 2004/05, which is an increase of 54.7%. Out of new primary schools more than 85% were constructed in the rural areas. In 2005/06 the number of primary schools has reached 19,412 and the average annual growth rate is 12.6%. The number of senior secondary schools has grown from 455 in 2001/02 to 835 in 2005/06 with an annual growth rate of 16.4%.

Gross Enrollment Rate at primary (1-8) level: GER is a crude measure of coverage. In 2005/06, although the primary school age population (grades 1-8) was estimated at 14,753,159 the total enrollment both in the regular and evening programs was 12,657,342 excluding the Alternative Basic Education (ABE) enrollment.

Hence, the primary GER at national level has become 85.8%, when disaggregated by gender; it is 78.5% for girls and 92.9% for boys. The 2005/06 figures show an increase of 6.0 percentage points for both sexes, and 7.0 and 4.9 percentage points for girls and boys respectively compared to that of the 2004/05²⁶. The enrollment for ABE was 817,332 for both sexes and 426,036 and 391,296 for boys and girls respectively. If we include ABE to 2005/06 figures the GER for primary increases to 91.3% (98.6% for boys and 83.9% for girls).

Net Enrollment Rate at Primary Level: NER is the best way of measuring participation and is a more refined indicator of coverage in terms of explaining the proportion of pupils enrolled from a specific age

²⁶ MoE- Education Statistics Annual Abstract, 1998 E.C (2005/06), Addis Ababa, February 2007, p.3

group. The NER for the year 2005-06 is 81.7% for boys, 73.2% for girls and 73.9% for both. The five years data on primary net enrollment rate shows an increasing trend for both boys and girls.

Table 4: 2005/2006 Net Enrollment Ratio at Primary (1-8) Level by Region

Region	Male	Female	Total
Tigray	85.0	88.8	86.8
Afar	16.6	14.5	15.6
Amhara	77.2	76.4	76.8
Oromia	83.7	70.5	77.2
Somali	31.3	22.5	27.2
Benishangul-Gumuz	91.7	77.3	84.7
SNNP	83.5	66.9	75.2
Gambella	110.0*	77.9	94.5
Harari	92.1	77.1	84.8
Addis Ababa	94.7	107.7*	101.2*
Dire Dawa	64.7	55.6	60.3
Total	81.7	73.2	73.9

* The net enrollment for Addis Ababa and Gambella is more than hundred due to the time difference between the census and the data collection.

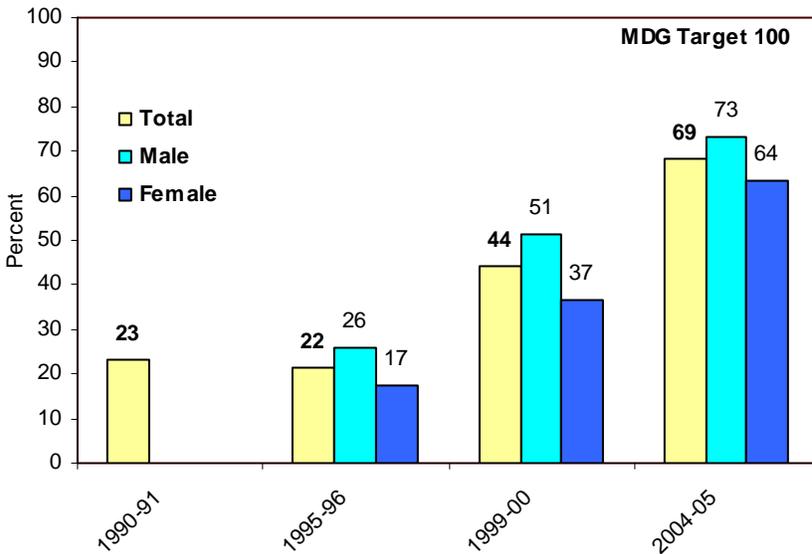
The table shows that Addis Ababa has the highest NER (101.2%) while Afar (15.6%) and Somali (27.2%) have the lowest NER respectively. The NER for Afar, Somali and Dire Dawa (60.3%) were below the national average (73.9%). The 9.6 percentage points in gender disparity of NER in 2004/05 at national level was lowered to 8.2 percentage points in favor of boys in 2005/06. The gender gap was in favor of girls only in two regions, Addis Ababa and Tigray.

For secondary level (9-10) the NER in 2005/06 was 15.5% for boys, 10.7% for girls and 13.2% for both sexes, while for preparatory (11-12) the corresponding rates were 3.3% for boys, 1.3% for girls and 2.3% for both sexes.

The GER and NER have both increased during the past five years. With respect to the NER, the rate of increase for a four year period is shown in Figure 5. Both programs (ESDP I and II) were aimed at increasing access to meet the target set for UPE by the year 2015. As described in section 3.6, this is a reflection of the Government's commitment to meet EFA and the MDGs.

However, looking into the regional perspective, the gap in the GER at primary level is still very wide. For instance in 2005/06, regional comparison shows that Addis Ababa (148.5%) has the highest participation rate while Afar and Somali Regions have the lowest 21.5% and 30.3% respectively. In terms of girls' participation (GER), Addis Ababa achieved the highest (161.3%); Somali (24.4%) and Afar (19.1%) have the lowest. Although there is an encouraging progress in enrollment, the variations between regions and gender inequality evidently demonstrate that there is still a lot to do to achieve UPE and maintain equity among regions.

Figure 5.
MDG 2 EDUCATION
Net Enrolment ratio in Primary Education



Source: MoE(EMIS) and MoFED

Apparent Intake Rate (AIR): It is the percentage of new entrants (irrespective of age) in Grade 1 out of the total number of children at an official admission age (7 in the Ethiopian case) in a given year. The total apparent intake rate for the year 2005/06 is 125.9% which is 132.5% for male and 119.2% for females. The AIR for the last five years has increased by a total of 28.5 percentage points for boys and by 35.6 percentage points for girls. Overall it has increased by 31.9 percentage points in the period under consideration. The gender gap has narrowed in favor of girls from 20.4 percentage points in 2001/02 to 13.3 in 2005/06.

Net Intake Rate (NIR): NIR is the percentage of new entrants in Grade 1 who are 7 years old, out of the total number of children at an official admission age (age 7 in Ethiopian case) in a given year. The total net intake rate for the year 2005/06 was 54.9% which was 56.6% for males and 53.3% for females respectively.

The trend of NIR shows an increase of 23.2 percentage points for the past five years although; it showed a decrease in the years 2002/03 (from 31.7% to 29.9%) and 2005/06 (from 60.9% in 2004/05 to 54.9% in 2005/06). It shows an increase of 23.3 percentage points for boys and 23.2 percentage points for girls in the five years under consideration (2001/02 – 2005/06).

Survival Rate to Grade 5: Survival rate at this grade is used to estimate the percentage of students who will complete the first cycle of primary education, since the completion of at least 4 years of schooling in Ethiopia is commonly considered as a pre-requisite for a sustainable level of literacy. Survival rate approaching 100% indicates a high level of retention and low incidence of drop out. Synthetic cohort method is applied to calculate this rate.

The cohort flow model constructed for the last five years, shows that survival rate to Grade 5 did not have a definite trend. It was at its highest in 2000/01 but decreased in 2001/02 and 2002/03 and showed increment in 2003/04 and followed the same suit in 2004/05. The survival rate to Grade 5 for the year 2004/05 was 57.2% for male, 61.9% for female and 59.3% for both sexes. These figures show that

more than 40% of the pupils did not continue in the second cycle of primary in the last five years under consideration.

Enrollment in Secondary Schools

In 2005/06, 1,066,423 students were enrolled in secondary 1st cycle (grades 9-10). Compared to the previous year's figure (860,734), it increased by 23.9%. Out of the total enrollment, 387,707 (36.4%) were girls. In 2005/06 the GER for girls and boys were 24.5% and 41.6% respectively. In the past five years, the GER at the first cycle of secondary (9-10) showed an increase of 16.1 percentage points (21.2 and 10.8 percentage points for boys and girls respectively). However, the gender gap increased from 14.8 percentage points in 2004/05 to 17.1 percentage points in 2005/06 in favor of boys. The NER of the first cycle of secondary (9-10) increased from 11.8% in 2004/05 to 13.2% in 2005/06. Thus, there has been a 5.8 percentage points increase in NER in the last five years (2001/02 – 2005/06). Despite this improvement in NER, the gender gap has shown a continuous increase (2.4 percentage points in 2001/02 to 4.9 in 2004/05) except for 2005/06 which is 4.8 percentage points.

3.3 Education Participation and Gender

The policies of the GoE on education favour equal opportunities for men and women, girls and boys. CEDAW and the Beijing Platform for action recommend equal distribution of resources and benefits like educational facilities and employment opportunities for both females and males in the population. One of the major targets of MDGs is to eliminate gender disparity in primary and secondary education by 2005 and to all levels of education not later than 2015. During the period 2002/03 to 2005/06, the average annual growth rate of enrollment at national level was 11.7%.

The direction of gender disparity can be indicated using the Gender Parity Index (GPI) which is the ratio of female to male enrolment rates. In a situation of perfect equality between boys and girls enrollment rates, GPI is 1 while 0 indicates the highest disparity. The gender disparity is at its lowest in Addis Ababa (1.19) and Tigray (1.00), the highest in Gambella (0.62) and Somali (0.69) respectively, and higher than the national average (0.84) in all other regions/City Administration. A comparison of rural and urban enrollment indicates that 75.7% of primary enrollment (regular and evening) was accounted for by rural areas and 24.3% by urban; whereas, for secondary (9-10) the proportion is 90.9% and 9.1% for urban and rural respectively. The proportion of girls is lower than that of boys both in urban and rural areas. However, it is much lower in rural than in urban areas.

Improving educational access to girls, retaining them in school, reducing dropout and repetition rates and thereby closing the gender gap was a major concern during the implementation of ESDP I and II. In connection with this, the MoE has undertaken a number of measures which contributed to a significant increase in girls' enrollment. The percentage of female students grew from 40.9 in 2001/02 to 45.3 in 2005/06 for primary education (1-8) and declined from 39.3 to 36.4 for secondary education (9-10). For technical and vocational education and training (TVET) the percentage of female students was 47.0% in 2001/02 and 50.3% in 2005/06. For higher education (undergraduate level) it increased from 15.9% in 2001/02 to 24.8% in 2005/06.

Repetition and dropout rates are commonly used to measure the efficiency of the education system in producing graduates of a particular education cycle or level. The repetition rate of 6.7% in 2002/03 was reduced to 3.8% in 2004/05. The lowest repetition rate was at grade 3 and the highest in grade 8. In grade 8, girls' repetition rate was higher than those of boys. The repetition rates for primary in each region during the 2003/04 academic year showed that Tigray, Amhara, Somali and Dire Dawa had rates

below the national average (3.8). Gambella had the highest repetition rate (7.5) and Somali had the lowest (1.6). Females' repetition rate is high in Gambella (9.2) and low in Somali (1.2).

The drop out rate at primary level was reduced from 14.4% in 2003/04 to 11.8% in 2004/05. In terms of grade, the proportion of pupils who leave school is in most cases higher for grade one. At national level, 20.6% of pupils enrolled in grade one in 2003/04 have left school before reaching grade two in 2005/06. Drop out rate is highest at grade one and lowest at grade 6. The average duration of study for dropouts is 3.1 years for boys and 3.0 for girls. In all grades except grade 8 the rate of dropout is high for boys than for girls. The target was to reduce educational wastage particularly drop out rate to 8% and repetition rate to 5%. The target for drop out rate has not been met.

The gender gap at primary level (1-8) that was around 20.5 percentage points during 2001/02 has started to decline since 2003/04 and has reached 14.7 percentage points in 2005/06. Although these are good signs of improvement in gender equity, it has not yet reached the desired level. The target was to eliminate gender disparities in GER of primary education and reduce regional disparities in GER of primary education. However this target has not been met in 2005.

Quality

Quality of education depends on several factors such as mode of delivery commitment and qualification of teachers, the supply of educational materials, pupil-teacher ratio, pupil teacher ratio etc. According to the national standards, the first cycle (1-4) primary education requires teachers with minimum qualification of a Teacher Training Institute certificate. Similarly a Teacher Training College diploma is required for the second cycle primary (5-8). At national level the target set for 2005/06 was 98.3% for the first cycle and 63% for the second cycle. However, the percentage of qualified teachers was 97.6 for the first cycle primary and 59.4 for the 2nd cycle. This shows that much effort must be made in order to attain the target set for second cycle primary.

The minimum standard for secondary school teachers is a first degree in a major subject. The proportion of qualified secondary school teachers in 2005/06 varies from region to region. It ranges from 85.1% in Dire Dawa (the highest) to 32.3% in Somali (the lowest). At national level only 49.6% of the teachers who have been serving in secondary schools in 2005/06 were qualified for the level: while the target set to be met in 2005/06 was 51%. This shows an increase of 9.0 percentage points compared to 2004/05. School facilities have impact on access, quality, efficiency and equity. In this respect 40.8% of primary and 76.1% of secondary schools have water facilities. Around 71.7% of all schools reported that they have latrines. Of all schools with grades 9 and above 85.4% have library facilities. Out of 574 secondary schools, 89 have reported that they do not have laboratories. In 2004/05 36.7% of primary and 56.9% of secondary schools have reported that they use shift system in their regular program. These data show that there is still much to be done to improve the availability of qualified teachers and school facilities that have an impact on quality of education at the different levels. The quality-related challenges facing the education system are manifested in unsatisfactory levels of learning achievement of a significant proportion of pupils in primary schools and the high repetition rates and relatively lower promotion rates in all grades.²⁷

²⁷ GOE/UNICEF – The Situation of Ethiopian Children and Women: A Right-Based Analysis, Addis Ababa, January 2002, p.71

3.4 Learning Achievement

National Learning Assessment (NLA) measures the quality of education and identifies factors that contribute to the outcome. The First NLA was carried out in 1999/2000 on grade 4 and 8 achievements and the second NLA was conducted in 2003/04 on the same grades.²⁸

The second NLA indicated that the development of students' attitude towards education, environmental protection, health care, civics and ethics is moving in the desired direction. However, significant changes were not observed in the other aspect as the students' achievement in both grades stand at 39.7 and 48.5 for grades eight and four respectively. The achievements for grade eight and four in the First NLA were 41.1 and 47.9 respectively, which shows a slight decline in grade eight achievement and very little upward move in grade 4 achievement.

The major reasons cited for the low achievement of pupils in the national assessment for the two grades included low teachers' perception of students learning and instructional quality, inappropriate use of instructional materials by teachers, students' background and shortage of teacher's guides and syllabus.

Adult and Non-Formal Education

The adult and non-formal education program includes a range of basic education and training components for out-of-school children and adults. The program is basically focused on literacy, numeracy and other relevant skills to enable learners to develop problem-solving abilities and change their lives.

The program has three sub-components: a program for out-of-school children with 7-14 years of age, literacy program for those youth and adults whose ages are above 15, and offering basic skill training to youth and adults in the community skill training centers.

The Community Skill Training Centers (CSTCs) offer specific learning skills related to the specific needs of the rural community. To this end, the centers prepare the community to participate efficiently in the development activities and to up-grade and improve the traditional rural skills. In addition, the CSTCs are making efforts to introduce and expand appropriate technology. Accordingly, over 58,614 adults were trained in 287 Community Skill Training Centers found in eight regions, (with exception of Dire Dawa, Afar and Somali). Problems encountered in relation to CSTCs are lack of budget, poor organization of the program, trained manpower and equipment.

3.5 Literacy

Ethiopia has a high level of adult illiteracy: the adult literacy rate is 33% for men and only 11% for women.²⁹ There is also a significant gender gap in the rural-urban literacy rate. The female literacy rate in the rural areas in 2000 is 11% compared to 32.8% for males. In the same year, the literacy rate for females in the urban areas is 60.6% while the male literacy rate is 81.8%. The gap is much less than the rural literacy rate. In the country as a whole, literacy rate for females is 19.4% compared to 39.7% for males.

The reasons for low female participation in the literacy program are due to heavy and tedious workload at home and outside home, working on an average 15 hours a day.³⁰ In order to achieve the MDGs, Ethiopia has to raise the level of literacy of the population as a whole. The expansion of the primary education system may be able to address this issue as all primary age children will be able to access schooling in the

²⁸ MoE-ESDP III (2005/2006-2010/2011), Program Action Plan, Final Draft, Addis Ababa, August 2005.

²⁹ UNDP-Development Partnership in Ethiopia, Addis Ababa, 2002

³⁰ WAO/UNFP Working Group on Gender-Gender Issues in MDGs, Needs Assessment for Ethiopia, Addis Ababa, December 31, 2004

near future. Each region can utilize its literacy campaign to strengthen aspects of its overall goals, policies and strategies. This would involve developing materials in the mother tongues of learners. These learning materials should cover areas of life skills such as primary health care, reproductive health, prevention of diseases such as malaria, HIV/AIDS etc. banking, agriculture, marketing, etc.

Learning materials which are linked to the MDG objectives and processes will enable the population as a whole to participate in the development process.

3.6 Major Actions Taken by Government and Development Partners

The Government is placing particular emphasis on education. Within the framework of the 1994 Education and Training Policy, the Government of Ethiopia launched the first five year Education Sector development Program (ESDP I) in 1997 as part of a twenty-year education sector indicative plan. ESDP I and II have been implemented in the past decade and the MoE is now implementing the ESDP III (2005/06 – 2010/11). The main thrust of ESDP is to improve quality, relevance, equity and efficiency of the system and to expand access with special emphasis on primary education in rural and under served areas as well as the promotion of education for girls in an attempt to achieve universal primary education by 2015. In view of this broad objective of the ESDP, the major actions taken by the Government during the period 2003 to 2007 can be summarized as follows:-

- Available data show that to increase access to schooling, 7323 primary (1-8) schools and 380 senior secondary (9-12) schools were built during the period 2001/02 to 2005/06. 76,158 teachers were deployed in primary schools. Thus enrollments in primary education, student/section ratio, pupil/teacher ratio, percentage of female students and percentage of female teachers have all improved.
- A three-year-fast track strategy has been developed in consultation with the regions in order to improve access in the pastoralist and semi-agriculturalist regions. The MoE has undertaken different initiatives that aim to increase access and narrow high gender and regional gaps in GER and urban-rural disparity in enrollment. In 2000 the MoE had conducted a policy study on “Alternative Routes to Basic Education” in a bid to achieve UPE by the year 2015. To provide educational access to the four emerging regions (Afar, Benishangul-Gumuz, Gambella and Somali), the government took a sector-integrated initiative through the Ministry of Federal Affairs.
- A Task force was established in the MoE in order to introduce the ABE package in the education system particularly in the pastoralist and semi-agriculturalist areas, which includes Borena and South Omo zones in addition to the four emerging regions. To this effect guidelines for the implementation of ABE have been developed, syllabi in four subjects for level 1 to level 3 of the ABE program have been developed and a number of training materials have been prepared. ABE centers were also established on a pilot basis in selected woredas of the four emerging regions and two zones.
- Alternative Basic Education has been fully accepted as part of the strategy to address the low enrollment problem in rural and underserved areas. Alternative Basic Education Centers are constructed closer to the community and this encourages out-of-school children and children from pastoralist communities to attend school.
- To help upgrade quality quickly a national “Teacher Education System Overhaul” is being implemented including:-
 - A new curriculum has been introduced in all teacher training institutions;
 - An advanced diploma program has been initiated for teacher trainers;

- A distance teacher education program has been designed to upgrade unqualified teachers – for instance 17,000 teachers have graduated in 2003/04 raising the proportion of qualified teachers in the second cycle to over 70%;
 - An “English Language Improvement Program” has been launched in the last two years focusing on improving the language skills of teachers;
 - The Guideline for organization of Educational Management, Community Participation and Educational Finance has been implemented throughout the country. Education and Training Boards have been established in woredas and kebeles. Parent Teachers Associations are operational in all schools. These have made it possible for communities to own and administer schools, and contribute in cash, labor and skill for the betterment of schools.
- To compensate for strains, introduced with decentralization, efforts have been made to build the capacity of the Woreda Education Offices through intensive training organized in the areas of educational planning and management, financial management, auditing and procurement. A number of education personnel drawn from all 600 woredas were trained in educational management, planning, monitoring and supervision.
 - Extensive awareness creation activities, on the importance of girls’ education, were undertaken among communities. Efforts have been made to make schools friendly to girls by constructing separate latrines for boys and girls, assigning female teachers and head teachers to provide close support to girls. Girls clubs were established in schools and tutorial and guidance and counseling services were provided to girl students. Such endeavors have contributed to the significant increase in girls’ enrollment.
 - School feeding was identified as a strategy in ESDP II to raise and maintain school enrollment. For instance, it was possible to reach about 544,000 primary school children in 2004/05. This program is implemented in six regions (Afar, Somali, Oromia, Amhara, Tigray and SNNPR).
 - MoE has carried out several activities to support and encourage regions for the provision of non-formal education program. A number of manuals and guidelines have been prepared. Several studies were also undertaken to expand the provision of adult and non-formal education. Strategies to promote women’s education and training through non-formal education were also developed.
 - The second National Learning Assessment on grade 4 and 8 was conducted in 2003/04.
 - In cooperation with the Government of Finland and UNESCO, the MoE carried out a situation analysis of special needs education services in the country (Report on the situation of Special Needs Education in Ethiopia, 2005).
 - In order to mitigate the impact of HIV/AIDS and to reverse its spread, HIV/AIDS education is integrated into newly developed curricula. Anti-AIDS Clubs were established in almost all primary and secondary schools.

Following the establishment of the National HIV/AIDS Council, MoE organized the HIV/AIDS Task Force which undertook several activities such as HIV/AIDS baseline survey, study on impact of HIV/AIDS on the sector, conducted national seminars, produced education booklets, posters, brochures and video film and a comprehensive source book on HIV/AIDS education for teachers.

3.7 Challenges³¹

- One of the important challenges facing the sector is to ensure that there is a unitary education system within the whole country whilst at the same time devolving most functions and money to regions, woreda, and school and community levels.

³¹ MoE – ESDP III, Program Action Plan, Addis Ababa, August 2005.

- Major efforts have to be made to further improve the quality education, in order to increase completion rates, to create the environment for teachers to effectively use their skill, and to maintain the confidence of parents in the school system. To this effect, urgent improvements need to be achieved in the areas of unit non-salary recurrent school budgets, student-section ratios, student-teacher ratios, availability of textbooks in schools, and supervision of the teaching-learning process.
- Lack of sufficient number of qualified teachers is a persistent problem. Although effort is being made to increase the supply and improve their professional capacity through various programs, the problem is very acute in the second cycle of primary and in secondary schools
- Weak program management and implementation capacity has also contributed to low budget utilization in civil works and procurement. High turnover of professional personnel was one of the contributing factors to the program management capacity.
- Inadequate planning and management capacity at the woreda and community level is a critical problem in realizing the goals of education especially with regard to primary education.
- Efforts made to improve quality of education are offset by the greater push given to increasing enrollment.
- The sector has a double burden of catering for over-aged children, who missed schooling due to the inaccessibility of education services, in addition to the school-age group.
- Drop-out rates remain high limiting the effectiveness of schooling. Many of the on-going measures are geared to reduce drop outs and improve quality.
- The number of students is increasing from one year to the other. However the number of classrooms as well as teachers could not grow with the same proportion. This has resulted in large class size and high student-teacher ratio affecting the teaching learning process. There is also a need to print more text books so that every student gets a copy of a text book for each core subject. Generally great effort and resource is required to lower down the class size and teacher pupil ratio from 74 and 65 respectively to 50.
- A major continuing challenge is the adequacy of non-wage recurrent funding at the local level; and the capacity of woreda level budgets more generally to finance all of the competing claims for expansion of services.
- Implementation capacity at woreda level is not yet at the level expected to carry out their responsibilities. Woreda capacity building programs have been initiated. Deployment of staff at regional level was undertaken as a first step in building the capacity at other levels. However, there is still a huge need for training on supervision, strategic planning and budgeting, education management information systems etc.

3.8 Key Areas for Future Action

The Government of the FDRE has to address a number of issues in order to meet the goals and targets of the WFFC PoA and the MDGs and other internationally agreed standards. Some of the relevant and critical areas for future action include the following:

- 1) The most effective strategy for under-served areas, including remote rural areas, is an adoption of the present Alternative Basic Education Centre (ABEC) model, which will enable every village to have a small multi-grade school, of its own. With this in view, the ABEC system needs to be integrated into a quality unitary education system which will incorporate the good aspects of the ABEC system into the national education system
- 2) The role of the MoE should be strengthened in the areas of: quality control, guidelines on investment and utilization of funds, improving the curriculum and textbooks utilized in all regions, monitoring and evaluation of the system and development of a test bank.

- 3) Some regions, in particular those with pastoralist populations are highly disadvantaged. The Federal Government should make additional efforts to support such regions including provision of both technical and financial support.
- 4) There is a need for diversification of the building models for primary schools to make them more adopted to local conditions and affordable to both government and the community.
- 5) At present there are some 4 million over-age children within the primary school system. It is possible for this backlog to be tackled decisively such that within the first five years of the plan period (2006-2010) this problem will be radically reduced, and that by the end of the plan period (2015) it will no longer be a major problem. A special program has to be arranged for them over the next decade.
- 6) Employment of a cadre of community teachers i.e. Para-professionals or facilitators who will be gradually integrated into the teaching service as qualified teachers over a period of several years. This strategy is very important for several reasons. The utilization of paraprofessionals will enable the education system to move away from its present teacher pupil ratio of 1:70, which is professionally and academically challenging and leads to deteriorating quality, to a more reasonable teacher pupil ratio of say 1:40. It is a necessary strategy for the coming ten years. It is necessary because of the shortage of certificated teachers, the need to have teachers recruited from within the community and cost constraints.
- 7) In order for the Regional Education Bureaus, Zonal Education Offices, Woreda education offices, schools and Parent Teachers Associations to be strengthened so that the devolution of powers to control the education is increased and strengthened in a phased manner, there will need to be serious capacity building in these institutions over the next decade.
- 8) Specific programs need to be targeted at special needs groups, such as children with disabilities, children of pastoralist populations, children living in extreme poverty, and street children. School feeding can be an intervention suitable for children living in deprived circumstances.
- 9) There is wide gender gap in all areas of education. Major improvements can be made within the next five years by using different approaches such as establishing grants for girls, increasing the number of women teachers to 50% of the total, Teacher Training Institutes, Teacher Training Centers and faculties of education to enroll equal numbers of men and women etc.

4. PROTECTING CHILDRENT FROM ALL FORMS OF ABUSE, NEGLECT, EXPLOITATION AND VIOLENCE

WFFC has four major goals that aim to protect children from abuse, neglect, exploitation and violence. These are additional safeguards to the rights of children embodied in the CRC, the African Charter on the Rights and Welfare of the Child, the Millennium Declaration and other international conventions.

With respect to the fulfillment of the goals priority areas of concern, selected achievements and key areas for future action are discussed in the following section. Article 36 of the Ethiopian Constitution ensures the legal protection of children. Other articles in the constitution also relate to children's rights (Article 33-37, 29, 27 and Article 18 (right to humane treatment). The Civil Code, the Penal Code and Criminal Code also contain provisions designed to protect the rights of children. The Revised Family Code Proclamation No. 213/2000 was proclaimed in July 2000 following amendment to the Family Law of Ethiopia which, up until then, was part of the Civil Code of Ethiopia of 1960. The Revised Family Code purports to give "priority to the well-being, upbringing and protection of children in accordance with the Constitution and International Instruments which Ethiopia has ratified". Ethiopia has ratified the CRC, the Minimum Age Convention and the Worst Forms of Child Labor Convention which is complementary to the Minimum Age Convention.

4.1 Child Labor

Child labour means employment or work undertaken by children, which does not conform to standards enshrined in the ILO Convention No.138 on the minimum age for employment and No.182 on the worst forms of child labour (WFCL).

There is limited or no empirical data to assess the situation, prevalence and magnitude of children involved in the worst forms of child labour in Ethiopia. The 2001 stand-alone Child Labour Survey was based on households and measured variables pertinent to analyze the working status and conditions of children in the country. The survey provides information on the employment status of children such as those children engaged in domestic employment. However, the survey does not provide disaggregated data showing the number of children by the different activities in domestic employment, which may be identified as the worst forms of child labour. Thus, the survey offers little or no data that is disaggregated by the different forms of child labour specifically to show the level of involvement of children in the so-called worst forms of child labour, like trafficking children in illicit trade and other activities unacceptable to be taken up by children.

According to the 2001 Child Labor Survey Report³² working children between the ages of 5-17 years were 18.2 million accounting for 32% of the total population, out of which 15.5 million (85.4%) were reported to have been engaged in productive activities, housekeeping activities and both. Of this, 81.2% (12.6 million) were below the age of 15 years. 50.6% were boys and 49.4% girls. The majority (88%) reside in rural areas where access to basic social services is limited.

Child labor distribution indicates that about 57.2% of rural children were engaged in productive activities, while only 18.8% of children in urban areas were engaged in productive activities. Boys concentrated more in primary activities while girls were mainly engaged in housekeeping activities. An overall 92.3% of children engaged in productive activities work as unpaid family workers and only 7.7% of them work

³² CSA/MoLSA/ILO Child Labor in Ethiopia, Analysis of a Survey Conducted in 2001, Addis Ababa, March 2006.

as paid laborers. In urban areas, only about half of the children engaged in productive activities were unpaid, while in rural areas 94.4% were unpaid. The hours of work in primary activities averaged 32.8 hours per week. Only 38.1% of children 5-17 years old reported attending school.

Since there are no comprehensive and adequate data, the prevalence of worst forms of child labor in Ethiopia is not known. The available data are highly limited in coverage to specific areas of Addis Ababa like the “Child Prostitution” study undertaken by Save the Children Denmark, Young Lives –Studies on childhood poverty by Save the Children – UK, Child Weavers in Gulele Locality by MCDP – a local NGO, Domestic Child Workers by ILO Addis Ababa Office, and Child Work in Tea and Coffee Plantations in Western Ethiopia by ILO. ILO Convention No. 182 identifies commercial sex work as one of the worst forms of labor open to children.

There are no concrete data that depict the scale of the problem, and it is difficult to determine whether the problem is on the increase or not. However, some small scale and focused studies shed some light on the gravity of the problem. In a study undertaken at Shashemene and Dilla, of the 46 female street children covered by the study, 13 were engaged in commercial sex work.

The appropriate strategy to reduce child labor and improve their working conditions to acceptable standards and at least to eliminate the worst forms of child labor is to tackle the root causes notably poverty and its related problems that force children to labor. Other causes are cultural values, educational problems, family disintegration due to divorce, various conflicts, war and civil strife, drought and resettlement, orphan hood due to AIDS and rapid urbanization. The Ethiopian Government has rightly introduced PASDEP strategy to end poverty. The government has placed poverty reduction at the center of its overall development strategy, and has instituted a welfare monitoring system to follow-up the impact of policies on living conditions.

Government Proclamation No. 377/2004 provides a number of basic protections for working children. However, the laws do not cover the large number of children working in the informal sector and due to limited institutional capacity and scarcity of the required trained manpower; their enforcement is weak even in the formal sector. The elimination of poverty is the main challenge faced by the Government. Key areas for future action include the following:-

- Revision of existing legislation that runs counter to international labor norms and standards;
- Focus in the short and medium term on identifying and eliminating the worst forms of child labor;
- Mainstreaming child labor within PASDEP;
- Strengthened partnership of NGOs in the implementation of the CRC and in reducing as well as eliminating child labor, particularly in areas where government is unable to reach the grassroots level;
- Similarly civil societies, professional associations, the private sector and sectoral associations should adopt the CRC and ILO Convention 138 and 182 on reduction and elimination of child labor in their regular programs;
- The National Child Labor Forum, comprising of Government, NGO and donor agencies should be revitalized. The forum should be focused on the implementation of the CRC in general.

4.2 Social Protection for Orphans and Vulnerable Children (OVC)

In 2005, it was estimated that there were a total of 4,885,337 orphans aged 0-17 years of which 744,100 were AIDS orphans.³³

³³ CSA – Welfare Monitoring Survey, 2004.

Most AIDS orphans' families are characterized by illiteracy, low family income and little access to safe water³⁴. About 50% of AIDS orphans and 46% of non-AIDS orphans lack adequate food. Securing their daily food is a major problem for most orphan children. It is reported that 6.1% are forced to beg in order to get their daily food and a large number also drop out of school due to lack of educational materials.

As stated in the OVC National Plan of Action (2004-2006), drawn by the Government and partners the HIV/AIDS pandemic has substantially increased the number of child-headed families, changed cultural patterns of child care and put an incredible strain on the social safety nets. As a result, OVC are very vulnerable to all forms of abuse and exploitation, loss of inheritance rights, loss of opportunities for education, basic health care, normal growth and development as well as shelter. They are also at risk to the future waves of HIV infection. The magnitude of OVC crises therefore, calls for concerted and intensified efforts from the government, the international community, civil society, and bilateral and multilateral organizations.

The OVC Plan of Action has been developed to guide all stakeholders in addressing the issue of OVC care and support in a holistic, coordinated and integrated manner. OVC Task Forces were established by the Government both at federal and regional levels to facilitate the implementation of the plan. The Task Force at Federal level comprised of members drawn from HAPCO, MoLSA, UNICEF, SCF-USA, SCF-Sweden, UNAIDS, USAID, WFP and Hope for Children.

The government also adopted alternative child care strategies which include:-

- Community based child care;
- Foster family care;
- Child-family reunification;
- Child care institution (not encouraged in Ethiopia); and
- Adoption.

There are also traditional coping mechanisms to help OVC such as the extended family, capacity building of the immediate family, and other traditional mechanisms e.g. "Yetut Lij" or "Yemar Lij".

Some of the major organizations which support various kinds of orphans include: the Ethiopian Orthodox Church, Ethiopian Evangelical Church Mekane Yesus and Abebech Gobena Children's Home. These and other organizations support only a tiny fraction of the large number of orphans and needy children. The following table shows the type of support given to OVCs in 2003/04 and the number of beneficiaries by type of residence.

Table 5. OVC who live with households who received support during the last 12 months, 2003/04

Type of support during the last 12 months	Both Sexes		
	Rural	Urban	National
Medical treatment for the last 12 months	10,133	12,416	22,549
Counseling service	9,003	9,660	18,663
Support related to education	18,135	28,080	46,215
Other social service, clothing, financial support etc.	76,261	25,103	101,364
No. of orphaned and vulnerable children who answered 'yes' to at least one of the four categories in question 1 through 4	98,576	46,696	145,2
Total number of orphaned and vulnerable children surveyed.	3,438,206	728,259	4,166,465

Source: - CSA, 2005

³⁴ MoLSA, UNICEF, and Italian Cooperation- National Study on the Prevalence and Characteristics of AIDS Orphans in Ethiopia., 2003

Development of relevant policy and strategy on orphans in general including HIV/AIDS orphans; and development and implementation of detailed plan of action remains a challenge for all stakeholders.

The key areas of action for the immediate future include thematic areas covered in the OVC National Plan of Action i.e. legal and regulatory framework, advocacy and capacity building consultation and coordination, and monitoring and evaluation.

4.3 Street Children

There is high variation of national figure that makes it difficult to know the magnitude of the problem of street children. As IRIN News report on street children rehabilitation project in Ethiopia (2004) quoted the Ministry of Labour and Social Affairs report that some 150,000 children live on the streets in Ethiopia of which about 60,000 live in the capital.³⁵ UNICEF and others estimate the number to be much higher. Many also agree that the number of street children is increasing in major urban centers, in particular in Addis Ababa.

As reported by several studies, the causative factors driving children to join street life are abject poverty, rapid population growth, and recurrent displacement as a result of civil war, drought and famine. Abuse, maltreatment and neglect of children by care takers are also contributing factors for children to go out on the streets.

Ethiopia is one of the signatories of the Convention on the Rights of the Child, and its constitution also protects the rights of children. As a step toward facing its responsibilities, the government is conducting a campaign through state-run media to make the public aware of the true nature of the problems facing children. Officials say Ethiopia's central government is also helping regional administrations to effectively address social problems, such as street children. According to the new structure, regions are responsible to identify and mitigate different social problems in their environment. At the federal level, the Ministry of Labor and Social Affairs is giving technical assistance in different forms, so those regions can alleviate different problems found in their respective regions. The ministry has good working relationships with different child-oriented NGOs that are giving different services to street children.

Civil Society forum for East and Southern Africa (2002) report showed the achievements as CRC incorporated into domestic legislation and translated into 11 local languages; regional, zonal and woreda level CRC committees formed; juvenile justice project in place; national study on street children in 25 urban centers; documentary film about street children; panel discussions on TV and radio; NGO programmes in place; child rights clubs and anti-AIDS clubs; awareness-raising for religious and community leaders; counseling and legal aid; research followed by 'outcome workshops' to exchange information with relevant actors; community-based government/UNICEF programme for prevention and rehabilitation of street children in 14 major towns; support for street children to access health services through issuing of identity cards; community-based childcare project; saving and credit scheme for mothers of street children; substance abuse programmes for street children; Forum for Street Children Ethiopia-initiated network between police commissions and NGOs in Kenya, Uganda, Tanzania and Ethiopia to promote child protection programmes.

The 100 street children covered in a study conducted in Shashemene and Dilla were asked if and what kind of violence they were facing on the streets. 88.1% of the female and 77.6% of the male respondents reported to have faced violence. According to the respondents, the major form of violence they were

³⁵ UNICEF/Addis Ababa Bureau of Social and Civil Authority and A.A Bureau of Finance and Economic Development- Baseline Survey of Children Living on the Streets of Addis Ababa, Draft, April 2007

facing was physical abuse and the frequently mentioned abusers were street gangs. The respondents reported that rape was not an uncommon occurrence. One fifth of the girls and one tenth of the boys stated that they were raped. The consequences of such violence, according to the respondents, included STDs, and HIV/AIDS, unwanted pregnancy, and mental and physical trauma.

The street children are assisted by several organizations which include: Mow, MoLSA, UNICEF, Save the Children – Sweden, FSCE, MoLSA – Italian Cooperation – Raada Barnen Projects, UNICEF and Italian Cooperation Project, Prevention, Rehabilitation and Protection of Street Children and Street Mothers Project in six cities. The six cities project is being implemented in Addis Ababa, Awassa, Bahir Dar, Shashemene, Mekele and Nazareth. The number of cities served has now reached 14 and includes Arba Minch, Dire Dawa, Harar, Jimma, Gimbi, Wolaita Soddo, Gondar, and Dessie.

The services provided to these children are very limited in scope and lack an overarching strategy. MoLSA works with UNICEF and Italian Cooperation in providing various rehabilitative/preventive services in Addis Ababa, Bahir Dar, Mekelle, Nazareth and Shashemene. A Joint MoLSA – Italian Cooperation and Raada Barnen project provides preventive and rehabilitative service i.e. education, recreation, health care, counseling, vocational training and credit, to some street children and their families in Addis Ababa.

Development of an integrated strategy and plan of action remains a challenge for the sector. Some of the key areas of action in the future include expansion of services that will avoid dependency and development of a strategy to guide the activities of all stakeholders. Increasing partnership between government and NGO services, implementation of the strategies specified in the Developmental Social Welfare Policy particularly those referring to the empowerment of the communities, community mobilization and usage of grass root organizations are other key areas of action.

4.4 Juvenile Justice

The Juvenile justice system is not yet developed in Ethiopia. Lack of enforcement of existing laws including the CRC, lack of community based correction centers, limited training of the police and the judiciary on child rights, and lack of correction institutions (except the Addis Ababa Remand Home) are some of the major indicators that show clearly the negligible development of the juvenile system.

To redress the situation, the Federal Supreme Court in collaboration with various NGOs, has established the “Juvenile Justice Project Office (JJPO) in June 1999. Since then a Steering Committee has been established and some efforts continue to be made to improve the legal protection of children who are in conflict with the law, and to reform the juvenile justice system of the country. Training of a few judges and police staff has been taking place, compilation of international instruments (on rights) has taken place and the problems of existing Ethiopian law in relation to the CRC have been studied. The office is working with MoLSA, UNICEF, Italian Cooperation, and Forum on Street Children –Ethiopia and the African Network for the Prevention of and Protection against Child abuse and Neglect (ANPPCAN-Ethiopia).

It is reported that a division within the Federal First Instance Court has been designated to handle cases of juveniles in Addis Ababa. The problem with the juvenile justice system is not only the lack of implementation, but also the incompatibility of some provisions of the civil, penal and criminal codes with the CRC. As a result some legislation has been revised.

Until very recently, there was no special arrangement within the court system to deal with cases where children were victims of violence. However, as of September 2004, a child friendly system where a child

victim need not personally appear before the formal setting of a court room has been put in place with the assistance of a Juvenile Justice Project Office at the Federal Supreme Court. Hence, there is now one separate bench in Addis Ababa that is connected to a special room through a ‘Close Circuit Television’. The child victim who will be sitting in the special room is assisted by an intermediary to answer all the questions forwarded from the court room. Thus they can testify freely without being further traumatized. At the initial stage of the program, training was given to the persons that were to be involved in the operation of the system. The judges have been oriented on the subjects through workshops and seminars.

In addition, the justice organs Professionals Training center that was established recently has started to provide a course on human rights. Components such as child rights and women’s rights are planned to be part of such a course. According to the project office at the Federal Supreme Court, there is a plan to set up a special system of the kind mentioned above in all regions of the country. Separate benches have been instituted in Tigray, Oromia and SNNP regions. A Human Right Commission and the Institution of Ombudsman have been established by proclamations (2000). Both institutions are mandated to receive and investigate complaints within their respective jurisdictions. Given the paucity of human and material resources in the country, building the capacities of these institutions will remain to be one of the major challenges.

4.5 Birth Registration

At the present Ethiopia has no civil registration and vital statistics system in place. However, a study has been conducted by the Population and Housing Census Commission Office on what kind of institutional framework and infrastructure should be adopted in the country.

The absence of registration of civil status has a negative impact on the protection of child rights. Among other things, registration is useful for age determination and for proof of paternity. The absence of age registration is also making the fight against the practice of early marriage very complicated.

A “National Plan of Action for the Establishment and Development of Civil Registration and Vital Statistics System in Ethiopia”³⁶ has been developed and awaits endorsement. It has the ambitious goal of reaching a registration coverage level of 90% for both birth and death registration areas in five years time after the endorsement of the plan. A draft Bill on Birth registration has been presented to parliament and awaits ratification. In view of the fact that a record of civil status serves a wide array of purposes such as better protection of the welfare and rights of the child, scaling up efforts to make it functional is a critical step. Important activities in this regard include: finalization and endorsement of the draft registration by the relevant authorities and designing and raising funds and putting the appropriate institutional mechanism in place.

4.6 Violence against Children, Sexual Exploitation and Gender Violence

4.6.1 Physical Violence

Children are subjected to physical violence in private as well as in public life. It is common for families in Ethiopia to inflict corporal punishment as a way of disciplining their children. Schools also employ physical punishment as a means of directing their students. A study by the African Child Policy Forum indicated that children face different kinds of punishments at home. Out of 1223 interviewed children,

³⁶ UNICEF/MoLSA – Ibid. (Violence against Children)

only 17 (1.4%) stated that they have never experienced corporal punishment at home. The study has revealed that despite directives that ban corporal punishment, it is still administered in schools. However, it is acknowledged in the study that the practice of corporal punishment in schools is demonstrably reduced (African Child Policy Forum, 2005).

4.6.2 Sexual Violence

Sexual abuse is a common form of violence perpetrated on children. For instance, out of 214 allegedly abused children under the age of 15 reported to one government hospital (Yekatit Hospital) during a period of one year (from July 2001 to June 2002), 74% suffered from sexual abuse. 93% of these children were female.

Sexual violence especially on children is under reported due to lack of awareness, taboos about sex and sexuality, a lack of faith in the justice system, and/or stigmatization of victims. For instance in one small scale study³⁷ conducted in Dilla (SNNPR) and Shashemene (Oromia Region) towns, 93 out of 198 high school students stated they were sexually abused. But of these, only 36 (38.7%) reported the incidence to the police, parents, friends and school teachers. According to the respondents, in 44.4% of the cases no measures were taken against the perpetrator of violence. Children who have experienced sexual abuse suffer from physical, sexual and psychological consequences.

Although there is no official statistics that indicates the scale of the problem of trafficking in Ethiopia, the International Organization for Migration estimates that large numbers of women and children are trafficked within the country and across borders (IOM 2004). According to this study an estimated number of five to ten thousand Ethiopian migrants in Lebanon alone are engaged in prostitution.

According to one study (Save the Children, Norway) child prostitution is reportedly on the increase. Children as young as 13-16 years of age are noted to be engaging in the practice in large numbers. One estimate puts the number of child commercial sex workers in Addis Ababa alone at 6000. Traffic in children for sexual exploitation empirically by engaging them in prostitution is also prevalent in Ethiopia. A National study on in-country traffic in women and children shows that 26.8% of children included in the study were victims of trafficking.³⁸

Available information on sexual abuse and exploitation of children (SAEC) is limited. According to the national crime statistics of the Federal Police Commission (unpublished) for the period September 1999 to September 2003, sexual outrage was the most prevalent form constituting 70.85%, 76.15%, 71.3% and 77.91% of reported crimes annually.

By way of intervention the government has performed the following:-

- It has provided appropriate and relevant policies and laws. These include the Developmental and Social Welfare Policy (1996), the labor law, the revised penal law and the Cultural Policy and the National Youth Policy (2004) which provide relevant guidelines that help to address the issue of SAEC in Ethiopia. The revised penal law officiated as of May 2005 deals with the issue of violence against children in a comprehensive manner. Many acts of violence are specifically criminalized in the penal law. There are specific provisions on infanticide, sexual violence, abduction, maltreatment, neglect and negligent treatment, sexual exploitation of children, subjection of children to pornography and

³⁷ Azeb Adefresew – Study on Child Sexual Abuse and Exploitation in Shashemene and Dilla Towns, 2003

³⁸ Agrinet – Assessment of the Magnitude of Women and Children Trafficked Within and Outside Ethiopia, 2003

- harmful information and trafficking. The revised penal law has made many positive changes. The removal of the provision that allowed corporal punishment is one example.
- It has established the National Inter-Ministerial Committee on the CRC.
 - MoLSA has prepared and is implementing the National Action Plan for Children, National Action Plan on OVCs (2004-2006) and the National Action Plan on sexual abuse and exploitation of children (2006-2010). The Ministry of Women's Affairs (MoWA) chairs the National Committee on SAEC.
 - MoLSA has conducted studies and surveys including the survey on the prevalence and characteristics of AIDS orphans in Ethiopia (2003) and prepared the orphans and vulnerable children Rapid Assessment, Analysis and Action Planning Report
 - The MoLSA is involved in direct interventions like airing a weekly radio program on child rights issues including SAEC, program on children in difficult circumstances (1997-2003), implemented focusing on street children and children in child care institutions and implementation of projects to address the needs of vulnerability by regional bureaus on CRC promotion and support to street children, disabled children and victims of SAEC and child labor.
 - Different Ministries have also undertaken intervention activities in the area of SAEC. Notable efforts by these actors include the organization of the Addis Girls Forum by the Women's Affairs Office (WAO), the MoE and the Addis Ababa City Administration in collaboration with UNICEF.
 - Other interventions by the government and NGOs include: the establishment of child protection units in police stations in Addis Ababa and major regional towns, made possible through collaboration between an indigenous NGO (FSCE) and the Federal and Addis Ababa Police commissions. Another intervention achieved through collaboration with two international NGOs is the study on the Worst Forms of Child Labor with special focus on child prostitution in Addis Ababa (2003) by the Addis Ababa City Administration Social and NGO Affairs Office in collaboration with Save the Children – Denmark and the Ethiopian Chapter of ANPPCAN.
 - The National Steering Committee Against sexual Abuse and Exploitation of Children was established as a direct response to the commitments entered by government and non-government actors in Ethiopia at the Stockholm World Conference and the subsequent national conference on child prostitution conducted in 1997. In terms of membership, the committee comprises of UNICEF, international NGOs and indigenous NGOs and is chaired by the Children, Youth and Family Affairs Department of MoLSA with FSCE serving as secretary. The Save the Children Alliance is a key actor in the operation of the committee.

Indigenous NGOs that are implementing programs and activities on SAEC are large in number. These organizations use different approaches and focus on different groups of children, but few of them also work directly on SAEC. These organizations include FSCE, the Ethiopian Chapter of ANPPCAN, the African Child Policy Forum, the National Committee on Traditional Practices of Ethiopia, Children AID Ethiopia, Integrated Family Services Organization, Ethiopian Women Lawyers Association, the Ethiopian Family Guidance association and action Professionals Association for the People.

One of the major challenges faced by intervention efforts in addressing the problem of SAEC in Ethiopia is lack of coordination; existing interventions in the area of SAEC are not coordinated to achieve clearly defined national goals and objectives in this area. In this context it is important for the government to take the initiative to provide leadership in setting overall goals and objectives as well as putting in place the necessary networking monitoring and evaluation structure. This way the government could give legitimacy and ensure sustainability of the coordinating structures.

Law enforcement could be a major challenge where the institutions including the police, the prosecutors office and courts, immigration and customs offices etc. are not specialized in the area of child sexual abuse and exploitation.

Key areas for future action should focus on establishment of an inter-agency task force operating on the basis of a document that clearly defines the mandates, responsibilities and roles of such a task force. The establishment of a systematic data collection system on SAEC and monitoring the impact of existing efforts is of paramount importance, including a comprehensive survey on the situation of SAEC at national level. Main areas of intervention include prevention, protection, rehabilitation and reintegration and coordination and monitoring.

5. COMBATING HIV/AIDS

WFFC has three major goals that aim to reduce the prevalence of HIV, particularly among mothers and infants and undertake integrated set of interventions to cope with the effects of HIV/AIDS on children and vulnerable families. These goals are directly aligned with MDG 6.

Progress towards achieving these goals and the corresponding MDG indicators is described in the following section. The main sources of data are the Strategic Plan (2004-2008), AIDS in Ethiopia, Sixth Report (2006), Accelerating Access to HIV/AIDS Treatment in Ethiopia, Road Map for 2004-2006, and the HSDP III.

5.1 Trends in HIV Prevalence³⁹

The 2006 Federal Ministry of Health's 6th 'Report of AIDS in Ethiopia' was published in September 2006. The 6th Report is based on sentinel surveillance of ANC (ante-natal care) sites targeting pregnant women. In 2005, Ethiopia also included testing for HIV prevalence in its DHS survey. As the estimated prevalence as a result of the ANC and DHS surveys differed, it was decided to perform a single point estimate taking both surveys into consideration. Through adjustments of the 2005 ANC and DHS-Plus factors, using updated EPP/SPECTRUM methodologies and other country experiences, in presence of international experts from WHO/UNAIDS, a provisional estimate of 2.1 % for 2007 was adopted for planning purposes in Ethiopia until the next opportunity for an update takes place following the completion of the current ANC Sentinel Surveillance later in 2007/2008. The reference for the following statistics and the target calculation is 'The Single Point Estimate for HIV/AIDS in Ethiopia'⁴⁰.

According to the calibrated single point estimate (2007), the National Adult HIV prevalence is reported to be 2.1%% (7.7 % in urban areas and 1.9 % in rural areas.)⁴¹. 977,394 Ethiopians are living with HIV/AIDS (41% male and 59% females.) It is estimated that there will be 75,420 new cases of HIV positive pregnant women in 2007. The highest HIV prevalence is in persons between the ages of 15 and 24, and prevalence is higher among females compared to among males in both urban and rural areas. Prevalence appears to have leveled off in urban areas but continues to rise in rural areas, where 85% of the population lives

According to "AIDS in Ethiopia – 6th Report", the regional HIV prevalence estimates ranged from 1.2% in Somali to 11.7% in Addis Ababa. HIV prevalence is higher among females (4%) than males (3%) and in urban (10.5%) than rural (1.9%) areas.

The overall unadjusted HIV prevalence among pregnant women attending ANC clinics was 5.3%. In 2005, the unadjusted HIV prevalence for urban areas was 9.5%, while it was 2.2% for rural areas. Women in the age-group 15-24 years in rural areas and 25-34 years old in urban areas had the highest prevalence rates. Of the total, the age group 15-24 had the highest prevalence of 5.6%

Some of the major HIV/AIDS indicators for 2005 are shown in the following table.

³⁹ FMoH – AIDS in Ethiopia, Sixth Report, September 2006

⁴⁰ 'The Single Point Estimate for HIV/AIDS in Ethiopia' will be printed in June 2007 and supersedes the '6th Report of AIDS in Ethiopia'

⁴¹ FHAPCO/MoH- National Guidelines on Prevention of Mother to Child Transmission of HIV, Final Draft 2007. DHS is a population based survey and the estimate given by the DHS (1.4%) is much lower than that given by the FMoH based on the Antenatal (ANC)-based Sentinel Surveillance data from 1989- 2005.

Table 6- Ethiopia: Selected HIV Indicators

Ser.No	Indicator	Value
1.	Estimated number of adults and children living with HIV/AIDS	1,320,000
	Males (15-49)	590,000
	Females (15-49)	730,000
	Children (0-14)	134,586
2.	Estimated number of annual AIDS deaths	
	All ages	134,458
	Children	20,929
3.	HIV prevalence rate (adult) - %	
	Country	3.5
	Urban	10.5
	Rural	1.9
	HIV prevalence among 15-24 year old pregnant women ANC clients	5.6
4.	New AIDS cases	
	All ages	137,499
	Children	21,707
5.	HIV positive pregnancies	105,675
6.	HIV positive births	30,338
7.	Number of children orphaned by HIV/AIDS	744,088

Source: FMOH AIDS in Ethiopia, Sixth Report, September 2006.

The HIV/AIDS epidemic continues to pose a threat to the development of Ethiopia, where 1.3 million people are living with the virus, 744,100 are orphaned due to AIDS and 277,800 are in need of anti-retroviral therapy (ART) in 2005. AIDS accounted for an estimated 34% of all young adult deaths 15-49 in Ethiopia and 66.3% of all young adult deaths 15-45 in urban Ethiopia. Universal access to ART can reduce AIDS deaths by 41% and AIDS orphans by 13% by 2010.

The HIV incidence in Ethiopia in 2005 was estimated at 0.26%. It increased until 1992, then stabilized between 1992 and 1996, and started declining beginning 1996 until 2001. It has remained and is projected to remain stable 2001 onwards until 2010. The estimated HIV incidence in 2005 was 0.99% and 0.12% for urban and rural areas respectively. This means there were a total of 128,922 new infections in 2005 including 30,338 HIV positive births (mother-to-child infection). It was estimated that there were 105,675 (urban 45,982 and rural 59,693) HIV infected pregnant women in 2005. The number of HIV positive pregnancies and HIV positive births are expected to decrease during 2005-2010 mainly due to the anticipated impact of the PMTCT program.

5.2 Prevention of Mother to Child Transmission (PMTCT)

The Annual Report of HAPCO for 2005/06 indicates that a total of 52,428 pregnant women were tested for HIV. Among these, 4172 (8%) tested HIV positive. Of these, 2208 (52.9%) of the pregnant women and 1341 (32%) of their babies received nevirapine (NVP) for PMTCT.

From all the program components, the PMTCT has been identified as the program with the most significant programmatic gap. Although PMTCT as a program was started in Ethiopia in 2003, well ahead of the free ART program that started in early 2005, the annual uptake in 2005/06 was 2,208 mothers having received NVP with 1,341 babies having received NVP over that same period while the estimated number of pregnant women being positive for that period was 70,500⁴² resulting in a programmatic gap of 96.9%.

VCT, PMTCT and ART services have all increased in 2005/06. For instance, the number of VCT centers increased from 525 in 2004/05 to 735 in 2005/06. In fact the actual number of VCT sites was 889 in 2006/07. The number of PLWHA on ART has grown from 21,000 to 45,597 as of June 2006.

According to the Annual report of HAPCO covering the period 2005/06 and the first half of 2006/07, from the assumption of women being offered pre-test counseling, the loss and (short-term) trends at the subsequent levels has been projected as follows:

- ANC attendance at PMTCT sites has increased by 27% which is less than the rate of expansion of PMTCT sites. This may be in part due to the roll out to non-hospital sites.
- Although the ANC uptake increased by 27%, the related pre-test counseling increased more; 51.2%⁴³
- From the 30.5% of all ANC attendees at PMTCT sites that were pre-test counseled, 58.2%⁴⁴ were actually tested. The trend shows a slight increase in women accepting testing after having been pre-test counseled; 6.5%
- Of the women that were tested, 4.2% were positive (higher than the national prevalence assumed due to the limited presence of PMTCT sites in the rural areas)
- Of the positive women, 50.9% received NVP. The trend shows that of the positive women, a slightly decreased percentage accepts treatment (4%)
- Lastly, of the women receiving treatment, only 63% of the babies end up receiving treatment. However, here, we see a slight increase in mothers that are accepting treatment for their babies as well. Interestingly enough, the urban areas (at regional level) don't show a significant increase over the rural areas in ensuring that the babies also receive treatment. The above information is summarized in the following table.

Table 7 ANC Statistics 2005-2006

Step in PMTCT process	Absolute number	Percentage	Remark
ANC attendance	527,900		Repeat visits unknown
Pre-test counseled	161,000	30.5%	Repeat counseling unknown
Acceptance of test	93,760	58.2%	
Women positive	6,750	4.2%	
Acceptance of Treatment	3,440	50.1%	(% of positive women)
Babies rec'd Treatment	2,170	32.1%	(% of positive women)

Source: HAPCO Annual Report

⁴² Provisional HIV/AIDS statistics based on the single point estimate

⁴³ Trend calculations are based on the first two quarters 1999 against half of the 1998 data

⁴⁴ A significant difference can be observed between the regions ranging from 20.9% to 92.6%

Another major gap resides in accessing the PMTCT service due to the limited sites offering PMTCT. With an estimated number of women being pregnant in 1998 (EC) of 2.83 M⁴⁵, it is clear that a large percentage of pregnant women are not accessing PMTCT services. Although the potential of pregnant women in relation to the existing sites is unknown, the national ANC coverage is projected at 40%⁴⁶. Lastly, the annual HIV/AIDS Monitoring and Evaluation Report notes that the DHS from 2005 found awareness and knowledge regarding the existence of ART to reduce MTCT is low; only 21.2% of women and 25.7% of men know that the risk of MTCT can be reduced through the use of drugs during pregnancy.

5.3 ART Needs by Age and Gender

In January 2005, the Government of Ethiopia launched the “Accelerating Access to HIV/AIDS Treatment in Ethiopia, Road Map 2004-2006”. The plan aims to provide universal access to ART for all AIDS patients by the year 2008. According to the Road Map, the plan was to enroll 100,000 patients by the end of 2006. By the end of July 2006, 45,595 patients had ever started on ART at 132 facilities across the country. Of these 35,460 were on treatment currently and 18,384 were enrolled in the first six months of 2006. Of the people ever started on ART, 47% were adult males > 14 years of age, 48% were adult females > 14 years of age and 4% were children. Among the children ever started on ART, 69% were among 5-14 years, 4% were infants less than 18 months of age and 27% were children 19-59 months of age.

The first Road Map has been revised and a second one has been prepared (Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map 2007 -2008/10 Version 6). The HIV national adult prevalence rate for 2005 is estimated at 2.1%, of which 7.8% is urban and 1.0% rural. People living with HIV/AIDS number about 777,500, of which 242,500 are in need of ART. Urban dwellers constitute an estimated 15.5% of the total population, making urban areas a potential high yield recruitment area. A large proportion of the 67,235 individuals ever started on treatment⁴⁷ are from urban areas. A total of 277,757 persons including 213,306 (76.8%) adults in the age group 15-49 years and 43,055 (15.5%) children in the age group 0 to 14 years were estimated to require ART in 2005. For 2006, of the total in need of ART, children under 15 account for 14,396 or 5.9%, while 3.6% of individuals currently on treatment are children or 2,434 of the 4,000 set as target for children for 2006. There were an estimated number of 13,970 positive births in 2005. It is projected that by 2010, 397,800 people will need ART; out of this 26,053 or 6.5% are children.

The free ARV service was launched in January 2005 with hospitals starting free ARVs through this program in March 2005. With the focus on ART rollout the number of ART sites is now at 260⁴⁸ against a target of 89 for December 2006. The accelerated access, especially including the Health Centers, started in June 2006 at a time when ART uptake remained behind target. Nevertheless, despite a substantial increase in access, ART uptake has not reached the target. At the beginning of January 2007 the number of people who had started ART was 67,235 (6.2%) against the targeted 100,000⁴⁹ by the end of 2006. Of major concern are the people lost to follow up, including death, (minimum survival rate of 7.2%)⁵⁰. The

⁴⁵ Health and Health Related Indicators 1998

⁴⁶ Health and Health Related Indicators 1998. However, this may include repeat visits as well

⁴⁷ M&E – Monthly ART Uptake Report Tahsas 1999 (10 January 2007)

⁴⁸ M&E – Monthly ART Uptake Report Yekatit 1999 (10 March 2007), 260 operational ART sites, 249 reporting ART sites. For 10 January 2007, this number was at 233 against the 89 ART sites set as target by the end of 2006

⁴⁹ The targets in the Road Map 2004-2006 are cumulative.

⁵⁰ M&E – ART cohort analysis – 20 hospitals from Meskerem 1995 to Tahsas 1998 (Sept 03 – Jan 06) – minimum survival rate as the survival status of individuals who have been lost to follow up is not known

pediatric ART uptake has been below the set target and deserves a more distinct and stronger focus. To track the HIV counseling and testing (HCT) performance against the stated target of the first Road Map is difficult as the set HCT target was cumulative. Over 2004/05, 2005/06 and the first quarter of 2006/07, 1.16 million people were counseled and tested. The Road Map suggests that 5.1 million people, cumulatively, should have been tested to put 100,000 on treatment. Although HCT data before 2003/04 is unavailable, it is fair to conclude that there has been underperformance in this area. Similarly, the number of fulltime counselors required to counsel and test the target number which was set at 1,668 while the actual number of VCT sites reporting at the end of the first quarter of 2006/07, was only 775 with less than one full time counselor per site. Similarly, PMTCT fell short with 184 sites⁵¹ reporting at the end of the first quarter 2006/07 against the December 2006 target of 326 PMTCT sites. The related PMTCT uptake in women receiving Nevirapine (NVP) was 2,208 in 2005/2006 well below the target of 10,514, representing a 21.2% achievement.

The goal of scaling up ART in the context of chronic HIV care and prevention is to reduce AIDS – related morbidity and mortality, eventually paving the way to universal access to treatment for all people in Ethiopia. Ethiopia has embraced the Global 3 by 5 initiatives that will ultimately lead to universal access to ART services. Ethiopia has adopted a phased approach to allow capacity building, and to make follow up and review of each phase before rolling out to the next.

5.4 Actions Taken by the Government and Partners

Background

HIV/AIDS poses a major threat to growth and poverty reduction and marks a major source of vulnerability in Ethiopia. HIV was first detected in Ethiopia in 1984 and the first two AIDS cases were reported in 1986. The Government of Ethiopia has been steadfast in its response to the epidemic. In 1985 prior to the first laboratory diagnosis of HIV in Ethiopia, the government established a National HIV/AIDS task force as well as a National AIDS control program at the FMoH in 1987. Two medium-term prevention and control plans were designed and implemented in 1989 and 1996 respectively. As the epidemic began to spread, the Government responded by issuing a National HIV/AIDS policy.

As part of the national response to HIV/AIDS a five-year (2000-2004) national strategic framework was implemented. This included the establishment in 2000 of a multi-sectoral and broad based National AIDS council (NAC) and the Secretariat which evolved into the current HIV/AIDS Prevention and Control Office (HAPCO). As of February 2001, all regions established Regional Councils and Secretariats. Compared to the magnitude of the problem the National response and intervention were still far from adequate. Hence, the Ethiopian Strategic Plan for intensifying multi-sectoral HIV/AIDS Response (2004-2008) was developed and is being implemented since 2004. The Strategic Plan focuses on the provision of voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), treatment of cases and provision of care and support to all including children. The overall objective is to reduce the spread of HIV/AIDS in the population mainly children, youth, women and other vulnerable groups. According to the plan, the implementations of all programs were to be based on the principles and approaches of multi-sectoralism, decentralization, community mobilization and ownerships, partnership and the “Three Ones” principles. Restructuring of the implementation and coordination mechanisms was done, whereby the MoH has started to spearhead the implementation and coordination of the national programs.

⁵¹ The PMTCT sites reporting at the end of 2006 were 184 as per the national M&E report while the pharmaceutical report shows 390 sites providing PMTCT services by March 2007

Actions Taken

Encouraging achievements were seen since the start of implementation of the five-year strategic plan. These include training and deployment of health extension workers who are implementing the health extension package (prevention and control of HIV/AIDS is one component of the package), the construction and furnishing of various health institutions especially in rural areas, and the massive involvement of communities in the provision of IEC/BCC, social care and support and other activities. NGOs, private and public sectors and civil society are engaged in awareness raising and sensitization activities in schools, health facilities and public and religious meetings. Media involvement is on the rise and HIV/AIDS related messages are transmitted through Ethiopian Television and Radio and local radio stations. A number of public and private news papers publish articles on HIV/AIDS regularly.

There has been increasing political commitment and the society as a whole has been mobilized. Civil society, faith based organizations of all faiths and PLWHA associations have been actively engaged in anti-stigma campaigns, promoting openness and caring for the sick. Bi-lateral and multi-lateral organizations have significantly increased their technical and financial support with Global Fund, the United States President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank's Map Program being the major donors. These resources have facilitated large scale social mobilization and expansion of HIV/AIDS prevention, care, and support and treatment services.

The health sector response has been strengthened and is now undertaking rapid and mass scale-up of prevention, care and treatment services including counseling and testing (CT), PMTCT and ART. The number of centers providing CT, ART and PMTCT has grown to 658, 132 and 173 respectively. The number of people using these services has also increased over the years. In short, there have been notable efforts especially during the last two years, to build the capacity of the health system and health professionals to support scale-up of HIV services.

Other significant actions of the Government related to anti-retroviral treatment include the development of key technical tools such as the national guidelines on the use of ARV drugs, PMTCT, ARV procurement and distribution, VCT, management of opportunistic infections, and the adaptation of integrated management of adult and adolescent illnesses guidelines for Ethiopia etc. HAPCO has also developed the "Guideline on Community Supported Care for HIV/AIDS affected families and orphan children". The behavioral trends (2000 vs. 2005) from the DHS survey among the general population reveal high level of awareness and changes in behavior – decreases in the prevalence of premarital sex and multiple sexual partners, increases in condom use at last high risk sex and increase in the prevalence of those ever tested for HIV among males.

5.5 Responses to Children Affected by HIV/AIDS

Prevention of infections: According to the Sixth Report on AIDS in Ethiopia, unadjusted HIV prevalence shows that young people 15-24 and young adults 15-34 years of age are the most affected ones with highest prevalence of 11.9% in urban and 4.3% in rural; and 12.5% in urban and 3.9% in rural areas respectively. These age groups thus constitute the most affected group in the country. The same report also depicted the fact that the prevalence of syphilis is relatively more apparent among adolescents and young people with the rate of 3.8% which is quite high as compared to prevalence in the other age categories. In the same report, a higher number of females in the age group 15-19 were infected. Anonymous studies attribute high rates of HIV/AIDS among children and adolescents is evident and is caused by the prevalence of early marriage, risky sexual practices including multiple sexual partners, unprotected sex, exposure to commercial sex work due to high unemployment especially in urban settings. The 2005 DHS indicated that, among those 15-19 years of age, awareness of HIV/AIDS was

well over 90%. However, much less of this proportion believe that there is a way to avoid infection. According to the findings, comprehensive knowledge however is quite weak calling for more action.

Over the last several years continued efforts have been underway to capacitate children and adolescents with relevant information, skills and services that would help them to protect themselves from infections and support the prevention interventions at different levels. At the moment, adolescents are engaged in routine dialogue in most of the regions on HIV infection, factors that make them vulnerable, how to protect themselves etc. Furthermore, life skills and peer education initiatives for both in-and-out of school adolescents have greatly contributed to avert some of the potential infections.

In 2005, it was estimated that there were a total of 4,885,337 orphans aged 0-17 years, of which 744,100 were AIDS orphans. The estimated number of orphans in urban areas has been greater than that in rural areas up to 2003, however, beginning in 2004, the number of orphans in rural areas is expected to exceed that in urban areas. Children infected or affected by HIV/AIDS suffer from socio-economic and psychological problems in addition to the medical problems they face. Death of a parent results in emotional trauma, rejection, and stigmatization and remains with little or no support. As the social support system is weak, they drop out of school early, end up in streets, engage in anti-social activities, face exploitative situations (child labor) and abuse. Girls in particular engage in commercial sex work.

The prevailing inadequate basic social services affect orphan children and also put them at greater risk of getting infected themselves. Orphaned children do not have access to basic health services, educational opportunities and other services due to weak economic positions and evident widespread stigma and discrimination. Moreover, the existing services are not organized to respond to the particular needs of these groups.

5.6 Challenges

Despite the encouraging developments mentioned above, much still remains to be done. The urban epidemic is at an unacceptably high prevalence level of 10.5%, prevalence of behavioral indicators such as condom use are not at optimal levels, counseling and testing coverage is still low with only 5% of the general population 15-49 years of age being ever tested, ART has been accessed by only 13% of those who need ART; and only 0.8% of HIV infection among births to HIV positive mothers was averted in 2005/06 through PMTCT programs.

Although the overall HIV prevalence in Ethiopia is low, because of the large population, the absolute number of persons infected with and affected by HIV is significant universal provision of prevention, care and support to the estimated 1.32 million PLWHA (278,000 of whom requiring ART) and 744,100 AIDS orphans poses substantial challenges to the public health system of one of the poorest countries in the world. The HIV epidemic will continue to tax the limited available health and social service delivery system. Universal access will be a challenge by the fact that 50% of the PLWHA live in rural areas where access to communication and health care infrastructures is poor. Probable challenges for the implementation of the strategic plan (2004-2008) include:-

- Resource availability and absorption/utilization capacity;
- Addressing the growing service demand and sustainability;
- Lack of clarity on the prevention strategies and poor targeting
- Rapid expansion of the epidemic to the rural areas;
- Getting the right type of staff and training and retaining them e.g. the high turnover of staff trained in VCT and PMTCT.
- Other challenges include weak laboratory facilities at regional level, the underutilization of PMTCT

and ART services and lack of common understanding on the concept of social mobilization at different levels.

5.7 Key Areas for Future Action

Some key areas for future action include the following:-

- Prevention efforts must focus on high risk groups and regions with comparatively high prevalence and rural hot prevalence spots;
- Prevention efforts should also focus on interrupting urban to rural transmission and containing the rural epidemic at its current low levels through social mobilization;
- Increasing access to HIV- testing;
- Decentralizing HIV care and ART services to selected health centers;
- Strengthening private sector involvement in the provision of VCT, ART and PMTCT services;
- Empowering the woreda (district) Health Offices and the Health Extension Workers to take the leading role for kebele planning, implementation and evaluation of community mobilization, linking with VCT services, addressing adherence to ART, common side effects at community level.

6. CONCLUSION AND THE WAY FORWARD

Even though the right policies and strategies are in place, achievement of most of the Goals of the WFFC and the MDGs ultimately rests on how the economy behaves in the next decade. Without sustainable and accelerated growth, Ethiopia's goal of reaching the MDGs and more generally fostering human development cannot be achieved.

Three MDGs (MDGs 4, 5, & 6) specifically refer to health. Health plays a central role for the well-being and development of a nation and it plays an equally important role to reach other MDGs.

Under the PASDEP, Government will continue its emphasis on the HSDPIII goals and targets which are aligned with that of the MDGs. HSDP III has clear focus on poverty-related health conditions-communicable diseases such as HIV/AIDS, Tuberculosis, malaria, and diarrhea, and health problems that affect mothers and children. Main implementation modalities include the Health Service Extension Program; the Accelerated Expansion of Primary Health Care Coverage; a Health Care Financing Strategy; and the Health Sector Human Resource Development Plan. Reaching the health MDGs implies substantial expansion of key services and the implementation of mechanisms to increase demand for and use of those services.

Due to low level of social development, poor health status, inadequate geographical access, extreme shortage and high turnover of trained personnel and highly inadequate financial and material resources; achieving the health MDGs in 2015 especially reducing the maternal mortality ratio from 871 to 600 per 100,000 will not be an easy task. However, the way forward in terms of achieving a reduction of under-five and maternal mortality include actions such as:

- Information and social mobilization for behavior change,
- Expansion and consolidation of the Health Service Extension Program,
- Upgrading 1st level clinical services,
- Upgrading clinical services for Comprehensive Emergency Obstetric Care, and
- Expansion and upgrading of referral clinical care.

Other than the health MDGs, access to water and sanitation is essential to the health and nutritional goals as well as to education and female empowerment. Key challenges are in part institutional, the need to closely coordinate sanitation interventions under health with those considered in the Water and Sanitation Strategies. With respect to water, priorities for action in this sector include:

- Clarifying the institutional framework (roles and responsibilities of the main stakeholders),
- Increasing private sector support especially in smaller towns,
- Study design and building new water supply systems,
- Support infrastructural investments with complementary interventions.

With respect to sanitation the priority actions include:

- Provision of latrines at household level in both urban and rural areas,
- Hygiene education services,
- Expansion of sewerage systems in Addis Ababa and nine other towns,
- Development and strengthening of solid waste management system in urban areas.

Ethiopia has progressed a lot during the last decade in terms of provision of education. Comparing existing trends in enrollment rates, the country has great prospects of reaching the Goal of Universal Primary Education even before 2015. However, despite the three-fold increase in primary enrolments over the past decade, Ethiopia still faces serious and increasing challenges.

It may have to more than double its present enrolments to achieve primary education for all⁵². It will need to change its education cost structure, as continuation of the present pattern of educational expenditure is not viable in the long-term. At the same time Ethiopia will also have to improve the quality of education substantially. If the MDG education goals are to be achieved by 2015, then it is absolutely essential to pay special attention to how rural primary school provision can be improved in terms of both access and quality.

There have been significant improvements in the prevention and control of HIV/AIDS. Yet, there still remains lack of clarity on prevention strategies to be applied and targeting. Given the fact that infection is widespread in specific geographic settings and among specific groups of the population programmatic prevention approaches should have taken this into consideration. In addition, successes registered to date have faced critical limitations to scale. The main ones include low implementation capacity, including in the health service, as well as in communities and the NGO sector; a lack of focus on priority intervention areas and targeted sustainable programs; the low level of coverage of prevention, care and support programs such as VCT, ART and PMTCT; and dependency on external inputs combined with, at times, problems of coordination, duplication of effort and inappropriate use of resources. Under such circumstances, meeting the relevant HIV/AIDS related MDGs is a formidable challenge

The issue of OVC is an increasing area of concern. OVC programming has been fragmented among many actors. However, a number of initiatives are currently underway to improve the coverage and quality of services. It is assumed that some 20% of the total orphan population will require care and support services in the form of schooling, shelter, nutrition, counseling and clothing at any given time during the PASDEP period.

As mentioned earlier most of the right policies and strategies are already in place; and there are encouraging developments in terms of increased access to primary health care for the majority of the population, substantial increase in both the GER and NER, access to safe drinking water and sanitation, improved legislative framework for children etc. Under current Ethiopian health policies and the HSDP, the contribution of health services to the achievement of MDG targets could be substantial. By doubling the current public spending on health, health services could contribute to reducing child mortality and the life time risk of dying of mothers by about 40-45 percent. However, public spending on health services is very low. The national health expenditure has reached 4.5 billion birr (US\$522 million) in 2004/05 from its level of 2.9 billion birr (US\$356) in 1999/2000. During the same period, per capita health expenditure increased to US\$7.14 from US\$5.6.⁵⁶ This average annual growth of 10.6% is significant and encouraging. However, even if this rate of growth continues for the next 10 years, the per capita expenditure by 2015 will only be US\$19.44, which is much less than the US\$34 recommended by the World Health Organization's (WHO's) Commission for Macroeconomics and Health to deliver essential health services in developing countries.

In the case of the education sector, Ethiopia is investing 2.8% of its GDP into education (2001/02). Under the ten scenarios developed in the World Bank Education Policy Simulation Model, the cost of implementing Ethiopia's stated education policies could vary from 5 – 10.2 % of GDP. In fact a lower investment than 5% will make it impossible to achieve MDGs for education.⁵³ The findings of the review could be summarized as follows:

⁵² MDGs – Education Needs Assessment, 18th September, 2004

⁵⁶ Ethiopia- Third National Health Accounts, 2004/05

⁵³ World Bank, Education in Ethiopia: Strengthening the Foundation for Sustainable Progress, Human Development Department, Africa Region, World Bank, February 2004

- Right policies and strategies are in place e.g. PASDEP, developmental social welfare policy, sector development programs etc.
- Other important frameworks also developed e.g. NPA for children, OVC National POA, the Ethiopian Strategic Plan for Intensifying Multi-sectoral HIV/AIDS Response (2004-2008) etc.
- Potentially on track with respect to:-
 - Ensuring universal primary education
 - Reducing under-five mortality
 - Halve proportion of people without access to safe drinking water and sanitation.
 - More distant prospects due to depth of poverty and under development, are achieving:-
 - Gender equality
 - Reduction in MMR
 - Decrease proportion of people who suffer from hunger
 - Halting and reversing the spread of HIV/AIDS

Other than the required financial resources, there are formidable challenges to be overcome if the MDGs are to be met in full. However, it could be stated that in view of the achievements registered so far, with accelerated implementation of the PASDEP and its component sector programs, the undertaking of extensive capacity building by all pro-poor sectors and with substantial and sustained financial, and technical support from the international community; Ethiopia has a better chance to meet most of the MDGs by the target year of 2015.

BIBLIOGRAPHY

1. CSA, ORC Macro – Ethiopia: Demographic and Health Survey 2005, August 2006
2. CSA, MoLSA, ILO – Ethiopia: Child Labour Survey Report, May 2002
3. CSA, ORC Macro – Ethiopia: DHS 2000, May 2001
4. Defense for Child International- UN Convention on the Rights of the Child
5. Ethiopian Economic Association –Family Planning Services: An Important Front in the Battle against Poverty in Ethiopia, Addis Ababa, 2003
6. FDRE/MoWR- Universal Access Program for Water Supply and Sanitation Services (2006-2012), December 2006
7. FMoH – Health Sector Strategic Plan (HSDP –III) 2005/6- 2009/10, PPD, 2005
8. FMoH/PPD – Health and Health Related Indicators 1998 E.C. (2005/06 G.C)
9. FMoH – Accelerated Expansion of Primary Health Care Coverage in Ethiopia (2005 -2009), Addis Ababa, November 2004
10. FMoH – National Adolescent and Youth Reproductive Health Strategy, 2007- 2015
11. FMoH/HAPCO –AIDS in Ethiopia-Sixth Report, September 2006
12. FDRE/UNICEF – The Situation of Ethiopian Children and Women: A rights-based analysis, Addis Ababa, January 2002
13. FMoH/HSDP Secretariat –Report on the Proceedings and Result of the Eighth Annual Review Meeting of HSDP (October 2-6, 2006), November 2006
14. FMoH- National Reproductive Health Strategy (2006 – 2015), March 2006
15. FDRE/Ministry of Youth, Sports and Culture – National Youth Policy (In Amharic) Addis Ababa, March 3, 1996 E.C
16. FMoH/DPCD – Accelerating Access to HIV/AIDS Treatment in Ethiopia, Road Map for 2004-2006
17. FMoH/DPCD- AIDS in Ethiopia, Fifth Report, June 2004
18. FMoH/DPCD – AIDS in Ethiopia, Fifth Report, June 2004
19. FMoH/DPCD _ AIDS in Ethiopia, Fourth Edition, October 2002
20. FMoH- Technical Document for the Fifth Report, September 2004
21. FMoH/HAPCO _ Ethiopian Strategic Plan For Intensifying Multi-sectoral HIV/AIDS Response (2004-2008), December 2004
22. FDRE/UNICEF Program of Cooperation 2002-2006 – “Water and Environmental Sanitation Mid-Term Review”.
23. FMoH – Report of the Final Evaluation of HSDP II (2002/03 – 2004/05), Vol.1, 31 January to 6 March 2006
24. FDRE/MoLSA – Orphans and Vulnerable Children National Plan of Action (2004 – 2006)
25. FMoH/WHO-CO – Implementation of the 2000 – 2004 Integrated Disease Surveillance and Response Initiative in Ethiopia, Addis Ababa, March 2005
26. FDRE/UNICEF – Ethiopia: Country Programme Action Plan (2007-2011)
27. FHAPCO/MoH – National Guidelines on Prevention of Mother to Child Transmission of HIV, Final Draft, May 2007.
28. FMoH/ UNICEF - The Enhanced Outreach Strategy of Targeted Interventions and the Targeted Supplementary Food Programme, Final Draft
29. FMoH/HAPCO – Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia, Road Map 2007-2008/10, Version 6
30. FMoH/WHO – Synthesis of Recent and Relevant Reviews and Studies conducted in the Health Sector, Addis Ababa, May 2004
31. FMoh/WHO – Synthesis of Recent and Relevant Reviews and Studies conducted in the Health Sector, August, August 2005

32. Solomon Belete, Demese Chanyalew et.al – Synopsis of an assessment of the causes of malnutrition, A contribution to the formulation of a National Nutrition strategy for Ethiopia, July 2005
33. MoH, MoWR, MoE, & Ministry of Urban Development and Housing & EUWI and CRDA Water Working Group – Ethiopia Needs Assessment to Achieve Universal Access to Improved Hygiene and Sanitation by 2012, Final Draft, May 2007.
34. MoE – Education Statistics Annual Abstract, 1998 E.C (2005-06), Addis Ababa, February 2007
35. MoE – Education Sector Development Programme II, (2002/03 -2004/05), Program Action Plan (PAP), Addis Ababa, June 2002.
36. MoLSA – National Action Plan on Sexual Abuse and Exploitation of Children (2006-2010), Addis Ababa, December 2005
37. MoLSA – Ethiopia’s National Plan of Action for Children (1993-2010 and beyond), Addis Ababa, June 2004
38. MoFED – Ethiopia: Sustainable Development and Poverty Reduction Program (SDPRP), Addis Ababa, January 2005.
39. MoLSA – Child Labour in Ethiopia, Analysis of a Survey Conducted in 2001, Addis Ababa, March 1, 2000
40. National AIDS Council – Strategic Framework for the National Response to HIV/AIDS in Ethiopia (2001-2005), June 2001
41. OAU – African Charter on the Rights and Welfare of the Child, November 19, 1999
42. UNSSC- Goal Statements: A World Fit For Children
43. UNICEF/MoLSA – Violence Against Children in Ethiopia: Manifestations, the Legal and Policy framework and Challenges of Implementation, June 2005
44. UN – Population and Development, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September, 1994
45. UNAIDS – “Sex and Youth: Contextual factors affecting risk for HIV/AIDS”, May 1999
46. UNICEF/A.A Bureau of Social and Civil Authority and A.A BoFED – Baseline Survey of Children Living on the streets of Addis Ababa, April 2007, Draft
47. World Development Indicators 2002 – Millennium Goals
48. World Bank – Ethiopia: A Country Status Report on Health and Poverty, July 2005.
49. WAO/UNFPA Working Group on Gender – Gender Issues in MDGs Needs Assessment for Ethiopia, Addis Ababa, December 31, 2004